Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19

Sophie Katherine Hardman Mylan

Thesis submitted in accordance with the requirements for the degree of
Doctor of Philosophy
of the
University of London
June 2025

Department of Global Heath and International Development

Faculty of Public Health and Policy

LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE, UNIVERSITY OF LONDON

Funded by the Economic and Social Research Council (ESRC), UK

My doctoral studentship was provided by the ESRC (ES/P000592/1). I received a COVID-19 extension from LSHTM. I received financial support from the Parkes Foundation, and LSE through the AHRC Safety of Strangers grant (AH/T007524/1), and ESRC Centre for Public Authority and International Development (grant numbers ES/P008038/1 and ES/W00786X/1). My doctoral project was awarded a prize from the Centre of Epidemic Preparedness and Response (CEPR) at LSHTM.

I, Sophie Katherine Hardman Mylan, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

Current framings of epidemic preparedness in refugee settings foreground biomedical and techno-scientific approaches. However, a growing body of critical social science literature highlights the need to pay much greater attention to the perspectives of those experiencing epidemics, and the socio-political dynamics shaping policies and practices on the ground. Despite this, there is a lack of ethnographic research foregrounding refugees' perspectives of epidemic preparedness.

This PhD explores how epidemic preparedness principles and practices intersect with the unique historical, socio-economic, spiritual and political challenges facing South Sudanese Acholi refugees. Fourteen months of ethnographic fieldwork was carried out in Palabek Refugee Settlement, northern Uganda, between April 2021 and June 2022, during the COVID-19 pandemic. In addition to living with a South Sudanese family, 158 semi-structured interviews were carried out with refugees, Ugandans living near the settlement, and humanitarian and government actors. The research also followed individuals and ideas from the settlement to district, regional and national meetings.

Four elements of epidemic preparedness are critically explored. First, COVID-19 containment policies, which were framed as a form of humanitarian 'protection', are juxtaposed with mobility-orientated forms of 'self-protection' amongst refugees. Second, COVID-19 vaccination is analysed as a 'suspicious business', problematising dichotomised debates in public health discourse regarding vaccine supply and vaccine hesitancy. Third, COVID-19 screening is explored by following the performance of counting COVID-19 in different contexts, demonstrating that seemingly 'objective' counting practices are entangled in complex social, economic and political dynamics. Lastly, the linear temporality central to public health approaches to preparedness is problematised through an exploration of the relational nature of time amongst refugees.

Overall, the PhD demonstrates how historical, spiritual, socio-economic and political dynamics are inextricable from the way in which epidemic preparedness is conceptualised, delivered and responded to. Current mainstream frameworks for preparedness ignore important perspectives from refugees that could usefully inform a re-thinking of preparedness, while also obfuscating the everyday suffering of refugees, and the (geo)political dynamics that perpetuate it.

Table of Contents

List of Figures

Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AZ	AstraZeneca
BCG	Bacillus Calmette-Guérin
CDC	US Centre for Disease Control and Prevention
CEPI	Coalition for Epidemic Preparedness Innovations
CEPR	Centre of Epidemic Preparedness and Response
COVAX	COVID-19 Vaccine Global Access
COVID-19	Coronavirus disease 2019
CPAID	Centre for Public Authority and International Development
CT	Computed Tomography
DAR	Development Assistance for Refugees
DLI	Development through Local Integration
DRC	Democratic Republic of the Congo
EPR	Emergency Preparedness and Response Cluster
ESRC	Economic and Social Research Council
EU	European Union
GDP	Gross Domestic Product

GFA	General Food and Cash Assistance
GHSA	Global Health Security Agenda
GOARN	Global Outbreak Alert and Response Network
GP	General Practitioner
HAT	Human African Trypanosomiasis
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
IAV	Influenza A Virus
ICRC	International Committee of the Red Cross
IDP	Internally Displaced People
IFRC	International Federation of Red Cross and Red Crescent Societies
IIHR	International Health Regulations
IPC	Infection Prevention and Control
IRC	International Rescue Committee
J&J	Johnson and Johnson
LC	Local Councillor
LRA	Lord's Resistance Army
LSE	London School of Economics and Political Science
LSHTM	London School of Hygiene and Tropical Medicine
MAT	Medicine Anthropology Theory
MOH	Ministry of Health
MRI	Magnetic Resonance Imaging
MSF	Médecins Sans Frontières
NATO	North Atlantic Treaty Organization
NEOC	National Emergency Operating Center
NGO(s)	Non-government organisation(s)
NPI	Non-Pharmaceutical Interventions
NRM	National Resistance Movement
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OPM	Office of the Prime Minister
PCR	Polymerase Chain Reaction
PHEIC	Public Health Emergency of International Concern
PHSM	Public Health and Social Measures

PPE	Personal Protective Equipment
PSN	People with Special Needs
RDC	Resident District Commissioner
RDT	Rapid Diagnostic Tests
RRP	Refugee Response Plan
RWC	Refugee Welfare Committee
R2P	Responsibility to Protect
R&D	Research and Development
SAGE	Strategic Advisory Group of Experts on Immunization
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
SPLM	Sudan People's Liberation Movement
SPLM-IO	Sudan People's Liberation Movement-in-Opposition
SSHAP	Social Science in Humanitarian Action Platform
TB	Tuberculosis
UCRRP	Uganda Country Refugee Response Plan
UGX	Ugandan Shilling
UK	United Kingdom
UN	United Nations
UNCST	Ugandan National Council for Science and Technology
UNHCR	United Nations High Commissioner for Refugees
UPDF	Ugandan People's Defence Forces
URA	Ugandan Revenue Authority
USAID	United States Agency for International Development
USD	United States Dollars
VHT	Village Health Team
WFP	World Food Programme
WHE	WHO Health Emergencies Programme
WHO	World Health Organization
4Rs	Repatriation, Reintegration, Rehabilitation and Reconstruction

Acknowledgements

Melissa Parker, my primary supervisor, has been an inspiration since I met her in 2009 whilst completing an MSc. She supported me in conducting my first ethnographic fieldwork in northern Uganda in 2010, and to say she was fundamental in developing my interest in Medical Anthropology and northern Uganda, would be an understatement. Melissa's patience and support continued for a decade, before I finally started a PhD with her in 2019. At LSHTM, she introduced me to Simon Cohn, who became my second supervisor. I will forever be grateful for Simon's ability to translate decades of anthropological theory into something my 'medic-mind' could grapple with, giving me the confidence to engage with literature I would have otherwise been hesitant to. Together, Melissa and Simon have been an exceptional consistent support throughout the development of this thesis, from conception to submission. I feel incredibly lucky to have been able to draw on their wealth of experience and constructive feedback.

A huge thank you to my whole family (including my close friends in the UK and Uganda) for their unwavering support throughout this process – even at times when I lost faith, they never did. Most of all, I would like to thank my son Oniba, who ensured I kept the PhD in perspective and took regular breaks. Charlotte and Helena Hardman, David Mylan and Oryema Geoffrey – you have been on this journey with me, and I will be forever grateful. Bastian Collet – you became my family in Uganda when I needed one most.

Ryan O'Byrne and Costanza Torre were essential for my fieldwork in Palabek, and I thank them for sharing the relationships they fostered so carefully. Ryan, your comments on my drafts have always been invaluable. Nick and Tessa Laing's friendship and kindness in reading and providing insightful remarks on my writing are highly appreciated. Kayima Peter ensured I made it to Uganda during COVID-19. Julian Hopwood and Aciro Jacky welcomed me into their family home in Gulu. Adonga Moses' teaching was not only formative but great fun too. The CPAID 'self-care' team helped me think through my project. Thank you to Charlotte Brown and Liz Storer for sharing their valuable insights into Uganda.

I would not have been able to complete this PhD without funding from the Economic and Social Research Council (ESRC). Studying at LSHTM has provided incredible access to a wealth of disciplines and individual academics. The time and temporalities reading group was inspirational – thank you for sharing your work and reading mine: Annelieke Driessen, Hannah Cowan, Elsbeth Roding, Maddy Pearson, Natassia Brenman, Maayan Ashkenazi and Praveena Fernes. Maddy Gupta Wright and Fred Martineau supported my PhD application and paved the way. I would like to thank Tim Rhodes and Jennifer Palmer for examining my PhD Upgrade, whose insightful comments and suggestions I took forward into fieldwork. Furthermore, I would not have been able to complete my research in northern Uganda without Grace Akello's invitation from Gulu University. My fieldwork has also been supported by Tim Allen and the Firoz Lalji Institute for Africa, London School of Economics and Political Science (LSE). Tim's passion for research has been contagious, and using LSE's car was particularly useful. Tom Kirk's encouragement and support was essential for chapter 6. Thank you to Josh Parker Allen and Dr Emmanuel Ochola for their constructive comments on chapter 3.

In Palabek, thank you to all the humanitarian and government staff who welcomed and facilitated my research. I am most grateful for the people living in Palabek for sharing their stories, teaching me, laughing with me, and showing me what is important. Obwoya Mariako Patrick and Achola Florence - you welcomed me into your home, *apwoyo matek tutwal - abi dwogo cok cok nii*.

My doctoral studentship was provided by the ESRC (ES/P000592/1), and I received a COVID-19 extension from LSHTM. I also received financial support from the Parkes Foundation, and LSE through the AHRC Safety of Strangers grant (AH/T007524/1), and ESRC Centre for Public Authority and International Development (grant numbers ES/P008038/1 and ES/W00786X/1). My doctoral project was awarded a prize from the Centre of Epidemic Preparedness and Response (CEPR) at LSHTM. Melissa Parker's research on Epidemic Preparedness and Response informed chapter 3 and was funded by a Wellcome Trust Collaborative Award (212536/Z/18/Z) and the UK Economic and Social Research Council (ES/P008038/1).

Chapter 1: Introduction

Studying Epidemic Preparedness

> *'…outbreaks have been on the rise for the past several decades and the spectre of a global health emergency looms large. If it is true to say "what's past is prologue", then there is a very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen killing 50 to 80 million people and wiping out nearly 5% of the world's economy. A global pandemic on that scale would be catastrophic, creating widespread havoc, instability and insecurity. The world is not prepared….'*
> (Global Preparedness Monitoring Board, 2019, p. IV)

A Global Focus on Epidemic Preparedness

In January 2020, I started my ESRC-funded doctoral studies, with a PhD title: 'Displacement and pandemic preparedness amongst refugees in northern Uganda'. The proposed PhD topic responded to the growing global focus on the concept of preparedness: the Global Preparedness Monitoring Board were not alone in their call for the prioritisation of pandemic theat. Preparedness was launched high on the political agenda following the 2013-2016 West African Ebola outbreaks (Heymann *et al.*, 2015; Commission on a Global Health Risk Framework for the Future; National Academy of Medicine, Secretariat., 2016). These outbreaks led to the deaths of over 11,000 people and involved a response costing more than 3.5 billion dollars (Parker *et al.*, 2019a).

The World Health Organization's (WHO) initial response to these outbreaks was widely criticised for being too slow to declare a Public Health Emergency of International Concern (PHEIC), a declaration that 'carries implications for public health beyond the affected State's national border; and may require immediate international action' (World Health Organization, 2019a). The slow response from the WHO in relation to Ebola followed criticism from the way in which the organisation had managed previous threats, most notably an 'overzealous' declaration of a PHEIC for H1N1[1] in 2009 (Abeysinghe, 2013). In contrast to the criticism regarding their management of Ebola and H1N1, the

[1] The H1N1 pandemic in 2009 was caused by the influenza A virus (IAV) (World Health Organization, 2009).

WHO received more positive praise for its response to the SARS[2] outbreak in 2003 (Kamradt-Scott, 2016), which prompted revisions of the WHO's *International Health Regulations (IHR)* in 2007 (Mullen *et al.*, 2020), and created a new approach to global health security (Kamradt-Scott, 2016). The IHR, a legal framework, defined a PHEIC, and outlined countries' obligations in regard to public health events and emergencies that have the potential to cross borders (World Health Organization, 2005).

Reflections on the 2013-2016 West African Ebola outbreaks were pivotal: they demonstrated a clear lack of international preparedness for global health emergences. A plethora of commissions and advisory groups subsequently occurred, all of which emphasised the importance of preparedness (Gostin *et al.*, 2016; Moon *et al.*, 2015). For example, the *Global Health Security Agenda (GHSA)* was launched in 2014, and builds preparedness through surveillance, laboratory systems, improving response capacity, and enhancing workforce training (Angulo *et al.*, 2017). In 2016, the WHO *Health Emergencies (WHE) Programme* was established, which was later renamed the *Emergency Preparedness and Response Cluster (EPR)* (World Health Organization, 2024a). In the same year, the *Coalition for Epidemic Preparedness Innovations (CEPI)* was launched to support vaccine development against 'priority pathogens' (Gouglas *et al.*, 2019). The year before, in 2015, The United Nations (UN) and the World Bank established the *High-level Panel on the Global Response to Health Crises*, whose subsequent recommendations included strengthening the WHO's capabilities in being the single global health leader 'with significant resources to determine and execute global health priorities' (United Nations, 2016, p. 5). This panel noted particular concern about the potential of pandemic influenza. The perceived risk of influenza significantly shaped conceptualisations of preparedness in Western nations including the United Kingdom (*UK Influenza Pandemic Preparedness Strategy 2011*, 2011) and the United States of America (Iskander *et al.*, 2013).

[2] This refers to the severe acute respiratory syndrome (SARS) outbreak in 2003, which was due to the severe acute respiratory syndrome coronavirus (SARS-CoV) (Wilder-Smith *et al.*, 2020).

The WHO remain a key actor in global health preparedness internationally, providing overarching legal, scientific and technical frameworks, coordinating various organisations and agendas, and strengthening countries' abilities to detect and respond to epidemic threats, with the ultimate goal of improving global health security (World Health Organization, 2024b). The organisation was involved in the development of early warning systems such as the *Global Outbreak Alert and Response Network (GOARN)*, providing 'real time' information on outbreaks (Mackenzie *et al.*, 2014). Other key WHO initiatives for preparedness include the *R&D*[3] *Blueprint for Actions to Prevention Epidemics Initiative*, which aims to reduce the time between the declaration of a public health emergency, and the availability of diagnostics, vaccines and treatment (Mehand *et al.*, 2018).

Reviewing these developments, it was clear that preparedness, as conceptualised by international public health organisations such as the WHO, and drawn upon by governments in the UK and across the world, provided a structured approach for dealing with the risk of epidemics and their potentially devastating consequences. Within the overall framework of preparedness, clinicians focused on diagnosing and treating the disease (Dagens *et al.*, 2020). For epidemiologists and statistical modellers, reproductive rates were the focus of analysis. This in turn, informed understandings of actual or potential epidemic scale and spread, with important implications for the provision of health services (Biggerstaff *et al.*, 2014). Economists, by contrast, focused on determining the fiscal consequences (McKibbin and Fernando, 2023). Preparedness, therefore, was often considered to be an amalgamation of policies and approaches to prepare nations for the disruptions associated with crises, typically prioritising scientific technological solutions to minimise social and economic disruption (Global Preparedness Monitoring Board, 2019). This included securing funding and resources, planning for public health messaging, considering social distancing methods, surveillance techniques, stockpiling medications, and setting up systems to enable the rapid development of therapeutics and vaccines (Oppenheim *et al.*, 2019). A summary of

[3] (Research & Development)

the indicators that were presented as able to assess preparedness are summarised in Figure 1.

These techno-scientific and biomedical approaches to epidemic preparedness, however, were flawed. For instance, there was no consideration of the perspectives of those people affected by disease outbreaks, who were only referred to as presumed recipients of public education and risk communication strategies. Furthermore, a variety of specialists, including epidemiologists and anthropologists, drew attention to the need to consider the inequalities accentuated by the spread of epidemics (Farmer, 2001; Garoon and Duggan, 2008; Public Health England, 2020) – none of which were captured in these indicators.

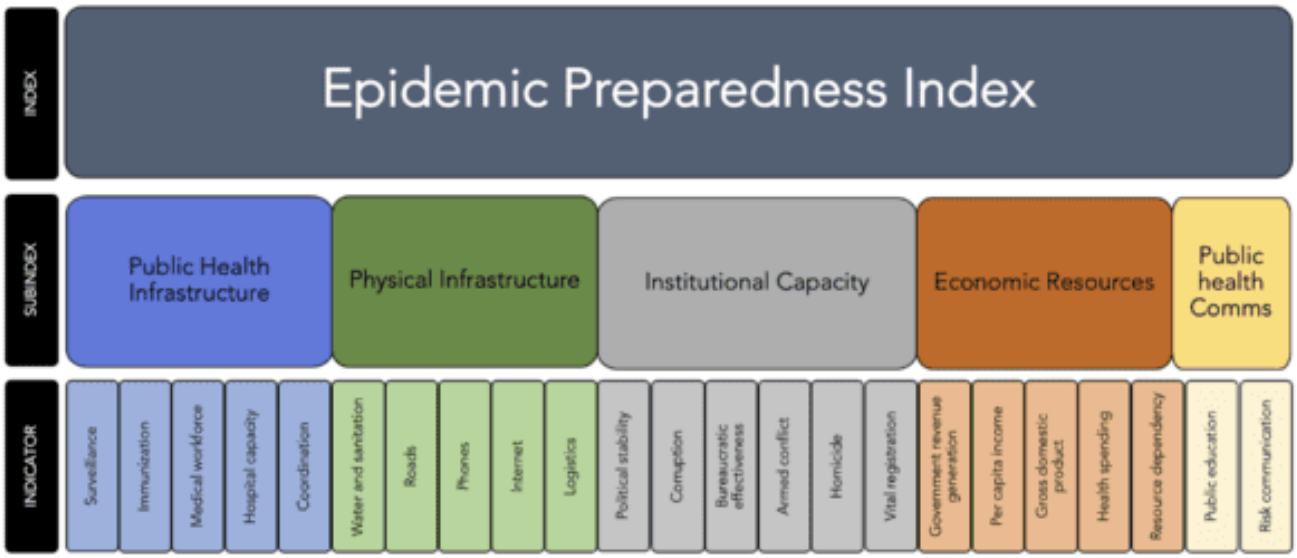


Figure 1. Epidemic Preparedness Index (EPI) design, published in the BMJ Global Health (Oppenheim et al., 2019.)

Anthropological Approaches to Preparedness

In parallel to the growing focus on epidemic preparedness by global health policy makers and practitioners, anthropologists such as Abramowitz *et al.*, (2018), Grant, (2018), Martineau *et al.*, (2017), and Nguyen (2014) raised important questions about this concept: what do measurements of successful preparedness reveal and obscure? Preparedness for *what,* and for *whom*? Martineau *et al.*, (2017) and Keck *et al.*, (2019) also reflected on how, and why, these Ebola outbreaks had enabled the incorporation of

anthropologists into national and international epidemic preparedness decision making boards.

Other anthropologists subsequently highlighted the importance of placing the 'politics of knowledge' production at the centre of preparedness (Leach *et al.*, 2022a), and exploring preparedness in the context of wider sources of uncertainty (MacGregor *et al.*, 2022). They have also foregrounded the need to incorporate historical, cultural, socio-economic and political considerations into conceptualisations of preparedness (Grant, 2023). These wider considerations profoundly shape the way in which people engage with formal approaches to epidemic preparedness and response, including vaccination campaigns during outbreaks (James *et al.*, 2023a; James and Lees, 2022; Kelly, 2018; Leach *et al.*, 2022b). Others have demonstrated the challenges to Ebola preparedness when outbreaks occur in complex borderland contexts, where borders are porous and people on both sides are highly connected for historical, social and economic reasons (e.g., Moro and Robinson, 2022; Schmidt-Sane *et al.*, 2020).

Rather than so-called 'communities' being seen as the recipients of interventions such as 'risk communication and community engagement' activities, anthropological research has demonstrated the importance of engaging with diverse public authorities in decision-making processes during outbreaks (Parker *et al.*, 2019a, 2019b, 2020) and incorporating their perspectives into conceptualisations of preparedness (Wilkinson *et al.*, 2017).

Anthropologists have also drawn attention to the inequalities exacerbated by epidemics and pandemics and suggested that preparedness needs to better recognise and address such disparities (Manderson *et al.*, 2021; Wilkinson *et al.*, 2023). Social inequalities are not only rendered visible by paying attention to the everyday lives of people before, during and after epidemics, but they also need to be considered in relation to global interconnectedness. Furthermore, what justifies a PHEIC, and therefore mobilises extensive international financial resources, is deeply political, and often heavily debated (Lakoff, 2019). Additionally, the funding of pandemics through the colloquially named

'Ebola Bonds' demonstrated the complex relationships between epidemics and the global financial system (Erikson, 2019).

Social scientists have analysed how health security agendas have shaped preparedness. A substantial focus on simulation exercises, for example, emerged in response to potential (bio)security threats (Lakoff, 2008, 2017). Wolf and Hall (2018) suggested such exercises were a way of bringing order to chaos. Keck and Lachenal (2019) analysed how simulations have become a technique of government in 'neoliberal societies'. It is particularly important for this thesis, to note how the temporality of preparedness has been analysed by scholars. For example, Caduff (2015) highlighted how preparedness became a type of scientific prophecy, and a constant state of readiness for a catastrophe that (perhaps) might never occur.

Researching Epidemic Preparedness in Refugee Settings

Despite this wealth of anthropological engagement with preparedness, there has been no long-term ethnographic research specifically examining epidemic preparedness in refugee settings. From the outset, the PhD intended to change that. There were two important reasons for doing so. First, refugee camps and settlements[4] in low-income countries are recognised to be particularly vulnerable to epidemics, with inadequate water, sanitation and hygiene, and overcrowding, often facilitating their spread (Altare *et al.*, 2019). Additionally, pre-existing malnutrition is likely to amplify the impact of epidemics (Connolly *et al.*, 2004).

Secondly, the precarious nature of living conditions in many refugee settings, including the increased risk of epidemics, contrasts sharply with the ethos underpinning humanitarian endeavours in refugee camps and settlements. Envisioned to protect, they are meant to provide food, safety, shelter and healthcare during times of crisis. In practice, it is far from straightforward. Studying epidemic preparedness in a refugee setting provided an opportunity to hone in on socio-political dimensions of power and

[4] The differences between refugee camps and settlements are discussed in chapter 2.

control at multiple scales: from geopolitical dynamics, to national policy, through to local politics in specific refugee settings. In so doing, it was possible to explore how, and why, such settings can perpetuate, rather than relieve, suffering.

To better understand the connections between preparedness and humanitarian assistance to refugees, I began by considering how both have been significantly influenced by processes of globalisation in the 21st century. This was associated with a 'fortification of national borders' against both refugees and pandemics (Spengler *et al.*, 2021). For epidemic preparedness and refugee crises, formal predominantly biomedical and techno-scientific approaches had attempted to predict, document and control not only the global movements of people and pathogens, but also their associated risks, including an emphasis on future anticipated occurrences. Although a wealth of anthropological literature has critically examined pandemic preparedness and biosecurity risk on the one hand, and refugee crises on the other, it was surprising to find that these two areas were rarely studied together through ethnographic means[5]. This was even more surprising given the parallels between epidemics and refugees, as problematised entities in relation to uncontrolled movement.

This thesis aimed to bring into dialogue, critical theoretical debates regarding preparedness on the one hand, and the (bio)politics of humanitarian 'states of exception' on the other. As a 'state of exception' (Fassin and Pandolfi, 2010), humanitarian settings justify 'a mode of power that is anything but benign' (Beckett, 2013, p. 87). Furthermore, humanitarianism has a complex relationship with military intervention, often connected to global (mainly Western) security risks (Allen, 2018). Simultaneously, global health security had propelled preparedness to the forefront of public health emergency thinking (Caduff, 2015; Lakoff, 2008), with epidemics representing 'the impossibility of securing the body politic in an ever-more interconnected, technological advanced and globalised world' (Keck *et al.*, 2019, p. 1). Little was known, however, about how these tensions played out in a humanitarian setting.

[5] Although not using ethnographic methods, Suzan Ilcan (a sociologist) and Kim Rygiel (a political scientist) did bring these areas of literature together to some extent, drawing on disaster preparedness to analyse resilience-focussed refugee policy (Ilcan and Rygiel, 2015).

Initial reading for this PhD also focused on how scholars described both epidemics and displacement in terms of 'emergency', 'crisis' and 'disaster'.[6] There was a wealth of academic literature, including insightful work from scholars grounded in anthropology (Barrios, 2017; Beckett, 2013) and political theory (Kennedy, 2011; Rubenstein, 2015) that eloquently described the distinctive but also overlapping features of each of these terms in both academic and popular use. This PhD does not re-write these accounts, but instead draws on this literature, where relevant, to explore what these terms mobilise or obscure in relation to epidemics and forced displacement. In particular, the PhD draws upon literature that points to the importance of understanding the consequences of 'emergency' thinking, for humanitarianism (Allen *et al.*, 2018; De Lauri, 2016) and 'states of exception' (Agamben, 2005; Fassin, 2012; Fassin and Pandolfi, 2010). Additionally, I considered how literature that pointed to the political consequences of temporal distinctions between disaster on the one hand, and crisis and emergency on the other (Rubenstein, 2015), could help understand the temporality of preparedness. On a similar theme, I became interested in scholarship that had explored the chronicity of crises (Vigh, 2008), slow emergencies (Anderson *et al.*, 2019) and the continuity and rupture of crisis (James *et al.*, 2023b).

Literature that problematised the temporality of emergency often suggested the need to examine the everyday lives and perspectives of those who were actually living in the greatest precarity. These perspectives were often set aside in global debates regarding both preparedness and refugee crises. This thesis, therefore, set out to study preparedness from the perspectives of refugees, to redress past imbalances in the literature. Furthermore, it sought to study the connections and disconnections between refugee perspectives, global preparedness policy, and techno-scientific and biomedical approaches to epidemics. Despite significant anthropological contributions to our

[6] The words 'crisis' and 'emergency' are often used interchangeably (Rubenstein, 2015), but their unique characteristics have also been analysed (e.g. Samimian-Darash and Rotem, 2019). Both 'crisis' and 'emergency' typically require immediate action to prevent future suffering, whereas in a 'disaster' or 'catastrophe' the bad outcome has already occurred (Rubenstein, 2015). A 'disaster' is a sudden catastrophic event, often divided into those from the 'natural' or 'technological' environment (Oliver-Smith, 1996). A 'catastrophe' has been described as being similar to a 'disaster', albeit of larger magnitude (Quarantelli, 2006).

understanding of, and engagement with, epidemics and preparedness, there was a paucity of long-term ethnographic research on epidemics in refugee camps or settlements in the Global South – a surprising gap, given decades of anthropological engagement in refugee studies.

The small amount of research that had been carried out suggested that historical, socio-political and economic issues fundamentally influenced people's experiences of official approaches to epidemic containment, and the success or otherwise of epidemic response efforts. For instance, McKay and Parker (2018) presented case studies of epidemics in humanitarian contexts, specifically examining outbreaks of cholera in North Kivu, Zaire in 1994 and Haiti in 2010, in addition to a polio outbreak in the Horn of Africa in 2013. They described how humanitarian agencies, in the case of outbreaks amongst Rwandan refugees in Zaire (now the Democratic Republic of the Congo) in 1994, '…may have helped to create the conditions for Vibrio cholerae and Shigella dysenteriae to spread' (McKay and Parker, 2018, pp. 82–83). Together, these case studies demonstrated that humanitarian assistance was more likely to be effective if it took into consideration the unique social, political and economic contexts in which epidemics were occurring.

The Onset of the COVID-19 Pandemic

Within a month of starting my PhD in January 2020 on 'pandemic preparedness', the world started to hear of a rapidly spreading new pathogen from China: we were on the verge of a pandemic. It raised the unexpected question: Could COVID-19[7] provide a lens to better understand preparedness?

With a training in General Practice, I continued to work clinically in London and I attended lectures to prepare my clinical skills for the forthcoming pandemic. On February 12th, 2020, I sat in a full lecture theatre at the Royal Colleague of Physicians, attending an

[7] From a biomedical perspective, COVID-19 is a disease caused by the virus SARS-CoV-2. This thesis, however, also uses the term COVID-19 to refer to the period of time when there was a global focus on this new disease.

event, ‘COVID-19: An Expert Update for Doctors’. The event included a panel of doctors who went on to become key figures in the UK COVID-19 response. At the time, the UK had not yet instigated COVID-19 restrictions, but cases were being confirmed within the country. Academic, medical and popular attention was intensely focussed on this new pathogen from China (Guardian, 2020). As the guest speakers described the current situation, I could feel the apprehension build in the packed lecture hall full of nervous physicians. Most of us had never lived or worked through a pandemic on our doorstep. The speakers were clear: It was going to be difficult for a few weeks, but then, ultimately, it would be ok. I remember the phrase: ‘we *can* deal with this’. I trusted in their experience, their knowledge and their judgement. I trusted them that ‘we’, the UK, were prepared.

In contrast to the UK, the speakers at the event expressed concern for the global consequences of the pandemic. A map similar to Figure 2, illustrating preparedness scores, was displayed for us all to see, with a thick red area in the middle. This map was used to demonstrate the premise that despite the forthcoming disturbance from COVID-19 in the UK, the devastation to occur across sub-Saharan Africa would be of greater concern, given the stark global inequalities in the capacity to respond to epidemics. What would this mean for my planned research amongst refugees in northern Uganda? Did this strengthen an argument for the greater need to understand epidemic preparedness in sub-Saharan Africa? Would a focus on COVID-19 facilitate this?

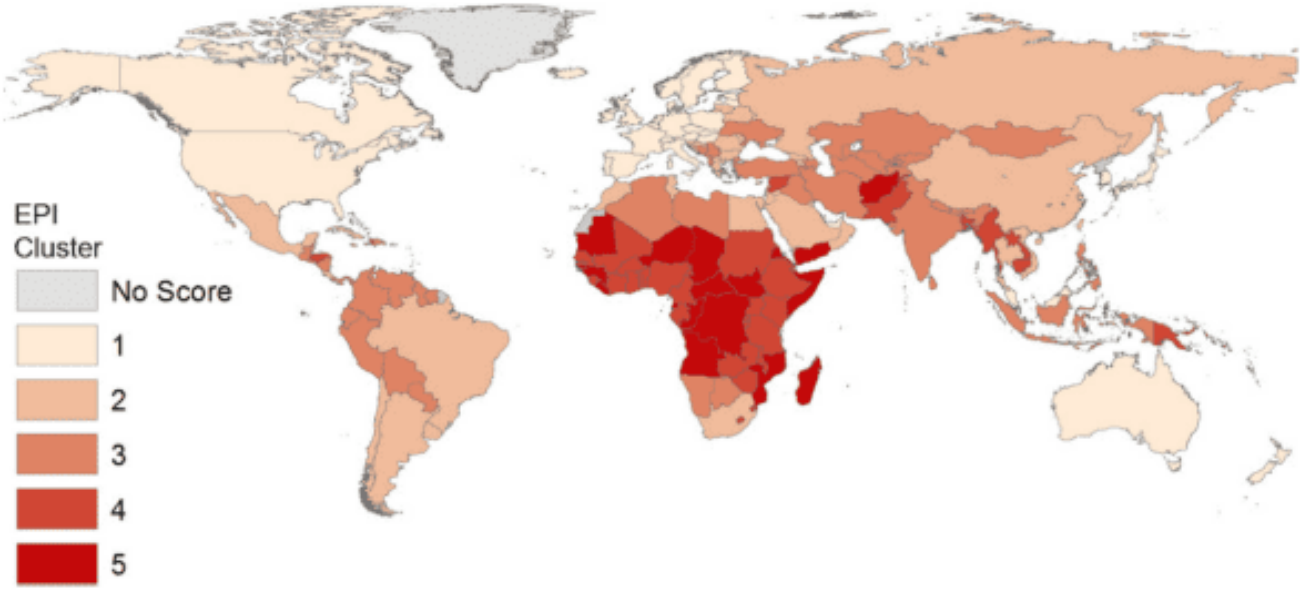


Figure 2. Global Distribution of Epidemic Preparedness Index Scores. 1= most prepared, 5=least prepared (Oppenheim et al., 2019).

Rethinking the Relationship between COVID-19 and Preparedness

The effects of the pandemic in both the UK and sub-Saharan Africa proved to be substantially different to the predictions made in early 2020. Parts of Western Europe (including the UK) and North America were more seriously affected than the preparedness scores had predicted (Mellish *et al.*, 2020). By contrast, despite contentious case numbers from variable testing, it is difficult to argue that sub-Saharan African was catastrophically affected by the consequences of COVID-19 in the way predicted by Figure 2. In fact, Oleribe *et al.*, (2024, p. 1) recently wrote in *Public Health in Practice* that: '...Africa was relatively spared from the worst of the pandemic, even after recognising that case ascertainment and reported mortality rates across the continent were far from complete' (p. 1). There have been many theories as to why this may have been the case, including demographic characteristics, rates of comorbidities, and environmental factors (Laing *et al.*, 2024). It also became clear that the indictors purporting to capture 'successful preparedness' (as found in the Global Distribution of

Epidemic Preparedness Index Scores summarised in Figure 1), were also problematic. In response to COVID-19, anthropologists have highlighted that a re-thinking of preparedness was clearly needed once again (Leach *et al.*, 2022a, 2022b; MacGregor *et al.*, 2020, 2022; Wilkinson *et al.*, 2023).

This thesis contributes to this literature by exploring the interconnectedness between epidemic preparedness, and the unfolding of a possibly serious epidemic of COVID-19 in real time. Firstly, research focusing on COVID-19 is used to analyse the way in which preparedness is conceptualised and measured. Whereas biomedical and techno-scientific framings of preparedness divide preparedness and response by chronological temporality, with preparedness before an incident, and response efforts occurring during an (ongoing) event, this thesis builds on anthropological literature that has problematised such a distinction, highlighting the importance of alternative epidemic temporalities (Roth, 2020). Second, this thesis positions COVID-19 as a means to explore what preparedness mobilises, is mobilised by, and what it obscures. In so doing, it aims to shed light on the interconnectedness of global dimensions of preparedness, and the everyday lives of people during an epidemic, particularly in a refugee settlement.

Despite anthropological engagement with both epidemic and pandemic preparedness, the thesis chooses to use the term epidemic[8] preparedness rather than pandemic preparedness going forward. This is to ensure that attention is not only paid to global dynamics (particularly regarding COVID-19), but also to ensure attention is paid to the comparable invisibility of epidemics that cause significant harm in a specific context without necessarily crossing state borders. In other words, the focus on epidemic preparedness is chosen to foreground people in their day-to-day lives, in particular contexts, incorporating epidemics (COVID-19 and otherwise), that do and do not, have international spread.

[8] The Centre for Disease Control and Prevention (2023) defines epidemics, outbreaks and pandemics as follows: an epidemic occurs when there is an increase in a disease above a level that is normally expected; an outbreak carries the same definition as an epidemic, but is limited to a smaller geographical area. If an epidemic spreads over several countries, it is referred to as a pandemic.

Essentially, studying epidemics within a refugee settlement will reveal important tensions at the heart of humanitarianism and epidemic preparedness, and consider: who is being protected, and against what?

Research Questions

So far, this introduction has established significant limitations with mainstream biomedical and techno-scientific conceptualisations of epidemic preparedness. It has also highlighted refugee settings as particular sites of epidemic vulnerability and unique, albeit problematic, power dynamics. An exploration of both of these areas requires more detailed attention to epidemics, and their preparedness, as they unfold in everyday life in refugee settings. In order to do this, the research shaping this PhD is grounded in critical medical anthropology, and draws on long-term, multi-sited ethnographic fieldwork across northern Uganda, with a particular focus on Palabek Refugee Settlement. The overarching aim is to explore the connections and disconnections between the way refugees conceptualise epidemic preparedness, compared to biomedically informed humanitarian policies and practice. By foregrounding their perspectives, not simply in terms of so-called 'knowledge, attitudes and practices', but crucially their understandings of wider socio-political, economic and spiritual dynamics, it will be possible to re-think epidemic preparedness in refugee settings. In other words, it will be possible to explore how the principles and practices of epidemic preparedness intersect with the everyday lives of South Sudanese Acholi refugees in their unique historical, socio-economic, spiritual and political context, during COVID-19.

This thesis does not consider preparedness to be distinct from response. Instead, I define preparedness as any set of experiences, ideas or practices that relate to epidemics and the uncertainty surrounding them: past, present or anticipated; and the way in which they are revealed in, and interconnected between, global policies, biomedical practices, and importantly, among people themselves in their day-to-day-lives. Specific research questions fall within two broad themes:

Theme 1: Official Biomedical and Techno-scientific Approaches to Preparedness

- What do the COVID-19 measures introduced in Palabek Refugee Settlement reveal about global, regional and national preparedness priorities?
- How do (bio)security agendas and global, national and regional geopolitical priorities shape official approaches to preparedness in Palabek?
- What can official approaches to preparedness learn from the way in which refugees negotiate epidemics and epidemic interventions (including, but not limited to, COVID-19)?

Theme 2: Looking Beyond Official Approaches to Preparedness

- How do refugees make sense of epidemics and official approaches to epidemics, especially in contexts where diverse kinds of uncertainty (e.g. related to refugee status, food insecurity, sickness, livelihood, education, and risk of violence) shape day-to-day lives?
- How do refugees navigate uncertainties related to epidemics? What histories, ideas and practices acknowledge or respond to these uncertainties? How do past, present or anticipated epidemics shape ideas that are relevant to preparedness?
- By paying greater attention to the voices and experiences of those people commonly seen as mere recipients of formal preparedness mechanisms in a refugee settlement, what is revealed about the social and political dimensions of formal epidemic preparedness that may otherwise remain invisible?

Outline of Thesis

The remainder of this chapter provides a brief overview of the thesis and important clarifications. This PhD highlights the multiple limitations of current mainstream techno-scientific and biomedical framings of preparedness, whilst providing alternative avenues of exploration for a re-thinking of preparedness in refugee settings. Chapters 6 to 9 present detailed ethnographic material that critically explores different elements of epidemic preparedness. This is achieved through an exploration of containment, vaccination, screening and the temporality of preparedness. Together, they demonstrate that recognising wider sources of suffering is essential in conceptualisations of

preparedness. Furthermore, by exploring preparedness during COVID-19 in a humanitarian setting, the (bio)politics of preparedness comes to the fore. This thesis also demonstrates how global political dynamics are negotiated by refugees in their day to day lives. Whilst chapters 6 to 9 interrogate core assumptions of mainstream approaches, they also offer alternative framings that foreground the importance of fluidity, which provides the overall theoretical argument of this PhD. For instance, exploring containment in relation to refugee self-protection reveals the fluid nature of spatial boundaries during a pandemic, heavily shaped by historical dynamics. COVID-19 vaccination is considered as a 'suspicious business', where suspicion is constantly negotiated by refugees in light of ever-changing socio-economic, political and spiritual influences (as opposed to static notions of trust and mistrust). Drawing on assemblage thinking to explore COVID-19 screening in terms of the practice of counting reveals that dynamics of care and control are deeply intertwined and ever-shifting in refugee setting. As the thesis progresses, the overarching analytical argument that emphasises the importance of fluidity becomes increasingly prominent. In chapters 6 to 8 (and indeed earlier chapters) the relevance of fluidity may be more subtle. However, this central concept takes centre stage in chapter 9, where fluidity is at the centre of a relational temporality found amongst Acholi in South Sudan and northern Ugandan. This is deeply connected to a sense of equilibrium, or a constant search for balance and moral order amongst Acholi, which requires an ongoing and constant negotiation between people, the environment and spiritual forces. Appreciating this fluidity is central to re-thinking preparedness, especially in humanitarian settings.

Chapter 2 reviews relevant background literature. This includes anthropological research on epidemics, humanitarianism and refugees. It summarises the main findings emerging from ethnographic research on epidemics in refugee settings, and the current gaps in this literature. This chapter also includes an overview of refugee policy in Uganda, and a description of the people, borders, epidemics, conflict and mobility in Acholi regions of northern Uganda and South Sudan.

Chapter 3 is a co-authored commentary in the *Journal of Biosocial Studies*, published in 2024. This article uses publicly available quantitative data from John Hopkins University

to question whether public health and social measures introduced in Uganda in response to COVID-19 was influential. In so doing, the chapter draws attention to the vital need for research that examines the social, economic, political and cultural dimensions of epidemics in Uganda.

Chapter 4 is a published article in the field notes section of *Medicine Anthropology Theory (MAT)* in 2022, which explores some of the methodological considerations related to starting a PhD on epidemic preparedness during a pandemic. It focuses on the transition from clinical work in the UK, to clinical work in Uganda, as well as my experience of preparing for ethnographic fieldwork with South Sudanese refugees in northern Uganda.

This is followed by Chapter 5, which outlines further orientations to fieldwork in and around Palabek Refugee Settlement, and my orientation to this setting. Traditionally, a methods chapter does not contain detailed ethnographic extracts. However, the reflections in the field notes section in *MAT* usefully demonstrates that it is not clear when fieldwork actually started. In part, this is due to studying preparedness during COVID-19. Including ethnographic details in this chapter also counterbalances the reduction in ethnographic detail presented in the subsequent article-style chapters, which are shaped in part, by journal word limits.

The main findings of this thesis are presented in the subsequent four article-style chapters. Each of these chapters are grounded in critical medical anthropology, and interrogates a key element of preparedness (which, in biomedical literature, may be referred to as a type epidemic response – a distinction that is problematised throughout this PhD). This is not meant to dismiss the importance of public health approaches to epidemics, but rather brings to light important connections and disconnections between epidemic policies and the diverse perspectives of refugees. Chapters 6 to 8 have been submitted to different journals.[9] The implications of the findings presented in these

[9] The formatting of chapters 6 to 8 varies in places, according to the preference of each journal. For example, the presentation of quotes with italics or quotation marks are dependent on each journal's style.

article-style chapters were written up for a Social Science and Humanitarian Action Platform (SSHAP) briefing, which is presented in the appendix.

Epidemic containment is the focus of Chapter 6. The chapter explores Ugandan COVID-19 interventions in relation to the humanitarian concept of protection. Here, COVID-19 policies focused on reducing the movement of people and the securitisation of borders to contain the virus. Refugees were framed as especially vulnerable to COVID-19 and in need of protection, whilst simultaneously framed as a significant threat to health security. To explore this tension, the chapter looks beyond standard notions of 'protection', to explore forms of 'self-protection' amongst refugees. This article has been submitted to *Global Policy* and is under peer review.

Chapter 7 explores the introduction of COVID-19 vaccines in Palabek Refugee Settlement, to problematise dichotomised debates in public health discourse regarding vaccine supply and vaccine hesitancy. Building on the 'vaccine anxieties' framework (Leach *et al.*, 2022b; Leach and Fairhead, 2007), a focus on 'suspicious business' is used to explore the interconnectedness between COVID-19 vaccine supply and hesitancy. This chapter explores how global inequalities and geopolitical dynamics influence vaccine access and uptake, and can be rendered visible by paying attention to people's personal perspectives on the vaccine. This article was published in *Social Science & Medicine* in 2024.

Chapter 8 explores COVID-19 screening amongst refugees. By following the performance of counting COVID-19, this chapter examines how counting cases of COVID-19 is not determined by biomedical logic, but rather, is shaped by socio-political dynamics. This is used to explore a central tension in humanitarianism, between care and control. In contrast to the other article-style chapters, this article focuses on humanitarian staff, bringing to the fore the daily struggles of humanitarian practitioners, whilst also revealing the constraints of the wider system they work within. The article-style chapter is currently under peer review in the *Journal of Refugee Studies*.

Chapter 9, the final article-style chapter, explores the temporality of preparedness through a focus on day-to-day life. It juxtaposes anticipatory action and flexibility

emphasised in linear public health approaches to preparedness, with a more relational temporality amongst Acholi refugees. Structured around a conversation with a South Sudanese health worker in Palabek, it explores epidemics, displacement, unexpected visitors, time and the environment, to reveal poignant insights from refugees who are highly accustomed to dealing with the unexpected. In contrast to the previous chapter, this chapter focuses primarily on ethnographic research with refugees.

Chapter 10 offers concluding thoughts to demonstrate the limitations of current biomedical and techno-scientific conceptualisations of epidemic preparedness in a refugee setting. With a focus on Palabek Refugee Settlement, it becomes evident that historical, social, economic and political dynamics inextricably shape the way epidemic preparedness is imagined, delivered and responded to. An exploration of COVID-19 as a (potential) health emergency also reveals the (bio)politics of preparedness in various ways. Furthermore, it details the way in which geopolitical dynamics and day-to-day lives are deeply interconnected. Lastly, the chapter suggests ways in which these findings might enable a much needed re-thinking of epidemic preparedness in refugee settings.

Chapter 2: Background Literature

This chapter presents an overview of the relevant literature framing the PhD thesis, to clarify important theories and provide contextual information. Given that the subsequent chapters are in article-style, some of them also draw on literature specific to the focus of that chapter, that is not included here. Other areas of literature discussed here are not directly drawn upon in the following article-style chapters but are still important to highlight as they provide additional depth and context to the overall arguments presented in the thesis. For example, the literature providing insight into how the colonial period is deeply intertwined with epidemic control measures and the creation of borders between Uganda and South Sudan, are highly relevant for the discussion regarding the making and breaking of borders in chapter 6, and the exploration of COVID-19 vaccine uptake in chapter 7.

This chapter is divided into three parts. Part 1 discusses anthropological research on epidemics; and part 2 focuses on anthropological research with refugees, which has been shaped by debates concerning humanitarianism, emergencies, and the origins of refugee studies. This part also foregrounds influential ethnographic research in refugee settings. Part 3 brings together historical, socio-economic, political, geographical and cultural considerations to situate epidemics amongst Acholi (refugees) in northern Uganda.

Part 1: Anthropology and Epidemics

The introduction to this thesis foregrounded the limits of biomedical and techno-scientific framings of preparedness, and briefly outlined anthropological engagement with this concept. Part 1 of this chapter provides a more comprehensive overview of key anthropological contributions to preparedness, and also the anthropology of epidemics more generally. In so doing, it demonstrates how broader anthropological literature on

epidemics, including epidemic response efforts, are relevant to discussions surrounding epidemic preparedness.

Part 1 then turns to another key anthropological engagement with epidemics: re-thinking context and community. Anthropology can assist techno-scientific and biomedical approaches by highlighting the social, political, historical, and economic dimensions that not only shape an epidemic in a particular context, but also the success (or otherwise) of interventions. Additionally, and less commonly described, some anthropological literature has usefully highlighted how a local context can be utilised as a source of histories, ideas and practices, to inform public health or biomedical interventions.

The Origins, Temporalties and Technologies of Preparedness

The term 'epidemic preparedness' needs to be considered in relation to its origins and temporality, and how it is connected and disconnected from broader conceptions of epidemic prevention and response. Examining the origins of preparedness reveals ties to historical dynamics and current geopolitics. Techno-scientific and biomedical approaches to epidemics are also centred around metrics and risk. These conceptions of risk all too frequently set aside or ignore the way historical power dynamics shape current practice, and the way in which wider concerns about security influence policy and practice.

Prevention, Preparedness, Response and Biosecurity

Biomedical and techno-scientific approaches to preparedness often define the concept through its chronological temporal distinction from response, separated by the onset of crisis (such as an epidemic) (International Organization for Migration, 2024). Preparedness is also considered distinct from prevention. The WHO (2021a), in their guidance for preparing and responding to health emergencies and disasters, consider prevention in terms of reducing the likelihood of emergencies, whilst 'sound preparedness will lead to more timely and effective response' (p. 18). Prevention,

preparedness and response are brought together in an 'emergency risk management cycle', conceptualised with the progressive temporal stages of prevention, preparedness, response and recovery (World Health Organization, 2021a).

Although the distinctions between prevention, preparedness and response are important to appreciate, I would argue that in current approaches to epidemics, preparedness, prevention and response often become intertwined, and they are often considered together rather than as discreet entities. For example, central to preparedness is an ability to effectively respond (International Organization for Migration, 2024; World Health Organization, 2021a). Furthermore, member states of the World Health Organization (WHO) have recently agreed to the development of an international instrument to strengthen 'pandemic prevention, preparedness and response' (World Health Organization, 2024c).

Anthropologists have also argued that foregrounding temporal distinctions between preparedness and response obscures other temporalities that may better capture alternative social, historical and political dynamics (MacGregor *et al.*, 2022). Lynteris (2014) argues that epidemics are both processes and events: processual in their shaping by social, political and economic contexts, particularly ongoing vulnerabilities, but also events as unexpected eruptions in time. Indeed, anthropological engagement with epidemics have often critically explored the notion of emergency as an 'event' (e.g. Beckett, 2013; Fassin and Pandolfi, 2010; Roth, 2020). Scholars have highlighted how epidemic temporalities focus on crisis and emergency, problematically distinguishing between an exceptional event and 'normal' everyday life (Calhoun, 2010). On the ground, however, epidemics may be experienced at the intersection of an extraordinary event and a multiplicity of chronic crises (James *et al.*, 2023b). The anticipatory nature of 'crises imageries' about COVID-19 have been shown to create and reinforce socio-economic and political crises at the local level (Lees *et al.*, 2023). The literature problematising the temporality of emergency will be discussed further in part 2 of this chapter, in relation to humanitarianism.

Despite the overlapping nature of preparedness, prevention and response, there are key defining aspects of preparedness that need to be considered. Whilst prevention manages risk, using metrics and statistics to render epidemics predictable and controllable, preparedness attempts to tame the unpredictable but potentially catastrophic event associated with a new epidemic (Roth, 2020). Preparedness, therefore, has greater concern with the unknown, using anticipatory technologies such as simulations or surveillance, which can be traced to a particular socio-political context (e.g. Keck and Lachenal, 2019; Wolf and Hall, 2018).

Preparedness emerged in Western nations from defence 'operations research' through the cold war era, which shaped the conceptualisation of emerging infectious diseases not only as biomedical and public health issues, but relevant to national security, with its alignment with biosecurity agendas (Lakoff, 2017). Before the 20th century, theories of risk assessment were the predominant means to conceptualise collective security, where probabilities for future events were calculated, based on historical patterns of incidence. But an evolving focus on potential catastrophe required a different conceptualisation of security. Lakoff's research (2008, 2017) has been particularly influential. He suggested that preparedness is not just about threats from infectious diseases; and showed how preparedness evolved to become a state of organisational being in relation to multiple threats to national security including earthquakes, hurricanes and (bio)terrorism (Lakoff, 2007). This involved a transition in public health discourse from a narrative of 'prevention' to that of 'preparedness', which included a shift to framing public health in relation to techniques developed in military and defence sectors. Initially 'populations' were considered the object of public health monitoring and intervention as a means of state control, through sanitation, nutrition, bacteriology and immunisation (all given credibility through probabilistic knowledge) (Lakoff, 2017). However, public health practitioners then faced the challenge of planning for a future catastrophic threat, which defied the previous means of estimating probability.

Preparedness for bioterrorism and infectious disease outbreaks, therefore, became entangled with the 'informational redefinition of biological life for the biopolitical economy of security' (Caduff, 2015, p. 107). At a time when emerging infectious disease

could have been framed as an issue of global health inequality, poverty, civil war and lack of basic healthcare (Garrett, 1994), the simultaneous evolving concerns regarding (bio)terrorism meant the dominant narrative became one of national security (Lakoff, 2008).

Risk and Metrics

The concept of risk is fundamental to biomedical approaches to epidemics, based on the translation of uncertainty into calculable probabilities. It is not only central to epidemic prevention strategies, but also to biomedical and techno-scientific approaches to epidemics more generally. Epidemiological investigation of epidemics depends on categorisations and quantifications of people and their social worlds into a defined 'population' (Coggon *et al.*, 2003), with categorised units of study such as 'family', or 'household'.

Risk can also be considered as an amalgamation of probabilistic knowledge, categorisations, time-framing, and values (Brown, 2020; Heyman, 2010). Through the scientific expert's processing of risk, they represent safety. 'Preparedness relies heavily on the role of scientists in their power to predict' (Caduff, 2015). Biomedical framings of risk, however, rarely acknowledge 'that risk is never just about probabilities but…entails a particular way of handling these numbers in relation to values' (Brown, 2020, p. 3). Processes of categorisations in establishing risk are not neutral, but often imply a legitimisation, or (de)valuing (Brown, 2020). When value is considered, it becomes easier to see how risk itself is deeply political (Douglas, 1992). The use of biomedical interpretations of risk to inform policy are inseparable from political values that dictate what 'evidence' will inform policy. Despite rhetoric suggesting the apolitical objective status of scientific 'evidence', COVID-19 has demonstrated how the production and interpretation of data is inherently political (e.g. Lancaster *et al.*, 2020). Epidemics provide opportunities for the translation of political values into intervention(s), behind the guise of 'objective' scientific risk.

A persistent focus on techno-scientific and biomedical conceptions of risk frames the problems and solutions in probabilistic knowledge, and eclipse the harder to quantify social, historical, cultural or political framings of uncertainty, that may, in fact, provide valuable understanding of epidemics. Scholars have suggested that rather than uncertainty being translated into risk, it is important to foreground other ways of studying uncertainty. From an anthropological perspective:

> *'…experiential reality is not uncertainty that needs to be reduced and rendered into risk, but is manifest as an ongoing flow of situations, to be lived with and negotiated. Nor are these uncertainties fully amenable to elimination through knowledge, since they are part of the lived, embodied fabric of social, ecological and political life…'* (MacGregor *et al.*, 2020, p. 119)

To illustrate this simply, biomedical and techno-scientific interventions tackle epidemics such as COVID-19 with interventions that render risk manageable. Containment measures such as self-isolation of infected individuals are designed to reduce social contact and hence transmission (Agusto *et al.*, 2022). In doing so, they push the reproductive rate below 1, and control the epidemic. In practice, self-isolation is far more complicated, especially if considered in relation to other sources of uncertainty, such as lack of income, childcare, or access to food (Pietrabissa and Simpson, 2020). Looking beyond conceptualisations of risk to appreciate wider sources of uncertainty, allows social, political or economic dynamics to be rendered visible.

Metrics are an essential component of conceptualisations of risk. Indeed, biomedical approaches to epidemics place great value on numbers, presenting metrics as neutral representations of truthful reflections of reality, turning complicated and contradictory social contexts into knowable and actionable scenarios or measurable indicators (Merry, 2016). The power of metrics is described by Adams *et al.*, (2024), who highlighted how metrics work to stabilise the complexity of lived social worlds. To quote:

> *'Metrical practices do this by…turning transient and situationally contingent phenomena into obdurate, reductive, and comparable data through modes of counting, modelling practices, algorithmic employment, and statistical evaluations' (p.150).*

The importance of both metrics and conceptualisations of risk can be seen in public health interventions such as containment or quarantine, which are based on probabilistic knowledge of transmission dynamics. For example, at the start of COVID-19, endeavours to mitigate the disease in refugee camp settings suggested that community-led shielding of high-risk individuals might be a realistic strategy (Butler and Tullock, 2020; Favas *et al.*, 2020). In this approach, 'high-risk' individuals were defined by biomedical vulnerability, which was assessed in terms of demographic factors such as older age and clinical conditions. These people would then be restricted to a specific area of the camp, called a 'green zone' (Dahab *et al.*, 2020; Schmidt, 2020). In short, conceptualisations of risk are routinely used to help produce evidence and justifications for biomedical interventions seeking to minimise the damaging consequences of epidemics.

Anthropological approaches offer alternative framings. For example, processes of quantification, categorisation, surveillance, vaccination, quarantines and containment highlight the extensive analytical possibilities to study the biopolitical nature of epidemics (Kelly *et al.*, 2019). In other words, by examining the technologies of outbreaks, a platform is created for understanding the relationships between politics, epistemology, and ethics and offers '… new ways of understanding the links between technologies of epidemic control and the distribution of mortality and vulnerability during and after an epidemic' (Lynteris and Poleykett, 2018, p. 433).

Re-thinking 'Context' and 'Community' During Epidemics

This section now turns to look at different anthropological explorations of epidemics, engaging with literature that draws attention to how social, political, historical, and economic dimensions not only shape an outbreak in a particular context, but also the success of interventions. Biomedical approaches to epidemics often describe the unpredictable and hard to quantify, social, cultural and political dimensions of an epidemic as 'context', and subsequently engage the skills of anthropologists to shed light

cultural and social dynamics (Stellmach *et al.*, 2018). In order to overcome issues such as 'mistrust' or 'misinformation', this 'context' is also targeted by biomedical interventions through 'community engagement' or 'risk communication' activities, '…but how engagement occurs, and with whom, is not always straightforward' (Parker *et al.*, 2019b, p. 2585).

For decades, anthropologists have shed light on historical, social, cultural and political dimensions of epidemics. Rather concisely stated by Hewlett and Hewlett (2008) in regard to the WHO: 'It took twenty-five years after the first Ebola outbreak in 1976 to consider bringing an anthropologist, but late is better than never' (p. 37). A significant movement occurred, however, during the 2013-2016 West African Ebola outbreaks, where biomedical interventions were found, at times, to be at odds with local practices (Piot *et al.*, 2014; SSHAP, 2020). This prompted a wealth of anthropological engagement with the outbreaks, including the rapid production of evidence that could inform ongoing response efforts. Key contributions have included the Ebola Response Anthropology Platform (http://www.ebola-anthropology.net/) and the Social Science in Humanitarian Action Platform (https://www.socialscienceinaction.org/) (see also Martineau *et al.*, 2017; Nguyen, 2014; Stellmach *et al.*, 2018). Anthropologists also highlighted that during these outbreaks, all too often, practitioners failed to ask: 'what is a community in this setting?' They failed to question whether 'community leaders' did actually represent the interests of their supposed 'community' (Enria, 2020). In Sierra Leone, for example, 'community engagement' with 'paramount chiefs' was rather misguided, as these figures, a product of colonial rule, did not necessarily have the authority to effectively impose national guidelines within their chiefdoms/'communities' (Parker *et al.*, 2019b).

In order to more successfully engage with people living through epidemics and resist deepening problematic power dynamics, Wilkinson *et al.,* (2017) have argued that:

> *'Policy options may seem limited in times of emergency. However, rather than relying on externally applied definitions or obscuring uncomfortable realities by continuing to perpetuate imagined qualities of communities, a more constructive response is to find ways to bring socio-political orders and relationships more sharply into focus' (*p. 5).

Anthropological approaches utilising ethnographic methods can focus on these hard to quantify day-to-day lived relationships and how they relate to the wider social, economic, historical and political influences. In so doing, they are able to provide more meaningful framings of what a 'context' or 'community' might mean, but also demonstrate alternative framings by bringing to the fore otherwise less visible and invisible local perspectives.

MacGregor *et al.,* (2022) propose 'intersecting precarities' as an alternative framing of preparedness, with the concept enabling attention to focus on the historical, socio-political and economic dimensions. Such a framing considers a different temporality, in which multiple intersecting precarities including epidemic control measures, are actively navigated by people in Sierra Leone and Uganda during COVID-19. These authors wrote: 'We illustrate how complex dynamics manifest as diverse actors interpret and modify approaches according to contexts and experiences' (p.1). In doing so, they also draw attention to the need to consider chronic insecurity.

Successful epidemic approaches in refugee settings have also illustrated the importance of adapting to contextual dimensions. For example, the successful response to an outbreak of polio in Somalia in 2013-2014, despite a context of war, famine, and displacement, was (mainly) attributed to the way in which the response built on long-term social research in the area and adapted to the unique social and political context in which the outbreak occurred (Haydarov *et al.*, 2016). Unsurprisingly, McKay and Parker's (2018) review of the literature on epidemics in humanitarian contexts concluded that '…Humanitarian programmes, which adapt and respond to the specific social, political and economic contexts in which they are working, tend to be more effective' (p. 81).

