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Understanding the politics of Covid-19 in Kampala, Nairobi and Mogadishu: A political settlements approach

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Abstract

This paper analyses the politics of the response to the Covid-19 pandemic in three East African capital cities: Kampala, Nairobi and Mogadishu. It does so by describing measures to treat, prevent, and mitigate the impact of the pandemic, especially in low-income neighbourhoods, tracing these to dynamics among policy actors in what it calls the "Covid policy domain". It also situates the character of the response within each country's "political settlement", tentatively suggesting that the fingerprints of a "broad-dispersed" political settlement type can be observed in some of the similarities of response, even as the pandemic provided a stimulus to an increased concentration of power. Differences, meanwhile, might be explained by the differential role of the capital city in each of these political settlements: Kampala being perceived mainly as a threat to be contained, Nairobi as a political prize to be gained, while Mogadishu was a comparative sanctuary for the top political leadership, whose population should not be unduly antagonised.

Keywords: Covid-19, health, politics, political settlements, policy, pandemic response, informal settlements, Uganda, Kenya, Somalia, cities

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1. Introduction

This paper analyses the politics of the response to the Covid-19 pandemic in three East African capital cities: Kampala, Nairobi and Mogadishu. That pandemic responses are driven by political as well as epidemiological factors is by now well-established (Greer et al. 2021). To our knowledge, however, rather few studies to date have explicitly focused on the politics of Covid and the city. To some extent this is surprising, since not only are capital cities – with their high population densities and comparatively well-developed state machineries – key sites in the struggle against rising infections: they are also often arenas of fierce political struggle, playing an outsized role in deciding the fate of political leaders (Collord et al. 2021; Goodfellow and Jackman 2020; Mitlin 2020).

The research on which this paper is based set out to describe the Covid-19 response in Kampala, Nairobi and Mogadishu, distinguishing between interventions aimed at prevention, treatment, and impact mitigation. It did so via a combination of desk-based research, focus group discussions (FGDs) and key informant interviews (KIIs) in selected areas of the city, with a sampling bias towards low-income areas (see Table 1). It then sought to understand the nature of the response, including such things as its components, timing, effectiveness and the distribution of benefits and harms, in relation to two arenas or "domains" of power (cf. Hickey and Hossain 2019; Hickey and Sen 2022 forthcoming). The first is what we call the "Covid-19 policy domain", that is, an arena of individual and organisational contestation and debate about the nature of the policy response, oriented typically to the national level, but sometimes with special relevance for the capital city. The second is what we call the "political settlement": the basic understanding or agreement – however contested – among powerful groups about the rules of the political and economic game and the role of the capital city therein. As we shall see, some of the key actors had a foot in both the political settlement and Covid policy domains.

We should stress from the outset that the research teams in our cities, although loosely guided by a common research design, worked relatively independently.[1] The research was inductive, the aim being to produce findings that made sense for each city, rather than to test hypotheses by producing strictly comparable results. In the context of Covid-19, the research teams also encountered different types of logistical challenges completing the research, which again militated against strongly comparable findings. Despite this, our sifting of the data has revealed certain patterns which we believe are capable of being illuminated by political settlements analysis, and which we present as

[1] The key research questions were as follows: 1. What has been the Covid-19 policy response in terms of treatment, prevention and mitigation? Who has been targeted and how effectively? 2. What has been the politics of the "Covid-19 policy domain" (including who are the major players with respect to Covid-19 policy decisions that affect the city, what motivates them, and where does the balance of power lie)? 3. What is the politics of the city and how does this politics relate to the national-level political settlement and the Covid-19 response?

a tentative contribution to the emerging literature, (a) on the politics of pandemic response and (b) the growing field of political settlements theory – especially that branch concerned with analysing cities (Goodfellow and Jackman 2020; Kelsall et al. 2021).

Table 1: A summary of research methods in the three field sites

City	Main research methods
Mogadishu	Forty-five interviews were conducted in Mogadishu with key informants from six districts as well as a review of secondary sources. Key informants included representatives from civil society, the business community, community leaders, government and both humanitarian and development actors. Informants were asked about prevention, mitigation and treatment measures, including questions about access. Interviewees were also asked about Covid-19 policy development, challenges and successes. Information was triangulated with secondary data.
Kampala	The study drew essentially on three methods: (1) reviewing a series of documentary sources, including but not limited to academic literature, media sources and other grey literature; (2) Focus group discussions (FGDs) and key informant interviews with a range of key stakeholders across the city; and (3) a mini-survey of 100 respondents in Kampala's less advantaged communities. The key informant interviews were carried out with 37 policy actors, including members of the National Covid-19 Task Force, Kampala Capital City Authority technical personnel and politicians, division mayors and councillors and local (village) council leaders. Covid-19 policy responses in Uganda were predominantly covered by Uganda's mainstream print and electronic media outlets. The analysis of media coverage of key policy developments for managing Covid-19 complemented the key government documents that were published by the Ministry of Health, Kampala Capital City Authority, Uganda Media Centre and (Uganda) State House.
Nairobi	A mix of research methods – which involved desk review of official documents and secondary published sources (scientific, media) – as well as qualitative primary data collection through key informant interviews (n=30) with various stakeholders in the community (n=20) and in the policy domain (n=10). Key informants in the community interviews included different cadres of community health workers, sub-county health officials, civil society representatives and community leaders. Respondents in the policy domain included members of the National Task Force on Covid, Ministry of Health officials, representatives from the media, religious leaders, business leaders, social influencers and researchers. Purposive sampling was used to select key informant interviewees on the basis of their role in or knowledge of the Covid-19 interventions in the community and the policy domain with a sampling bias towards low-income areas in the city. Participants were asked about measures around prevention, treatment, mitigation and vaccination.

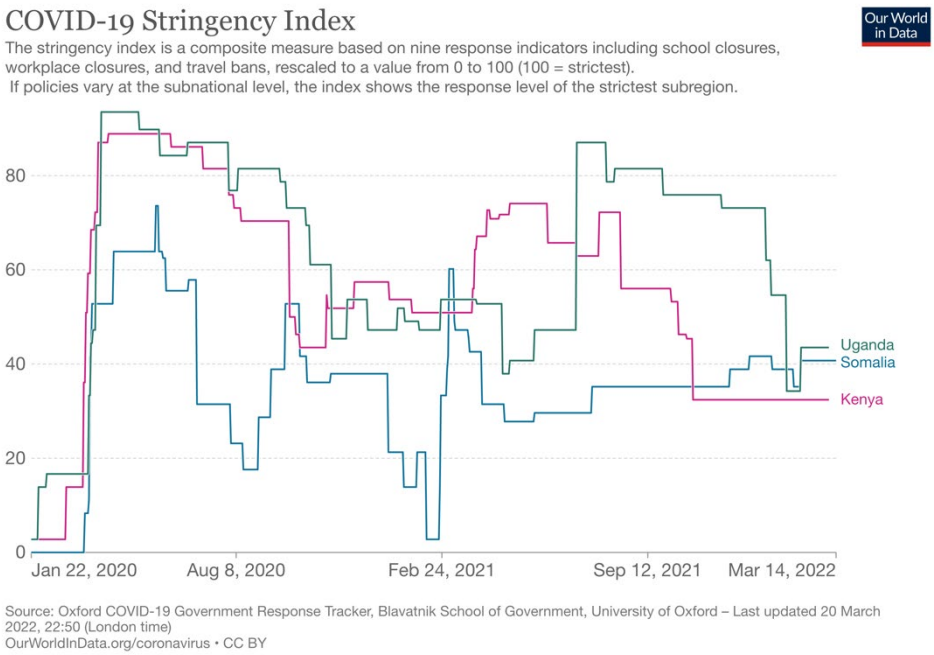
To summarise these findings, then, there was a considerable degree of similarity in the policy response to the pandemic across the three cities, at least in its early stages. The policy package included a panoply of measures designed to prevent transmission, including public information campaigns, hand-washing and masking, quarantining of

cases, contact tracing, closure of schools, workplaces and businesses, curfews, and, in some cases, full lockdowns; plus a range of measures designed to mitigate the economic impact of the pandemic and the policy response, such as tax reductions, food relief and cash transfers. On the clinical front, the purchase of more ventilators and medical oxygen allowed intensive care to be ramped up. Although, as we will explain, all our countries share a broadly similar political settlement "type", the fairly generic response across so many countries the world over, suggests that supranational drivers were dominant here. Indeed, at the level of global ideas, there has been a fairly high degree of international consensus around the pandemic response, manifested in the WHO's embrace of some of the policies first introduced by the Chinese authorities in Wuhan (Green 2021), though these were later adapted as more information became available.

These were not the only similarities. In all of our cities, the state arguably surpassed previous levels of commitment in terms of delivering a public policy response. The pandemic, then, may have represented, albeit briefly, the functional equivalent of a physical threat to regime survival, stimulating a concerted and unified elite response (for an argument about threats and elite cohesion, see Slater 2010). Also, in all of our cities, the negative impact of the pandemic response measures fell more heavily on low-income residents, who were sometimes exposed to brutal crackdowns. The policy response also became entangled in election dynamics, and there were reports of corruption everywhere – from procurement of supplies to enforcement of curfews.

Yet there were also differences: differences in the duration, stringency, compliance with and "effectiveness" of the measures, that deserve to be explained. According to the University of Oxford's Covid-19 Stringency Index (see Figure 1) – a composite measure based on nine response indicators, including school closures, workplace closures and travel bans – of the three countries, Uganda appears to have suffered the longest and most stringent prevention measures, followed by Kenya and then Somalia. This is also the impression we have gained from our qualitative research in Kampala, Nairobi and Mogadishu. Our data also suggest that the Ugandan authorities did rather less to mitigate the impact of these measures on the urban population than their counterparts in Kenya. In Mogadishu, meanwhile, social distancing measures were never as stringent, were relaxed more quickly, and their collateral impacts were mitigated largely by the enhanced international community response.

