Firoz Lalji Institute for Africa

Indigenous lockdowns

A historical exploration of epidemic containment in Arua District, West Nile sub-region, Uganda

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Research project: Living the Everyday: Health-seeking at Uganda's borders

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"Living the Everyday: Health-seeking in times of sickness and epidemics at Uganda's borders", is hosted by the LSE Firoz Lalji Institute for Africa in partnership with Muni University. "Living the Everyday" principally addresses how social relations and everyday life affect knowledge and the management of sickness. The project contributes to policy approaches focused on containing epidemic diseases, including Ebola and COVID-19, across national borders.

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Contents

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The Firoz Lalji Institute for Africa (FLIA) focuses on engagement with Africa through cutting-edge research, teaching and public events, strengthening LSE's long-term commitment to placing Africa at the heart of understandings and debates on global issues.

“We already had our traditional education system or the indigenous knowledge in which we made the herbal [medicines], so when they [Europeans] brought their new systems; we abandoned the traditional systems because the Europeans colonialists had prepared ready-made solutions to our problems. They created pharmaceuticals to treat our diseases and because their medicine was ready, we became the market and thus there was no chance for any further research or development for the Africans’ [drugs] because they became the market. The religions that were brought by the Europeans called all the traditional medicines satanic and were thus shunned by the populations who bought into the philosophy.”

Lugbara elder, August 2021

1.1 Introduction

This working paper explores histories of containing epidemic diseases in West Nile, North West Uganda. It focuses particularly on strategies devised since the colonial period among Lugbara-speaking populations in present day Arua and Maracha Districts to contain disease outbreaks. The paper also draws upon wider experiences of managing affliction from communities across the sub-region.

Whilst we term these "indigenous" strategies, we recognise that attempts to contain diseases, often instigated by elders and so-called "traditional" authorities, have drawn upon available biomedical and other forms of knowledge, and have been fundamentally shaped by external changes including state-building, violent upheavals and associated population movements. Thus, rather than present untouched examples of "traditional wisdom", we are interested in the endurance of grassroots strategies to limit the spread of epidemic diseases, but simultaneously recognise these to be continually in flux. In addition, we understand that efforts devised to protect the health of the population may compromise the rights of individuals understood to be "sick" and may function through stigmatisation of people deemed to be carriers of disease. Yet, we deploy "indigenous" since it was a vernacular term which was deployed by Lugbara people during COVID-19. It was a term used strategically, as will become clear.

In part, this term was evoked as a means of political resistance. Particularly during the first months of the COVID-19 pandemic, under conditions of lockdown but with few reported caseloads, there was fierce resistance to COVID-19 measures – and containment in particular – from many communities across West Nile. This included organised rejection of officially designated quarantine sites in Arua and Moyo districts. This resistance occurred in a context where lockdowns were widely criticised by regional leaders, as well as West Nilers. The region is one of the poorest in Uganda, and the implementation of nationwide lockdowns had a significant impact on the livelihoods of the sub-region's traders and agriculturalists. A common refrain which circulated during Lockdown 1, in early 2020, was whether people of West Nile would die first of hunger or of COVID-19. As part of this resistance, the Lugbara Kari, a traditional institution which provides cultural representation for Lugbara-speakers, appealed to the government to "unlock Arua" in a story published on the regional

online news platform 'West Nile Web' (Odama, 2020). Part of this resistance involved the Prime Minister, Tuku Ismael, highlighting historical practices that have been used in the region to contain, for example, meningitis, measles, sleeping sickness, plague and leprosy. Thus this working paper assesses strategies to contain epidemics and pandemic diseases, but it recognises such calls to encapsulate historical memories as well as political sentiments.

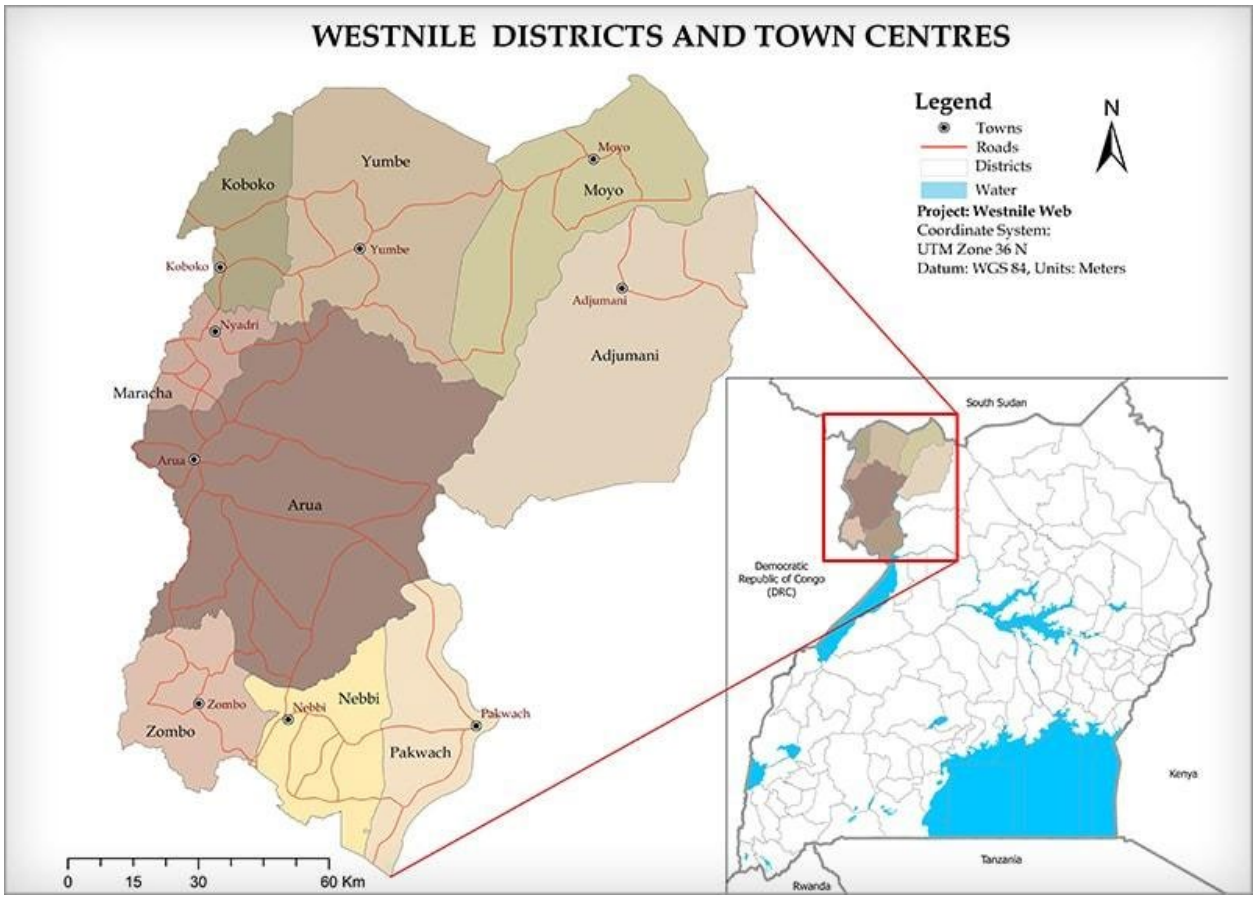
This research is based on interviews conducted by Clement Aluma between July and September 2021, complemented by remote research conducted by Elizabeth Storer between June and September 2021. Additionally, the paper draws on the ethnographic fieldwork (exploring patterns of plural health-seeking) conducted by Storer along with Jimmy Osuta, David Angualia and Patricia Nyirivu between May 2016 and January 2018. This contemporary fieldwork is supported by historical sources collated by social and medical anthropologists between 1949-1990.