Anthropological approaches have provided important insights into contextual dimensions of epidemics described thus far. These approaches have also explored the less commonly acknowledged 'preparedness from below' (Abramowitz *et al.*, 2015a), where the local context can be seen as a source of knowledge and experience that can potentially be used for more successful 'preparedness', actively resisting the neocolonial dimensions of biomedical approaches (Parker *et al.*, 2019a, 2019b; Richardson, 2020).

In 2014, Abramowitz *et al*., (2015a) conducted research in 15 settings in Liberia exploring Ebola and 'views from below', describing how 'communities' instigated their own community-based quarantine and home-based healthcare, designing their own PPE. Along similar lines, Richards (2016) refers to a 'people's science' to describe the 'co-production' of knowledge between biomedical and 'local' responses to Ebola during the 2014-2016 outbreaks in Sierra Leone. The work of Parker *et al*., (2019a) in Sierra Leone during these Ebola outbreaks highlighted how a 'morally appropriate people's science' emerged under the radar of official public authorities. The authors describe how this was beneficial to those being treated outside of formal biomedical Ebola Treatment Centres. More recently, in exploring resistance to COVID-19 lockdown measures, Aluma *et al.,* (2022) explored 'indigenous' strategies for epidemic containment amongst Lugbara-speaking people in West Nile and North West Uganda. These strategies included forms of quarantine, and herbal medicines, passed down through oral histories from elders (Aluma *et al.*, 2022).

Part 2: Humanitarian Assistance, Refugee Settings and Anthropology

Engaging with critical literature on humanitarianism is helpful when studying epidemic preparedness in refugee settlements, with the literature demonstrating that these settings also need to be understood as states of exception, and in relation to the temporality of emergency. Critical anthropological engagement with the field of refugee studies also highlights the importance of considering the heterogeneity of people referred to as 'refugees'. This section draws heavily on the anthropological literature, but also draws on wider critical literature, for example in history or political science. It demonstrates that there is a lack of long-term ethnographic engagement with refugees on epidemic preparedness.

Humanitarianism: Important Historical Considerations

Colloquially, most people associate the term 'humanitarian' with an aid worker or organisation helping those 'in need' or preventing or relieving suffering. This is often in

response to war, (forced) displacement[10] or another type of disaster. From an academic standpoint, however, there are multiple interrelated words and concepts that need clarification, including humanitarianism, medical humanitarianism, humanitarian assistance and humanitarian intervention. By tracing the historical emergence of these terms, this section foregrounds unifying and distinctive aspects of the terms, as well as underlying tensions in this field of study.

To start with, the term, humanitarianism. This may be considered an overarching concept, which Allen (2018) defined as a 'doctrine or combination of doctrines, premised on commonly unquestioned beliefs about intent' (p.143). Along similar lines, humanitarianism, according to De Lauri (2016), 'embodies a whole set of beliefs, practices, categories, discourses and procedures' (p.1). The unquestioned beliefs about intent at the core of humanitarianism, Allen (2018) describes, is 'a quality that can make it immune to conventional criticism or scrutiny and can potentially result in impunity for acts that might otherwise be viewed as crimes' (p.143). De Lauri (2016) agrees, arguing that rather than simply relieving suffering, humanitarianism is actually a 'political mode of controlling territories and lives and governing international relations' (p.2).

The moral foundations of humanitarianism date back to the 19th century, shaped by religious ideas and tensions between humanism and market capitalism (Allen *et al.*, 2018; Barnett, 2011; Beshar and Stellmach, 2017; Haskell, 1985). They are often understood in relation to European and Christian missions and colonial endeavours. For example, from the 1820s onward, the term humanitarianism became linked with the interests of humanity at large, but it remained imbued with Christian and European morals, and as Allen (2018) describes, 'became associated with missionary work and the purported civilising agenda of colonial rule' (p.143). The selfless and heroic imagery of humanitarianism evident today can be seen to at least in part represent these Christian

[10] Forced displacement usually refers to displacement in response to violence, conflict or human rights violations, whereas displacement often refers to the movement of people due to other non-conflict related issues such as 'natural disasters' (Christensen and Harild, 2009). This thesis, however, does not distinguish between these terms. This is because environmental challenges and conflict often occur simultaneously, or are interrelated, and the reason for displacement may not be distinguishable. Furthermore, issues such as food insecurity can be just as 'violent' as conflict (Farmer, 2001).

and European morals that draw on ideas of a 'greater good' or 'transcendental significance' (Barnett and Stein, 2012, p. 13).

In the late 19th Century, the ideological components of humanitarianism became visible in the emergence of the International Committee of the Red Cross (ICRC)[11] and the First Geneva Convention. The Red Cross began in 1863, inspired by Henry Dunant, a Swiss businessman, in response to concerns regarding the number of wounded men left to die on battlefields. In addition to creating relief societies to provide impartial help to the wounded during war, he suggested an international agreement be adopted recognising medical services during war: this was the original Geneva Convention, adopted in 1864 (International Committee of the Red Cross (ICRC), 2024). During this time, therefore, humanitarianism became connected with medical relief and regulation, with medical humanitarianism particularly focusing on providing medical services and preserving health. Medical humanitarianism, thus, focussed on human suffering from crises in terms of pathology and medical intervention (Beshar and Stellmach, 2017).

To be able to provide medical care during conflict and treat the wounded (rather than viewing individuals as combatants), the notion of neutrality emerged, and with it the conception of international humanitarian law (Allen, 2018). The First World War cemented the important role of humanitarian organisations in providing neutral aid (Hardy *et al.*, 2016), followed by the establishment of the High Commission for Refugees and the International Relief Union (Barnett, 2011; De Lauri, 2016). A central tension in humanitarianism became evident: humanitarian actors were simultaneously considered separate from wars, but were also working with imperial powers and Christian missionaries whilst being protected by military forces (Allen, 2018).

The Red Cross continued to be an influential humanitarian organisation; and their principles of humanity, impartiality, neutrality, independence, voluntary service and universality have subsequently been adapted by the United Nations Office for the

[11] The ICRC is now part of the International Red Cross and Red Crescent Movement. The latter includes 191 National Red Cross and Red Crescent Societies, and the International Federation of Red Cross and Red Crescent Societies (IFRC) (International Committee of the Red Cross (ICRC), 2024).

Coordination of Humanitarian Affairs (OCHA). Humanitarian principles, according to OCHA, are: humanity (to address human suffering wherever found); neutrality (to not take sides); impartiality (action is based on need rather than characteristics such as nationality or political opinion); and independence (humanitarian action must be autonomous) (OCHA, 2022). The General Assembly Resolution 46/182 adopted in 1991 outlined the first three of these principles, whilst independence was added under the General Assembly resolution 58/114 in 2004 (OCHA, 2022).

Despite these principles (including neutrality), humanitarian organisations or UN agencies such as the OCHA, continue to be affiliated with, or work alongside and in tandem with, armed forces. Humanitarianism is thus, rarely neutral, because it is interconnected with military action, international politics, and neocolonial oppression (Allen, 2018). More recent research has continued to problematise distinctions between humanitarians and combatants – a distinction which remains central to the image of humanitarianism. For instance, research in eastern Democratic Republic of the Congo (DRC) found that humanitarian and rebel spheres were deeply interlinked: not only did ex-rebels become humanitarians, but these individuals were central to 'brokering' relationships and often moved between these spheres (James, 2022a).

The Second World War is often described as a pinnacle moment for humanitarianism. The United Nations (UN) was founded in 1945 with the hope that this international organisation could maintain peace whilst respecting the sovereignty of individual states (United Nations, no date). Simultaneously, governments and private agencies expanded their remit. To quote Barnett (2011):

> *'During World War II governments and private voluntary agencies expanded relief to new populations, and after the war set about rebuilding Europe. Against this backdrop of a newly decolonized world, many nongovernmental organizations that once had concentrated on Europe now discovered a whole world waiting to be helped, and many international organizations originally created for European relief and reconstruction and located within the United Nations system, began to act like global organizations. Humanitarianism had gone global' (p.17).*

It is useful, here, to draw attention to the distinction between humanitarian assistance and humanitarian intervention. Humanitarian assistance implies aid to relieve suffering. On the other hand, intervention usually describes force to prevent atrocities (Allen, 2018), or in other words, military force to achieve humanitarian objectives (Calhoun, 2010). Whilst a focus on humanitarian intervention had been increasing since the mid-nineteenth Century, this accelerated after the Second World War, and again during the Cold War period, when nation states' stability became undermined, with new forms of sovereignty created: humanitarian intervention thus became the main way that protection, aid and democratization was framed at the global level (De Lauri, 2016).

Humanitarianism has included militaries since its inception – the Red Cross worked alongside armed forces (Allen, 2018), and the WHO constitution refers to the importance of security in attaining health (World Health Organization, 1948). However, since the end of the Cold War in the 1990s, and the emergence of so-called 'complex humanitarian emergencies' (Barnett, 2011), there were significant changes in the way in which medical humanitarianism was intertwined with security agendas and military action. It became deeply entangled with military intervention (Fassin and Pandolfi, 2010). From the mid 1990s, humanitarian assistance and humanitarian intervention became more blurred, with medical humanitarian organisations, such as Médecins Sans Frontières (MSF), expressing concern over the military entanglement with humanitarian assistance in crises such as Somalia and Afghanistan (Parker *et al.*, 2022).

The success of humanitarian intervention, however, was being reconsidered by the end of the 1990s (Allen, 2018; Parker *et al.*, 2022). The mixed results and high costs of intervening in Somalia in the early 1990s led to a failure to recognise (and therefore intervene in) the Rwandan genocide in 1994 (Allen, 2018; Ludlow, 1999), and NATO intervened without UN authorization in Kosovo (Thakur, 2016). To address the failings of humanitarian intervention, different strategies were introduced in the early 2000s, such as 'Responsibility to Protect' (R2P), which was embraced by the UN in 2005 (Gagro, 2014; Thakur, 2016). This strategy was intended to provide an alternative to previous forms of humanitarianism that threated national sovereignty. R2P focussed on preventative strategies (emphasising the responsibility of sovereign states), with enforcement

described as a ‘last resort’ when crimes fulfilled particular criteria (e.g. for genocide, war crimes, or crimes against humanity) (Gagro, 2014). R2P did essentially, therefore, give the UN and its member states the ability to override another country’s sovereignty (Allen, 2018). Key humanitarian actors such as MSF dismissed R2P on the grounds that doing so ‘would effectively be legalising a new form of imperialism’ (Weissman, 2010, p. 204). The success of R2P has also been called into question in response to the situation in Libya in 2011-2012, where invoking the R2P led to worsening instability and violence (Nuruzzaman, 2015).

Despite these problematic dimensions, the power of humanitarianism has remained substantial. De Lauri (2016) has delineated three ways in which humanitarianism has remained in ‘good health’. Firstly ‘proxy humanitarianism’, which encompasses the sympathy of public figures and intellectuals for the underlying principles of humanitarianism, fuelled by beliefs premised on a universalist perspective of what constitutes progress and development. Secondly ‘the migration of experts’ into the Global South, which creates employment opportunities for donor countries. Thirdly, De Lauri describes the ‘humanitarian business and hierarchies’: the political and economic interests of donor states (which are often tied to security), create the need for intervention in other countries. This can also be seen in the difficulty of distinguishing between humanitarian assistance and intervention. In 2010, Calhoun wrote: ‘…even when militaries are not involved, humanitarian action has a managerial orientation, minimising the threats that displaced populations pose to the otherwise smooth operation of global economies’ (2010, p. 41). Furthermore, UNHCR’s evolving mandate has been described in relation to ‘neoliberal government’, with a ‘humanitarian marketplace’ providing a platform for competing agencies (Ilcan and Rygiel, 2015). To quote De Lauri (2016, p. 3): ‘The dependency between the Global South and North is two way: …while in the North we are used to hearing how much people in the Global South are in need of humanitarian intervention and aid, we less often hear how much the Global North is in need of delivering it’. Ultimately, humanitarianism is deeply political and is tied to complex economic and geopolitical dynamics and competing interests. Simultaneously, it is important to recognise, as Allen (2018) articulated:

‘Humanitarianism requires human suffering. It cannot exist without it, and what is done in its name can never be enough.’ (p143).

The (Bio)politics of Humanitarian Emergencies

Humanitarianism, since the Second World War and the subsequent Cold war, can be considered distinct from previous forms, in that it draws extensively on emergency - as a sense of urgency and as an exception (Calhoun, 2010). The terms emergency, crisis, catastrophe and disaster are not neutral or objective, and the meanings attributed to them have been described as both distinct and overlapping (e.g. Barrios, 2017; Beckett, 2013; Fassin and Pandolfi, 2010). This sub-section focuses on the political and temporal aspects of the concept of emergency. It describes the (bio)political mobilisation of emergency, drawing on literature that points to emergency as a state of exception (Fassin and Pandolfi, 2010), and the way in which specific agendas are enabled through an anticipated, uncertain, and dangerous future orientation (Collier and Lakoff, 2015). Fassin (2007) outlined how humanitarianism can be considered in relation to biopolitics in the way it governs the lives of refugees. He distinguished this biopolitics from the ‘politics of life’, which instead focuses on ‘the lives saved versus the lives to be risked’, or in other words, ‘the radical inequality that underlies this transaction in human lives’ (p500). The author clarified that whereas biopolitics may relate to power over a population, the politics of life relates to the meaning of existence.

State of Exception

Fassin and Pandolfi (2010), in their collection of anthropological and social science accounts of humanitarian and military intervention in emergencies or crises, describe the ‘state of exception’ as a type of global biopolitics. Despite being inscribed in a temporality of emergency, this transient state can become one of perennial military or humanitarian intervention that supersedes state power or sovereignty. Military and humanitarian actors become blurred, with reciprocal justification of their interventions.

> *'The state of exception mobilizes technologies in the legal, epidemiological, and logistical fields, and even a form of technicality, which neutralizes political choices by reducing them to simple operational measures. ...the state of exception derives from a desire to intervene, and it increasingly appears that compassion for far-away suffering and its translation into the moral obligation to act has become one of the strongest political emotions in contemporary life'* (Fassin and Pandolfi, 2010, p. 16).

The moral obligation to intervene is based on a universalist perspective, where there is a presumed clear moral right and wrong - in times of emergency, a specific political and moral order is created or maintained (Beckett, 2013). It has been argued, however, that such 'interventionist universalism' fails to appreciate diverse needs and priorities in any given situation, or more critically, is a type of 'altruistic imperialism' (Fassin, 2023). It is, therefore, imperative to question, *who* gets to intervene in a state of exception. Although based on a moral imperative of compassion for suffering, and a presumed universal applicability of moral action, the intervention justified by such moral imperatives cannot be separated from the vested interests of those states with the power to intervene. This critique could also be applied to universalist presumptions in global approaches to preparedness that conceptualise a united 'world at risk' (Global Preparedness Monitoring Board, 2019), with a 'common human security' (Horton, 2020). Does the fact that COVID-19 played out so differently across the globe highlight the illegitimacy of this universalist perspective? The significance of this literature and these issues will be explored in subsequent chapters.

The Temporality of Emergency (Claims)

The significance of an emergency is located in its declaration of an unexpected moment of danger, which demands immediate action (Beckett, 2013; Rubenstein, 2015). Whereas in a catastrophe or disaster, the bad outcome has already occurred, at least in part, 'An emergency is…an impending disaster that can potentially be warded off, at least to some extent' (Rubenstein, 2015, p. 105). Crises are similar to emergencies, this author explains, but tend to be considered longer in duration than emergency. Rubenstein (2015)

called for a focus on 'emergency claims' to render visible 'emergency politics'. The latter she wrote: '…refers to many different actors making and not making, contesting and not contesting, and accepting, ignoring, and rejecting a wide array of overlapping and competing emergency claims' (p. 102). An emergency narrative, she writes, is central to an emergency claim, to ensure immediate action. This requires consideration of a past 'normal' or 'status quo', from which an emergency has deviated, thus requiring immediate action, to change the course of the future. Along similar lines, Calhoun (2010), in his description of the 'emergency imaginary', describes emergencies as exceptions to 'normal' social conditions (p. 45).

Rubenstein (2008) described the value of 'emergency claims' in creating space to see the implications of emergency politics for marginalised groups. Emergency claims that aim to restore a previous normality can entrench pre-existing inequalities, be powerful tools for people with power, justifying actions that would otherwise be unacceptable, and ingrain the domination of some groups of people by others. What if so-called normal is not peaceful or prosperous, but is instead characterised by enduring suffering? What about the suffering that does not reach thresholds for emergency? What about less dramatic, everyday forms of structural violence? Indeed, the presumed distinction between emergency and everyday in emergency governance has been called into question. Along these lines, Vigh (2008) calls for the need to explore chronic crisis, or in other words, explore crisis as context, rather than crisis in context. Anderson *et al*., (2019) describe the concept of 'slow emergencies', to demonstrate that the anticipatory temporality of emergency governance is intimately tied to racialized difference. Literature focussing on the intersection of exceptional and everyday aspects of crisis or emergency have also included analyses of epidemics such as Ebola and COVID-19, which James *et al*., (2023b) describe as 'continuity and rupture'. This thesis will demonstrate that literature which problematises the temporality of emergency is particularly pertinent for a re-thinking of preparedness.

Anthropology, Refugees and Refugee Settings

Many humanitarian aid operations focus on forced displacement (European Commission, 2024). If someone is forcibly displaced across an international border, they are classified by international humanitarian organisations as a refugee, albeit with specific legal definitions (UNHCR, 2024a). The 1951 Refugee Convention defines a refugee as 'someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion' (*Convention and Protocol relating to the Status of Refugees*, 2007, p. 3). A person is called an asylum seeker when they are in the process of seeking international protection, or in other words, they are applying to be legally recognised as a refugee (UNHCR, 2024b). Those who are internally displaced within their country of origin are referred to as internally displaced people (IDPs). UNHCR (2024c) write that displacement is a 'continuum', and highlight how someone who is initially displaced within their country, may subsequently become a refugee when they cross an international border to seek safety. Furthermore, a refugee may return to their country but remain an IDP if they do not return to their initial area of origin (UNHCR, 2024c). There are, however, important distinctions. To quote Ian Fairweather (1997): 'Unlike refugees, who are under the protection of UNHCR, IDPs are covered by a hotch-potch of international laws which leave a number of gaps and loopholes' (p.19).

This thesis primarily focuses on refugees, whilst also exploring and problematising such classifications (Glasman, 2017). It does this in a refugee settlement, which, along with refugee camps, are a common means of providing humanitarian assistance (Idris, 2017). I use the term 'refugee setting' to encompass both camps and settlements.[12] Camps, however, are considered distinctive in their segregation of refugees from the 'host community' and its associated economy (Schmidt, 2003). In contrast, settlements are intended to be characterised by freedom of movement, opportunities for self-sufficiency and integration into the local economy (Idris, 2017). Making a distinction between camps

[12] This thesis does not discuss informal settlements, which occur when people who are displaced 'self-settle in spontaneous locations' (UNHCR, 2024d).

and settlements can be difficult, and these settings have been described as a continuum from segregation to integration (Schmidt, 2003). Furthermore, sites that are officially considered to be settlements may fail to implement freedom of movement and integration, and refugee camps are often highly connected to the surrounding area through entrepreneurs selling goods and refugees moving out for work or education (McConnachie, 2016). This thesis draws on critical anthropological literature that analyses both camps and settlements. Both settings are based on humanitarian principles and aim to offer protection (including from epidemic threats) to those forcibly displaced. However, this section demonstrates that in a 'state of exception', they often end up being a source of suffering (including from epidemics). Part of the problem is that they fail to appreciate the agency of refugees, and render the political dimensions of crises invisible.

Refugee Camps

> *'Refugees became the focus of a global emergency response in the 1930s, and indeed, it is from this point on that the association of refugees and emergencies became consistent'* (Calhoun, 2010, p. 29).

Many accounts of refugees and forced displacement start with an overview of how 'the refugee' emerged from Europe in the post-World War II era, when 'certain key techniques for managing mass displacement of people first became standardized and then globalized' (Malkki, 1995a, p. 497). The management of large numbers of displaced people, much of which was focused on post-war Europe, evolved from the blueprints of military camps; ideas which morphed into concentration camps in Germany during the war, and 'Assembly Centres' for refugees in the post war period (Malkki, 1995a). Camps, therefore, were not initially a humanitarian conception, but rather a military one to house soldiers or prisoners of war (Cooper-Knock and Long, 2020). Refugee camps, therefore, are areas of containment as well as markers of humanitarian space (Cooper-Knock and Long, 2020).

During the post-war period, increasing attention was paid to the legality around refugees, with the emergence of the field of refugee law (Goodwin-Gill, 2017). In 1951, the General Assembly of the United Nations established the United Nations High Commission for Refugees (UNHCR) to aid the millions of European refugees displaced during the Second World War. UNHCR's statute aimed to provide international protection to refugees, and to find durable solutions in conjunction with governments (UNHCR Regional Representation in Rome, 2007). The concept of durable solutions had also emerged after the Second World War, and included voluntary repatriation, resettlement and local integration (Bidandi, 2018). Resettlement was the preferred solution until 1985, when UNHCR shifted its focus to voluntary repatriation (Chimni, 1999).

As the focus on the legal rights of those displaced became more prominent in global discourse in the post-war period, refugees were no longer seen in terms of a military framing, but rather as a humanitarian and social problem. At the heart of this important transition was the refugee camp, which not only became an accessible location for refugee interventions, their study and documentation, but also the image of 'the refugee' was created.

> *'The refugee camp was a vital device of power: The spatial concentration and ordering of people that is enabled, as well as the administrative and bureaucratic processes it facilitated within its boundaries, had far reaching consequences. The segregation of nationalities; the orderly organization of repatriation or third-country resettlement; medical and hygienic programs and quarantining, "perpetual screening" and the accumulation of documentation on the inhabitants of the camps; the control of movement and black-marketing; law enforcement and public discipline; and schooling and rehabilitation were some of the operations that the spatial concentration and ordering of people enabled or facilitated. Through these processes, the modern, post-war refugee emerged as a knowable, nameable figure and as an object of social-scientific knowledge' (Malkki, 1995a, p. 498).*

Refugee camps are, therefore, often considered a pragmatic humanitarian tool to managing emergencies, providing food, shelter, and healthcare to the recipients of aid

(UNHCR, 2024e). The reality of living in these settings, however, has been extensively problematised, with literature often drawing on the notion of 'bare life', in which valueless life remains after being stripped of its legal-political protection (Agamben, 1998). Scholars have highlighted how refugee camps or settlements can be the focus of violence, epidemics, limit opportunities for self-sufficiency, and essentially create a space in which refugees 'can be contained, controlled, and relatively forgotten' (Cooper-Knock and Long, 2020, p. 58). Indeed, refugee camps are notorious sites for disease outbreaks, including epidemics of measles, cholera and meningitis (Altare *et al.*, 2019). Simultaneously, the design of camps enables the control of infectious disease through surveillance and containment - two important biomedical approaches to epidemics. Malkki (1995a) wrote that 'the concentration camp was itself quasi-military in design and specifically suited to mass control of people. Immediately after the liberation, the camp architecture allowed for efficient... quarantines for the prevention of epidemics' (p. 500). Humanitarian agencies have responded to the significant risk of epidemics in refugee camps by focussing on mass vaccination and water and sanitation facilities (UNHCR, 2023a). However, as Abramowitz *et al.,* (2015b) note, a failure to understand the perspectives and health practices of refugees themselves can reduce the effectiveness of humanitarian assistance.

Understanding the origins of 'refugees' and 'camps' is important in order to understand how refugee camps are designed to control people and pathogens. It is also vital, however, to capture the agency of people living in refugee settings. The next sub-section, therefore, discusses the field of refugee studies, which pays particular attention to the perspectives of those labelled 'refugee'.

Comments on the Origins of Refugee Studies

In the 1960s, whilst many colonial administrations were abolished, refugees began to be seen primarily as a 'third world' or 'developing world' problem (UNHCR, 2000). In the 1970s and 1980s, however, there were increasing numbers of asylum seekers in Western nations and major refugee crises in Asia, Africa, and Central America (Fiddan-Qasmiyeh *et al.*, 2014). As indicated above, before and during the early 1980s, legal scholars were

at the forefront of refugee studies, taking a 'policy-orientated approach', providing examination of foreign policy in relation to displacement and the role of international refugee organisations such as the UNHCR (Fiddan-Qasmiyeh *et al.*, 2014). Refugees and forced displacement had certainly been considered across humanities and social and political sciences (including anthropology) during this period (e.g. Colson, 1971; Rogge, 1977), but during the 1980s, key milestones in the development of 'refugee studies' emerged. For example, in 1981, Stein and Tomasi introduced a volume in the *International Migration Review*, which highlighted the need for a 'comprehensive, historical, interdisciplinary and comparative perspective which focuses on the consistencies and patterns in the refugee experience' (1981, p. 6). This publication was followed by an 'explosion' of academic literature and the establishment of specific refugee studies programmes (Black, 2001).

At the University of Oxford, the Refugee Studies Programme was founded by Barbara Harrell-Bond, a legal anthropologist. Harrell-Bond's (1986) seminal publication 'Imposing Aid; Emergency Assistance to Refugees' was based on fieldwork with Ugandan refugees in Sudan. It was one of the first attempts to critically explore the implementation of humanitarian aid in a way that had previously been reserved for 'development'. In so doing, she argued that the commonly depicted notion of refugees as passive and dependent, was in fact actively created by the political and humanitarian systems providing aid and assistance. She called for research to be *for* rather than *about* refugees, suggesting refugees should themselves be engaged with research, which in turn, she suggested, would promote their rights and agency. Moreover, it has become widely accepted within the field of refugee studies that it is vital to acknowledge the 'heterogeneity and agency of forced migrants' (Fiddan-Qasmiyeh *et al.*, 2014).

The development of refugee studies as an academic field of study has been analysed in relation to concurrent developments in refugee policy – for example, the Association for the Study of the World Refugee Problem - the first organisation that was specifically focused on studying refugees – was created in 1950 in Lichtenstein, at a similar time to the establishment of UNHCR (Black, 2001). The emphasis on policy-relevant research in refugee studies, however, has also been heavily criticised. Bakewell (2008) described

how this focus has foregrounded the '...categories, concepts and priorities of policy makers and practitioners...privileging the worldview of the policymakers...[leaving]... large groups of forced migrants invisible in both research and policy' (p. 432). Harrell-Bond (1986) advocated for a study not only of displaced people, but also the organisations, structures, politics and policies providing assistance. To this end, anthropologists have critically engaged with the underlying principles and day-to-day realities of humanitarian assistance and refugee settlements, studying both refugees and elements of humanitarian assistance.

A case in point is the work of Lissa Malkki's (1995b). Her book, *Purity and Exile,* included a year living in western Tanzania with Hutu refugees from Burundi. She compared those located in Mishamo Refugee settlement, with those living in a township. In doing so, she created a seminal text that explored the identify and histories of these people. In other publications, Malkki (1995a) outlined the lack of attention in refugee studies and humanitarian policy to the political histories that have themselves created displacement. The political origins of the crisis causing displacement, she argues, are often obscured by humanitarian activities. To quote:

> *'...people who are refugees can also find themselves quite quickly rising to a floating world either beyond or above politics, and beyond or above history - a world in which they are simply "victims"...it is this floating world without the gravities of history or politics that can ultimately become a deeply dehumanizing environment for refugees even as it shelters' (Malkki, 1995a, p. 518).*

Malkki (1995a) critiques the international development agenda for refugees along these lines, highlighting the way in which it fails to capture the political and historical process that generates refugee crises. The author explains, however, that the argument is often made for conceptualising refugees as a 'problem for development', to encourage agencies to establish long term development aid for refugees, rather just providing immediate emergency relief. The 'development approach' to, or 'development agenda' for, refugees, became a fundamental component of UNHCR policy in 2003, when their *Framework for Durable Solutions* specifically included the 'Development Assistance for Refugees (DAR)', along with 'Repatriation, Reintegration, Rehabilitation and

Reconstruction (4Rs)' and 'Development through Local Integration (DLI)' (UNHCR, 2003). The focus on a development approach has since continued. For instance, in 2017 the World Bank, in partnership with the UNHCR, produced a report encouraging the 'development approach' to forced displacement, to foster relationships between humanitarian and development partners, who can work together to 'build resilience while supporting inclusive and sustainable growth in host countries' (World Bank, 2017, p. ix).

The development agenda for refugees is characterised by a focus on 'resilience' along with 'self-reliance' and 'economic inclusion'. Scholars have highlighted how this has driven '...neoliberal principles of market primacy, individual responsibility and the dismantling of social support' (Omata, 2023). For decades before this, however, anthropologists critiqued development approaches to refugees, including Tanya Kaiser's (2005) exploration of Uganda's 'Self-Reliance Strategy' (SRS). She conducted long term ethnographic fieldwork in Ugandan refugee settlements. Her work revealed the '...inherently political nature of a refugee presence [which] makes the implementation of a more developmental response much more difficult than one might expect' (Kaiser, 2005, p. 353). In Kaiser's (2011) later research with South Sudanese refugees in multiple settlements across Uganda, she questioned the homogeneity imbued in descriptions of refugees and wrote:

> *'...my research ...assumes that the people living in refugee...settlements are people – and, as such, social actors – first and displaced people second. Their ways of life are likely to have been affected by their conflict experiences and displacement, but also by numerous other factors...their activity in exile is not just simply about survival – about some kind of refugee "bare life" – but should be investigated with reference to their aspirations, plans, and objectives for the present and future.*' (Kaiser, 2011, p. 114).

These findings reflect broader trends in refugee studies, which have emphasised the importance of recognising how people interpret and understand their own existence. It has been questioned how much power humanitarian agencies actually have over the lives of refugees in settlements. 'We may...want to focus instead on the negotiation of

everyday life in refugee camps and explore what forms of power and authority are drawn upon in these negotiations, and to what effect' (Cooper-Knock and Long, 2020, p. 60). Indeed, operational considerations for COVID-19 and forced displacement have highlighted how:

> *'the places where forcibly displaced people settle become sites of pleural or hybrid authorities. Humanitarian programmes, religious organisations, elders' committees and customary courts, political and civil society organisations and local financing cooperatives operate alongside each other, offering various opportunities for leadership and participation, including in collaborating with public health interventions'* (Duclos and Palmer, 2020, p. 2).

Ethnographic Research in Refugee Settings

More recently, researchers carrying out long term ethnographic fieldwork in refugee settlements in Uganda have continued to describe the importance of recognising the way in which refugees respond to precarity whilst maintaining agency. They have done this through a focus on mental health (Torre, 2023a, 2023b), food insecurity and corruption (Brown and Torre, 2024; O'Byrne, 2022; Torre, 2023b), resettlement programmes (Nakueira, 2020) and the material representations of agency (Wainman *et al.*, 2022). Many of these authors have criticised the 'responsibilisation' of refugees in Uganda (Brown and Chiavaroli, 2023; Torre, 2023a).

Beyond Uganda, Cindy Horst conducted research amongst Somalis in Kenyan refugee camps from 1999 to 2001. She explored how refugees coped with their new lives in Dadaab, by drawing on 'nomadic' characteristics of their previous life in Somalia prior to displacement (Horst, 2006). Michael Agier (2002) also carried out ethnographic fieldwork in camps around Dadaab, northeast Kenya, from 2000. He lived with MSF aid workers and visited the camps during the day, to explore the social and cultural complexities of 'city-camps'. Later, in his book, *Managing the Undesirables,* Agier (2011) combines ethnographic insights from Kenya with fieldwork between 2000 and 2007 in refugee spaces across Zambia, Liberia, Sierra Leone, Guinea and the West Bank, to provide a critique of the foundations and politics of humanitarian action.

Ethnographic research has also been used to critically examine refugee camps from the perspectives of humanitarian actors. Jennifer Hyndman (2000), a geographer by background, used ethnographic methods to explore the politics of humanitarianism. The author draws on insights from Kenyan refugee camps, where she had worked with NGOs and UN agencies. Peter Redfield (2013), in his book *Life in Crisis: The Ethical Journey of Doctors Without Borders*, focussed on MSF. His book describes how the work of MSF is expansive and difficult to define, but the organisation is also united by a humanitarian belief regarding the sacredness of human life.

More recent ethnographic work on refugee camps has focused on the material aspects of such settings, including an 'ethnography of cement' in a Palestinian Refugee Camp (Abourahme, 2015). In contrast, Brankamp (2022) has drawn attention to the methodological importance of centring emotions during his ethnographic research in a Kenyan refugee camp, where his fieldwork between 2015 and 2017 explored policing and enforcement. This researcher lived in NGO accommodation whilst conducting research in the camp.

COVID-19 brought a new wave of ethnographic research in refugee settings. A number of studies focussed on refugees and migrants in Europe living in refugee accommodation and reception centres (e.g. Marabello and Parisi, 2020), and COVID-19 vaccination amongst undocumented migrants (e.g. Torre and Storer, 2023). A further ethnographic study of refugees in Germany, Greece and Kenya also turned to remote methods, conducting a primarily digital ethnographic exploration of perspectives from Kakuma refugee camp in Kenya during COVID-19 (Böhme and Schmitz, 2022). This study revealed that the socio-economic consequences of the COVID-19 restrictions were profound in Kakuma camp, prompting refugees to display diverse forms of agency in creating entrepreneurial or social activity, or establishing strategies to leave the camp.

Other studies pivoted to using remote or digital ethnography, such as Islam *et al.*, (2022), who examined the health seeking behaviours of Rohingya refugees in Cox's Bazar during COVID-19. The authors analysed their mistrust of healthcare services in relation to

precarity, vulnerability and histories of systemic oppression. A further study included in-person 'convivial' ethnography in addition to digital ethnography amongst Malawian migrants living in an informal settlement in Zimbabwe to explore sociality and belonging during lockdowns (Bhanye, 2024). This study, however, focussed on migrants in an informal settlement rather than refugees in a formal camp or settlement.

Beyond COVID-19, there has been minimal direct engagement of anthropology with epidemics in refugee settings, despite McKay and Parker (2018) outlining the importance of examining epidemics in humanitarian settings from an anthropological perspective. Anthropological literature examining Ebola Treatment Units have drawn parallels with refugee camps (Nguyen, 2019), but there is a stark lack of long-term in-person ethnographic research specifically within refugee settings, examining epidemic preparedness or response.

To reiterate, in spite of all the ethnographic fieldwork carried out in refugee settings and mentioned above, no researcher has conducted long term in-person ethnographic fieldwork in a refugee camp or settlement in a low resource setting specifically exploring epidemic preparedness. Furthermore, most researchers tend to be affiliated with humanitarian organisations, and/or leave the camp or settlement at the end of the day. Relatively few researchers have specifically outlined living with, or alongside refugees, in a formal camp or settlement, as a central methodological component (Harrell-Bond, 1986; Horst, 2006; Kaiser, 2011; Malkki, 1995b; Nakueira, 2020; Torre, 2023a, 2023b; Wainman *et al.*, 2022). This PhD, therefore, makes an original contribution, using ethnographic methods to explore epidemic preparedness in Palabek Refugee Settlement. It draws on the established literature in refugee studies presented here, that highlights the essential need to pay attention to the perspectives of refugees, in addition to studying the humanitarian system delivering assistance.

Part 3: Situating Epidemics and Displacement amongst Acholi in northern Uganda and South Sudan

Understanding the specific historical, socio-economic and political context in which epidemics and displacement occur is clearly essential. Part 3 of this chapter, therefore, introduces Ugandan refugee policy and scholarship on Acholi. It considers the period of colonial administration, and the borderlands between Uganda and South Sudan. This will be followed by a summary of important epidemics in the region, including the importance of Human African Trypanosomiasis for the British Protectorate, and the political significance of HIV/AIDS for the current President Museveni. The large Ebola outbreak in northern Uganda in 2000 and 2001 will also be described, including how this has shaped epidemic preparedness policy in Uganda. The chapter concludes with a brief overview of mobility, war and displacement in the region.

Refugee Policy in Uganda

In 2022, it was estimated that more than 1.5 million refugees lived in Uganda, with over 900,000 from South Sudan (UNHCR, 2022a). Uganda continues to be Africa's largest refugee hosting nation, and fifth largest in the world (UNHCR, 2024f). With the exception of those residing in urban Kampala, the majority of refugees in Uganda still live in, or close to, refugee settlements (UNHCR, 2020).

Northern Uganda hosts a large proportion of the country's refugee settlements, along with the western and southwestern districts (UNHCR, 2024g). Refugee hosting districts are some of the poorest areas of the country (Government of Uganda and UNICEF, 2018). The greatest number of refugees come from South Sudan, followed by the Democratic Republic of the Congo (DRC), with smaller numbers from Eritrea, Somalia, Burundi, Rwanda and Ethiopia (UNHCR, 2024g). Refugees from South Sudan are granted refugee status on a prima facie basis (UNHCR, 2015). Since armed conflict re-started in South Sudan in December 2013, 4.5 million people have experienced displacement, fleeing violence and food insecurity (Checchi *et al.*, 2013).

Uganda's approach to the influx of refugees is internationally recognised, and the country is often praised for its 'open door policy' (UNHCR UK, 2024). The country's refugee policy has become another marker of Uganda's recognised international success, along with

reductions in poverty, gender empowerment, and a growing Gross Domestic Product (GDP) (Wiegratz *et al.*, 2018). Praise for Uganda's refugee policy often focuses on the way it has embraced UNHCR's Comprehensive Refugee Response Framework (CRRF). This framework was launched by UNHCR in 2017, building on the New York Declaration for Refugees and Migrants (UNHCR, 2018a), which emphasised the welcoming of new refugees (UNHCR, 2017). To quote UNHCR (2019):

> *'Uganda's favourable protection environment for refugees is grounded in the 2006 Refugee Act and the 2010 Refugee Regulations. The legislations allow refugees freedom of movement, the right to work, establish a business, own a property and access national services, including primary and secondary education and health care'* (p. 7).

The CRRF built on Uganda's longstanding 'development approach' to refugees, with the aim of reducing reliance on humanitarian assistance in the long term. This is reflected in Uganda's previous refugee policies, including the Self-Reliance Strategy (1999) (Clements *et al.*, 2016), the Development Assistance to Refugee Hosting Area Programme (2004), and in 2015, the Settlement Transformative Agenda which specifically called for refugee settlements rather than encampments, and included refugees in Uganda's development plans (Moyo *et al.*, 2021).

Refugee settlements in Uganda are run by a branch of the Ugandan government – the Office of the Prime Minister (OPM). They are supported by UN organisations, primarily UNHCR and World Food Programme (UNHCR and WFP, 2023). Non-government organisations (NGOs) work as 'implementing partners' to deliver refugee services in accordance with sectors of the humanitarian response. These sectors include refugee education; environment, energy, settlement and non-food items; food security; health and nutrition; livelihoods and resilience; protection; and water, sanitation and hygiene (OPM and UNHCR, 2022a). Refugees receive a monthly (two-monthly during COVID-19) ration of either cash or food items.

The importance of Uganda's flagship refugee policy has been associated with significant national and international priorities. Moyo *et al*., (2021) have argued that whilst the welcoming of refugees is essential in order to maintain donor funding, it also works to divert international attention away from less attractive dimensions of the Government of Uganda. These include the maltreatment of opposition leaders and journalists (Human Rights Watch, 2018), the expelling of development and aid workers that do not align with presidential priorities (Biryabarema, 2021), and harsh LGBTQ+ laws (United Nations, 2023).

The reputation of Uganda's refugee response was significantly marred by a large refugee scandal in 2018. During this time, it was reported that refugee registrations were being sold by staff working in the humanitarian response. Furthermore, repeated registrations of the same individuals were drastically elevating estimated refugee numbers (Titeca, 2022). Evidence of corruption in terms of refugee registration and food allocation has been described in Palabek Refugee Settlement (O'Byrne, 2022; Ogeno and O'Byrne, 2018).

In response to the corruption in Uganda, UNHCR introduced a biometric registering system to ensure that no individual could receive duplicate registrations (UNHCR, 2018b). Despite evidence that such corruption involved individuals in significant positions of power in the Ugandan refugee response (Titeca, 2022), such high-level corruption, has in many ways, been swept under the carpet. This has been considered in relation to the value of Uganda's internationally recognised welcoming refugee policy, which UNHCR requires as a flagship refugee policy (Titeca, 2021).

Uganda's refugee response is facing further difficulty, with significant funding shortfalls. The refugee response depends on external donors. In 2022 (the year that fieldwork ended), UNHCR highlighted that Uganda only received 38% of its required funding for its refugee response, or 132 of the 343 million United States dollars it required (USD) (UNHCR, 2022b). More recently, the UNHCR's 2024 South Sudan Regional Refugee Response Plan stated:

> *'Funding for the Uganda Country Refugee Response Plan (UCRRP) has dwindled in the past years, and the capacity of Refugee Response Plan (RRP) partners to provide life-saving support and protection services to new arrivals and basic assistance to refugees has diminished. This has manifested as significant reductions in food rations, with over 80 per cent of the population receiving USD 3 per person per month, which is barely enough to survive'* (UNHCR, 2024h).

Food Insecurity, Corruption and the Prioritisation Strategy

It has been suggested that refugees are not provided with adequate opportunities for self-reliance in the way that Ugandan refugee policy suggests. People are hungry, their food aid is being cut drastically, they do not have adequate opportunities for farming on their small plots of land, and malnutrition rates are high (Brown and Torre, 2024).

Food insecurity has been a concern in Ugandan refugee settlements for many years (Herbert and Idris, 2018). A report published in 2018 mentioned concerning rates of malnutrition and anaemia in many settlements, including Palabek (Government of Uganda *et al.*, 2018). Although food rations were intended to last 30 days, the survey found that in Palabek they only lasted 22 days. Refugees thus turned to alternative strategies to survive, including borrowing money and food, reducing the number of meals eaten per day, reducing the portion size of meals, and reducing the quantities consumed by adults including the mothers of young children.

Despite this concerning picture regarding food insecurity, chronic under-funding of the refugee response has led to further reductions in the food assistance provided to refugees (Neiman and Titeca, 2023). This has been part of a wider prioritisation agenda, to restructure the general food and cash assistance (GFA) to refugees (Brown and Torre, 2024). Prioritisation exercises have attempted to protect support to those considered the most vulnerable, such as newly arrived refugees, whilst reducing or withdrawing the rations to those considered to be less vulnerable (World Food Programme, 2024). Brown and Torre (2024) have outlined multiple problems with this prioritisation, including a lack of transparency with measuring vulnerability, problematic data and misallocation of

categories. They have also described the damaging consequences of these restrictions which include increasing malnutrition, stunting, reduced healthcare seeking behaviour, poor school attendance, increasing sexual and gender-based violence, and cross-border mobility. The first phase of the reduced GFA was introduced in Palabek Refugee Settlement in 2021.[13] The focus of this thesis is on Acholi refugees from South Sudan, living in Palabek Refugee Settlement in the northern Ugandan district of Lamwo. The next section will, therefore, provide further details on Acholi.

A focus on Acholi

The word Acholi refers to people, a geographical area, and a language. Acholi are described as a Nilotic ethnic group of Luo (also Lwo) people, who live in northern Uganda and South Sudan (Atkinson, 1989). In South Sudan, Acholi live in Magwi County, Eastern Equatoria (O'Byrne, 2015a). In northern Uganda, Acholi live in the districts of Lamwo, Kitgum, Pader, Agago, Gulu, Nwoya and Amuru (Hopwood and Atkinson, 2015). The word 'Acholiland' typically refers to the geographical area within which the Acholi language is spoken in Uganda (Finnström, 2008; Hopwood, 2022), corresponding generally to the Acholi sub-region of northern Uganda. This section introduces the colonial era of Acholiland, and highlights the focus on war and displacement among Acholi in northern Uganda.

Acholi during Colonial Times

Scholars have emphasised both the precolonial origins of Acholi ethnic identity (Atkinson, 1989), and the role of British colonialism in shaping Acholi identity (Amone and Muura, 2014). The interconnectedness of Acholi with other groups such as Madi and Lugbara, has also been emphasised, with separate identities only becoming categorically distinct from one another during the colonial period in the late 19th Century (Allen, 1993). It would be a mistake to infer that Acholi ethnic identity was uniquely constructed by colonial administration. Instead, it is important to emphasise, as many

[13] Further details of the phases of prioritisation can be found in Brown and Torre, 2024.

scholars have, that prior to the colonial administration, other dimensions of identify such as clans, lineages, and chiefdoms, were more important than categorisations such as Acholi or Madi (p'Bitek, 1971; p'Bitek *et al.*, 2019).

Acholi live on both sides of the current border between Uganda and South Sudan. In the latter half of the 1800s, the region was invaded by multiple slave traders and British and Belgium imperial powers (Allen, 1996). The major borders in East Africa tended to follow a 'sequence whereby boundaries were defined on maps, delimited by treaties, and demarcated on the ground by colonial officials' (Khadiagala, 2010, p. 267). In the case of the border between South Sudan and Uganda, colonial governments did not use 'tribal boundaries' to define borders, and so the 1914 'definition' cuts through Acholi and Madi ethnic groups (Leonardi and Santschi, 2016).

The colonial administrations of Uganda and Sudan created very different conditions for Acholi in each setting. Uganda was colonized by the British in the late 19th Century, and it was officially declared a British protectorate in 1894 (von Weichs, 2009). The British colonial intrusion into Acholi regions has been described as slow and gradual, but ultimately the administration significantly influenced life for Acholi in northern Uganda (Amone and Muura, 2014). A common figure associated with the colonial administration amongst Acholi in northern Uganda is Samual Baker, a British explorer and colonial officer, who is said to have played a role in suppression of the Arab slave trade in East Africa, and built Fort Patiko on the outskirts of Gulu, northern Uganda (Amone, 2014). This site is often referred to as 'The Samual Baker Fort' and remains a tourist attraction to this day.

Key scholars who have contributed to literature on Acholi in Uganda during the late Protectorate and during early independence (Uganda gained independence in 1962) include Frank Girling and Okot p'Bitek (Allen, 2019). Frank Girling was British colonial officer and an anthropologist, whose work *The Acholi of Uganda* (1960) (in p'Bitek *et al.*, 2019) has remained largely unappreciated until recently, which may be explained by the fact his relationship with the British Protectorate became sour and 'Girling himself became disillusioned with the kind of anthropological approach his African work

represented, and openly disparaged it as a neo-colonial product' (Allen, 2019, p. 9). Okot p'Bitek is a celebrated Acholi poet and creative writer (p'Bitek, 1966). He also wrote internationally recognised anthropological texts on Acholi (p'Bitek, 1971), although these texts were not acknowledged by the Anthropology Department at the University of Oxford, when they failed his D.Phil in 1970 (Allen, 2019). Okot p'Bitek, in both his fictional and non-fictional writing has been highly critical of the colonial encounters with Acholi.

There was a contrasting lack of colonial impact on Acholi in Sudan from the British-Egyptian condominium which was established in 1899 (Daly, 1991). Acholi in Sudan remained isolated physically from other regions by long wet seasons, mountains and thick vegetation, with O'Byrne describing how Acholi in Pajok remember only meeting a white person for the first time in the 1940s (O'Byrne, 2016). Indeed, it was not until later in the twentieth century, that the colonial administration of Sudan began to intervene in the lives of Acholi or others living in the South (Leonardi, 2015; O'Byrne, 2016).

Acholi and Forced Displacement

There is a wealth of literature exploring Acholi in northern Uganda. Much of this has focussed on the civil war from the mid 1980s to mid 2000s, between the Lord's Resistance Army (LRA) and President Museveni and his UPDF forces, and the aftermath of this conflict. During the civil war, millions of Acholi were forced to live in squalid conditions in Internally Displaced People's (IDP) Camps, which have been described as a type of 'social torture' (Dolan, 2011). Furthermore, it has been estimated that more than 50,000 people were forcibly recruited by the LRA, half of whom were children (Allen *et al.*, 2020). The challenges of the post-conflict period have also been explored, including difficulties with land disputes for Acholi returning home after displacement (Hopwood and Atkinson, 2015), the legacies of humanitarian neglect (Parker *et al.*, 2021), and how to heal the social, psychological and spiritual wounds of war (e.g. Allen, 1997; Allen *et al.*, 2021; Baines and Gauvin, 2014; Torre *et al.*, 2019; Williams, 2022) .

Anthropologists have also examined other types of violence; for example, Holly Porter (2017) explored experiences of rape among Acholi women. In her work, Porter highlighted the centrality of 'social harmony' for Acholi (Porter, 2017, 2012). The concept of social

harmony, along with similar notions such as the balancing of good and bad surroundings, will be returned to multiple times in this thesis, especially to describe the significance of spiritual powers for Acholi. Finnström (2008), in his book *Living with Bad Surroundings,* captured the importance of appreciating the inextricable spiritual dimensions of Acholi life, which are central to the way in which people made sense of the civil war in northern Uganda. Less academic attention has been paid to Acholi in South Sudan. However, a useful contribution is from Ryan O'Byrne, who studied Acholi cosmology in South Sudan, and described how Acholi beliefs that surround ancestral worship became entangled with Christianity, so that distinctions between the two are often impossible (O'Byrne, 2015b, 2021).

In addition to the wealth of literature on Acholi in the midst and aftermath of the civil war, there has been significant anthropological engagement with Acholi in relation to epidemics, particularly in relation to the Ebola outbreak in Gulu from 2000 to 2001. The next section will shed further light on the importance of epidemics in Uganda, including amongst Acholi.

Epidemics in Uganda

Epidemics have had a long and entwined history with Uganda and Acholiland. This section first outlines more general connections between epidemic control and colonialism, before discussing the significance of specific epidemics, including African Trypanosomiasis, HIV/AIDS and Ebola.

Epidemics and Colonialism

Epidemic control measures that feature in current policy worldwide are also evident in colonial histories (Lynteris and Poleykett, 2018). Although quarantine and social distancing practices date back to Europe in the 14th Century, epidemics first prompted a coordinated international response in the 19th Century, coinciding with European colonial expansion, and the introduction of smallpox to Africa and the Americas (White, 2020). The history of epidemic control has, therefore, been heavily influenced by

European colonial agendas, focusing on diseases that posed a risk to international trade routes at the time and/or those that threatened imperial administrations (Anderson *et al.*, 2021). In 1892, the first International Sanitary Convention was adopted to address concerns regarding the plague, cholera, and yellow fever. To quote White (2020):

> *'The threat of diseases emerging from colonial sites that could disturb systems of trade and travel led to aggressive control of these diseases in sites of epidemic outbreak and aggressive scrutiny of those people deemed to be responsible for disease spread…The heightened scrutiny and bias against non-Europeans who were blamed for spreading disease have historically resulted in aggressive racist and xenophobic responses carried out in the name of health controls' (p. 1250-1251).*

Historical epidemics in Uganda clearly demonstrate the interconnectedness with colonial intervention. For instance, Human African Trypanosomiasis (HAT), or sleeping sickness, is a disease found in Uganda and South Sudan. Human Trypanosomiasis is classified by the WHO as a neglected tropical disease and without treatment, is usually fatal (World Health Organization, 2023a). This disease is caused by a parasitic infection, which is mainly transmitted by tsetse flies. There are two subspecies of parasite that cause disease in humans: *Trypanosoma brucei gambiense* and *Trypanosoma brucei rhodesiense* (World Health Organization, 2023a). Both of these types have been found in Uganda, with the northwest affected by *T.b.gambiense,* and south-eastern and eastern regions by *T.b.rhodesiense* (Aluma *et al.*, 2022). Between 1896 and 1906 there was a large epidemic of sleeping sickness in Uganda and the Congo Basin (World Health Organization, 2023a). The control of this disease was a high priority for imperial officers (Palmer and Kingsley, 2016), based on colonial 'humanitarianism', a threatened labour workforce, and scientific motivations (Headrick, 2014). In Uganda, British commissions were sent from London to establish the cause of sleeping sickness, to find a way to control it, and to assess the impact upon the economy and society (Summers, 1991). These activities are described as fundamental to the birth of British tropical medicine in Africa (Headrick, 2014). Given the extensive epidemics in Uganda and Congo, the Anglo-Egyptian colonial administrates in Sudan implemented control measures before any cases were found in the country, but this failed to prevent subsequent epidemics in this

country too (Palmer and Kingsley, 2016). Colonial attempts at controlling African Trypanosomiasis included measures that mirrored military campaigns, closing borders and forcibly displacing people away from tsetse fly areas in both Uganda (Tilley, 2016) and Southern Sudan (Palmer and Kingsley, 2016). Screening for trypanosomiasis in Africa during the colonial period involved a medical inspection, which often became a public affair with 'entire populations' being subjected to examinations and investigations to diagnose cases (Palmer, 2019). When the epidemic crisis was considered over in Uganda, trypanosomiasis left an administrative legacy. To quote Summer (1991): 'The intervention left behind…a pattern of administrative intervention in the health and lives of the protectorate's people by a system of local administration that oversaw public health, and a pattern of visiting medical commissions that advocated advanced and coercive therapies and population management' (p. 789).

From a global perspective, cases of HAT remained low for many decades following the epidemics in the colonial periods. However, there was a rebound of cases in the 1960s. This has been attributed to 'political instability and conflicts of the period following decolonisation in countries such as DR Congo, Angola and Sudan [which] led to the dismantling of health services, including disease control programmes for HAT and other diseases' (Picardo and Ndung'u, 2017, p. E28). Cases in Uganda increased from the 1970s during periods of conflict and internal displacement. Although these cases reduced with an intensive international campaign, there have been concerns that the more recent influx of refugees from South Sudan to Uganda, particularly since 2016, risks further outbreaks (Picardo and Ndung'u, 2017).

Epidemics other than HAT continued to characterise colonial times in Uganda, including smallpox, dysentery, cerebro-spinal meningitis, bubonic plague, and influenza (Summers, 1991). The protectorate in Uganda were also particularly concerned about other diseases reaching epidemic proportions, including syphilis, a sexually transmitted disease. In the eyes of the colonial administration, this was not only an issue of medical, but also moral, intervention, with missionaries administering purity campaigns (Summers, 1991).

HIV/AIDS and Ebola in Uganda

A moral response to epidemics in Uganda also characterised the HIV/AIDs epidemic in Uganda in the 1980s and 1990s, with the government's famous 'ABC' campaign: Abstain, Be Faithful, and use a Condom, which placed emphasis on abstinence and fidelity (Murphy *et al.*, 2006). The HIV/AIDS epidemic in Uganda received international attention for both its initial worrying size, but also its apparent successful containment (Allen, 2006). For example, Slutkin *et al.*, (2006) wrote that 'Uganda is only one of two countries in the world that has successfully reversed the course of its AIDs epidemic' (p. 351), concluding that this can be explained by the direct result of nationally coordinated prevention programmes and activities. The narrative surrounding Uganda's HIV/AIDS success has been called into question, however (Parkhurst, 2002). In particular, scholars have suggested that a focus on abstinence over condom use leaves women at risk of infection in settings where they are not able to decline sexual intercourse (Murphy *et al.*, 2006). Furthermore, the actual accuracy of the HIV/AIDs data in Uganda has been called into question, with data biased toward regions in the southwest of the country (Allen, 2006). Scholars have also pointed to the political dimensions of the success of the HIV/AIDS campaign in Uganda (de Waal, 2003). It has been suggested that President Museveni and his National Resistance Movement (NRM) party, from the year 2000, harnessed the declining HIV rate to galvanize donor support. This was at a time, when, to quote Tumushabe (2006):

> *'the earlier political and economic gains of President Museveni's government were being seriously eroded by rising economic mismanagement, high-level corruption, maintenance of a de factor one-party state, failure to pacify the northern half of the country, the fomenting of regional instability and attendant human rights violations'* (p. iv).

The political significance of epidemic success in Uganda in relation to HIV/AIDS has been mirrored somewhat with the more recent COVID-19 response. In 2020, for example, Uganda received extensive praise for the swift response to COVID-19 which has been attributed, at least in part, to drawing on previous experiences of epidemics, such as HIV/AIDS (The Lancet COVID-19 Commissioners *et al.*, 2020). Uganda also has extensive

experience with Ebola. From 2000-2001, Gulu, Northern Uganda, was the epicentre of an Ebola outbreak with 425 cases and 224 deaths and a case fatality rate of 53% (Omaswa *et al.*, 2015). The outbreak coincided with the civil war in Acholiland, and the armed forces were present in the region (Allen and Parker, 2023). To this day, the outbreak is well remembered amongst Acholi, and scholars are still returning to learn from those who lived through it (Park and Akello, 2017). When Acholi in Gulu discuss Ebola, it is usual for the local hero, Dr Matthew Lukwiya, to be mentioned. He was living in Kampala but returned to work in Gulu in 2000 in response to the Ebola outbreak. His mural is painted on the entrance to St Mary's Hospital Lacor, a private Catholic Missionary Hospital. This hospital treated those people infected with Ebola, and many cases occurred amongst healthcare workers. This included Dr Lukwiya, who died of Ebola after providing care for an infected colleague (Kao, 2001). The 2000-2001 Ebola epidemic in northern Uganda was also significant for anthropologists, who joined the formal WHO response effort (Hewlett and Amolat, 2003; Hewlett and Hewlett, 2008). By doing so, they were able to stress the importance of incorporating local views and 'cultural explanations' of Ebola into 'sensitization strategies'.

Since the large Ebola outbreak in Gulu, Uganda, there have been multiple smaller Ebola outbreaks in Uganda, including both the Zaire Ebolavirus (which caused the west African Ebola outbreak in 2013-2016), and the Sudan Ebolavirus, which was responsible for the 2000-2001 outbreak and the latest outbreak in 2022 (US Centre for Disease Control and Prevention (CDC), 2024). Uganda's Ebola preparedness has also been put to the test by multiple outbreaks in neighbouring DRC (Kinganda-Lusamaki *et al.*, 2024; Schmidt-Sane *et al.*, 2020). Furthermore, specific anthropological engagement with epidemic preparedness for Ebola in this region has focussed on the complex borderland dynamics in East Africa involving Uganda, Tanzania, DRC, South Sudan, Rwanda and Kenya (Lamarque, 2022; Lamarque and Brown, 2022; Moro and Robinson, 2022; Pendle *et al.*, 2019).

It is not surprising, then, that Uganda's epidemic preparedness policies have been significantly shaped by Ebola, which were then tailored to the COVID-19 pandemic (Lumu, 2020). Akello and Parker (2021) describe Uganda's infrastructure for epidemics

as incorporating the following elements: the National Emergency Operating Center (NEOC) for health-related disaster (within the disaster preparedness department at the Prime Minister's Office); the Ministry of Health including its disease surveillance mechanisms; international and national development partners and NGOs; and district and national taskforces. The authors highlight the far-reaching power that the president's office has in this architecture. For instance, districts report to local government which in turn report directly to the president's office. This chain of command is separate from the Ministry of Health. Furthermore, district taskforces, including those for disease response, are chaired by the Resident District Commissioner (RDC), who are political representatives (usually soldiers or retired soldieries) directly appointment by the president.

Anthropologists have also described how the COVID-19 epidemic in Uganda was characterised by a militarised response, which as Allen and Parker (2023) highlight, 'helped entrench autocratic public authority' (p. 1). Although connections between security, military action and disease control have a long and intertwined history discussed above, the type of epidemic control seen in Uganda has become increasingly accepted since the UN Security Councils response in 2014 to the West African Ebola Outbreaks, which legitimised military responses (Allen and Parker, 2023; Parker *et al.*, 2022). In general, therefore, Uganda's preparedness and response infrastructure can be seen to reflect the global trend in epidemics as conceptualised in terms of threats to health security, discussed in part 1 of this chapter.

Borders, Conflict and Mobility

This last section moves away from the spread of epidemics to focus attention on the movement of people in the borderland areas between South Sudan and Uganda. Here, it becomes evident that people in the region have experienced generations of repeated displacement, often moving back and forth in an endeavour to avoid violence, food scarcity, and inadequate educational opportunities and healthcare.