Figure1: Covid-19 Stringency Index for Uganda, Kenya, Somalia



These differences can be explained by a variety of phenomena, including extant levels of state capacity, prior experience of fighting serious infectious diseases, and the weight of health specialists versus other stakeholders in the Covid-19 policy domain. Another factor which we suggest was important was the role of the capital city in the national political settlement. To wit, in Uganda, the balance of power in President Museveni's ruling coalition leans towards rural areas. Kampala is a hotbed of opposition support and is seen as an area not so much to be courted as contained (Muwanga et al. 2020). In Kenya, by contrast, Nairobi may have the ability to swing a general election when margins are very tight, as they seem to be.[2] This means Nairobi's approximately 2.5 million voters[3] will be strongly courted; indeed, there is evidence of rigorous campaigning in the capital focused on basic needs and employment, since the majority is poor and badly impacted by Covid-19.[4] While this may have encouraged an emphasis on trying to respond to the needs of the city's populous low-income inhabitants, the failures in the Covid-19 response will also be blamed on the incumbent. Mogadishu presents another kind of case for two reasons. First, the government there is elected not by the mass of the population but by a rather narrow electoral college made up of Somali clan elders. Second, the state's writ barely runs outside of Mogadishu, the security of which must be maintained to prevent the

[2] Although there are large uncertainties, one useful analysis of how close the election is likely to be is Hornsby (2022). The 2017 election, riddled with irregularities, formally had Kenyatta with 1,400, 557 more votes than Odinga and margins could be even tighter.
[3] Nairobi had 2,250,853 in the last election, according to the IEBC (www.iebc.or.ke/registration/?stats, accessed 26 April 2022). It is currently leading in the number of newly registered voters, so this number is likely to climb much higher. Note that uneven voter registration can also be a tactic.
[4] See Kipling (2022).

government from being overthrown by Al-Shabaab's Islamist insurgency. This may also have inclined the regime not to risk too much pushback from society, in a context where its hold on power is decidedly fragile, opting for less stringent control measures instead.

2. Describing the pandemic response in Kampala, Nairobi and Mogadishu

All three of our cities are located in Eastern Africa, Nairobi being the largest of the three, with an estimated population of 4.34 million in 2019. Kampala has an estimated 1.75 million inhabitants, while estimates for the population of Mogadishu range from 1.7 to 2.9 million. Each of the cities houses a disproportionate share of the country's formal sector businesses and employers, although in each the informal economy is also very large, much of the population lives in informal settlements, and public infrastructure and government services leave much to be desired (Earle 2021; Ernstson and Mukwaya 2021; Sverdlik 2021). Problems are most acute in Mogadishu, where, challenged by a virulent extremist insurgency, there is a large population of internally displaced persons (IDPs), the government is extremely fragile, and would likely not survive without the presence of an international peacekeeping force. Politically, each city is also the official seat of the national government. Sub-nationally, Nairobi is governed by an elected City County, though some of its functions have recently been transferred to the non-elected Nairobi Metropolitan Services. Kampala is governed by the Kampala Capital City Authority, a non-elected body, while Mogadishu is governed by the Benadir Regional Administration whose leader is also the Mayor of Mogadishu, appointed by the President (Earle 2021; Ernstson and Mukwaya 2021; Sverdlik 2021).

All three of our cities experienced their first confirmed cases of Covid-19 in March 2020, carried by travellers returning home via international airports. In the cases of Nairobi and Mogadishu, this triggered a policy response that was already weeks or months in the making. In Kampala, by contrast, the authorities had already introduced a number of restrictions on travel and social mixing (ACRC 2022; Bukenya et al. 2022; Klopp et al. 2022).

2.1. Treatment

In all three cities, treatment options were limited, and largely determined by pre-existing health sector capabilities, which are somewhat stronger in Uganda and Kenya than in Somalia. Prior to the pandemic, Somalia's entire annual government health budget was only $9.4 million, increasing to $33 million during the pandemic (Amnesty International 2021). As the initial wave hit, formal healthcare providers reported being overwhelmed. In the words of one, there was, "a lot of confusion and gaps in the health facilities. Essential materials like oxygen cylinders and ventilators weren't enough". While another explained, "When the pandemic hit, it affected everyone and it was clear that

the government did not have adequate resources".[5] Health workers faced multiple challenges, including insufficient or appropriate training, an initial lack of sufficient personal protective equipment (PPE), prolonged working hours and, in many cases, poor and/or delayed remuneration (Amnesty International 2021). It was not until mid-April that the first oxygen-concentrators arrived at De Martini, the city's main treatment hospital, with capacity subsequently increasing in a piecemeal way, both there and at other locations in the city. In October 2021, a milestone was reached when Mogadishu's first oxygen plant was opened, financed by the Hormuud Salaam Foundation.[6]

In Kampala, the situation was better but not by much. For serious cases, treatment centred at three main hospitals: Mulago National Specialised Hospital, Naguru China Uganda Hospital and Entebbe Grade B Hospital, as instructed by the Ministry of Health (MoH). Mulago is a tertiary health facility with only 36 adult intensive care unit (ICU) beds; Entebbe Regional Referral Hospital is some distance from Kampala, with only four ICU beds. Official policy at the beginning of the pandemic was that "all Covid-19 positive cases would be managed in isolation units at Covid-19-designated health facilities including Mulago NRH, Entebbe hospital, all RRH, designated private facilities, and selected district hospitals and HCIVs" (MoH 2020).

While the country aimed to contain the outbreak and isolate cases within hospital settings, thresholds were set to triage cases according to need. Both clinical condition and facility isolation capacity would determine whether a suspect case would be admitted to an isolation unit within a health facility, admitted to a designated isolation unit outside a health facility, or advised to self-isolate at home (MoH 2020). At these facilities, patients were offered medicines such as azithromycin, hydroxychloroquine, Panadol, vitamin C and Zinc tablets. As the number of cases rose, hospital settings were overwhelmed and available bed capacity was critically inadequate; posing a challenge for health care givers. There were also many reports of patients falling back on private facilities, which were often ill-equipped to cope or too expensive to afford (Kyeyune 2021). In October 2020, the MoH adopted home-based isolation and care as official policy (MoH 2020); especially for asymptomatic patients, those with mild disease and those who were not at risk of developing severe disease. In addition, containment of the spread of the Covid-19 pandemic was faced with challenges in executing critical prevention and control activities, such as isolation of confirmed cases in designated facilities, surveillance, contact tracing, testing and quarantine (AFENET 2021). The government also converted Mandela National Stadium in neighbouring Wakiso District into an auxiliary hospital, Namboole Covid-19 Treatment Unit (CTU), to particularly support asymptomatic and mild Covid-19 patients who did not have access to home-based care and treatment.

In Nairobi, the situation was somewhat better, with several national referral public and private hospitals taking on treatment for serious cases. Treatment was centred on two

[5] Interviews with health workers, Mogadishu, 2021.
[6] See Sheikh (2021).

main public hospitals: Kenyatta National Hospital and Kenyatta University Teaching and Referral Hospital; and three main private hospitals: Nairobi Hospital, Aga Khan University Hospital and Mater Hospital. Kenyatta National Hospital has the highest bed capacity, with 55 ICU and high dependency unit (HDU) beds, followed by Kenyatta university Hospital with 44 ICU and HDU beds. In the private sector, Aga Khan University has the highest number, with 27 ICU and HDU beds, followed by Nairobi Hospital with 13 ICU beds. Less serious cases were managed at Mbagathi Hospital, a county hospital that is just a few metres away from Kenyatta National Hospital. Mbagathi Hospital – a 300-bed capacity County Hospital facility – was a major isolation and treatment facility for Covid in Kenya. ICU bed capacity in all county hospitals was ramped up but many could only provide supplemental oxygen and medication, with limited capacity for high-flow nasal cannula oxygen or mechanical ventilation.[7]

As the number of cases rose, several public county and private hospitals in the city set aside spaces dedicated to handling Covid-19 cases. But as the number continued to grow, these facilities became insufficient, and there are many reports of patients failing to get beds, isolation rooms, oxygen and ventilators, and with manifest shortcomings in the prehospital emergency care system, including ambulatory services (Wachira and Mwai 2021). To help deal with this crisis, the MoH introduced home-based care as an official policy. Patients with mild cases were given antibiotics (amoxicillin and azithromycin), antipyretics for fever (paracetamols), vitamin C, and zinc tablets. Overall, as in other places Covid-19 exposed some of the weaknesses in the healthcare system in Nairobi and Kenya more generally, including low national expenditures on health, leading to inadequate ICU facilities, and poor insurance coverage, which can inhibit people from seeking timely treatment (41% of people in Nairobi have coverage, much higher than in most parts of the country) (Mohiddin and Temmerman 2020).[8]

2.2. Prevention

With treatment options limited in all three cities, a large emphasis was placed on prevention. In Mogadishu, the government, led by the MoH, implemented measures calling for face masks, handwashing, and social distancing. This was supported by an enhanced public information campaign through community leaders, religious leaders at the local level, and coordination with private companies such as Dahabshiil Bank and Hormuud Telecom, which used voice dialback technology to spread awareness. Schools, madrasas, markets and workplaces were closed, and a curfew was introduced. In some cases, this led to clashes with the authorities, and in late April 2020 there was a public outcry after two people were killed by police. In response, the

[7] Kenya Health Federation (KHF). See www.khf.co.ke/covid-19-treatment-centers/ (accessed 26 April 2022).

[8] Interestingly, the national government classified all county-level government workers as civil servants, qualifying these individuals for the National Hospital Insurance Fund (NHIF) and ensuring they were in place to address the pandemic. See McDade et al. (2020).

curfew was shortened and lockdown measures informally eased, followed by an official relaxation in July, after the first wave had peaked (ACRC 2022).

In Kenya, after the first Covid-19 case was detected in March 2020, the government launched nationwide media campaigns to inform citizens about proper handwashing techniques (Wangari et al. 2021). In Nairobi, residents received information about Covid-19 through multiple channels, including mass media, online platforms and traditional health education talks by healthcare workers as well as community health workers.[9] Hand and respiratory hygiene were promoted, and all public places were mandated to have hand washing facilities, hand sanitisers and infrared thermometers for fever screening (though this could only be enforced in formal and well-established premises). Manufacturing of facial masks was ramped up, while export of the same was banned. The government also made efforts to identify and isolate positive cases. It became a requirement for all international arrivals to show negative test results and additional targeted testing among healthcare workers, hoteliers and long-distance truck drivers was recommended (Klopp et al. 2022).

In terms of social distancing, the government instituted several measures, including school closures, and guidelines on the size of funerals, weddings and other social events. Certain categories of businesses, such as bars, restaurants as well as places of worship, were closed. Guidance on distances between persons in public places was offered and public transport vehicle carrying capacity was reduced to minimise risk of contagion (Klopp et al. 2022).

As the pandemic expanded, especially in early 2021, central government and the county governments of Kilifi, Mandera and Nairobi imposed restrictions on inward- and outward-bound travel. The greater Nairobi metropolitan area (Nairobi city, Kiambu and Machakos) closed off all movement into and out of the area. Curfews between 7pm and 5am were instituted across the country for some time. Needless to say, in practice, social distancing faced tremendous challenges in some parts of Nairobi, due to living and work conditions among low-income communities, which are often quite crowded, and cultural factors such as the high levels of expected social behaviour. Mobility restrictions may also have prevented timely treatment and healthcare access for other medical problems, in addition to reduced capacity at the health facilities themselves and fear of contracting SARS-CoV-2 from health facilities (Klopp et al. 2022).