1.2 West Nile sub-region

The West Nile sub-region lies in Uganda's North Westerly corner, bordering South Sudan and Democratic Republic of Congo (DRC). According to the Uganda Bureau of Statistics (2018), the West Nile sub-region has 2.9 million inhabitants living in approximately 500,000 households. The borderland features intense ethnic and linguistic diversity. The majority Lugbara-speaking population are accompanied by Ma'adi, Kakwa and Alur speakers. Arabic and Swahili are also widely spoken, particularly within Arua. The region too features religious diversity, including Roman Catholics, Anglicans, Muslims, Adventists, Pentecostals, and traditionalists.

By comparison to the wider Ugandan state, the West Nile sub-region is poorly developed. This has particular implications for health and well-being: mortality rates remain higher than the rest of the country; families often cannot afford the cost of care in either government or private facilities. As the latest Uganda Health Demographic Survey (UHDS) shows, West Nile's under-5 mortality rate of 86 deaths per 1,000 live births is significantly higher than the national average of 64 deaths per 1,000 live births (UBOS, 2016).

Figure 1: West Nile Districts and Town Centres



Source: The West Nile Web (2018).

This legacy endures from pre-colonial period, where slave raiding and the violent establishment of Belgian and British administrations affected the region. Through Protectorate Rule, 2014-1962, Leopold (2011, p. 465) describes that the area functioned as a “labour reserve” for military conscription and recruitment for plantation work in South and Central Uganda. Inequalities carried into the post-independence period have been compounded by recent conflict legacies. The 1979 war, which followed the overthrow of Idi Amin and subsequent rebellions, like the West Nile Bank Front, and the Uganda National Rescue Front I &II meant that the majority of the residents remained in exile in DRC and South Sudan until after 1986 when the current government took power and residents started returning from exile (ibid).

Following return, the region has been characterised by severe inequality. In the decades following war, these inequalities have been made plain through a consideration for those included in cross-border trade, and those for whom return constituted a re-establishment of agriculture, which produced

profound distinctions between town and the countryside. As Arua town's markets flooded with commodities, and trade shifted from basic commodities to fuel, manufactured goods and even Chinese motorcycles, many farmers struggled to re-establish prosperity. Whilst involvement at different levels of trade—for example in cartels such as the 'OPEC boys' (a group of businessmen who smuggled commodities from DRC into Uganda)—proffered a means to access cash, it did little to improve the lives of many farmers (Titeca, 2021). The LRA bush war in Acholiland cut the North from the South, making travel between West Nile and Kampala almost impossible until the mid -2000s, forcing people to rely on their own resources to survive (Titeca, 2012).

West Nile's underdevelopment is also a result of its political marginality, made starkly visible in the denial of infrastructure and other state provisions to the region. Beyond the immediate vicinity of Arua City there is no electricity, and only in 2017 was the spinal road that traverses the western perimeter of the district fully tarmacked, connecting people to the wider district (Acemah, 2019). The arrival of the road reflects West Nile's changing political leadership: over the last two electoral cycles, candidates of the ruling National Resistance Movement (NRM) and NRM-leaning independent candidates have won seats in Arua Municipality, and in selected rural county seats. By way of reward for their shifting political loyalties, the central government has afforded some "obedient" counties district status. These reward campaigns have drawn on colonial sub-county boundaries, to assert developmental claims to autonomy. As such, the West Nile sub-region is currently comprised of 12 Districts (Adjumani, Moyo, Obongi, Yumbe, Koboko, Maracha, Terego, Ayivu, Mad'i-Okollo, Nebbi, Zombo and Pakwach), up from the three at the time that the NRM assumed power in 1986. Arua, the regional economic centre, was granted formal city status in July 2020. Whilst recent changes may have brought hope for some, the difficulties of the COVID-19 lockdown threatened to plunge many into further food insecurity and poverty (see below).

Socially, the "ethnic" groups in the region are organised around what has been termed in the "segmentary structure" in the classical anthropological vernacular. Though this rigid classification belies social flexibility, prior to the imposition of the colonial state, people of the region did not recognise an overall authority figure, beyond the intermittent influence of prophets or rainmakers. Though "indirect" rule through the Protectorate period saw the installation of the modern state, and

the “invention” or solidification of “ethnic identities”, to date, the influence cultural entities command is relatively smaller than their religious counterparts in the region. Within the region, there are significant differences in traditional structures of eldership. The Alur Kingdom is by far the biggest in size and most organised. It is recognised by the central government, which currently channels a series of COVID-19 messages through the institution. By contrast, cultural institutions of the Lugbara, Okebu, Madi, and Kakwa have had limited authority over their respective populaces during the pandemic. Elders at the clan and/or family level have however, retained significant authority in the management of social group conduct, disputes and the diagnosis of affliction.

1.2.1 Implications for state- legitimacy/ patterns of health seeking:

1) Government/ biomedicine is just one trusted actor among many in the realm of health, healing and well-being. Presently, government facilities, including Arua Regional Referral Hospital (ARRH), remain underfunded and often associated with harm, rather than healing. ARRH has recently been publicly associated with numerous corruption scandals, including relating to the provision of Oxygen during COVID-19 (Amvesi, 2021).
2) Health care is often experienced by West Nilers in “emergency mode” – with particular health priorities elevated among routine diagnosis and care. This has occurred in relation to: sleeping sickness and the MSF response in the 1980s; HIV/AIDS, with widespread awareness and testing driven by INGOs, NGOs and the Ugandan government entering the region from the late 1990s (and antiretroviral treatment (ART) being administered from 2002 in ARRH); the 2016 Hepatitis B response led by the Ugandan government; the 2018-9 Ebola response driven by government-donor partnerships in view of the threat from across DRC; and in the 2020 COVID-19 response led by the Ugandan government’s COVID-19 Taskforce. Whilst these threats provoke panic in the general population, provisions to contain/ treat and prevent epidemics and pandemics rarely builds capacity in the wider regional/district/village health system. Crucially, too, what epidemic threats are defined as requiring assistance depends much on the international context. A plague epidemic in Zombo in 2018, which in contrast to Ebola did cause fatalities, went largely unacknowledged at the national and international level (Al Jazeera, 2019).

3) Healthcare remains thoroughly plural (Allen and Storm, 2012). Indigenous healers, including elders, herbalists and diviners (now nominally Christian), all maintain an important stake in diagnostic processes. Whilst these specialists all hold legitimacy for particular types of illness in everyday care (e.g. herbalists for poisoning or skin lesions and female spiritual diviners for mental illness, possession or bewitching), in moments of crisis people often draw on specialists according to the anticipated needs of the symptoms, as well as options within their geographical and financial reach.
4) Elder's authority, expressed in their words, remains of paramount importance for their families. In part because of legacies of maintaining order in a rural society away from the violent and coercive arms of the state, elders continue to discipline through curses. As a 2018 paper by Verginer and Juen highlight, even today many types of illness are linked to *atrita* (curses). When basic clinical consultations fail, diagnosis is often pursued through tracing a history of family conduct, being managed at home.