Mobility and Borders

To understand mobility and displacement in this borderland region it is useful to first have an idea of the geographical landmarks that are particularly relevant to the field site of this PhD, which will be introduced in further depth in chapter 5. Figure 3 shows multiple important geographical locations on both sides of the Ugandan-South Sudan international border. On the Ugandan side of the border, Google maps captures Palabek, the site of the main refugee settlement. Lokung is also marked, which is the site of a remote reception centre 40kms from the main settlement. The reception centre at Lokung was subsequently turned into an isolation and quarantine centre during COVID-19. On the South Sudanese side of the border, Pajok is located, the previous home of Acholi refugees residing in Palabek. On main roads, it is approximately 65kms between Pajok and Palabek. I have also added other markers to this map, which indicate the commonly used formal border points between Uganda and South Sudan. Ngomoromo, Elegu (that borders with Nimule on the South Sudanese side) and Madei Opei are the 'most official' border points. Waligo and Aweno Olwii are smaller, but still considered 'official' given the presence of immigration officers and soldiers. Across this border, however, people use unofficial points of crossing. The nature of these borders and border points is explored in more detail in chapter 6.

Figure 3. 'Official' border crossing points used to travel between Palabek and South Sudan, adapted from google maps.

The movement of people across borderlands between South Sudan and Uganda have complex histories that are not so easily depicted in the map in Figure 3. For centuries people have been mobile. 'When old people are asked to tell their stories of their lineage…they describe the past in terms of movement from one place to another. Commonly these movements occurred to avoid fighting' (Allen, 1996, p. 223). This chapter has already described how, in the latter half of the 1800s, the region was also invaded by multiple slave traders and British and Belgium imperial powers. Although stories of people's movement in this region pre-date colonial rule, it is also clear that people fled to avoid such violence (Allen, 1996). The generations of displacement in this borderland area have also included millions of internally displaced people in northern Uganda during the decades of conflict from the 1980s between the Ugandan People's Defence Forces (UPDF) and the Lord's Resistant Army (LRA) led by Joseph Kony.

Mobility has long been part of everyday life for many (South) Sudanese, and they have moved across borders during peace as well as during times of conflict (O'Byrne and Ogeno, 2021). For refugees in Palabek, this cross-border movement may be in response to conflict, but it also reflects long-lasting personal connections (e.g. visiting family,

friends, funerals), economic opportunities, health, livelihoods, food security and schooling (Moro and Robinson, 2022; O'Byrne and Ogeno, 2021). People continue to deal with the uncertainties in the precarious nature of day-to-day life in Palabek, shaped by the uncertain and unpredictable provision of food and healthcare, and barriers to accessing the benefits of refugee rights, that may or may not lead to 'informal repatriations' back to South Sudan (O'Byrne and Ogeno, 2021). Furthermore, considering the long-lasting personal connections that shape such mobility, problematises the formal categories of 'refugee' or 'displaced person'. People crossing these borders have settled in different areas, facilitated by long-lasting connections (e.g. kin relations), and they have not necessarily received external assistance from refugee agencies. Others have been labelled by international organisations (e.g. UNHCR) or host governments as 'displaced', 'refugee', 'returnee', or 'arrival' during multiple journeys, sometimes leading to formal assistance with policies of mass repatriation, or integration (Kaiser, 2005). Given the long and complex history of displacement, Allen and Turton (1996) wrote:

> *(to) '…focus, in such a case, on a single movement of people, in one direction and at a particular point in time, would be to give a false, if comforting, impression that one is dealing with a simple and well circumscribed event rather than with an untidy process, involving multiple, and sometimes overlapping migrations in both directions, and considerable flexibility with respect to nationality and ethnicity' (p. 7).*

Conflict and Violence

It is impossible to adequately capture the details of centuries of violence that have contributed to repeated displacement and sometimes enduring or repeated relationships with humanitarian actors and agencies, with numerus wars in both Sudan and Uganda displacing (often the same) people back and forth across this border (Allen, 1996). Some of these historical invasions and wars have already been discussed above, but it is useful to provide a little more information regarding the conflict and violence in (South) Sudan that has not yet been discussed.

From 1899 Sudan was ruled by the British and Egyptian, with the 'Anglo-Egyptian Condominium' (1899-1956) effectively separating the country into a mainly Arab north,

and Christian south (Daly, 1991). The Arab north was considered to have received more formal development of infrastructure during this time. In contrast, the Christian South was somewhat 'protected' from the Arab north, and engagement with economic developments was hampered (Roach, 2023). The British also maintained their control through indirect rule, distributing control and authority to certain groups (legacies of which are still present in the current Sudanese conflict), as well as utilising informal chiefdoms to exert this indirect control (Searcy, 2019). When Sudan became independent in 1956 from imperial powers, the country, had already been internally divided.

Two major civil wars (amongst others) have ravaged Sudan (Collins, 2007). During the first Sudanese Civil War (1955 to 1972), between the mainly Muslim north of the country, and the mainly Christian south, people travelled from Sudan to Uganda to seek safety (Rolandsen, 2011). However, the civil war following President Idi Amin's rule in Uganda in 1979 saw many Ugandans and Sudanese flee north of the border to Southern Sudan (Lomo *et al.*, 2001). In 1983, a second Sudanese civil war erupted, and many Sudanese were once again internally displaced, or travelled south to Uganda, along with previously displaced Ugandans (Searcy, 2019). In 2011, South Sudan became an independent nation for Sudan, but only two years passed before a civil war broke out within this new state (Moro, 2019). The war that erupted in 2013 was fought between two main opposing political coalitions: President Salva Kiir (and the ruling Sudan People's Liberation Movement, SPLM); and his former deputy, Riek Machar (who led the Sudan People's Liberation Movement-in-Opposition, SPLM-IO) (Johnson, 2014). Despite an official ending of the civil war in 2020, violence and instability has continued, with the continued displacement of now millions of refugees from South Sudan into neighbouring countries, such as Uganda (UNHCR, 2022a). The ongoing instability in the region has been linked to South Sudan's large reserves of oil and gas. Jason Hickel wrote:

> *'…this has not just been a regional battle. China has long backed Khartoum and controls the majority of the region's oil concessions. The United States, on the other hand, has armed and funded the Sudan People's Liberation Movement to counter-balance Khartoum's Islamist influence in hope of gaining privileged access to the oil after independence'* (Hickel, 2012).

I do not intend to give a comprehensive summary of the complex history of instability within Sudan and South Sudan, but rather want to draw attention to the fact that the most recent forced displacement of refugees into Palabek cannot be easily separated from centuries of instability and conflict which involved colonial powers and their neo-colonial counterparts.

The first two parts of this chapter provided some background literature regarding anthropological engagement with epidemics, humanitarianism and refugee studies. In so doing, they have highlighted the vital importance of paying attention to the specific contexts in which epidemics and displacement occur. Furthermore, preparedness needs to pay greater attention to the wider socio-economic, historical and political dynamics that shape such contexts, including in refugee settings. The final part of this chapter, therefore, provided contextual information to better understand epidemics and the lives of refugees in northern Uganda. Emphasis has been placed in this final part on using historical perspectives to challenge conceptualisations that simply categorise people in terms of national affiliation. For instance, the historical accounts of the borderland region between Uganda and South Sudan start to problematise the notion of a 'refugee' as a discreet entity, when the interconnectedness of Acholi in northern Uganda and South Sudan is appreciated. Furthermore, epidemics were clearly interconnected with colonial administration as well as current political powers. This suggests, therefore, that epidemic preparedness measures amongst refugees in the region would benefit from understanding such socio-political and historical dynamics.

Chapter 3: A critique of Uganda's COVID-19 Success

Figure 4. COVID-19 public messaging in Uganda, taken in Lamwo District, Uganda, May 2021.

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Journal of Biosocial Science		
When was the work published?	March 2024		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	N/A		
Have you retained the copyright for the work?*	**No**	Was the work subject to academic peer review?	**Yes**

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	
Please list the paper's authors in the intended authorship order:	

Stage of publication	Choose an item.

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I initially drafted the paper, which was subsequently edited by Melissa Parker (MP) and Nicolas Laing (NL). The quantitative data was extracted from the John Hopkins Database by NL: I subsequently reviewed NL's presentation of the data. All authors were involved in reviewing and amending the final manuscript. I was the corresponding author for finalising the manuscript and submitting it to the journal.

SECTION E

Student Signature	[redacted]
Date	12th December 2024

Supervisor Signature	[redacted]
Date	13th December 2024

Figure 5. This Figure confirms that this article was published via a Creative Commons CC-BY license, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Article Title: Does epidemiological evidence support the success story of Uganda's response to COVID-19?

Published in the *Journal of Biosocial Science* in 2024.[14]

Authors: Nicolas Laing (NL)[1], Sophie Mylan (SM)[2] and Melissa Parker (MP)[2]

[1]OneDay Health, Gulu, Uganda

[2]Department of Global Health and Development, London School of Hygiene and Tropical Medicine (LSHTM), London WC1H 9SH, UK

Corresponding author: Sophie Mylan; Email: Sophie.mylan@lshtm.ac.uk

Abstract

Uganda has received praise for its success in dealing with the COVID-19 pandemic. This opinion piece uses publicly available data from Johns Hopkins University to suggest that it is far from clear whether the Public Health and Social Measures (PHSM) introduced in Uganda influenced the course of the first outbreak. In addition, the analysis of data from the second and third waves in Uganda suggest that government action had little or no effect on these outbreaks. The dominant narrative of successful PHSM, therefore, needs to be reconsidered, and alternative explanations for the low rates of COVID-19-related mortality in the country need to be further understood.

Keywords

COVID-19; epidemiology; Uganda; public health and social measures; biosocial

[14] Full Reference: Laing, N., Mylan, S. and Parker, M. (2024) Does epidemiological evidence support the success story of Uganda's response to COVID-19? *Journal of Biosocial Science*, 11, pp. 1–8.

Legitimate Praise for Uganda's Response?

In October 2020, the Lancet ranked Uganda as one of the world's top ten countries in suppressing COVID-19 (Ainebyoona, 2020). This was based on the Lancet COVID-19 Commission Statement, published first in September 2020, which categorised countries in terms of level of suppression according to 'the number of new cases per day per million population' (The Lancet COVID-19 Commissioners *et al.*, 2020). Suppression was defined as ≤5 new cases per million per day, when tests per case ≥20. Nineteen countries were categorised as achieving suppression according to these criteria, with Uganda (1.2 new cases per million per day, with 157.2 tests per case) and Rwanda (5 new cases per million per day, with 169.3 tests per case) the only two African countries to achieve such suppression. The commissioners attributed their success to effective key non-pharmaceutical interventions (NPI). 'We note with satisfaction that many low-income countries have achieved sustained successes by deploying the NPI package to suppress the epidemic. Notable examples include Uganda, which has extensive experience with the AIDS epidemic' (ibid, p. 1110).

Other influential organisations took a similar view. In March 2021, Patricia Scotland, the Commonwealth Secretary General, lauded the Ugandan President for his response, stating that he had succeeded by 'listening to science, listening to the empirical evidence, planning and helping to get the population to support the measures' (Ajuna, 2021). In August 2021, the Global Fund published a blog entitled Uganda's Remarkable Response to COVID-19. The blog stated that: 'Uganda achieved that feat by swiftly deploying health systems and community responses created to fight other infectious disease, including HIV, TB and malaria' (The Global Fund to Fight AIDS, 2021).

This opinion piece challenges this narrative of success. Drawing on publicly available aggregated epidemiological data (including data reported to the World Health Organization), which has been collated by Johns Hopkins University (see: https://github.com/CSSEGISandData/ COVID-19), it presents epidemic curves for the three main waves of COVID-19 in Uganda (Fig. 6, 7 and 9), a comparison with the South African Delta outbreak (Fig. 8), and COVID-19 mortality rates (Figs. 10 and 11). Data for

Uganda and South Africa are analysed with reference to the different NPI's – or Public Health and Social Measures (PHSM) that were introduced during these waves of infection. In so doing, it is argued that it is unclear how much the PHSM influenced the course of the first outbreak in Uganda. Furthermore, data from the second and third waves in Uganda (Figs. 7 and 9) suggest that government actions had little or no effect on these outbreaks. If government responses had been effective, then slowing of the outbreak or 'flattening of the curve' would have been observed as was seen in the South African delta outbreak (Fig. 8). Instead, the epidemiological curves suggest rapid uncontrolled spread and spontaneous resolution of outbreaks. More broadly, this opinion piece demonstrates the problems with reifying a small number of epidemiological indicators at the expense of considering how these indicators relate to socio-behavioural measures and the wider political context. Developing broader biosocial perspectives for Uganda – and elsewhere – would enable more accurate assessments of COVID-19 public health policy and practice.

The initial COVID-19 outbreak in Uganda, March 2020 to January 2021

Uganda instigated its first COVID-19 measures on 20th March 2020, the day before the first case was confirmed in the country. From April 1st, 2020, the harshest lockdown of the entire two-year period was implemented. With the help of the armed forces, no private or public transport was allowed, schools and places of worship were closed, and trade was forbidden unless it involved the sale or purchase of food. Air and land borders were also closed, although trucks carrying goods were permitted to cross if the driver had tested negative for COVID-19. Some of these restrictions were lifted on the 2nd June 2020, and others were removed on 21st September 2020. However, schools remained essentially closed (apart from a proportion of classes approaching exams), along with bars and nightclubs. Political rallies continued to be forbidden (Parker *et al.*, 2020).

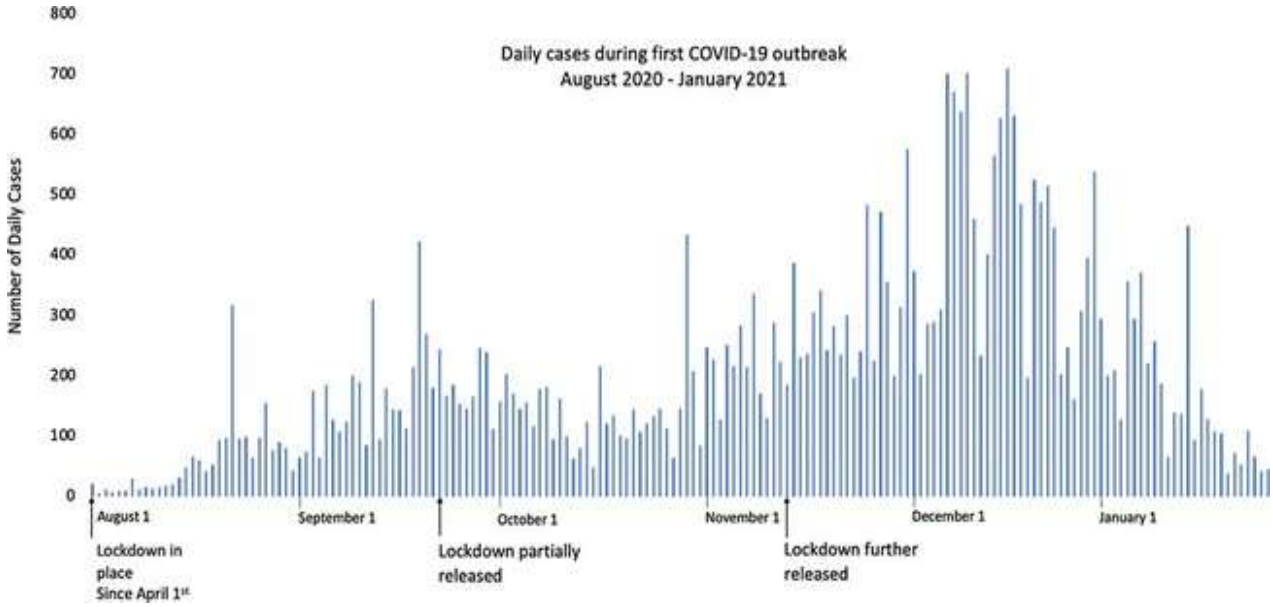


Figure 6. Daily cases of COVID-19 from August 2020 to January 2021

Uganda's strict and early restrictions may have delayed the onset of the epidemic to later in 2020 (Fig. 6), with cases only rising to the highest point in December, after lockdown measures were released in September. However, it is not straightforward interpreting these data. In March 2020, the Ugandan Viral Research Institute (which is based in Entebbe) was the only place in the country able to provide PCR testing. Testing capacity gradually increased during 2020 and by the end of the year testing was available in most major urban centres. These higher testing rates may also have contributed to higher case numbers, as monthly tests increased from an average of just 1277 tests a day earlier in April, to three times that number later that year – peaking at 3646 in December (Johns Hopkins University, 2022). From this point onwards, however, the number of COVID-19 PCR tests done in Uganda was relatively consistent, supporting the premise that although reported numbers of cases are unlikely to represent the 'true' numbers of cases, overall trends are more reliable with consistent testing rates. These data are, therefore, suitable for analysis.

The Delta Outbreak in Uganda, May to August 2021

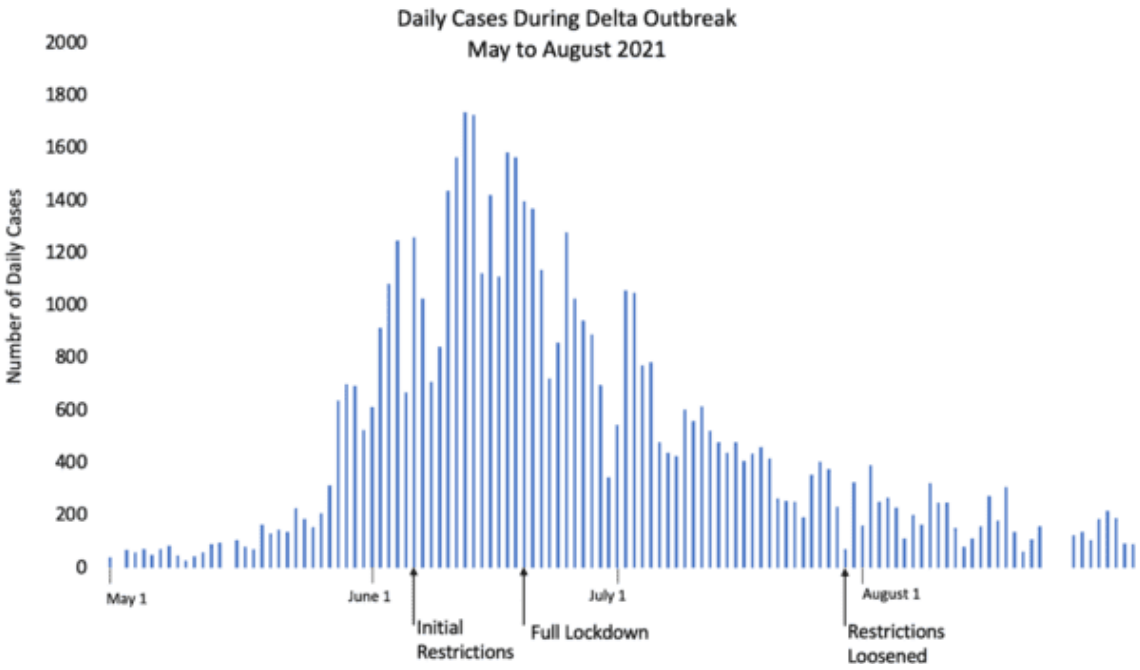


Figure 7. Daily cases during the Ugandan Delta outbreak (Wave 2) May to August 2021.

The Delta wave in Uganda progressed rapidly from the early stages of a rolling average of 100 cases a day on 18th May 2021, to the outbreak peak on June 12th 2021 (Fig. 7). Less than a month passed from the start of the outbreak to the peak. In just three months between June and August 2021, the Ugandan government reported 2,328 coronavirus deaths, over half of the overall Ugandan death toll.

The epidemiological curve of COVID-19 cases during the Delta outbreak (Fig. 7) steeply rises and falls, with no correlation between government policies of lockdowns, restrictions, or the subsequent loosening of restrictions and changes in case numbers. Initial restrictions were instituted only on June 7th, over 2 weeks after the start of the outbreak. During these 'light' restrictions, people moved freely on motorcycles and public transport within districts, and most markets and shops were open. An outside observer may not even have realised there were restrictions in place. In Gulu, northern Uganda, for example, where two of the authors (NL and SM) were living and working as medical practitioners at the time, it was often hard to discern whether any restrictions were actually in place. For people living close to international borders, the situation was

different. In Kasese and Pakwach districts, both of which border the Democratic Republic of Congo (DRC), the Ugandan armed forces reduced movement from urban conurbations to rural areas, but the imposition of enforcement measures inadvertently created new modes of mutuality to subvert or actively resist the regulations, including the establishment of new forms of cross-border movement (Parker *et al.*, 2022). In other words, ethnographic research carried out during this time suggested that these 'light' restrictions were unlikely to have had an impact on transmission. It is also noteworthy that the peak of the outbreak had already passed before a more extreme lockdown was instituted on the 18th of June, with all public transport banned and retail shops closed. This contrasts with the South African Delta outbreak during the same period (Fig. 8), where 2 months passed between the start of the outbreak and the peak, and flattening of the curve was observed after restrictions were imposed in mid-June (South African Government, 2022).

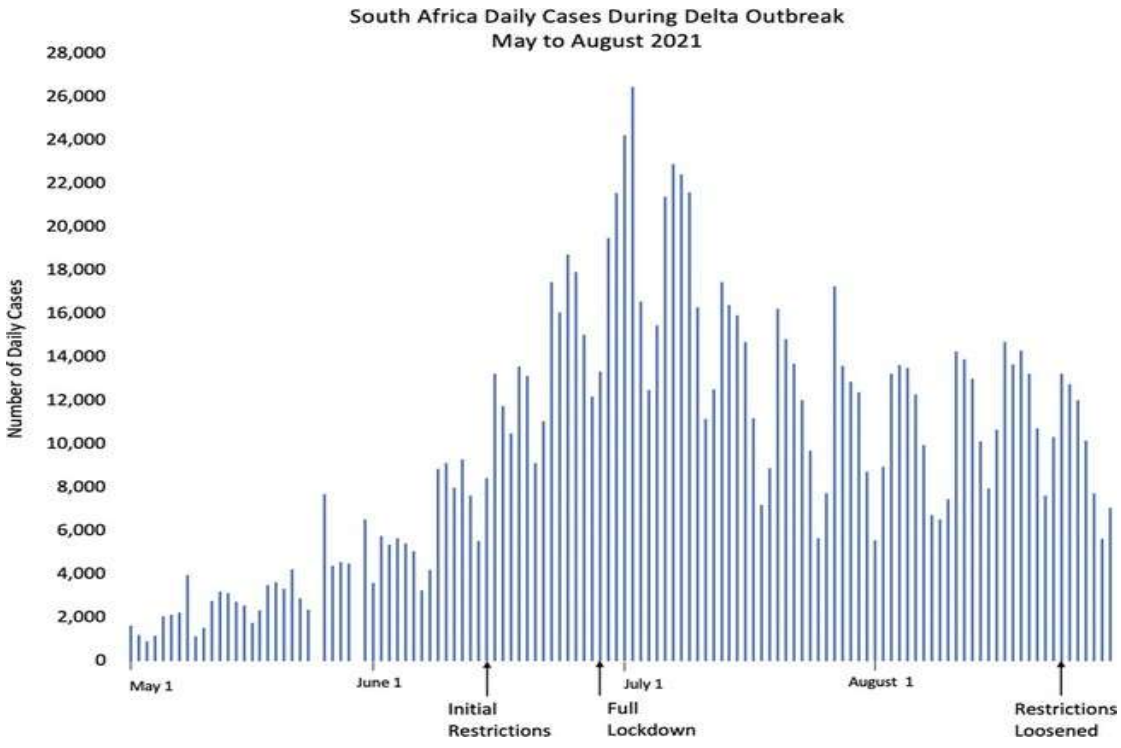


Figure 8. Daily cases during South African Delta outbreak from May to August 2021.

The Omicron Outbreak in Uganda, December 2021 to January 2022

The Omicron outbreak followed a similar but even more rapid course than Delta in Uganda, with the peak occurring only 2 weeks after the start of the outbreak (Fig. 9). Although vaccines for COVID-19 had been introduced in Uganda during 2021, most Ugandans had not yet been vaccinated by the time of this wave (Mathieu *et al.*, 2021). Unlike the first two waves, the Ugandan government made minimal effort to control the outbreak and imposed no new restrictions.

Schools were re-opened fully for the first time in 20 months on January 10th 2022, while the outbreak continued unabated. The outbreak peaked quickly, with a steep rise and fall in the epidemic curve in under 2 months.

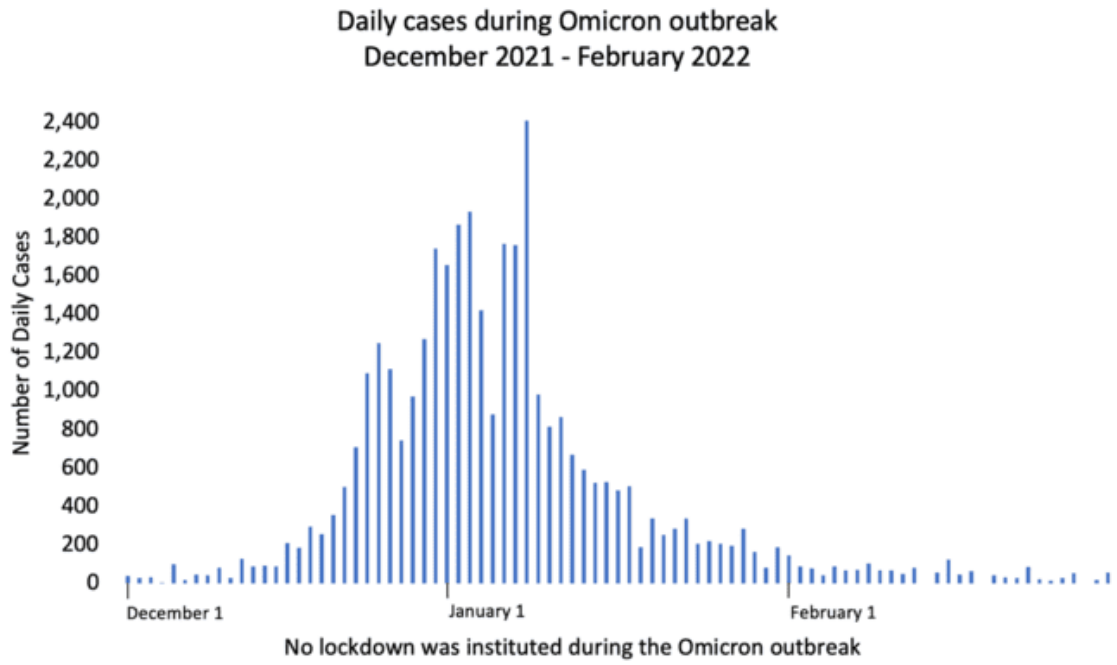


Figure 9. Daily cases during Omicron outbreak in Uganda, December 2021 – February 2022.

Alternative Conclusions

Uganda's COVID-19 outcomes reflected a general trend across East, West, and Central sub-Saharan Africa. Despite stark initial warnings from the WHO and others, these regions were almost universally spared from overwhelmed hospitals and high mortality, despite weak tertiary care infrastructure in many countries (Bwire *et al.*, 2022; United Nations, 2021). Neighbouring countries had similarly favourable outcomes to Uganda with low mortality between 12 and 108 deaths per million (Fig. 10). These rates were among the lowest in the world (Fig. 11) and were consistently low across the region despite countries adopting a wide range of COVID-19 management approaches. Kenya had fewer and less extreme nationwide lockdowns than Uganda, while the Tanzanian government denied the existence of COVID-19 until April 2021 and no lockdowns were implemented (Buguzi, 2021). Although Tanzania, DRC, and South Sudan generated poor quality data due to low testing capacity (Buguzi, 2021; Dinyo *et al.*, 2020; Juma *et al.*, 2020), Kenya, Rwanda, and Uganda may be more reliably compared as they have comparable coronavirus testing rates, life expectancy, and age demographics (Johns Hopkins University, 2022; World Bank, 2022). No observers within any of these countries reported overwhelming COVID-19-related mortality. Given these countries' different approaches to the pandemic, it is likely that PHSM were less influential than claimed, and other explanations may carry more weight.

Alternative explanations for these low mortality rates include sub-Saharan countries having young populations and low rates of co-morbidities such as diabetes and obesity (Adams *et al.*, 2021) and high rates of physical activity (Wachira *et al.*, 2022). There may also be pre-existing immunity from previous infections, such as other coronaviruses causing the common cold (Ashworth *et al.*, 2023; Nordling, 2020). Malaria might also protect people through stimulation of the innate immune system (Habibzadeh, 2023). Environmental factors such as climate have also been postulated (Njenga *et al.*, 2020). In addition, there may be other yet unknown factors that led to the region not suffering the same morbidity, mortality, and public health crises that much of the rest of the world endured.

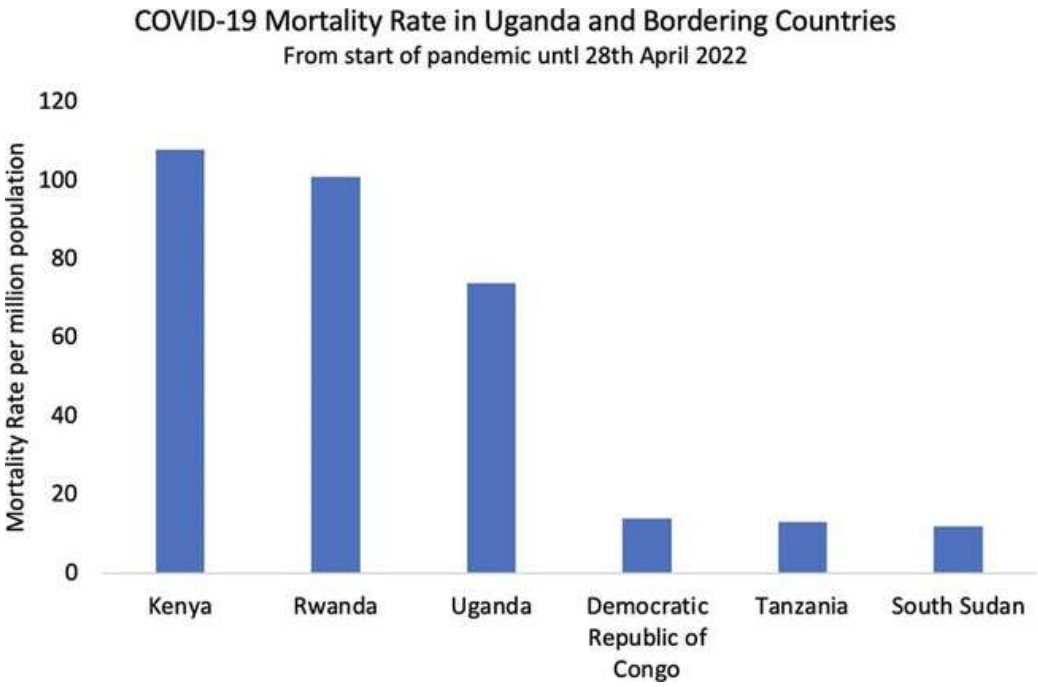


Figure 10. COVID-19 mortality rate in Uganda and bordering countries.

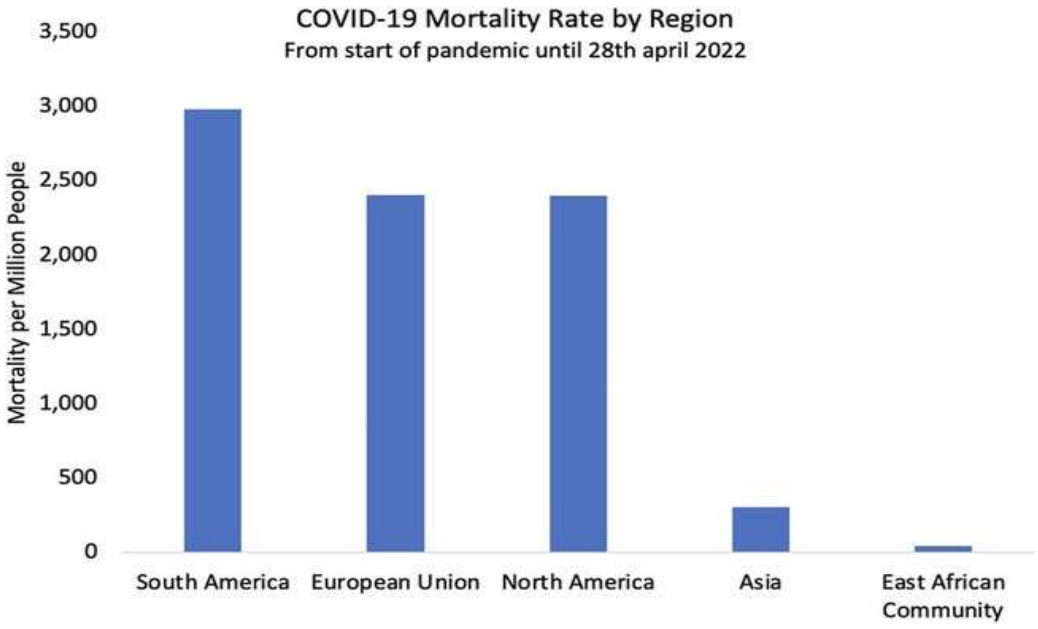


Figure 11. COVID-19 mortality rate in five regions of the world.

If Uganda's COVID-19 response was as effective as the international praise has suggested, then better outcomes than neighbouring countries would have been expected, and epidemic curves would have risen and fallen more gradually, as was

observed in South Africa where PHSM measures may have been more effective. Rather, epidemiological evidence suggests that Uganda's favourable outcomes were likely due to these alternative explanations, rather than PHSM.

Given that factors other than PHSM were likely to be responsible for the good COVID-19 outcomes in countries such as Uganda, alternative methods of measuring 'success' in pandemics should be explored. Countries could be compared within smaller regions where countries have similar demographic profiles rather than on a global scale. Countries could also be assessed by process measures as well as direct outcomes. These measures could include logical timing of lockdowns and releases, and whether planned PHSM were effectively implemented on a national scale.

Whatever measures are used to gauge public health successes and failures in the future, the dominant narrative of Uganda's COVID-19 success story needs to be reconsidered, especially when the use of lockdowns had such detrimental effects on the lives of many people already living in precarity. Scrutiny could usefully be given to broader historical, political, and social issues shaping the collection and interpretation of data, including the clustering of cases and the generation of 'at risk' populations (Storer *et al.*, 2022), and the tendency to overlook widely reported, troubling events on the ground. As Parker *et al.*, (2022) have pointed out, the militarised response to COVID-19 in Uganda was sometimes violent and strengthened the position of President Museveni and his political party, the National Resistance Movement. The tendency to uncritically reify partial epidemiological data – and set aside the socio-political contexts in which enforcement measures occurred – vitiates against developing more sophisticated and nuanced understandings of public health and unwittingly lends itself to a trend towards more authoritarian forms of governance.

Chapter 4: In the Shadows of COVID-19

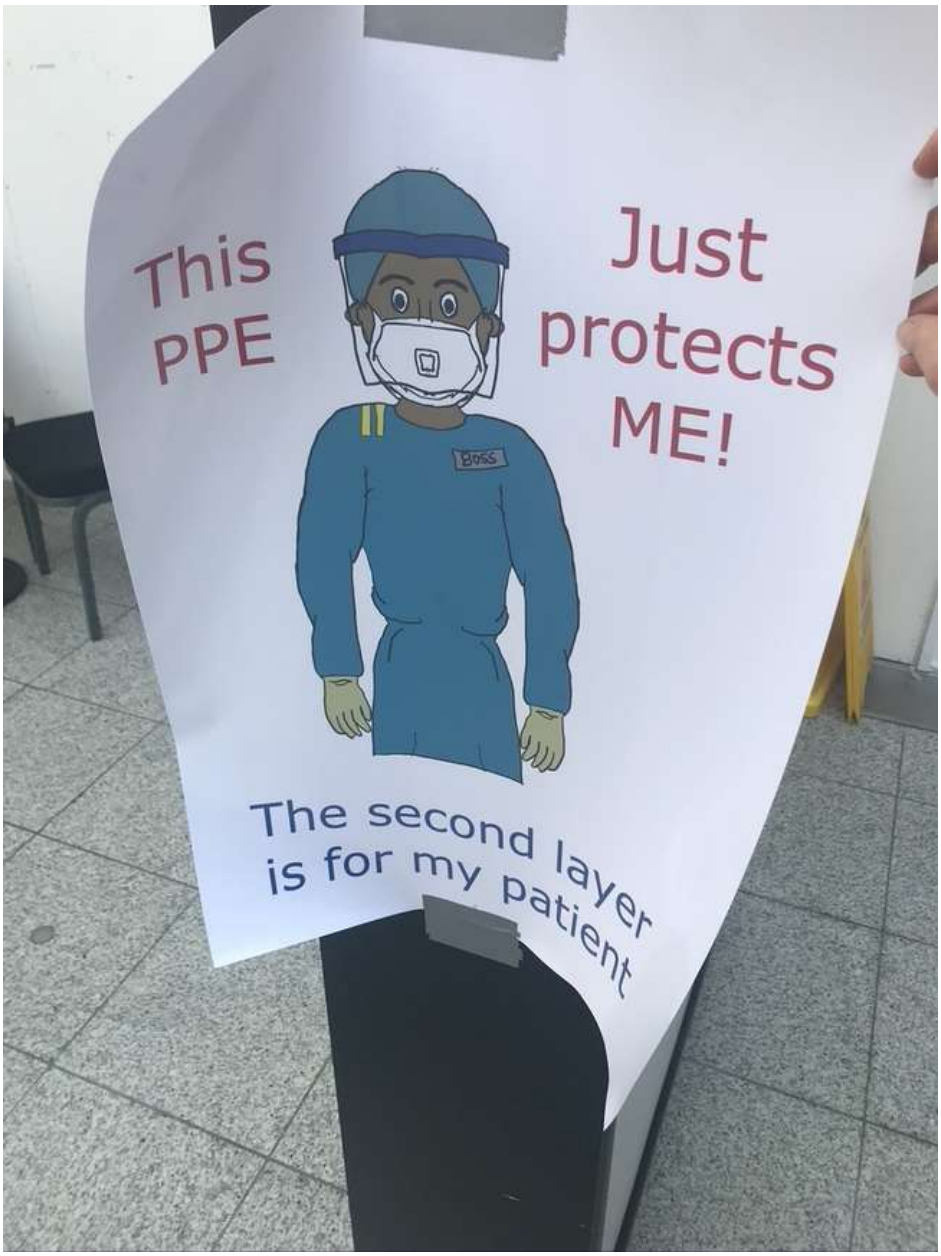


Figure 12. A sign in a UK hospital during COVID-19, to assist healthcare workers (HCW) understand the two layers of personal protective equipment (PPE) they were required to wear when caring for patients in an intensive care setting. The inner layer is intended to protect the HCW, whilst the outer layer is to protect the patient.

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Medicine Anthropology Theory		
When was the work published?	September 2022		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	N/A		
Have you retained the copyright for the work?*	**No**	Was the work subject to academic peer review?	**Yes**

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	
Please list the paper's authors in the intended authorship order:	

Stage of publication	Choose an item.

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	N/A - single author

SECTION E

Student Signature	[redacted]
Date	12th December 2024

Supervisor Signature	[redacted]
Date	13th December 2024

Medicine Anthropology Theory 9 (2): 1–8; ISSN 2405-691X; https://doi.org/10.17157/mat.9.3.5632.

Figure 13. This figure confirms that this article was published via a Creative Commons CC-BY license, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Article Title: In the Shadows of COVID-19. From January 2020 to October 2021

Published in the FIELD NOTES section of *Medicine Anthropology Theory (MAT*) in 2022.[15]

Author: Sophie Mylan

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.

Introduction

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

[15] Full reference: Mylan, S *(2022).* In the Shadows of COVID-19: From January 2020 to October 2021. *Medicine Anthropology Theory*, 9(2) pp. 1–8.

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 dutybound 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 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, when 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 associated 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.

Chapter 5: Orientations to the Field and Methods

Chapter 4 described the start of my 'informal' ethnographic considerations whilst embarking on a PhD intending to study preparedness, and how this was influenced by the onset of COVID-19 in both the UK and Gulu, Uganda. Chapter 5 builds on my initial experiences in Gulu, Uganda, and subsequently pays more attention to my research in, and around, Palabek Refugee Settlement, including a description of my field sites and methods. Writing this PhD in article-style was a choice to enable early publication of the content of the thesis, especially given that some findings were relevant to topical global debates, such as the international roll out of COVID-19 vaccines. The drawback of this approach, however, is that the main 'data chapters' (chapters 6 to 9) may not present as much in-depth ethnographic description as a more classical monograph would have allowed. To balance this, I have added further ethnographic descriptions in this chapter.

Establishing a Field Site

This section describes how I established a base in the small city of Gulu, in northern Uganda, and subsequently my main field site in Palabek Refugee Settlement in the district of Lamwo.

Gulu, Uganda

I arrived in Uganda in Jan 2021, in the middle of the UK's second wave of COVID-19 (the Delta wave). Within 48 hours of arriving in Uganda, and during my self-imposed quarantine in Entebbe, national presidential elections were held, and with it, a country wide internet shutdown. During COVID-19 lockdowns in the UK, I had become more accustomed to spending prolonged amounts of time on my own without significant social interaction, but it felt very different having no WhatsApp or email connections with

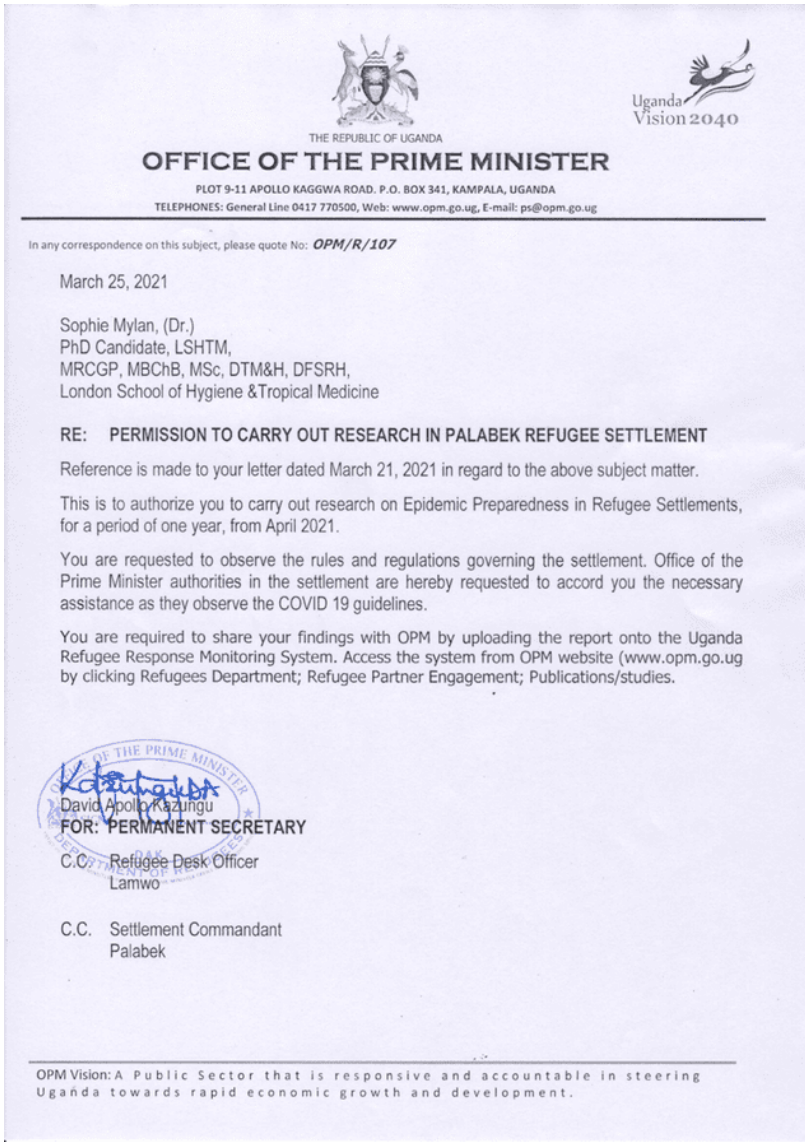
people during the election in Uganda. Luckily, this was short-lived and soon enough I was heading to Gulu, which would be my base for 18 months.

In Gulu, I stayed with a colleague's Ugandan family for the first month and then found my own home – a middle bungalow in a compound of three. On my left, I had an Italian expat and her Acholi husband; and on the other side, a Swiss NGO volunteer. These people became close friends, significantly facilitated by our shared dedication to heavily critiquing the way in which global humanitarian and development agendas played out in Gulu. In January 2021, however, Gulu was not the usual 'NGO-hotspot' that I had experienced on multiple previous visits since 2010. The previous burgeoning expat community had shrunk considerably, with most people leaving at the onset of COVID-19.

During these initial months, I focused on developing my Acholi language skills. From January to May 2021, I had lessons with an Acholi language teacher three mornings a week. These sessions focussed on basic spoken and written form, but also helped me get to grips with important cultural norms and concepts. In the UK, I work as a GP, and I was also keen to maintain my clinical skills whilst in Uganda. I started volunteering at St Philips Health Centre in Gulu, a not-for-profit private health centre, practicing my Acholi with patients but also using a translator in clinic. To work clinically in Uganda, I registered with the Ugandan Medical Council. As I will describe below, however, this also assisted ethnographic fieldwork. These initial months in Gulu were also a significant social change for me. Although there were some COVID-19 restrictions still in place in early 2021 (as discussed in chapter 3 and 4), Gulu was bustling with social activities, in stark contrast to the UK. After a period of initial adjustment, I enjoyed making new friends and joined a regular yoga class at a café in town.

During these initial months in Gulu, I also focussed on obtaining ethical clearance. This included three applications: one from London School of Hygiene and Tropical Medicine, a second from Gulu University, and a third from the Ugandan National Council for Science and Technology (UNCST) – the national ethics board in Uganda. Once I had my ethical clearance, I obtained written permission from the Commissioner of Refugees in Kampala at the Office of the Prime Minister to conduct research in Palabek Refugee

Settlement. Obtaining this permission was not simple, navigating a complex web of bureaucracy, providing a hefty pile of paperwork, and essentially waiting for the Commissioner to arrive at the Office of the Prime Minister's (OPM) Department of Refugees in Kampala, and opportunistically accosting him as he entered the building and started climbing the stairs. This clearance letter from OPM, shown in Figure 14, was essential for fieldwork in Palabek Refugee Settlement. I was instructed to always carry this paper with me, and it became progressively more scrappy. It was presented to every subsequent figure of public authority that I met, who often signed it, marking their official acceptance of my presence. In April 2022, I extended my clearance to continue fieldwork for a few months. By then, my presence was more known and accepted by officials in the settlement, and I rarely had to present my letter of extension.



THE REPUBLIC OF UGANDA

OFFICE OF THE PRIME MINISTER

PLOT 9-11 APOLLO KAGGWA ROAD. P.O. BOX 341, KAMPALA, UGANDA
TELEPHONES: General Line 0417 770500, Web: www.opm.go.ug, E-mail: ps@opm.go.ug

Uganda Vision 2040

In any correspondence on this subject, please quote No: *OPM/R/107*

March 25, 2021

Sophie Mylan, (Dr.)
PhD Candidate, LSHTM,
MRCGP, MBChB, MSc, DTM&H, DFSRH,
London School of Hygiene &Tropical Medicine

RE: PERMISSION TO CARRY OUT RESEARCH IN PALABEK REFUGEE SETTLEMENT

Reference is made to your letter dated March 21, 2021 in regard to the above subject matter.

This is to authorize you to carry out research on Epidemic Preparedness in Refugee Settlements, for a period of one year, from April 2021.

You are requested to observe the rules and regulations governing the settlement. Office of the Prime Minister authorities in the settlement are hereby requested to accord you the necessary assistance as they observe the COVID 19 guidelines.

You are required to share your findings with OPM by uploading the report onto the Uganda Refugee Response Monitoring System. Access the system from OPM website (www.opm.go.ug by clicking Refugees Department; Refugee Partner Engagement; Publications/studies.

David Apollo Kazungu
FOR: PERMANENT SECRETARY

C.C. Refugee Desk Officer
Lamwo

C.C. Settlement Commandant
Palabek

OPM Vision: A Public Sector that is responsive and accountable in steering Uganda towards rapid economic growth and development.

Figure 14. My Initial Clearance Letter from OPM.

An Introduction to Palabek Refugee Settlement

A total of 14 months of fieldwork was completed in, and around, Palabek Refugee Settlement (often referred to as 'Palabek'), in the district of Lamwo, in the Acholi sub-region of northern Uganda. This involved 8 months between April and November 2021, and 6 months from January to June 2022. At the start of fieldwork, the number of refugees in Palabek was quoted as being approximately 55,000 (OPM and UNHCR, 2021), but this rose to over 69,000 by the end of fieldwork (OPM and UNHCR, 2022b).

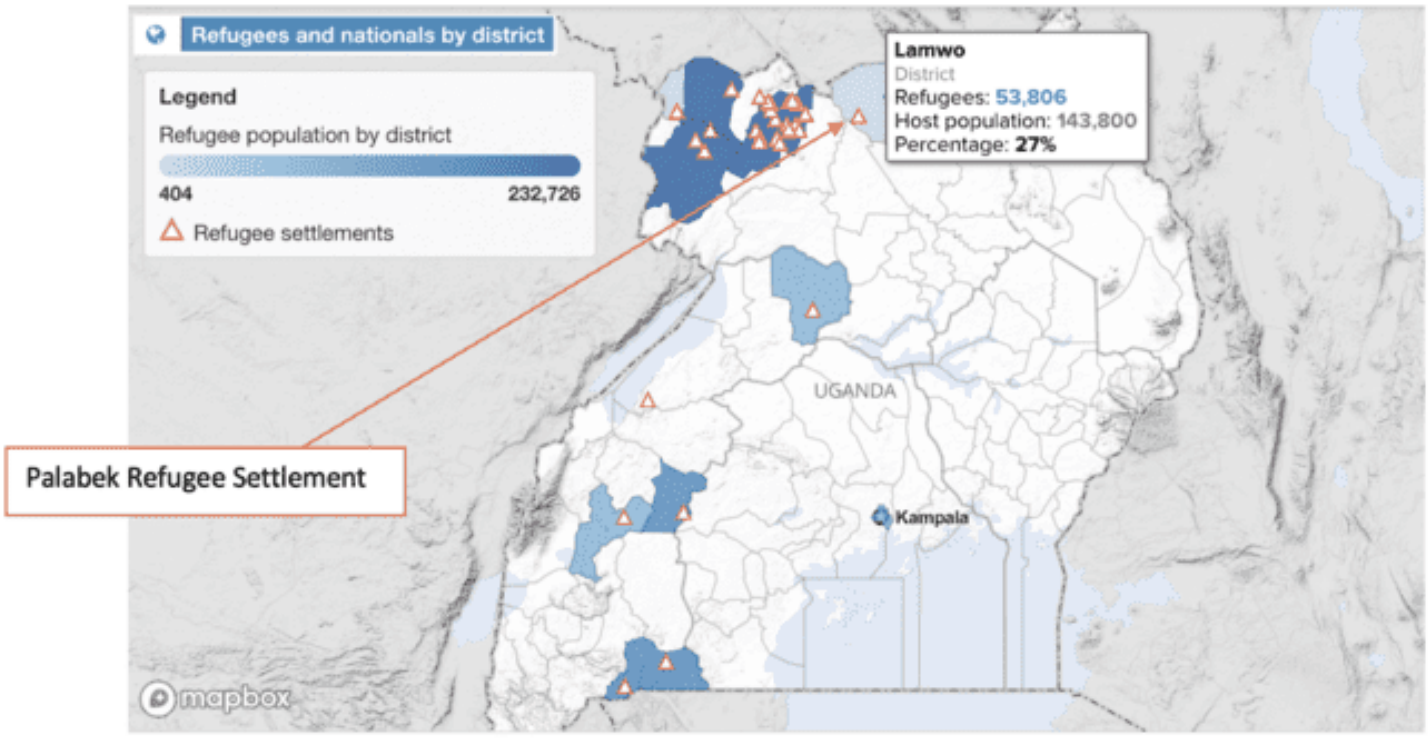


Figure 15. Refugees and Nationals in Lamwo District, northern Uganda, taken from the UNHCR website in December 2020 (UNHCR, 2020).

The settlement was established in April 2017, following a major attack in the Acholi County of Magwi, located in the Eastern Equatoria state of South Sudan, which led to a mass displacement of thousands of people, many from the town of Pajok. Therefore, many of the original inhabitants of Palabek Refugee Settlement were from the Eastern Equatorial state of South Sudan, largely from Acholi-speaking areas (O'Byrne and Ogeno, 2021). The settlement has grown considerably since 2017, however, hosting refugees from a variety of different parts of South Sudan, and a small number from Sudan and the

Democratic Republic of Congo (OPM and UNHCR, 2021). During fieldwork, I endeavoured to establish the official proportions of different ethnicities in the settlement, but official agencies declined to release this information, which is captured during refugee registration processes. 'We don't divide ourselves by tribes here', was the reason given for refusal to release this information. However, refugees and professionals working in Palabek both described the settlement as still having an Acholi majority from South Sudan. When I started fieldwork in April 2021, however, I could see that this was slowly changing. There were growing numbers of new arrivals from other parts of South Sudan, including Nuer from the states of Jonglei, Unity and Upper Nile; Murle from Jonglei; and Lutugo, Lango, Lopit, Lokoya and Didinga from Eastern Equatoria. Despite the growing number of new arrivals from various areas, the 'Acholi-feel' of Palabek persisted during fieldwork to quite a large extent. This was partly because the initial refugees inhabiting the settlement were Acholi, but also because many of the Ugandans living in the vicinity of the settlement were Acholi, in addition to many humanitarian employees.

Finding Palabek Refugee Settlement

I first visited Palabek in April 2021. I travelled with a research assistant, Richard[16], from Gulu, who had family in Lamwo, and knew the roads well. I borrowed a car from a research group at London School of Economics and Political Science (LSE) who had a base in Gulu. Driving from Gulu to Palabek, there are multiple routes to choose from. The longest route goes via the large northern town of Kitgum, on a fast tarmacked road, before it joins a busy marram road that winds through trading centres of Palabek Ogili and Palabek Kal, bypassing Palabek Gem, before reaching the Palabek Refugee Settlement. If I was driving on my own, I often used this route, reassured by the busier and more frequent trading centres if I encountered car trouble, or got stuck in the mud. I sometimes gave a lift to aid workers between Kitgum and the settlement, who were appreciative of the ride to the settlement.

[16] Many of the names in this chapter are pseudonyms to protect the anonymity of those I worked with. I have used real names where individuals have explicitly agreed to this, to acknowledge their contribution to this research.

On my first few visits to Palabek I stayed in Palabek Kal, around a 40-minute drive from the settlement, where many Non-Governmental Organisations (NGOs) working in the refugee settlement had their offices. The roads were bad in Kal. Whereas most of the surrounding roads were marram, Kal had the remnants of tarmac, but it had been left in such a state of disrepair, that the potholes were more like huge crevices, which even large trucks found hard to navigate. During the day, multiple NGO vehicles bounced up and down the main road. At night, the few dingy guesthouses turned into slightly aggressive drinking spots. I was keen to minimise the amount of time I spent in Kal, particularly at night.

Figure 16. Guesthouse in Palabek Kal.

The preferable route from Gulu to Palabek in terms of petrol consumption was called the 'short cut', weaving through more remote areas. The marram roads skirt out the back of Gulu, past Fort Patiko (famous for its association with the colonial officer, Samuel Baker) and forests of tall pine trees, dotted with dilapidated huts used by soldiers stationed at the nearby barracks. Occasionally, a swarm of people in bright yellow prison clothes

could be seen digging in large gardens (fields), their outfits signalling the proximity of the large prison farm. The marram road then became narrower, especially during the wet season, with the wild grasses quickly growing tall and framing the roadside. This grass was left to reach its full potential before it was harvested at the onset of the dry season, providing essential material for the fixing of rooves.

Taking a small right turn, the route entered deeper bush. Along this part of the journey, there were often groups of men standing next to precarious looking vehicles, there to collect the illegal trees cut down for charcoal. Each journey, the bush became that bit sparser, having once been dense forest covering most of this landscape. The road twisted and turned, finally giving way to a rather impressive view, with the mountains of the borderlands visible. South Sudan was just the other side. The journey was dotted with small villages, selling large tubs of mangos around the month of May each year, which I would sometimes purchase and bring to the settlement.

On reaching a main road, the route passed more army barracks, which served as a checkpoint during COVID-19 lockdown, and then over the river Aswa. From there, the route actually passed the perimeter of the settlement, but there was no indication of this if you didn't know it was there. This main road continued for a few kilometres. The proximity of a close trading centre was marked by an increase in people making their journeys by foot, usually women carrying babies on their backs, and the branded Land Cruisers from the settlement whizzing past at breakneck speed (there were multiple stories of fatalities from these vehicles). Finally, the formal entrance to the settlement would appear, marked by numerous signs, each carefully depicting the numerous organisations working in, or having donated funds to, the settlement. This entrance felt rather incongruent in comparison to the winding shortcut through rural Gulu and Lamwo. Whereas the surrounding area felt rural and under-resourced, the entrance to the refugee settlement marked a place with significant resources.

This section has, so far, situated Palabek within northern Uganda, describing its proximity to nearby towns, South Sudan, and to rural parts of the district of Lamwo. Next, I provide further details regarding the settlement itself.

Figure 17. The entrance to Palabek Refugee Settlement.

The 'Reception Centre' and 'Base Camp': An Introduction to 'semi-permanence'

There were many ways to enter the settlement, with the main roads of Lamwo district filtering into smaller branches that winded through the different zones of the settlement. The area referred to as the 'Reception Centre', however, felt like the most official entry point for refugees, the 'host community', and those working in various humanitarian organisations. It was marked by a rope barrier, but was rarely used or manned by security personnel.

The 'Reception Centre' contained a reception area for refugees, which was fenced by tall, barbed wire. This was a temporary measure during the pandemic, whilst the pre-pandemic larger reception centre in Lokung (30km away) was closed due to the suspension of Uganda's open-door policy to refugees with the closure of international borders. Inside this temporary reception area in the main settlement there were large shelters, a health screening post, and large empty spaces, dotted with night-time solar lighting. It was easy to know when new arrivals had been moved inside this reception

centre. People were visible, and the numerous clothes and pieces of cloth thrown onto the barbed wire could be seen from further afield. Intermittently throughout my stay in Palabek, the informal pieces of land opposite this fenced temporary reception area became populated by new arrivals, who could be seen cooking outside, or sometimes erecting temporary shelters.

Figure 18. The reception centre at night in Palabek Refugee Settlement

Figure 19. The reception centre in the day.

Around the reception centre in the main settlement there was a trading centre (referred to as the 'Reception Centre'), which was home to various small restaurants, my favourite being 'Sheraton Hotel'. These businesses were run by Ugandans and refugees, catering for truck drivers, aid workers, OPM employees and the odd researcher looking to take tea or local food. If I weaved through this small collection of restaurants, (mostly made of UNHCR tarpaulin, and temporary poles) I would come to the main line of shops. There were electrical shops selling phones, solar panels, batteries and radios; and there were also salons, bars for drinking alcohol, and general stores selling soda, soap, and bread. Tailors hung their colourful kitenge cloth at the front of their shops or stalls. A main market sold the usual produce of grains, fruits, vegetables, and dried fish. It was also possible to buy UNHCR branded foodstuff, blankets and tarpaulin, although these items were not so obviously displayed as other products. This trading centre was very similar to any other trading centre in the region, and although it was located at the most formal entrance to the settlement, it was described as being under the jurisdiction of the Ugandan 'host community', as opposed to 'Jerusalem', the other main trading centre in the settlement, which was mainly used by refugees.