In Kampala, measures included contact tracing, isolation and quarantine, and lockdowns. The government closed all international entry points but later instituted mandatory Covid-19 screening and testing, enforced institutional quarantine for all international visitors, and instituted a surveillance team of health workers to track down

[9] In an interesting study, Kiptinness and Okoye (2021) analysed media coverage in Kenya's *Daily Nation* compared to Tanzania's *Citizen* and found that "the *Daily Nation* newspaper in Kenya mainly employed the social frame and depicted the Covid-19 pandemic as a national crisis. On the other hand, *The Citizen* newspaper in Tanzania employed predominantly basic frames and portrayed the challenge as a global problem", with the *Daily Nation* providing more coverage and presumably more information to citizens as well drawing in part on government data and briefings.

returnees from abroad. Upon identification of positive cases, contact tracing and identification of community hotspots was conducted, coupled with a 14-day mandatory quarantine. The country also adopted active case finding, double ring contact tracing, isolation, and institutional quarantine (Lumu 2020). Lockdown measures included travel bans and other restrictions on movement; closing schools; closure of many markets or reduction in the items they could sell; augmented health measures in factories; and an enhanced level of vigilance and surveillance, including hand washing and use of temperature guns in various city venues. There was increased attention to disinfecting facilities, limiting the number of visitors, recording all personal details for persons visiting, and the use of PPE. A curfew was introduced, with pubs, bars and other entertainment venues effectively shut down. The stringency of the response was highest between the end of March and the beginning of May, with no significant loosening until September 2020. Even then, significant restrictions remained, including the world's longest school shutdown (Bukenya et al. 2022).

Globally, a key weapon in the fight against Covid-19 has been vaccination, and the inequality in vaccine distribution is a key problem and vulnerability in the ability to fight the pandemic. On 15 March 2021, the first batch of 300,000 doses of the AstraZeneca vaccine arrived through the COVAX programme in Mogadishu, to be distributed to frontline workers, with local vaccination sites established in the city, days later.[10] Then, in April, 200,000 doses of the Sinopharm vaccine arrived. The arrival of the vaccines coincided with the pause in the distribution of the AstraZeneca vaccine in Europe[11] and uptake was affected by fears of blood-clotting. As demand remained low, the vaccine rollout strategy shifted from offering it first to medical workers and those with underlying conditions, to offering it to everyone aged 18 and older.[12] By August, supply constraints had eased, with the donation of more vaccines by the US and France.

In Kampala, vaccinations also began to be offered from March 2021. The main objective of the National Deployment Vaccination Plan (NDVP) was to vaccinate up to 49.6% of the population in a phased manner (each phase covering 20% of the population), targeting individuals of 18 years and above (OCHA 2021a). The country has relied heavily on donated vaccine types, including AstraZeneca, Pfizer and Moderna, raising several accountability questions in regard to billions of shillings budgeted for their procurement. The first phase of vaccination targeted health workers, security personnel and other frontline workers. Other categories of people were considered for vaccination during the second wave. By September 2021, Uganda had administered at least 2,058,553 doses of Covid vaccines, about 4.37% of the total population (under the assumption that every person receives the two needed doses).[13]

[10] www.reliefweb.int/report/somalia/covid-19-vaccines-arrival-and-rollout-somalia-300000-doses-oxford-astrazeneca-vaccine (accessed 25 April 2022).
[11] https://hub.jhu.edu/2021/03/26/fallout-of-pausing-astrazeneca-vaccine/#:~:text=Was%20halting%20the%20use%20of,problematic%20if%20transmission%20was%20low.
[12] High-level remote interview.
[13] www./covidvax.live/location/uga (accessed 25 April 2022).

Similarly, in March 2021, Nairobi's vaccination programme started to roll out after Kenya received 1.12 million doses of the Oxford-AstraZeneca Covid-19 vaccine on 3 March 2021 as part of the COVAX Facility, an initial allocation to Kenya of 3.56 million doses. With no internal manufacturing capabilities, different vaccines would continue to trickle in, depending on foreign support. Prioritised populations for round one vaccination included frontline workers, including health workers, teachers, police and military, as the priority groups, which were targeted during round one of the inoculations, and later those aged 58 years were also included.[14] In September 2021, the government expanded the eligibility criteria for vaccination to include persons over 18 years of age, with medical conditions or disabilities and, currently, has expanded eligibility (including booster shots) to all adults and is giving the Pfizer vaccine to those aged 15 and above. Initially, the rollout was slow, with poor public information, and some glitches raising suspicions that wealthier and connected people were able to access the vaccines more easily than others and many others not wishing to take the vaccine in any case (Ombuor and Bearak 2021). Nairobi faced significant vaccine hesitancy, especially in low-income neighbourhoods, stemming from distrust and misinformation, which provoked fears around its safety and also some apathy linked to poor availability, long lines and information problems, especially in low-income neighbourhoods.[15] To combat hesitancy, in November 2021, the minister for health declared that anyone seeking in-person government services would need to be fully vaccinated and have proof of vaccination by 21 December 2021; after that, vaccinations increased and maintained a steady rate of increase (Mukami 2021). As of March 2022, according to the MoH, Nairobi City County has 46.7% of the population fully vaccinated, the second most vaccinated county in the country after Nyeri.

2.3. Hardship and mitigation

Lockdown measures caused significant economic hardship, especially for lower-income segments of the population. In Mogadishu, many residents depend on remittances from abroad, but lockdown policies, including restrictions on global travel, led them to slow at the beginning of the pandemic (World Bank 2020), while supply chain problems caused prices of essential commodities to rise (Carver and Kruber 2020; Hassan 2020). The greatest hardship was said to be felt in the city's internally displaced people (IDP) camps, where the population is most vulnerable. In recognition of this, the government introduced tax exemptions on food imports and other commodities. Yet, for some, the measures were insufficient. In the words of one IDP,

[14] "Kenya completes its first round of COVID-19 vaccinations" 12 May 2021. www.gavi.org/vaccineswork/kenya-completes-its-first-round-covid-19-vaccinations (accessed 25 April 2022).

[15] See Jerving and Ibrahim (2021). One study found that the overall level of Covid-19 vaccine hesitancy in Kenya self-reported via phone interviews is high (36.5%) but slightly lower in Nairobi at 29% and there is a correlation between those who do not follow Covid restrictions and hesitancy, which may suggest a link to lack of trust in the government. Orangi et al. (2021).

> "The government announced a tax relief for some goods. I don't think it was effective, it was not properly implemented, and the food prices increased, no matter this measure."[16]

In Nairobi, preventative measures also created severe hardships, especially in low-income areas of the city. Participants in community interviews reported that measures such as lockdowns and curfews, and closure of schools, restaurants and entertainment venues, threatened the livelihoods of these populations, most of whom earn a daily wage.

> "Most of the businesses closed. Casual workers were stopped from going to work. So, they stayed at home with no source of income."[17]

While schooling for better-off households moved online, this was not a viable option for most children in low-income areas of the city. As schools remained closed and low-income families in slums struggled to survive, young girls who grappled with the threat of poverty and pregnancy faced the possibility of child marriage.

> "… children were not going to school and that is when they got pregnant."[18]

Many girls risked never returning to school again, as families turned to child marriage or child labour to ease their economic burdens (Pinchoff et al 2021). There are also reports of people missing essential health services, in general, and reproductive healthcare services, in particular, such as ante-natal care visits and deliveries because of movement restrictions, night-time curfews, cumbersome public transport and closure of some health facilities' outpatient services (Ahmed et al. 2020).

In Kampala, there were similar effects. Hunger was reported, and there were many tales of families selling their daughters into prostitution or early marriage to fund basic living expenses.[19] Several unconfirmed reports showed that an increasing number of teenage girls were being drawn into sex work to help their families make ends meet and buy everyday goods including food and sanitary pads (Hayden, 2020). A FAWE (2021) report on *School Going Girls and Young Women in Uganda* reported that between March 2020 and June 2021, there was a 22.5% increase in pregnancy among girls aged 10-24 seeking first antenatal care, from 80,653 to 98,810. There was also an increase of child labour[20] from 21% to 36%, affecting girls in particular (Datzberger et al. 2022). The longer these teenagers stayed out of school, the worse the situation became. This was most reported in informal settlements, where limited access to food sources for over three months of the lockdown presented unprecedented challenges for household members (AFRICHILD 2021). The UNICEF-supported child tollfree line, Sauti 116, reported over 600 cases in the month of June 2020 alone, with cases

[16] Interview, Mogadishu, 17 August 2021.
[17] Interview with NGO, Mathare, 31 January 2022
[18] Interview with community health coordinator, Kibra, 26 January 2022.
[19] FGDs, Kampala, 2021.
[20] See *Uganda National Household Survey 2019/20*. Available at www.ubos.org/wp-content/uploads/publications/06_2021UNHS2019-20_presentation.pdf (accessed 26 April 2022).

ranging from sexual abuse, physical abuse and even one instance of murder. In addition, approximately two out of every ten children had less than a meal a day, as they no longer had access to the meals provided under the school feeding programmes Safieldin (2021).

Cramped living conditions often made it impossible to stay indoors, leaving residents vulnerable to intimidation, extortion or brutality by the authorities. Some communities reported an increase in drug abuse, amid fears that students will have dropped out of school permanently. In some areas there was also a disruption to basic services. Dysfunctional water systems were slow to be repaired, waste went uncollected, and sanitation facilities became overfilled. Routine health services were also negatively affected.[21] For example, the restrictions disrupted access to, and delivery of, routine child, maternal and HIV/AIDS services (Tumwesigye et al. 2021). More positively, the handwashing, sanitisation and face masking reportedly had a positive impact in the form of improved household hygiene.[22]

To varying degrees, the authorities attempted to mitigate the impact of the pandemic and protect livelihoods. In Mogadishu, existing social protection and safety net programmes were scaled up. April 2020 also saw the launch of the Covid-19 Country Preparedness and Response Plan, supported by US$256m in humanitarian aid. Existing programmes run by humanitarian organisations were also scaled to provide relief. This included scaling the World Bank-funded Shock-Responsive Safety Net for Human Capital Project (SNHCP) (WFP 2021). Originally funded for $65 million, in June 2021, the programme would receive an additional $110 million from the World Bank to,

> "continue the delivery of critically needed cash transfers […] to chronically poor and vulnerable households disproportionately impacted by the recent multiple shocks of the Coronavirus Disease 2019 (Covid-19) pandemic, locust outbreak and floods, among others" (World Bank 2021).

