

In the Shadows of COVID-19

From January 2020 to October 2021

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Abstract

In this Field Note piece, I use my clinical and research experiences in the UK and Uganda during the COVID-19 pandemic to explore the contrasting ways it unravelled in each setting during the period between January 2020 and October 2021. In the UK, working as a clinician while also studying at a leading public health institution, my life became monopolised by COVID-19, particularly in relation to concerns around direct transmission of the virus and the illness it causes. Whilst conducting fieldwork and working in a health centre in Uganda, however, I was reminded to pay greater attention to the effects of COVID-19 restrictions and the burden of other causes of ill health. Bringing together these experiences, this piece explores how priorities and preparedness for fieldwork developed in one setting do not necessarily translate to another location, thereby underlining the challenges of planning adequately for fieldwork.

Keywords

Fieldwork, COVID-19, Pandemic preparedness, Lockdown, United Kingdom, Uganda.

I am currently a PhD student in medical anthropology studying the notion of pandemic preparedness, in addition to being a general practitioner (GP) in North London, England. This Field Notes piece explores my decisions to conduct research overseas during a pandemic; what informed decisions to pursue such fieldwork; who to trust when making such decisions; and the fluidity of each of these. In other words, in what follows I explore my experiences of preparedness and decision making in relation to my fieldwork during this pandemic. I will reflect on working across two diverse settings—London, England and northern Uganda—revealing that experiences of the pandemic and pandemic preparedness do not necessarily translate across sites, thereby underlining the importance of tuning into local contexts and concerns. This disparity can be challenging but is even more essential when contrasting perspectives challenge dominant narratives at leading research institutions, even and not least during a global pandemic.

In the following sections, I will first describe working as a clinician during the COVID-19 response in London, showing how these environments shaped my understanding of the pandemic, and preparedness for it, in a Western country. Secondly, I move into the academic world of my PhD studies and describe the impact of COVID-19 on fieldwork planning, then move on to lay out my transition to life in Uganda, where I began to see beyond COVID-19. Lastly, comparisons between my time in the UK and Uganda will be made in order to comment on the ways in which this pandemic has come to overshadow so much else, suggesting that the priorities that informed my understanding of preparedness in one setting did not easily translate to another.

COVID-19 in the UK

In February 2020, two months into my PhD in medical anthropology, delving into anthropological literature on ‘preparedness’, and auditing MSc modules on epidemiology and communicable disease control, COVID-19 increasingly became of global concern. The very topic of my PhD became a lived experience, and my academic and clinical experiences of significant ethnographic interest, so I started keeping field notes—months before any official start date of PhD ‘data collection’—as my life became monopolised by COVID-19.

As concerns over COVID-19 began to grow in early 2020, lecturers at my institution started using ‘Wuhan data’ to teach epidemiological calculations of viral reproduction rates. Local, regional, and national guidelines started filling up my @nhs.net email inbox regarding the need to take detailed travel histories from coughing patients attending GP practices. Healthcare workers were soon after called to the ‘frontline’. Clinicians in research roles were returned to clinical duties and non-urgent hospital appointments and investigations cancelled. I felt duty-

bound to pause my PhD and return to full-time clinical work. Rather quickly, it became apparent that, with all non-urgent care on hold, the need for extra clinical staff in primary care was not particularly great. So, I signed up to work in an intensive care setting at a COVID-19 temporary hospital for a short stint.

Moving from primary care to intensive care was challenging, but many of the ‘ward doctors’ in this makeshift field hospital-esque set-up were also GPs like myself. Exceptional times call for exceptional measures: in common with many aspects of COVID-19 care, I noticed how quickly people adjusted and adapted. I became accustomed to how the patients I was caring for became ‘bodies’ that I only transiently connected with as real people: moving in and out of consciousness, intermittently able to communicate in basic ways, make eye contact, squeeze a hand, before they inevitably felt the uncomfortable sensation of the endotracheal tube in their throat, started to cough, and we once more increased their medications and sent them back to a sedated unconsciousness, while we fiddled, prodded and poked, trying to maintain their bodies as they fought for their lives.

In stark contrast to my work in primary care, I started to expect death and stopped presuming the patients I cared for on any shift would still be there on the next. Working as a team helped with processing the sadness and suffering I was witnessing, and I learned fast how to read my colleagues’ eyes—the only part of the body visible, with the rest of it covered in top-to-toe personal protective equipment (PPE), their name and position scrawled over their chest and face shield. These unique experiences of a rapidly changing clinical landscape not only shaped my understanding of the pandemic, but undoubtedly contributed to my obsessions with COVID-19 transmission and illness. Working within the NHS as it was rapidly reconfiguring to accommodate this new illness, it was hard to see beyond the pandemic.