Figure 20. The trading centre at the 'Reception Centre'.

Just opposite the reception centre and in close proximity to the bustling trading centre, was ‘Base Camp’, a fenced compound just past the formal entrance to the settlement. ‘Base Camp’ was the humanitarian headquarters of Palabek settlement. On my first visit to Palabek, this was my first stop. I introduced myself and my research to the staff members of OPM. I was told it was particularly important to introduce myself to the Refugee Desk Officer, and the Camp Commandant. Both of these government officials were rather intimidating tall men, whom I felt at the time, were rather suspicious and apprehensive of me. With formal clearance from Kampala, however, they signed my letters and permitted my entry into the settlement. The next step, they told me, was to introduce myself to the various refugee leaders around the settlement.

Figure 21. The reception centre behind the barbed wire. The red roofed building at the end of the road is ‘Base Camp’.

'Base Camp' was manned by security guards. Along with OPM and UNHCR, smaller NGOs also had offices in this gated compound, along with a small canteen and sheltered area that acted as a kind of conference space for workshops and meetings. When I first arrived in the settlement in April 2021, the base camp was in a state of transition. The OPM and UNHCR offices were temporary rigid plastic structures that would get intolerably hot if it had not been for their very effective air conditioning devices. However, during the course of fieldwork, formal buildings were erected by OPM and UNHCR, with bright white walls and red tin rooves, to which, staff slowly migrated. A marker of 'semi-permanence'. This phrase was also branded on the signs for the three health centres dotted around the settlement, which seemed uncomfortably accurate, given the likely duration of stay of most refugees, but without any reassurance of permanent settlement. '*When it is safe to do so, they will be expected to return home'* I was told by the camp commandant on my first visit. The more permanent buildings, however, would remain, to be used by Ugandans.

First Impressions of 'Semi-permanence' beyond the 'Reception Centre'

It was easy to forget this 'semi-permanence' as I travelled through the settlement, which felt like a vast expanse of land, dotted in most zones with grass huts housing both Ugandan 'host community' and refugees, who lived side by side. To begin with, I found this confusing, not quite able to understand how host community and refugees were arranged over this space. I soon began to conceptualise it like two maps, superimposed on top of each other. The settlement was located on land owned by 'host community', who had temporarily donated it to the settlement. When this was agreed in 2017, they were told they would benefit from an influx of jobs and infrastructure like roads, schools and hospitals, which would be brought by the development of the settlement.

At the time of fieldwork, Palabek settlement had 9 different zones (1, 2, 3, 4, 5a, 5b, 6, 7 and 8). Each zone was further divided into blocks. In total, the settlement covered approximately fifty-three square miles. Marram roads navigated through the different zones. The settlement had three 'semi-permanent' health centres: two were at the level of Health Centre II (Awich in Zone 5a and Akworo in Zone 2) and one was a Health Centre

III, called Paluda, in Zone 3. There was a temporary health post in Zone 8 which accommodated the newest arrivals, as well as health posts in the reception centres. Health facilities were run by the health partner, International Rescue Committee (IRC), who provided free at the point of access health care to all refugees and host community. In addition, IRC also provided additional support to the Ogili government health centre, which was utilised by refugees and the 'host community'. If these health facilities needed to refer patients for further care, for example for further diagnostics, or for acutely unwell patients, they would usually first be referred to Kitgum, to either Kitgum Government Hospital, a district hospital, or St Joseph's Hospital, a private non-profit community hospital. Patients were, on occasion, also referred to Gulu, for consultations at Gulu Regional Referral Hospital or the private non-profit St Mary's Hospital Lacor. For those refugees who were previously living in the Eastern Equatorial Region of South Sudan, these Ugandan hospitals in Kitgum and Gulu were often their preferred place for seeking care for serious illness whilst they were in South Sudan.

Figure 22. The 'Semi-permanent' Paluda Health Centre III.

There were nine primary schools across the settlement, but only one secondary school. For the majority of my fieldwork, however, these schools remained closed due to COVID-19 restrictions, and children only returned to school in large numbers in early 2022.

The landscape changed in different zones of Palabek. Large rocks created distinct landmarks in zone 5a and 5b. The mountains of borderlands dominated the landscape in other parts. Pajok, South Sudan, where many refugees came from, and returned to for digging in their gardens, could be walked to in one day I was told, or was only a few hours drive with a motorcycle.

When I first arrived in Palabek, new arrivals were being settled in Zone 8, which felt remote and rugged in comparison to other zones. There were no huts, but rather temporary structures had been built with wooden poles and UNHCR branded plastic sheets. There was no nearby school or 'semi-permanent' health centre here yet. This is what, I was told, the rest of the zones looked like when people first came to occupy them in 2017. It had taken years to tame the landscape into the neat looking homesteads that resembled any Ugandan village, along with the 'semi-permanence' of the rest of the settlement.

Figure 23. Zone 8 for new arrivals.

The more established zones of Palabek could be considered beautiful in many ways. Homesteads and their grass thatched huts, either square or round, were sometimes decorated with murals, with neat hedges and flower beds in the gardens. Around 60% of homesteads had their own pit latrine (otherwise there were temporary communal ones), and boreholes were said to be within walking distance to most homesteads. Trees provided adequate shade for sitting, eating, chatting and the like, and the bush had been carefully tamed to create clear compounds with sandy floors, paths between the neighbouring compounds, and small gardens for the growing of a few greens, maise or cassava. Some homesteads had small brick structures with iron rooves, mostly built in the dry season when the burning of bricks would occur using the soil from the homesteads. It was not uncommon for homesteads to be keeping chickens, rabbits, goats, ducks, pigeons or occasionally pigs.

Figure 24. A well-maintained compound with dried grass to repair the huts.

Figure 25. A sunny morning in Zone 3.

Figure 26. Maintaining a grass roof.

Figure 27. An established compound in Zone 3.

Behind the Beauty: The Problems of 'Semi-permanence'

On the first appearances described above, Palabek could seem like a pleasant place to stay. This was an image often referenced when I spoke to OPM staff in the settlement. They would describe Palabek's 'welcoming attitude' to refugees, who were supported by Ugandan's unique open-door policy. An image of peaceful existence was supported by a description of a lack of formal fencing, with refugees and host community living side by side, and the narrative that refugees were 'free' within Uganda. This did not align, however, with all aspects of life in Palabek, as the next chapters will describe in detail.

On the one hand, refugees were being provided with free land. However, most refugees I spoke to did not have access to more than 30m-by-30m plots for their homestead, which had to accommodate up to 16 people. They were unable to grow enough food to feed their families, or even make produce to sell. Instead, people continued to rely on the monthly food rations distributed at large tented warehouses (which was every two months during COVID-19). There were exceptions, of course. For instance, a well-respected refugee leader in the settlement had a large patch of land that he and his family farmed very

successfully. My point is, however, that this didn't necessarily translate to the vast majority of refugees.

In general terms, and according to Uganda's national framework, refugees were free to move in and out of the settlement, seek employment or visit friends and family elsewhere. This is a fundamental premise to the approach of 'integration' and characterises a settlement rather than a camp setting (Government of Uganda, 2018). However, refugees struggled to materialise this 'freedom of movement'. To leave the settlement, they were meant to seek formal permission, as they were described as under the 'protection' of UNHCR and OPM. When the one-year-old child I was living with became ill with severe malaria, his father was not happy with the treatment being given at the health centre in the settlement, but he was told he was not allowed to take his child to an alternative health centre for treatment, as formal approval from the authorities would have to be sought first. To obtain formal permission to leave the settlement, individuals were required to find an OPM employee who was willing to provide them with this permission. Finding such an individual was not always possible, and there were accounts of refugees being turned away, or told to come back a different day. Going through this process could be long and tedious, and instead, refugees often left 'on their own accord', to seek alternative medical care, to visit friends and family, and pursue opportunities for income. But this decision was associated with a sense of reduced 'protection' - if anything untoward occurred when this formal permission had not been obtained, the individual was not guaranteed the formal OPM/UNHCR support, which characterised their residence in the settlement. Hence, people constantly had to weigh up the risks of staying in the settlement, as opposed to leaving.

There were few formal job opportunities in the region, and so many refugees made small bits of money (around £2 a day) by offering to dig in local gardens owned by the Ugandan host community, to supplement their rations. Other refugees had small businesses such as selling dried fish or sugar in the markets or small shops around the settlement. Many of the NGOs working in the settlement were involved in livelihood activities, such as promoting savings groups encouraging these small businesses, rearing livestock, or providing vocational training such as tailoring, bread making, salon work, or mechanics.

Other NGOs had brought 'perma-garden' projects, supporting people to grow vegetables on their small plots of land. As will be discussed in more detail in chapter 6, most of these livelihood activities were halted for long periods during the pandemic. It was only when the easing of restrictions in 2022 brought back a more 'pre-pandemic' state, that I was able to get a good idea of what activities were occurring in the settlement.

Figure 28. Growing green vegetables on a homestead in Zone 8.

Figure 29. Perma-gardens in Zone 8.

The alternative, in terms of land for farming, was to rent privately from the Ugandan 'host community', but most refugees I spoke to found that the land around Palabek was not particularly fertile. Furthermore, there was the potential for conflict with members of the host community: refugees were fearful that the host community would steal their agricultural produce. The host community charged around UGX 100,000 (around £20) per season (around 6 months) to rent one acre of land. Some crops, such as cassava, take a year to produce, so the land needed to be rented for two seasons. The likely yield for a year's work was approximately UGX 300,000, given the land was not considered fertile. This would, therefore, only make a profit of around UGX 100,000 (approx. £20). For many, this profit did not seem worth the effort of a year of labour. Instead, it made more sense to travel to Abuloro (the fertile borderlands in South Sudan). Refugees from South Sudan did not have to pay for farming in Abuloro, but they did have to spend money on transport. After a year of farming there, the reward was likely to be far greater given the fertile land. This travel did, however, come with associated risks of encountering conflict and violence. Chapter 6 describes how farming in Abuloro emerged as an increasingly common choice for many refugees whilst I was in the settlement.

Palabek Settlement and Ugandan Host Community

Palabek Refugee Settlement is located mainly on land donated by Ugandan landowners in Lamwo district. Other settlements in Uganda are built on government-owned land. The Ugandans living in Lamwo at the site of the settlement refer to themselves as the 'host community'. Although living in or near Palabek Refugee Settlement, there is a distinct geographical and local government structure for Ugandans. The smallest unit of local government is a village, and each village has a Local Councillor 1, or 'LC1'. A collection of villages make a Parish, led by a LC2. Multiple parishes form a subcounty, which are led by a LC3. The Ugandan district of Lamwo has 9 sub-counties, which include Palabek Kal, Palabek Ogili and Palabek Gem. Palabek Refugee Settlement occupies land that is situated within, or in proximity to, these Ugandan sub-counties.

The refugee settlement has its own independent authority structure, but is likened to a subcounty of Lamwo district, with its own elected refugee camp chairman (Refugee

Welfare Committee 3, RWC3, similar to a LC3). The zones in the settlement each had a refugee elected leader, a RWC 2, (similar to a parish leader), and each zone was divided into various blocks, each with a block leader, RWC1, similar to a village leader, LC1.

Despite different chains of command in terms of local government and leaders, the 'host community' lived side by side on the same land as refugees, sharing the same trading centres, schools and hospitals. Invariably though, at sites close the settlement's main infrastructure, refugees often outnumbered the 'host community'. At the start of fieldwork, the population of Lamwo was estimated to be just under 200,000, with refugees accounting for between a quarter and a third of the population of the whole district (UNHCR, 2020). Humanitarian assistance in refugee settlements followed the '30/70 principle', where '…projects in refugee hosting districts reserve at least one third of the deliverables to the hosting community' (UNHCR and Government of Uganda, 2018, p. 10). This does not include food assistance, which was only given to refugees.

In common with discussions regarding the inadequate support to refugees, Ugandans living in the district in which settlements are located, were also struggling with issues regarding poverty (Uganda Bureau of Statistics, 2024a). In the context of widespread poverty and limited resources, tensions between refugees and host communities had arisen. Moyo *et al.*, (2021) wrote: '…the huge influx of refugees in recent years, particularly from Southern Sudan, as well as the increasingly protracted situation, has heightened tensions between refugees and hosts. Expectations of hosts benefitting from development funds for refugees have often stayed unfulfilled, which has led to increased frustrations' (Moyo *et al.*, 2021). The allocation of humanitarian assistance to both refugees and host communities has in part addressed this, but tensions were still present. In particular, the host community expressed discontent that their needs were not being met in the way that had been promised when the settlement was first being established. It was not uncommon for Ugandans to tell me that they had welcomed 'their brothers and sisters from South Sudan', but questioned how long this could go on for, given the failures of the humanitarian response in keeping to their promises and failing to adequately improve the lives of Ugandans in the region.

Establishing a Research Team

Prior to research, I made contact with two colleagues (now dear friends), who had already conducted research in Palabek. Costanza Torre completed her ethnographic fieldwork for her PhD in Palabek just before the pandemic, exploring mental health (Torre, 2023b). Costanza had herself been introduced to Acholi refugees in Palabek by Ryan O'Byrne, an anthropologist who first met people living in Palabek before they had been displaced, whilst he was living in South Sudan for his PhD examining 'cosmo-ontological systems' amongst Acholi (O'Byrne, 2016). Both Ryan and Costanza have been hugely helpful to my PhD, enabling the building of important relationships. They put me in touch with refugees in Palabek, who were keen to meet a friend of Costanza or Ryan. Rather than being a total stranger, I was a friend of a friend. This initial trust worked both ways.

I first met Obwoya Mariako Patrick on a late afternoon after numerous meetings with leaders across the settlement. He welcomed me into his home with his wife Achola Florence (usually called Flo), and their three children. Patrick had worked with Costanza but never hosted a researcher in his homestead. He quickly offered his spare hut to me as a place to stay. This became my 'home' in the settlement. Living with an Acholi family gave my research an Acholi focus. I could have chosen to pay greater attention to smaller groups of refugees not represented by the 'Acholi feel' in Palabek, which would have no doubt given different but equally valuable findings. However, I chose to focus on developing more long-term relationships with Acholi interlocutors over more than a year. This provided a more in-depth understanding, which would not have been possible if I had divided my time in other ways.

I initially tried to take a broader approach by spanning every zone (especially those with new arrivals), and interviewing a wider variety of people with different languages. As fieldwork progressed, however, I realised I was only scratching the surface of what I wanted to know amongst Acholi interlocutors, and it felt unrealistic to try and expand this further by incorporating other languages. The more time I spent with Acholi, the more I realised how much I didn't understand, and the more visible the cracks in my research became. There is an inevitability to this to some extent, which highlights the need to

question who should be researching what, and possibly indicates the value of auto-ethnographers, as more immediate 'insiders' (Abonga *et al.*, 2024). I would argue, however, that there is also value in the 'outsider' perspective, particularly to enable critical reflections of the taken-for-granted ideas and outlooks shaping everyday life.

During my fieldwork I worked with two Acholi research assistants, one Ugandan and one South Sudanese from Pajok. Living with Patrick, he quickly became a key source of trusted information, and we agreed that he would work as one of my research assistants. His position as a block leader also enabled easy access to other refugees and the leadership system. Working with Patrick was vital. This was revealed when I went through a period of trying to navigate the logistics of fieldwork on my own. I wanted to spend more time in Zone 8, one of the newest zones. We met the zone leader at a training session, and in my broken Acholi, I explained the research and we agreed that we would go to meet him the following day. I was happy that I had manged to explain that we wanted to talk to a variety of people in the zone to hear about their lives, and in particular about their experiences of epidemics. However, when we arrived in Zone 8 a few days later, there had clearly been a communication error. The zone leader had called for a zone wide meeting with a huge number of people waiting for us. I was expected to make a lengthy introduction, translated into three different languages. This was followed by an even lengthier process of individuals taking 'to the floor' to discuss their individual complaints. This was not the collection of individual semi-structured interviews I had envisioned. A number of hours later, and with no sign that things were slowing down, we managed to close the meeting with apologies, trying to work out how to best distribute the inadequate amount of soap and masks that we kept for individual interviews. Thereafter, I always asked Patrick to check my plans.

Geoffrey was chosen as a second research assistant due to our personal relationship. I first met Geoffrey whilst he was running a yoga class in Gulu, and our relationship began soon afterwards. We currently live in London together and we welcomed our son to the world in October 2022. When a second national Ugandan lockdown was declared in June 2021, I wanted to be based in Palabek for the foreseeable future. Lockdown restrictions

forbade inter-district travel, and so I was unsure when I would be able to leave Lamwo to return to Gulu. I had not yet developed friendships with people in the settlement. Geoffrey had previous experience of conducting qualitative research and had a personal interest in working in refugee settings. He also spoke Acholi as his primary language. He was keen to join the research team, and it was reassuring to have the emotional support of a partner throughout fieldwork. There were challenges of working with a partner, and our personal and work life quickly became indistinguishable. Perhaps, however, that is inevitable with this kind of ethnography, especially living with all sorts of 'family'. Having Geoffrey as an emotional support was particularly valuable at the start of fieldwork when everything was new, and I often inadvertently broke social norms, such as declining food when I was not hungry. At these times, it was useful to have Geoffrey there to tell me honestly when I had offended someone, so I could learn about what was, and was not, acceptable behaviour. People less close to me were often hesitant to correct my behaviour. I did not always welcome Geoffrey's feedback, missing at times, the benefits of claiming ignorance.

Geoffrey also faced his own challenges in the settlement. In his role as a research assistant in Palabek, he was both an insider and outsider (Clifford and Marcus, 1986). He shared Acholi language and cultural norms with Acholi refugees from South Sudan. Geoffrey was born in Gulu but grew up in Kitgum, close to Lamwo and South Sudan. He was also an outsider, however. Most recently he had lived in Gulu, a large urban centre and worked in the arts industry. He had travelled abroad, teaching dance and gymnastics in Nairobi, Kenya. This made people in rural settings, such as Palabek, sceptical about his morality, or 'true character'. For example, people in Palabek found it hard to believe that he didn't drink alcohol. Even when the temperature reached 40 degrees Celsius in Palabek, Geoffrey always wore a hat when leaving the home compound, to prevent judgement regarding his dreadlocks.

Geoffrey and Patrick were not only united by their shared Acholi identify, but also by experiences of war and displacement. Geoffrey often compared his experience of living in Palabek to his own experience growing up in Internally Displaced People's (IDP) camps during the Ugandan civil war. In some ways Palabek, according to Geoffrey, seemed well

resourced in comparison to these IDP camps which were overcrowded and lacked basic water and sanitation. As described in chapter 2, the Ugandan government's policy of essentially moving all the inhabitants of northern Uganda into such spaces during the civil war with the Lord's Resistance Army (LRA) has been described as a form of social torture (Dolan, 2011). Geoffrey also had relatives living in northern Ugandan in very difficult situations, with little access to adequate livelihood opportunities. From Geoffrey's perspective, therefore, the experiences of refugees were rather similar to ordinary Ugandans living, and suffering, in rural and urban areas.

Geoffrey and Patrick were also united by trying to care for the vehicle we continued to borrow from a research team at LSE. Having a vehicle in the settlement was associated with great status, but also came with challenges. In Patrick's home compound, our focus was trying to protect the car from goats. Flat tyres and engine malfunctions were also common given the difficult roads, and we regularly visited the mechanics in both Jerusalem and Palabek Kal.

Figure 30. Protecting the car from goats.

Figure 31. Patrick and his neighbours' goats.

In and out of Palabek

After around a month in Palabek from June to July 2021, and during the second COVID-19 lockdown, I obtained permission from the Resident District Commissioner (RDC) in Lamwo to be able to travel between Palabek and Gulu. Geoffrey and I were then able to travel between Palabek and Gulu as I had originally planned. In Gulu, I continued to have my bungalow, where I could spend time reflecting on fieldwork and writing up initial findings, as well as continue my clinical practice at St Philips Health Centre. I soon realised that these visits back to Gulu were essential for my own mental health, and the success of fieldwork. Each trip to Palabek varied but was usually a couple of weeks at a time. Fieldwork in Palabek was intense and exhausting, physically and emotionally, and I found it hard to set boundaries with the people around me. Instead, I found it easier to retreat to Gulu and try to digest and make sense of my findings, before heading back. This transition between rural and urban settings also provided unique insights.

For example, chapter 4 indicated that perceptions of COVID-19 as a health threat varied. These differing perspectives were evident in Gulu during the second wave of COVID-19. Whereas some friends described the second wave as more 'real', others felt that the first

wave was more 'real'. By 'real', they were referring to direct illness and death. In contrast, when it was not 'real', it was considered a type of 'political spin'. This is important to acknowledge: there were differences in people's perspectives about COVID-19, and it would be misleading to present one single perspective on COVID-19 in Gulu, never mind for the whole of Uganda. However, it is also important to explore why some perspectives were more common in some contexts, and not in others, and how this relates to wider dynamics. For example, although there were some similarities and differences between perspectives in Gulu, there were much more pronounced differences between rural and urban settings. In urban Gulu, I came across some people who thought that the second wave was more 'real', given the number of people becoming unwell and testing positive in the city, in addition to more reports of people dying from COVID-19. I was unable to find this perspective in rural Palabek at all. In both rural and urban settings, however, different parts of COVID-19 were seen as innately 'political', and everyone had experienced difficulties arising from lockdown. These themes will be explored in more detail in subsequent chapters.

National restrictions were loosened on the 30th July 2021, and by 1st November, large gatherings were permitted, and NGO activity in the settlement was further re-established. Despite a third wave of the virus, mainly experienced between December 2021 and January 2022, no further national or local restrictions were implemented, and schools reopened fully during this peak. The official registering of refugees slowly restarted from January 2022, the borders officially reopened in March, and by June 2022, NGO activities and the processing of refugees resembled pre-pandemic practices, but they were still heavily influenced by COVID-19. The screening of all new arrivals and the isolation of positive cases continued.

I returned to the UK in December 2021 to spend Christmas with family. When I returned to Palabek in January 2022, my visits to Palabek were often shorter, because I also wanted to pursue specific emerging themes, many of which involved following people and issues to other places in Lamwo, to nearby towns, and to Kampala. I also attended humanitarian workshops in Gulu that I had been invited to, and interviewed humanitarian and government actors in different positions who were often based in urban centres.

Spending less time in Palabek was difficult. The family I stayed with preferred it when I stayed for longer periods, like during the lockdown. They felt that my Acholi suffered when I spent too much time away. To some extent, they were right, but I was also very keen to explore, ethnographically, humanitarian perspectives. These latter relationships had taken a long time to foster, and it was only months into fieldwork that I felt I was getting more than the official rhetoric from many humanitarian actors. However, I chose to prioritise research with refugees during the first half of fieldwork, to ensure that I did not become seen as affiliated with the humanitarian response. I felt like I had gained a successful level of access with refugees when Geoffrey explained the conversation he had overheard between the 4-year-old girl we lived with, and her friend. As Geoffrey and I had passed them in the car, arriving at the settlement for one of our trips, the friend shouted '*munu*', a general term for 'white person'. The girl we stayed with replied to her friend: 'no that's not *munu*, that's Sophia'. Becoming known as an individual, rather than as a generic white visitor by the 4-year-old I lived with, felt like a huge step forward.

An ethnographic Approach to Research

This PhD can be described as a 'multi-sited ethnography'. It follows people and ideas through various geographical areas, whilst considering how concepts moved between 'global' and more 'local' domains (Marcus, 1995). I used semi-structured open-ended interviews, and 'participant observation' (Clifford and Marcus, 1986). Ethnography, however, is about more than a set of methods, and is better considered as a wider approach to research. This PhD has chosen ethnographic methods to pay attention to the complex social phenomena relevant to understanding epidemic preparedness in a refugee settlement. This included, as Sverker Finnström (2008) wrote, 'painstakingly investigating and analysing the common, general, mainstream, and even taken-for-granted stuff of everyday life in a particular context' (p. 10). This approach is illustrated with the following vignette.

> *In June 2021, I sat under a large mango tree outside the District Headquarters, waiting for the Lamwo COVID-19 taskforce meeting to start. I had been invited by Emmanuel, one of the humanitarian staff working in a public health position in the*

settlement. It had rained heavily overnight, and I had anticipated that muddy roads would prolong my drive from the refugee settlement, where I was staying. Keen to make a good impression and not be late, I had left early, leaving extra time to navigate the challenging environment. Unfortunately, this meant, to the dismay of the Patrick and Flo, missing breakfast. They had looked at me with a puzzled expression as I left our home compound, still engulfed in a misty drizzle, thirty minutes earlier than I would have done on a sunny day. I arrived at the district headquarters five minutes before the official start time of 10am, with a rumbling stomach, but rather pleased I had made it just in time. But I was the only one. Emmanuel was nowhere to be seen. The plastic chairs arranged under the tree, anticipating the heat promised by the now clear blue sky, were empty. I sat and waited.

An hour and 15 minutes later, with people still slowly arriving, I spotted Emmanuel. The meeting started shortly afterwards with a review of previous action points and first on the list was the ongoing issue with lateness. 'We have a problem with time-keeping', the chair of the meeting announced. Today, however, this was at least in-part justified by the heavy rain. Now nearly lunch time, I realised I had adapted poorly that morning. I had failed to imagine that the start time of the meeting would naturally adapt according to the weather, rather than the attendees fighting environmental challenges to keep to a fixed start time.

This vignette highlights that the most insightful ethnographic findings were often found from simply being around, rather than actively seeking out a particular task, often referred to as 'hanging out' (Geertz, 1998), or in relation to 'participant reflection' (Finnström, 2008). The most interesting bit of attending this meeting did not occur during the meeting itself, but rather through actively engaging and reflecting on the process of getting to the meeting in this specific context.

Figure 32. Waiting under the mango tree for the Lamwo District Taskforce Meeting to start.

Through my fieldwork, I had to learn how time in northern Uganda was not always dictated by hours on the clock, but rather, events unfolded in day-to-day life, often shaped by uncontrollable wider influences (such as the weather), determining the rhythm of life, including formal meetings. Although, as this vignette illustrates with the chairperson declaring the 'problem with time keeping' - this did create tensions. The unfolding temporality of daily life contrasted with the more fixed approach that organisations and meetings were bound by (to varying degrees), which was far more linear, and productivity- or output- driven. This linear temporality frames humanitarian and development architecture (or more specifically, their funding and accountability mechanisms).

These contrasting temporalities are just one manifestation of a central tension, or 'margin' (Kleinman, 1995) that I encountered throughout fieldwork. This margin concerns the bridging of two standpoints: on the one hand, a positivist approach based on Western

scientific thought, where time, space and knowledge is measurable, categorizable, and knowable; and on the other hand, an approach to life found through in-depth ethnography with Acholi of South Sudan and Uganda, which was far more fluid or dynamic, and suggests the need to look beyond categorisations. This tension is found throughout this research, and the temporality of life for Acholi is specifically explored in chapter 9.

The Routine of Interviews with Refugees

After my initial meetings with all the leaders in the settlement, Geoffrey, Patrick and I started to structure our days by conducting semi-structured interviews with refugees around the settlement, exploring epidemics and people's wider histories. Especially at first, conducting interviews provided a structure to our days (more useful for my mental health than anything else), and helped me see different parts of the settlement. They provided an opportunity to explore specific areas of interest with people that we wouldn't necessarily meet in our usual day-to-day life in zone 3, where I was staying in Patrick's compound.

Patrick and I would discuss who to interview, and he would then reach out to try and arrange a time when they would be available for us to visit them. He always had suggestions of people he thought would be good to meet, but often I expressed preferences, such as those living in specific zones, or those who had experienced the COVID-19 isolation facilities. I was also keen to meet refugee members of the Village Health Teams (VHT), the Ugandan equivalent of community healthcare workers. At the start of fieldwork I conducted the interviews, with Patrick and Geoffrey translating and clarifying topics, whilst also adding their own questions. As fieldwork progressed and Geoffrey and Patrick felt comfortable with the research, they also conducted interviews together without me, usually following up on specific themes that I wanted to know more about.

In total, we conducted 158 semi-structured interviews. Out of these, 10 were with humanitarian and government actors discussed below, 143 were with refugees, and 5

were with ‘host community’. Out of the interviews with refugees, 20 of these were follow up interviews with case studies that we returned to visit over the course of fieldwork. The majority of interviews with refugees were with Acholi refugees from South Sudan. However, we interviewed 2 Nuer refugees, 1 Langi refugee and 5 Congolese refugees. Patrick was able to translate when needed (including using Arabic) for all of these interviews bar one, when we sought the help of a Nuer translator.

I amended my study protocol for my ethics applications during fieldwork in order to complete the 5 interviews with people from the ‘host community’, who I had initially not included in my study protocol. By the time my amended study approval came through in 2022, however, I had insufficient time to explore Ugandan host community perspectives in depth. The wider suffering of Ugandans living in the poorest parts of the country is an important area of further exploration. The divisions of aid between those considered to be legitimate and illegitimate recipients of assistance is one of the most uncomfortable aspects of this research, that I regret I was not able to explore further.

Figure 33. An interview with Isaac, Innocent, Moses and Dennis. We re-revisited these interlocutors from Pajok multiple times throughout fieldwork. At times, some of them had returned to Pajok, South Sudan, or even Juba. Some of them had children and it was a pleasure to meet Dennis’ newborn baby just before I finished fieldwork.

Figure 34. An interview with Maureen and Kevin. I often passed by these women as I would walk to the borehole to collect water. They appreciated it when I visited them to spend longer sitting and hearing their stories.

We conducted interviews outside, maintaining social distancing, and did not engage with gatherings, unless it was spending time with a family already living together as was the case in Figure 33 (or was a mistake on my part, as discussed above in zone 8). We also provided a mask and soap to every person we interviewed. Conducting in person fieldwork during the pandemic required detailed consideration of infection prevention and control (IPC) strategies and shaped how we initially conducted these interviews. As the following chapters will reveal, worries of COVID-19 transmission soon dissipated, but the performative element of these IPC strategies, particularly in terms of providing soap, remained important. It would have felt inappropriate if we had not brought some form of material support to the people we visited. Indeed, this is something that Geoffrey and I did every time we arrived in Palabek, bringing food items from Gulu for Flo and the children, and something Geoffrey also does when visiting his own family.

Figure 35. John was a well-respected man with a large family. He spoke at length about the different times he had lived in Uganda as a refugee, including his experiences of different refugee settlements.

Written informed consent was obtained from all those we interviewed. We used participant information sheets and a consent form that was explained in the individual's chosen language (usually Acholi, but sometimes English or Arabic). The purpose of the research was explained, along with processes for safeguarding anonymity. This included using pseudonyms and changing personal information so that individuals could not be identified. Individuals either signed their names or left a mark, with a co-signature from a further individual who was present (relative or research assistant). Interviews were recorded if the individual consented to this. Additionally, photos were taken if an individual agreed, and written consent was obtained. In some cases, individuals have specifically asked me to use their true identity, and I have therefore not anonymised their contributions.

Figure 36. Jane was often busy caring for her family, especially her unwell relative. She kindly discussed these difficulties with us one morning in 2022.

Participating In, and Reflecting On, Daily Life with Refugees

Sometimes we did interviews in the morning and afternoon. I preferred, however, to spend the afternoons 'hanging out' (Geertz, 1998) with Flo and the children, collecting water from the borehole, attempting to cook over the charcoal stove, and meeting neighbours as they passed by. At other times I followed the priorities of the family. Patrick had been burning bricks and wanted to start building his first 'semi-permanent' brick house, in addition to his huts. So, I joined Flo and the children collecting water and bricks whilst Patrick and Geoffrey laid them. I was allowed, on one occasion, to lay a single brick, but was encouraged to go back to the work of the women and children. Whilst in

Patrick's home compound, I was often treated like his sister, and therefore a woman, who was, by nature, subordinate. Patrick and I had a more equal relationship during interviews, or when I was discussing medicine, when I was treated more like a kind of 'honorary man'. I constantly oscillated between these two roles throughout research.

My 'participation' (Clifford and Marcus, 1986) in daily life was just as valuable as the interviews that Geoffrey, Patrick and I conducted. So much of my understanding of the relevance of research findings stemmed from this wider participant-reflection (Finnström, 2008). I spent time trying to engage with activities that were talked about as central to life as a refugee. Specific practices, such as gaining monthly food rations (provided every 2 months during COVID-19), were seen as central to 'refugeeness', which, as Malkki (1996) describes, is a process of *becoming*. Joining these practices felt uncomfortable, with the aid workers delivering food rations slightly flummoxed by a white woman in the queue, whilst other refugees made repeated jokes about me having lost my refugee registration card. Participating in this way, however, revealed important day-to-day realities, but also showed a commitment to understanding the aid system from the perspectives of refugees, which was invaluable for building relationships with interlocutors on the receiving end of humanitarian assistance.

Whilst on maternity leave in May 2023, Geoffrey and I went back to Palabek to visit Patrick, Flo and their children, introducing them to our son, Oniba. Having just begun weaning, our son sat on a mat with Flo's children, eating chicken that Flo had cooked, and Flo then bathed him in a basin. These seemingly simple tasks of sharing food and caring for children cemented a bond between us all, but also revealed the centrality of food and children for Acholi. I am no longer referred to by my first name to many Acholi, but have become *min Oniba* – the mother of Oniba – this is my defining identity. Simply writing about 'participating' in daily life, therefore, feels inadequate in capturing how fieldwork became my life whilst in Palabek, but moreover, how I developed long-lasting and ongoing relationships with Patrick, Flo and their family, which continue to this day.

Figure 37. Learning to Cook with my 8-year-old 'teacher'.

Figure 38. Helping to build a brick house.

Figure 39. Waiting to enter the food distribution area. Guards directed refugees to sit on each overturned USAID tin.

In a section above I described a vignette, in which Flo and Patrick were taken aback at me missing breakfast on the way to a meeting. By participating in, and reflecting on, day-to-day life, I begun to understand their dismay at my early departure. It was not only rooted in surprise at a different approach to time, or an expression of concern about my physical needs in terms of hunger, but was also related to my breaking of important social rhythms. Breakfast is not just about eating, it's an important social shared moment. Despite a focus on epidemic preparedness, much of the most valuable ethnographic research I completed, did *not* focus directly on epidemics. Instead, shared moments, whether eating, chatting, or even moments of waiting on my own, highlighted by the vignette at the start of this section, were highly informative. Often such in-between moments, the travelling around, the comments before or after interviews, the informal chats, revealed more about day-to-day life than more formal interviews.

Through day-to-day activities, I also began to understand the significant impact of COVID-19 on life in Palabek. At the beginning of fieldwork, I joined Patrick as he went to the local school (that was closed), in order to vote in the Refugee Welfare Council (RWC) elections. In most of the refugee elections in Palabek, anonymous paper voting was used. On this occasion, however, the process returned to line voting, where refugees stood in a specific line representing their chosen candidate. It felt tense, and Patrick and I discussed the lack of anonymity, with the candidates all standing nearby, clearly seeing each individual who did, or did not, vote for them. We discussed why the method of voting had changed. An NGO employee who was overseeing the process had commented that line voting was a good option because there would be no invalid votes. Most people, however, attributed the problem to a lack of money for ballot papers. Patrick explained, however, the relevance of COVID-19. He said that now people just say: 'Corona! Then no other explanation is needed. Before this, the excuse was 'too many refugees!' he explained. Patrick described how any change of policy could now be attributed to COVID-19 without further questioning. This demonstrates how people felt that the pandemic was infiltrating every aspect of daily life, being manipulated and used as an excuse for other dynamics. The impact of COVID-19 on day-to-day life is a theme that is further explored in the following chapters.

Research with Humanitarian and Government Actors

In addition to appreciating the importance of perspectives from refugees, I was also keen to understand the everyday life of aid workers. This included a diverse array of professionals including senior figures in international aid organisations such as UNHCR. These included those that would be categorised as expat and Ugandan. They worked at settlement, regional and national levels. I also spent time with the employees of a variety of NGOs working in the settlement, and engaged with their staff at regional and national positions, most of whom were Ugandan, and some of whom were Acholi. I talked to OPM employees, including those in senior positions as well as support staff, most of whom were Ugandan but many were not Acholi. Additionally, I spoke to Ugandan employees working in government positions, particularly regarding health, in district and national

positions. To engage with some of these actors, I needed to travel to other parts of Lamwo, to Kitgum, Gulu, Adjumani or even Kampala to conduct interviews.

I conducted 10 formal interviews with a selection of these professionals, the majority of which were in-person, with one on zoom. However, many preferred to share their perspectives with informal discussions. Formal interviews followed the same processes for consent, recording and anonymity as the interviews with refugees. For the informal discussions, I also made sure that interlocutors were aware of the purpose of the research, and assured them of their anonymity.

Within the settlement, I joined the health partners' COVID-19 taskforce, 'hung out' with healthcare and humanitarian staff going about their usual activities, whether screening for COVID-19, doing malaria tests in a lab, going with an outreach team to monitor people who had testing positive for COVID-19, or joining Village Health Team (VHT) training sessions. Near the start of research, as we entered the second wave of COVID-19, I tailored some Infection Prevention and Control (IPC) teaching that I had provided to healthcare workers in the UK and in Gulu, for healthcare workers in the settlement. Other aspects of fieldwork were far more informal - sometimes I just went to have a soda and chat with staff when I was in the vicinity of their offices. I often used these opportunities to clarify questions I had that were arising through research or ask them about topical issues.

At first, the humanitarian and government staff that I spent time with found it slightly strange that as a white overseas researcher (and medical worker), I was living with refugees. Apparently, some of the OPM staff came to visit Patrick's homestead whilst I was away in Gulu, not believing that I was really staying there. But they soon got used to waving at me from their jeeps or motorcycles as they sped past the compound where I was staying.

My medical training also helped me gain access to healthcare workers in the settlement. James (2022b) describes the performance of neutrality or 'blank slates' of aid workers, in that they are meant to reflect the so called 'neutral' humanitarian system. Getting beyond

this, to understand individual perspectives, and for interlocutors to feel comfortable to honestly reflect on their humanitarian work, was key to my research, in order to explore the 'politics of everyday aid practice' (James, 2022b, p. 353). This took time, however. The methods I chose also mattered with different humanitarian and government actors, demonstrating the heterogenicity within categories of 'local' aid workers (James, 2022b; Peters, 2016). For example, some humanitarian actors spoke freely and engaged in deep conversation during informal discussions and were keen to engage with the research. However, when I conducted a formal interview with the same individuals, it was sometimes shocking to see the change, as they resorted back to providing the humanitarian 'blank slate' responses. These interviews were useful, however, in revealing the main humanitarian narratives. On the other hand, some senior government officials were keen to be interviewed when they knew I was conducting interviews around the settlement: their perspective, they felt, was important to capture too.

Figure 40. Joining a community outreach visit.

Figure 41. Spending time in the laboratory in one of the health facilities.

Ethnographic fieldwork with humanitarian and government actors could be described as 'studying up' (Ho, 2012), and was often harder than the ethnographic research with refugees. It felt more delicate, and I often did this part of research on my own, without research assistants. I was often unsure what would be revealed, and how much I could probe. It was not easy to know where individuals would situate themselves in rather politically delicate topics of conversation. I was often concerned about saying the wrong thing and compromising my presence in the settlement as a researcher. It often felt as if there was a 'correct' way to discuss things, a 'correct' language to use, and some things were really not meant to be said out loud, although they could be inferred. Building relationships was key.

Figure 42. Visiting a health post in Zone 8, where I sat through patient consultations.

Figure 43. Waiting for a healthcare worker training session to start.

Figure 44. A well-attended training session for VHT staff.

At times, however, personal safety or comfort was more important than building relationships. OPM ran the settlement, and their power and influence was clear. I felt very safe living with a family in the settlement, especially with my partner. I had the equivalent of brothers and sisters to watch out for me, and neighbours who always knew my whereabouts. This was not the case when I was with humanitarian and government professionals. I joined a border monitoring visit near the end of fieldwork and was given a lift at the end of the day by a group of professionals, including one very boisterous middle-aged man who worked for OPM. On the journey back he persisted in asking me personal questions, especially about my personal life and relationship status. I did not feel comfortable discussing such personal information, and I deflected the questions, which only seemed to encourage him further. Having shared my telephone number with all the staff at the start of the visit to enable logistics, he subsequently embarked on regular phone calls with demands on the need for me 'to help him with his loneliness' in Palabek whilst he was away from his family. I did not seek further clarification. Inclined to rudely

reject his offers and ask him to stop contacting me, I was also concerned about my status in the settlement as a researcher being compromised if I offended him. As a family, we agreed that the best way forward was for me to always have a male accompaniment from Geoffrey or Patrick. If this individual continued to contact me, he would be invited to Patrick's home to discuss this with the whole family. In the meantime, Flo reiterated that I would not be left alone. Although I was uncomfortable and intimidated, I was never in a position of danger, no doubt protected by my white privilege. What this story does highlight, however, is the huge potential for exploitation from those in positions of power in the settlement – the very same people, who in name, are there to 'protect' people more vulnerable than themselves. Furthermore, this account undermines the claims of people at the start of research, who had been taken aback and concerned for my safety, when hearing of my intention to live in the settlement amongst refugees. There had been a presumption, which I think many oversees visitors (researchers or humanitarian personnel) make, that living amongst government and humanitarian interlocutors would somehow have been safer than living with refugees. My experience was exactly the opposite of this.

At the Margin

Throughout fieldwork I often worked at the margin of anthropology and medicine (Kleinman, 1995). Anticipating that my training in medicine might be a point of tension during ethnographic fieldwork, I registered with the Ugandan Medical Council and volunteered at a health centre in Gulu, to maintain my clinical skills. This also enabled me to understand approaches to common health problems in this setting. For instance, how to test and treat for malaria and when referral was needed, the most appropriate antibiotics to prescribe for common infections, and thresholds for the treatment of common childhood infections. At St Philip's Health Centre I worked with 'Dr Nick', a New Zealand trained medic who had lived and worked in Gulu for nearly a decade. I trusted him and had known him for a number of years. I first went to Gulu in 2010 for fieldwork for my MSc in Medical Anthropology, and in 2017 I completed a short piece of fieldwork in the city as a research consultant for London School of Economic and Political Science (LSE). I met Nick on this visit in 2017, through a mutual friend. Before arriving in Gulu in

2021, I had arranged to work with him at St Philip's. From then on, we often rang each other to discuss medical cases when we were not in clinic together, or we would catch up whilst having lunch in one of the small local restaurants near the clinic. Since 2021, Nick has become a good friend.

Continuing my medical practice in Uganda provided me with reassurance of the contextual appropriateness of my medical knowledge in Palabek, and gave me a vital network of medical colleagues that I could call on for advice. It did not, however, absolve me from the difficult situation of treating the family members I was staying with. This is not necessarily unique to doing ethnographic fieldwork – even in the UK I face awkward situations in providing medical advice for family and friends. This tension was, however, more exaggerated in Palabek, where formal treatment sometimes felt inadequate, and medical professionals were often stretched. Being emotionally connected to the family I stayed with, I found it challenging to known whether I was making appropriate medical decisions, and so did, where possible, try to promote medical advice being sought from medical professions in the settlement. At times, when I felt too little was being done, I would ring Dr Nick in Gulu. Sometimes he would tell me he thought the treatment plan was sufficient. At other times, he was appalled by the treatment I described in Palabek and agreed that more needed to be done. Most of the time this led to a kind of hybrid system where I acted as a medically informed family member, directing the family to the health centre, and supplementing this with other medical input supported by trusted medical colleagues when I felt I was ethically bound to do so in the best interests of the family I was staying with. This usually did not cause any tension with the formal health services in Palabek.

There was one occasion, however, where I did utilise my medical position and connections with the senior medical doctors in the NGO providing medical care in the settlement – connections I had fostered for the purpose of the ethnography. This felt like 'pulling rank' and was very uncomfortable for me. On this occasion, I called one of the senior doctors in Palabek regarding the youngest of Patrick's children, who was being treated for severe malaria in one of the settlement's health facilities. He had been on first line intravenous treatment but was failing to respond adequately. The health care workers

in the settlement had suggested a second line agent, but the medicine they needed was out of stock. There didn't seem to be anything else to be done – the child continued to deteriorate. We agreed with the senior doctor that medication would be sought from one of the other health facilities. I also planned with Patrick, that if medication was not obtained, we would transport his son to Gulu for treatment. This would be a difficult situation, if it occurred, given that a referral like this to a different health facility was either meant to be done formally through the settlement health partners, or would have to be done informally against official settlement policies, which I would clearly be complicit in. I tried to remain respectful to the healthcare professionals who were working in a challenging setting with often inadequate supplies, but also tried to advocate for a child that I had a close personal relationship with. My positionality here wobbled between doctor, ethnographer and family member. Patrick reminded me on this occasion, that I must never be rude to doctors, because they have access to medicine and needles, and you never know what they might do. This suspicion was always present. Luckily Patrick's child recovered, and we never had to transport him to Gulu.

I have highlighted how despite not having a formal medical position in the settlement, my medical knowledge was often drawn upon by the family I stayed with, and their friends and wider family. When it came to interviews, therefore, it was often known that I was a doctor in addition to my primary role as a researcher. And so, at the end of interviews, people often sought my opinion about the widely discussed COVID-19 vaccine. At first, I felt strange giving my own personal perspectives, heavily influenced by my biomedical training and medical work. Over time, however, I realised that withholding such information, was also inappropriate, especially when people were asking for advice. I dealt with this by trying to ensure I presented my perspectives as no 'truer' than any other perspective, endeavouring to create open dialogues, when one form of knowledge was equally valued to any other. Interestingly, the more I did this, the more people seemed to engage with the idea of becoming vaccinated. Perhaps without an agenda to be pushed, the knowledge I was presenting became less suspicious.

My position as a medic and researcher, as well as this chapter as a whole, reveals many unresolved ethical issues. Indeed, ethics was a constant state of negotiation throughout

fieldwork, rather than as an initial process of approval. This chapter has demonstrated a variety of research elements that required on-going attention and negotiation: my relationship with Patrick and his family; my personal relationship with Geoffrey whilst he worked as research assistant; navigating uncomfortable situations with figures of authority; and working at the margins of roles of medic and anthropologist. I have also drawn attention to the semi-permanence of the settlement and described the importance of paying attention to the 'in-between moments' of ethnography. This chapter suggests, therefore, that ethics, field sites, methods, interlocutors and researchers are not best understood as fixed categories, but rather are all continually made, and re-made throughout, before, and beyond formal research. Subsequent chapters will reveal the relevance of recognising these fluid and ever-changing dynamics.

Chapter 6: COVID-19 Containment and Humanitarian Protection

Figure 45. A UNHCR truck arrives outside the fenced reception centre in Palabek Refugee Settlement.

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?			
When was the work published?			
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*	Choose an item.	Was the work subject to academic peer review?	Choose an item.

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	Global Policy
Please list the paper's authors in the intended authorship order:	Sophie Mylan

Stage of publication	**Undergoing revision**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	N/A - single author

SECTION E

Student Signature	[redacted]
Date	12th December 2024

Supervisor Signature	[redacted]
Date	13th December 2024

Article Title: Protection and Containment: Surviving COVID-19 in Palabek Refugee Settlement, northern Uganda

Under peer review in *Global Policy*.[17]

Author: Sophie Mylan

Abstract

Humanitarian assistance is framed around 'protection'. Deciding whom to protect, and against what, is not straightforward, particularly during a pandemic. In Uganda, policies to protect against COVID-19 embraced containment, through the reduction of movement and the securitisation of borders. Refugees in Uganda were simultaneously described as particularly vulnerable to COVID-19 and therefore in need of protection, whilst at the same time perceived to be a health security threat. This article critically explores containment and protection, by focusing on refugee self-protection.

Ethnographic research was carried out during COVID-19 in Palabek Refugee Settlement, northern Uganda, amongst refugees from South Sudan. In contrast to containment policies that curtailed mobility to protect, research findings demonstrate that self-protection included dynamic social boundaries around the settlement, and harnessed mobility. The latter drew on social, political and historical borderland dynamics between (South) Sudan and Uganda. Effective social boundaries around Palabek were only created when policies of containment had legitimacy. Boundaries were circumvented when legitimacy waned and wider socio-economic challenges, particularly regarding food insecurity, came to the fore. If humanitarians and the Ugandan government had understood these important dimensions of self-protection, they might have paid more

[17] At the time of pre-viva submission this paper was under peer review. After minor corrections and re-submission of the thesis, this article was published under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium,
provided the original work is properly cited. The article reference is: Mylan, S (2025) Protection and Containment: Surviving COVID-19 in Palabek refugee Settlement, northern Uganda. *Global Policy*; 16(1):98-113.

attention to ensuring the long-lasting legitimacy of COVID-19 containment policies amongst refugees.

Border Monitoring in northern Uganda

In November 2021, in the middle of ethnographic research in Palabek Refugee Settlement, northern Uganda, I arrived at a small stop sign and a simple road barrier, marking the Ugandan side of the border with South Sudan. Further up the track, I could see a collection of white jeeps, carrying a group of humanitarian staff travelling with employees of The Ugandan Government's Office of the Prime Minister (OPM), who worked across various Ugandan refugee settlements. They were carrying out a week-long programme of border monitoring visits at various official crossing points between Uganda and South Sudan and were meeting government officials working at each border crossing. The latter included immigration officers, local councillors, members of the national army - Ugandan People's Defence Force (UPDF) soldiers, police officers, and Ugandan Revenue Authority (URA) customs officers.

The team from OPM and humanitarian agencies along with government officials from the border (in this case, soldiers), found some shade under a tree adjacent to the mud huts and temporary brick structures usually occupied by the soldiers. The team leader opened the discussion, focussing on issues referred to as 'security' and 'protection'. The soldiers monitoring the border point described refugees crossing back to South Sudan daily:

> People are moving back and forth. Refugees are going back to South Sudan, but we cannot document this. They are under the protection of UNHCR, but they don't bring their refugees cards - they just come and say they are going to funerals, or to dig. They cannot be stopped. People then tend to come back [to Uganda] but we don't know how. They go through the bush. The Prime Minister has not opened the borders to refugees... But people pass. We just don't know how... (Soldier, fieldnotes 11th November 2021).[18]

[18] Quotes are included from fieldnotes and from interviews. Italics are used to indicate verbatim transcription from recorded interviews. All interlocutors have been anonymised, using pseudonyms and generic terms such as

Such unregulated movement was seen as a (health) security issue: COVID-19 certifications of vaccination, and COVID-19 testing, were both important national containment measures being circumvented by unofficial movement. A senior humanitarian actor summarised the problem:

> We need to ensure sufficient protection is given to persons of concern, without moving to also cater for those that usually move as normal migration. Seeing these border points has helped me understand what is happening in Palabek. The border communities share some identity, but they are split by political borders. There are push and pull factors on both sides of the border that we need to understand… (Humanitarian actor, fieldnotes, 11th November 2021).

This vignette illustrates how the enactment of COVID-19 containment policy among refugees became entangled with issues of protection during the pandemic. As highlighted by the humanitarian actor above, however, knowing who to protect, and against what, is far from simple in borderlands such as this. The need for a border monitoring visit emerged from tensions facing the refugee humanitarian response in northern Uganda. On the one hand, they were mandated to provide refugee protection to those fleeing South Sudan, under International Refugee Conventions, and Uganda's open-door policy to refugees (Government of Uganda, 2019; Hansen, 2018). On the other hand, COVID-19 containment measures closed Ugandan international borders, and paused procedures for processing new asylum seekers. But refugees, both new arrivals claiming asylum and those already living in settlements, along with Ugandans, continued to move across this border in various ways (Gidron, 2022). As the pandemic progressed, humanitarian staff were caught between these two policies. They were required to maintain national COVID-19 containment policies. But simultaneously, they were also required to provide humanitarian protection to refugees, who were fleeing conflict-affected areas of South Sudan (UNHCR, 2023b).

'humanitarian actor', rather than revealing a specific organisation. When an interlocutor's name was not known, an alternative descriptive feature, such as their profession, is included.

To understand the tension from the simultaneous framings of refugees as both a threat to security, but also a vulnerable group in need of humanitarian protection, it is` necessary to look beyond standard notions of protection, to include forms of self-protection. This article, therefore, poses the following questions: What did self-protection encompass for refugees living close to the border in northern Uganda, during COVID-19? How was self-protection shaped by national policies seeking to contain COVID-19 and global humanitarian policies seeking to protect refugees? How can refugees' perspectives usefully inform future humanitarian policies of protection which rely on containment measures during pandemics?

The article is divided into seven further sections to address these questions. Part 1 provides a brief overview of containment and humanitarian protection, as well as relevant historical, social and political literature about the Uganda and South Sudan borderland region. Part 2 describes the main field sites in and around Palabek Refugee Settlement, and the ethnographic methods deployed. Parts 3 and 4 present ethnographic research findings to describe the first and second waves of COVID-19 in Palabek. Part 5 also uses ethnographic data, this time to describe how refugees turned to mobility for survival. The following discussion and concluding thoughts describe the divergence of approaches to protection and self-protection. In so doing, it becomes clear that whilst official pandemic containment-orientated protection activities quickly became subsumed with national politics and a failure to protect, self-protection for refugees came to the fore. Through this article, it will become clear how this entailed the making of boundaries but also harnessing mobility to circumvent official borders.

Background

Containment, Protection and Refugees

A large proportion of humanitarian aid is framed around the ambiguous term 'protection'. The term encompasses a broad range of interventions with a view to protecting so-called 'persons of concern', from violence and conflict. Protection may also refer to specific interventions addressing violence against individuals, as well as international legal

framing of protection, and issues of human rights (Fast, 2018). The term has become almost synonymous with the raison d'etre of humanitarian organisations, emerging in parallel with the popular moral imperative to intervene (Dubois, 2009). A growing critical literature has highlighted the need to pay greater attention to how people approach protection themselves. In other words, self-protection (Baines and Paddon, 2012; Carstensen, 2016; Jose and Medie, 2015; Suarez, 2017).

The COVID-19 pandemic brought a new wave of interventions framed as protection. The virus was positioned as an unknown foreign threat, with metaphors of 'fighting disease' utilised to rally response efforts and justify draconian containment policies, with national lockdowns considered a normalised response (Allen and Parker, 2023). Uganda was lauded for its successful containment of COVID-19, particularly in relation to the first wave, introducing strict restrictions on mobility (including the closure of international borders) and social mixing (Laing *et al.*, 2024).However, such border shutdowns had hugely detrimental effects on the livelihoods of people living in borderlands (Allen and Parker, 2023; Jones and Schmidt-Sane, 2020; Parker *et al.*, 2020). Furthermore, COVID-19 lockdowns in Uganda significantly worsened food insecurity for both refugees (UNHCR, 2021a) and Ugandan nationals (Kansiime *et al.*, 2021).

During COVID-19, humanitarian protection for refugees fleeing violence pivoted to protection from pandemic threat. Multiple discourses emerged regarding refugees and protection from COVID-19. On the one hand, refugees, and particularly their movements, became associated with the disease itself, with forced displacement turning into a health security threat. Migration is often discussed in terms of 'security', but during COVID-19, this was framed as health security. To quote Pacciardi (2023): 'Since the spread of the COVID-19 pandemic, migrants' mobility has been increasingly securitised as governments have been adopting extraordinary measures to close both external and internal borders' (p. 176). Security and humanitarian intervention became interconnected in relation to policies concerning the movement of people (Aradau, 2004). Tazzioli and Stierl (2021) examined the enforcement of border closures in the EU, particularly Italy and Malta, during COVID-19. They described the reconfiguration of humanitarian logics, highlighting the 'contain to protect' connection, against a global

health threat. To quote: ‘the security-humanitarian rationale that underpins migration governmentality has been restructured by and inflected in light of hygienic-sanitary borders which enforce racialised confinement in the name of both migrants’ and citizens’ safety from infection by COVID-19’ (Tazzioli and Stierl, 2021, p. 539).

During COVID-19, Uganda’s well-known international porous borders became a particular focus of concern regarding health security, with specific containment measures directed at refugees and truck drivers that regularly crossed the country’s international borders (Moyo *et al.*, 2021; Storer *et al.*, 2022). The militarised response to COVID-19 in Uganda has been explored in detail by Parker *et al.*, (2022). They showed how the on-going securitisation of global health helped to create political space for the militarisation of epidemic response efforts. The authors draw attention to key events in the United National Security Council in 2014, in response to the West African Ebola Outbreak: the outbreak was described in terms of a threat to international security, legitimising enforcement action, and normalising the involvement of armies in epidemic responses.

However, conceptualising epidemics in terms of health security predates this. For instance, the notion of pandemic preparedness emerged in Western nations from defence ‘operations research’ through the cold war era. So-called ‘emerging infectious diseases’ were viewed not only as biomedical and public health issues, but relevant to national security, with its alignment with biosecurity agendas (Lakoff, 2017). Preparedness for bioterrorism and infectious disease outbreaks have now become entangled with the ‘informational redefinition of biological life for the biopolitical economy of security’ (Caduff, 2015, p. 107). At a time when emerging infectious diseases could have been framed as an issue of global health inequality, poverty, civil war and lack of basic healthcare (Garrett, 1994), the simultaneous evolving concerns regarding (bio)terrorism meant the dominant narrative became one of national security (Lakoff, 2008). Conceptualising pandemics in terms of a threat to health security can contribute to the legitimacy of containment policies, with political and institutional legitimacy being described as essential for effective crisis management (Hartley and Jarvis, 2020). But legitimacy is about far more. Clements (2014) argued that ‘legitimacy is about social,

economic and political rights, and it is what transforms coercive capacity and personal influence into durable political authority. It is the stated or unstated acceptance of unequal political relationships where some are given, assume, or inherit power over others' (p. 13). The author went on to explain the importance of 'grounded legitimacy', when 'the system of governance and authority flows and is connected to local realities' (2014, p. 15).

In contrast to narratives of health security, refugees were also described as particularly vulnerable to the negative consequences of COVID-19, with public health interventions directed at refugees, framed as protection. Crowded conditions and poor sanitation were considered particularly risky conditions for the spread of the virus, with inadequate healthcare infrastructure unlikely to be able to deal with the high burden of COVID-19 related disease. Oxfam specifically referenced their work involving 'Protecting Refugees from Coronavirus' (Oxfam, 2020). Similarly, the United Nations agency for refugees (UNHCR) wrote: 'In coordination with the government, UNHCR and partners continue to provide protection and humanitarian assistance to refugees in Uganda, and support efforts towards a comprehensive refugee response. To respond to the pandemic, refugee response partners have redoubled efforts to ensure continuity of life-saving services and mitigate the impact of COVID-19' (UNHCR, 2021b).

The dual framing of refugees as a health security threat and a 'risk group' vulnerable to COVID-19 have both been utilised to justify policies that aim to contain the virus with reduction of movement and the securitisation of borders. Much less is known, however, about how refugees responded to such interventions, and how the threat of COVID-19 compared to other challenges they faced.

Uganda-(South) Sudan Borderlands

This article brings together anthropological, political and public health scholarship on COVID-19 containment and humanitarian protection described in the subsection above, with historical and anthropological scholarship on borderlands, summarised here. An appreciation of borderland dynamics is essential in order to critique contain to protect

policies, and reveals mobility as a central form of self-protection. Goodhand (2013) usefully wrote about 'how detached policy-making and intervention in the twenty-first century … became from the reality of life in the frontier zones' (p. 247). In policies of containment, borders are often mistakenly considered as fixed and knowable boundaries. In fact, as borderlands scholarship has emphasised, boundaries only become real on the ground through the work of borderland inhabitants and border-crossers in imagination, negotiating and exploiting them (Feyissa and Hoehne, 2010; Johnson *et al.*, 2011). Leonardi *et al.,* (2021), therefore, talk about the need to explore local imaginaries of space, and the way these relate to political and economic geographies.