In addition, community organisations, including in the IDP camps, sometimes responded with their own contributions and self-help measures.[23]

For much of the population in Kampala, Uganda's existing social protection mechanisms were of little help, since they do not cover informal sector workers. Instead, the government rolled out a food distribution programme. In April 2020, the government allocated about US$17 million towards food distribution targeting 1.5 million vulnerable persons in the Greater Kampala Metropolitan Area. Each member of the approximately 683,000 households was apportioned six kilograms of maize flour and three kilograms of beans (Owori 2020). Special consideration was to be given to female-headed households, elderly, sick, and pregnant women, who were supposed to receive additional nutritious foods, such as powdered milk, sugar and salt. However, the foods supplied to vulnerable populations, especially the maize flour and dry beans,

[21] FGDs and interviews, Kampala, 2021.
[22] Interviews, Kampala, 2021.
[23] KII – youth leader, Mogadishu, 27 July 2021.

were reported to be often substandard and not fit for human consumption (Musisi 2021) and over 100 metric tonnes were recalled and returned to government stores (OAG 2021). Multiple civil society organisations (CSOs) reached out to the most vulnerable communities to enhance their protection against the crisis and its impacts. Churches and schools partnered with Kampala Capital City Authority (KCCA) and development partners to house the homeless, especially street children, coupled with the provision of beddings, food and other essential items (CHILDFUND et al. 2020).

On 25 April 2020, Nairobi's population benefited from the Tax Law (Amendment) Act, 2020 which included a number of key measures to reduce the economic impact of COVID. This included a reduction of personal income tax rate from 30% to 25%, complete tax relief for individuals earning less than 24,000 shillings (approximately US$224), a reduction in the resident corporate income tax rate from 30% to 25%, a reduction of the turnover tax rate for small and medium-sized enterprises from 3% to 1%; and non-immediate reduction in the value added tax (VAT) to cushion businesses and individuals from Covid-19-induced shocks. The government also announced an economic stimulus programme amounting to Ksh 53.7 billion to help businesses stay afloat. The Central Bank of Kenya stepped in to stop unregulated mobile money lenders from listing defaulters with the Credit Reference Bureau (CRB), which would have made future borrowing, especially for the very low-income households, difficult. Local manufacturing of protective gear was promoted, while export of the same was banned, as well as importation of used clothes and other personal items. For much of the population living in informal settlements, however, Kenya's tax mechanisms were of little help in mitigating the adverse impacts of Covid-19, since the measures were temporary, and most are informal sector workers anyway.[24]

The government and its development partners tried to respond to informal workers through revitalising and expanding access to social safety programmes, such as the Covid-19 cash transfer programme and a public works programme called Kazi Mtaani (Neighbourhood Work).

> "There were people who were getting 1,000/= shillings weekly, and there were people who were getting 2,000/= per month, which was Covid-19 cash transfer, which brought an impact since most people had lost their jobs."[25]

The Kenyan government and other local and international partners, such as Red Cross, World Food programme, Shining Hope for Communities (SHOFCO), and Plan International, also implemented food aid programmes at both national and county levels to support citizens struggling to obtain essential food items due to stringent Covid-19 prevention measures.

> "There was food from the government. Red Cross was sponsoring people by giving them food and money through Mpesa. World Food Programme and the government

[24] Interview with public health officer, Kibra, 27 January 2022.
[25] Interview with a community health volunteer, Mathare, 27 January 2022.

> were also giving people money. Everybody's name was written. If you were lucky, you would get."[26]

Yet early attempts at direct food aid provision encountered major challenges, including stampedes at distribution points that caused injuries and fatalities, accusations of favouritism and misappropriation of foodstuffs, and a lack of social distancing while waiting in line to receive food rations. Serious problems also emerged in terms of implementation of the Covid-19 cash programme, with Human Rights Watch estimating that it only reached less than 5% of the socio-economically vulnerable families in Nairobi and was characterised by nepotism and corruption (Human Rights Watch 2021). Finally, the high levels of police brutality, including extrajudicial killings of mostly low-income young men accused of violating Covid-19 restrictions, led to great anger and protests (Human Rights Watch 2020).

In the next section, we describe the arena in which decisions over responses were made.

3. The Covid-19 policy domain

We define the "Covid-19 policy domain" as an arena of debate and contestation over the nature of the policy response to the pandemic, populated by a variety of actors, including but not limited to health experts, politicians, and international actors, some of whom also have significant weight in the country's political settlement (see below). In many, especially high- income countries, there have been intense debates among scientists, politicians and the public about how stringent preventative measures should be and for how long they should last.[27] Although a few countries, such as Sweden, opted against compulsory society-wide lockdowns others, such as Korea, managed to avoid them thanks to sophisticated contact tracing systems, while others, such as the US, took a patchwork approach, most countries have imposed them at some point or other during the pandemic (Jarman 2021). In this, they have followed the lead of the WHO, which began to recommend such measures in the wake of the Chinese authorities' apparently successful response to the pandemic in Wuhan (Green 2021: 177-181), though they later distanced themselves somewhat from the Chinese approach. For the most part, these policies were adopted irrespective of their practicality in the circumstances, or the collateral damage they might cause. Uganda and Kenya appear to follow this pattern, with their responses peaking at 93.52 and 88.89 on the Oxford Stringency Index, respectively, compared to the UK's peak of 87.96. Somalia, by contrast, had a rather more relaxed approach, peaking at 73.61, and this only momentarily (Hale et al. 2021).

[26] Interview with a community health volunteer, Kibra, 26 January 2022.
[27] See, for example, Dominic Cummings' testimony before the UK House of Commons Health and Social Care Committee and Science and Technology Committee, Weds 26 May 2021. Available at www.parliamentlive.tv/Event/Index/d919fbc9-72ca-42de-9b44-c0bf53a7360b (accessed 25 April 2022).

What, then, dictated these policy responses? In Uganda, the picture appears rather similar to the one in already well-documented cases such as the UK. The government repurposed its existing pandemic response machinery, creating a national taskforce (NTF) to respond to Covid-19. The NTF was chaired by the prime minister and comprised political and technical leaders from the most influential government entities including security, finance, transport, trade and health. Other institutions with representation included civil society and the parliamentary political parties, while Kampala was represented by KCCA and the Private Sector Foundation (most of whose members hail from the capital).

Beneath this taskforce were various other organs, including a scientific advisory committee (SAC), comprised mainly of eminent scientists from Makerere University. The committee members reportedly scoured scientific evidence, some of it international, in order to advise the government, and played a leading role in the development of the different guidelines and standard operating procedures (SOPs) that the government used to guide its response in different sectors. In some countries, notably the UK, there have been intense debates about whether to protect "lives or livelihoods" in responding to the pandemic. Our evidence suggests that the SAC erred on the side of the former. To SAC, the decision was reduced to a simple question: what would kill people faster, poverty or Covid-19? As one respondent put it:

> "…no country doesn't want to care about its citizens… but you have to take tough decisions because you comprehend the extent of danger that the people face if nothing [or little] is done … if it is war time, you can have one meal a day and survive [but] if you catch Covid-19 you die."[28]

Although the advice provided by SAC was filtered through other layers of the policy domain, including politicians and bureaucrats, who also fielded advice from civil society groups and private sector lobbyists of various sorts, including casino operators and international schools, this perspective potentially explains the extreme stringency of Uganda's response, at least in part (Bukenya et al. 2022). Over time, however, the SAC came to be challenged by another organ, the National Planning Authority (NPA), which developed its own model. The NPA questioned whether the "small health benefit" coming out of saving some lives justified the economic cost arising from locking down. According to NPA, the impact of the prolonged lockdown of the education sector, for example, is immense.

> "By January [2022] … we are going to have 7 million children in Primary one, 7 million! That means we need to have three times the usual number of inputs. Three times the number of teachers, three times the classes, three times the logistics …, and that will go on for at least 15 years, [until that cohort graduates]. So, does the country have those resources that we need to recover? … What does that speak about the future?"[29]

While SAC insisted that the best option was to open up when a significant proportion of vulnerable people had been vaccinated, the NPA argued that it was better to open up

[28] Interview with male SAC member, November 2021.
[29] KII, details withheld.

once the curve started to go down. Although Uganda's approach continued to be comparatively stringent, the NPA does seem to have contributed to a more balanced approach (Bukenya et al. 2022).

Following the outbreak of the Covid-19 pandemic, the Kenyan government immediately responded with a strategy and structure to address the inevitable arrival of the virus. Before the first case in March 2020, the MOH issued the National 2019 Novel Coronavirus Contingency (Readiness and Early Response) Plan February-April 2020, and on 28 February 2020 the President issued an executive order establishing the inter-governmental National Emergency Response Committee (NERC) on Coronavirus, chaired by the Health Cabinet Secretary for Health and consisting of 21 high-level government members from relevant ministries and state entities like the Kenya Airports Authority, Kenya Medical Services and Immigration. The Committee was tasked with coordinating the country's Covid-19 preparedness, prevention, and response.[30]

The National Covid-19 Task Force, meanwhile, was tasked with leading implementation of the contingency plan. The Task Force comprised the Ministry of Health, other government agencies, United Nations agencies, development partners, NGOs and CSOs. It supported the country's response through sub-committees to implement its functions, which included: resource mobilisation; public health emergency operations; media, communications call centre; case management and capacity building for health workers; laboratories for sample handling and testing; facility preparedness, human resources for health and mental health and psychological support.[31] Decisions on whether to tighten or relax Covid-19 measures were informed largely by data on the pandemic, specifically by the increment or reduction of cases and positivity rates characterised by different waves:

> "The measures I would say changed with the number of cases, we can classify them in three waves, it was just the number of cases and the type of variant we were having at different times that was informing the changes."[32]

Coordination between the national level and county level was also necessary, given the important role that counties play in Kenya's devolved system of government: in fact, counties have primary responsibility for delivering healthcare services. The Council of Governors represented the 47 counties on NERC, "ensuring their voices are elevated to the national level, the diverse range of counties' concerns are addressed, and there

[30] Specifically, the tasks were: 1. Coordinate Kenya's preparedness and response to Covid-19. 2. Coordinate building capacity of medical personnel and other professionals. 3. Enhance surveillance at all points of entry. 4. Coordinate the preparation of national, county and private isolation and treatment facilities. 5. Coordinate the supply of testing kits, critical medical supplies, and equipment. 6. Conduct economic impact assessment and developing mitigation strategies. 7. Coordinate technical, financial and human resources efforts with development partners and key local stakeholders. 8. Formulate, enforce, and review processes and requirements that regulate entry of people travelling from Covid-19-affected countries.

[31] ThinkWell Strategic Purchasing for Primary Health Care. 2020. "Covid-19 summary update for Kenya". Washington, DC: ThinkWell.