1.3 Resisting COVID-19 containment

With the onset of COVID-19, the Ugandan government, through its COVID-19 Taskforce, attempted to locate multiple quarantine centres in West Nile's urban centres (including Arua and Moyo). On several occasions across these districts, communities living in the vicinity of the proposed centres resisted such a move, protesting and in some cases mounting resistance, including using bows and arrows in Arua. Whilst this was largely due to the fear of the uncertainty brought by a "new" sickness with no cure, it was also because the response lacked legitimacy owing to, for example, mistrust in state authorities.

By May 2020, the first quarantine center set up at Arua School of Comprehensive Nursing (within ARRH) was at capacity with suspected cases. Accordingly, there was a need to designate more centres throughout the region. That same month, communities living in the villages surrounding Arua Prison Primary School rejected a proposal to set up a COVID-19 quarantine centre at the school. Community members organised and demanded a meeting with the district COVID-19 Task Force. At the meeting, community members expressed fears that the proposed centre was in an area of high

population density and lacked “proper fencing”. People denied audience to the district chairman Wadri Sam Nyakua who tried in vain to explain that the center was only meant for suspected cases but not those confirmed. Additionally, there was concern that suspected cases could escape into the community. Moreover, the community were concerned that if used as a quarantine centre, the school would not be able to house pupils due to take national exams. Teachers residing in the staff quarters of the school would be in great danger if the isolation centre was set at the school.

On another occasion in April 2020, communities living around Arua Core Primary Teachers’ College in Mvara, a suburb of Arua city, vehemently rejected plans to locate a COVID-19 quarantine centre at the institution All local leaders, the Anglican Church and the local population joined forces to successfully prevent the district’s plans to use the college premises for isolating suspected COVID-19 cases. The Bishop of the Anglican Madi and West Nile Diocese, whose official residence is close to the proposed quarantine centre, wrote to the district task force to formalise the protest from the Church. Residents celebrated when the Task Force eventually changed their plans and removed their equipment from the college.

The next proposed quarantine site was St Joseph’s college Ombaci, a secondary school nearly 10km away from the Arua city center. The residents of Manibe Sub-County where the school is located rose up in similar resistance.

On the other hand, Aruans feared that outsiders – associated with bringing COVID-19 into the sub-region during the early months of the pandemic (March-July 2020) – would be able to evade state quarantine procedures. They had reasons to fear. In March 2020, two Chinese contract workers quarantined in a Zombo Hotel tested positive for the virus. They were part of a wider group of eight (including six Chinese nationals and two Ugandans) who had departed northwards from Kampala before completing their 14-day mandatory quarantine in the Ugandan capital. They had escaped their original quarantine site. Months later, Zombo locals refused to visit or stay in the hotel for fear that it could still be harboring virus left behind by the Chinese.

Such occurrences therefore informed widespread resistance to the government pandemic response. And, once firmly established within the community, resistance involved evading admission to the

quarantine centre. As late as August 2021, health workers in Yumbe district reported widespread resistance from communities with regards to the management of COVID-19 cases. Specifically, the parents and relatives of suspected cases were resisting giving up suspected cases to the quarantine centres, instead facing enforcement from community services. In some cases, relatives threatened health workers with taking them to court, should they recommend referral to quarantine centres. In part, this was because of continued perceptions, particularly from the youth, that COVID-19 was a common flu. It is also because people preferred to be treated by medicines obtained at trusted private pharmaceutical retailers or remedies from herbalists. In Bidi Bidi refugee settlement, also located in Yumbe district, many quarantined at centres had reportedly escaped. At this time, the COVID-19 prevalence rate in the district was 8.9% (compared to a national average of 6.2%) (Elema, 2021).

1.4 COVID-19 Containment

1.4.1 Lockdown 1, March 2020

Analysts agree that the response of the Ugandan government to COVID-19 was one of the most stringent on the continent (Haider *et al.,* 2020). Noting the parallel timing of the movement restrictions with the national election (held on 14thJanuary 2021), Ugandan and international observers drew connections between the stringency of measures and attempts by the ruling party to subdue political dissent. Thus, public health measures were widely regarded by Aruans as having potent political uses.

COVID-19 measures were put in place prior to Uganda officially registering a single case of the virus. On 18th March 2020, President Yoweri Museveni announced nationwide measures to contain COVID-19. This included: an immediate closure of schools, suspension of religious gatherings for one month and a ban on cultural and political rallies.

On 22nd March 2020, the Ugandan Ministry of Health confirmed its first COVID-19 case, a Uganda national arriving from Dubai. After this, the President suspended the arrival of all passenger planes into the country. As reported cases increased, on Wednesday 25th March, all public transport within the country was banned.

On 31st March, the President instituted a 14-day lockdown on the country beginning 1st April. Mobility of all private vehicles was prohibited and a curfew from 19:00 hours to 6:30 was instituted. All

individuals, except cargo transporters, were ordered to stay indoors. All non-food stores were closed. By this time the country had registered 44 cases.

Across West Nile, these measures produced acute difficulties for many citizens. Addressing the press, the Prime Minister of the Lugbara Kari (cultural association) said that the then "hunger, starvation, domestic violence, family breakups, rising crime, trauma, [and] breakdown in health, education and extension services calls for government review of its current response strategy on Covid-19" (Odama, 2020).

In the context of restrictions, local bus companies increased the transport fare from Arua to Kampala as they were ordered to operate at half capacity to facilitate social distancing between passengers. Even essential travel was thus prohibited by its increased cost, isolating West Nile's traders from national markets. As in wider Uganda, West Nile traders responded to movement restrictions by hiking the price of basic goods including salt and sugar. For example, the price of common salt rose from Ush.700 to Ush.3000 and 4000 or beyond. On 25th March, the Resident District Commissioner (RDC) – the representative of the president in local government – of Koboko District, Capt. Yahaya Kakooza, arrested four businessmen on allegations of extortion (The Observer, 2020).

Though the President responded with promises to mobilise cadres from his NRM party to bring food from the villages, this largely benefitted urban settlements within the capital. For example, the food distribution efforts of the National COVID-19 Task Force, which reached 1.5 million urban poor, were confined to Kampala and the surrounding districts of Wakiso, Entebbe and Mpigi. And even then, the scheme was marred by wide-ranging allegations of corruption by officials under the Office of the Prime Minister. In any case, such programmes did not reach West Nilers.

Nationally, allegations of corruption circulated around the COVID-19 response. In September 2020, a section of MPs from across parliament demanded for a comprehensive accountability of the COVID-19 donations that had been given by corporate entities in Uganda. Donations through the national COVID-19 task force totalled to over Ush28 billion. Although the government defended its use of these donations (and the wider work of the task force), regular allegations of corruption have since been synonymous with the COVID-19 response. The lack of a clear recovery plan by the government

and sustainability during the lockdown equally gave rise to resistance, with members of the public often equating COVID-19 restrictions to a “money-minting” scheme by corrupt government officials.