The border between Uganda and South Sudan is known to be highly porous (Hopwood, 2015), with mobility related to maintaining kin relationships and securing livelihoods (Gidron, 2022). The borderlands in this area are known to be fertile, characterised by two rainy seasons and good soil. They are described as 'a surplus agricultural area' (Moro and Robinson, 2022, p. 3). The South Sudan-Uganda border 'cuts across multiple ethnic communities, with significant interlinkages within and between groups on both sides of the border' (Moro and Robinson, 2022). It is not surprising then, that people on both sides utilise this area for farming in order to feed their families and sell produce. People also cross to Uganda from South Sudan to access education and healthcare. For refugees, cross border movement, in principle, is illegal, but in practice is accepted or at least tolerated, and it is often circular (Gidron, 2022). For those in Palabek Refugee Settlement, mobility has been described as an important expression of agency in the context of great uncertainty and precarity (O'Byrne and Ogeno, 2021), and as a type of 'mobile resistance' in response to humanitarian failure (O'Byrne, 2022).

Cross-border movement between Uganda and (South) Sudan has been occurring for generations, including during the decades of conflict from the 1980s between the Ugandan People's Defence Forces (UPDF) and the Lord's Resistant Army (LRA) (Finnström, 2008). For centuries, people were mobile (Allen, 1996). These stories of movement pre-date colonial rule, but the major borders in East Africa were drawn up by international treaties and imposed by colonial officials (Hopwood, 2015; Khadiagala,

2010). During the first Sudanese Civil War (1955 to 1972), people travelled from Sudan to Uganda. The civil war following President Idi Amin's rule in Uganda in 1979 subsequently saw many Ugandans and Sudanese flee north of the border to Sudan. In 1983, a second Sudanese civil war began, and many Sudanese were once again internally displaced, or travelled south to Uganda, along with previously displaced Ugandans. There was a period of relative peace from 2005. South Sudan became a newly independent country in 2011, but this was followed by a further civil war in 2013 (Moro, 2019). Violence during this latter civil war led to most of the journeys made by people to Palabek Refugee Settlement. However given the long and complex history of displacement, I draw on Allen and Turton (1996), who wrote'…to focus…. on a single movement of people, in one direction and at a particular point in time, would be to give a false, if comforting, impression that one is dealing with a simple and well circumscribed event rather than with an untidy process, involving multiple, and sometimes overlapping migrations in both directions, and considerable flexibility with respect to nationality and ethnicity' (Allen and Turton, 1996, p. 7).

Field sites and Methods

Ethnographic fieldwork was conducted in Palabek Refugee Settlement (also referred to as Palabek), in the border district of Lamwo, an Acholi region of northern Uganda, between April 2021 and June 2022. Depending on the route, the journey from Palabek to the South Sudan border is estimated to be between 45 and 80 kilometres. During fieldwork, the settlement hosted just over 60,000 refugees. Humanitarian personnel described the establishment of the settlement in 2017 in response to a major attack in Magwi in the Eastern Equatoria state of South Sudan, which led to a mass displacement of thousands of Acholi people, many from the town of Pajok. Refugees however, often made the point that an informal settlement originated prior to this.

The settlement has grown considerably since 2017, hosting refugees from several different parts of South Sudan, and a small number from the Democratic Republic of Congo. However, refugees and professionals working in Palabek both described the settlement as having an Acholi majority from South Sudan. The settlement spreads over

fifty-three square miles, with land mainly donated by Ugandan Acholi landowners. There is no fence or spatial indication as to where Palabek settlement stops, and other land in the district starts. Across the geographical area of the settlement, Ugandan Acholi so-called 'host communities' still reside, living in homesteads side-by-side with refugees.

Uganda has a flagship open-door policy to refugees outlined in the Comprehensive Refugee Response Framework (CRRF) (UNHCR, 2017), which promotes self-reliance, characterised by settlements rather than encampment, with an associated narrative of greater freedom of movement and access to employment (Hovil, 2018). Within Uganda's refugee settlements, the term protection is used in association with specific activities, such as those addressing child protection or sexual and gender-based violence (SGBV). UNHCR, OPM and partnering NGOs all employ specific 'protection officers', who provide a variety of roles, including registering refugees and addressing specific concerns related to 'people with special needs' (PSN), such as the elderly or those with a disability. However, the term was often used by humanitarian staff in UNHCR and NGOs, by OPM, and by refugees themselves, to refer to the overall humanitarian response, as well as encompassing specific interventions provided to refugees as part of this wider response. The term 'self-protection' was not used by interlocutors, but rather has been introduced in this paper in the process of analysis.

Interventions that intended to protect refugees from COVID-19 easily amalgamated with the wider humanitarian apparatus in the settlement. COVID-19 rules merged with general law enforcement: oversight for both was always from OPM, supported by UNHCR, with the resident police officers called upon when required. Soldiers were not commonly seen in Palabek but were present on occasion to enforce COVID-19 curfew, or to respond to a significant outbreak of (potential) violence.[19]

Promoting self-reliance, livelihood projects in Palabek provided training in tailoring, salon work, fixing shoes or making bags. They also focused on farming and food production.

[19] For example, during fieldwork there were clashes between children and soldiers at one of the secondary schools, following accusations from the students against the headteacher.

Refugees were encouraged to maximise their 30 metre-by-30 metre plots of land, provided with seedlings and equipment to grow green vegetables. Formal humanitarian livelihood activities provided incentives for refugees to rent larger plots of land from, or farm with, the host community. Other refugees rented land from the host community on an independent basis. NGOs working in the livelihood sector also focused on promoting small businesses. Refugees, however, often considered the land in Palabek as infertile, especially in comparison to the borderlands with South Sudan. Other refugees experienced conflict with members of the host community when harvesting their produce. Indeed, the reality of Ugandan's policy of self-reliance has been greatly contested (Hunter, 2009; Soudan, 2024) with a wide literature documenting its inadequacies in catering to the basic needs of refugees, predating the pandemic (Kaiser, 2005; O'Byrne, 2022; Ogeno and O'Byrne, 2018).

Refugees in Uganda are provided with basic food rations from World Food Programme (WFP). However, in April 2020 these were reduced to 70% of what they were previously, and they were further reduced to 60% in February 2021. These reductions have been a contributing factor to worrying rates of malnutrition in Ugandan settlements (Integrated Food Security Phase Classification, 2021). Reducing food rations have been explained in relation to substantial international funding shortfalls, with UNHCR consistently reporting huge funding gaps in the required budget for the Ugandan refugee response (UNHCR, 2022a). In more recent years the problem of food insecurity in Ugandan refugee settlements and associated concerns regarding malnutrition have been compounded by the COVID-19 crises, during which time refugees experienced significant disruption to both formal and informal livelihood activities (Integrated Food Security Phase Classification, 2021). There have also been reports of large-scale corruption within Ugandan's refugee response, with refugees not receiving adequate food even prior to the reductions in rations (O'Byrne, 2022), and COVID-19 becoming another opportunity for food related scandals (Titeca, 2021). An alternative framing of resilience-based refugee policies such as self-reliance, therefore, question the emphasis on the 'responsibilisation' of refugees. Brown and Chiavaroli (2023) highlight connections with 'neoliberal power structures', where emphasis is placed on individual refugee

responsibility rather than addressing significant humanitarian failures such as chronic food insecurity. This enables the political abandonment of refugees (Torre, 2023b).

In order to survive, many refugees relied on informal work, unrelated to any formal livelihood activities provided by NGOs. This has been described by Torre (2023a) as a form of self-protection in light of inadequate humanitarian support. For example, refugees went to 'dig' on host community land for a daily fee of around 10,000 UGX (approx. £2). Others worked as motorcycle taxi drivers or engaged in commerce. Refugees, along with Ugandans, ran the multiple shops around the settlement, which sold soap, sugar, salt, other food items, electric goods and clothes. These economic opportunities fluctuated during the pandemic, in response to government restrictions. This significantly contributed to the day-to-day challenges faced by refugees in adequately feeding their families. Similar damaging consequences of the pandemic in terms of worsening food insecurity have been described amongst Ugandan nationals (Kansiime *et al.*, 2021).

Health services in Palabek were provided by a combination of three main health centres, plus temporary health posts for new arrivals. Village health teams (VHTs) utilised refugee representatives across the whole settlement. The main 'implementing partner' for health supported government health facilities close to the settlement, which also treated refugees. The distance to travel to reach a health centre varied greatly across Palabek, with some refugees having to walk for an hour to reach a facility. COVID-19 testing and treatment within government health facilities and those run by the humanitarian partners were free of charge. In the first wave, most COVID-19 treatment occurred in the settlement health centres, with a remote site repurposed for a COVID-19 isolation centre. In later waves of the pandemic, home-based care for COVID-19 was introduced, in line with national Ugandan policy.

During fieldwork, I moved between the settlement, and Gulu, a town in the north of Uganda, with occasional trips to the capital, Kampala. In the settlement I lived with an Acholi family from South Sudan, who had lived in the settlement since 2017. I worked with two Acholi research assistants, one Ugandan and one South Sudanese. In total, 158

semi-structured interviews were conducted, in addition to informal 'chats', with both refugees and professionals working in and around the settlement. The interviews with refugees were mainly conducted with those established on plots of land. I was not able interview 'new arrivals' whilst they were still in reception centres. In order to understand the processing of new arrivals, however, I was permitted to join humanitarian personnel in their activities registering and screening new arrivals. With settled Acholi refugees already living in their allocated plots of land, I participated in daily life, cooking, cleaning the compound, collecting water, visiting the market, playing with children and chatting to neighbours.

I spent time with humanitarian actors working in the settlement, attended their inter-agency meetings, training sessions, and joined them for lunch for informal discussions. I interviewed employees working for OPM (the organisation with formal oversight of the settlement), as well as international humanitarian organisations such as UNHCR and non-government organisations (NGOs) known as the 'implementing partners'. I also interviewed district government employees and joined the Lamwo district COVID-19 taskforce, attending their regular meetings at the district headquarters. Attendance at these district meetings varied but they were usually chaired by the Resident District Commissioner (RDC) or a member of his team, with significant input from the District Medical Officer. There was usually a collection of Local Councillors (LCs), sometimes joined by members of the security forces such as the police or UPDF. Humanitarian representatives from Palabek settlement also attended. Overall, attendance at these meetings reduced as the pandemic progressed and priorities shifted.

The next ethnographic sections focus on three key issues that had a profound influence on containment as a form of protection from COVID-19, and the evolving forms of self-protection amongst refugees: legitimacy of containment measures; wider socio-economic consequences; and borderland dynamics.

Legitimacy of Containment: COVID-19 fears, National Borders and Social Boundaries

In response to COVID-19, Uganda's first restrictions were implemented in March 2020. Schools and places of worship were closed, the use of private or public transport was forbidden, and social gatherings were limited. The restrictions banned all businesses not selling food, and closed international borders, with the exception of trucks carrying goods, whose drivers required negative COVID-19 tests. Officially, the borders were closed, and a national curfew was implemented (Laing *et al.*, 2024; Parker *et al.*, 2020). Palabek Refugee Settlement followed the national COVID-19 containment policies, outlined by the Ministry of Health and described in detail by President Museveni in his national briefings. The OPM ensured the implementation of these national Standard Operating Procedures, colloquially referred to as 'SOPs'. All the usual activities conducted by NGOs were interrupted, and many humanitarian personnel were withdrawn from their in-person work in the settlement, instead having to work remotely. With the exception of essential services provided by health partners, food distribution, and some water and sanitation activities, those NGOs who continued their work in the settlement stopped interacting directly with refugees, relying heavily on so-called 'community representatives' such as VHTs and refugee leaders. In general, violent enforcement of COVID-19 rules, as described elsewhere in Uganda (Allen and Parker, 2023), may have been less within the settlement, due to its association as a place of humanitarian protection. However, refugees in Palabek did report the violent enforcement of curfews - those outside their homesteads after curfew were often beaten.

Dorothy, a 25-year-old refugee from South Sudan, returned to Palabek in April 2020 during the first lockdown, after visiting her brother in Juba. She made the journey back to Palabek using a motorcycle taxi where she could, but also walked some of the way, avoiding any of the official border points. When she approached her compound, her father, who held a position in the formal refugee leadership system, stopped her from entering their home. Keeping his distance, he took her straight to one of the settlement's health centres. From there, she was taken to Lokung, a remote site, set up for COVID-19 testing and quarantine.

At the start of the pandemic all individuals were required to undergo COVID-19 testing before being allowed to re-enter the settlement regardless of any symptoms. There were also strict isolation policies in place, with anyone testing positive being removed from the settlement to either treatment or isolation facilities. In May 2021, Robin, a refugee from South Sudan, and a senior member of the refugee leadership committee, reflected on the first lockdown the previous year: 'During this time, it was very difficult to enter the settlement! There was a very tight network – no one entered.' Refugees monitored any movement in and out of Palabek and ensured the quarantine of any new person by escorting them directly to a health centre. I asked Dorothy how she felt about this, and what happened next.

> *I was not happy because I was afraid that they may find corona in me…When I got back the community was keeping their distance from me and it gave me lots of thoughts…I was worried that I might have brought Corona from South Sudan …They told us that there are people entering Uganda illegally, and that's why if anyone comes here, they need to be taken for testing and quarantine…They picked us from [the] Health Centre III and took us to Lokung…When we reached, they gave us a sheet…to first get tested for Corona* (Dorothy, interview 16th October 2021).

After staying in Lokung for one week and two days, awaiting her COVID-19 result, Dorothy was informed it was negative, and she travelled back to her father's compound. After arriving back with her family, she described feeling '*happy because when I got back, I had my result and people were coming to greet me'*. Despite her difficult time in Lokung, Dorothy thought the COVID-19 response *'did well isolating people there'*.

The first COVID-19 lockdown in Palabek was characterised by a strong commitment from formal authorities and refugees, mediated through local leaders and the settlement COVID-19 task force to the principles and implementation of containment, and a socially monitored boundary to the settlement was created. A senior refugee leader described the whole COVID-19 response in the settlement during the first wave as structured around this taskforce. In addition to humanitarian agencies and OPM, there were a variety of refugee representatives on this taskforce, including cultural leaders, religious leaders,

VHTs, hygiene promoters, and block, zone and settlement-wide leaders.[20] There were clear chains of command and routes of dissemination of information from humanitarian agencies and OPM, through the various refugee leadership positions, to other refugees, and vice versa.

This meant that when Dorothy reached the settlement, she encountered this clear boundary. Despite international borders being officially closed, Dorothy had managed to make the journey back from South Sudan to Uganda with relative ease, utilising unofficial routes, encountering little restriction, until she reached the settlement. This social boundary, along with Dorothy's positive engagement with quarantine, can be understood in relation to the significant fear regarding COVID-19 in Uganda, including amongst refugees in Palabek, at the start of the pandemic.

In the first wave, COVID-19 fear in Palabek was often described in relation to information that had been gathered on TV, radio, and social media, reporting overwhelmed healthcare systems in high income countries, with deaths from the new virus increasing daily. Deaths from COVID-19 in Uganda were also clustering in cities such as Kampala, particularly affecting the wealthy. Furthermore, comparing the healthcare infrastructure of nations experiencing such difficulties, to the resources available in Uganda or South Sudan, conclusions were drawn to the inevitable devastation in the latter. This idea that refugees and refugee settlements might be especially vulnerable to COVID-19 was felt by those living in such settings, reflecting wider national and global discourses.

In Palabek, and Uganda more generally, COVID-19 intensified fears of cross-border migration, with perceived outsiders becoming the focus of blame and othering (Dionne & Turkmen, 2020; Leonardi *et al.*, 2021; Storer *et al.*, 2022). Truck drivers and refugees became a focal point of concern, resonating with the 'long history to the role of epidemic fears and controls in contributing to boundary-making and the pathologization of migrants' (Leonardi *et al.*, 2021, p. 1). In June 2022, I spoke to Ronald, a senior public

[20] Elections are held amongst refugees for leaders that represent different areas of the settlement, divided into blocks, zones and a settlement-wide leader. These leaders constitute the Refugee Welfare Committee (RWC), which mirrors the local council structure in Uganda.

health official in the Ugandan humanitarian response, who described the borderlands as a particular concern.

> *Initially…there was a feeling that South Sudan was not doing enough. Therefore, there could be a problem for us. You know with the mutation of the virus, of the variants, there was the possibility of one country not doing enough, to get a mutated variant, that was more virulent, and to some extent the border areas became a point of focus to be monitored closely (Ronald, interview 1st June 2022).*

In the context of the substantial fear regarding COVID-19, particularly in relation to borderlands, and the risk associated with those crossing such borders, the first national lockdown, was, in general, welcomed by most established refugees in Palabek, who helped to create a strict boundary around the settlement. The stringent containment measures to restrict all movement and implement quarantine was perceived to be a legitimate and a proportional response, to protect them from an outside threat (including the threat carried by new or returning refugees).

Simultaneously, there were relatively few COVID-19 cases in Uganda (Laing *et al.*, 2024), and indeed only a small number of COVID-19 related deaths in rural settings such as Palabek. A narrative of successful COVID-19 containment emerged in Uganda (Cheeseman, 2021). The Lancet lauded Uganda as a country whose successful COVID-19 response could be attributed to its historical experience with epidemics (The Lancet COVID-19 Commissioners *et al.*, 2020). This success was also highlighted by interlocutors in Palabek. In April 2022, I discussed the small numbers of COVID-19 related illnesses and deaths with Rachael, a humanitarian actor working with an NGO in the settlement. She described why containment was so successful in Palabek.

> In the settlement…there was strict guidelines from OPM….they were worried about what would happen in the settlement with overcrowding, so all gatherings stopped…all these strategies worked well…community structures were strengthened so they didn't allow outsiders to come, they were sent for screening….it really helped…and screening all new arrivals…and borders were

> closed…there were porous borders, but still….they were not allowed to mix, the health partner screened them, if positive they were taken to Lokung… there has not been so much death in the settlement because OPM were so strict (Rachel, fieldnotes 25th April 2022).

In this quote, low levels of COVID-19 death are attributed to 'strict' containment. I suggest, however, that compliance with containment in Palabek was not determined by the level of 'strictness' or in other words, securitisation, but rather by the legitimacy of interventions. Containment did not necessarily occur at international border points, as government policy might suggest. Despite a policy of highly securitised national borders, people passed through (Parker *et al.*, 2022). Instead, alternative boundaries were created to enforce policies of containment. In particular, boundaries were created when refugees' perspectives aligned with policies regarding who should be protected, and against what. Despite no perimeter fence, Palabek settlement, in the first lockdown, had a clear and socially monitored boundary, enforced by OPM, the police and soldiers when needed, UNHCR, NGOs, and refugees themselves, including members of the refugee leadership system. Dorothy's story, with her return back to Palabek during the first lockdown and subsequent quarantine in Lokung, suggests the boundaries imposed for refugees in Palabek were not related to geopolitical borders (she successfully negotiated the officially closed international border between South Sudan and Uganda through an informal crossing), but rather alternative boundaries were created by refugees within the settlement.

These boundaries adjusted in response to shifting priorities as the pandemic continued, and as COVID-19 shifted from an anticipated threat to a lived reality. The next section highlights the way in which people organised themselves and their social worlds, especially in times of great difficulty, which bore little relation to formal national borders that were prioritised in containment strategies. Rather, boundaries were created, broken down and recreated, as contextual dimensions changed, and challenges emerged, dissipated, or worsened. People's priorities shifted, influenced by various intersecting precarities (MacGregor *et al.*, 2022), particularly in relation to food and livelihood opportunities.

"Government restrictions were a plague of sorts": The Wider Socio-economic Consequences of Containment.

From 2nd June 2020, national restrictions were reduced. On 21st September 2020, many lockdown measures were lifted. However, political rallies remained forbidden and the re-opening of schools was still limited. International borders were officially re-opened to a degree with COVID-19 screening measures but remained officially closed to new refugees. As with the rest of the country, those in Palabek entered a period within which they attempted to return to a degree of 'normal life' with the easing of restrictions. Some formal NGO activities resumed in the settlement, albeit dominated by talk of 'COVID SOPs'. However, the wider effects of the pandemic on everyday life never really lifted during these periods of relative freedom, with the persistence of food insecurity, limited NGO activity, and high transportation costs interfering with economic and educational opportunities.

A second wave of COVID-19 from May to July 2021 brought a new sleugh of national restrictions, this time during my fieldwork. All schools and religious gatherings were once again closed, village markets or 'auction days' were suspended, inter-district travel was halted, and public transport was limited. In Palabek, once again, most formal NGO activities ceased, if they had even re-started, mainly due to the limitations on gatherings. However, the strict monitoring of movement in and around the settlement, as had been the case in the first lockdown, never materialised.

In contrast to the previous year, there was no coordinated COVID-19 settlement taskforce in this second wave. Testing was focussed on individuals presenting with COVID-19 symptoms at health centres, with additional asymptomatic screening of all new refugee arrivals. Reflecting national guidance, home-based care was introduced for refugees, who were advised to stay in their homes in the settlement if they tested positive for COVID-19. All new arrivals were tested for COVID-19, but there was no routine asymptomatic testing of refugees living in Palabek, or their visitors, on entering or leaving the settlement (officially or unofficially), as there had been in the first wave.

There was a considerable shift in attitudes towards pandemic containment measures in Palabek after the first wave, and the clear settlement boundaries that were present in the first lockdown, subsequently dissolved. Fiona, a refugee from South Sudan, who worked as a VHT in Palabek, described the difference between the first lockdown, and the subsequent shifting perspectives.

> *Back then people were living in fear when Corona just came, but people are now getting used to the situation… Corona was a bigger problem before… The biggest problem that people are facing currently is lack of money… People also worry about food because the food we have is little or there is hunger'* (Fiona, interview 2nd October 2021).

Robin, a senior figure in the refugee leadership committee, also described the shifting attitudes towards COVID-19 after the first lockdown: 'People have accepted it is now with us…we live with it…we need to allow life to go on.' These quotes from Fiona and Robin illustrate a number of considerations that need to be taken into account in order to understand the waning legitimacy of containment measures.

The overwhelming COVID-19 related sickness and death predicted at the onset of the pandemic, never materialised. By the completion of fieldwork in June 2022, there had only been three reported deaths from COVID-19 in the settlement. There were cases of severe disease requiring hospital referral, but the vast majority of cases were either asymptomatic or experienced as mild disease. Furthermore, for many people in Palabek, COVID-19 was something they had heard of but never seen. The disease was seen to be affecting mainly people in high-income countries or wealthy Ugandans living in cities such as Kampala or Gulu, rather than something that they, or any of their friends or family, had ever experienced in the settlement. They had all, however, experienced COVID-19 containment measures.

Whilst fear of COVID-19 waned, other aspects of life became of greater concern. '*Kwor pe yot',* life is not easy, was a common response to initial questions about life in Palabek. Invariably, this was followed by a description of reduced food rations. The first COVID-19

lockdown coincided with the reduction in food rations in April 2020, and by the time of the second lockdown in June 2021, rations were at 60% of their initial quantities (Moyo *et al.*, 2021). This curtailment of rations was attributed, by both refugees and professionals working in the settlement, to COVID-19. Evelyn, a refugee from South Sudan described the connection between lockdown and its restriction on food rations.

> Life is hard during lockdown. Food is reduced, schools are closed, all because of Corona…food was reduced because the people with lots of money who were supporting WFP [World Food Programme] all died, so they didn't give so much money to WFP…Corona killed the people donating money (Evelyn, interview 16th June 2021).

This was a common explanation of reduced food rations in Palabek. In March 2022, I interviewed Gerald, a senior humanitarian actor, who confided in me that there is '*partial truth in this',* describing the diversion of international aid, '*as most governments across the world diverted money to concentrate on the pandemic [in their own country]*'. This led to substantial reductions in the support UNHCR, including through WFP, was able to provide to refugees. In February 2022, I discussed the issue with Ronald, a senior public health professional, who expressed his concerns regarding this: 'Life is difficult. Work is difficult. There is not enough money…UNHCR services in Uganda are 70% funded by the USA. But funding is now only 30% of what it was 3 years ago…' However, as Gerald acknowledged, attributing the reduction in rations to COVID-19 is only a partial truth: funding shortfalls were present prior to the reductions in rations in April 2020, before the pandemic (UNHCR, 2019).

In theory, according to the humanitarian partners in Palabek, this reduction of food rations from 100% to 60% was meant to be offset by livelihood opportunities, and in official narratives, could be considered as part of the transition from emergency to development stages of the settlement (Hovil, 2018). Indeed, most refugees were not able to survive on such rations alone, and so embarked on either formal or informal opportunities to supplement this. COVID-19 complicated matters, however. In March 2022, I was in Kampala, and met with Joseph, a senior humanitarian actor. He told me,

‘Government restrictions were a plague of sorts’. Policies of containment that restricted movement and interactions made it impossible to run informal small businesses that many refugees relied on for their survival. Humanitarian partners in the settlement were not able to deliver a large proportion of their intended livelihood activities, due to strict SOPs. Although some livelihood opportunities managed to ‘bounce back’ between periods of the strictest containment measures (for example, motorcycle drivers returned to work), for many, the restrictions became chronic over a two-year period, and their livelihoods never fully recovered. For example, if a refugee had not had support with farming in the previous season, this continued to affect them as the year progressed, even if the strictest periods of restriction had ceased. This was worsened by the rapidly rising cost of living during this period (United Nations Development Programme, 2022).

As life became harder in the settlement, rates of suicide attempts and SGBV rose. In November 2021, I attended the Lamwo district COVID-19 taskforce meeting at the district headquarters. An NGO working in Palabek described their activity tracking attempted and completed suicides in the settlement since March that year, and had noted a large increase during periods of lockdown, which subsequently reduced when lockdown was lifted. They described to the taskforce, the reasons for the suicide attempts:

> Most clients in the interviews talked about food, people couldn’t move, they couldn’t do any activities. The triggers for cases were usually SGBV. For instance, food is being sold by the husband to get some small money for drinking, which is worse when food rations are low. So then there is SGBV, plus alcohol, and then lack of basic needs like food (Humanitarian actor, Lamwo district taskforce meeting 23rd November 2021).

These findings are supported by published material from UNHCR. To quote: ‘It adds to UNHCR’s own recording of an alarming increase in the number of suicides among refugees, linked to the pandemic’s disastrous socio-economic impact’ (UNHCR, 2021b). This adds a further dimension to Torre’s (2023a) description of the intimate relationship between chronic food insecurity and mental health problems amongst refugees in Palabek prior to the pandemic.

In sum, the dominant priority for those living in Palabek became surviving COVID-19 containment measures, which far overshadowed the fear of COVID-19 related illness. COVID-19 containment measures were no longer seen to be protecting people from an outside threat of a deadly disease. The persistence of such national containment measures, despite such disastrous socio-economic consequences, were therefore explained in terms of political and financial gain. In October 2021, I was invited for tea with Pastor John and his wife. John was a refugee from South Sudan residing in Palabek, who was also studying at a university in Uganda. His studies had been delayed by COVID-19. John told me about the pandemic.

> COVID is political. It was used by the government to get re-elected and do what they want. There has been more lockdown in Uganda than other places, and the schools are still not open, so everyone is idle, they are not studying. The government have used COVID to do what they want, whilst other people have suffered (John, fieldnotes 28th October 2021).

The narrative of Uganda's successful COVID-19 containment measures seemed to stick throughout the pandemic, despite a number of other factors likely to be contributing to the relatively low rates of COVID-19 illness and death in the country (Laing *et al*., 2024).These COVID-19 containment measures, however, also served other purposes. In the first lockdown, they restricted any political campaigning from the opposition party in a national election (Cheeseman, 2021). COVID-19 also raised significant funds throughout the pandemic both internally generated and from international donors for specific COVID-19 activities (Initiative for Social and Economic Rights, 2021). This money, however, was not seen to filter down to people on the ground, such as those living in Palabek, but was rather seen to 'fall into the hands' of political figures. Furthermore, the rationale for COVID-19 policy was seen by many interlocutors, to be based on financial incentives 'of a stakeholder somewhere', rather than health protection. In this context, COVID-19 containment measures, or in other words, government restrictions, became more associated with protecting political interests and the associated narrative of success, than protecting the health of both Ugandans and refugees. And so, a type of

resistance emerged amongst refugees in Palabek, utilising mobility as a form of survival, as has been done for generations.

Borderland Dynamics: Mobility for Survival in the Context of Containment

This section reveals that as life became harder in the settlement, with reduced food rations and the lack of formal and informal livelihood opportunities, many refugees, as they have done for decades, turned to mobility, negotiating borders in a number of ways. This resonates with what O'Byrne (2022) describes as 'mobile resistance'. Containment measures for COVID-19, intended to reduce movement both within Uganda and across international borders, in practice, may have added to increased mobility, through the removal of essential economic opportunities in the context of reduced food rations. This is supported by an IOM flow monitoring registry suggesting by September 2020, migration to South Sudan from Ugandan settlements was higher than baseline levels in February and March the same year (International Organization for Migration, 2021). People from Palabek travelled to the borderlands between Uganda and South Sudan despite ongoing risks of encountering violence in relation to the conflict in South Sudan, or from the militarised Ugandan COVID-19 response (Parker *et al.*, 2022). But as I was told by Robert, a refugee from South Sudan, 'Hunger is more dangerous than Corona…Hunger is more dangerous than a gun…you can dodge a bullet, but you cannot dodge hunger'.

At the time, Robert was in his thirties and had lived in Palabek since 2017. We sat down together to have dinner one evening in March 2022, and discussed the journeys people were making back to South Sudan, particularly to a village called Abuloro, in Magwi county. The border between Uganda and South Sudan is marked by topographical features, like hills and rivers, which Hopwood (2015) describes as indicating generally uncontested borders by both Ugandan and South Sudanese governments. However, there are still tensions regarding land ownership in the borderlands. I was told by refugees that where Ugandan soil exactly becomes South Sudanese is contested in various places. Amongst those in Palabek, Abuloro was described as being in South Sudan, just the other side of the border, and hence involved either a formal or informal border

crossing of some sort. Michael, a refugee from South Sudan, described why people were making this journey.

> *Abuloro is far but we need extra rations of food to feed our families. We are left with no options - so that's why they go … People started cultivating and farming in Abuloro last year when the rations of food were reduced. So, for people who have a large family, they have to do farming so they can sustain their families… Here at Palabek the lands are not fertile because we tried when we just came here… but you hardly harvest anything…. (Michael, interview 1st March 2022).*

Refugees also made these journeys to generate additional income to help with other financial challenges, such as healthcare or education. Grace, a 28-year-old refugee explained: '*So with this life, it's hard, and for this year, everyone is praying at least that they could get something in Abuloro, so that it can generate something for paying fees…[or] supporting health as well.*'

This increase in mobility to utilise farmland in South Sudan was generally accepted by humanitarian actors and OPM in Palabek, even when it undermined official COVID-19 SOPs. There was an acknowledgement that this was a survival method that would be inappropriate to curtail, despite the rhetoric around the challenges that 'porous borders' posed to principles and policies of COVID-19 containment. As Gerald, a highly experienced humanitarian interlocutor described:

> *There was no true containment…Displacement is a natural coping mechanism. Mobility is a way to survive. The restrictions we have enforced to make people stay, did not actually make people stay, it made people pass through unregulated channels…We need to acknowledge…the natural behaviours, of coping, of displaced people. We always think, preservation of life, self-preservation. This is the key element that drives people to move. It's almost like a maxim…this is the knowledge that has been there for ages (Gerald, interview 9th March 2022).*

As I sat down with Robert for dinner, he gave his own perspective.

> The lockdown has opened the way for refugees to go back to South Sudan. At the border they will ask you where you are going and you say, 'to dig'. But if you are registered as a refugee in one country the law says you are not meant to go back to your country. It is illegal. But the Ugandan government are allowing, they are using the border. There are only three ways [that people from Palabek use]; Ngomoromo, Aweno Olewii and Waligo - the three checkpoints. And all these checkpoints are controlled by the Ugandan government. By international law, they are saying if you are registered in one country, you are not meant to go back to your country if there is still war. Why are they allowing them to go back then? Because they are allowing people to go and dig. (Robert, fieldnotes 27th March 2022).

Going to farm, or 'dig' as people refer to it, is accepted as a legitimate reason for crossing the international border between Uganda and South Sudan. There are several routes used by people in Palabek to cross from northern Uganda to South Sudan. Some of these are more 'official' border crossings. Ngomoromo, Elegu (that borders with Nimule on the South Sudanese side) and Madei Opei were described as the 'most official' border points, owing to the fact documents such as visas could be issued by the immigration officers at these sites. Waligo and Aweno Olwii were described as smaller check points, but still 'official' given the presence of immigration officers and soldiers.

Refugees, however, often choose to use the more dangerous informal routes, to avoid the official points that were associated with political and state actors, and associated taxation (Moro and Robinson, 2022). 'People like short-cuts', Robert added, referring to the more informal crossing points. 'There are many shortcuts that the government doesn't know about…during lockdown people used these local ones, not the official ones', he explained. Some of these 'short cuts' are located in fairly close proximity to the more official border crossing, such as Ngomoromo and Waligo. 'Like at Waligo' he continued, 'you can take the short cut before the border point'. This highlights not only the porous nature of this border, but also raises a question about the distinction between official and unofficial routes of travel.

This distinction dissolved further, given the way the 'official' check points were used. 'The Waligo border point is for people within the area' Robert confided, 'and if you say you are

farming, you can pass. People use this for farming in Abuloro.' He described Waligo as a 'porous farmers' border', and explained that 'if you cross the border, maybe you pay something like five thousand (Ugandan shillings), or get a temporary visa, or maybe they just write your name, and you don't pay.'

Regular passage across this porous international border is part of daily life for farming or buying or selling at a trading centre or market. This is seen, even by the officials tasked with manning the checkpoints, as a legitimate reason for crossing back and forth. Stopping someone from moving across this rather arbitrary border would mean removing a main source of survival. And even during a national lockdown, when the borders were closed, Robert explained 'the official check points were used to farm. Because the officials were telling people to go and farm. People liked passing through Waligu for this.' Even during strict COVID-19 containment measures, employees of official authorities, such as the soldiers in the initial vignette, acknowledged that people relied on moving across the border for farming, in order to survive. Of course, this could easily be manipulated for other means. Robert added: 'During lockdown people just said they were farming but then they could go further, even like Juba'.

Given the historical context of Palabek and the borderlands between Uganda and South Sudan, turning to mobility is not surprising – people have done this during times of difficulty for generations. This is not only accepted by refugees but also by OPM, humanitarian agencies, soldiers and government border officials working in the area, whose practices in terms of border control acknowledge the importance of the 'leakiness' of this border for those who rely on farming to survive. But it does, however, cause dilemmas, as discussed in the border monitoring visit.

Discussion

This discussion will foreground the agency of refugees in responding to worsening food insecurity and economic precarity in the context of a global pandemic. They did this through the making and breaking of boundaries and harnessing informal mobility. Adapting to these multiple threats involved the continual search for survival, revealing

multiple examples of self-protection (Baines and Paddon, 2012; Carstensen, 2016; Jose and Medie, 2015; Suarez, 2017). At first, self-protection included the making of a highly monitored border to the settlement, engaging with a settlement level taskforce, in response to the potential threat of COVID-19. As time went on, priorities shifted. Whilst fear of COVID-19 related disease waned, legitimacy for public health measures was eroded by the day-to-day struggles of food insecurity and inadequate livelihood opportunities. Self-protection shifted to break previously erected boundaries, with informal mobility building on established borderland dynamics, opening up avenues to access other vital resources.

In the first COVID-19 lockdown, examples of self-protection aligned initially with official containment-orientated approaches to protection. In Uganda, protection against COVID-19 came from national policies of containment, restricting movement and closing international borders, justified by COVID-19 as a substantial threat to health security (Parker *et al.*, 2022). This aligned with fears amongst refugees already living in Palabek, of an outside threat. The focus of concern in containment policies, and amongst refugees, was directed towards those entering the settlement from outside. This chimes with the wealth of literature describing the stigmatisation of migrants and refugees in relation to the spread of disease (Pacciardi, 2023). Dionne and Turkmen (2020) have explored the connections between pandemics, blame and othering and write 'although othering occurs during pandemic and "normal" times, pandemic othering is more directly linked to the study of international relations due to the nature of pandemics crossing borders' (Dionne and Turkmen, 2020).

National containment policies and lockdowns relied on particular understandings of 'state borders' as solid, fixed and permanent. Migdal (2004) writes that 'borders are impermanent features of social life, dependent on particular circumstances rather than being permanent fixtures of human society…Borders shift; they leak; and they hold varying sorts of meaning for different people' (p. 5). The historical borderland dynamics between (South) Sudan and Uganda show us how borders and not fixed, but rather boundaries become real on the ground through social lives (Feyissa and Hoehne, 2010; Johnson *et al.*, 2011). By paying attention to the local imaginary of space (Leonardi *et al.*,

2021), it became clear how boundaries around Palabek settlement were created when policies of containment had what Clements (2014) describes as legitimacy.

As the pandemic progressed, the legitimacy of such containment measures, and understandings of who needed to be protected, from what, drastically changed, and boundaries were once again re-imagined. There was a clear divergence between official policies of protection, and examples of refugee self-protection. For refugees in Palabek, circumventing COVID-19 containment was essential for survival. This chimed with other accounts of resistance to epidemic control measure in the 2013-2016 West African Ebola outbreak (Wilkinson and Fairhead, 2017). Living near the borderlands, mobility was harnessed by those in Palabek, as people have done in this region for generations prior, in response to adversity. I return to the pertinent point by O'Byrne and Ogeno (2021) who described mobility as a pragmatic response to adversity and uncertain lives for refugees living in Palabek, and as a form of mobile resistance (O'Byrne, 2022). In this way, mobility can be considered as key method of self-protection. This was acknowledged by humanitarian actors working in the settlement, who openly discussed the essential nature of mobility. Although the term self-protection was not used, 'self-preservation' similarly emphasises the agency of refugee in securing their own survival. These humanitarian actors (and also border officials), however, were still constrained by policies of containment which were largely determined by the Government of Uganda.

In Palabek, it was not COVID-19 as a disease itself that worsened the condition of life for people, but rather the pandemic response. As Caduff (2020) writes; 'A virus causes disease, not hunger. It is not the pandemic, but the response to it that threatens the livelihood of millions of people…The poor, marginalized, and vulnerable bear the brunt of the pandemic response' (p. 478). Pandemics highlight and entrench inequalities, disproportionally affecting those already disadvantaged in any given society (Mukumbang, 2022). For those already living highly precarious lives, in a context of minimal COVID-19 illness, it was the containment itself that caused the most damage (MacGregor *et al.*, 2022). Self-protection, therefore, is not only in response to displacement and the more direct effects of COVID-19, but also encompasses the need to survive containment.

COVID-19 policy did not adequately consider these borderland dynamics, and how these were intimately connected to the legitimacy of containment and the wider negative consequences of lockdowns. Bringing together an understanding of the specific borderland dynamics between northern Uganda and South Sudan, with understandings of protection and containment, not only demonstrates the interconnectedness of people living across this region, but also helps to explain why containment lost its legitimacy as a form of protection. Gidron (2022), in his analysis of self-reliance strategies in Uganda, wrote that 'efforts to promote refugee self-reliance should acknowledge that mobility, interdependency and horizontal redistribution across transnational networks play an important role in the livelihoods of refugees' (p. 7). This premise is also essential to explain the limits of COVID-19 containment as protection in this setting. For decades, scholars have documented, as Allen and Turton (1996) write, 'the considerable flexibility with respect to nationality and ethnicity' (p. 7). Trying to distinguish, therefore, who was a legitimate recipient of refugee protection, as opposed to other forms of cross border migration, (as described in the opening vignette), may be near-on impossible given such flexibility, interdependency and transnational networks.

Overlooking these well-established historical and contextual dimensions, the narrative of COVID-19 as a health security threat dominated, evidenced by the persistence of Uganda's COVID-19 containment measures and border closures, and the borderlands region as a focus of security concern (Moyo *et al.*, 2021). Uganda only officially opened its borders to register new asylum seekers in March 2022. But why did this narrative prevail for so long, when there was clear evidence of people circumventing the rules to cross the well-known porous borders (and were possibly even encouraged to do so as a means of self-reliance), without any particularly devasting consequences for COVID-19 illness and death? According to people in Palabek, the policy of containment became less about protecting refugees, and more about protecting certain political and financial incentives related to COVID-19 containment. Protecting people from COVID-19 became a valuable narrative during the pandemic, mobilising specific COVID-19 resources, which were important at a time of decreasing international aid (Moyo *et al.*, 2021). Furthermore, the narrative of COVID-19 related hunger also worked to obfuscate the longstanding

humanitarian failures of worsening food insecurity in Palabek, adding to literature pointing to the institutional neglect, or political abandonment, of refugees (Torre, 2023a).

Conclusion

Knowing who to protect, and against what, and with what consequences, is far from simple. In northern Uganda, there was a central tension between policies of COVID-19 containment as a form of protection from a health security threat on the one hand, and refugee (self-)protection and their right to move, on the other hand. The ethnographic data presented here have explored this tension and revealed three main findings. Firstly, boundaries were created in line with COVID-19 containment policy when such policies had legitimacy. Secondly, waning legitimacy in combination with significant unintended consequences of COVID-19 policy, created a situation where containment drove increased mobility. This could have been predicted by established social, political and historical scholarship in this borderland area. Lastly, there was a failure of containment policies to adjust to evolving dynamics. Instead, government COVID-19 policy in Uganda maintained misleading narratives. Ultimately, this led to a situation whereby COVID-19 containment became little more than rhetoric as a means of health protection.

Policy Implications

The following recommendations are relevant to humanitarian and state actors responsible for refugee protection, particularly those that utilise containment during disease outbreaks. This includes international humanitarian organisations, government and non-government organisations, and is particularly relevant for those in public health positions, or those working in outbreak preparedness and response. These actors should:

- Appreciate the agency of refugees in determining their own priorities, which may or may not align with formal policies of contain to protect. Conceptualising such agency in terms of self-protection may help shed light on dynamics that challenge official policies, revealing important social and economic challenges that will undoubtedly shape (dis)engagement with humanitarian agencies.

- Further explore the wider social and economic impacts of containment and consider how policies can mitigate these. For instance, livelihood opportunities and food security may take precedence over outbreak containment or risk of violence. In this way, food security could be considered an essential component of containment policy.
- Be aware of the dynamic nature of legitimacy surrounding policies of containment. Policies, therefore, need to be regularly reviewed, adapted and redefined, otherwise they lose their local legitimacy.
- Understand how historical and socio-political issues such as borderland dynamics, can be used to inform protection policies. This wider understanding can specifically shed light on how people might respond to rapidly changing social and economic challenges surrounding livelihood opportunities and food insecurity.

Chapter 7: The Suspicious Business of COVID-19 Vaccination

Figure 46. A mural in the remote reception centre in Lokung, encouraging refugees to get vaccinated.

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Social Science and Medicine		
When was the work published?	April 2024		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	N/A		
Have you retained the copyright for the work?*	**No**	Was the work subject to academic peer review?	**Yes**

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	
Please list the paper's authors in the intended authorship order:	

Stage of publication	Choose an item.

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	N/A - single author

SECTION E

Student Signature	[redacted]
Date	12th December 2024

Supervisor Signature	[redacted]
Date	13th December 2024

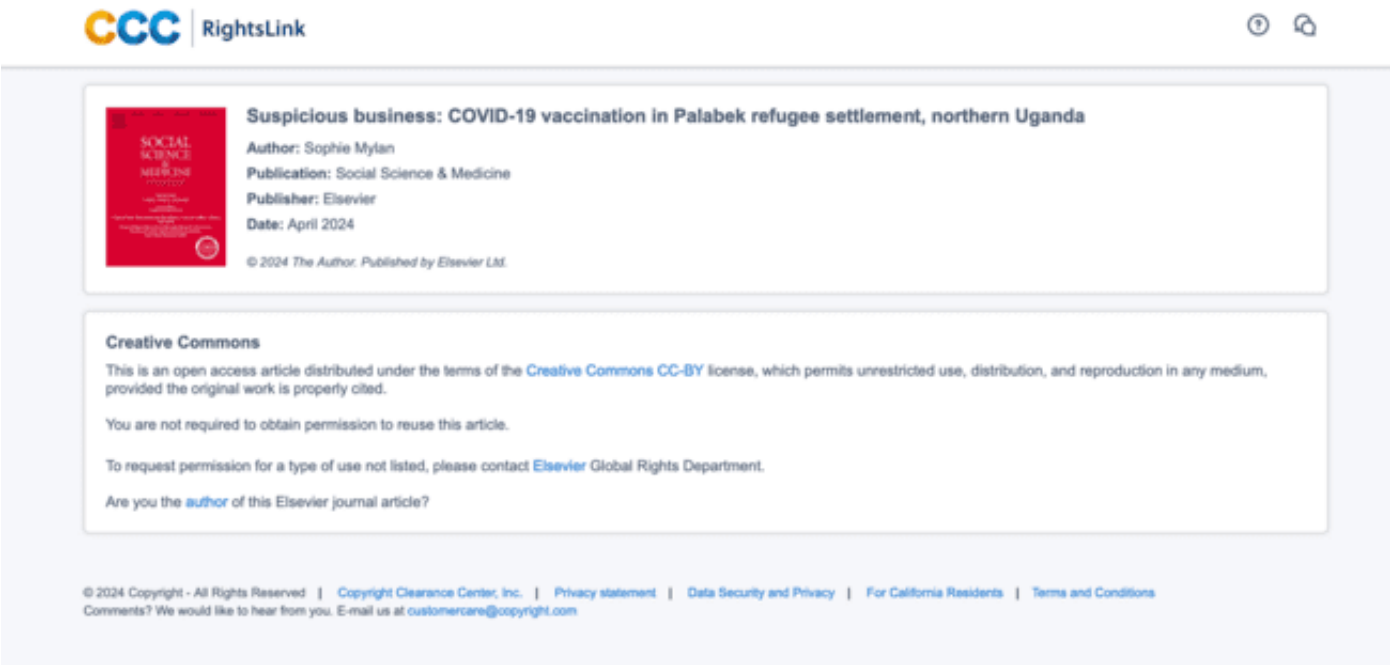


Figure 47. This Figure confirms that this article was published via a Creative Commons CC-BY license, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Article Title: Suspicious business: COVID-19 vaccination in Palabek Refugee Settlement, northern Uganda

Published in *Social Science & Medicine*, 2024.[21]

Author: Sophie Mylan

Abstract

Dichotomised debates in public health discourse regarding COVID-19 vaccine supply and vaccine hesitancy do not capture the realities of vaccine uptake in Palabek Refugee Settlement, northern Uganda. Issues of supply, which analyse manufacture and distribution, foreground global inequalities and political influences. In contrast, vaccine hesitancy, emphasising rectifying deficiencies in knowledge and trust, leaves little room for the politics that shape vaccine uptake. The 'vaccine anxieties' framework problematises these dichotomised debates and proposes consideration of bodily, social and political dimensions.

This article builds on the vaccine anxieties framework in relation to ethnographic research conducted in Palabek. Using the worldview of Acholi refugees from South Sudan, a focus on 'suspicious business' demonstrates that debates surrounding vaccine supply and hesitancy are intertwined, and, additionally, suggests spiritual elements should be paid greater attention.

In Palabek, inconsistencies in distribution directly impacted vaccine uptake. Furthermore, vaccine interventions that built on deficiency models did not work. Vaccine uptake was inseparable from its biopolitical context that continued to perpetuate the same unequal dynamics of power and control that kept wealth circulating amongst certain powers, whilst others faced worsening precarity but remained perpetual

[21] Full reference: Mylan, S. (2024) Suspicious business: COVID-19 vaccination in Palabek refugee settlement, northern Uganda, *Social Science & Medicine*, 346(116695), pp. 1-9.

recipients of humanitarian assistance and global health intervention, with little prospect of meaningful change.

Suspicious business captures fluid dynamics that move between spiritual and physical realms, capturing wider geopolitical dynamics as they are revealed in everyday lives. In doing so, this flexible approach reveals the centrality of the politics of COVID-19, whilst constantly incorporating evolving dynamics. This flexibility provides potential for improving vaccine uptake, if wider geopolitical inequalities are addressed.

Keywords

Vaccine hesitancy; Politics; Refugees; Uganda; COVID-19

Introduction

It was a rainy morning in Palabek Refugee Settlement ("Palabek") in April 2022, during the wet season in northern Uganda. I was nearing the end of ethnographic fieldwork among Acholi refugees from South Sudan, and I had become accustomed to the welcome drop in temperature, compensating for the inevitable rise in mosquitoes and ubiquitous muddy roads. I headed to the humanitarian headquarters, in search of Isaac and Peter, who worked in the health sector. Although sometimes difficult to track down, this morning I found them at their desks. The rain, they explained, had been "disturbing their work", delaying their "malaria sensitisation" visits in preparation for World Malaria Day. This focus on malaria was timely, they explained; malaria continued to be a serious health threat.

I asked about the COVID-19 vaccination programme and the conversation took a less energetic turn. Despite the availability of the Johnson and Johnson (J&J) vaccine (a one-dose schedule), the turnout of refugees for vaccination was below target. Palabek settlement hosted approximately 63,000 refugees, plus host communities and humanitarian personnel. Around 8000 people had had a first dose of a COVID-19 vaccine (Moderna or AstraZeneca), that required a later second dose. The numbers having had their first dose, however, did not translate to the second dose. "The problem is, the

vaccine [was] delayed" explained Peter, "if we had [had] a continuous supply we would have got more uptake". Isaac agreed, adding that after receiving a dose of AstraZeneca (AZ) or Moderna, "people were looking for a second dose of this, but when they were looking, there was no vaccine, and now they don't want a dose of something else".

We had had similar conversations multiple times previously. Initially, these were more positive, discussing successful accounts of "community sensitisation" to "build knowledge and trust" and increased vaccinations. Now, our conversation was less optimistic. Isaac explained; "no-one is paying attention to COVID now. Even if we campaigned, no-one would come". I asked about their plans for the following week, and Peter happily returned to discuss their malaria activities.

This vignette captures two important points. First, the inconsistencies in vaccine supply and distribution were intertwined with people's perspective on the vaccine, and subsequent uptake. Second, the vignette draws attention to the inadequacy of community sensitisation, and the problematic assumption that low vaccine uptake is explained by deficiencies in knowledge and trust. In fact, as Peter and Isaac suggested, community sensitisation failed to increase vaccine uptake. These two points exemplify the inadequacies of mainstream public health discourses regarding COVID-19 vaccination, that have mistakenly separated debates over supply issues (which include political analyses in terms of equality and justice) on the one hand, and hesitancy (also referred to as demand side) issues on the other (Leach *et al.*, 2022b). By making such a crude distinction, public health discourses fail to appreciate the political dynamics intrinsic to issues of hesitancy. This article will explore this issue further, through an ethnographic case study of COVID-19 vaccines in Palabek. To understand the hidden but central role of politics surrounding COVID-19 vaccine uptake in Palabek, however, a brief summary of the wider political context of COVID-19 vaccines is first provided in the next section.

COVID-19 Vaccines in Political Context

The COVID-19 Vaccine Global Access (COVAX) was established in April 2020. This was in response to calls for an equitable approach to vaccine access; and it brought together international players in vaccine development and procurement. A specific proportion of COVAX vaccines were allocated for humanitarian use (Berkley, 2020). Despite such calls, the supply of vaccinations across the globe has not been equitable (Wilkinson *et al.*, 2023). The vaccine became available in late 2020 but despite international pledges, two years later UNHCR were concerned that it was still not reaching refugees (UNHCR, 2022c). Wealthier countries stockpiled COVID-19 vaccines whilst other parts of the world were not able to obtain adequate supplies (Harman *et al.*, 2021). Rather than vaccine supply being determined by global health principles of equitable healthcare access, neoliberal principles and intellectual property prevented freely available generic vaccines. There were significant financial incentives in the vaccine development race, with the vaccine seen to be the magic bullet alternative to economically damaging lockdowns (Sparke and Williams, 2022). COVID-19 vaccination became another example of inequitable distribution of pharmaceuticals across sub-Saharan Africa (Adebisi *et al.*, 2022).

Prior to COVID-19, the WHO declared vaccine hesitancy to be among the top 10 threats to global health (World Health Organization, 2019b). The WHO's Strategic Advisory Group of Experts on Immunization (SAGE) conceptualised vaccine hesitancy in relation to three overlapping factors; complacency, convenience, and lack of confidence (MacDonald *et al.*, 2015). Trust is described in relation to lack of confidence, with trust and distrust as dichotomous states of being following processes of risk perception, with so-called 'culture' seen as a modifiable factor in decision-making (World Health Organization, 2017). Ultimately, focus tends to be limited to rectifying mistrust in science, with little attention paid to (mis)trust in wider government and non-governmental organisations and their political affiliations.

The WHO claimed that refugees might be particularly susceptible to vaccine hesitancy (World Health Organization, 2021b). For refugees, official documents typically explain vaccine hesitancy in terms of knowledge deficits, mistrust, discrimination, and lack of access to healthcare (Tankwanchi *et al.*, 2020; Thomas *et al.*, 2021). These issues are

considered amenable to outreach, sensitisation, or educational activities (e.g. World Health Organization, 2021). Vaccine hesitancy debates that place emphasis on rectifying deficiencies in knowledge and trust and modifying 'culture' to improve vaccine uptake, leave little room for valuing alternative perspectives from those considered by dominant public health discourses as merely the recipients of interventions. Furthermore, while geopolitical dynamics are acknowledged in supply debates, political elements are lost in vaccine hesitancy debates, which instead locate the problem (and solutions) in individuals, detached from wider contextual dimensions.

In contrast to mainstream public health discourses, literature in the social sciences and humanities has foregrounded the politics of public health approaches to infectious disease control (e.g. Harper and Parker, 2014) including epidemics (de Waal, 2021; Leach and Tadros, 2014) and has drawn attention to the importance of political, historical, social and cultural dynamics, and the way in which these shape how people interact with vaccines. This includes historical analyses of vaccination campaigns (Allen, 2007) and the anti-vaccination movement (Durback, 2005), research detailing the way in which vaccines may (not) engage with local knowledge (Nichter, 1995; Streefland *et al.*, 1999) and how local vaccine behaviour is shaped by global health policy (Closser *et al.*, 2016). Work in sub-Saharan Africa includes Richardson *et al.*, (2019), who highlight how coloniality shapes 'empiricist methodologies', when examining mistrust during Ebola outbreaks in West Africa and Democratic Republic of Congo (DRC). The effects of colonial and postcolonial inequalities were also emphasised by Storer and Anguyo (2023), in their work on vaccine fears in Uganda. They, too, emphasised the need to politicise and historicise understandings of trust. Particularly useful is the work of Leach and Fairhead (2007) who argued that public health concepts such as risk, trust and rumour are insufficient to understand low vaccine uptake, and that it is vital to foreground what people think, understand and value in everyday life. Drawing on ethnographic research carried out in the UK and West Africa, the authors developed a 'vaccines anxieties' framework, which focused on bodily, social and political dimensions.

Leach *et al.*, (2022b) updated their vaccine anxieties framework in response to COVID-19. Their work highlights how global dynamics can be revealed in day-to-day experiences,

and they call for a need to '… address the longer-term structural, social and political relations in which vaccine delivery and distribution are embedded; and beyond narrow assumptions about vaccine demand or hesitancy to address the real anxieties … embedded in bodily, social and wider political experience' (p. 8). The updated framework uses vaccine anxieties to demonstrate the connectedness of supply and demand issues of Covid-19 vaccination in Africa, contributing to a more contextually informed vaccine preparedness.

The obscuring of the geopolitical dynamics of vaccines with a focus on hesitancy resonates with debates in refugee studies where humanitarian interventions in states of exception often obscure the politics of forced displacement (Fassin and Pandolfi, 2010). Uganda has one of UNHCR's flagship open-door refugee policies, hosting more than 1.5 million refugees (UNHCR, 2022d). Following global developments in refugee policy (see Hansen, 2018 for a summary of UNHCR's Comprehensive Refugee Response Framework), Uganda is transitioning to a state of 'self-reliance', which involves reducing aid, as refugees utilise their so-called 'resilience', and become responsible for their own survival (Clements *et al.*, 2016). The reality of opportunities to successfully obtain self-reliance has been criticised considering the increased precarity and worsening food security associated with these changes in policy (O'Byrne and Ogeno, 2021). The focus on individual responsibility has been described as normalising neoliberal governmentality (Torre, 2023a; Welsh, 2014).

This article builds on the vaccine anxieties framework in a new contextual setting – that of a refugee settlement. Ethnographic fieldwork in Palabek provided a unique opportunity to ask: what historical, socio- political, economic and spiritual dynamics shaped the uptake of COVID- 19 vaccines among South Sudanese Acholi refugees? To answer this, the article is divided into four further sections. The next section introduces the field site and methods, whilst also explaining the rationale for analysing data with a focus on suspicious business. Such a focus helps to foreground the worldviews of interlocutors, and so avoids separating physical and spiritual elements. Ethnographic findings are then presented, detailing how, and why, COVID-19 vaccines became a suspicious business in Palabek. The discussion explores how a focus on suspicious business can add to, and

enrich, the vaccine anxieties framework. Such an approach reveals how vaccine manufacture, development and distribution, wider health inequalities, fears of vaccine-induced illness, colonial histories, and demonic transactions with the spiritual world are not separate from, but rather are deeply intertwined with, and inescapably shape, personal perspectives on the COVID-19 vaccine amongst refugees.

Field Site and Methods

Ethical approval was obtained for the study from London School of Hygiene and Tropical Medicine (UK), Gulu University (Uganda), and the Ugandan National Council of Science and Technology. Ethnographic fieldwork was carried out in Palabek Refugee Settlement in the Acholi northern district of Lamwo, Uganda from April 2021 to June 2022. I lived with a research assistant and his South Sudanese Acholi family, spending time participating in the routines of cleaning the compound, collecting water, cooking, playing with children and chatting. I also 'hung out' (Clifford, 1997) with actors working in the settlement, particularly those in the health sector, attending training sessions, COVID-19 taskforce meetings, community engagement and sensitisation visits, and Village Health Team (VHT) meetings. The findings presented here draw on these experiences as well as information emerging from 158 semi-structured interviews. The majority of these interviews included specific questions about COVID-19, in addition to wider discussions about epidemics and displacement. All interlocutors have been given pseudonyms. Most of the interviews were with refugees, but some were carried out with members of the Acholi host community. In all cases, interviewees were recruited during informal day-to-day conversations or by my research assistants. Interviews were also carried out with key medical and humanitarian actors, but many preferred to chat more informally as I joined their daily activities.

Healthcare workers and refugees are not discreet groups. Refugees are routinely employed in healthcare roles, particularly as VHTs, but also in other positions at the settlement health centres. As a researcher I tried to access different spaces within Palabek. Living with a family who had fled from South Sudan enabled a more informal day-to-day perspective of life for refugees to be acquired. It also allowed me to build

personal relationships with people living in the settlement. As a white European, living in a hut on a plot of land with a family of refugees, was considered strange by some interlocutors I encountered, but was important for my ethnographic methods. Living in this way reduced (but by no means eliminated) suspicion directed towards me and my research, especially since the family I lived with could vouch 'for my character', and were themselves, well respected by other refugees. It also set me apart from many of the humanitarian actors who left the settlement before dusk. Drawing on my own experiences as a qualified and practicing healthcare worker in the UK and Gulu, Uganda, it was also relatively straightforward to talk to staff working in the settlement's healthcare facilities. These conversations enabled access to formal narratives regarding the vaccine as well as more informal, off the cuff perspectives.