[32] Interview with a researcher at a research organisation, Nairobi, 3 April 2022.

is ownership and buy-in of NERC directives."[33] However, despite this important role, some in the national government still tend to see the role of counties as just implementing:

> "Issues of policy generally not just for Covid are done at national level and so all counties, Nairobi included, implement policies developed by their national government and national government develops policies informed by global guidance. So, policy issues are developed at national level and decisions are also made at that level and all counties just implement them."[34]

At the local level, the counties also have county response committees, revised budgets and developed local recovery strategies; county-level data was also collected to be able to compare statistics across the country. Nairobi county had in fact shown itself ahead of the national government on community health structures, having passed the Nairobi City County Community Health Services Act 2019. Championed by an elected Member of the County Assembly (MCA), Pius Mbono, this Act compels the county to recognise community health volunteers (CHVs) as county workers, and as such provide them with a stipend and medical cover as well as train and certify them. Further, it sets up democratically elected community committees and requires the county to allocate funding as part of its budget for the support of CHVs (Nairobi City County 2019). While the Act was passed in 2019, the first KSh 308 million allocation to support 6,250 CHVs occurred during the pandemic (Omulo 2021). The national government, prompted by the importance of community health volunteers during Covid-19, finalised the Community Health Bill to present to parliament as a framework for community health in all counties.

In Somalia, the initial response effort was coordinated by a National Covid-19 Task Force led by the Ministry of Health, which developed the National Contingency Plan for Preparedness and Response to the Coronavirus Diseases 2019, with support from the WHO.[35] The Task Force included the Prime Minister's Offices, all state ministries, the WHO, UN agencies and health experts. The MoH, with international actors, also convened the Incident Management System Team (IMST), a structure that was replicated in the federal member states that make up Somalia and also within Mogadishu.[36] The IMST mirrored the structure of the WHO, allowing for easy sharing of information about situation reports, contact tracing, and the activities of different partners and the private sector, among other things.[37] However, in April 2020, near the beginning of the pandemic, the MoH director of finance was removed, following corruption revelations, and the response effort came under the closer control of Prime Minister Khaire (Somali Dispatch 2020). The PM's office had the power to convene

[33] The National Coordination of Pandemic Responses Collaborative, *Coordinating the National Pandemic Response in Kenya – Kenya Case Study*. Available at www.acceleratehss.org/wp-content/uploads/2022/03/Covid-Collaborative-Kenya-Case-Study.pdf (accessed 26 April 2022).
[34] Interview with Ministry of Health official 17 March 2022.
[35] High-level remote interview, 27 October 2021.
[36] High-level remote interview, 27 October 2021.
[37] High-level remote interview, 27 October 2021; and OCHA (2021b).

actors across government ministries, coordinate with the UN, call in outside expertise, and cut through red tape to speed approval processes.[38] Informants noted that in the early days within the PM's Covid Taskforce there were non-stop decision-making meetings. The best description we have of the process is the following:

> " …. we presented issues to the PM, what are we going to do, points of entry, the lockdown that was happening, what about schools and markets, all these decisions were made in these forums. There was a subcommittee of partners, and we were part of it as technical advisors. We were also submitting our responses and issues to international NGOs and partners. There was no parallel coordination, we were submitting our issues to the PM's office and the decision was coming from there. And up to June, as Covid was not only a disease, it was affecting the economy, the social sector as a whole, and the response was quite effective. There were also subcommittees with private partners. Some of the responses come from the diaspora and from the private sector."[39]

Respondents also noted the Covid-19 response became a "whole of government" effort during this period. The Ministry for Disaster Preparedness worked with UNHCR, EFP and other humanitarian actors to deploy PPE. The Ministry of Information created a platform for information dissemination, the Ministry of Planning assisted with developing comprehensive plans[40] and, lastly, the Ministry of Religious Affairs assisted with outreach to religious leaders. The information campaign in Mogadishu also received strong support from the Benadir Regional Administration. While policy was developed at the national level, the local authorities played an important role in implementation. Although we have no direct evidence to support this, it seems plausible that coordination was made easier by the fact that the leader of the Benadir Regional Administration is also the mayor of Mogadishu, a presidential appointee, who also appoints district commissioners. At the community level, district commissioners were essential for mobilising community leaders to spread awareness and prevention messages. Key informants spoke of the relationship between the Benadir Regional Administration, Ministry of Health and Federal Government of Somalia as being positive (ACRC 2022).

The international community also played a pivotal role. Key actors included the WHO, UNICEF and WFP. These groups drew upon their existing organisational mandates and adapted where possible. At times they provided supporting, parallel or independent decision-making processes. The agencies divided work based on technical areas of expertise and organised regular meetings to strengthen coordination. These started as weekly, then phased down to bi-weekly and then bimonthly.[41] In addition, humanitarian cluster meetings served as an important forum for UN agencies and humanitarian actors to share information and, where possible, coordinate activities.

[38] High-level remote interview, 2 November 2021
[39] High-level remote interview, 27 October 2021.
[40] High-level remote interview, 27 October 2021
[41] High-level remote interview, 22 October 2021; high-level remote interview, 10 November 2021.

We do not have much direct evidence of the debates surrounding the policy package in Somalia. However, we do know that while the response initially followed international best practice norms – unsurprising, given the pivotal role of the international community in Somalia – these were rapidly relaxed following popular protests. Although the reasons for doing so were not made explicit, the government seems to have defaulted to the option of protecting livelihoods over lives.

As discussed below, there is also some indication that the policy response lost focus in the second and third waves, due to electoral politics. On 25 July, Prime Minister Khaire, who was coordinating the response, received a vote of no confidence from parliament and later resigned. According to Crisis Group, Khaire disagreed with the President on the election process, preferring that elections happen sooner rather than later, and many saw his dismissal as the President's attempt to regain control over the electoral process (International Crisis Group 2020). As election uncertainty continued, the government's attention was pulled away from the pandemic. As one high-level informant noted,

> "The first wave, the coordination was awesome. With the leadership of the PM by himself, and the ministries, and also the UN. The coordination went well because of the fear of Covid, so we responded accordingly. The plans were effective, reporting mechanisms, and evaluations were in place. The second and third wave did not give too much attention to the pandemic, we missed that role of leadership and coordination, coming together …. even though cases were higher than the first wave."[42]

In the words of one community leader,

> "The reason why the government did not put in place all the measures, was because the government was more focused on the election and people seemed uncontrollable."[43]

Moreover, the government was accused by the opposition and some observers of using the pandemic as a pretext to ban opposition protests. However, aside from diluting high-level attention to Covid-19, it had limited impact on how the response was unfolding.

Prevention and mitigation efforts were inflected by election dynamics in our other cases also. In Kampala, Covid-19, which arrived in Uganda some ten months ahead of the January 2021 general election, appears to have been interpreted by President Museveni as both a threat and an opportunity. In the run-up to the election, the security forces arrested journalists and opposition party leaders and dispersed or blocked opposition campaign rallies with tear gas and live bullets for allegedly flouting Covid-19 guidelines, with at least 19 people killed in November 2020 (Burke and Okiror 2020). Despite attracting similarly large crowds, security forces allowed rallies and processions for the ruling National Resistance Movement (NRM) party to continue uninterrupted (Human Right Watch 2020). Museveni's main challenger, Kyagulanyi

[42] Remote interview, Mogadishu, 27 October 2021.
[43] Key informant interview, Mogadishu, 3 August 2021.

Ssentamu (aka Bobi Wine), was brutally arrested, and charged, ostensibly for contravening Covid-19 prevention regulations. Towards the climax of the campaigns, the Electoral Commission, working on the advice of the Health Ministry, stopped campaigns in the populous central Ugandan districts with claims that Covid-19 infections there were fast rising. Critics interpreted this as a deliberate move to block campaign rallies in opposition strongholds, while giving the incumbent advantage (Lucima 2021). Meanwhile, Museveni used his prerogative as the sitting president to launch government projects in the restricted districts, just as his opponents were locked out.

In Nairobi, the introduction of social support for low-income neighbourhoods, often with foreign assistance, fitted very well into Kenyatta's "generative' strategy for Nairobi".[44] Prior to Covid-19, Kenya had been gradually expanding its social protections through new programmes as part of Kenya's Vision 2030 (Republic of Kenya 2017) but the pandemic and the need to mitigate negative impacts of public health restrictions on the vulnerable provided an opportunity to access resources and to highlight and roll out high profile programmes before the elections slated for 9 August 2022. At the same time, while urging residents to follow the rules and having the police enforce them, often brutally,[45] many politicians were unwilling to follow these same restrictions against gatherings, frequently violating them to campaign.

As in many countries – including the UK – where the Covid response has been associated with lax procurement procedures, corruption also featured. In Mogadishu, the MoH director of finance was removed in April 2020, following corruption revelations. Moreover, police sometimes used violation of lockdown measures as a pretext for extortion. In Kampala, family members of the President were said to be handling the Covid-19 procurement deals, including for hotels and hostels to be used as quarantine centres. Lower down the chain, the foods supplied to vulnerable populations were reported to be often substandard or outdated. Moreover, there were reports that nutritious food items, such as milk and rice, that were supposed to be given to the elderly and lactating mothers were often sold by the people that were distributing them, thereby allowing government supporters to profit from the pandemic (Bukenya et al. 2022).

In Kenya, the Kenya Medical Supply Authority (KEMSA) became engulfed in scandal over procurement fraud linked to the provision of critical Covid-19 medical supplies, including PPE and other essential items. Kenyans spoke of "Covid millionaires", many being made in "Mafia House", a play on "Afya (Health) House", where the MoH is located. In addition to generating popular anger, this form of corruption hindered the effectiveness of the social programmes designed to support the poor and therefore worked in contradiction to the governing coalition's regenerative strategy. The KEMSA

[44] Goodfellow and Jackman (2020) describe as "generative", constructive policies designed to win legitimacy and support.
[45] Approximately 144 people may have been killed by police "enforcing Covid-19 restrictions", according to a source at Missing Voices, an effort to document all police killings in Kenya (personal communication via Zoom, March 2022).

board was disbanded by the President, Uhuru Kenyatta, and the Ethics and Anti-Corruption Commission have urged prosecution of individuals involved (Igunza 2020).

4. Political settlement dynamics

We have seen, then, that the Covid-19 policy response in our three cities was shaped by debates within the scientific community about the correct balance of approaches, as well as by political and economic considerations, such as pressure from lobby groups or outbursts of protest.[46] In this section, we see whether a political settlement framing can shed any further light on the nature of the response, or whether the response can tell us anything about the political settlement in these three countries.

Political settlements analysis (PSA) has become increasingly commonplace in academic and policy-making circles in recent years (Khan 2010; Kelsall et al. 2022; Levy 2014; Parks and Cole 2010; Booth et al 2014) with a few forays into the field of health (Kelsall and Heng 2014; Kelsall et al. 2016; Kelsall 2020; Kitson 2019). The idea of a political settlement has been defined in various ways, but we will adopt the Effective States and Inclusive Development Research Centre's (ESID) definition, namely that a political settlement is *an agreement or understanding among powerful groups about the basic rules of the political and economic game that, by providing opportunities to those groups to secure a minimally acceptable level of benefits, prevents all-out warfare* (Kelsall et al. 2022).