1.4.2 Lockdown II, June 2021

Uganda’s second lockdown, introduced in response to fast-spreading COVID-19 variants in June 2021, had starkly different challenges and approaches. Whereas there was no single case when the first lockdown measures of March 2020 were imposed, the June 2021 lockdown was imposed at a time of elevated case numbers and accompanying deaths. There was no more widespread testing.

The MoH figures showed that, as of 6th June 2021, cumulative COVID-19 cases stood at 52,929 with confirmed deaths at 374 and 43,487 recoveries. President Museveni on Sunday June 6th 2021 re-instituted a strict lockdown on the country that included the suspension of inter-district travel and a nationwide ban on public transport. Schools, worship places and open markets were closed for 42 days. He warned that the sudden spike would exhaust available bed space and oxygen supply in hospitals unless urgent public health measures were instituted.

Yet, even despite the recognition of rising cases, because of the allegations of corruption and mishandling of the first lockdown, the response of many of West Nile’s citizens was of defiance, rather than compliance, to measures.

As in lockdown 1, compliance was enforced through the introduction of fines, and on occasion, arrests and short periods of imprisonments served as deterrent factors (BBC, 2020). Vendors, especially women, in desperate need of the day’s bread often clashed with city enforcement officers for selling on the streets. At the peak of these clashes, a woman threw her baby into the back of the truck used by the enforcement officers in protest after her basin full of bananas was confiscated by the officers (Angucia, 2021). This became a symbol of the desperation felt by many in West Nile. That evening, police on foot patrol were reportedly caning and extorting money from those who flouted restrictions, especially the curfew. Boda boda (motorbike taxi) drivers who continued to operate on motorable footpaths after the 5pm curfew, when caught, had their motorcycles impounded and heavy fines imposed.

On 19th July, local media reported that the District Police Commander in Arua had come under fire from the Parliamentary COVID-19 taskforce for northern Uganda for allegedly selectively enforcing the ban on night discos. There were rumours that hospital ambulances were being used as transport to the disco. Many Aruans understood that restrictions on movement depend on one's connections to people in power and felt deeply let down by the flagrant complicity of the state in lockdown violations. An interviewee, a retired ambassador (Acemah, 2021), said the pandemic has worsened trust in government, as "leaders do not believe that they are servers of the people, it's just the culture of impunity that we have been having here as authorities enforce the lockdown regulations".

In between the need to secure already insecure livelihoods, and following poor leadership examples, many in West Nile ignored restrictions during lockdown II. On 21 July, members of the Ugandan Parliamentary Technical Committee on COVID-19 declared Arua the worst district at sticking to lockdown restrictions (Storer and Osuta, 2021). This was a particular concern to the MoH, given that the region represents a "porous" international border through which the virus could potentially spread.

1.4.3 Summary of West Nilers' experience of lockdowns:

1) Lockdowns have brought challenges for the majority of West Nilers, whose livelihoods depend on movement either within the country or across the border to trade, or on movement to rural farms to produce goods. Given the pre-existing high rates of cash poverty in the region, with many families lacking financial safety nets in times of crisis, the lockdowns were interpreted as a threat that rivalled the health threat of the virus.

2) In a context where the government lacks legitimacy, lockdowns have been interpreted by many, particularly young people, to be acts of political manipulation. It was notable too that whilst citizen movement was restricted, cargo (plus the police and the army), continued to be transported along national roads. This led to the belief that the lockdown was being manipulated by the elite at the expense of the poor. Publicised violations from local government officials have further tarnished the legitimacy of government public health plans. Such recognitions found expressions in popular rumors, that COVID-19 was a hoax, or that it did not affect young people, but those who were elderly and vulnerable (particularly during lockdown 1). These rumours were entangled in resistance to lockdown measures.

1.5 Indigenous approaches to containing epidemics

1.5.1 History of containment strategies

- In Lugbarati, the term used for containment is *atriza,* meaning 'to bring to a stop' (with containing a disease being - *azo dri atriza).*
- Contemporary West Nile is deeply shaped by people's historical experiences of managing epidemic diseases, which have affected the area since the first contact with slave raiders and European explorers in the 1860s (Lyons, 1985). What documentation exists (including oral histories collected by John Middleton, the social anthropologist during Protectorate rule) suggests that from 1890, outbreaks of cerebro-spinal meningitis became endemic in dry seasons, as did outbreaks of smallpox and plague (Middleton, 1963). At that time, meningitis was known as *ndindia*, and small-pox as *mua*, both terms that mean 'sickness' or 'sickness sent secretly' (ibid, p.92). Rinderpest wiped out cattle herds from 1890-1920 (Middleton, 1971, p. 8). Through the first decade of Protectorate rule (1914-1920), mass mortality of humans and cattle swiftly altered the distribution of authority and agricultural productivity, resulting in famines (particularly severe in 1895) and the mass migration of northerners to the south (King, 1972).
- In the late 19th/ early 20th century, the spread of cerebro-spinal meningitis was linked to the spread of a spirit cult, *Yakan*, based on the leadership of the Prophet Rembe who administered sacred water, which was believed to confer immunity from disease. Epidemics were said to come from Europeans and *Adro* (God) (Middleton, 1963). In the context of mass death from epidemics, a new cadre of Lugbara leaders localised the prophetic powers of Rembe, in symbolic performances which inverted the distribution of patrilineal authority. In a time of "collective despair", people turned to dangerous metaphysical powers for healing, radically re-adapting moral norms in the process. By 1919, *Yakan* water was believed to offer immunity against diseases and the resurrection of dead ancestors and cattle, and reportedly even protection from Protectorate guns (ibid).
- Lugbara origin myths denotes that their ancestors bore present day clans after 'Ofunyaru' (mother of the Lugbara people), who was suffering from *ofu* (leprosy), met her husband

'Dribidu', and he treated her with local herbs whilst in *oji* (quarantine and/or self-isolation) in a cave (Odama, 2020).

- Oral histories of Lugbara elders, and available historical records, indicate divergent traditions in healing, with implications for types of containment. These improvised measures became more significant from the early 20th century, when land pressure made it impossible to migrate. Prior to this, when land was plentiful, in cases of a sudden outbreak of a disease with high rates of mortality, under the instruction of elders, entire lineages would migrate and settle in alternative locations.
- Subsequently, throughout reported history, upon encounters with outbreaks of either physical or mental symptoms deemed to be contagious, strategies were devised to quarantine the sick in their home. During the colonial, and early post-colonial period, during outbreaks now believed to be measles or smallpox, people suspected to be ill were quarantined in their homes. Children were often quarantined with the mother. Ill individuals were encouraged to sleep on dry banana leaves or dry spear grass because these could not be shared and the bedding would be burnt when the person was cured.
- Homesteads which formed the site of quarantine were sealed to the wider population – other community members (and even family members) were not prohibited to visit the sick. Ash was sprayed along the route to the patient's home to signal danger to anyone unknowingly visiting their home. Sole access was granted by a herbalist/ medicine man. Relatives would provide food but would be required to leave the food at the gate to avoid contact with the sick person. These were all measures improvised by local communities and instituted by elders.
- With regards to the consumption of food and drink, strict conditions were reportedly followed in the case of disease outbreaks. For example, if a child was suffering from measles, they would not give that child cold water, but would instead administer warm water for drinking and bathing. The rationale was that if that child was given cold water, the sickness would remain internal then kill the child, but that hot water would "flush out" the affliction. Rashes on a child's body were considered a sign of the curing process.
- When an outbreak of smallpox was registered, elders prohibited people from sleeping in pairs — even couples were not allowed to sleep together until the threat was deemed to have gone.