Some of my interlocutors had been living or working in the settlement since it was established in 2017. Since then, it has grown substantially, and in 2022, it was estimated that over 63,000 refugees lived in Palabek (UNHCR, 2022d). Growing numbers of refugees arrived from other parts of South Sudan, but initial occupants, who still form the largest group in Palabek, are mainly South Sudanese refugees from the Acholi-speaking area of Pajok, Magwi County, in Eastern Equatoria. In the last two decades, ongoing violence has led to mass displacement from (South) Sudan into Uganda. In 2011, South Sudan became independent from Sudan, but only two years passed before a civil war broke out in this new state (Moro, 2019). Despite an official ending of the civil war in 2020, violence and instability has continued, with the ongoing displacement of now millions of refugees from South Sudan into neighbouring countries (UNHCR UK, 2020). For many refugees in Palabek, this is not their first displacement. People in the region have experienced repeated displacement over generations, and move back and forth navigating violence, food scarcity, and inadequate education and healthcare (Allen, 1996). This repeated movement and displacement has led to the development of long-standing relationships with humanitarian organisations working in both (South) Sudan and Uganda. The displacement from civil war that led to people's most recent status of 'refugee' and relationship with humanitarian aid, cannot be separated from centuries of instability and conflict which involved colonial powers and their neo-colonial counterparts.

This paper foregrounds perspectives from Acholi refugees. A large proportion of scholarship regarding Acholi has focussed on the Ugandan conflict between the Lord's Resistance Army (LRA) and President Museveni's army (Allen *et al.*, 2021; Baines, 2005; Dolan, 2011; Finnström, 2008; Victor and Porter, 2017), but there is increasing literature on Acholi from South Sudan too (O'Byrne, 2015b; Torre, 2023a), in addition to relevant work on groups other than Acholi residing in this border area between Uganda and (South) Sudan (Allen, 1996; Allen and Storm, 2012; Harrell-Bond, 1986). Amongst this wealth of literature, it has become evident that a central part of Acholi life is that of cosmological equilibrium and social balance of power and moral order (Porter, 2017), which Porter (2012) has described as 'social harmony'. Finnström, in his ethnography about Acholi during the Ugandan civil war, explores people's endeavours to establish such control and balance in their daily lives in terms of good and bad surroundings (Finnström, 2008). This quest for equilibrium involves balancing inseparable physical and spiritual dimensions (Baines, 2010; Finnström, 2008; O'Byrne, 2016; p'Bitek, 1971).

Suspicious Business

As my fieldwork progressed, it became apparent that it would be hard to understand any aspect of daily life without engaging further with the spiritual (and religious) dimensions of life and death. For Acholi, *jok,* or *jogi* (plural) are central to this spiritual understanding (p'Bitek, 1971, p. 26) and are responsible for moral order (Baines, 2010). *Jogi* have been translated as chiefdom gods, clan deities, and naturally occurring spirits, and described in relation to witchcraft (see Allen, 2015). *Jok* can be translated as god, considered by some as synonymous with, but by others as distinct from, a Christian God. O'Byrne (2016) describes how Christian principles have been incorporated into Acholi 'traditional' conceptions with a surprising degree of fluidity. Overall, these understandings of a supernatural, or meta-physical dimension of Acholi cosmology, are at the core of explanations of misfortune, ill-health, uncertainty, and precarity. Central to notions of *jok* is that they can be appeased with specific practices; if something bad is happening then it is due to an imbalance in this delicate equilibrium, and practices are directed to restore this balance (O'Byrne, 2016). There is inherent flexibility in this: fortunate or unfortunate (with the latter including evil associations) occurrences lie on different sides of the same

coin, intimately interlinked, involving often the same spiritual powers (which are deeply intertwined with the physical environment, like lakes or hills). The term suspicious business usefully brings together these often-shifting supernatural dimensions in everyday life (O'Byrne, 2015b). In doing so, it captures a fluid and innately flexible state of questioning, often concerning the *why* more than the *what* (Evans-Pritchard, 1976), as people pragmatically negotiate misfortune (Whyte, 1997), while seeking to establish control and balance in their day-to-day lives. Indeed, it enables an open and evolving approach to understanding and responding to changes in life, particularly in relation to misfortunes such as forced displacement, epidemics, personal illnesses, and in some cases, the introduction of a new vaccine. The emphasis on flexibility is important. It foregrounds the point that suspicion is not fixed. Instead, it is bound up in an ever-shifting and responsive quest for moral order in the face of misfortune or uncertainty, which is often understood in relation to an imbalance in spiritual dimensions. Just because a person may be suspicious of something today, does not mean they will be suspicious tomorrow.

Suspicion (of supernatural powers or witchcraft) is deeply connected to trust, a point evident in anthropological scholarship in many parts of sub-Saharan Africa (Geschiere, 2013; Somparé and Somparé, 2019; White, 2000). In Palabek, one of my research assistants summed up the issue when he said: "To not trust means you are suspicious". The Acholi word *gen* is generally translated as trust, with a lack of trust, as *gen peke.* To indicate a milder form, *pe gene totwal,* is translated as not trusting fully, or suspicion. When using the term suspicion, I encompass all discussions I had surrounding *gen peke*, or *pe gene totwal*, but also a large proportion of ethnography that never referenced *gen* specifically. Rather, through long-term ethnographic fieldwork, I learnt a great deal about what to be wary of, when and with whom to take caution and why, but surprisingly there were few overt discussions of trust. Yet, I cannot remember a single day in Palabek when my research assistant (and later I), were not suspicious of something. Suspicion could be just a heightened awareness of the potential for wrongdoing, a wariness, caution, or consideration of ulterior motives.

There was a lot to be suspicious of in Palabek. For instance, suspicion was directed towards the Office of the Prime Minister (OPM) – a branch of the Ugandan government responsible for the settlement - and security forces. Fieldwork took place during the second national lockdown in Uganda, a country with a highly militarised COVID-19 response, connected to the political interests of the ruling government (Parker *et al.*, 2022). The formal security presence included uniformed police and soldiers, who sometimes dealt with (potentially violent) unrest when enforcing COVID-19 rules by using violence. However, non-violent means of control, both related to COVID-19 and the wider running of the settlement were more pervasive. People felt they were always being watched by OPM, who were thought to have people working under cover. Other figures of public authority in the settlement, including healthcare workers, refugee elected settlement leaders, and religious figures, were particularly influential in shaping opinions in Palabek, some of whom promoted vaccine uptake, and some of whom did not. They were suspicious.

More broadly, suspicion towards unknown neighbours was common, including fear of poisoning (Storer *et al.*, 2017). Deeper layers of suspicion were directed towards people who on the surface, appeared like well-known friends (O'Byrne, 2016). I was told by my research assistant; "you do not know what is deep in someone's heart." An ongoing suspicion was a preparedness for the possibility that people can behave in unexpectedly antisocial ways, or for unexpected events.

Suspicion was often associated with the accumulation of wealth at the expense of others. Associating suspicion with 'a business' in this article directly references this understanding, with the term 'business' being an exchange for financial gain. Significantly, it is not always clear what is being exchanged or sold for financial gain, and this often amplifies suspicion that it could be something sinister, notably metaphysical (O'Byrne, 2021).

People were suspicious of corruption within the refugee system. Large sums of money intended for aid were seen to reach the pockets of humanitarian staff (government and NGO), rather than reaching the intended beneficiaries. Indeed, fraud and corruption have been documented both in Palabek and other Ugandan refugee settlements (O'Byrne,

2022; Titeca, 2023). There was also suspicion regarding the official financing of humanitarian aid and development in Uganda. The financial benefits associated with the refugee system were not seen to filter down adequately to refugees themselves. Perhaps, therefore, there was an ulterior motive to Uganda's hosting of refugees; rather than a humanitarian endeavour, it was considered likely to be of financial benefit to those with higher authority. As one interlocutor informed me, refugees become the "bargaining chip". In a global context of increased (forced) migration, there is a brokering of displacement between western powers and lower income countries such as Uganda (Titeca, 2021).

Furthermore, the impact of generations of war and repeated displacement in the region between (South) Sudan and Uganda cannot be underestimated (Allen, 1996). The precarity associated with this has profoundly influenced suspicion towards international agencies, governmental and non-governmental organisations, as well as other refugees and Ugandan neighbours.

'Suspicious business' helps to connect suspicion *and* the financial or economic dynamics considered as 'business'. Business was very often suspicious, and suspicion often involved a financial, or business, element. Together, suspicious business therefore resonates with scholarship regarding the 'Ebola business' during the largest West African outbreak (Somparé and Somparé, 2019), and the work of contemporary anthropologists who have foregrounded modernity, globalisation, or development, in their analyses of metaphysical dimensions or witchcraft (see, for example, Ashforth, 2005; Comaroff and Comaroff, 2001; Geschiere, 2019). Just as scholars have documented how spiritual explanations articulate inequalities (Niehaus, 2007; White, 2000), the spiritual powers implied by suspicious business are inseparable from the wider financial and geopolitical dynamics that shaped people's lives. What is less appreciated in established literature, however, and what suspicious business (or in shorthand going forward, suspicion) intends to capture, is a flexible approach to negotiating new dynamics, or misfortune, in daily life, which involved the balancing of spiritual powers, encompassing these wider geopolitical dynamics.

COVID-19 Vaccination as a Suspicious Business

There were multiple interrelated ways COVID-19 vaccination emerged as a suspicious business in Palabek. For ease of reading, they have been divided into the following four subsections: inconsistencies in vaccine supply and type; lack of health threats from COVID-19; health threats related to the COVID-19 vaccine itself; and the business of vaccine development and the supernatural in everyday life. Mirroring the way in which my fieldwork progressed, the first three subsections do not reference spiritual dimensions specifically, but rather they are intended to remain an absent presence for the reader, as was the case when I was conducting a large proportion of fieldwork. In the last subsection, however, I make the connections with metaphysical dimensions more explicit.

Inconsistencies in Vaccine Supply and Type

By 22nd April 2022, more than 6000 people had received the first, but not the second dose, of a two-course COVID-19 vaccine regime in Palabek. This shortfall in vaccination uptake can be understood in relation to inconsistencies in vaccine distribution.

I arrived in Palabek in mid-2021. My initial meetings with different leaders regarding the COVID-19 pandemic invariably included discussions regarding the AZ Vaccine, which had become available in Uganda from March 2021. By May 2021, healthcare workers, teachers, and leaders across the settlement had been offered the vaccine, many of whom had happily accepted their first dose of this vaccine. The subsequent uptake of the vaccine by refugees in the settlement was attributed to the acceptance of the vaccine by the formal refugee leadership system, in addition to respected religious and cultural leaders. “If leaders had not been so keen, the people would not be accepting,” I was told. Yet, there was considerable suspicion about the vaccine, particularly at the start of the campaign, when people had not had a chance to observe its impacts. As leaders were vaccinated and increasing numbers of people were seen to have had the vaccine, with few adverse events being recorded, suspicion dissipated for a number of months, but then increased again in December 2021.

In April 2022 I spoke with Oscar, an experienced Ugandan healthcare worker, in a management position. As we waited for a meeting to start at one of the health centres, we chatted about the rollout of the COVID-19 vaccine. He described a significant setback to the vaccination campaign in December 2021. The vaccine available at the time was the Moderna vaccine, and a large shipment had arrived in the settlement. “We had a target of 15,000 doses!” he explained. However, there was a caveat: the vaccines were going to expire within a month. The health partner in the settlement set about vaccination campaigns in the health centres and arranging “community outreach” visits. Boasting, Oscar said: “We managed 200 doses in just one outreach!” The campaign was considered a success, with approximately 7000 people vaccinated in a matter of weeks before the expiry date.

This large campaign, using the Moderna vaccine, followed the guidance from the vaccine manufacturers. Everyone who had their first dose was booked for their second dose three weeks later. But the vaccine supply did not continue. Expired vaccines had to be disposed of, and no new doses arrived in the time frame expected by people for their second dose. This created a situation whereby individuals wanting their second dose were unable to access the vaccine. In the next few months, the settlement received further vaccination doses, this time from J&J, but few people sought the vaccine.

Inconsistencies in supply generated significant suspicion and unanswered questions: what happens if you receive the second dose late? Does a late dose cause harm? What happens if you mix vaccines? These anxieties are not dissimilar to discussions that took place globally in public health forums regarding the mixing of COVID-19 vaccine manufacturers within a vaccine course, some of which concluded that it was advantageous to do so (Callaway, 2021; Rashedi *et al.*, 2022). I never heard these advantages discussed in Palabek but rather, what was particularly difficult for people to overcome, was that they had engaged with a clear vaccination plan, only for this to be changed because of reasons related to vaccine availability rather than a superior biomedical rationale: a suspicious change of plan. The process by which these conclusions and subsequent policies came into being is important. Policies whose rationales originate from inadequate or unreliable access to vaccinations, rooted in

global vaccine inequalities, do not go unquestioned by those at the receiving end of such policies. In this case, people in Palabek decided they would prefer not to have a second dose of a different vaccine, and would prefer not to have any second vaccine, rather than a late second dose, due to suspicion triggered by inconsistencies in vaccine supply and type.

Lack of Health Threats from COVID-19

It was not only inconsistent availability or type that prompted suspicions regarding the COVID-19 vaccine. As time went on, the pandemic's legitimacy as posing a significant threat to health waned**,** primarily because the high numbers of COVID-19 related deaths seen abroad never translated to northern Uganda. COVID-19 was not seen to be causing much ill-health in Palabek. This contrasted significantly with the high burden of ill-health caused by other infectious diseases such as malaria. Other epidemics were perceived to be far more dangerous, including cholera and measles, and the ongoing possibility of Ebola outbreaks spreading from neighbouring Democratic Republic of Congo.

This became evident when I attended a COVID-19 community sensitisation visit towards the end of fieldwork; here was COVID-19 policy being implemented on the ground. I joined Alfred, a Ugandan healthcare worker in an entry-level position. After Alfred had disseminated his information regarding the threats of COVID-19 and how to prevent spread, people were invited to ask questions. For the next hour or so, many questions were asked, but the vast majority concerned malaria, hypertension, and other health concerns. Fear of overwhelming COVID-19 illness and death, common at the discovery of COVID-19, and particularly felt in more urban centres of Gulu or indeed Kampala, was never evident among people living in Palabek.

By 31st May 2022, the COVID-19 sit-rep reported that 414 cases of COVID-19 had been confirmed in the settlement since the start of the pandemic, with only three reported deaths from COVID-19, two of which had been Ugandan nationals, and one a refugee. Given the level of testing, establishing an accurate sense of COVID-19 rates in Palabek was challenging, and there were probably many mild and asymptomatic cases.

Nevertheless, the relatively small numbers of reported COVID-19 cases (which included asymptomatic cases found in routine screening of new arrivals, as well as symptomatic cases reporting to health centres) supported the general perception that COVID-19 was not a significant health threat to those living in Palabek. Global health literature has debated why COVID-19 did not cause the same burden of ill-health and death in rural low resource settings in Africa (Laing *et al.*, 2024; Nordling, 2020). Some of those working for humanitarian organisations in the settlement proudly attributed it to the rapid and effective control measures, but many were not convinced by this official narrative. Other possible theories include the demographic age structure and fewer comorbidities (Adams *et al.*, 2021).

Against this background, COVID-19 became a focus of humour in my day-to-day life in the settlement. If a child coughed, parents would shout "ah corona!" before rolling around laughing, often to the dismay of the rather flummoxed child. Large donations of clothes from China, distributed by UNHCR, were referred to as "corona clothes" with a cheeky smile, and worn freely despite finding used masks and Chinese coins in pockets. These clothes were thought to have come from people who died of COVID-19 in China, and were worn in Palabek, usually with little concern.

Why were so many resources pivoting to COVID-19 vaccination when the disease itself was not seen as a significant health threat? Both refugees and humanitarian staff explained the phenomenon in terms of the fact that people in the West were dying from COVID-19. They were the ones with money, and it logically followed to them that everywhere else in the world had to follow their lead. They assumed that global health agendas were being set by Western nations and it was not, therefore, surprising that irrelevant policies were rolled out in places like Palabek. Furthermore, actual lives in the West – especially those with money and power –had greater value, than the lives of refugees. If these superior lives were being lost to COVID-19, then it made sense that the whole world would have to try to control the pandemic, just for the benefit of the rich and powerful. It was suspicious business nonetheless.

Health Threats from COVID-19 Vaccination

As the perceived threat from COVID-19 waned during 2021, concerns about side-effects from the vaccine gained momentum. The persistent focus of humanitarian efforts to vaccinate against COVID-19, therefore, became a suspicious business, especially with circulating ideas about the dangers of the vaccine. The following example illustrates this point: Susan, a 34-year-old South Sudanese refugee, worked as a VHT. When I met her in May 2021, she was suspicious about the vaccine; but said that if her paid work as a VHT was going to be withdrawn if she was not vaccinated, then she would accept vaccination. Susan explained: "I will not go for it if not by force". Part of her suspicion related to the concerns regarding bloods clots with the AZ vaccine that were circulating on international news and social media and discussed in the settlement. Susan asked me about these risks, especially in women her age. She had seen other countries reporting an association and advising against the vaccine for this demographic. The link between the AZ vaccine – the only COVID-19 vaccine available in Palabek at this time – and blood clots, was being discussed in high-income countries, with many changing their vaccination policies to alternative vaccines, especially for younger people (Public Health England, 2021). In Palabek, AZ was the only vaccine type available and was recommended for everyone over the age of 18 years.

Susan's concerns were further complicated by the fact she believed "we don't have corona here". Weighing up abstract risks of the vaccine, with no lived experience of COVID-19, was challenging, especially when there was an underlying premise that what was considered avoidable in some high-income countries for young women due to safety concerns, was still advised for young women in Palabek, because it was the only vaccine available. The inequities of this were not lost on Susan.

There were also fears that the vaccine interfered with fertility. Fears or 'rumours' of sterilisation effects of vaccines and other pharmaceuticals or food aid has been well documented in sub-Saharan Africa, both in colonial and post-colonial periods. (e.g. Feldman-Savelsberg *et al.*, 2000; Parker and Allen, 2011; White, 2000). In Palabek, an Acholi Pastor from South Sudan told me:

> "[In] other countries, they restrict numbers of children. White people want us to reproduce less … they will use the vaccine … when they inject, it can stop you reproducing … white people, they are lacking places … they want to bring their ideology here, but they need to reduce (us) …".

The sterilisation effect of the vaccine is explained in terms of population control to address global overpopulation. I was told people in Western countries were running out of land, and so would be looking to come and re-settle in Africa, where they would then want to control African people, to allow white people to populate the area. These conversations resonate with colonial histories but also reflect new discussions related to climate change and population growth. For both associations, there is an underlying suspicion of white people exerting power and control over people in Africa in order to gain an advantage for the former, at the expense of the latter. The next section explores this in more detail.

The Business of Vaccine Development and the Supernatural in Everyday Life

Interlocutors in Palabek were suspicious that different countries across Europe and China were making their own vaccines, rather than working together. Indeed, the speed at which COVID-19 vaccines were developed and the significant competition between pharmaceutical companies and their national affiliations, was in stark contrast to integrated routine immunisations, with the later being far less politicised. By way of illustration, I spoke to a group of four men, aged between 21 and 31 years old, in June 2021. They were all Acholi refugees from South Sudan, with reservations about the vaccine. One was unemployed at the time, one was a carpenter, and two were students (with one proceeding to university during fieldwork). They described how they thought "corona" had been made intentionally by a doctor in a laboratory as a biological weapon, and that it was a "disease made by humans", chiming with alternative theories surrounding HIV in Africa (e.g. Rödlach, 2006). They went on to emphasise the business of COVID-19 vaccines:

> "They do that as a business because they know that people will fall sick and (then) they will supply the vaccine …. superpower countries are taking this as a window of opportunity and that's why they have made it a competition amongst themselves …"

Explaining the scepticism he witnessed among people in Palabek towards the vaccine, one of these young men explained; "… they are confused and they don't know the right one (vaccine) to use … so it's only the World Health Organization … recommending a vaccine that can be used by the whole world".

Wider geopolitical dynamics regarding vaccine manufacture directly play out in these accounts. The market competition to develop vaccines amongst powerful countries places the vaccine in a suspicious space, where COVID-19 vaccines are sold to accumulate wealth and power, in response to COVID-19 which was developed exactly for this purpose. There is little recognition of the donation of vaccines as philanthropic. Rather, people recognised the potential of the African market, claiming "corona was made so they can sell the vaccine to Africa". Furthermore, these interlocutors were familiar with international public health architecture and the role of organisations such as the WHO, who call for greater equity in global health. The failure of egalitarian aspirations such as COVAX to provide equitable access to vaccines, with market forces taking precedence, is clear.

The financial dimension of vaccine development adds to the suspicious nature of COVID-19 vaccines, illustrated by the spiritual dimensions of those who live underwater (*te pii*), as described in this section. The COVID-19 vaccine was considered by Acholi interlocutors to have been developed by those involved with *jok*, originating from a satanic group who practice witchcraft. These satanic people are related to those that live underwater. A 22-year-old South Sudanese refugee, who was employed as a healthcare worker in Palabek, explained the vaccine and this satanic underwater realm:

> "people are saying the vaccine is from underwater and if you have the vaccine, you will have 666 on your forehead … 666 is a sign of Satan …"

The idea of an underwater realm connected to evil or malevolent forces has been documented amongst Acholi (Allen, 2015). Victor (2019) writes of *lute ceto pii* (those who go under water) in relation to witchcraft or spirit attacks amongst Acholi school children, and describes those who go underwater as a 'a category of devil worshippers thought by many Ugandans to be the source of ill-gotten wealth, power and fame, to cause misfortune … ' (p. 385). In a biography of an Acholi evangelical Pastor in South Sudan, O'Byrne (2021) provides a detailed description of the occult economies of underwater cities inhabited by demons who trade in the souls of people for power and wealth. The author writes: 'In return for the souls of the innocent, satanic powers flow up from underwater cities in the demon world to those on earth who trade people for worldly success … evil is repaid with status, power, and wealth' (O'Byrne, 2021, p. 138). Indeed, my research assistant explained to me the links between evil forces, underwater, and accumulation of wealth.

> "Here we believe evil come from underwater. There are different types of evil. Like people getting rich through evil ways, like sacrificing [your] son or daughter. If you do something evil then they say you are from underwater."
>
> I probed further, asking for further examples of evil.
>
> "Getting rich without having a business, or without people understanding how you get there. Other people take years to get rich. So you have [to] use evil ways, like sacrificing someone …."

Here the connections between evil, wealth and sacrifice are revealed. Gifts can be used to obscure sacrifices, with the beneficiary of the gift instead being the entity of exchange (O'Byrne, 2021). This helps to understand the suspicious business of COVID-19 vaccines (or indeed humanitarian assistance more generally), when provided by inconsistent altruistic donations. The connections between the global pharmaceutical industry and its development of COVID-19 vaccines and those who go underwater are thus clear. Interlocutors did not outrightly describe pharmaceutical companies in China or the USA going under water. Rather, the vaccine was more generally associated with evil forces from the underwater realm, combined with an understanding that riches (including from vaccines) are obtained through engagement with malevolent forces and harming others.

These considerations of the underwater realm provide an articulate means of understanding the suspicious business of COVID-19, capturing the global dynamics of money and power.

Discussion

By foregrounding understandings of suspicious business among Acholi living in Palabek, this article has problematised the disconnection in global health discourse of vaccine supply and hesitancy debates, and highlighted the central role of politics in shaping COVID-19 vaccine uptake. In common with scholars writing about vaccine hesitancy in other low- and middle-income countries (Butter and Knight, 2023), it has shown the limitations of vaccine hesitancy. Deficit models and static notions of trust, mistrust, and culture fail to capture how COVID-19 vaccines came to be understood in Palabek, emphasising the need to historicise and politicise understandings of trust in relation to the COVID-19 vaccine (Storer and Anguyo, 2023). Instead, the emphasis on vaccine hesitancy has diverted attention away from the important political dynamics of (the business of) global vaccine supply, historical encounters with colonialism, and the way in which (the business of) humanitarianism acts as a neo-colonial replica of unequal power dynamics (Parashar and Schulz, 2021) - all of which clearly shaped COVID-19 vaccine uptake in Palabek.

Identifying the limitations of vaccine hesitancy and foregrounding the broader politics shaping demand for vaccines matter. The ethnographic vignette presented at the beginning illustrates how current approaches to COVID-19 community sensitisation are woefully inadequate to address vaccine uptake, captured in Isaac and Peter's lack of enthusiasm for implementing such policies. Furthermore, mainstream public health research, key policy documents, and the ways they are embodied in practice, are imbued with a sense of some knowledge being superior to others. The problem to be rectified is misleadingly located in the 'beneficiaries', at the expense of confronting the unconformable wider geopolitical dynamics that shape the issue. As de Waal (2022) has argued, the current mainstream public health discourses regarding pandemics allow the perpetuation of practices that (unintentionally) propagate these unequal power

dynamics, leaving little room to meaningfully consider alternative framings of the problem and the solution.

Mainstream debates surrounding vaccine supply are also problematic. The ethnographic findings presented here demonstrate that inconsistencies related to vaccination supply and distribution cannot be considered purely in relation to debates regarding the challenges of global vaccine equity but are embodied in everyday understandings of the vaccine. Geopolitical dimensions, so easily side-lined as background 'context' in policy documents, are not lost on the people of Palabek, and these wider contextual dimensions were deeply intertwined and inseparable from personal perspectives and understandings of the vaccine itself, resonating with previous anthropological contributions to the study of vaccines (e.g. Closser *et al.*, 2016; James and Lees, 2022). However, the findings presented here through suspicious business uniquely demonstrate how the dynamics of a refugee setting interrelate with vaccine uptake: the biopolitical nature of firstly the refugee settlement, and secondly COVID-19 vaccination, each enhance the visibility of the other. These can be seen even more clearly through this focus, not least because it foregrounds spiritual dimensions. Suspicious business reveals how vaccine supply inconsistencies, wider health inequalities, fears of blood clots and infertility, colonial legacies, WHO policy, demonic transactions, geopolitical dynamics of vaccine development and perpetual war and displacement are inseparable dynamics of vaccine uptake.

Particularly pertinent spiritual considerations were captured in the underwater realm where 'demonic power flows alongside global wealth' (O'Byrne, 2021, p. 146). COVID-19 vaccines involved large sums of money between global powers, but they were provided to people in Palabek as humanitarian assistance. In a setting with a high burden of infectious diseases causing significant illness and death, COVID-19 was not perceived to be a legitimate health threat. Furthermore, the vaccine supply was inconsistent, and life was already shaped by a refugee system fraught with corruption and dwindling support (Titeca, 2023). So perhaps, as the interlocutors here outline, there was an ulterior motive, and the vaccine was not a gift but rather the beneficiary of the vaccine was the object of sacrifice, with vaccine threats of blood clots and sterilisation working to curb population

growth for the benefits of those with wealth and power, who are working with malevolent forces underwater (O'Byrne, 2021). This chimes with their experiences of the business of refugees, and with historical legacies of colonialism, and the current geopolitics of poverty. Vaccine uptake was inseparable from its biopolitical context that continued to perpetuate the same unequal dynamics of power and control that kept wealth circulating amongst certain powers, whilst others face worsening precarity but remain perpetual recipients of humanitarian assistance and global health intervention, with little prospect of meaningful change. The material dimensions, geopolitical power and supernatural forces are inseparable. They directly collapse public health debates that separate unseen wider forces from the visible material world. This central argument was made visible by exploring the spiritual dimensions of vaccine uptake, a dimension neither appreciated in public health discourses, nor by anthropological contributions such as the vaccine anxieties framework which only focus on bodily, social and political aspects (Leach *et al.*, 2022b). By exploring suspicious business, this article has illustrated the deeply interconnected nature of political, material and spiritual elements in expressions of vaccine anxieties, in stark comparison to understandings of, and utilisation of (mis)trust, as employed by global health actors.

Conclusion

This article uses Acholi understandings of suspicious business to explore the historical, socio-political, economic and spiritual dynamics shaping the uptake of COVID-19 vaccines among South Sudanese Acholi refugees in Palabek. Whereas dominant models in public health may have labelled the views of interlocutors described here as mistrust, suspicious business has in fact revealed a far more nuanced understanding, which emphasises the interconnections of material, spiritual, and political dynamics. Such an approach, which foregrounds Acholi cosmology, demonstrates that spiritual dimensions are not simply a 'cultural factor' to be tackled. Instead, they reveal the importance of not underestimating the powerful and far-reaching effects of historical and current forms of inequality and exploitation that cannot be side-lined in public health interventions. The spiritual realm demonstrates that if the politics of vaccine uptake, and in this case also displacement, are not addressed, then other public health efforts become obsolete. In

short, foregrounding suspicious business helps to move beyond stable notions of (mis)trust as objects of public health intervention, and instead emphasises the importance of understand dynamics of vaccine uptake as a fluid state of constant negotiation, including material and spiritual dimensions, that needs ongoing attention to maintain a delicate equilibrium. This brings flexibility to the fore: interlocutors were not fixed in their understanding of the vaccine, but rather, as they do with other aspects of life, constantly incorporate evolving dynamics. This potential to incorporate new perspectives is useful for the public health goal of improving vaccine uptake. These shifts are unlikely to be achieved through community sensitisation, however, but rather require attention to the wider geopolitical dynamics inherent to suspicious business.

Chapter 8: Counting (and not Counting) Cases of COVID-19

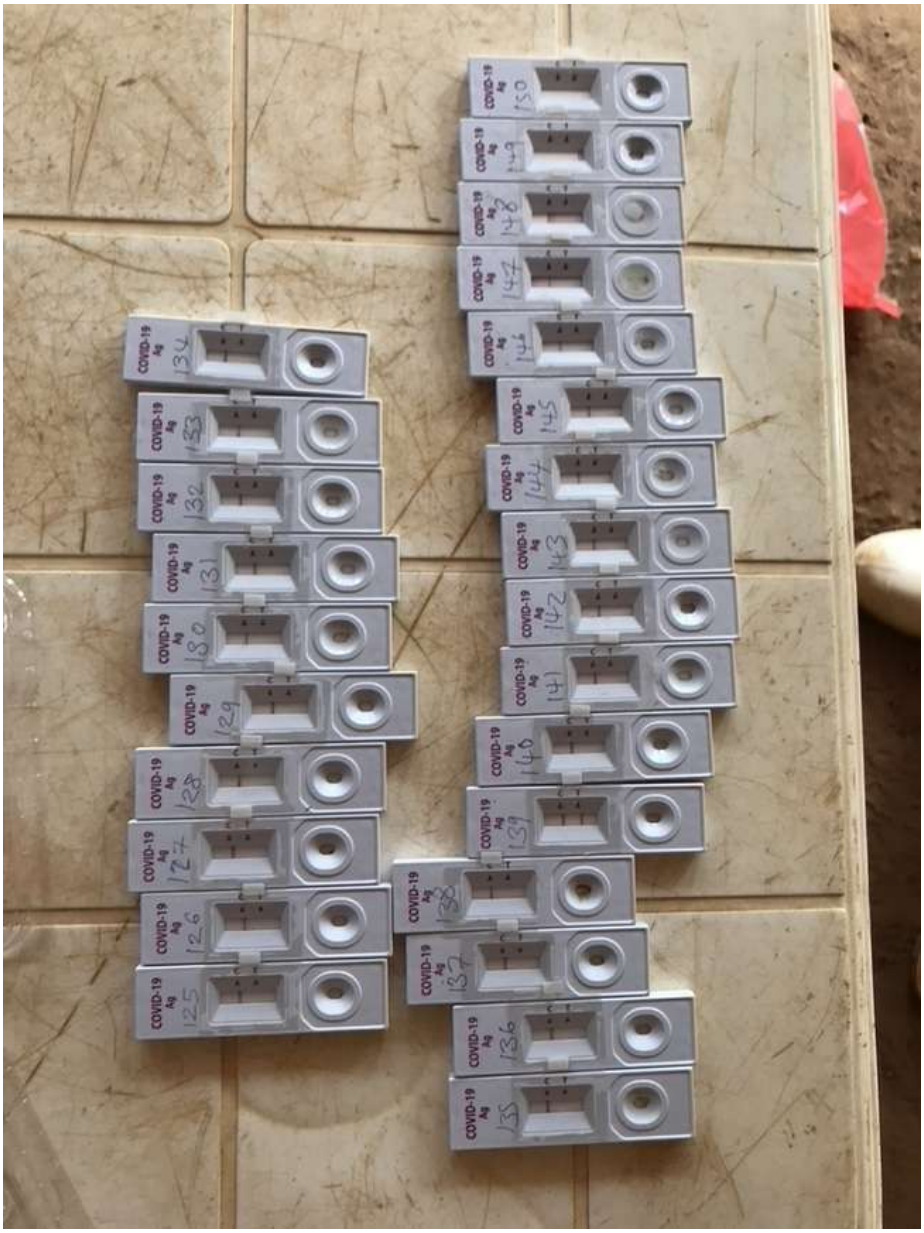


Figure 48. Labelling COVID-19 tests in the reception centre whilst participating in the screening of new arrivals.

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?			
When was the work published?			
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*	Choose an item.	Was the work subject to academic peer review?	Choose an item.

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	Journal of Refugee Studies
Please list the paper's authors in the intended authorship order:	Sophie Mylan

Stage of publication	**Undergoing revision**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	N/A - single author

SECTION E

Student Signature	[redacted]
Date	12th December 2024

Supervisor Signature	[redacted]
Date	13th December 2024

Article Title: Mediating Tensions between Care and Control - An Ethnographic Exploration of Counting (and not Counting) COVID-19 amongst Refugees in Uganda

Under peer review in the *Journal of Refugee Studies*.[22]

Author: Sophie Mylan

Abstract

There is a long-standing tension in humanitarian work between care and control. This is reflected in current debates which juxtapose humanitarian ideologies to relieve suffering, with the biopolitical administration of refugees. Numbers play a central role, and they are widely recognised as a technology of control within refugee settings. This article shifts the focus from the numbers produced to the practice of counting. Drawing on 14-months of multi-sited ethnographic research, it analyses why COVID-19 cases were counted among refugees in some contexts, but not others. Irrespective of the numbers produced, the practice of counting (and not counting) COVID-19 cases was shaped by social and political logics and served important purposes. Whilst mobilising humanitarian ideologies and rhetorics of care, counting was actually more about the control of dangerous 'others'. Simultaneously, practices of counting on the front-line, which visibly control the movement of people, were in-fact important relational moments of care.

Introduction

> '…numbers can deceive…They appear as seemingly neutral bearers of truth. They offer a sense of mathematical precision, making things seem more certain than they actually are and displacing attention away from the conditions under which they were produced' (Caduff, 2020, p. 473).

[22] This paper was subsequently rejected for publication after peer review in 2025.

Critical social scientists, such as Carlos Caduff, have problematised the reliance on, and superiority of, numbers. This includes the role of numbers in humanitarian settings (Agier, 2011; Harrell-Bond *et al.*, 1992). Critiques focus on what numbers mobilise or obscure, and how they become entangled with processes to control refugees. However, minimal attention has been given to the actual practices that generate these numbers i.e. counting. This article draws on long-term ethnographic research which followed the counting of COVID-19 cases among refugees in a settlement in Uganda. It asks, why was so much effort put into counting COVID-19 cases among newly arriving refugees? Conversely, why was no effort put into identifying cases of COVID-19 among established refugees, some of whom were moving to and fro across the international border during the same period that new refugees were arriving? More generally, what do selective practices of counting reveal about the relationships between those counting and being counted? Do they shed any light on the tensions between care and control in refugee settings and humanitarian assistance more broadly?

The article begins with an overview of the literature regarding numbers, care and control in humanitarianism and public health. This is followed by a description of field sites and research methods in Uganda. Assemblage thinking is then introduced, which is drawn upon throughout this article, to highlight the range of elements that come together in counting COVID-19. Next, ethnographic data are analysed to explore different dimensions of counting, both in relation to COVID-19 and refugees. By following counting from a settlement inter-agency meeting, to the material and often mundane day-to-day elements, and then to district, national and international political narratives, counting COVID-19 is found to have a multiplicity of logics, with social and political elements intertwined with a biomedical rationale. In so doing, the seemingly contradictory policies of screening all new arrivals for COVID-19, without aligned testing for established refugees making similar journeys, or concurrent isolation practices, can be understood in terms of the social and political work that counting COVID-19 is doing, and the entangled relationship between counting refugees and counting COVID-19. This, in turn, demonstrates that while numbers are deeply connected to control, the practice of

counting involves a complex interplay between both care and control for those on the front-line.

Numbers, Care and Control

Two strands of literature are highlighted in this section. Firstly, the tensions between care and control in refugee settings and humanitarianism more generally are outlined. Secondly, attention is drawn to scholars who have described the problematic nature of numbers and numerical indicators, and how they can be used to control certain groups of people.

Care and Control in Refugee Settings

The nature of control in humanitarian settings has been extensively theorised (e.g. Fassin, 2012; Malkki, 1995a; McConnachie, 2016), and typically draws on the biopolitical dimensions of refugee administration, while also situating camps in a wider context of disciplinary forms of governance (Foucault, 1994). Agamben (1998, 2000) describes migrant states of exception, where emergency powers become the normative form of power and control, in combination with 'bare life', where only biological existence is considered. COVID-19 sparked renewed interest in states of exception, with suspensions of rules of law justified by the pandemic. Spengler *et al.*, (2021) expose a different perspective for those forcibly displaced:

> 'for refugees in camps around the globe…COVID-19 does not really present a 'new' state of exception. In fact, it has only aggravated – but thus also made visible – the constant state of exception…' (p. 128).

Discussions of control have been juxtaposed with notions of compassion and care that are central to humanitarian ideology, creating a contradiction at the heart of refugee camps, with a core tension between 'care and control' (Malkki, 1995a, p. 498). McConnachie (2016), in her historical analysis of the genealogy of refugee camps, draws attention to the use of displaced persons camps across Europe to care for those fleeing Nazi concentration camps, writing that 'at the very height of camps as spaces of cruelty, they were adopted as spaces of compassionate humanitarianism' (p. 404-405). In the

ethnography *Managing the Undesirables*, Agier (2011) explores humanitarian government in multiple refugee camps, highlighting how despite providing aid and shelter, they also control mass-scale movement, choose who receives support and who does not, confining and separating those considered foreign. He writes, 'Humanitarian intervention borders on policing. There is no care without control' (p. 4).

Beyond refugee camps, this tension between care and control is found in the principles of humanitarianism more generally. To quote Barnett (2013): 'Humanitarian governance exists only because of the existence of compassion, care, and concern for others. The desire to emancipate and protect the welfare of others can also lead to new forms of domination and configurations of power' (p. 394). In *Humanitarian Reason*, Fassin (2012) explored this contradiction in terms of compassion and repression, writing that 'humanitarianism has become a language that inextricably links values and affects, and serves both to define and to justify discourses and practices of the government of human beings' (p. 2). Care and control are by no means separate entities, and forms of technology or data in humanitarian governance can further blur such distinctions (Jacobsen and Fast, 2019).

The Power of Enumeration

Numbers play a central role in control. In situations of mass forced displacement, the first question to be asked is 'how many refugees?' Harrell-Bond *et al.*, (1992) elaborated: 'Since the time international humanitarian agencies became involved in assisting refugees in developing countries, this seemingly entirely reasonable requirement – the need to count the refugees – has, to a significant extent, dominated policy, planning, implementation and evaluation' (p. 206). Similarly, Crisp (1999) wrote: 'It is almost impossible to think or write about refugee-related issues without some reference to statistics' (p. 2). The focus on numbers and the question of size has undoubtedly shaped the way refugees and humanitarian responses are conceptualised (Edwards, 2013). Often the focus of such enumeration surrounds processes of registration, where 'total populations' can be estimated (Telford *et al.*, 1997). Numbers powerfully define so-called refugee populations and allow the allocation of aid.

The reliance on numbers in humanitarian assistance generates contentious questions: Are the numbers reliable? What do numbers mobilise? Do they obscure other important realities? Scholars and practitioners have described the difficulties in generating reliable statistics in humanitarian settings, and also the politics of enumeration. In '"Who has counted the refugees?" UNHCR and the politics of numbers,' Crisp (1999) highlighted the operational and definitional challenges of collecting accurate statistics about refugees. He also drew attention to the way in which political dynamics shaped the collection of statistical data at different levels in 'the international refugee regime'. Similarly, Harrell-Bond (1992), described 'the requirements to enumerate refugee populations' as a process that led to 'oppressive practices in refugee assistance forming part of an "ideology of control"' (p. 205).

Running parallel to discussions in refugee studies about the use of numbers as a form of control, scholars specialising in global health have highlighted geopolitical dynamics and discourses influencing the production and utilisation of metrics (e.g. Adams, 2016). In the broad sphere of epidemic preparedness and response, numbers are embodied in practices of screening and disease surveillance (Ratnayake *et al.*, 2020; Van Boetzelaer *et al.*, 2020). Critiques question the purported objectivity and transparency of quantitative evidence in global health, suggesting it can misleadingly side-line socio-political dynamics shaping both the production and interpretation of statistical data (Rottenburg and Merry, 2015; Tichenor, 2017).

Specific technologies, such as purportedly 'neutral' statistical 'indicators', in fact represent the values of transnational actors (Gorsky and Sirrs, 2017). Sally Engle Merry's book, *The Seductions of Quantification* (2016) foregrounds the importance of numerical indicators such as country rankings, to satisfy processes of accountability in relation to measuring human rights, gender violence and sex trafficking. Using ethnographic research, the author highlights the problematic use of numerical knowledge in trying to capture complex social phenomena. Merry describes how indicators are produced in specific socio-political contexts, but are then distributed elsewhere, thereby becoming decontextualised from local systems of meaning. This is an important contribution to

literature that explores the social and political ramifications of quantitative data, to question their purportedly neutral, objective and transparent features.

In short, numbers are anything but neutral, revealing only partial social realities. Despite the wealth of literature critiquing the reliance on numbers and their biopolitical nature, there has been less attention given to the practice of counting. Here, counting is analysed as an assemblage of people, processes, material objects, social relationships, and political influences. Rather than exploring what numbers obscure or reveal as they try to represent social phenomena, it looks at the *practice of counting itself*, as a social and political phenomena.

Focusing on the practices of counting, rather than the numbers that have been produced, also provides an opportunity to better explore the tensions between care and control. Drawing on ethnographic research in a refugee settlement in Uganda during the COVID-19 pandemic, this article explores the practices and processes of counting COVID-19 cases among refugees in different situations. Particular attention is given to the seemingly mundane material elements involved in the dynamics between those counting and being counted, and how this is influenced by political dynamics.

Field Sites, Methods and Analysis

Fourteen months of multi-sited ethnographic fieldwork was carried out in and around a Ugandan refugee settlement between 2021 and 2022, during the COVID-19 pandemic. During fieldwork, the settlement was occupied by refugees from South Sudan and Democratic Republic of Congo, some of whom had been living in the settlement for years, whilst others arrived during fieldwork. The specifics of this settlement have not been included to protect the anonymity of key interlocutors and it is therefore referred to as ‘the settlement’. It is important, however, to understand Uganda’s national refugee policy.

Uganda has an ‘open-door policy’ to refugees (Momodu, 2019). Most of these refugees are residing in settlements in northern and western districts. The Office of the Prime Minister (OPM), a branch of the Ugandan government, is responsible for the

administration of the settlements, supported by UNHCR. In May 2022, OPM and UNHCR published the Inter-Agency Uganda Country Refugee Response Plan (UCRRP), stating that: 'Uganda has long been a global leader in its approach to peaceful co-existence and local settlement of refugees with the host communities…' (2022a, p. 6). Such documents foster the perception that Uganda has 'one of the most progressive refugee policies' worldwide, and usefully promotes UNHCR's flagship Comprehensive Refugee Response Framework (CRRF). However, 'in February 2018 the image of Uganda as a role model was marred when journalists revealed that the country's refugee response was riddled with large-scale fraud' (Titeca, 2021, p. 2). Registration was the focus of controversy, including concerns regarding the exaggeration of refugee numbers, diversions of food aid, and the 'buying and selling of refugee registration' (Ogeno and O'Byrne, 2018). Titeca (2021) pointed out that corruption was enabled by 'mutual dependency' between the Ugandan government and international community. To quote:

> 'While the Ugandan government relied on aid from the international community, the international community had interests in the success story as proof that their policies work (for the United Nations High Commissioner for Refugees), and in response to the European migration crisis (for bilateral donor governments)' (Titeca, 2021, p. 1).

During fieldwork, life in the settlement was described by refugees as precarious, with reduction in food rations, inadequate livelihood opportunities, and uncertain futures associated with the ongoing reliance on the 'hospitality' of their host country. The implementation of national lockdowns to contain COVID-19 restricted access to income-generating and educational activities, with schools essentially closed for two years. Reflecting changes in their international funding, most non-governmental organisations (NGOs) shifted their activities in the settlement to a focus on COVID-19 activities. However, direct COVID-19 deaths and severe disease in the settlement were rarely reported by refugees and humanitarian employees alike.

A multi-sited ethnographic approach was essential for this research, using long-term engagement to establish in-depth understanding of social phenomena. Ethnography is the hallmark of anthropological approaches to research and is about more than a set of

research methods, being better understood as an overall approach to enquiry. Janmyr (2022) wrote that 'ethnography pays particular attention to everyday lived experiences and struggles, thereby capturing the complexity of important empirical issues' (p4). For instance, Barbara Harrell-Bond's seminar book *Imposing Aid* (1986), used ethnographic methods to highlight the importance of not only studying people who were displaced, but also the organisations, structures, politics and policies involved in providing them assistance. Furthermore, multi-sited ethnography does not simply refer to multiple geographical sites. Marcus (1995) explained the nature of multi-sited ethnography: 'Ethnography moves from its conventional single-site location, contextualised by macro-constructions of a large social order, such as the capitalist world system, to multiple sites of observation and participation that cross-cut dichotomies such as the "local" and the "global", the "lifeworld" and the "system"' (p. 95). The research presented in this article draws on this understanding of multi-sited ethnography, to reveal the various elements of counting COVID-19, moving through different sites of observation, and paying attention to how this relates to broader socio-political dynamics.

My ethnographic methods included semi-structured interviews and participation-observation with refugees, humanitarians, and government employees. Two research assistants helped recruit interviewees and assisted with translation. Living in the settlement with a family from South Sudan, I participated in daily life, such as cooking, cleaning the compound, playing with children, collecting water and chatting to neighbours. Time was spent with humanitarian actors as they went about their usual tasks. I followed actors and ideas to towns close by, and further afield to the capital, Kampala. I had a base in a nearby town, where larger regional NGO offices were located. I attended COVID-19 related meetings in the settlement, and at district and regional levels. Informal discussions and formal interviews were sought with key public health and humanitarian actors working in the settlement, and at district and national headquarters. This included employees of the Ugandan National COVID-19 taskforce, UN agencies and NGOs. During private discussions, the inherent tensions between controlling and caring for refugees came to the fore. Openly discussing the politics of the response, and critiquing the current humanitarian system in relation to the management of both COVID-19 and refugees in Uganda, would not have been possible without

ensuring the anonymity of interlocutors. I have ensured their perspectives cannot be associated with a particular agency or individual by changing personal and contextual dimensions of the research presented here.

To analyse ethnographic data collected during fieldwork, the article draws on assemblage thinking to explore, as Rhodes and Lancaster (2022) have, the social and political conditions under which numbers are produced during pandemics. It also builds on those using assemblage thinking to understand the biopolitical nature of the migration crisis (e.g. Wiertz, 2021). Using assemblage thinking in this way will reveal important elements of the practice of counting, which in turn will uncover significant socio-political dynamics, that would otherwise remain less visible. Assemblage thinking helps to analyse an ever-changing social world, and the multiple ways in which actors, processes and organisations relate to one another. It has been extensively applied to health research (e.g. Davis and Sharp, 2020; Duff, 2014). Within an assemblage, attention is paid to the entanglement of human and non-human or material elements, and the constantly evolving and unfolding relations between them (e.g. Gan and Tsing, 2018; Law, 2004). Müller and Schurr (2016) highlighted the importance of 'the socio-material, i.e. that the world is made up of associations of human and non-human elements (p. 217)'. As connections between these elements erode in one place, others begin elsewhere. The constantly moving, coming apart and then back together nature of assemblages, takes work. Inherent to assemblages, is multiplicity: the things we research have multiple logics (Ong and Collier, 2005). Erikson (2012) writes 'statistics enable other things of value' regardless of a 'hollowness in the numbers' (p. 373). Building on these insights, this article explores the multiple practices and subsequent performances of counting from the material day-to-day elements of screening for COVID-19 and registering refugees, through to district and national narratives. It particularly draws on the work of Law and Singleton (2000), who write:

> 'Performances are material processes, practices, which take place day by day and minute by minute. Since performances are specific, this also leads to multiplicity, so that what appears to be one thing…may be understood as a set of related performances' (p. 775).

Taking such an approach does not render biomedical logic pointless! Public health endeavours to count the number of cases in outbreaks are essential. So, too, is the attempt to create an evidence-base to inform public health practice in refugee settings. However, in mainstream discourse regarding epidemics, counting is usually presented in terms of its numerical 'worth'. By contrast, the ethnographic research presented in this article demonstrates that there are other logics at work. It captures particular moments during a pandemic when considerable emphasis was placed on counting, despite a relatively small number of COVID-19 cases in a refugee settlement, with little associated severe illness or death. Echoing Eriksen (2012), counting allowed a multitude of logics to flourish, enmeshed in a nexus of political, social, biomedical and humanitarian influences. This usefully reveals tensions between care and control.

Findings

This section outlines three central areas of ethnographic data regarding COVID-19 screening, thereby following different elements of the counting assemblage. Firstly, ethnographic observations from a settlement inter-agency meeting are presented to demonstrate an important performative dimension of counting COVID-19. In so doing, it reveals a central element of the counting assemblage: the contingent nature of counting COVID-19 and counting refugees. Understanding these contingent elements sets up the subsequent sub-sections, which reveal more about care and control. The second sub-section focuses on the material elements of counting, highlighting the social relationships that shape, and are shaped by, counting, whilst the third sub-section details the political dimensions of counting.

The Contingent nature of Counting COVID-19 and Counting Refugees

In September 2021, I attended one of the regular interagency meetings in the settlement headquarters. These events brought together key humanitarian actors. It was chaired by OPM staff who sat on a head table, along with members of the UNHCR team. I sat with other NGOs on rows of wooden benches. These NGOs were generally accountable to the actors on the head table, as well as their respective organisations' in-country and

international offices. An employee from the head table opened the meeting, providing an up-to-date account of recent counting activities in the settlement.

> *We still have new asylum claims…zone 6 is still open and new people are being settled there… the population is 78, 128…In South Sudan there is still fighting…though the borders are closed officially, people find themselves here, they are seeking asylum, we cannot refuse them…*[23]

After the initial introductions, the lead NGO for health took over.

> *There are 129 active cases of COVID at a district level…the cumulative number of cases in the settlement is 172, with 112 of these in refugees…*

He went on to give a detailed account of all the active COVID-19 cases and described how new arrivals were screened before gaining access to the reception centre. The COVID-19 screening of all new arrivals, alongside the testing of symptomatic people in the settlement health centres, revealed a steady number of new cases. A member of the head table explained the policy:

> *We have a duty to receive people…we have agreed with our health partner that they should first be tested. When they are allowed inside, then they can be registered and given land.*

Most meetings that I attended during the COVID-19 pandemic started with a similar summary to this one, demonstrating the paramount importance given to the counting of refugees and cases of COVID-19. The more important the meeting, the longer the numerical description. Furthermore, it can be seen how counting COVID-19 amongst new arrivals became integrated into the system of humanitarian assistance, becoming a focal point of care for new refugees. These counting practices were intended to protect Ugandan nationals and refugees already living in the settlement from the potential threat of COVID-19 associated with new arrivals.

Before the pandemic, new arrivals were registered at reception centres or transit points at the official border points between Uganda and neighbouring countries. In March 2021, a national COVID-19 lockdown was declared in Uganda closing the international border

[23] Quotes from fieldnotes are indicated with italics. Quotation marks indicate verbatim transcription. Exact numbers have been changed to ensure anonymity.

points receiving refugees and the border reception centres. But refugees continued to arrive. Utilising 'porous borders', they avoided the official entry points, and made their way directly to the settlement, arriving, to the dismay of OPM, directly on their doorstep. They congregated under some large trees near the humanitarian headquarters, which happened to be opposite the settlement's on-site reception centre.

Under these trees, people could often be found cooking and chatting. Over the coming weeks the number of people staying under the trees grew, and sometimes reached several hundred as they waited to be moved into the reception centre. Once their presence was officially recognised, counting would begin. But before being officially recognised, their presence in the settlement was officially unknown, despite being clearly visible to the naked eye.

Under the trees, people stayed in close proximity to each other and mixed freely with those in the main trading centre, located near the reception centre. The trading centre was bustling with shops and small restaurants regularly visited by humanitarian actors for lunch, and a daily market, serving both Ugandan nationals and refugees.

Humanitarian actors were tasked with providing mandated care to these new people, which, in turn, involved formally registering them as refugees. However, COVID-19 added a complication. The humanitarian actors also needed to consider the 'risks' of COVID-19 transmission associated with the movement of people they were soon to register, and so a plan was made to screen them all for COVID-19 on arrival. Those who tested positive were taken to an off-site isolation centre approximately 40 kms away.

As I sat in the interagency meeting, I became increasingly confused. I raised my hand and was given permission to speak. By the time new arrivals are tested for COVID-19, I asked, haven't they already been staying under the trees for some time, mixing with nationals and other refugees? There was a rather uncomfortable silence. This indicated that no-one wished to publicly acknowledge that any virus carried by these people was free to spread with little mitigation measures in place. It was an important public secret (Geissler, 2013; Taussig, 1999). This remained a secret because it undermined the

practices of care for both refugees and Ugandan nationals, essentially allowing cases of COVID-19 to spread.

In contrast to the screening of new arrivals, the movement of other refugees already living in the settlement across international borders was not associated with COVID-19 screening, despite this movement being rather common. Many refugees made regular journeys back to their country of exile or the border areas, to farm (O'Byrne and Ogeno, 2021). In the settlement, refugees were given a 30 by 30 metre plot for their homestead and small-scale cultivation. More extensive farming was challenging. Additionally, during fieldwork, food rations were 60% of what they had been two years previously. In this context, cross-border farming was a means of survival.

The movement of settled refugees back to their country of origin was fleetingly commented on in an oral report by a livelihood partner at the interagency meeting. However, the reply below from a member of the head table reveals that what is accepted as common knowledge in more private spheres, cannot necessarily be commented on publicly in official meetings.

> *Do we have evidence people are moving back to South Sudan? Is this voluntary repatriation? If you have evidence, then please share it but if you don't then please don't say so. What I know, here in Uganda, people are free to move. They can go to Arua to see friends, maybe they are going to see relatives in Kiryandongo [both locations in Uganda].*

Such comments demonstrate how unofficial movements are difficult to acknowledge publicly, given that refugees fleeing a country are not usually permitted to return to their country whilst maintaining their refugee status. In private spheres, humanitarian actors acknowledged that such movement was essential for survival and hence ignored on 'humanitarian grounds' or was considered consistent with policies of self-reliance.

These settled refugees were not screened for COVID-19 on their return to the settlement. Just as the movement of settled refugees at this inter-agency meeting was not acknowledged, counting COVID-19 related to this movement did not occur. COVID-19

testing only happened if established refugees presented to one of the settlement health facilities with suggestive symptoms. This contrasted significantly to the asymptomatic screening of all new arrivals, despite both groups making similar journeys through porous borders to Uganda. The movement of established refugees was not considered to be a threat in relation to COVID-19 transmission.

How were the different approaches to counting COVID-19 among new arrivals and established refugees rationalised among humanitarian personnel? One interlocutor working in public health explained the policy in terms of established refugees only going 'just over the border' to farm, where there were no concerns about different COVID-19 variants - the people resident there were considered to be almost the same as those in the settlement. By contrast, he thought the new arrivals were coming from further afield and posed a greater threat in terms of bringing new COVID-19 variants into the settlement. Conversations with refugees, however, suggested that despite informing officials that they were going to farm in the borderlands, in practice they also travelled further afield to cities such as Juba to seek economic opportunities.

COVID-19 testing was generally accepted by refugees but there was still significant suspicion regarding its entanglement in the wider humanitarian apparatus of the settlement (Mylan, 2024). Life was hard with inadequate food rations, infertile soil, long queues at the health centre, few teachers, and uncertainty about the guaranteed invitation to stay in Uganda despite ongoing violence in their country of origin. The humanitarian system (and COVID-19 activities) did offer, although impermanent and sometimes suspicious, a degree of safety amongst such ongoing precarity.

Thus far, perspectives from humanitarian actors at an interagency meeting have revealed settlement policies for counting COVID-19 cases based on biomedical logics about containing the disease. This has been juxtaposed with the realities of the implementation of these policies, from ethnography with refugees themselves. The counting of COVID-19 cases in different scenarios reveals seemingly illogical testing policies. However, when understood in relation to maintaining public secrets, the wide range of logics coming together in regard to counting COVID-19 becomes clearer, as is the contingent

relationship between counting refugee movements and counting COVID-19 cases. The presentations of numbers of refugees and cases of COVID-19 were important at the interagency meeting. I argue, however, that the importance of these numbers did not come from their numerical values. Instead, it was the fact that the practice of counting was occurring that was important. Counting worked to perform the official story regarding refugee movements, both in terms of when new arrivals could be officially seen, and the permanently unseen movement of established refugees. To understand why this was the case, it is helpful to analyse other elements of the counting assemblage. The next section, therefore, focuses on the seemingly mundane material elements of counting COVID-19 and counting refugees.

The Material Elements of Counting COVID-19 and Refugees

It was a hot day in February 2022. I joined healthcare workers in the formal reception centre screening new arrivals for COVID-19. They arrived carrying boxes of personal protective equipment (PPE), rapid diagnostic tests (RDTs), and a hefty supply of drinking water and biscuits. We put on the PPE, with the aprons, gloves, face masks and face shields generating significant heat, in addition to the dry season temperatures approaching 40 degrees Celsius. As the day progressed, and sweating profusely, we were grateful for the litres of water.

New arrivals had been moved to the formal reception centre. While they waited their turn to be tested, they bunched up together on wooden benches. One-by-one, they were brought by an assistant to a table manned by one of the health care workers. Each new arrival was given a number as they were registered in a large logbook, and each RDT was numbered as a COVID-19 swab was taken, and the sample applied to the test strip. I was given the job of numbering each test with a pen. Every so often, a batch of tests were read as negative, and the results were recorded. On that day in particular, 149 tests were done, with one positive result.

Once new arrivals had been screened for COVID-19, they underwent screening to establish legitimacy in obtaining refugee status. By April 2022, systems were returning to

pre-pandemic policies; new arrivals were no longer congregating under the trees near the on-site reception centre. Instead, the processing of new arrivals was taking place at a re-opened remote site, 40 kilometres away. Before the pandemic, the remote site was used as a reception centre for new arrivals, but it was closed along with international borders in March 2020. For a time, it was repurposed as a COVID-19 quarantine and isolation centre. In March 2022, the borders officially re-opened and the building returned to a refugee reception centre. I visited it in April 2022. The site was bustling with new arrivals from South Sudan, awaiting transfer to the settlement. These new arrivals had been tested for COVID-19, and those who were positive were kept in a quarantine block located within the remote site, supposedly separate from the rest of the occupants.

The remote site was a large expanse of sandy soil and grass, dotted with trees, permanent concrete buildings decorated with COVID-19 murals, and semi-permanent tarpaulin and bamboo pole shelters. Over a thousand people occupied the site at the time of my visit. I joined the humanitarian staff, locating them by their characteristic large white jeeps. In one of the bamboo structures, humanitarian staff were rearranging plastic furniture, wooden benches and electronic devices for capturing biometric information. George, one of the more senior staff, asked for the wooden desk, used for nationality screening, to be moved away from the growing queue of potential refugees who had started to gather in response to the increased humanitarian activity. He explained that he did not want the screening taking place near the queue of people in case they overheard each other's answers. George was cheerful and explained that despite an hour's drive for staff to reach the remote site, it was better than registering refugees at the on-site reception centre. *This place has more space and proper latrines in comparison to the reception centre in the settlement*, he described.