In Uganda, for example, the president is chosen by means of a popular election every five years, in which the playing field is tilted heavily in favour of incumbent, Yoweri Museveni, in power for the last 36 years. While in office, he has used the state to create money-making opportunities for his inner circle, while rewarding lower-ranking supporters, especially from his large rural support base in the South and West of the country, with a mixture of patronage and, in some cases, popular policies. Opponents have also sometimes been courted in this way. However, those who look capable of mounting a serious challenge to him – whether politicians seeking election through conventional means or violent insurgents – have often been brutally suppressed. The polity is settled as much as the country's most powerful groups understand the rules and agree to them, at least insofar as they have not taken up arms to try to force change.

In Kenya, the president is also chosen by means of a popular vote every five years. Although they do tend to be quite close-run affairs, as in Uganda, elections tend to be tilted in favour of the incumbent – with thuggery, assassinations, manipulation of the vote and all manner of dirty tricks commonplace. Again, sitting presidents have used the state to enrich themselves and their inner circles, while placating ordinary voters with a mix of patronage, service delivery and policy. Unlike in Uganda, however, the Constitution dictates that presidents may serve no more than two terms in office, which guarantees a degree of turnover in who holds power – the patronage opportunities

[46] See Bukenya et al. (2022) for more detail in the case of Uganda.

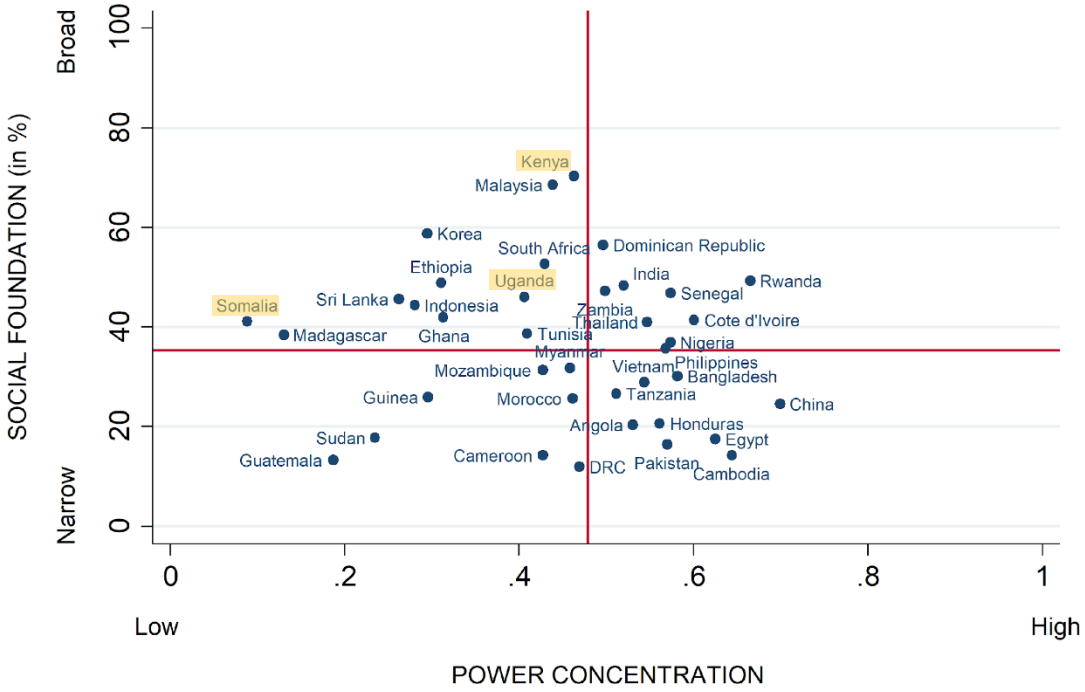
associated with this being captured locally by the expression, “It’s our turn to eat” (Wrong 2009; Branch 2011). This encourages the formation of new ethnic coalitions, with relations among the Kikuyu, Luo and Kalenjin ethnic groupings historically very important here. The 2010 Constitution also devolved significant amounts of power to elected county governments, which has meant that those locked out of national power may nevertheless have a chance to compete as well as to “eat” locally (D’arcy and Cornell 2016), taking some of the heat out of the presidential contest. Even though Kenya teeters quite frequently on the brink of serious violence, the country’s most powerful groups seem happy or at least resigned to playing this game, even if they are challenged periodically by the courts, civil society and violent protests.

Somalia is the least settled of our countries, having been at war for much of the past 30 years. More recently, the threat to established elites from insurgent group Al-Shabaab has stimulated a degree of cooperation amongst its erstwhile warring clans, institutionalised under the country’s 4.5 formula (Menkhaus 2018). Here, the government is elected by a college of clan notables, with close to 90% of parliamentary seats and government positions – including leadership of the five federal states – distributed among the country’s four “major” clans, with the remainder going to the country’s minority clans. As in Kenya and Uganda, governing elites have used the power of the state to enrich or reward themselves, while they have often been dependent on the international community to try and build the institutional capacity to deliver services, or in some areas to act as a surrogate for the state. Although this system has attracted a minimal level of buy-in from powerful groups, the nature and timing of elections, together with the constitutional status of Mogadishu, remain contested, while the entire secular basis of government is challenged by Al-Shabaab.

ESID has created a typological theory to help explain differences in elite commitment and state capacity for inclusive development. To do so, it pays attention to two key dimensions of the settlement. The first is the breadth and depth of the social foundation, which represents that proportion of the population that (a) has the power to make a significant difference in political struggles around the settlement, and (b) the ruling coalition tries to co-opt. The second is the configuration of power, in other words the degree to which power is concentrated in the top leadership, in the sense that the leader feels able to prevail over opponents, either inside or outside the ruling coalition, whether by constitutional or extra-constitutional means (Kelsall and vom Hau 2020; Kelsall et al. 2022).

As of 2018, the closest date we have to the onset of the pandemic, the ESID political settlements expert survey coded all three of our countries in the upper-left quadrant of its typology (see Figure 2), that is, as “broad-dispersed” (Schulz and Kelsall 2021c).

Figure 2: ESID political settlement types in 42 countries in 2018



Expanding on the ESID framework, Kelsall et al. (2022) posit that elites in broad-dispersed settlements will be motivated by the presence of powerful groups in society to try and distribute development benefits broadly, but will lack the elite cohesion or state capacity to do so in a particularly effective way. Government action is likely to be diluted by political infighting, factionalism, the need to make side payments to spoilers, and a generally short-term orientation to policymaking. In such circumstances, effective public goods provision, such as it exists, is likely to come either from multi-stakeholder coalitions or pockets of effectiveness in the administration, sometimes working in combination (Kelsall et al. 2022).[47]

We do see elements of these putative relationships in our cases. For example, none of our governments sat back and did nothing. All tried to prevent Covid-19 from spreading and all also took at least some measures to mitigate the economic impact of these measures. In this, they were often assisted by multiple stakeholders, including international donors and civil society groups, and all also created special task forces within the administration to try and address the problem. At the same time, there were reports of corruption in all our cases, and a short-term perspective was evident as election pressures began to inflect the response.

More surprising, perhaps, is the degree to which all our countries – regardless of whether they made wise policy choices – were able to marshal state power in a fairly concerted and effective way. Both Kenya and Uganda, for example, were able to

[47] Broadly similar points are made by Mushtaq Khan (2010) in his discussion of "competitive clientelist" settlements and by Brian Levy (2014) in his "personalised competitive" settlements.

exercise a degree of social control over their populations, which one would normally associate with more concentrated power configurations. Even in Somalia, the first wave of the pandemic witnessed an unusual degree of government coordination and effectiveness. How should we interpret this?

One response would be simply to say that political settlements theory is not a very good guide to state capacity in a pandemic situation. We can certainly agree that to some extent the Covid-19 global pandemic represented an exceptional moment that confounded normal political settlement dynamics and some of the predictions emanating therefrom. And yet there may still be a way of interpreting the facts that is consistent with political settlements theory, and which can help to illuminate the deeper dynamics involved. To wit, in many countries, the fear-inducing effects of the pandemic seem to have both enhanced cooperation among domestic elites – much as though they were facing the combination of an internal and external enemy (cf Doner et al. 2005; Slater 2010, Downing 1992; Ertman 1997) – and rendered populations quiescent.[48] The combination of enhanced elite unity or strength plus an increasingly compliant population signals a shifting of the settlement towards the concentrated end of the spectrum, enhancing what it would be possible for the state to achieve in the process. In other words, the pandemic impacted political settlement type just as much as political settlement type impacted the pandemic.

In Somalia, this effect appears to have been temporary, since the settlement's fissiparous tendencies reasserted themselves as election pressures mounted. In Uganda, the effect may be more enduring, since the pandemic provided a pretext for an increased militarisation of state organs, while in Kenya, the pandemic coincided with the elevation of the non-elected Nairobi Metropolitan Services, whose mandate has since been extended, even if its long-term future is unclear.[49] Thus, one of the puzzling features of our findings – the better-than-expected state response – has a potential explanation.

But there is another aspect of the story that existing political settlements theory does not do justice to. With the important exception of Goodfellow and Jackman's work, political settlements theory to date has been focused at a national level: it has not regarded the city as a special object of concern. Yet, as we noted in the introduction to this paper, cities, especially capital cities, play an outsize role in determining the fate of political leaders and so have a special place in political settlements. Crucial here would seem to be the magnitude or weight of the city in this regard, and its valence – that is,

[48] The pandemic may also have acted, at least temporarily, as the kind of threat to elites and stimulus to public goods provision that infectious diseases such as cholera did in European cities in the 19th century (Rosen 1993).

[49] At time of writing, the NMS mandate had been extended for another six months – see www.capitalfm.co.ke/news/2022/03/nairobi-metropolitan-services-term-extended-by-6-more-months/ (accessed 26 April 2022) – with its longer-term future seemingly embroiled in electoral coalitional politics, see www.capitalfm.co.ke/news/2020/11/bbi-seeks-to-restore-nairobi-county-status-once-nms-term-ends/ (accessed 26 April 2022).

the extent to which it is politically aligned with the country's leader and his or her ruling coalition.

Kampala, for example, has long been a thorn in the side of President Museveni, being a hotbed of political opposition that he has tried to contain via a combination of repressive and "generative" strategies (Muwanga et al. 2020). This reality seems also to have conditioned the pandemic response. Kampala was locked down more stringently than Nairobi and Mogadishu, the pandemic response organised through a highly militarised body. Here, the Uganda National Security Council set up an Inter-Agency Joint Task Force (JTF) to support the MoH at the national and regional levels, led by the then UPDF Deputy Chief of Defence Force (now Chief of Defence Forces), Lt General Wilson Mbasu Mbadi (Masaba 2020). Among other duties, the JTF monitored and ensured compliance with the Presidential Directives and the MoH. Indeed, the entire Covid-19 emergency response mechanism was placed under the superintendence of the military while sidelining and subordinating the civilian health system leadership to the periphery (Nkuubi 2020).