In markets and during cultural gatherings, public announcements were made about the presence of a bad disease and so people were constantly discouraged from coming close to one another and take precautions.

1.5.2 Elders' authority

- Over the last century, elders have played important, through flexible roles, in directing society. At the centre of this social organisation is the promotion of virtues of *ru* (respect), whereby the words and wishes of elders, were upheld by the community. Respect was based on elders' protecting their juniors. When communities feared the threat of a disease, or became aware of an outbreak among proximate neighbours, elders would "sing" a kind of prayer which "asks" the disease to bypass his descendants. Elders also gathered to collectively "pray" over the patient, pleading that the disease did not spread any further to the members of the community.
- In critical cases, where disease outbreaks were spreading rapidly and there was mass mortality among specific clans, powerful elders representing major lineages would perform a ritual *trita* (curse). In times of epidemics, elders used these rituals to condemn practices which were linked to the spread of disease. To date, such curses are believed to "work" on blood descendants of the elders, and bring either physical and/or mental illness, or a host of misfortunes on those who violate the demands/ requirements of the curse. For example, during the onset of HIV/AIDS in the 1980s curses could prohibit sexual intercourse with one's partner within a given time period. A girl could successfully be stopped from marrying people who had diseases like HIV, or any other through the rituals. If the warnings of elders were violated, it was believed the implicated person would experience misfortune, for example in the form of the snake or scorpion bite.

1.5.3 Summary

- Overall, memories of epidemic control pointed to the existence of quarantine measures, where the sick individual was separated from the community. Elders had a privileged position in enforcing this order, as well as praying for protection for their lineages. Defences against outbreaks were thus material and spiritual.

- Throughout the 20th century, as land became scarce and disease outbreaks more common under colonial role, indigenous forms of quarantine became more significant.
- Herbal medicines, as well as the use or prohibition of particular foods played an important role.
- Passed down through oral histories, many elders had vague recollection of managing outbreaks. Experiences of COVID-19 reinforced the importance of alternatives. This can be seen as an expression of self-reliance, but also as a political protest to mass quarantines.

1.6 Responses to outbreaks: case studies

Recent epidemic responses involved both local responses, as well as public health measures. As biomedicine has become a significant influence on health-seeking, such approaches have both transformed local approaches to managing outbreaks, and also acquired a social life. The socio-moral influence of elders in enforcing disease control has remained significant. This working paper now explores transformations in the context of Sleeping Sickness, HIV/AIDS and Ebola.

Case Study 1: Sleeping Sickness Containment in the Colonial/ Post-Colonial Era

Sleeping sickness or human African trypanosomiasis is a vector borne parasitic disease caused by the parasite *Trypanosoma brucei*. The disease, prevalent in sub-Saharan Africa is transmitted by infected Tsetse flies (*Glossina spp*). Accounts of the disease, in cattle (commonly known as *nagana/ N'gana*) and humans, can be traced back across centuries, with the parasite identified at the turn of the twentieth century (Steverding, 2008). There are two sub-species of *T.brucei* that cause disease in humans – *T.b. gambiense* and *T.b. rhodesiense* – exhibiting some differences in patterns of transmission and pathologies. While they are geographically distinct across SSA, they are both endemic in Uganda, with *T.b.gambiense* affecting the northwest of the country, and *T.b. rhodesiense* affecting the eastern and south-eastern regions. *T.b. gambiense,* the sub-species that causes disease and outbreaks in West Nile, progresses more slowly.

The first stage of disease causes symptoms such as headache, intermittent fevers, and general fatigue, which progresses to a second stage where neurological symptoms manifest

(including aggression, delirium, hallucinations and disturbed sleep-awake patterns – hence the common name of “sleeping sickness”) (Kovacic *et al.*,2016).

West Nilers often linked the onset of “epidemics” of mental illness to outbreaks of sleeping sickness. A variety of traditional cures and preventative methods have been developed and adopted by different groups within West Nile, particularly in response to the disease during the colonial era. During the 1980s, measures adopted by groups, which incorporated biomedical strategies, were improvised as the disease resurged.

Sleeping sickness among the Teregian Lugbara was given the local name *Omvutaa* (touch, Lugbarati) and later an English-Lugbara blend called *Glandi* from ‘gland’. Alternatively, in the rest of West Nile , the sickness is popularly known as “Mongoto” (Médecins Sans Frontières, 1997), a term Lugbara elders say has roots in Runyoro, the language of Bunyoro, the large kingdom across the Nile to the south of Pakwach. In unknotting the etymology of Mongoto, Simoni Aya (2022), a Lugbara elder and an Anglican reverend in Arua, narrated how the West Nile workers ferried to tend to the Kakira Sugar Plantation in Bunyoro returned home with the term.

“I remember I was very young when the White men took young people from West Nile to go and work in Kakira. There they [the laborers] learned that the sickness that made people sleep a lot and sometimes drool while sleeping was called Mongoto,” said Aya. *“As very many West Nilers who went to work in Kakira have continued to return home over the years, they have widely spread the word Mongoto across the region*.” Among Banyoro populations to the South, the term Mungoto is believed to be based on the noun “*ngoto”* (neck in Runyoro) – to convey how the sickness makes the neck droop. The etymology of the word within the West Nile society captures the colonial legacy of the British using the region as a labour reserve.

Meanwhile, both *Omvutaa and Glandi* reflect one of the early signs of first stage sleeping sickness – palpable, swollen lymph glands in the neck –an examination used by colonial public health officers to screen for signs of the disease in the population, before sending

individuals for further invasive investigation (blood taking or lymph node aspiration) or treatment (by injection).

A 2011-12 study reported that elders in West Nile remembered checks on their glands conducted during the colonial period (Kovacic *et al.*, 2016). In this study, elders recalled that if somebody showed the first signs of the *Glandi* disease, they would be treated at home or in a treatment camp. It is important to note that the available treatment, discovered in 1949, was an arsenic-based compound that caused significant, including potentially fatal, side effects (World Health Organization, 2022). In the 1930-1940's, the West Nile centre for sleeping sickness was established at Ombasia in the present day Anyufira parish, Omugo sub county, Terego district by the colonial public health officials after discovering cases in the area. More recently, suspected cases are sent to ARRH for further tests and subsequent treatment.

For preventative measures, colonial authorities enforced the clearing of household compounds, riverbanks and grassland areas, and trees were sprayed with insecticide to clear the Tsetse flies from their breeding grounds and habitat. In extreme cases, communities would be driven out of an area as measures to clear the tsetse fly habitat were undertaken.

Beyond this, people improvised preventative cures. For example, some people started drinking a liquid obtained as a result of sieving an ash-water mixture with the ash obtained from the leaves of some selected medicinal plants and shrubs. Alternatively, specific roots were pounded and the resulting liquid consumed as a medicinal drink. Consequently, it was discovered that the leaves and the roots of the Mahogany tree, dried and grounded into fine powder to be mixed and drunk with hot water, was most effective in treating the disease. These discoveries occurred alongside medical research on treatments for the disease.