The first step was to record biometric information to establish whether an individual had been registered as a refugee elsewhere. The modern equipment with multiple cables looked out of place in comparison to the bamboo structure, plastic chairs, wooden benches, scraps of paper and large logbooks used in the rest of the registration process.

The next stage was the remaining elements of 'Level 1 registration', which UNHCR (2022e) describes as capturing 'basic biodata, including the age, sex and number of individuals in a family' (p. 9). Each family were asked questions surrounding the head of their 'household', numbers of accompanying people, and any special needs. George had a sheet of paper with the names and numbers of individuals in each family. Once each family member had been screened for nationality, they were ticked off the list and handed a wrist band: mostly blue, but a yellow one indicated a PSN (person with special needs e.g. elderly or disabled), or white if they were an unaccompanied minor below the age of eighteen.

George studied each family. I was particularly drawn to an individual waiting to be registered who wore a T-shirt with a large slogan: 'Stop Corona, stay at home'. Those whose 'tribes' (a term used by refugees and by humanitarian actors) were found in South Sudan but not Uganda (e.g. Nuer) were immediately considered a legitimate refugee because South Sudanese have Prima Facie rights to refugee status (UNHCR, 2015). It took longer for those refugees whose tribe was found both in Uganda and South Sudan (e.g. Acholi, Madi). They were asked to evidence their South Sudanese nationality, either through the location of their BCG scar below the elbow (as opposed to Uganda where BCG vaccines are given in the upper arm), or by singing the national anthem of South Sudan. Through these physical or verbal examinations, legitimacy as a refugee was decided. People were either allowed to continue their registration processes or they were sent away.

Level 2 registration was referred to as 'profiling'. It took place at another table a few metres away. In policy documents, Level 2 'provides more detailed data on the family composition/links and protection needs to facilitate their movement and integration into the settlements' (UNHCR, 2022e, p. 9). Each 'household' had been given one sheet of paper, recording their names and ages. Level 3 was data entry onto a computer system, and a refugee identification card was issued in Level 4. These last two steps were done at the humanitarian headquarters in the settlement.

George and his colleagues tried to find order amidst the chaos in the shelter. They wanted three queues of people: one for biometrics, one for Level 1, and a further queue for Level 2. However, the space was not big enough. Queues merged and people mingled. When it reached a level of disorder intolerable to those processing the registrations, a booming voice demanded order. Queues separated and neatened up, before the progression to disarray began again. It was a clear process, but mistakes were made. My South Sudanese male research assistant was registered as female when he first arrived, and he enjoyed telling the story of how he was able to collect aid in the form of menstrual products.

This section has described the material dimensions of screening new arrivals for COVID-19 and registering refugees, to demonstrate the coming together of these different elements. For example, the remote site was purposed and repurposed for the counting of refugees and COVID-19, and moved between the ordering of people in regard to refugee status and in relation to COVID-19. Moreover, the screening of COVID-19 and the registration process for new refugees, both of which sought to control and manage the movement of people, were eerily comparable. This draws attention to the similarities in humanitarian approaches to pandemics and refugees, using overlapping methods to establish control among 'dangerous', 'unknown' entities. People were transferred into numbers on bits of paper, categorised as legitimate or clean, collated into logbooks and numerical summaries. For new arrivals, the practices of counting refugees and COVID-19 allowed dangerous contingent unknowns of people and pathogens (both outsiders) to be made safe, with uncertainties moulded into tick boxes and protocols. This arduous work, however, required great precision and care from front-line humanitarian staff.

The next section focuses further on practices of counting COVID-19 among new arrivals. It traces how these are shaped by district, national and international policies and politics.

'The politics got stuck': Regional, National and International Considerations

After sitting with George in the refugee registrations, I headed over to greet Alan, a healthcare worker based in another temporary building in the remote site. Alan was working alone and seemed disheartened. That morning, he had made the long journey to the remote site from the main settlement to test new arrivals for COVID-19. To Alan's dismay, the positive cases were mixing with other new arrivals, despite a policy of quarantining. *When we go to check on them, we find other family members in the room with them*, he explained. This was frustrating: the mixing of everyone in the reception centre undermined the meticulous and hot work of testing everyone for COVID-19.

I asked why the processes continued as they were. *It's Ministry of Health guidance that all new refugees are tested for COVID*, Alan responded. *It's their first point of contact so they must be tested here*. He then offered his personal view - blanket testing of all new arrivals should only be conducted if COVID-19 was found to be a significant public health threat in South Sudan, which he believed was not the case. However, the Ugandan Ministry of Health guidance testing policies were strict, he explained. They had no choice but to follow these guidelines. Although biomedical logic for testing new arrivals in terms of preventing the spread of disease was undermined by the lack of isolation, Alan's account suggests there may be other logics at play which explain COVID-19 counting regardless.

I explored these alternative logics with other humanitarian staff. One interlocutor, Susan, described the process of screening new arrivals in terms of *'due diligence'* and explained:

> *'So new arrivals don't become a threat, because there is a way for us to know based on the knowledge that we have right now. The knowledge is saying we have to isolate the person....'*

Susan also described how the policies of testing might be contradictory, but added:

> *'...we are doing it according to procedure...it's ticking the boxes...Prevention measures are mentioned in the government's policy, [but] it's not there... Who is wearing masks? Who is social distancing? No one...it's setting policy just for the sake of having policy...'*

This illustrates the importance placed on following policy created by central government. Susan went on to explain:

> *'it becomes political…the problem of the response is the response itself. The science disappears because of the politics that comes…'*

COVID-19 testing policy had little to do with public health, according to Susan. Earlier in the interview we had discussed the role of politics in the pandemic:

> *'There is too much politics… it's just a political circus…politicians and administrators started talking about the politics of what they do, "you can't handle this"…or "I could handle it better in my time"…The emphasis on the facts between the virology, how it impacts on a body of a person, when the person is affected, the upsurge, was overtaken by the politics of the response. So the response itself becomes the new fact that overrides the knowledge…'*

This quote illustrates how the numbers became almost meaningless whilst COVID-19 activities became associated with wider political concerns. The *politics of the response* likely references both district and national factions of the Ugandan government, and infers a connection to political (and hence financial) power dynamics related to the ruling party. The Resident District Commissioner (RDC), a senior civil servant appointed directly by the President, plays a pivotal role in district administration and politics. Moreover, the President used district and national officials to implement an often-militarised response to the pandemic, cementing his position of power (Parker *et al.*, 2022). Furthermore, the pandemic generated significant COVID-19 funds both nationally and internationally, which have been associated with widespread corruption (Initiative for Social and Economic Rights, 2021).

The *politics of the response* can also be interpreted beyond presidential military control and financial gain. Emmanuel worked for an NGO, and together we discussed the political will from national government to ensure that all new refugees were screened for COVID-19. He described how the government wanted to keep refugees apart from settled refugees and the host population until they were *clean from COVID-19*, primarily because they were perceived to be potential super-spreaders.

When the border restrictions in Uganda were loosened for trade and travel at various points during the pandemic, and informal movement began to flourish, new arrivals of

refugees in the settlements continued to be tested, and positive cases moved to isolation units. Despite small numbers of COVID-19 cases among new arrivals of refugees being detected, the government remained committed to the policy of blanket COVID-19 screening for all refugees. *The politics,* Emmanuel described*, just got stuck thinking it was dangerous…the Ministry of Health, but also the politics at the district level, the RDC…they set the rules…For COVID, we would make recommendations and then the strategic committee would change it*, he explained. Emmanuel added: *you need to see smaller epidemics, they are different*, insinuating that these alternative outbreaks are less shaped by political dynamics.

Whilst it is clear that political issues shaped screening, it is less clear why the politics 'got stuck' counting COVID-19 among new arrivals. Why was it so difficult to move away from the policy? Why was COVID-19 so different to other epidemics? To answer these questions, it is useful to consider the settlement as a 'state of exception' in the eyes of the national policy makers, with new refugees still 'othered' (Dionne and Turkmen, 2020), despite having to abide by national COVID-19 policy. Emmanuel explained that *with COVID-19…it's like picking something from somewhere else and moving it here… if it was malaria or diarrhoea it wouldn't grab attention*. Here, the geopolitical significance of COVID-19 is juxtaposed against diseases of less political concern. Furthermore, malaria and diarrhoea are deemed to be straight-forward medical concerns, which only seriously affect populations in the global south as opposed to COVID-19 whose threat focuses on people in the global north.

Hence, the national political dynamics that shaped the counting of COVID-19 among new arrivals can also be understood in relation to geopolitical dynamics with nations in the Global North perceiving the pandemic to be a threat to global (i.e., their) health security. Such arguments created the political space for highly militarised lockdowns to be imposed (Parker *et al.*, 2022) and enabled the flow of substantial international funding. The securitisation of global public health also placed pressures on governments to respond to donor wishes - even when it might not have been in their interest to do so. It reflects a wider biopolitical issue of some lives being valued more than others. To return

to Emmanuel's comparison - dying of COVID-19 is given greater attention than dying from malaria or diarrhoeal disease.

The persistent focus on screening new arrivals can also be explained by the association between refugee settlements and what Fassin (2012) describes as the moral imperative to intervene. In humanitarian settings there may be even greater challenges in setting aside the potential consequences of a global pandemic, regardless of whether or not the disease in question is perceived to be locally relevant. This is particularly poignant given the international focus on Uganda's refugee response. Counting demonstrated adherence to, and control of, the official refugee registration processes in light of the previous political scandals described by Titeca (2023). Counting refugees, therefore, became a commitment to accountability, to counter histories of corruption, and publicly conveys engagement with international guidelines, not dissimilar to the work of numerical indicators (Merry, 2016). In Uganda, this maintained the legitimate narrative of a flagship refugee policy, and humanitarian ideologies of care. Simultaneously, counting COVID-19 demonstrated compliance with dominant western discourses on appropriate pandemic control efforts, purportedly based on biomedical rationales underpinning prevention strategies. These contrasting narratives led to contradictory screening processes, but are understandable in terms of district, national and international politics.

Discussion

Numbers play a major role in humanitarian assistance to refugees, but are embedded in dynamics of control (Harrell-Bond *et al.*, 1992). Contributing a novel perspective, this article followed the counting of COVID-19 cases to shift the focus from numbers to the practice of counting. Such a shift requires the use of assemblage thinking to examine the entanglements of different people, policies, political influences and material objects; shedding light on the conditions under which numbers were produced (Caduff, 2020). Assemblage thinking thus enables the multiplicity of logics that shaped counting to be seen, including both social and political elements. Taking this approach revealed further key contributions of this research. This reveals additional dynamics of care, and renders

visible a central tension between care and control. To date, academic literature discussing the tension between care and control in refugee settings has focused on examining humanitarian ideologies of care and the biopolitical control of the moment of people in states of exception (Agier, 2011; Fassin, 2012; Malkki, 1995a; McConnachie, 2016). The findings presented in this article confirm this tension, but also reveal another dynamic that has not received attention in current debates: on the front line, humanitarian practices that look like control, are also about care.

This was not immediately apparent. On the contrary, COVID-19 screening practices appeared nonsensical when analysed in terms of public health principles of disease containment and interruption of viral transmission. By moving beyond the hollowness of the numbers (Erikson, 2012), assemblage thinking (Ong and Collier, 2005) revealed that the process of counting COVID-19 cases was in fact being shaped by socio-political dynamics that merged with biomedical and humanitarian technologies. This point has been demonstrated by exploring when and why COVID-19 cases were counted in relation to refugee movements across international borders. Moreover, the wider socio-political dynamics that shaped practices of counting were made visible by examining the contingent aspects of the assemblage, particularly the relationship between the counting of COVID-19 cases and the counting of refugees, and by the different screening policies for new arrivals in comparison to established refugees.

For new arrivals of refugees, counting COVID-19 cases drew on a global rhetoric of care for the protection of refugees and those hosting them during the pandemic (UNHCR, 2021b). In this way, counting became a vocabulary of assistance. It was mobilised by district, national and international political figures, attempting to control narratives regarding migrating threats of people and pathogens. To understand why the counting of COVID-19 cases amongst new arrivals of refugee was politically important, it is vital to consider the pervasive narrative of making the foreign *clean*. This narrative was so pervasive in refugee settlements, that the politics *got stuck*. The sense of COVID-19 being ‘indelibly tied to those who enter from outside’ has also been observed among truck drivers entering Uganda (Storer *et al.*, 2022). In the settlement, however, the association of new refugees with COVID-19 drew on humanitarian principles of care for existing

refugees. Transforming unknown *dirty* entities into something *clean* and knowable, through methodical processes, created a rhetoric of safety, becoming ingrained into Fassin's (2012) 'moral sentiment of humanitarian practice'. For district, national and international political figures, attempting to control narratives of migrating threats and making the foreign clean were also inseparable from COVID-19 financial incentives. This related to district and national political leverage (Initiative for Social and Economic Rights, 2021) and military control (Parker *et al.*, 2022), as well as international refugee narratives (Titeca, 2021).

For established refugees, however, asymptomatic cases of COVID-19 were not routinely counted in the same way, because the movement of these refugees remained a public secret. As Gidron *et al.*, (2022) write; 'The cross-border movement of refugees is considered illegal, on paper, but is tolerated in practice' (p. 6). This was acknowledged by interlocutors in private discussions but remained a public secret at the interagency meeting. Yet, publicly available UNHCR documents acknowledge that refugees move back and forth across international borders to check on their land and fetch food (UNHCR, 2022e). An important public secret to maintain at settlement level was actually printed openly in international documents (and accepted by humanitarian actors on the front-line). Settlement leaders may be constrained by national and district political dynamics, referred as the '*politics of the response'*. UNHCR policy documents on the other hand, are not constrained by these national and district politics dynamics in the same way.

Comparing the counting of COVID-19 cases amongst new and established refugees reveals that biomedical and humanitarian rationales were consumed by political decisions that controlled the level of visibility of refugees and COVID-19. Just as numbers mobilise, and are mobilised by, politics (Rottenburg and Merry, 2015), the same is true for the practice of counting. Invariably, this led to a situation where refugee movement, and hence COVID-19 cases, were only sometimes visible. International discourses surrounding appropriate refugee management and pandemic control valued performances of counting that demonstrated an alignment with normative approaches for the control of disease and the relief of suffering, thereby chiming with a humanitarian

rhetoric of compassion and care. However, public health principles of disease containment loose legitimacy when the numbers become hollow. In this sense, it confirms that counting is not really about controlling migrating threats as rhetoric might suggest, but rather, about attempting to control the narrative of migrating threats.

Examining material non-human elements of the counting assemblage (Gan and Tsing, 2018), revealed a further important dimension of the tension between care and control. I draw on Sverker Finnström (2008), who usefully pointed out that anthropology is about 'painstakingly investigating and analysing the common, general, mainstream, and even taken-for-granted stuff of everyday life in a particular context' (p. 10). Indeed, in this case, exploring the seemingly mundane material elements of counting provided essential insights. On the surface, the multiple ways of ordering people and stuff through refugee registration and COVID-19 screening appeared at best impersonal and at worst inhumane. Instinctively, George and Alan's attention to controlling the movement of people in the remote reception centre draws on the biopolitical nature of refugee settings discussed above. Further attention to their work, however, also reveals care. These elements of care, (which to my knowledge have not been discussed in relation to practices of enumeration), were rendered visible through detailed attention to the everyday material dimensions of counting. The importance of this intense, frontline work, beyond the generation of numbers, should not be overlooked. It demonstrates that the work of counting is valuable, even when the numbers it produced were hollow.

To elaborate further, for those on the front-line, counting refugees and COVID-19 was an arduous task. Policies of counting stayed fixed whilst people did not. Yet, the task of counting remained of the utmost importance. Both humanitarian staff registering refugees and health care workers carrying out COVID-19 screening engaged with personal interactions, amidst an often-impersonal refugee system. Refugees were acknowledged, often for the first time. Their needs were documented, marking entry into 'the international refugee regime' (Crisp, 1999). Through queues of people and lines of plastic COVID-19 tests, dangerous uncertainty was tamed for both humanitarian staff and refugees, creating a sense of safety. In the context of a global pandemic and diminishing humanitarian refugee funding (Moyo *et al.*, 2021), counting was a consistent

relational moment of care between those counting and those being counted. This occurred within the context of potential threats from a global pandemic, which had clearly infiltrated everyday life for new refugees, as demonstrated by the 'Stop Corona, stay at home' T-Shirt.

Furthermore, without the exhaustive work of staff on the front-line, performances of counting in other locations would have lost their meaning. Whatever numbers were produced on the front-line, their importance lay in their association with counting rather than their numerical worth. Any number was needed to demonstrate counting had occurred, which could then be reported at the inter-agency meeting, and passed upstream for use by humanitarian and government actors. This illustrates Duff's (2014) more fundamental point about the contingent nature of elements in the assemblage, and Law and Singleton's (2000) focus on related performances.

Conclusion

In the context of forced displacement and a pandemic, this research has demonstrated that exploring counting as a socio-political phenomena is just as important as critically examining the numbers. In fact, this approach has shown that irrespective of the numbers produced, the practice of counting and its subsequent performances render visible a central tension between care and control. Whereas numbers have been associated with control in established literature, this article is novel in showing how a focus on counting reveals both care and control. This was enabled through assemblage thinking, which placed people, material objects, and socio-political relationships at the heart of the analysis. In so doing, it became clear that care and control are deeply connected, utilising the same practices by the same people, often at the same time. The lines between them are often blurred.

The biopolitical nature of numbers enables the control of people, but even when the numbers are hollow, counting can control, reflecting district, national and international politics. Practices of counting which are shaped by political logics, mobilise humanitarian ideologies and rhetorics of care for refugees in the face of COVID-19, but

are actually more about the control of dangerous ‘others’. Simultaneously, the acts of counting on the front-line, which visibly control the movement of people, also represent care in a time of reduced aid and livelihood insecurity. The arduous work of counting tames migrating threats from people and pathogens. This offers reassurance to refugees being counted, healthcare workers doing the test, to district and national political leaders, and to global health and humanitarian organisations that place great importance on numbers, whatever they are. Documenting such hitherto unseen practices helps to explain seemingly contradictory public health processes, which in fact represent an important relational moment of care.

In sum, rhetorics of care can be about control, but practices that look like control can also be about care. Such tensions are mediated daily by those working in humanitarian settings. Before criticising public health practices that at first sight might seem contradictory, alternative logics, shaped by wider social and political dimensions, should first be considered.

Chapter 9: The Temporality of Epidemic Preparedness and Diseases that Come with the Wind

Figure 49. Sheltering from a storm in Palabek Refugee Settlement.

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?			
When was the work published?			
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*	Choose an item.	Was the work subject to academic peer review?	Choose an item.

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	Medical Anthropology
Please list the paper's authors in the intended authorship order:	Sophie Mylan

Stage of publication	**Not yet submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	N/A - single author

SECTION E

Student Signature	[redacted]
Date	12th December 2024

Supervisor Signature	[redacted]
Date	13th December 2024

Article Title: Epidemic preparedness and relational time - exploring diseases that come with the wind among Acholi refugees in northern Uganda

Author: Sophie Mylan

Abstract

Mainstream public health approaches to epidemic preparedness foreground techno-scientific solutions. Despite valuing flexibility, contemporary approaches are based on a biomedical (Western) linear temporality, and struggle to embrace the uncertainty surrounding unpredictable and uncontrollable events, with successful preparedness assessed in relation to fixed, pre-defined and quantifiable indicators.

This article draws on long-term ethnographic research with Acholi refugees in Palabek settlement, northern Uganda, to explore epidemics and other unexpected occurrences past, present and future. It suggests that epidemics, like the wind, are indeterminate, and inseparable from broader relationships between people, the environment and spiritual powers. Acholi refugees anticipate and incorporate unpredictable and uncontrollable situations, such as epidemics, into their day-to-day lives. This adaptability is grounded in a relational temporality and a constant search for equilibrium. Accommodating such an approach requires a re-thinking of how 'successful' preparedness is conceptualised and measured.

Introduction – Storms Ahead: Meeting Consy

> It was April 2022 in Palabek Refugee Settlement, northern Uganda. I had been doing ethnographic fieldwork for about a year, and I felt comfortable weaving through homesteads, on the way to interview Consy[24], an Acholi refugee from

[24] Most of the names presented in this article are pseudonyms. I have included real names when individuals have explicitly asked me to do so, to acknowledge their contribution.

> South Sudan. I was keen to meet her, because she was one of the few people I had encountered who tested positive for COVID-19.
>
> Consy lived close to where I was staying in the settlement, in one of the first 'zones' to be established. Along with her neighbours, she had cultivated her 30 metres-by-30 metres plot of land. They had built mud huts with grass-thatched rooves, dug latrines, and were growing green vegetables. Although trees had been culled for building and firewood, those remaining were vital sources of shade in the dry season, when the main roads were engulfed in clouds of dust by speeding NGO cars. In April it was the wet season, and many roads had been replaced by muddy swamps spinning vehicles in all directions.
>
> As I walked with two research assistants, Patrick and Geoffrey, I could see the clouds forming overhead, threatening the possibility of rain. I shoved my jacket into my bag and we started weaving through people's plots of land on informal paths, greeting neighbours as we passed, avoiding the main roads. Women sat on brightly coloured plastic mats or against their huts, destalking greens and shelling corn, preparing food for their evening meals. Casava and millet were being dried in order to make local alcohol to be drunk or sold.
>
> When we reached Consy's homestead, she greeted us warmly, clearly expecting us. A child ran to her neighbours' homestead to collect plastic chairs. We arranged ourselves around a Dictaphone propped up on Geoffrey's shoe. Having introduced the research, Consy signed a consent form, and we quickly put away the loose sheets of paper that threatened to be swept away by gusts of wind.

This vignette introduces Consy, who will be mentioned at various times throughout the article. A focus on Consy helps to reveal several key elements of research exploring epidemic preparedness among refugees. Firstly, it will foreground individual voices and day-to-day lives. Secondly, it will use a conversation to place emphasis on the present moment, as a key methodological choice. Thirdly, this in turn will establish the centrality of relational temporality amongst Acholi South Sudanese refugees. This is juxtaposed

with a measurable linear temporality that frames public health approaches to epidemic preparedness. Fourthly, this vignette is intended to emphasise that epidemics, rather than invoking states of emergency or crisis, are better understood as indeterminate parts of everyday life for Acholi refugees, inseparable from other sources of misfortune. Lastly, exploring epidemics in this way usefully problematises the linear temporality imbued in mainstream public health approaches to preparedness.

The term 'epidemic preparedness' emerged alongside global health initiatives dedicated to combatting the risks associated with so-called 'emerging infectious diseases' (Garoon and Duggan, 2008; Garrett, 1994; World Health Organization, 2015). In mainstream public health approaches to preparedness, time is linear and measurable (Lynteris, 2014). Preparedness strategies are separated from epidemic responses according to a chronological temporality and the so-called 'start' of an outbreak (Fisher *et al*., 2020). Successful preparedness is measured against global indicators that focus on technical, scientific, economic and logistical dimensions (the success of which can only truly be revealed after an outbreak has occurred). The people actually affected by an epidemic are seen as mere recipients of education and risk communication (Kentikelenis and Seabrooke, 2021; Oppenheim *et al.*, 2019; World Health Organization, 2023b).

Despite working within a fixed and measurable temporality, scientific and public health approaches to preparedness also claim to value flexibly and adaptability. For instance, 'being prepared means being ready for change' (Centre for Epidemic Preparedness and Response, 2022). Hashim *et al*., (2012) describe adaptability/flexibility as an essential element of pandemic preparedness activities, and Bryce *et al*., (2022) emphasise flexibility and adaptability in conceptualisations of preparedness in their examination of organisational resilience in the UK's NHS during COVID-19. Biomedical claims to supposedly value adaptability are misleading, however. Their approaches are still based on making the future more knowable and measurable through greater control. In searching for greater flexibility, the answer is still found in technical, scientific, economic and logistical domains that work to reduce uncertainty. It is questionable, therefore, whether flexibility or adaptability is truly valued by these approaches, given that they are ultimately still structured around the strict ordering of activities and events in relation to

a linear temporality. In contrast, in-depth exploration of day-to-day lives such as Consy's, help to reveal more authentic examples of flexibility in relation to alternative temporalities.

Consy was 22 years old. She came from Pajok, South Sudan, and had lived in the Palabek for five years. Consy lived with her mother and children and worked in the nearby health centre, which was important 'to raise money to survive.' She received a monthly ration of food items, cooking oil and soap. In common with other refugees in the settlement, she found this inadequate to support her family, particularly during the pandemic, and even more so when she was restricted by home-based care for COVID-19. During the COVID-19 pandemic, the settlement followed national policies. In the second wave (May to August 2021) this included the transition to home-based care for all milder cases of COVID-19. Consy explained her experience of home-based care:

'The hardest part of it was being alone and isolated and not moving [around], and eating alone', she described.

How long was this for? I asked.

'One month'. Consy replied.

Consy fell ill with a sore throat, sneezing and chest pain. She attended the health centre, who tested her for COVID-19, and she was diagnosed with 'Coronavirus'.

'When I was diagnosed, I didn't doubt it because they tested using a machine', Consy explained. Her colleagues at the health centre gave her medicine and told her to take care of herself.

'They told me to stay alone and that the plates and cups at home are supposed to be separated. I was also told to keep social distance, and to wash my bedding, and that I should be doing exercises in the morning, and having plenty of fruits.'

As Consy described her segregation, I was reminded of other conversations I had had with an elderly women, Jaja, a few months previously. She had described the ways in which measles, *anyo*, had been dealt with 'back then', *kare macon*. Jaja said that when a 'person is isolated, they cook food and take it to him because people don't come near that person'. She described how different crockery was

used to identify what had been touched by whom, with the sick person being given the broken or chipped plates.

Maintaining separateness was challenging for Consy. She had a young child, and also cared for her sister's child. Along with Consy's mother, they all shared the same hut for sleeping. 'The advice wasn't easy because when I came back home, I was meant to sleep in a separate place', Consy explained.

Consy started to feel better after three days, but then started to get symptoms again. It took one month for her second COVID-19 PCR test to come back negative, and only then was she allowed to stop isolating herself.

'Before home-based care, people were taken to isolation stations. What do you think was better?' I asked.

'For me,' Consy replied, 'I think the isolation places was better than home-based care, because there was a space of confinement for the sick and all the services inside there were for the sick. And it was safer, because home-based care is kind of risky – people from home can easily come into contact with, lets say, the plates and the cups, that a Corona patient uses at home.'

Recognising that refugees are accustomed to rapidly adapting to changing circumstances, this article asks: in the context of protracted, enduring crises, including food insecurity and displacement, how are epidemics conceptualised? How do epidemics relate to other sources of misfortune, and how is this understood in relation to social, environmental and spiritual dimensions? How does the linear temporality of public health approaches to preparedness compare to the temporality of life by which Acholi refugees live by? What are the consequences of failing to appreciate more locally grounded understandings of epidemics? These questions will be explored through the lives of refugees, travelling between the past, present and anticipated futures. I show how discussions of epidemics merge with ideas concerning the wind, seasons, time and unexpected visitors, and analyse the way people adapt to unexpected events more generally. Together, this reveals the indeterminacy of living with epidemics, which is near-impossible to capture in mainstream indicators of successful preparedness. By indeterminacy, I mean an inexact, borderless, in-between state of being, that remains

unfixed and imprecise, with shifting meanings. In doing so, this article presents a cautionary tale: the more that mainstream approaches measure 'success' in relation to an ordered, optimised and time-efficient orientated preparedness, the more they risk losing useful characteristics of alternative temporalities such as relational time, notably its adaption to uncontrollable events. This has significant consequences for those delivering, and receiving, humanitarian assistance.

Background Literature: Anthropology and Epidemic Preparedness

This section outlines relevant literature, drawing on anthropological engagements with epidemic preparedness: firstly, temporal considerations for epidemics and humanitarian crises, and secondly the importance of attending to local contexts to examine what successful preparedness might be. Whereas existing literature has focused heavily on what epidemic response efforts can learn from specific local contexts, there is a growing literature that examines the value of alternative framings of preparedness, reframing predictable and controllable futures (Leach *et al.*, 2022a).

Epidemic Temporalities and Conceptualising Crisis

Anthropologists and other social scientists have problematised global framings of preparedness (Lakoff, 2017; Leach *et al.*, 2022a; Wilkinson *et al.*, 2023), and they have particularly focussed on temporal dimensions of an anticipatory approach to an imagined forthcoming emergency (Caduff, 2015; MacGregor *et al.*, 2022). Preparedness represents a fundamental shift towards managing uncertainty associated with emerging pathogens through anticipatory technologies and imaginaries (Caduff, 2015; Lakoff, 2017; Roth, 2020). The construction of an anticipated future, however, is linked to security agendas, pointing to the politics of pandemic temporality (Jarvis, 2021). Preparedness emerged in Western nations from defence 'operations research' through the cold war era, where emerging infectious diseases were not only conceptualised as biomedical and public health issues, but also in terms of national biosecurity agendas (Lakoff, 2017).

Anticipatory actions central to preparedness often revolve around stockpiling, imaginary scenarios and focussing on logistical dimensions that enable the swift allocation of people and things in the face of an outbreak (Caduff, 2015; Lakoff, 2017; Samimian-Darash, 2022). This promotes the collection and organisation of resources, to be swiftly deployed when needed. Successful preparedness, therefore, favours high resource settings, presuming those without such resources have little to offer. This is reflected in global country rankings of epidemic preparedness (e.g. Oppenheim *et al.*, 2019). But the accuracy of these rankings has been called into question in light of the COVID-19 pandemic (Abbey *et al.*, 2020). For example, countries in North America and Western Europe, which scored high in preparedness scores prior to the pandemic, subsequently reported some of the most catastrophic consequences from COVID-19. Furthermore, assessment of successful preparedness in terms of quantifiable public health 'indicators' which focus on disease rates, mortality and vaccination coverage, fail to capture socio-political and economic dimensions of pandemics.

Anthropological engagement with the temporality of outbreaks goes beyond preparedness. Roth, in her concise summary of 'epidemic temporalities' provides an overview of the ways in which anthropologists have engaged with issues before, during and after epidemics, concluding that 'epidemics are acute disease events which problematize time…The textured experience of outbreaks relies entirely on these overlapping epidemic temporalities' (Roth, 2020, p. 16). This draws on Lynteris (2014), who, in his introduction to a special section on *The Time of Epidemics*, points to the importance of seeing epidemics as events, experienced as unexpected eruptions in day-to-day lives. He also points to the more usual engagement of anthropologists with epidemics as processes, in their shaping by social, political and economic contexts, particularly in terms of ongoing vulnerabilities. Along these lines, Leach *et al*. (2022a) have suggested that epidemic preparedness plans which focus on technical risk management often ignore the political dimensions that create vulnerabilities, with the authors calling for the need for a greater appreciation of the politics of knowledge and the construction of time and space, particularly embracing incertitude. According to Lynteris (2014), 'What is then crucial for an anthropological enquiry of the eventual and

processual aspect of epidemics is the examination of their temporality, as both experienced and performed by implicated or constituted subjects' (2014, p. 27).

Epidemics are often described by biomedical and humanitarian professionals, as well as in mainstream media, as crisis events, drawing on the temporality of emergency. Scholars have problematised the focus on acute events, or crises of emergency with humanitarianism, pointing to the enduring nature of displacement (Anderson *et al.*, 2019; Ramsay, 2020). Related to this, Vigh (2008) usefully calls for examining crisis *as* context, rather than *in* context, and thus emphasises enduring contexts rather than individual events. However, the concept of emergency can be useful for justifying intervention, or the moral imperative to intervene in states of exception (Agamben, 2005; Fassin, 2012; Fassin and Pandolfi, 2010).

Local Contexts

In contrast to mainstream public health approaches, anthropological analyses of epidemics have looked beyond 'resource rich' settings to reveal how local contexts can be seen as a source of knowledge and experience that can potentially be used for more successful epidemic approaches, actively resisting securitised and neocolonial framings (Abramowitz *et al.*, 2015a; Parker *et al.*, 2019a; Richardson, 2020; Wilkinson *et al.*, 2017). For instance, Hewlett and Hewlett (2008), in their anthropological studies of Ebola in Uganda and DRC have described how rather than seeing 'local culture' as a barrier to control measures, 'local people's beliefs and practices may be useful in efforts to contain an epidemic' (p. 30). Abramowitz *et al.*, (2015a) described how 'communities' in Liberia during Ebola instigated their own community-based quarantine and home-based healthcare, designing their own PPE. Richards (2016) coins the terms 'people's science' to describe the 'co-production' of knowledge between biomedical and 'local' responses to Ebola during the 2014-2016 West African outbreaks; while Parker *et al.*'s (2019a) work on Ebola in Sierra Leone described the emergence of a 'morally appropriate people's science' under the radar of official public authorities, with beneficial impacts for those being treated away from biomedical facilities such as Ebola Treatment Centres. There is a paucity of anthropological literature, however, specifically focussing on epidemic

preparedness and response amongst people who have been displaced, despite there being much to learn from people whose survival is dependent on adaptability.

The research presented in this article draws on the beliefs and practices of Ac(h)oli, a Nilotic group of the Luo found across parts of northern Uganda and South Sudan (p'Bitek, 1971). Scholars have, in detail, documented Acholi in Uganda (Atkinson, 1989; Finnström, 2008; p'Bitek, 1971; p'Bitek *et al.*, 2019; Porter, 2013), particularly in relation to conflict and displacement (Allen *et al.*, 2021; Victor and Porter, 2017). They have usefully explained that central to Acholi, is the search for social balance and moral order, involving inseparable physical and spiritual elements (Baines, 2010; Finnström, 2008; p'Bitek, 1971). Finnström (2008) described this in terms of good and bad surroundings, not as discreet categories, but rather representing an (often uncertain) continuum. To quote:

> 'Peaceful life can be infested with conflicts and frustrations, but in the peaceful order of things, problems are handled, strategies beyond mere survival are developed, life is continuously constituted and reconstituted. Uncertainty is handled' (Finnström, 2008, p. 11–12).

Porter (2017, 2012) coined the term 'social harmony' to capture this important quest for cosmological equilibrium. Furthermore, moral spaces have temporal and spatial dimensions, with the imagined 'olden times', *kare macon*, associated with rural (often pre-colonial) village life, acting as a type of moral compass (Porter, 2019).

Epidemics amongst Acholi and neighbouring populations in northern Uganda have also been well described (Akello and Parker, 2021; Hewlett and Hewlett, 2008; Park and Akello, 2017; Parker *et al.*, 2020; 2022). From 2000 to 2001, Gulu was the epicentre of a large Ebola outbreak (Park and Akello, 2017). Hewlett and Amolat (2003) explored the local cultural context of Ebola in northern Uganda, and described explanatory models for the disease among Acholi, which distinguished between 'indigenous' and 'biomedical' dimensions. These authors explained epidemics in relation to *gemo,* an indigenous model related to 'bad spirits that comes suddenly and rapidly and effects many people' (p. 1244). During COVID-19, further attention was paid to *gemo,* particularly describing

ryemo gemo – a practice of banging loud pots and pans to chase away bad spirits (Alexander, 2020).

There are also detailed ethnographies of Acholi in South Sudan exploring their cosmo-ontological systems (O'Byrne, 2015b, 2021). Long term ethnographic research amongst Acholi refugees in Palabek has focussed on mobility (O'Byrne and Ogeno, 2021), conceptualisations of resilience (O'Byrne, 2022) and mental health intervention (Torre, 2023a), but less detailed attention has been given to their experiences of epidemics. Although not specifically referencing Acholi, Kindersley (2021) does provide a more general overview of lessons from community approaches to epidemic management in South Sudan. However, little attention has been given to how Acholi from South Sudan experience epidemics. The next section will provide a detailed overview of the field sites and methods in northern Uganda among Acholi refugees from South Sudan. This is followed by four ethnographic sections, a discussion and concluding thoughts.

Field Sites and Methods

I lived in northern Uganda between January 2021 and June 2022 and carried out ethnographic research in and around Palabek Refugee Settlement, in the northern Acholi district of Lamwo. Palabek was officially established as a refugee settlement in 2017, after fighting in the Acholi region of Pajok, Magwi Country, South Sudan, led to mass displacement of thousands of people across the border to Palabek. Acholi people have moved back and forth across the international border and the wider region for generations, both before, during and after colonial interventions (Allen and Turton, 1996; Atkinson, 1989). This reflects strong kin networks, in response to violence, in search of economic opportunities, healthcare and education (Gidron, 2022). Between 2017 and the time of fieldwork, Palabek grew substantially: by mid-2022, over 60,000 refugees were registered in Palabek settlement. Although Acholi make up the majority of refugees, new arrivals were from a variety of other so-called 'tribes' from South Sudan, as well as smaller numbers from Democratic Republic of Congo.

The Ugandan Office of the Prime Minister (OPM) was responsible for Palabek settlement, supported by UNHCR. 'Implementing partners', mainly local and international Non-Governmental Organisations (NGOs), delivered activities across the humanitarian sectors of health, water and sanitation, education, and livelihoods. Refugees described life as hard, often referring to worrying rates of food insecurity (Torre, 2023a). At least in part dictated by a deficit in international funding for refugees, policies of 'self-reliance' in the settlement legitimised a reduction in material support (Clements *et al.*, 2016). But the success of such self-reliance strategies has been challenged with a profound scarcity of actual opportunities, and a focus on the 'responsibilisation' of refugees detracting from structural failures in the humanitarian response (Brown and Chiavaroli, 2023; Torre, 2023a).

I worked with two research assistants: Geoffrey, an Acholi from northern Uganda, and Patrick, an Acholi refugee from South Sudan, both of whom had lived through war and displacement. It is important to note that the contrasting perspectives of Geoffrey and Patrick revealed in this article are likely to reflect, in part, differences between South Sudanese and Ugandan Acholi, and their diverse engagement with modernity and education.

During fieldwork, Uganda experienced its second and third waves of COVID-19, with a national lockdown from June 2021, which was loosened in August 2021 (Laing *et al.*, 2024). I lived in Palabek settlement, including during periods of lockdown, with Patrick, his wife Flo, and their children. Living with Patrick's family in Palabek and participating in daily life was an integral part of this research. Ideas were often clarified or emerged over dinner time conversations or chance encounters, as we considered the interviews we had conducted that day, or other occurrences in the settlement. These informal conversations were hugely important in shaping and re-shaping the direction of the research. During fieldwork I explored how ideas of epidemic preparedness moved through space and time. Although focussing on Acholi refugees in Palabek, I also spoke with humanitarian aid workers, government officials, and Ugandans living amongst the settlement. I attended district meetings and followed people further afield to the capital,

Kampala. In total, Patrick, Geoffrey and I, completed 158 semi-structured interviews, such as the one I introduced in the initial vignette.

This article pays particular attention to a conversation with Consy, a young woman in Palabek who was introduced in the initial vignette. This conversation weaves throughout the four subsequent sections: diseases that come with the wind; dealing with unexpected events; understanding time and seasons; and adapting to unexpected events. The way this information is presented may appear somewhat random to those who prefer a more chronological or ordered approach. However, structuring the article in this way is important for two reasons. Firstly, it is a methodological choice to emphasise the relational dimensions of the present (Jackson, 2005). The appreciation of time as a social phenomenon shaped by events has been well described, with Thompson (1967) using the term 'task-orientated time'.[25] Evans-Pritchard, in his descriptions of time amongst the Nuer, distinguished between 'oecological time' defined by relationships with the environment, and 'structural time' shaped by social interaction, both contrasted with western scientific time. Evans Pritchard describes both of these examples of Nuer time as 'social notions, being man-made and referring to successions of events' (Evans-Pritchard, 1939, p. 189). African scholars such as John Mbiti similarly describe how African conceptions of time differ from a western linear time with its divisions between past, present and future (Babalola and Alokan, 2013; Mbiti, 1990; Nari, 2024). Mbiti emphasises two dimensions of African concepts of time in terms of past and present, defined by events, with the future 'virtually absent because events which lie in it have not taken place' (Mbiti, 1990, p. 17). A focus on the present amongst Acholi is foregrounded by Adonga, an Acholi linguist who wrote: '…the language itself is structured so as to make the now, the moment of dialogue, the relationship between the speaker and hearer, the momentary focus and centre of existence' (Adonga and Hopkins, no date, p. 18). This highlights the unknown but contingent nature of the future, which is interpreted through what is known to have worked now and in the past. To explore epidemic temporalities

[25] There is a vast literature exploring conceptions of time from various philosophical standpoints. There is not scope to outline this literature in detail here. Furthermore, the emphasis of this article is on providing in-depth contextual exploration of the temporality of a specific local context and its relevance to epidemic preparedness.

among Acholi, I have therefore made the methodological choice to focus on conversations. This emphasises the most crucial dimension of this research: for Acholi, the moments that happen in the current situation, between people, or in other words the *relational dynamics of the present,* form a platform to interpret the rest of reality. Secondly, the chosen structure renders visible the role I played in collecting this ethnographic material, how the associated challenges became part of the narrative, and how this shaped further analysis. Such an approach emphasises, once again, the centrality of relational dimensions of the research, and draws attention to the indeterminacy of my methods as well as the themes of analysis.

Diseases that Come with the Wind

To explore Acholi understandings of epidemics, fieldwork had initially focussed on working out how to translate the words 'epidemic', 'pandemic' or 'outbreak' from English to Acholi. Three key terms emerged: firstly, the term *two gemo,* with *two* meaning disease or sickness, and *gemo* referencing a type of spiritual causation; secondly *two yamo*, with *yamo* translated as wind; and thirdly, *two mapoto atura*, translated as diseases that come unexpectedly.

COVID-19 was translated as *two gemo* on local Acholi radio and by humanitarian actors working with Acholi refugees in northern Uganda*,* including in reference to common symptoms of the disease, and when encouraging people to abide by lockdown rules. It was interesting that public health messaging used the word *gemo,* which specifically referenced a type of 'bad spirits'. In contrast, Acholi refugees from South Sudan often described COVID-19 in terms of *two yamo,* emphasising the wind. This section demonstrates the interchangeable nature of *two gemo* and *two yamo*, with each term shedding light on important dimensions of the same phenomena.

> Is Corona *two gemo*, *two yamo*, or *two mapoto atura*?' I asked Consy. [26]
>
> '*Two yamo'* she replied.

[26] This article includes long quotations and passages of conversation. For ease of reading, these have been indented. Shorter quotes remain in the body of the text.

> Trying to explore the relevance of the wind, I probed further.
>
> 'If you say it's *two yamo*, does it mean that if the wind is coming, the disease comes with the wind?' I asked, focusing on the more literal translations.
>
> 'No,' Consy replied. 'It's not like that… when we say *two yamo*, it means that it's a disease that can move through the cough and the air and then when another person inhales the cough he or she also acquires the sickness'.
>
> 'So when it's very windy like this, do people worry that *two yamo* is coming?' I postulated.
>
> 'No', Consy replied.

I felt somewhat disheartened by Consy's frank reply. Foreseeing a more cosmological metaphorical answer, I was struck by the frank explanation that seemed to align with biomedical conceptions of airborne transmission. At the beginning of fieldwork, I had connected the wind with airborne transmission, or respiratory viruses, especially in light of the current COVID-19 pandemic. By the time I met Consy, I had been living in the refugee settlement for nearly a year and I recognised that the metaphysical and physical words were deeply connected, particularly through the environment. Spirits lived amongst and within people. They were found in the local hills and bodies of water. Literature has also highlighted the cosmological significance of the wind for Acholi. Okot p'Bitek (1971) describes the wind in a metaphorical sense to refer to the omnipresence of spiritual forces that can be heard and appreciated, but never directly seen, but also as direct manifestation of *jok*. The term *jok* (singular), or *jogi* (pleural), is commonly translated as spirit, god or demon, which are associated with certain mountains or expanses of water (O'Byrne, 2015b). Through its association with *jok,* therefore, the wind is directly associated with bad omens, sickness or misfortune. For Acholi of Pajok, there are specific spirits that manifest as clouds of dust or whirlwinds, with specific *jogi* harnessing the power of wind against enemies (O'Byrne, 2015b).

One evening in November 2021, I sat with Patrick and Flo having dinner. We sat inside their main hut as the wind whipped around it. We reminisced about big storms we had experienced. Patrick said that there never used to be storms with wind like this in

Palabek. He described how the 'host community'[27] were blaming refugees for the storms, which were increasing because the refugees were not respecting the land. 'Refugees are climbing Ogili Hill to get firewood.' Patrick explained. 'The *jok* of Ogili is not happy, and this is why the wind and storms are coming.' I asked Patrick if wind always comes from God. He said 'yes'. I asked Flo the same question, and she said 'no', explaining that wind can be made by some humans too.

I was still struggling, however, to understand how the wind in these terms, related to Consy's description of *two yamo*, and I was not satisfied with her comparatively superficial connections to airborne transmission. This could have been related to Consy's younger age, her work in a health facility, or the influence of the church she attended, in comparison to older interlocutors, who may have more readily narrated stories of bad spirits found in literature. I suspected, however, that I was failing to appreciate something important in my discussion with Consy. Shortly after meeting her, I chatted to Dorothy, one of her neighbours of a similar age, who helped me understand the relevance of the wind in a way that aligned more closely with the literature I have highlighted. In order to make these connections, however, I needed to understand scale (i.e. how many people were affected).

Dorothy explained that similar to *two yamo, two gemo* is a disease spread through the wind, adding that 'it kills many people in a community'. Dorothy provided examples of measles, COVID-19 and cholera. Although COVID-19 and measles have degrees of airborne transmission and are respiratory pathogens, cholera is spread via contaminated water or food. The onset of cholera, however, is sudden and can affect many people at speed. It was important to understand that in discussing *two gemo* or *two yamo,* emphasis was given to the large number of people affected in a short period of time. Although at first the relevance of the wind in descriptions of both *two yamo* and *two gemo* seemed to align with biomedical models of airborne transmission (assisting public health activities to explain transmission and reduce spread), it gradually became

[27] 'Host community' is a term used by refugees, Ugandans living in the vicinity of Palabek, and by humanitarian and government actors working in the area.

apparent that the relevance of the wind was more related to its ability to affect many people at speed, whilst still remaining unseen, or at least only seen through its effects on people and the environment, rather than with the naked eye. This resonates with p'Bitek's (1971) description of the omnipresent but invisible nature of the wind.

I began to understand more about the spiritual relevance of *two gemo* by talking to Jeff, who described that *two gemo* '…started long before we were born and so we have to pray to god as a community for it to go away…' Jeff used the term god to refer to a supernatural or spiritual causation. God and bad spirits are deeply related, with Christian notions of God and Satan, intertwining with other aspects of Acholi cosmology often described in relation to *jok*. Although some people distinguish between *jok*, spirits and god(s), to many these interweave as part of the same spiritual dimensions of daily life (O'Byrne, 2021).

Jeff continued to explain his understanding of *two gemo*; '…the only way to get rid of *two gemo* is God… we can't stop it as humans but if it comes, we need to follow the medical guidelines as we pray…' Here we see how the spiritual dimensions of *two gemo* and biomedical models are not seen as separate or contradictory in any way. Just as Jeff described, a spiritual causation does not necessarily require a spiritual approach to treatment or prevention. Indeed, many people informed me that *two gemo* came from god, but that it could be managed by doctors. As a result, they followed medical advice from the health facilities in the settlement, but this didn't exclude them from also engaging with practices to address cosmological imbalances.

The amalgamation of spiritual and biomedical explanations is further illustrated by Grace who often came to visit Consy from a neighbouring zone in the settlement. Their families had lived close by in Pajok, and Grace knew Consy and her mother well. Grace explained her understanding of *two gemo* and the multiple ways in which it could be managed.

> **'***Two gemo* is a disease that affects people in a large numbers within a few hours or days. It can go away when it is treated by doctors or local medicine… If the doctor says "stay in your room", [then] you stay in your room. If they say, "wash your hands before eating", [then] you wash your hands before eating. If you follow the rules, then *two gemo* will go away.'

By exploring epidemics in relation to two Acholi translations, *two yamo* and *two gemo*, this section has foregrounded the relevance of the wind, capturing the rapid but invisible nature of epidemics, that affect a large number of people. Secondly, spiritual and biomedical dimensions of causation and cure have been revealed. Here, we see a fluidity in how epidemics are conceptualised. There is an adaptability regarding people's understanding, that allows new information to be intertwined with existing understandings of how the world works, and why things happen.

Dealing with Unexpected Events

I decided to move the conversation with Consy towards a different topic, to the third translation of epidemics, in relation to their unexpected nature. *Two mapoto atura* translates as a disease or sickness that comes unexpectedly. Here, the emphasis is not just on affecting lots of people, but on the unexpected nature of the sickness. This unexpected onset can also be a characteristic of *two gemo* and *two yamo*. As Consy's neighbour, Dorothy, explained, '*two gemo, two mapoto atora,* and *two yamo* are all the same…because they all come unexpectedly'. Unlike *two gemo* and *two yamo*, however, *two mapoto atora* can affect one person or many people, but the defining feature is its unexpected nature. As this section will demonstrate, this was best explored by situating the discussion in relation to dealing with unexpected events more generally.

> I tried to think about anticipating the unpredictable, and asked Consy: 'what happens if there are things like bad weather, or a pandemic, or flooding or war or violence? What will you then do if these things come?'
> Consy replied: 'If flooding occurs here, I prepare in a way that I have to look for another place to stay, or move to another place, or migrate.'
> So if something is dangerous you move somewhere else?' I clarified.
> 'Yes, if dangerous things happen, often I just leave' she responded.

I had become more interested in exploring how people anticipated unpredictable occurrences after an interesting discussion with a neighbour a few months before meeting Consy. I was walking back from Jerusalem, one of the main trading centres in the

settlement. It was a bustling market day. Flo and I had rummaged through piles of second-hand clothes on the roadside and were discussing our purchases as we slowly meandered home, greeting neighbours on the way. As we passed the health centre where Consy worked, we bumped into another neighbour, Auma, a young lady who was staying with her aunt in the same zone as Consy and Patrick's families. Flo and I promised to go and visit Auma. I was also looking for female research assistants and Flo thought Auma might be a good fit.

A couple of days later we found Auma at home, sweeping the compound. The sun was hot so we found shade behind the cooking hut, where a large tree laced in passionfruit vines provided more than adequate shelter. Auma was keen to hear about my project, and I explained my interest in epidemics. Flo encouraged me to ask some more specific questions. I was taken off guard, expecting a more informal meeting. Keen to utilise the opportunity, I rummaged for a pen and notebook in my bag. I hesitantly asked Flo and Auma:

'How do women prepare for epidemics?'

Auma was quick to reply: 'By mopping, washing utensils, washing clothes, and preparing food'.

'What is the role of women more generally?' I said, thinking I should have started with this question. Flo and Auma smiled and started firing off a long list.

'Weeding, harvesting crops, children!' Auma exclaimed.

Flo agreed: 'Yes children, especially cleaning their body and their clothes. Women always do more cleaning than men. And it has increased with Corona. Especially if you have a visitor, you have to clean more.'

'But you can also clean for decoration' Auma added.

'Why is cleaning important' I asked?

'It controls epidemic diseases like cholera, diarrhoea, and Ebola,' Auma proudly replied. At this point, I realised the very leading nature of my questions (we had just discussed that my research topic is epidemics).

Flo also chipped in: 'but cleaning is also to be smart, *maleng!*'.

Flo and I smiled at each other. Only that morning she had sent me back into my hut to change my clothes before we left the compound, remarking that I did not look smart enough. My newly washed white T-shirt was marked with children's handprints from breakfast.

> Flo continued to explain: 'Being smart means not having a dirty face, it's what you look like. You need to clean your clothes to be smart. Also ironing is important to kill germs like *Nwuki*, that lay eggs in the skin that grow to maggots.'
> Auma agreed with Flo's analysis of 'smartness'. Grinning at me, she added: 'If you are smart, then you control getting other diseases like cholera, diarrhoea and typhoid that come from dirty water'.
> They both agreed that they cleaned clothes and their homes to prevent diseases.
> 'So what does the word *yube* or *yubo* mean?' I asked them.
> 'To prepare' they both replied.
> 'What does prepare mean?' I probed.
> Auma replied: To prepare is to have a plan beforehand.'
> Flo nodded in agreement.
> 'When do you prepare?' I asked.
> 'Like if you are cooking, you have to get all the ingredients you need', Flo explained.
> 'How do you prepare for a visitor', I asked?
> Auma responded: 'Before they arrive, you need to clean the house, mop the house, get a cock or chicken to cook, get drinks, maybe local alcohol…'
> 'How much food do you know how to prepare?' I asked, genuinely intrigued. From experience, there was often an unpredictable number of people around at dinner time.
> 'When you have cooked and you are serving' Flo added, 'you need to leave some food inside, in case someone else comes. You always leave some food, just in case someone else comes.'
> 'Can you prepare for the unexpected?' I asked, almost thinking out loud, wondering if this might be an important theme of my research.
> 'When you are celebrating a birthday, like a surprise' Auma replied.
> I smiled at the perfect reply and re-phrased the question.

‘Can you prepare for *two mapoto atora*?’ I asked instead.

'By cleaning!’ they replied in unison.

Flo was clearly thinking. After a short silence, she responded to my previous question about preparing for the unexpected.

‘In South Sudan you always have to be ready to move, [and] always have your things ready to run, you can never settle. If the rebels come, they have sex with you, and your husband, if he is there, he cannot do anything, if he tries to stop them they will kill him. You have to always run from the rebels.’

But it would be difficult to run with multiple children Flo explained: 'When we were running from South Sudan in 2017 I had only my eldest child…we were in the garden digging when we heard the fighting, so I didn't have the usual things I had prepared in case I needed to run, so it made it harder. Back then, you always take the children when you go to dig, as you don’t know what will happen. Now with three [children], I could not manage. You have to walk through the water…many children drowned…you have one on your back, but you cannot manage with more…At least here [in Palabek], you may be hungry, but you are free.’

Flo had previously told me how she kept a small package of flour, wrapped in a blanket for her child, by the door of her hut. If she heard gun shots and needed to run, then she knew she could grab these essentials quickly as she fled.

‘Who taught you how to prepare like this?’ I asked Flo.

‘My mum. In the evenings she would say in those years of war, you prepare like this, otherwise you run with nothing.'

We sat in silence for a short time, hearing children play at the borehole nearby.

The conversation turned to what jobs women can do, and how they get money. Auma described how women can have many jobs, including being a teacher, or a doctor, working in the health centre like Consy, or becoming a shopkeeper, a tailor or hairdresser.

> 'But they have to wake early!' Flo explained. 'To do the cleaning first, then they go to work, then they come home early to cook…'
> 'But often women don't have money' Auma added. '…you have to wait until after October to do your hair…you get a few bits of money in October from the harvest, like from *sim sim* (sesame), then you can do your hair at the salon.'

That afternoon, I retreated to my hut, trying to reflect on our discussion that day. It had ranged from the importance of cleaning, to fleeing war, and then to hair. All part of life, I wrote in my fieldnotes.

This section has explored dealing with the unexpected among Acholi, particularly women. It has demonstrated that unexpected events are regular occurrences. The unexpected folds into everyday life, including anticipating visitors but also epidemics and forced displacement. It is also evident that the unexpected can be anticipated and prepared for, with approaches to preparedness and response often inseparable. In relation to epidemics, this takes a lot of work, particularly through cleaning, which is highly gendered. In common with the wind, cleaning resonates with biomedical models of interrupting disease transmission, but it is also an important social act of maintaining 'smartness'.

Changing Seasons, Changing Times

This section situates epidemics, and their unexpected nature, within the temporality of Acholi life more generally. To do this, two different concepts of time are explored; one reflects a more ordered 'clock time' common in the West (Thompson, 1967), and the other a more malleable, relational time. The best way to explore this second more flexible time, is in relation to the environment and seasons (Evans-Pritchard, 1939), especially given the historical and contemporary centrality of agriculture in Acholi society (O'Byrne, 2023). I was particularly interested in understanding how refugees dealt with repeated unexpected events, including famine, war, forced displacement and epidemics. I was increasingly struck by the contrast with public health understandings of epidemic preparedness and their temporality. Clumsily, I tried to explain this to Consy, but she

looked bemused. I changed tack, thinking it might be easier to start with understanding some important words related to time.

> ‘Ok, so how do you tell what time it is now?’ I asked.
> ‘I can see or tell the time through the phone or radio’, Consy replied, smiling somewhat quizzically at what seemed to be a rather obvious question.

Her description was consistent with my understanding of the Acholi word *cawa*, which had been translated to me as ‘clock time’. I was very familiar with clock time. ‘Success’ in my UK life was at least in part measured by my organisational ability, manipulating my time as a precious commodity. Living in Uganda had changed my relationship with time. Embracing such changes proved essential, both methodologically and practically. In Acholi, *kar*e was used to describe time in relation to activities, past, present or future. For instance, ‘*kare macon*’ is translated as ‘the olden days’. My Acholi teacher, Adonga Moses, explained that in the Western world it seems that *cawa* is more important. Whereas for Acholi, he explained, approaches to time are better understood in relation to *kare*.

I came to appreciate the importance of *kare* by talking with Geoffrey who explained the relational nature of time: ‘it is not like the clock we follow. Time is what is happening in a certain period….’ He went on to illustrate this in relation to seasons and the land, saying: ‘with [the] dry season, we know it’s coming, so people start to prepare, for hunting, harvesting, when it’s coming for the rainy season, we prepare the garden.’

> I tried to bring this understanding into my discussion with Consy, and asked her: ‘What is the difference between *cawa* and *kare*?’
> Consy looked puzzled.
> Observing Consy’s confusion, I tried to phrase the question differently: ‘What types of *kare* are there? Maybe you can tell me?’
> ‘When we say *kare ma anyim*, it means the near future’ Consy replied.

I was not sure where to go next, and so I turned to Geoffrey and Patrick.

Geoffrey tried to rephrase the question to Consy. 'Most of the time, when people say *kare*, what do they mean exactly?'

He looked at me and said: 'You see, to me, *kare* means seasons, and *cawa* means time. Most often, people talk about *kare me pur*, which is the season for farming.'

Hearing Geoffrey talk about *kare* in terms of farming, Consy agreed, and explained that *kare* does not mean time to her.

I tried to clarify: 'So *kare* comes or changes when the weather changes, is that right?'

Geoffrey corrected me: 'It's not just about the weather changing, it can be about a period of famine, or a period of harvest, and so on.'

'I think the challenge here,' Geoffrey explained, 'is not the question, but how we translate.'

Patrick chipped in: 'This thing is a little bit tricky and hard to understand, but you'll understand according to what someone is meaning or talking about. Because we can say this is the time for digging and also the season for digging.'

Feeling rather muddled, I tried to clarify.

'So if you say, *cawa me pur,* that means it's time for digging?' I ask.

'Yes, for the morning, but only for that duration when someone is preparing to go for digging.' Geoffrey responds.

'But of course, not even only in the morning!' Patrick clarifies. 'When the rain starts to pour you can say *cawa me pur*, but at the same time you can also say *kare me pur*, which means the season for digging'. Patrick is keen to add 'generally according to me, it will depend on what someone is meaning, because to me, season or time, is kind of the same'.

Geoffrey agrees with Patrick that in order to understand, you have to know what it is in relation to.

I am still confused but we are interrupted by light drops of rain on our noses. We look up to the sky to see the clouds rolling in. Geoffrey shields the Dictaphone from the light drizzle.

'Should we go inside?' I ask, 'it looks like it's coming to rain.'

We hear the heavy pounding of water on tin roofs nearby and soon enough the clouds opened above us, rain soaking the ground instantly. We dashed inside Consy's hut to try and finish the interview, but Consy became busy with duties at home. Her mother had been selling local alcohol, and was now drunk, requiring Consy's help to make further sales. Consy offered us shelter in her cooking hut, whilst she assisted her mother.