In Kampala City, the JTF was operationalised at the non-elected KCCA and supported by presidentially appointed resident city commissioners, most of whom were military personnel, whether retired, reservists or in active duty (Kamoga, 2019; Nkuubi, 2020). The JTF, including the local defence units (LDUs), were deployed to enforce lockdown measures, including but not limited to issuance of movement permits, enforcing movement restrictions and curfews along critical road intersections, and stopping social gatherings at the urban and neighbourhood scale, including spaces that would attract crowds and the "invisible" night economy. As we saw in an earlier section, the pandemic was also used as a pretext for intimidating opponents and suppressing the opposition.

A plausible interpretation of the pandemic response in Kampala, then, is that the city was vigorously locked down in order to prevent the virus spreading to rural areas, the heartland of the regime. The collateral damage of lockdown policies meanwhile was focused on low-income urban residents, most of whom lay outside Museveni's support base. To prevent open revolt, there was a virtual military occupation of informal settlements, while the same agencies supplied food relief to further secure compliance. The Ugandan authorities seem to have been relatively successful in limiting Covid transmission, recording fewer Covid deaths and fewer estimated excess deaths than our other countries, though whether the benefits justify the cost is open to debate.[50]

Nairobi, by contrast, has typically been split between supporters of President Uhuru Kenyatta, an ethnic Kikuyu, and his long-time rival, Raila Odinga, a Luo. Since 2018's "handshake", the two leaders have been campaigning on the same side, with the likely result that Odinga will capture a large share of the vote in Nairobi's presidential

[50] Briefly, Uganda recorded 78 confirmed deaths and 1,504 excess deaths; Somalia 85 confirmed deaths and 1,763 excess deaths, and Kenya 104 confirmed deaths and 1,919 excess deaths, per million population. Source (paywall): https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates.

election, to be held later this year. Nevertheless, to defeat his main competitor, Kalenjin leader William Ruto, it will still be important to get Nairobi's vote out in large numbers. And although the policy response in Nairobi was far from perfect, with significant reports of corruption, rent-seeking and, in some cases, police brutality and extortion, there also seems to have been a genuine attempt to strike a balance between limiting the spread of the disease and mitigating its economic impacts in a way that would be electorally popular, at least among the middle class. The low-income population, however, have disproportionately suffered from the often brutal implementation of Covid-19 measures as well as evictions that impacted livelihoods, and many blame the incumbent. Trying to capitalise on this class dimension, always present in Nairobi but deepened by Covid-19, William Ruto has tried to frame his campaign as "hustlers" vs "dynasties", an attempt, perhaps, to transcend the historically powerful ethno-regional basis of Kenyan politics in favour of a more populist approach. Interestingly, one of the key vehicles the national government has used in Nairobi has been the Nairobi Metropolitan Services, an interim non-elected entity, which has assumed some of the functions of the elected but dysfunctional city county government. Led by a military man, Major Mohamed Badi, and accountable to the president, this takeover of elected government functions by a military led institution is deeply concerning. Nevertheless, the county government continues to function and also contributed to the response, implicitly making a case for the continued relevance of local democracy, not least by providing a budget to pay and support popular community health volunteers, as required by a 2019 county law expanding their role (Klopp et al 2022).

Mogadishu is different again. The writ of the president barely runs beyond the city, which is a comparatively rich source of rents through which to sustain his tenuous rule (Ingiriis 2020). Already threatened by Al-Shabaab, and with the support of many clan leaders and politicians contingent at best, the ruling coalition can ill afford an uprising from Mogadishu's population. This perhaps explains on the one hand the genuine, if rather rudimentary, attempts to control the pandemic in the first wave, followed by the swift relaxation of preventive measures once there was pushback from society. Not long after, the imperatives of political survival appeared to trump the threat of the pandemic, which subsequently received little in the way of high-level political attention. The response, however, continued to be administered with some success by a multistakeholder coalition, including the MoH, international donors, the Benadir Regional Administration, and private business (ACRC 2022).

5. Conclusions

To conclude, the policy response to the Covid-19 pandemic was broadly similar across our three cities, albeit with some significant differences in the stringency of control measures and the seriousness with which the government attempted to mitigate the pandemic's impacts. There were also reports of corruption around the provision of relief, and of electoral dynamics skewing the nature of the response, across all three cities. At the level of implementation, we have explained the similarities by reference to each of the three countries sharing a roughly similar "broad-dispersed" political

settlement type, in which elite incentives to distribute public goods broadly and effectively tend to be undermined by political short-termism and/or a lack of elite cohesion. At the same time, the pandemic did seem to induce an increased level of elite cohesion and a better-than-may-have-been expected governmental response in all of our cases, at least temporarily. Yet it also gave rise to disgruntlement against incumbents, given the disproportional impacts of both Covid-19 and the measures to address it on the low-income population.

Whether going forward this will feed into any challenge to the existing settlement or whether these measures lead to more concentrated power configurations – with their attendant advantages and disadvantages – remains to be seen. Significant differences in the response, meanwhile, might be explained by the differential weight of health scientists in what we have called the Covid-19 policy domain, together with the different place of the capital cities in their respective political settlements. We tentatively suggest that Kampala was perceived mainly as a threat to be contained, Nairobi as a political prize to be gained, while Mogadishu was a comparatively safe haven for the top political leadership, whose population should not be unduly antagonised.

References

ACRC (2022). "The politics of Covid-19 in Mogadishu". Mimeo. Manchester: African Cities Research Consortium, The University of Manchester.

AFENET (2021). "Supporting the Covid-19 response in Uganda through implementation of the home-based care strategy". African Field Epidemiology Network (AFENET), 10 February. Available online (accessed 25 April 2022).

AFRICHILD (2021). "The effect of Covid-19 on the wellbeing of children in Uganda". The AfriChild Center of Excellence for the Study of the African Child, Makerere University. Kampala, Uganda: AFRICHILD.

Ahmed, SAKS, Ajisola, M, Azeem, K, et al. (2020). "Impact of the societal response to Covid-19 on access to healthcare for non-Covid-19 health issues in slum communities of Bangladesh, Kenya, Nigeria and Pakistan: Results of pre- Covid and Covid-19 lockdown stakeholder engagements". *BMJ Global Health* 5(8).

Amnesty International (2021). *"We Just Watched Covid Patients Die": Covid-19 Exposed Somalia's Weak Healthcare System but Debt Relief Can Transform It*. Report, 18 August. London: Amnesty International.

Booth, D, Cooksey, B, Golooba-Mutebi, F and Kanyinga, K (2014). *East African Prospects: An Update on the Political Economy of Kenya, Rwanda, Tanzania and Uganda*. Report. London: ODI.

Branch, D (2011). *Kenya: Between Hope and Despair, 1963–2011,* New Haven, CT and London: Yale University Press.

Bukenya, B, Mukwaya, P and Oyana, T (2022 forthcoming.) "The politics of Covid-19 in Kampala". ACRC Research Brief. Manchester: African Cities Research Consortium, The University of Manchester.

Burke, J and Okiror, S (2020). "Bobi Wine protests: Death toll rises in Uganda's worst unrest in years". *The Guardian*, 18 November. Available online (accessed 25 April 2022).

Carver, S and Kruber, S (2020, May 15). "To act, or not? Al Shabaab's response to a Covid-19 crisis in Somalia". *The Interpreter*. Available online (accessed 25 April 2022)

ChildFUND, Plan International, Save the Children, SOS Children's Villages, Terre des Hommes International Federation, and World Vision (2020). "Keeping children safe in Uganda's Covid-19 response. Joining forces – Protecting children during Covid-19 in Uganda". Available online (accessed 25 April 2022).

Collord, M, Goodfellow, T and Asante, LA (2021). "Uneven development, politics and governance in urban Africa: An analytical literature review". ACRC Working Paper 2021-02. Manchester: African Cities Research Consortium, The University of Manchester.

D'Arcy, M and Cornell, A (2016). "Devolution and corruption in Kenya: Everyone's turn to eat?'". *African Affairs* 115(459): 246-273.

Datzberger, S, Bhatia, A, Parkes, J and Devries, K (2022). “Uganda closed schools for two years – the impact is deep and uneven”. *The Conversation*, 14 February.

Doner, RF, Ritchie, BK and Slater, D (2005). "Systemic vulnerability and the origins of developmental states: Northeast and Southeast Asia in comparative perspective". *International Organization* 59(2): 327-361.

Downing, B (1992). *The Military Revolution and Political Change: Origins of Democracy and Autocracy in Early Modern Europe*. Princeton, NJ: Princeton University Press.

Earle, L (2021). “Mogadishu: City scoping study”. Manchester: African Cities Research Consortium, The University of Manchester.

Ernstson, H and Mukwaya, P (2021). “Kampala: City scoping study”. Manchester: African Cities Research Consortium, The University of Manchester.

Ertman, T (1997). *Birth of the Leviathan: Building State and Regimes in Medieval and Early Modern Europe.* Princeton, NJ: Princeton University Press.

FAWE (2021). *Research Findings on the Situation of, and Impact of Covid-19 on School Going Girls and Young Women in Uganda*. Kampala Uganda: Forum for Uganda Women Educationalists (FAWE). Available online (accessed 25 April 2022).

Goodfellow, T and Jackman, D (2020). “Control the capital: Cities and political dominance”. ESID Working Paper 135. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester.

Green, T (2021). *The Covid Consensus. The New Politics of Global Inequality*. London: Hurst.

Greer, SL, King, EJ, Massard da Fonseca, E and Peralta-Santos, E (eds) (2021). *Coronavirus Politics: The Comparative Politics and Policy of Covid-19*. Ann Arbor, MI: University of Michigan Press.

Hale, T, Angrist, N, Goldszmidt, R, Kira, B, Petherick, A, Phillips, T, Webster, S, Cameron-Blake, E, Hallas, L, Majumdar, S and Tatlow, H (2021). “A global panel database of pandemic policies (Oxford Covid-19 Government Response Tracker)”. *Nature Human Behaviour* 5: 529-538.

Hassan, M (2020). “Police killings spark protests in Somali capital”. *VOA*, 25 April. Available online (accessed 25 April 2022).

Hayden, S (2020). “Child labour increasing in lockdown Uganda while schools are closed”. *The Irish Times*, 9 July. Available online (accessed 25 April 2022).

Hickey, S and Hossain, N (eds) (2019). *The Politics of Education in Developing Countries: From Schooling to Learning*. Oxford: Oxford University Press.

Hickey, S and Sen, K (2022 forthcoming). *Pathways to Development: From Politics to Power*. Oxford: Oxford University Press.

Hornsby, C (2022). "Predicting winners and losers in the August 2022 poll: The numbers game". *The Elephant*, 28 March. Available online (accessed 25 April 2022).

Human Rights Watch (2020). "Kenya: Police brutality during Covid-19: Several dead, others with life-threatening injuries". April 2022. Available online (accessed 25 April 2022).