After independence in 1962, there were limited interventions to manage sleeping sickness. The second recorded major wave of sleeping sickness in the West Nile region was between the late 1980's and the late 1990's when people returned from a period of exile in the then southern Sudan (now South Sudan) and Zaire (now the DRC). With large areas of West Nile

uninhabited during the period of exile, the Tsetse fly habitats along the rivers had taken hold. On returning to their land, people were exposed to the disease once more.

Tsetse flies were reportedly eradicated in the west Nile region during their first wave in the 1940s and there about but remained untouched in the forested places known as the equatorial belt in DRC and Sudan (Kovacic *et al.*, 2013). When people returned from Congo and Sudan, they came with their animals through Koboko and Yumbe districts, these areas along with Terego and Maracha became heavily infested with the Tsetse flies. The confluence of rivers Ora, Enyau and Atu became breeding grounds for Tsetse flies. In affected areas, cases of mental health began to rise quickly, indicating the presence of the disease known to be Sleeping Sickness. People also noted how the disease manifested in their cattle. Today, signs of the disease in cattle bring warning of the potential for Sleeping Sickness in human populations.

In the 1980s and 1990s, with limited state-led provision, MSF France was providing much of the health services in the region and deployed village-based screening and treatment of patients in regional hospitals (Kovacic *et al.*, 2016). Such activities were an extension of the response to post-Amin exiles, where the organisation had been assisting displaced Ugandans. However, elders remember that, during this period, West Nilers again sourced traditional, herbal medicines. People discovered that the herbal medicine was effective, though much information had been lost during the flight to exile, cures were improvised with input from surviving elders. Reportedly, due to the fear of reprimand from authorities, the local people used these herbs in 'silence' without exposing much information about them. Reportedly, clinicians at local health centres also used these herbs, and curbed the death toll through the administration of locally specific cures.

Case Study 2: Improvising Containment during HIV/AIDS (prior to the roll out of ART)

Uganda is widely regarded as the quintessential African success story in controlling and containing HIV/AIDS. Despite testing programmes reporting some of the continent's highest HIV-prevalence rates in 1987, a strong government response has been attributed to a

reduction by the early 2000s (Whyte, 2014). Whilst interventions often emanated from a meshwork of government and NGO services, to date, the response is largely attributed to the strong leadership of President Museveni. At a time when other African countries were denying or failing to address HIV/AIDS, he publicly preached a mass education campaign of abstinence, monogamy and the use of condoms. He developed strong relations with religious, cultural and educational institutions as avenues for further spreading the message. An extensive media campaign using print, radio and television was also launched around this same period to further spread the prevention messages.

Importantly, Uganda's success story is largely constructed from data reported in the south/central regions of the country. Allen (2006) notes the overrepresentation of southern Uganda within surveys of national prevalence, with 15 or 21 sentinel sites used up to the mid-1990s located in the south and central regions of the country.

In West Nile, the history of the illness differs from this widely reported narrative of success. Our interlocutors recognised the appearance of a "new sickness" – "*Silimu*" characterised by bodily wasting. In Arua, the sickness was also known as: *onziri* (Lugbarati for the deadly one);"ezia" (Lugbarati for thin); "azo ewu di vuri", (generally meaning the sickness of our times). It is a simple way of communicating not only the novelty of the sickness, but also the lack of traditional knowledge systems to respond to and contain it. In some contexts, such as parents giving advice to their children or elders speaking to the youth or leaders addressing communities, the phrase is often weaponised to warn people of the threat the disease poses in current times and to the current generation. The term serves as a caution to younger generation against behaviour which may lead to contracting the disease. In this context, it speaks to the deadliness of the disease in cutting lineages to the present rather than allowing them to continue to the "ewu drile ri" (times ahead). Thus young people know that they carry the burden of continuing the lineage of their clans – something that would depend on their ability to survive the *azo* of their time. It is a loaded phrase that conveys the existential threat HIV poses to the Lugbara as a people. Lugbara elders use the phrase to signal that HIV/AIDS is disease of the current times for current generations to deal with. Needless to say, it is a

smart way of apportioning blame for the origin of the disease – the behavior of the current generation as an overture to the end of the timelessness of Lugbara culture.

But the phrase has a different meaning when used by those in religious circles or by moralists – in calling HIV ``"azo ewu di vuri", they deploy it as an adjective emphasising the worldly ways in which the disease is contracted. They seek to paint an image of those with HIV as persons who are concerned with the ordinary life of satisfying bodily desires rather than a spiritual existence. In these circles, the phrase is instrumentalised not only to moralise an immoral Lugbara society but also blame non-Christians (or immoral behaviours) for the disease, its origin and continuity. HIV is evoked as a mark of earthly behaviour. Often, the phrase "azo ewudi vuri'' is followed by "emu di ama dri ja" (has come to annihilate us). The whole sentence would then read as "the sickness of this world has come to annihilate us" or "we shall perish of the sickness of this world". These moralising accounts are invoked at funerals and weddings alike, often paralleling sermons urging people to forsake their worldly ways as a first step to getting "born again" and taking the path to an unending afterlife. Conclusively, it is important to understand the context in which the phrases for describing HIV are used in Lugbara society.

The power of these terms to convey moral experience relates to regional panic and remembered experiences of suffering. In the two decades following return from exile in the early/mid-1980s, new patterns of death emerged, wherein family members perished one by one. Before testing or ART was available, deaths, now presumed to be from AIDS, were previously attributed to witchcraft, as well as to curses and unpaid bride wealth that were said to follow families. A community health worker explains:

When HIV/AIDS started in West Nile, the population didn't know anything about it. They looked at it as witchcraft – being bewitched, that is how they looked at it. Even when they were tested, and told that they had the virus, they never believed it and they still continued to look for ways of healing, because it was a new thing, and they never believed it. For those who believed it, they were traumatised. They didn't want to be identified as people who had this problem. Because of the beginning of HIV, it is changing its way — in the beginning it would only take about 6 months

for somebody to die… They resorted to traditional sort of things — if they will see, for example, your mother's dowry was not paid, that is why the uncles are talking [or invoking the curse]—they will also go to the witchdoctor, who would tell them a different story. They looked at it as a curse, more especially from their uncles, their unpaid debts..[1]

In Moyo, Allen (2006) describes how village councils (headed too by elders) became involved in HIV/AIDS interventions. Because of the concurrent involvement of these councils in debates about *inyanya* (poisoning), these explanations became attached to HIV/AIDS from the 1990s. Following deaths (presumably from AIDS), women were excluded from local society and evicted from their marital homes. Practices of widow inheritance, whereby the woman would be re-married to a brother or male relative of the deceased, were discontinued amidst fears of HIV/AIDS.

Understandings changed as testing was rolled out throughout the 1990s. At this time, prevalence and mortality remained high. Whilst it was impossible to estimate the exact HIV-prevalence rates in West Nile (access being prohibited by continuing instability and war in Acholiland), one survey conducted in the late 1990s across the North in Arua, Soroti and Lira by Uganda's Makerere University scholars, reported high rates of AIDS-mortality among Lugbara respondents. Recorded mortality was significantly higher in Arua at 26.9% than Soroti (9.7%) and Lira (12.9%) (Ayiga *et al.*, 1999). The scholars linked such high prevalence to the commercial boom and increased mobility that amidst relative peace post-war.