COVID-19 and fieldwork planning

I returned to full-time PhD studies in July 2020, where I found fellow researchers also engrossed by COVID-19. Studying at a leading public health research institution, most colleagues had pivoted to COVID-19, some busy producing expert evidence for governments and UN agencies about the unravelling pandemic. With strict travel restrictions, research projects—irrespective of their disciplinary focus—had to change and innovate to accommodate delays and remote ways of working. In common with most research students, I considered whether to pivot my own PhD, firstly to COVID-19, and secondly to the UK. Would travel restrictions ever lift to allow me to travel? With an unravelling and unpredictable pandemic, was it ethical to consider undertaking fieldwork in Uganda? Within the institution, there was great emphasis placed on COVID-19 mitigation measures, ensuring the

process of research itself did not lead to greater transmission. This was reflected in an extensive travel risk assessment and approval process for any overseas work carried out by my institution. I felt like a rather lone wolf, informed I was the only student in the department at that time trying to embark on overseas fieldwork during the pandemic. I considered changing my fieldwork site to the UK, but after repeated discussions with friends and colleagues in Uganda, whose experiences were so different to mine, I felt more and more inclined to see their perspectives for myself. Additionally, the pandemic had added to the potential value of my initial plans to study preparedness in a refugee settlement in Uganda, given the humanitarian concerns regarding the potential devastating impact of COVID-19 in such settings. Despite the additional challenges of overseas work, and the increased academic interest in the pandemic in the UK, I felt uncomfortable turning my back on my previous plans to understand what was happening in a less-resourced part of the world.

But it did also feel uncomfortable to go ‘against the grain’, especially in late December 2020, when a new UK lockdown was being declared, and there was growing concern over a new variant. I was faced with a dilemma: keen to start formal PhD fieldwork but concerned about the prospect of travelling internationally (albeit for permitted work), aware of public health concerns, and now with added personal worries, about spreading this new variant. Shuddering at the thought, I called a doctor friend in Uganda. Laughing, he said: ‘The borders are open here.’ I suggested I did a self-imposed quarantine on arrival in Uganda, in addition to my mandatory COVID-19 test before flying. ‘Well as long as you know you are only quarantining for your own conscience’, he laughed, ‘what an expensive conscience you have!’ My anxiety seemed absurd to him. COVID-19 was not the main concern for people in Uganda: ‘They have more important things to worry about, other diseases killing more people, and there is a national election on the 14th of January!’, he told me. I listened and tried to take on board what he was saying, trying to contemplate a world not monopolised by this pandemic. Ongoing discussions with friends and colleagues in Uganda continued to reveal a very different pandemic story, with deaths caused directly by COVID-19 of far less concern than I was used to in the UK. Determined to travel, but still wary and not fully convinced, I ordered a lengthy list of PPE to take with me—adequate masks, hand sanitisers, all of which I had carefully outlined in my institution’s travel risk assessment.

COVID-19 and restrictions in Uganda

Arriving in Uganda in January 2021, I was taken aback at the generally *laissez-faire* attitude towards COVID-19 in comparison with the UK, at that time in the midst of a national lockdown. But before long, I began to appreciate the humour

my Ugandan friends and colleagues had found in my former anxiety regarding 'spreading the virus'. Not strictly part of my PhD, but rather to maintain my clinical skills during fieldwork, and while I went through the lengthy approval process required to gain access to the refugee settlement, I started spending time in a health centre in Gulu, in the north of the country. In stark contrast to my clinical work in the UK, COVID-19 was quickly slipping down my priority list. Instead, I was concerned with managing more prevalent diseases such as malaria and diarrhoeal illness. The staff in the health centre had little doubt that COVID-19 was circulating, but there just happened to be lots of other illnesses and afflictions that were just as, if not more, important. I started going into the health centre more consumed by trying to juggle the biomedical rationale for recommending a medical investigation with the financial consequences of any management plan for a patient and their wider family than by concerns about COVID-19. In a place where obtaining any type of reliable microbiological culture (for the diagnosis of infections) is challenging, and where trying to locate a reliable CT, MRI, or endoscopy outside of the capital Kampala is equally difficult, my obsession with COVID-19, normal as that had been in the UK, faded into the shadows.

Overall, COVID-19 as a direct cause of illness has not dominated my life in Uganda in any way close to resembling the way it did in the UK. However, it is important to note that there have still been periods of time, during 'waves' of increased infection, where COVID-19-related illness became part of daily life. For example, in May 2021, official government reporting in Uganda revealed increasing case numbers. At that time, I could also see rising respiratory cases at the health centre in Gulu. In the midst of the rainy season, other respiratory infections were also increasing, along with febrile illnesses like malaria, and with limited COVID-19 testing available, one febrile or respiratory illness was often hard to distinguish from another.