Human Rights Watch (2021*). "We Are All Vulnerable Here" Kenya's Pandemic Cash Transfer Program Riddled With Irregularities*. Report. Available online (accessed 25 April 2022).

Igunza, E (2020). "Coronavirus corruption in Kenya: Officials and businesspeople targeted". *BBC News*, September 2020. Available online (accessed 25 April 2022.)

Ingiriis, MH (2020). "Profiting from the failed state of Somalia: The violent political marketplace and insecurity in contemporary Mogadishu". *Journal of Contemporary African Studies* 38(3): 437-458.

Jarman, H (2021). "State responses to the Covid-19 pandemic: Governance, surveillance, coercion and social policy". In SL Greer, EJ King, E Massard da Fonseca and A Peralta-Santos (eds), *Coronavirus Politics: The Comparative Politics and Policy of Covid-19*. Ann Arbor, MI: University of Michigan Press, pp. 51-66.

Jerving, S and Ibrahim, A (2021). "Is conflicting information driving Covid-19 vaccine hesitancy in Nairobi?" *Devex News*, 21 October. Available online (accessed 25 April 2022).

Kamoga, J (2019). "More military men don police uniform as Uganda polls loom". *The East African*. Available online (accessed 25 April 2022).

Kelsall, T and Heng, S (2014). "The political economy of inclusive healthcare in Cambodia." ESID Working Paper 43. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester.

Kelsall, T, Hart, T and Laws, E (2016). "Political settlements and pathways to universal health coverage." Working Paper 432. London: ODI.

Kelsall, T (2020). "Political settlements and maternal health in the developing world: A comparative case study of Rwanda, Ghana, Uganda and Bangladesh." ESID Working Paper 137. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester. Available online (accessed 25 April 2022).

Kelsall, T and vom Hau, M (2020). "Beyond institutions: A political settlements approach to development". IBEI Working Paper 2020/56. Barcelona: Institut Barcelona d'Estudis Internacionals.

Kelsall, T, Mitlin, D, Schindler, S and Hickey, S (2021). "Politics, systems and domains: A conceptual framework for the African Cities Research Consortium". ACRC Working Paper 2021-01. Manchester: African Cities Research Consortium, The University of Manchester.

Kelsall, T, Schulz, N, Ferguson, W, vom Hau, M, Hickey, S and Levy, B (2022, forthcoming). *Political Settlements and Development: Theory, Evidence, Implications*. Oxford: Oxford University Press.

Khan, M (2010). "Political settlements and the governance of growth-enhancing institutions". Draft paper. In research paper series on "Growth-Enhancing Governance". London: School of Oriental and African Studies (SOAS), University of London.

Kipling, J (2022). "Raila, Ruto in city supremo contest as elections beckon". *The People's Daily*, 20 January. Available online (accessed 25 April 2022).

Kiptinness, AM and Okoye, J-B (2021). "Media coverage of the novel coronavirus (Covid-19) in Kenya and Tanzania: Content analysis of newspaper articles in East Africa". *Cogent Medicine* 8(1).

Kitson, N (2019). "Informal payments in the public health system in Guinea-Bissau". Working Paper 564. London: ODI

Klopp, J, Wekesa, E and Ziraba, A (2022, forthcoming). "The politics of Covid-19 in Nairobi". ACRC Research Brief. Manchester: African Cities Research Consortium, The University of Manchester.

Kyeyune, H (2021). "Uganda health facilities charging Covid-19 patients a fortune: Complaints about healthcare, ethical issues grow as private hospitals accused of profiteering from pandemic". ANADOLU Agency, 1 July. Available online (accessed 25 April 2022).

Levy, B (2014). *Working with the Grain: Integrating Governance and Growth in Development Strategies.* Kindle Edition. New York: Oxford University Press.

Lucima, O (2021). "How Museveni exploited Covid-19 to control info and tie down opponents ahead of 2021 polls". *Vox Populi,* 22 April. Available online (accessed 26 April 2022).

Lumu, I (2020). "COVID-19 response in sub-Saharan Africa: Lessons from Uganda." *Disaster Medicine and Public Health Preparedness*. 14(3): E46-E48.

Masaba, S (2020). "Security teams hunt for Covid-19 carriers". *New Vision*, 27 March. Available online (accessed 26 April 2022).

McDade, KK, Ogira, D, Onyango, J, Ojal, J, Kokwaro, G, Mao, W and Yamey G (2020). *Kenya's Policy Response to Covid-19*. Policy Report. The Center for Policy Impact in Global Health. Available online (accessed 25 April 2022).

Menkhaus, K (2018). *Elite Bargains and Political Deals Project: Somalia Case Study*. London: FCDO Stabilisation Unit. Available online (accessed 25 April 2022).

Mitlin, D (2020). "Dealing with Covid-19 in the towns and cities of the global South". International Institute for Environment and Development. Guest blog. 27 March. Available online (accessed 25 April 2022).

MoH (2020). "National guidelines for the management of Covid-19". Kampala, Uganda: Ministry of Health.

Mohiddin, A and Temmerman, M (2020). "Covid-19 exposes weaknesses in Kenya's healthcare system. And what can be done". *The Conversation,* 27 July.

Mukami, P (2021). "Will 10 million Kenyans get at least one dose of a Covid-19 vaccine by Christmas day?" *The Elephant.* 10 December. Available online (accessed 25 April 2022).

Musisi, F (2021). WATCH: Inside OPM, UPDF and Police Covid-19 cash deals. *Daily Monitor*, 1 July. Available online (accessed 25 April 2022).

Muwanga, NK, Mukwaya, PI and Goodfellow, T (2020). "Carrot, stick and statute: Elite strategies and contested dominance in Kampala". ESID Working Paper 146. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester.

Nairobi City County (2019). *Nairobi City County Community Health Services Act 2019*. Available online (accessed 25 April 2022).

Nkuubi, J (2020). "When guns govern public health: Examining the implications of the militarised Covid-19 pandemic response for democratisation and human rights in Uganda". *African Human Rights Law Journal* 20(2): 607-639.

OAG (2021). *Thematic Audit Report on Covid-19 Pandemic Government Interventions*. Kampala, Uganda: Office of the Auditor General. Available online (accessed 25 April 2022).

OCHA (2021a). *Uganda receives 864,000 doses of COVID-19 vaccines*. Uganda: UN Office for the Coordination of Humanitarian Affairs. Available online (accessed 25 April 2022).

CHA (2021b). *Covid-19 Impact Update* (No. 16). UN Office for the Coordination of Humanitarian Affairs. Available online (accessed 25 April 2022).

Ombuor, R and Bearak, M (2021). "'They have another door': Kenya's vaccine rollout exposes rich-low income divide". *The Washington Post*, 3 April. Available online (accessed 25 April 2022).

Omulo, C (2021). "Kenya: Community health volunteers in Nairobi to receive monthly stipend". *Daily Nation*. 30 June. Available online (accessed 25 April 2022).

Orangi, S, Pinchoff, J, Mwanga, D, Abuya, T, Hamaluba, M, Warimwe, G, Austrian, K and Barasa, E (2021). "Assessing the level and determinants of Covid-19 vaccine confidence in Kenya". *Vaccines* 9(8): 936.

Owori, S (2020). “Socioeconomic impact of Covid-19 in Uganda: How has the government allocated public expenditure for FY2020/21?” *Development Initiatives*. Available online (accessed 26 April 2022).

Parks, T and Cole, W (2010). “Political settlements: Implications for international development policy and practice”. The Asia Foundation Occasional Paper 2, July. The Asia Foundation.

Pinchoff, J, Austrian, K, Rajshekhar, N, et al. (2021). “Gendered economic, social and health effects of the Covid-19 pandemic and mitigation policies in Kenya: Evidence from a prospective cohort survey in Nairobi informal settlements”. *BMJ Open* 11(3).

Republic of Kenya (2017). *Kenya Social Protection Sector Review 2017.* Nairobi: Ministry of Labour and Social Protection State Department for Social Protection. Available online (accessed 25 April 2022).

Rosen, G (1993). *A History of Public Health. Revised and Expanded Edition*. Baltimore, MD: Johns Hopkins University Press.

Safieldin, M (2021). “Prioritise re-opening of schools to secure children’s wellbeing”. UNICEF Uganda, 2 July. Available online (accessed 25 April 2022).

Schulz, N and Kelsall, T (2021a). “Political settlements (PolSett) dataset codebook”. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester.

Schulz, N and Kelsall, T (2021b). “The political settlements (PolSett) dataset. An introduction with illustrative examples”. ESID Working Paper 165. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester.

Schulz, N and Kelsall, T (2021c). “The political settlements (PolSett) dataset”. Manchester: Effective States and Inclusive Development Research Centre, The University of Manchester. Available online (accessed 25 April 2022).

Sheikh, A (2021). “Somalia opens first public oxygen plant to help treat Covid-19 amid severe shortage". Reuters, 30 September. Available online (accessed 25 April 2022).

Slater, D (2010). *Ordering Power: Contentious Politics and Authoritarian Leviathans in Southeast Asia* (Cambridge Studies in Comparative Politics). Cambridge: Cambridge University Press.

Somali Dispatch (2020). “Health Minister confirms the arrest of director Buule”. *Somali Dispatch*, 6 April. Available online (accessed 25 April 2022).

Sverdlik, A (2021). “Nairobi: City scoping study”. Manchester: African Cities Research Consortium, The University of Manchester.

Tumwesigye, NM, Okethwangu, D, Kaakyo, M and Biribawa, C (2021). “Effects of the Covid-19 pandemic on health services and mitigation measures in Uganda”. Working Paper 571, March. Washington, DC: Centre for Global Development.

Wachira, BW and Mwai, M (2021). “A baseline review of the ability of hospitals in Kenya to provide emergency and critical care services for Covid-19 patients”. *African Journal of Emergency Medicine* 11(2): 213-217.

Wangari, EN, Gichuki, P, Abuor, AA, Wambui, J, Okeyo, SO, Oyatsi, H, Odikara, S and Kulohoma, BW (2021). “Kenya's response to the Covid-19 pandemic: A balance between minimising morbidity and adverse economic impact”. *Open Research Africa* 4(3).

WFP (2021). *WFP’s Work in Enabling Social Protection in Somalia*. Rome: World Food Programme.

World Bank (2020). *Somalia Economic Update, Fifth Edition: Impact of Covid-19: Policies to Manage the Crisis and Strengthen Economic Recovery*. Washington, DC: World Bank.

World Bank (2021). *Shock Responsive Safety Net for Human Capital: Additional Financing* [Project Paper]. Washington, DC: World Bank. Available online (accessed 25 April 2022).

Wrong, M (2009). *It’s Our Turn to Eat. The Story of a Kenyan Whistleblower*. London: Fourth Estate.