Prior to the roll-out of ART, the condition was named, but could not be treated. "AIDS" was seen as a new disease which was only got by those who had many sexual partners and were irresponsible people. Indeed, the above survey reported AIDS mortality was highest in "unstable marriages", where the couple cohabited but were not formally married, and where bride wealth had not been transferred (ibid, p.145). Death was thus interpreted in contexts

[1] I, Anglican Pastor/ CHW, Ediofe, 14/06 2017. In a similar way, during the present research, when Hepatitis-B testing arrived in the region, suffering related to imbalanced relations shifted in relation to a positive diagnosis of Hepatitis-B. As indicative of shifts to public health medicine, Hepatitis-B was understood through the prism of HIV/AIDS, and was said to be "worse than HIV".

where normative social relations were unfulfilled, presented simultaneously as a medical and moral crisis.

In the absence of the qualified counselors who could offer care-giving to those infected and affected by the disease, elders assumed the role of the counselors. Some families abandoned or denounced their own when they heard that he/she was HIV positive. Elders mounted an approach in families and through the Lugbara cultural institution which emphasised particular aspects of Lugbara culture connected to moral sexual behaviour. An elder explained: "The cultural approach is that early and unauthorized sex is forbidden by our culture, sex for girls is allowed only after marriage, sex is also not for pleasure and for making money, when a girl is forced by the boy to have sex, that girl is forcefully taken into that boy's home and becomes his wife there and then", he says.

Parents advised their children to delay sex until they were old enough and ready for marriage and wanted a say in the type of suitors their sons or daughters would bring lest they end up in the same shame their neighbors brought when they contracted the virus. An elder summarised that "sex was only allowed for girls when their breasts had drooped and therefore allowed to get married which was above 20 years." Those suspected to have the virus, or to be in a family with the virus were avoided to preserve the "family name" of those members of the population deemed "healthy". Whilst this approach may have some utility in containing a disease, it also wrought particular consequences for social exclusion. For this reason, it is said that in early days of HIV/AIDS, those who were infected by the disease did not die of it but of "stigma", a term learnt from NGO interventions.

In 2002, Arua Hospital AIDS Program provided free access to ART for nearly 1,100 people living with HIV/AIDS. Since then, antiretroviral therapies have been cheaply and widely available from the referral hospital, Kuluva hospital, NGOs, district health centers and private clinics (Whyte, 2014). This has shifted dynamics of management. However, memories of moral regulation persist.

Case Study 3: Improvising Containment during the threat of Ebola 2018-2020

In Uganda, Ebola Virus Disease (EVD) outbreaks have been recorded in 2000, 2014, 2017 and 2018. The Gulu outbreak in 2000 led to 220 deaths out of 425 registered cases according to the MoH. To date, the West Nile sub-region has been affected at a minimal scale compared to the other parts of the country.

However, in view of the 2018-19 outbreak in Eastern DRC, the threat of Ebola crossing the border precipitated concern regarding the potential for containment, should the virus spread over the border.

In response to the panic caused by the death of a 10-year old Congolese boy at ARRH on April 26th 2018 (presenting with signs of the EBV, but later declared negative after tests from Uganda Virus Research Institute (UVRI)), a proactive Infection, Prevention and Emergency Response Committee was formed at ARRH to handle cases. Authorities stepped up sensitisation and surveillance, especially along the common border entry points at Vurra and Odramacaku in Arua District, Goli in Nebbi District, Kolokoto in Pakwach District, and Padea in Zombo District.

In June 2019, another case from Panyimur Sub-County, Pakwach District, also tested negative. Nonetheless, a team of health workers was later dispatched to Dei, also in Pakwach, to assess the situation at the border sub-county to sensitise the public. At this time, health and security officials in Pakwach District expressed serious concerns over a threat caused by Congolese nationals who they said entered the country without going through mandated screening at the designated border points. Generally, West Nile was under more threat after a case was confirmed in the Eastern Congolese near-border town of Ariwara, about 15km from the Uganda-Congo border at Odramacaku in Arua District. Given traffic to and from the borderland market, there was fear that EBV could enter the general population.

In Arua town during 2019, it became evident that many community members perceived Ebola to be highly contagious and transmitted through contact with infected people, and suggested that should they suspect Ebola, they would be most likely to attend the main government

hospital for diagnosis and treatment (Storer and Pearson, 2019). Many interlocutors regarded Ebola as an illness that “comes from Congo”, and is brought across the border by Congolese citizens, or Ugandans who have contact with the Congolese. Whilst this reflects the epicentre of the contemporary outbreak, and the panic from reported cases (confirmed positive or otherwise), it also reflects histories where new epidemics are attributed to the Congo (Middleton, 1987).

Following the cases in Ariwara, West Nilers began actively avoiding people from Congo. Public health officials discouraged practices including handshaking, hugging and mass attendance at burial places while at the same time encouraging behaviours like hand washing with soap in public places. In towns and any other urban centres in West Nile, water points were also placed at the entrance of shops and shopping centres for locals to wash hands before accessing the premises while others used sanitisers. A designated quarantine centre was set up in Arua’s urban suburb of Oli Division.

These measures were accompanied by social surveillance. Many Aruans obtain a living through conducting cross border trade in Congo, or with Congolese citizens. As such, there was concern that the Congolese may travel from an Ebola-zone into Uganda. During 2018/19, there was a general concern among locals and neighbours whenever one received a visitor and they often wanted to know where he/she was from. It was worse when they heard that the visitor was from Congo.

Information was quickly passed to the local council authorities at village level who then intervened to interview the suspect, to their judgment if they were suspicious of the suspect, they easily alerted the health emergency team, which was often on standby to attend to such cases.

Parents often told their children not to play or mix with the neighbours whom they suspected might have contracted the disease. They were also warned against shaking hands or coming into close contact with anybody they didn’t know. Water with soap for washing hands was often placed at the entrance of homesteads as recommended by health authorities — with

every person that enters a home encouraged to wash their hands to minimise the spread of the disease.

In religious facilities, leaders discouraged their congregations from shaking hands during services and any other prayers. Bodies of people who were suspected of having died of Ebola were only to be buried by trained health workers and viewing or traditional Lugbara culture of washing the body by relatives before burial was strictly forbidden.

1.7 Discussion

- In West Nile, stark resistance has accompanied the designation of quarantine centres, as well as the interaction with established centres when infection is suspected. There is limited trust in the capabilities of state health facilities to manage outsiders who were thought to bring COVID-19 into communities, or to manage relatives with an appropriate standard of care. This resistance was particularly acute during the early months of the pandemic, at a time when there was severe uncertainty regarding whether COVID-19 exists on the one hand, or the potential impacts of a virus with “no cure” on the other hand. In many ways, these patterns echo those widely reported during the first months of the West African Ebola epidemic. Here too, quarantine centres were seen as centres of contagion, and relatives often opted for home care, away from the purview of foreign health workers and an often-militarised response (Parker, MacGregor and Akello, 2020).

- The roots of resistance are strongly related to mistrust of the state and echo wider patterns where alternative cures are sought for a host of conditions. Resistance is also related in practices of care where routes believed to offer trusted care (for example, herbalists) are sought instead of healthcare providers who are socially dis-embedded. The militarisation of the state, in a periphery where many have lived through war and displacement, has further damaged the legitimacy of the response. The police and the military were heavily involved in enforcing lockdowns, as well as care upon registration of suspected cases.