But, more and more, people in urban settings such as Gulu or Kampala started discussing those known to them who had become ill or died of COVID-19. People made comparisons with the first wave in 2020: for instance, a friend explained to me, as he described the death of a loved one who had recently tested positive, 'last year COVID was just political, now it feels real'. In the first wave he hadn't known anyone who had died following a diagnosis of COVID-19, he continued, but was suspicious of the way the pandemic had featured so strongly in justification of the restriction of opposition campaigning in the run up to the presidential election in January 2021. Others I have spoken to feel that the first lockdown, which had been imposed in March 2020, was more legitimate than subsequent more 'political' lockdowns and containment decisions. The initial lockdown was legitimised by significant fear regarding the new pandemic sweeping the world, causing devastation in Western developed nations. But as the pandemic continued, this

devastation has never really materialised in Uganda from COVID-19 illness, limiting the credibility of subsequent harsh restrictions. From both perspectives, it is clear that people associate COVID-19 policy with political endeavours.

Despite the wave in May 2021, by September of the same year, COVID-19 concerns had faded rather quickly. Up to the time of writing, possible cases continue to appear sporadically, but discussions about this illness with medical colleagues feel like our regular discussions about other diseases or conditions. And as I spend more time in rural settings and the refugee settlement, many people describe no personal experiences of COVID-19, never having known anyone affected by this virus. But they have, without exception, experienced the harsh effects of related restrictions.

The first lockdown in Uganda in March 2020 was followed by a slew of more long-term, less stringent measures. In June 2021, a new lockdown was initiated in response to a further wave, followed again by reduced but still significant restrictions. Some measures, such as the closure of schools, were only ultimately lifted fully in January 2022. The consequences of these lockdowns have been severe and undoubtedly caused a substantial number of deaths (Broadbent et al. 2020). During the first lockdown, no public transport or private car travel was allowed, except for permitted essential workers. People were left to make essential journeys on foot, even when seeking medical attention. Those with severe illness, or giving birth, especially from more remote villages, were often not able to reach medical facilities. Many people's incomes just stopped, with no government welfare support to rely on. For instance, opportunities for *boda boda* (motorcycle-taxi) driving and selling clothes in a market were suddenly removed. The closure of schools has been associated with an increase in teenage pregnancy, and there is a fear that many children will never return to school, having become essential contributors to household income.

Living and studying in Uganda over the past year has enabled me to appreciate the profound impact of COVID-19 restrictions on people's lives. It is not my intention here to critique the decisions to implement such restrictions. Rather, I am drawing attention to the suffering related to the consequences of such restrictions, when measures to mitigate the former are not also introduced. This is particularly pertinent when the suffering related to restrictions may be felt more substantially in everyday life than are the direct effects of the virus itself.

In the shadows

Looking beyond COVID-19, I am acutely aware of the burden of illness in Uganda and am reminded daily of people's struggle to make sufficient earnings to pay for medical bills, in addition to other basic needs (e.g., food, shelter, and education).

Despite coming from the midst of the COVID-19 crisis in the UK, here in Uganda death feels like a common occurrence, but is more an accepted part of life. As someone told me in passing, 'people die here all the time, the difference is, we are just used to it here, whereas in the West, you are not'. In contrast to my previous preoccupation with COVID-19 infection and transmission, my focus has now shifted to daily experiences of ill-health and suffering more generally, and the precarious nature of people's lives; in parallel, the more 'indirect' consequences of COVID-19 lockdowns (e.g., school closures and lack of employment) feel far more important to consider.

Appreciating how engrossed I became with COVID-19 in the UK in contrast to subsequent experiences in Uganda has forced me to see the pandemic in a different light. In retrospect, paying greater attention to the accounts of friends and colleagues in Uganda, whose priorities were at odds with my perspectives, which were informed by my experiences in the UK, would have prepared me more appropriately for fieldwork. Once in Uganda, reflecting on my daily life and being willing to reconsider my preconceptions and preoccupation with COVID-19 enabled me to appreciate the disconnection between the lived experience of the pandemic in Uganda and the precedence it was given in the research environment I had witnessed in the UK, which was presumed to translate to my fieldwork overseas. It is clear that a preparedness informed by one setting can easily become obsolete elsewhere.

What is troubling is that when I was seeking in the UK all the necessary permissions to travel, it was hard to believe that COVID-19 really wasn't the most important thing to be talking about. Not only did I fall into a rather ethnocentric hole, but there is a possibility the research systems around me fell in too. This hole has far-reaching consequences. Pandemic experiences in Western states like the UK shape global research and policy agendas. This in turn influences health priorities and the implementation of restrictions in diverse settings, which have substantially different financial and social systems in place to deal with the often-catastrophic consequences of such policies, and also have very different experiences of the illness itself. But as my experiences from COVID-19 have revealed, suffering that does not directly result from pandemic illness can easily become overshadowed.

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