- Resistance to COVID-19 must also be interpreted in the context of a one-size fits all response which was seen as highly damaging to people’s livelihoods. Additionally, during the first six-

months of the pandemic, there was significant denial regarding the existence of COVID-19, particularly since few cases had been registered in West Nile. Yet, many decried the food insecurity and damage to incomes wrought by the lockdown, which were deemed to pose more risks to survival than the lockdown. Prior to the pandemic, many had relied on movement to markets both within and beyond the sub-region for survival, and its prohibition was highly detrimental in a region where many are self-reliant. Government support failed to make up for shortfalls in income during lockdowns. In a poor peripheral region of Uganda, people lack financial safety nets to cushion against shocks to household income.

- Whilst the resistance rallied by cultural institutions was in part an act of political resistance in the face of restrictions widely deemed inappropriate, it was also an attempt to revive indigenous knowledge and practices of containing disease.

- Historical memories of indigeneity diverge from realities of hybrid forms of local response to disease outbreaks. Such practices have drawn on diverse forms of public authority, including local government, healthcare facilities, as well as on networks of clan and family elders, herbalists and religious leaders. Maintaining health among West Nilers has long been a plural enterprise, and responses to crisis are no exception. Whilst skeptically, health crises are an opportunity for alternative healers to expand their markets. That their care is widely sought after is demonstrative of citizens' desires to seek protection and curing from socially embedded authorities, where the efficacy of medicine can be validated. People often seek recommendations for herbalists from family or extended networks – specialists are only consulted on the basis that their interventions "work", i.e. are perceived to restore well-being.

- Indigenous approaches to lockdown are effective since they are seen to maintain the livelihoods of the majority through quarantining the minority (see Working Paper 2).

- Since sickness is both physical and moral, the interventions of elders often serve to involve normative (patriarchal) principles. This may include the restriction of women's sexuality, or the enhancement of social surveillance networks governing marriage and neighbourhood. At times, the social responses to crisis can also include exclusion, through tarnishing the name of those deemed to bring viral diseases into homes and the community. That said, these

measures might be effective, precisely because they are embedded in authority, and the granular structure of authorities.

1.8 Concluding Remarks

This paper has explored claims for an "indigenous" lockdown which emerged in North West Uganda amidst the restrictions of the COVID-19 pandemic. We have suggested that such calls were a political response to nation-wide restrictions. Yet, taking calls seriously, we have exposed a dynamic terrain of locally-situated responses to outbreak threats. We have shown how such approaches responded to colonial disease threats and have been continually adapted throughout the post-independence period. Increasingly, responses have incorporated aspects of biomedical practice. We have shown the global health responses are not imposed onto a blank canvas, but rather onto active attempts of borderland populations to resist disease.

On the other hand, we have noted that indigenous lockdowns function within patriarchal, gerontocratic framework of society. Since outbreaks – notably HIV/AIDS – have been perceived as moral crises – outbreak control has often reasserted boundaries of masculine control. Equally, quarantines have long compromised the rights of the sick for the protection of the wider community. Thus, whilst we suggest it is important to explore emergent political protests of communities during crisis, it is essential to understand these calls to be expressions of power-holding groups. It is no coincidence that indigenous lockdowns were valorised by elders who have long retained moral, social and spiritual standing within borderland society. For these groups, advocating for improvised approaches, rather than one-size-fits all, has benefits which are not equally shared among marginalised members of the populace.

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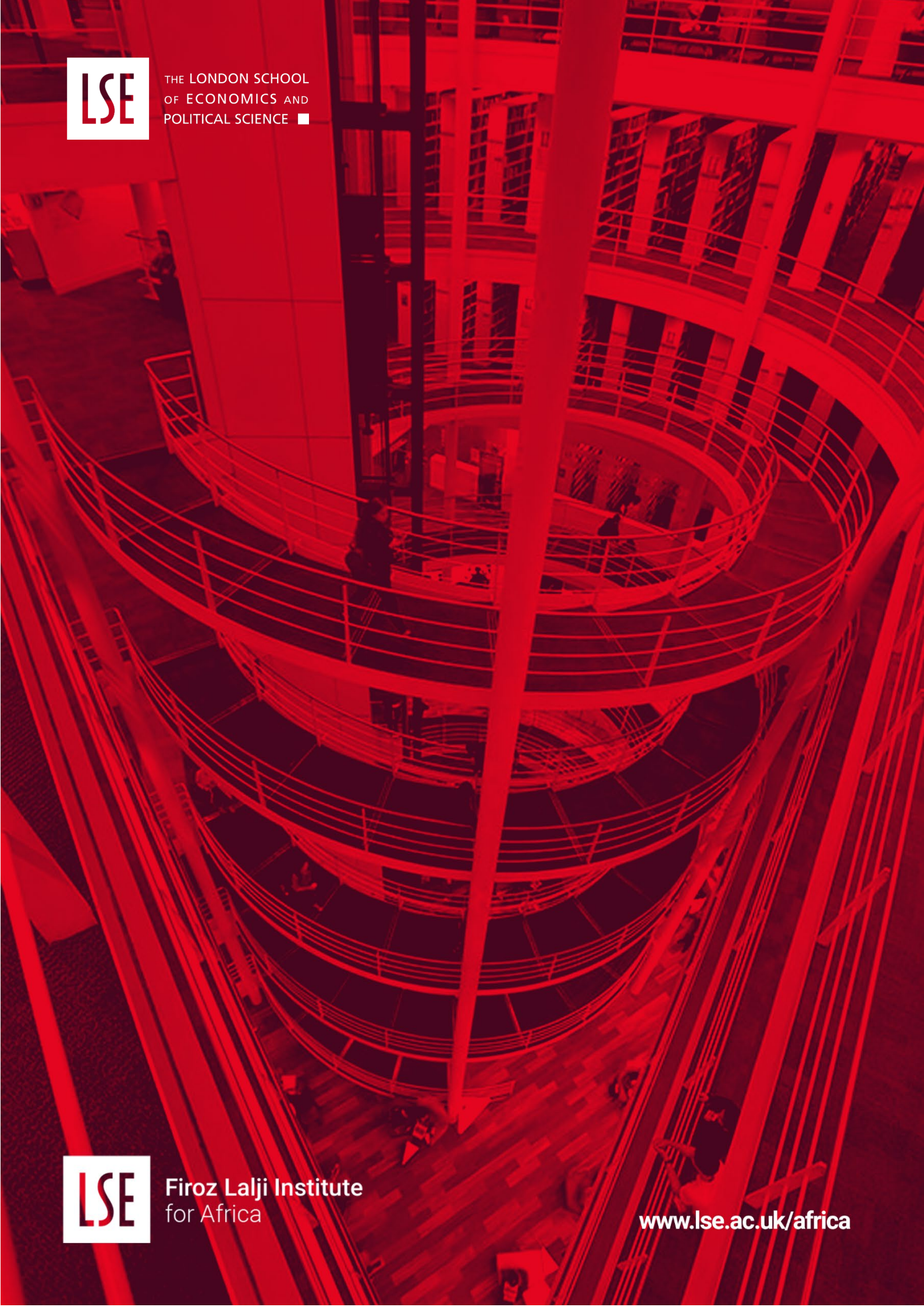
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