'We are created in such a way that we can adapt to it'

The previous section contrasted two different concepts of time: a 'clock time' (which underpins public health approaches to epidemics) and relational time. The latter is easier to understand with reference to environmental changes such as the weather or seasonal changes, because of the centrality of land and agriculture for Acholi. Yet, relational time is about more than the environment. Its importance is located in the nature of the relationship between time and events: periods of life are not dictated by time, but rather, *time moulds to occurrences happening within it*. Furthermore, linguistically defining temporal units of measurement, such as 'season' or 'time', is inherently problematic given the contextual dependence of such terms, and the variations between the people using them, as Geoffrey and Patrick eloquently describe. This section builds on the relational nature of time, exploring its centrality in how people adapt to something that is indeterminate and out of their control, such as an epidemic.

Geoffrey, Patrick and I gathered in Consy's dim cooking hut, sitting beside the pots and water jug, to continue our conversation. We left the door open for a crack of sun light, and a thin cotton curtain danced in the wind. Geoffrey, feeling like we are now making some progress, was keen to continue the conversation, and stated that *kare* 'will also just happen, whether you like it or not'.

We all agree that *kare* is always related to something, dependent on context, or in other words, relational or situational. Additionally, *kare* is not in the control of people.

I ask Geoffrey and Patrick: would people say 'it's the season for epidemics?'

> Patrick replies: 'I don't think people would say that, but during the rainy season, people say that this season is when children fall sick so much with diseases like cholera and so on'.

From my Acholi interlocutors I learnt that there is little expectation that time, or indeed other aspects of life, can be controlled by humans. This does not mean that you do not anticipate or respond to events, indeed you do, with great adaptation. Epidemics are not part of everyday life in terms of simply being expected in a certain period of time (e.g. season), although this may sometimes be the case (when the rain comes, waterborne outbreaks are more common). What is more important to appreciate is that, for Acholi, there is a degree of anticipation for any kind of unexpected event, which is enabled by their situational and relational temporality. The temporality of life, when considered in terms of *kare,* was malleable, adaptable, and remarkably different to a rhythm of life dictated by *cawa*.

This can be illustrated by examples from daily life. The start time of formal meetings were often presumed to be deferred until after the rain has ceased. Learning to change my personal rhythm to adjust to this different temporality proved to be essential for successful fieldwork. Humanitarian actors working on the front line in Palabek also tailored their activities to complement this way of life, understanding that meetings or training sessions with refugees had to be tailored to other facets of daily life, including the weather.

Geoffrey elaborated further:

> '... for things that we can't predict that we don't know are coming, that we don't know what will come next, we take it as something we don't have control over, but we are created in such a way that we can adapt to it. Not to know is ok, we receive it the way it comes.'

I probed Geoffrey further, asking him how you can prepare for something that you can't predict. He explained how past experiences are important in informing how to deal with unexpected events.

> '…because if something happened some time back, you know ahead of time this might happen [again]. If it happens, somehow you use your past experience as a starting point. You don't start from scratch. You understand where you would have done better…let's look at diseases like Ebola….it killed a lot of people back then [2000-2001]. This time when Corona came, they knew they needed to run back to their villages [away from towns and cities]. In the first wave people ran back to the village, because they got concerned, and used their experience from the previous one [Ebola].'

Successfully dealing with epidemics is not just about learning from history. It is also about being flexible, and adjusting, Geoffrey continued:

> 'We didn't know when it [COVID-19] would reach here. When you take it locally here, we call it *two gemo*, or something that comes unexpectedly. When it comes we have to be flexible, or to adjust, or adopt changes…here we adjust just like that. In other parts of the world they love to be ahead of time. Situations forced them to adjust but they are not willing to. The setting of life there, it's a fixed or parallel line and you go on that programme no matter what.'

It became quieter outside, as the pounding of the rain eased back to a drizzle. Taking advantage of the change, we went outside to find Consy. She was already walking across the compound to greet us.

Discussion

This article draws on long-term ethnographic research with South Sudanese Acholi refugees in Palabek Refugee Settlement, northern Uganda, during the COVID-19 pandemic, to critically reflect on public health conceptualisations of epidemic preparedness. These approaches to preparedness emphasise anticipatory actions to mould uncertainty into quantifiable and actionable risk (Roth, 2020), whilst claiming to value adaptability (Bryce *et al.*, 2022). There is still a tension, however, and even contradiction, between the rhetoric around flexibility in public health discourse, and the

way successful preparedness is measured. Current approaches evaluate success on the basis of a narrow range of logistical, epidemiological and clinical criteria (Kentikelenis and Seabrooke, 2021; Oppenheim *et al.*, 2019; World Health Organization, 2023b). These markers of success are measurable and essentially controllable, with the ultimate goal of making preparedness more knowable through the minimisation of uncertainty. If flexibility is only possible in terms of measurable criteria, however, it can be argued that such an approach is inherently inflexible. Furthermore, this biomedical approach can easily ignore social and spiritual dimensions, particularly those that are difficult to pin down or categorise. Instead of adapting to uncertainty and shifting social circumstances, biomedical anticipatory actions to promote flexibility and readiness for change often revolve around optimising material resources (Caduff, 2015). This may not be possible in resource poor settings, and so mistaken conclusions are drawn that low resource settings are necessarily less prepared (Oppenheim *et al.*, 2019).

Public health approaches to epidemic preparedness are framed by a linear temporality where time, as an important resource, is something to be optimised and measured, reflecting capitalist logics that manage time in relation to production (Thompson, 1967). A 'neoliberal' temporality also shapes humanitarian aid. Refugees are encouraged to be self-reliant resilient individuals, responsible for their own economic survival, and the 'humanitarian marketplace' ensures every intervention is monitored and measured, determined by international donor funding cycles (Ilcan and Rygiel, 2015). This leaves little room for alternative temporalities that may more easily allow adaptation to difficult circumstances (particularly relevant for both preparedness and displacement) despite being unmeasurable by current indicators.

Leach *et al*., (2022a) foregrounded the need to consider alternative constructions of time to think about uncertain futures in socially and culturally grounded ways. In response, this article has centred a different relational temporality that frames Acholi refugees' understandings of epidemics and unexpected and uncontrollable events more generally. It explains how this relational temporality is central to the ability of Acholi refugees to adapt to unexpected events, easily incorporating the indeterminacy of, and uncertainty surrounding, epidemics. As a methodological choice, it has intentionally included

periods of confusion to capture the indeterminacy of epidemics, but also of life in general. I have tried to write in a way that foregrounds the indeterminacy of meanings, to avoid overly determined interpretations. Presenting less confusion and greater clarity would have more easily aligned the data with the standardised presentation of academic findings, but it risks undermining the very essence of the research. The open-ended approach to interviews and conversations, and the back and forth of searching for meaning, captures the importance of shifting understandings for different people, which cannot be appreciated with simple translations of 'time' or 'epidemic'. This confusion also captures the indeterminacy of literal and metaphorical understandings, reflecting a key part of Acholi language: literal and metaphorical distinctions are often not made, with meanings dependent on context, and the language leaving room for ambiguity and interpretation (Adonga and Hopkins, n.d.). Removing the indeterminacy of the research through overinterpretation for the sake of standardised presentation would violate this core premise.

I did not appreciate this indeterminacy at first: my confusion with Consy initially arose because I had mistakenly assumed discreet explanatory models. Hewlett and Amolat (2003) suggest that Acholi often move between contradictory biomedical and spiritual understandings of epidemics. This article has problematised this approach, given that even thinking with explanatory models is attempting to distinguish the indistinguishable. Epidemics, like the wind, are difficult to pin down, with various interpretations. There were overlapping translations of *two gemo*, *two yamo* and *two mapoto atora*, with shifting causation and cure in different scenarios and for different people. Each term emphasises different elements of overlapping phenomena, but there was always the potential for deeply intertwined dynamics between physical, spiritual, social and environmental dimensions. For example, spiritual elements that address 'why now', do not necessarily contradict biomedical explanations of physical causation (see Evans-Pritchard, 1976). Biomedical and spiritual causations of epidemics cannot be separated because, as O'Byrne (2015b) describes, spiritual elements are an inseparable element of life.

This can be understood further in relation to the constant search for equilibrium, social balance and moral order among Acholi, which intrinsically involves relationships

between the living and the dead (Porter, 2012). When spiritual forces are inseparable from other dimensions of life, ultimate control is not found amongst humans. Rather, humans can engage with activities to maintain social harmony with each other, with the environment, and with the spirits that live amongst and within them. If misfortunate unexpected events occur (a sign of imbalance), then Acholi shift their activities to seek to restore balance and moral order. Epidemics, as potential indicators of imbalance, cannot be isolated as 'normal' occurrences, nor as discreet crises, but rather they become part of what Finnström (2008) refers to as a lived, and at times, uncertain, continuum of good and bad surroundings. This becomes even clearer through an understanding of relational time.

P'Bitek (1966), in his infamous Acholi poem, Song of Lawino, writes 'there is no fixed time'. Indeed, this article's exploration of *kare* has demonstrated how *situations produce time*, or in other words, time adapts to a given event (Mbiti, 1990). This is not dissimilar to classic descriptions of task-oriented or event-focussed temporalities (e.g. Evans-Pritchard, 1939; Thompson, 1967). For Acholi, adaptation follows relational time because most of life cannot be controlled and is constantly shifting, as described in relation to balance and equilibrium. Rather than time being conceptualised as a limited resource (and means of production) into which people must insert their lives (a temporality that frames public health and humanitarian interventions), time, for Acholi refugees, instead helps to order and orient peoples' lives – it is flexible. From their perspective, it is difficult to 'waste' or 'lose' time, because there is always more of it.

The discussions with Patrick and Geoffrey revealed that the relational nature of time is made particularly visible through understanding the interconnections between the environment and time, resonating with Evans-Pritchard's (1939) description of 'oecological time'. Relationships with the land are at the heart of Acholi life. As agriculturalists, the land is how people survive to feed their families and create extra crops to sell. But land is more than about just food - it provides a rhythm to life. The wet and dry seasons come and go with a degree of predictability, determining when crops are planted and harvested. Epidemics associated with weather changes or flooding are considered, to some extent, seasonal and part of the rhythm of life, as well as

simultaneously having the possibility of being associated with untoward misfortunate events related to an imbalance of moral order. Any disruption of the environment is inseparable from cosmological dimensions; *jogi* live amongst mountains, hills, and expanses of water (Baines, 2005; Finnström, 2008; Porter, 2013). Forced displacement, therefore, not only denies access to ancestral land and an important agricultural source of income, but it can also disrupt cosmological equilibrium.

In Palabek, Acholi refugees are well accustomed to dealing with unexpected events, whether that be conflict and displacement, epidemics, food insecurity, or other day-to-day challenges. In common with trying to control the wind, ultimate control over epidemics seemed implausible, but people still anticipated them. In contrast to public health approaches to epidemic preparedness, where emphasis is placed on seeking to control the present and future, Acholi refugees anticipating unexpected events did not come from a position of trying to control what was thought of as uncontrollable. This was revealed in very material ways, such as completing the necessary tasks of daily life, but also adapting to events as they occur. The practical dimensions of adaptation were seen in the day-to-day work, particularly of women, as they cooked and cleaned, and kept food to one side, anticipating unexpected visitors, whether that be neighbours joining for a meal, or a disease coming with the wind. The practical elements of anticipating unexpected visitors and epidemics overlapped with one another. Furthermore, distinguishing between preparing in the present, or for the future, felt artificial, as they generated similar practical tasks. This problematises the public health temporal distinction between preparedness and response, or in other words, the temporal distinctions in definitions of preparedness (Lakoff, 2017; Roth, 2020).

The relational temporality amongst Acholi refugees, with its innate adaptability, also problematises the temporality of emergency in humanitarian practice (Anderson *et al.*, 2019; Vigh, 2008). For instance, Consy and Flo were constantly anticipating and adapting to a variety of challenges, that included day-to-day unexpected visitors, as well as epidemics, and conflict and violence. For these women, they were all aspects of day-to-day life, which was often incredibly challenging given the context of substantial food insecurity. Distinguishing an acute emergency from other challenges is, therefore,

artificial. Consy adjusted her home life to a diagnosis of COVID-19 to protect her family from the disease, but she was also willing to shift her life entirely if circumstances required her to do so. Similarly, Flo described a constant readiness to leave her home whilst protecting her children in response to conflict. In times of conflict, she prepared for violence and displacement by leaving a small package by the door. Day to day, they always found food, however small, to give unexpected visitors. These forms of anticipation are highly relevant to understandings of epidemic preparedness. Public health framings of epidemic preparedness, however, obscure alternative temporalities that frame epidemics as part of everyday life. Periods of life that might be categorised as 'emergency', however, are often indiscriminate from the general rhythm of life that requires equal amount of adaptation and flexibility, particularly in settings of high precarity. This chimes with Vigh (2008) who emphasises the need to appreciate crises *as* context, rather than crisis *in* context, to place emphasis on its enduring nature, rather than a focus on individual events.

Conclusion

Epidemics, indeterminate and uncontrollable, are significant events, but they are also inseparable from everyday life. Acholi refugees were quick to adapt to changing circumstances. Over time, it emerged that *not* being ready for change was never really an option, especially for those with histories of repeated displacement. This adaptability is grounded in relational time and a constant search for equilibrium. The inherent flexibility of this approach is highly relevant to conceptualisations of preparedness. It contributes a novel perspective to evolving anthropological engagement with epidemics, providing long-term ethnographic evidence that the more that an ordered and fixed approach to time in public health intervention is sought with measurable activities, the greater the risk of losing valuable characteristics of relational time, particularly when resources are limited. In this way, mainstream public health approaches to preparedness continue to subjugate those whose temporalities do not align with global agendas, maintaining the current power dynamics between those perpetually in need of, and those able to deliver, humanitarian assistance.

These conclusions have not only emerged in the detailed ethnographic material presented here, but also in the analytical choices. Rather than writing out confusion or methodological detail, attention has been given to the way in which methods can reflect the topic of analysis. In so doing, it has revealed the indeterminacy of knowledge acquisition as well as the adaptability required in data collection, whilst always maintaining emphasis on the moment of dialogue, as the platform from which other understandings can emerge. This, in turn, confirms the utility of alternative temporalities.

Chapter 10: Concluding Thoughts

Problematising Epidemic Preparedness

Dominant approaches to epidemic preparedness privilege biomedical and techno-scientific framings, with a combination of scientific, technical, logistical, and legal considerations defining the problem as well as the solution (Leach *et al.*, 2022a). Categorisations and fixed ideas monopolise these approaches to preparedness, which reaffirm current power dynamics and maintain the status quo. They define what is, and what is not, considered acceptable as 'normal', and ensure certain types of knowledge are privileged whilst others are neglected. Whilst mainstream approaches purport to be apolitical, in practice, they are framed by health security agendas, created primarily in the Global North (Caduff, 2015; Lakoff, 2008). Additionally, epidemic preparedness is based on an inherent future orientation, embracing anticipatory strategies for potential epidemic disasters. Epidemics invoke 'emergency imaginaries' (Calhoun, 2010) to attract donor funding and prevent future suffering. Although preparedness strategies and emergency discourses attempt to prevent suffering, *whose* suffering is privileged is influenced by broader political processes, which shapes the kinds of people who become targets of intervention. To elaborate, current mainstream approaches to preparedness fail to capture people's lived experiences in the diverse socio-economic and political contexts during epidemics, and the way in which they relate to other sources of suffering. In other words, little room is left for the lived experiences of those actually affected by epidemics, or other forms of suffering or crisis that people have to deal with simultaneously. In light of these concerns, there is overall consensus – at least among anthropologists – that mainstream biomedical and techno-scientific approaches to epidemic preparedness, need to be reconsidered. A broader approach to epidemic preparedness, is, undoubtedly, needed.

An Approach to Re-thinking Epidemic Preparedness

This PhD has focused on epidemic preparedness amongst South Sudanese Acholi refugees in Palabek Refugee Settlement, northern Uganda. Drawing on 14-months multi-sited ethnographic research during a global health emergency, the thesis has examined how Acholi refugees (and to a lesser extent humanitarian and government actors) made sense of, and responded to, the events that unfolded around them.

It has built on two distinct and quite separate literatures: anthropological research on refugees (e.g. Kaiser, 2006, 2010; Malkki, 1995a; O'Byrne, 2023; O'Byrne and Ogeno, 2021; Torre, 2023a) and anthropological research on epidemics (e.g. Akello and Parker, 2021; Hewlett and Hewlett, 2008; Kelly *et al.*, 2019; Leach *et al.*, 2022b; MacGregor *et al.*, 2022; Richardson *et al.*, 2015). This thesis has brought this literature together through a focus on epidemic preparedness amongst refugees during COVID-19. This period brought a new wave of ethnographic research with refugees exploring their experiences of COVID-19, although this research mainly focussed on remote ethnography (Böhme and Schmitz, 2022; Islam *et al.*, 2022), was either conducted in a high-income country (Marabello and Parisi, 2020), or was located in informal refugee settings (Bhanye, 2024). There has not, therefore, been long-term ethnographic research within a formal refugee setting (camp or settlement) in a low-income country, specifically exploring *epidemic preparedness*. Doing this research in a formal refugee setting in a low resource country was important – it has provided a unique lens to critically reflect on mainstream (biomedical and techno-scientific) framings of preparedness.

This PhD has focused on four dimensions of epidemic preparedness in Palabek Refugee Settlement: containment; vaccination; screening; and the linear temporalities underpinning biomedical approaches to epidemic preparedness. While recognising that this is not an exhaustive list of the different dimensions of preparedness, these chosen elements are sufficient to reflect on some of the fundamental framings of contemporary approaches to preparedness. Moreover, these dimensions were not decided upon in advance. They emerged in the field, and either captured crucial issues impacting the day-

to-day lives of refugees or were the most prominent issues for humanitarian and government actors.

Summary of Chapters

Chapter 1 introduces the concept of epidemic preparedness, highlighting the problems with dominant biomedical and techno-scientific framings, including the way in which successful preparedness is currently conceptualised and measured. Such framings ignore the harder to quantify historical, social, economic, political and spiritual dimensions. Furthermore, the need to enhance epidemic preparedness measures in refugee settings is essential – not least because they are known to be at risk of disease outbreaks. Refugee settings, such as camps and settlements, also provide unique opportunities to study epidemic preparedness in relation to problematic power dynamics attempting to control the movement of people and pathogens. This chapter, therefore, outlines the importance of studying epidemic preparedness in a refugee settlement, from both biomedical and anthropological perspectives. Two broad themes and related research questions were identified: first, to critically explore biomedical and techno-scientific approaches to preparedness; and second, to look beyond official approaches, to focus on what could be revealed by paying attention to refugees' histories, ideas and practices.

The second chapter reviews relevant literature informing this PhD. It is divided into three parts. Part 1 focuses on anthropological literature regarding epidemics. It draws attention to the historical emergence of preparedness in relation to health security agendas, the central importance of numbers and concepts of risk in biomedical understandings of epidemics, and the way in which anthropologists have foregrounded the need to better understand the unique socio-political contexts in which epidemics occur. Part 2 of this chapter reviews relevant literature on humanitarianism and the (bio)politics of emergency. This is followed by a discussion highlighting the origins of refugee camps and the scholarly field of refugee studies. Examples of ethnographic research in refugee camps or settlements are also outlined. Finally, part 3 focuses on epidemics and

displacement among Acholi in northern Uganda and South Sudan. This includes an overview of Uganda's flagship 'open-door' refugee policy, which promotes the 'self-reliance' of refugees. It then introduces Acholi, paying attention to colonial administrations and their interconnectedness with important historical epidemics. This chapter also highlights the complex socio-political dynamics that characterise the borderlands between Uganda and South Sudan.

Chapter 3, a published commentary in the *Journal of Biosocial Science*, critically reflects on the international praise for Uganda's approach to COVID-19. The chapter suggests that the prevailing narrative of Uganda's success regarding COVID-19 needs to be reconsidered, given the evidence indicating that COVID-19 lockdown measures had little impact on the epidemic curves in Uganda, especially in the second and third waves. Furthermore, it highlights evidence demonstrating that Uganda's approach to COVID-19 was anything but successful for many people living in the country.

Chapter 4 presents my initial experiences of starting this PhD during COVID-19 in the UK, and my transition to Uganda. which was published in the Field Notes section of *Medicine Anthropology Theory*.

Chapter 5 describes my methods and fields sites, specifically describing my initial impressions of Palabek Refugee Settlement. The apparent beauty of the settlement that I first encountered, may well have reflected the pride and resourcefulness of refugees. This is important to acknowledge to counter the image of refugee existence as 'bare life' (Agamben, 1998). These first impressions of beauty, however, also capture an imagery promoted by OPM staff in terms of 'peaceful existence' between Acholi refugees and Acholi Ugandans, who share aspects of identity and kin. This research subsequently found, however, that despite the rhetoric of 'peaceful existence', there is a darker and much more uncomfortable side of life in Palabek, which is explored further in the subsequent chapters.

The thesis proceeds by presenting research findings focusing on four different elements of epidemic preparedness. Chapter 6 focuses on containment – a commonly used

mainstream approach to interrupting transmission during epidemics. Containment was a central component of lockdown policies across the globe. In Uganda, COVID-19 containment was also presented as a form of humanitarian protection and entailed the reduction of movement and the closure of international borders. This chapter explains how refugees were simultaneously framed in Uganda as especially vulnerable to COVID-19 and therefore in need of protection, whilst also being described as a significant threat to health security. To understand this tension, the chapter describes the need to look beyond formal notions of protection, to explore forms of 'self-protection'.

At first, self-protection included engagement with formal approaches to containment, but through subsequent waves, the fear of illness from COVID-19 waned, the legitimacy of public health measures was eroded, and day-to-day struggles, particularly regarding food insecurity, came to the fore. In response, self-protection shifted to a focus on mobility (reflecting historical borderland dynamics), with refugees crossing international borders to access vital resources. People clearly circumvented the border restrictions without this leading to a catastrophic rise in the numbers of people becoming ill with, or dying from, COVID-19. Despite this, the borderland areas remained a focus of security concern in Ugandan COVID-19 policy. This chapter questions why this was the case. It reveals how containment policy became more about protecting political interests, rather than about protecting the health of refugees and Ugandans. This points to the way in which global discourses about COVID-19 were successfully mobilised to elicit specific resources, whilst obfuscating other failures. In its policy recommendations, this article calls for humanitarian and government actors to appreciate the agency of refugees in responding to containment according to their own priorities, irrespective of whether or not they align with official policies. Such work points to the need to develop broader, multi-faceted and more flexible approaches to epidemic preparedness too.

Chapter 7 focuses on another, equally important dimension of preparedness: vaccination. The chapter, which has been published in *Social Science & Medicine*, explores the introduction of the COVID-19 vaccine in Palabek Refugee Settlement. Typically, global debates regarding the COVID-19 vaccine have been rather dichotomised, foregrounding vaccine supply on the one hand, and vaccine hesitancy on

the other. This chapter demonstrates that vaccine supply and hesitancy are deeply intertwined. 'Suspicious business', which builds on Leach and Fairhead's (2007) and Leach *et al.*'s (2022b) 'vaccines anxieties' framework, revealed that geopolitical dynamics (historical and current) inescapably shaped people's perspectives on the vaccine, which are not captured in the notion of 'vaccine hesitancy'. These geopolitical dynamics, that often reflect ongoing power imbalances, were visible in the inequalities of vaccine supply. Crucially, they were also understood by Acholi refugees in relation to spiritual dimensions of life. This was explored through accounts of people who go underwater, *te pii*.

Chapter 8 focuses on the screening processes for COVID-19. The chapter demonstrates how screening for COVID-19 was significantly shaped by political, rather than just biomedical logics. Screening, explored through the idea of 'counting COVID-19' as an assemblage, was found to be mobilising humanitarian ideologies and rhetorics of care, while simultaneously being used to control narratives about dangerous 'others'. Counting COVID-19 enabled district, national and international political figures to control the narratives regarding migrating threats related to both refugees and COVID-19.

However, this article also pointed to the importance of acknowledging the work of humanitarian professionals on the front line. Although their work, at first sight, may seem to be focused on the control of people, it is also important to recognise the humanity underpinning their work, reflecting relational moments of care. Just at literature points to the problematic way refugee experiences are often homogenised (Kaiser, 2011; Malkki, 1995b), there is also a tendency to homogenous humanitarian actors, with those individuals working on the front line presented as representatives of their respective humanitarian organisations, rather than individual actors (James, 2022b; Peters, 2016). This chapter, therefore, brought to the fore the daily struggles of individual humanitarian practitioners, whilst also revealing the constraints of the wider system they worked within.

Chapter 9 focuses on a rather different dimension of preparedness – temporality. The chapter problematises the linear (and Western) temporality of mainstream public health

approaches to epidemic preparedness. It does this by exploring the relational temporality that frames life for Acholi refugees. This temporality is explored through conversations with interlocutors that analyse different translations of the word 'epidemic', exploring the relevance of the wind, as well as trying to understand how people deal with unexpected events in life. These discussions reveal that adaptability is a central aspect of relational temporality amongst Acholi. This is highly relevant to mainstream conceptualisations of preparedness that value adaptability, at least in rhetoric. Chapter 9 reveals the importance of relational temporality amongst Acholi through the choice of ethnographic data, but also through the methods chosen to analyse and present the findings. Weaving in and out of conversations maintained the relational moments of dialogue as the focus of the chapter. In some respects, this chapter could have been positioned earlier on, introducing Acholi conceptualisations of epidemics as a fundamental starting point. However, this risked 'local conceptualisations' being examined as problematic starting point in relation to more mainstream approaches to preparedness. This thesis has inverted this: the adaptability of relational time is not the initial problem, but rather offers alternative ways forward in re-thinking preparedness.

Limitations

Although this research has focused on perspectives from refugees in the district of Lamwo, it was limited by its inattention to Ugandans in this district, who are living in some of the poorest areas of the country. The Uganda Bureau of Statistics (2024b) published multidimensional and monetary child poverty rates across Ugandan districts for 2019/2020: the Acholi subregion[28] of Uganda averaged 84% and 72% respectively. Within the Acholi subregion, multidimensional child poverty rate for the district of Lamwo was 90.0%.[29] In comparison, child poverty rates in Kampala, the capital, were 8% and 2%. It is likely that Ugandans living in Lamwo have experienced political neglect in a similar way

[28] The Acholi Sub-Region includes the following districts: Agago, Amuru, Gulu, Kitgum, Lamwo, Nwoya, Omoro and Pader.

[29] The report does not specifically comment on whether any refugees are included in the household surveys. However, the statistics are broken down by sub-counties within each district (including those in Lamwo that do not contain Palabek Refugee Settlement), which confirm similarly high rates of child poverty to the overall district and subregion.

to refugees. In part, this is demonstrated by the number of Acholi Ugandans who attempted to register as refugees in Palabek (see chapter 8).

This thesis has been informed by Acholi interlocutors from both South Sudan and Uganda. Whilst it primarily focussed on South Sudanese Acholi refugees living in Uganda, it was difficult to distinguish which parts of my understanding or interpretation was informed by Acholi Ugandans, including Geoffrey, and Acholi friends and colleagues in Gulu. Furthermore, amongst South Sudanese Acholi, many had been living in Uganda for years, and sometimes decades. It was not unusual for the refugees I spoke to in Palabek to have been born in a different Ugandan refugee settlement: they had subsequently returned to South Sudan for a period of time, before being displaced once again to Palabek. Given this interconnectedness, I have not attempted to overly distinguish which ideas are unique to Acholi who identify as either South Sudanese or Ugandan, unless they were immediately evident, such as describing epidemics in relation to *two gemo* or *two yamo* in chapter 9. However, if further research was to be conducted, looking at such differences may provide an interesting line of enquiry - although I would be inclined to think in terms of broader characteristics than nationality. For instance, I imagine wealth, educational status, religion and exposure to urban settings may be more influential than nationality alone.

Contributions

Despite these limitations, this PhD makes several contributions to contemporary critiques of epidemic preparedness which are relevant for, but not limited to, refugee settings.

Recognising Wider Sources of Suffering

Biomedical approaches to preparedness do not adequately engage with the socio-economic and political contexts in which outbreaks unfold. MacGregor *et al.,* (2022) use the term ‘intersecting precarities’ to suggest that preparedness should pay greater attention to the specific contexts in which epidemics occur. These authors, however, did

not consider refugees. This PhD suggests it is important to consider the specific socio-economic effects of an epidemic and its restrictions in the unique context of refugee settings. Indeed, chapters 6 and 7 have clearly demonstrated how multiple intersecting precarities were inextricable from the way refugees' (dis)engaged with formal epidemic preparedness approaches in Palabek, where funding shortfalls, food prioritisation activities and corruption have led to disastrous food insecurity and inadequate livelihood opportunities for refugees. The challenges that refugees regularly navigated to avoid disaster were a direct result of displacement and epidemics but were also caused by the same public health and humanitarian aid that were intended to protect and assist them. For instance, rather than protecting refugees from COVID-19, lockdown worsened the socio-economic conditions for refugees living in Palabek.

The way in which refugees in Palabek navigated containment, vaccination, and a wealth of other intersecting precarities, was influenced by historical dynamics. This includes colonial encounters, which shaped people's perspectives of the vaccine. Furthermore, coping strategies for containment were shaped by historical borderland dynamics, despite the more immediate risk of encountering conflict. Containment policy, porous borders, Covid-19 screening, and vaccine uptake were all influenced by the specific historical, political and socio-economic dimensions that shape life for Acholi refugees in Palabek. By using an ethnographic approach, this PhD has demonstrated the deeply interconnected nature of historical and socio-economic conditions in influencing the success of preparedness activities. These dimensions cannot be easily separated out as 'context', and furthermore, may not have become as visible if alternative research methods had been employed, or had focussed solely on epidemics.

At the start of this PhD, it was difficult to establish whether unexpectedly studying preparedness during 'a pandemic' was serendipitous or problematic. Over time, it became evident that studying preparedness during COVID-19 was helpful for several reasons. This sub-section has demonstrated the first of these reasons: it rendered visible the inherent problematic priorities imbued in concepts of preparedness. The way in which epidemic preparedness was conceptualised shaped policy priorities during

COVID-19, and therefore influenced how COVID-19 success was measured. Examining the realities of COVID-19 success, therefore, sheds light on the problems inherent to conceptualisations of preparedness. This sub-section has demonstrated this by showing that if the wider historical and socio-economic dimensions of epidemics are ignored in conceptualisations of preparedness, they continue to be ignored during an epidemic. Furthermore, when approaches to preparedness that are heavily shaped by actors in the Global North, are subsequently transported to humanitarian settings in the Global South, the pivoting of attention and resources, despite based on a moral authority to relieve suffering, may actually detract from more pressing concerns.

Revealing the Hidden (Bio)politics of Preparedness through the Temporality of COVID-19 in Ugandan Refugee Settlements

This thesis has also revealed a more complex relationship between COVID-19 and preparedness: COVID-19 was not simply explored as a 'case study' of preparedness. With the exception of the urban elite (especially in Kampala), the devastation of COVID-19 never materialised in Uganda, especially in rural settings such as Palabek, but COVID-19 policy remained prominent. By studying preparedness through different waves of COVID-19, therefore, it became apparent that Ugandan policy (which was implemented in Palabek) was characterised by a persistent focus on the anticipated (potential) threat of this disease. This can be considered in relation to the anticipatory nature of preparedness, but also as a future orientated 'emergency claim' (Rubenstein, 2015). The power of a declaration of emergency is linked to a *future* temporality. In disasters or catastrophes, the bad outcomes have happened (to at least some extent), whereas, as Rubenstein (2015) writes: 'An emergency is…an impending disaster that can potentially be warded off, at least to some extent' (p105). Understanding this future orientated temporality of emergency helps to reveal the politics of preparedness. Whereas mainstream biomedical and technical conceptualisations of preparedness fail to adequately acknowledge the way in which this concept is mobilised for political purposes, this thesis reveals that epidemic preparedness is profoundly political.

Exploring COVID-19 and preparedness together through a focus on temporality, reveals not only what preparedness can mobilise, and what it can obscure, but also the consequences of (in)action. It was notable, for example, that preparedness enabled the simultaneous neglect of the wider socio-economic effects of COVID-19 restrictions discussed in the subsection above, whilst obscuring the (bio)politics of COVID-19 policies in Uganda. The next paragraphs describe how data suggesting relatively low rates of mortality and morbidity from COVID-19 in Uganda,[30] were used politically to demonstrate the supposed success of national COVID-19 policy, and how refugee policies became entangled in this narrative.

To understand the broader political influences that shaped COVID-19 policy in Uganda, this thesis has paid attention to the different ways in which epidemic policy played out on the ground in Palabek Refugee Settlement. This has highlighted how similar technologies of power in Palabek were triggered by refugee and epidemic crises. For example, chapter 8 revealed the contingent nature of counting refugees and COVID-19, with the material elements of refugee registration easily pivoting to COVID-19 screening. This demonstrated how COVID-19 policy became enmeshed with Ugandan refugee policy. Chapter 8 also describes how the Ugandan government persevered with COVID-19 screening amongst refugees, despite public health advice suggesting it was unnecessary, because screening was important for other non-biomedical reasons, including district and national political and financial incentives, as well as a commitment to fostering greater accountability. Chapter 6 also details how containment policy, involving the prolonged official closure of international borders to refugees, conveyed a persistent focus on managing the health security risks posed by refugee movement. In essence, these chapters demonstrate that containment and screening were essential to maintaining the 'emergency claim' of COVID-19 in Uganda.

The persistence of COVID-19 activities, that drew on 'emergency', were strengthened by health security agendas designed primarily in the Global North. This, in turn, was

[30] Chapter 3 presents the overall mortality rates for COVID-19 in Uganda and compares the low rates in the East African Community to other regions of the world. Chapters 6 and 7 highlight that by the end of fieldwork in mid-2022, there were only 3 reported deaths of COVID-19 in Palabek Refugee Settlement.

beneficial to political figures who had vested interests in the perpetuation of COVID-19 restrictions which reaffirmed existing political power. As Calhoun (2010) wrote: 'The managerial response to an emergency focuses on restoring the existing order, not in changing it' (p. 55). For example, considering COVID-19 as an emergency in Uganda enabled a militarised response, which in turn favoured the president's election campaign and entrenched authoritarian rule (Parker *et al.,* 2022; Allen and Parker, 2023). Furthermore, the persistent focus on containment and screening amongst refugees deflected attention from the more negative impacts of COVID-19 policy for refugees. These damaging consequences included the wider socio-economic consequences of lockdowns, and the worsening hunger amongst refugees. Instead, a focus on containment and screening attempted to indicate that Uganda was considering the COVID-19 risk posed to established refugees (in order to 'protect' them). This aspect of policy also portrayed the image that Uganda was considering the global health security risk of uncontrolled movement of people and pathogens, which is central to global mainstream approaches to preparedness. Doing so strengthened the narrative of Uganda's success regarding firstly, its refugee policy, and secondly, its national management of COVID-19. The narrative of COVID-19 success chimed with Uganda's long history of reported success internationally, including its flagship open-door policy to the now 1.7 million refugees it hosts (UNHCR, 2024f), and progress in overall development (Wiegratz *et al.*, 2018).

However, viewing COVID-19 in terms of an emergency (claim), also revealed how it protected certain political interests, whilst it simultaneously failed to appreciate the significant consequences for those in the most vulnerable conditions. This resonates with literature that has contested the crisis narrative during COVID-19: the label of crisis and its anticipatory regime can obscure other priorities related to health and security, as well as state neglect of vulnerable populations (Lees *et al.*, 2023). In this case, it was at the expense of refugees, who continue to live in great precarity and whose voices are largely ignored. Given the connections between COVID-19 and preparedness outlined in this chapter (and this thesis), it follows that conceptualisations of preparedness (in addition to 'crisis' or 'emergency') also focus on certain suffering, whilst obscuring others.

In Palabek, a continued focus on COVID-19 worked to obscure other specific dynamics: the idea that food rations were reduced *because* of COVID-19 was in many ways beneficial to government and humanitarian actors, as indicated in chapter 6. This is despite evidence that such plans had already been discussed prior to COVID-19 as part of a global shift in the 'prioritisation' of food and nutrition assistance to refugees, in light of substantial funding shortfalls (World Food Programme, 2024). The narrative of COVID-19 related hunger detracted from pre-existing humanitarian failures of worsening food insecurity in Palabek (Torre, 2023b), which ultimately detracted from Uganda's positive reputation regarding refugees. These humanitarian failings need to be considered not only in terms of international failings of inadequate refugee funding (UNHCR, 2024h), but also in terms of significant fraud and corruption within Uganda's refugee response (O'Byrne, 2022; Titeca, 2021).

Examining COVID-19 as an emergency (claim) has revealed important political dynamics. This, is turn, has created space to examine the day-to-day lives of refugees in chronic emergencies, (including problematising the idea of epidemics as an acute event distinguishable from 'normal' times) (e.g. Anderson *et al.*, 2019; Rubenstein, 2015) to make visible the more immediate suffering being experienced by refugees in Palabek. Here, I draw on James *et al*., (2023b) who wrote: '…the COVID-19 pandemic could be experienced at the crossroads between the exceptional and the everyday, where "states of exception" brought by emergency measures shed new light on long-standing political tensions and structural problems' (p. 12). For refugees in Palabek, more current struggles were shaped by ongoing food insecurity compounded by COVID-19 interventions which reduced livelihood opportunities. This was made particularly visible in how refugees responded to lockdown measures in chapter 6, but also in chapter 9, which demonstrated that epidemics are part of everyday life, whilst also being unexpected events (Lynteris, 2014). Forced displacement is also part of everyday life whist simultaneously being a significant moment. This, therefore, adds to literature challenging a temporality of emergency that categorically distinguishes between 'normal' times and otherwise.

Capturing the Global Politics of COVID-19 in Palabek

So far, this chapter has mainly focused on revealing the national Ugandan politics that are relevant to preparedness. This section discusses wider geopolitical dynamics, which came to fore when researching 'local' perspectives in Palabek. International market-driven principles have shaped global approaches to COVID-19, clearly visible in the pharmaceutical development and distribution of vaccines described in chapter 7. Uganda's overall 'development-approach' to refugees focuses on individual rather than collective responsibility, through a focus on 'resilience' and 'self-reliance' (Brown and Chiavaroli, 2023; Omata, 2023). These geopolitical dynamics have had detrimental consequences for people in the most challenging of circumstances, whose needs have been ignored.

COVID-19 has become another means to obtain financial assistance from international donors, largely dictated by global agendas of health security, dressed in rhetoric of attending to the needs of 'poor people in Africa' whose vulnerability draws on the heart strings of the wealthy. This financial assistance in the name of COVID-19, however, is not dictated by the actual needs of people in the greatest precarity. Furthermore, in a refugee setting in Uganda, it may never reach those to whom it was envisioned to 'save', due to corruption (O'Byrne, 2022). This is rarely exposed adequately, because of mutual dependency: not only is Uganda dependent on international donors for ongoing financial assistance, but international actors are dependent on Uganda as a marker of success for ensuring the ongoing status of its flagship refugee policy (Titeca, 2021). These policies enabled refugees to be used, as one interlocutor told me, as an international 'bargaining chip'. Refugees are kept away from the Western world and its 'migration crisis', hosted in a country with an internationally praised refugee response. However, refugees' basic needs were rarely met. Epidemic preparedness, in its current conceptualisations, fails to resist being engulfed in such systemic geo-political failures.

Chapter 7 described how these wider global inequalities cannot be separated from spiritual powers. Stories of those who go under water, *te pii,* to a realm connected to evil or malevolent forces (Allen, 2015; O'Byrne, 2021; Victor, 2019), revealed the importance

of not underestimating the powerful and far-reaching effects of historical and current forms of inequality and exploitation. As O'Byrne (2021, p. 138) described, amongst the Acholi of South Sudan, entities or phenomena that might be considered 'unreal' to a scientific audience, are 'paradigms that reflect local interpretations of global flows of power and evil' (p. 138). Attending to spiritual dimensions of life for Acholi refugees in Palabek has revealed the complexity of socio-economic and political dynamics that play out in everyday life. Geopolitical dynamics that keep wealth circulating amongst some people, whilst others remain in enduring precarity, is captured in the suspicious business of vaccine uptake, which incorporated spiritual elements as an 'absent presence' throughout chapter 7. Although this chapter primarily focussed on dynamics related to the COVID-19 vaccine, it is not a far reach to see how any form of preparedness or humanitarian assistance could also be seen as suspicious business, given the interconnectedness with geopolitical dynamics described above, and the fact that the continued existence of humanitarianism relies on the persistence of human suffering (Allen, 2018; De Lauri, 2016).

O'Byrne (2021) clarifies, however, that these metaphysical or spiritual elements not only help make sense of global networks but also what is happening within 'local communities' within the 'global system'. Entanglements with global actors are not taking place in some removed 'global' place, but rather are played out in the 'local', or rather in the day-to-day lives of refugees in Palabek, as they engage with each other, with Ugandans, public health, humanitarian and government actors, and researchers.

Throughout this PhD, the research has demonstrated that refugees are acutely aware of the international involvement in the policies that shape (or fail to shape) their lives. Power dynamics with international actors were inextricably connected to wider understandings of what was happening in their lives, including through expressions of connections with spiritual powers. This fact, however, was rarely acknowledged by mainstream public health and humanitarian actors, which made their formal activities even more suspicious. Indeed, when refugees resisted these unequal power dynamics, by circumventing containment policies, or failing to engage with vaccination, it was often seen as 'noncompliance', or 'disengagement'. These strategies, however, may be better

understood as an acknowledgement, and possibly resistance to, the geopolitical dynamics that shape, or fail to shape, their lives. Whilst the politics of preparedness may remain invisible in mainstream approaches, political dynamics were clearly visible to interlocutors in Palabek.

Re-thinking Preparedness

So far, this chapter has described how preparedness, by drawing on a future-orientated temporality, defines 'normal', and consolidates current power dynamics. Simultaneously, it does not allow alternative perspectives, including those that articulate inequalities, to be heard. Therefore, although preparedness, on the surface, may claim an apolitical stance – in practice, it is not. Moving forward, this section offers a re-thinking of preparedness, that pays greater attention to the perspectives of refugees, as people who are living though epidemics in settings considered to be particularly prone to outbreaks.

A commonality between the perspectives from refugees is the rejection of categorisations that are central to mainstream biomedical and techno-scientific approaches to preparedness. Such categorisations are at the heart of the specific indicators that assess what is, and is not, successful preparedness (Oppenheim *et al.*, 2019). In contrast to categorisations, prioritising perspectives from refugees have revealed the centrality of fluidity: fluidity of time, space, numbers, and knowledge. Borders and boundaries were described as fluid in chapter 6, which also highlighted that knowing who to protect, and against what, are not simple distinctions. Refugees were difficult to categorise - they were both a threat to health security and simultaneously in need of protection. Chapter 7 described how interlocutors were not fixed in their knowledge of the COVID-19 vaccine, but instead, incorporated evolving evidence into their understanding as a fluid state of constant negotiation. Suspicion reflected a far more dynamic engagement with vaccines, in contrast to binary notions of trust and mistrust which are embedded in public health framings of vaccine hesitancy. The focus on counting as assemblage in chapter 8 revealed the fluid logics that determined when COVID-19 was counted and why. This chapter also revealed that dynamics of care and

control are exceedingly difficult to disentangle. Fluidity is also clear in the description of relational temporality amongst Acholi in chapter 9, where time adapts to situations as they unfold in day-to-day life, resonating with scholars who document event-orientated temporalities (Mbiti, 1990). Furthermore, the historical and social complexity of the borderland region between Uganda and South Sudan outlined in chapter 2, problematises the category of 'refugee', in determining who does, and does not, receive aid.

This focus on fluidity, or the dynamic nature of life, resonates strongly with Acholi approaches to existence, which have been touched upon in chapter 7 and chapter 9. Holly Porter (2017, 2012) examined this in relation to the importance of 'social harmony', as a state of balanced social power and moral order and cosmological equilibrium, involving the living and the dead. For Okot p'Bitek (1986), it is not that normal good life infers the absence of difficulty, but rather '…when things are normal, the society is thriving, facing and overcoming crises' (p27). It is not that crises are absent, but they are managed. Finnström (2008) wrote extensively on this in relation to good and bad surroundings amongst Acholi in northern Uganda, emphasising that these are not absolute categories, but rather form a continuum. To quote:

> '*Peaceful life can be infested with conflicts and frustrations, but in the peaceful order of things, problems are handled, strategies beyond mere survival are developed, life is continuously constituted and reconstituted. Uncertainty is handled.*' (p11-12)

Through a focus on fluidity and a constant search for balance, important social, economic, political and spiritual dynamics are made visible, exposing problematic inequalities. This more dynamic outlook, which is less fixed in meaning, is driven by the priorities of those living in the most challenging of circumstances.

Final Words

Through a multi-sited ethnographic exploration of mainstream approaches to COVID-19 in Palabek Refugee Settlement, this PhD has rendered visible mistaken assumptions embedded in current conceptualisations of epidemic preparedness. It has demonstrated how historical, spiritual, socio-economic and political dynamics are inextricably intertwined with the way in which public health and humanitarian assistance are conceptualised and delivered by practitioners, and negotiated by refugees. It has also revealed how global dynamics play out on the ground, often in catastrophic ways. COVID-19 dominated global agendas, primarily shaped by health security agendas (in the Global North), ignoring the priorities of people in the most precarious positions who experienced the most damaging consequences of lockdown. COVID-19 policy in Uganda drew on international health security agendas which justified prolonged lockdown measures and removed livelihood opportunities for those already living in great precarity. This happened at time when refugees in Uganda were already living in particularly difficult conditions due to the increasing focus on individual responsibility and self-reliance whilst food aid was removed. When health security agendas and policies of 'responsibilisation' collide in this way, the outcome is worrying. This worsening precarity has been systematically set aside and ignored by those applauding the government for their 'successful' refugee policies and COVID-19 management.

Researching COVID-19 in a refugee settlement revealed important problems with the temporality of preparedness. Epidemic preparedness and refugee policy both draw on the concept of 'emergency'. By foregrounding the everyday lives of refugees, this research concludes that emergency narratives privilege anticipated futures, thereby obfuscating the more immediate everyday (often disastrous) suffering of refugees, and the (geo)political dynamics that perpetuate it. Despite rhetoric promoting humanitarian compassion, epidemic and refugee emergencies are majorly determined by risks posed to those in the Global North, whether that be the threat posed by people or pathogens crossing borders. Humanitarian assistance and epidemic preparedness both prioritise future suffering (of people in the Global North) over current suffering (in the Global South). In other words, drawing on ideas of emergency obfuscates other suffering, as a

smoke screen for the wider problematic geopolitical dynamics that remain largely unaddressed.

The manipulation of COVID-19 narratives in Uganda was enabled by the way in which successful preparedness was measured. Success was conceptualised in terms of low fatality rates of COVID-19, and the implementation of containment, screening and vaccination. By focussing on these elements of success, and in so doing excluding the socio-political elements of preparedness, mainstream biomedical and techno-scientific approaches to preparedness were politically manipulated.

However, national and global dynamics are clearly visible to refugees at the receiving end of COVID-19 measures. Vaccine inequalities and the influence of geopolitical and financial elements of the pharmaceutical industry were clear to refugees, who actively questioned and resisted problematic power dynamics. People negotiated containment according to their own priorities rather than national rules. The politics of COVID-19 and the way it mobilised public health interventions was clear to the people delivering and receiving assistance. Foregrounding these perspectives will be a crucial step to re-thinking preparedness.

References

Abbey, E. J., Khalifa, B. A. A., Oduwole, M. O., Ayeh, S. K., Nudotor, R. D., Salia, E. L., *et al.* (2020) The Global Health Security Index is not predictive of coronavirus pandemic responses among Organization for Economic Cooperation and Development countries, *PLoS ONE*, 15(10), pp.1-11.

Abeysinghe, S. (2013) When the spread of disease becomes a global event: The classification of pandemics, *Social Studies of Science*, 43 (6), pp. 905–926.

Abonga, F., Atingo, J., Awachango, J., Denis, A., Hopwood, J., James, O., *et al.* (2024) Collaborative Autoethnography and Reclaiming an African Episteme: Investigating "Customary" Ownership of Natural Resources, *African Studies Review*, 67(2), pp. 416–430.

Abourahme, N. (2015) Assembling and Spilling-Over: Towards an 'Ethnography of Cement' in a Palestinian Refugee Camp, *International Journal of Urban and Regional Research*, 39 (2), pp. 200–217.

Abramowitz, S. A., Hipgrave, D. B., Witchard, A. and Heymann, D. L. (2018) Lessons From the West Africa Ebola Epidemic: A Systematic Review of Epidemiological and Social and Behavioral Science Research Priorities, *The Journal of Infectious Diseases*, 218 (11), pp. 1730–1738.

Abramowitz, S. A., McLean, K. E., McKune, S. L., Bardosh, K. L., Fallah, M., Monger, J., Tehoungue, K. and Omidian, P. A. (2015a) Community-Centered Responses to Ebola in Urban Liberia: The View from Below, *PLOS Neglected Tropical Diseases*, 9 (4), pp.1-18.

Abramowitz, S., Marten, M. and Panter-Brick, C. (2015b) Medical humanitarianism: anthropologists speak out on policy and practice, *Medical Anthropology Quarterly*, 29 (1), pp. 1–23.

Adams, J., MacKenzie, M. J., Amegah, A. K., Ezeh, A., Gadanya, M. A., Omigbodun, A., *et al.* (2021) The Conundrum of Low COVID-19 Mortality Burden in sub-Saharan Africa: Myth or Reality? *Global Health: Science and Practice*, 9 (3), pp. 433–443.

Adams, V. (2016) Introduction, in: Adams, V. (ed.) *Metrics: What Counts in Global Health*. Duke University Press.

Adams, V., Chandler, C., Kelly, A. H. and Livingston, J. (2024) A pandemic of metrics, *Medical Anthropology Quarterly*, 38 (2), pp. 149–163.

Adebisi, Y. A., Nwogu, I. B., Alaran, A. J., Badmos, A. O., Bamgboye, A. O., Rufai, B. O., *et al.* (2022) Revisiting the issue of access to medicines in Africa: Challenges and recommendations, *Public Health Challenges*, 1 (2), pp. 1-13.

Adonga, M. and Hopkins, B. (no date) *Some Aspects of Acoli Grammar and Cosmology*.

Agamben, G. (1998) *Homo Sacer: Sovereign Power and Bare Life*, Heller-Roazen, D. T. by (ed.). Stanford: Stanford University Press.

Agamben, G. (2000) *Means without end. Notes on Politics*. Minneapolis and London: University of Minnesota Press.

Agamben, G. (2005) *State of Exception*. Chicago: University of Chicago Press.

Agier, M. (2002) Between War and City: Towards an Urban Anthropology of Refugee Camps, *Ethnography*, 3 (3), pp. 317–341.

Agier, M. (2011) *Managing the Undesirables. Refugee Camps and Humanitarian Government*. Cambridge: Polity Press.

Agusto, F. B., Erovenko, I. V., Fulk, A., Abu-Saymeh, Q., Romero-Alvarez, D., Ponce, J., *et al.* (2022) To isolate or not to isolate: the impact of changing behavior on COVID-19 transmission, *BMC Public Health*, 22 (1), pp. 1-20.

Ainebyoona, E. (2020) Uganda's Top Position in Suppressing COVID-19 Is Rooted in Her History of Combating Epidemics, *Ministry of Health, Republic of Uganda*. Available from: https://www.health.go.ug/2020/10/01/ugandas-top-position-in-suppressing-covid-19-is-rooted-in-her-history-in-combating-epidemics/ [Accessed 24 May 2022].

Ajuna, D. V. (2021) Commonwealth lauds Museveni for Covid-19 response | Monitor, *Monitor*. Available from: https://www.monitor.co.ug/uganda/news/national/commonwealth-lauds-museveni-for-covid-19-response-3325576 [Accessed 23 May 2022].

Akello, G. and Parker, M. (2021) Confronting epidemics, in: Onyango, G. (ed) *Routledge Handbook of Public Policy in Africa*. Abingdon; New York: Routledge, pp. 459–473.

Alexander, P. I. (2020) Religious construction of disease: An exploratory appraisal of religious responses to the COVID-19 pandemic in Uganda, *Journal of African Studies and Development*, 12 (3), pp. 77–96.

Allen, A. (2007) *Vaccine: the controversial story of medicine's greatest lifesaver*. New York; London: W.W. Norton & Company.

Allen, T. (1993) *Social upheaval and the struggle for community: A study of the Ugandan Madi.* PhD Thesis, University of Manchester.

Allen, T. (1996) A Flight from Refuge The return of Refugees from Southern Sudan to Northwest Uganda in the late 1980s, in: Allen, T. (ed.) *In Search of Cool Ground. War, Flight & Homecoming in Northern Africa*. London: James Currey Ltd, pp. 220–261.

Allen, T. (1997) The Violence of Healing, *Sociologus*, 47 (2), pp. 101–128.

Allen, T. (2006) AIDS and evidence: Interrogating some Ugandan myths, *Journal of Biosocial Science*, 38 (1), pp. 7–28.

Allen, T. (2015) Vigilantes, Witches and Vampires: How Moral Populism Shapes Social Accountability in Northern Uganda, *International Journal on Minority and Group Rights*, 22 (3), pp. 360–386.

Allen, T. (2018) What is Humanitarianism, in: Allen, T., MacDonald, A., and Radice, H. (eds.) *Humanitarianism: A Dictionary of Concepts*. New York: Routledge.

Allen, T. (2019) Introduction - Colonial Encounters in Acholiland and Oxford: The Anthropology of Frank Girling and Okot p'Bitek, in: Allen, T. (ed.) *Lawino's People: the Acholi of Uganda*. Berlin: LIT Verlang.

Allen, T., Atingo, J., Atim, D., Ocitti, J., Brown, C., Torre, C., Fergus, C. A. and Parker, M. (2020) What Happened to Children Who Returned from the Lord's Resistance Army in Uganda? *Journal of Refugee Studies*, 33 (4), pp. 663–683

Allen, T., Atingo, J. and Parker, M. (2021) Rejection and Resilience: Returning from the Lord's Resistance Army in Northern Uganda, *Civil Wars*, 24 (2–3), pp. 357–384.

Allen, T., Macdonald, A. and Radice, H. (2018) *Humanitarianism: A Dictionary of Concepts*. New York: Routledge.

Allen, T. and Parker, M. (2023) In the line of duty: Militarising African epidemics, *Global Policy*, 15(S4), pp. 97–108.

Allen, T. and Storm, L. (2012) Quests for therapy in northern Uganda: Healing at Laropi revisited, *Journal of Eastern African Studies*, 6 (1), pp. 22–46.

Allen, T. and Turton, D. (1996) In Search of Cool Ground, in: Allen, T. (ed.) *In Search of Cool Ground. War, Flight & Homecoming in Northern Africa*. London: James Currey Ltd.

Altare, C., Kahi, V., Ngwa, M., Goldsmith, A., Hering, H., Burton, A. and Spiegel, P. (2019) Infectious disease epidemics in refugee camps: a retrospective analysis of UNHCR data (2009-2017), *Journal of Global Health Reports*, 3: e2019064.

Aluma, C., Anguyo, I, Storer, E and Pearson, G (2022) *Indigenous lockdowns: a historical exploration of epidemic containment in Arua District, West Nile sub-region, Uganda. A working paper.*

Amone, C. (2014) Reasons for the British Choice of the Acholi as the Martial Race of Uganda, 1862 to 1962, *Asian Journal of Humanities and Social Sciences*, 2 (2), pp. 72–77.

Amone, C. and Muura, O. (2014) British Colonialism and the Creation of Acholi Ethnic Identity in Uganda, 1894 to 1962, *Journal of Imperial and Commonwealth History*, 42 (2), pp. 239–257.

Anderson, B., Grove, K., Rickards, L. and Kearnes, M. (2019) Slow emergencies: Temporality and the racialized biopolitics of emergency governance, *Progress in Human Geography*, 44 (4), pp. 621–639.

Anderson, C., Arnold, D., De Barros, J., Bair, L. and Peckham, R. (2021) Epidemics in the Past and Now: A roundtable on colonial and postcolonial history, *Journal of Colonialism and Colonial History*, 22(1), pp. 0-0.

Angulo, F. J., Cassell, C. H., Tappero, J. W. and Bunnell, R. E. (2017) Progress and opportunities for strengthening global health security, *Emerging Infectious Diseases*, 23 (Suppl 1), pp. S1-S4.

Aradau, C. (2004) The Perverse Politics of Four-Letter Words: Risk and Pity in the Securitisation of Human Trafficking, *Millennium: Journal of International Studies*, 33 (2), pp. 251–277.

Ashforth, A. (2005) *Witchcraft, Violence, and Democracy in South Africa*. Chicago and New York: University of Chicago Press.

Ashworth, J., Mathie, D., Scott, F., Mahendran, Y., Woolhouse, M., Stoevesandt, O., Mduluza, T. and Mutapi, F. (2023) Peptide microarray IgM and IgG screening of pre-SARS-CoV-2 human serum samples from Zimbabwe for reactivity with peptides from all seven human coronaviruses: a cross-sectional study, *The Lancet Microbe*, 4 (4), pp. e215–e227.

Atkinson, R. R. (1989) The Evolution of Ethnicity among the Acholi of Uganda: The Precolonial Phase, *Ethnohistory*, 36 (1), pp. 19–43.

Babalola, S. F. and Alokan, O. A. (2013) African Concept of Time, a Socio-Cultural Reality in the Process of Change, *Journal of Education and Practice*, 4 (7), pp. 143-148.

Baines, E. (2010) Spirits and social reconstruction after mass violence: Rethinking transitional justice, *African Affairs*, 109 (436), pp. 409–430.

Baines, E. and Gauvin, L. R. (2014) Motherhood and social repair after war and displacement in Northern Uganda, *Journal of Refugee Studies*, 27 (2), pp. 282–300.

Baines, E. K. (2005) *Roco Wat I Acoli Restoring: Relationships in Acholi-land: Traditional Approaches to Justice and Reintegration*. Liu Institute for Global Issues.

Baines, E. and Paddon, E. (2012) 'This is how we survived': Civilian agency and humanitarian protection, *Security Dialogue*, 43 (3), pp. 231–247.

Bakewell, O. (2008) Research beyond the categories: The importance of policy irrelevant research into forced migration, *Journal of Refugee Studies*, 21 (4), pp. 432–453.

Barnett, M. (2011) *Empire of Humanity: A history of Humanitarianism*. New York: Cornell University Press.

Barnett, M. N. (2013) Humanitarian governance, *Annual Review of Political Science*. *16*(1), pp. 379– 398.

Barnett, M. N. and Stein, J. Gross. (2012) *Sacred Aid: Faith and Humanitarianism*. 1st edition. New York: Oxford University Press.

Barrios, R. E. (2017) What Does Catastrophe Reveal for Whom? The Anthropology of Crises and Disasters at the Onset of the Anthropocene, *Annual Review of Anthropology*, 46 (1), pp. 151–166.

Beckett, G. (2013) The Politics of Emergency, *Reviews in Anthropology*, 42 (2), pp. 85–101.

Berkley, S. (2020) COVAX explained | Gavi, the Vaccine Alliance. Available from: https://www.gavi.org/vaccineswork/covax-explained [Accessed 4 August 2022].

Beshar, I. and Stellmach, D. (2017) Anthropological approaches to medical humanitarianism, *Medicine Anthropology Theory*, 4 (5), pp. 1–22.

Bhanye, J. (2024) "Nimble Sociality and Belonging": an Ethnography of Migrants' Responses to Bans on Associational Life During the COVID-19 Pandemic, *Urban Forum*, 35 (3), pp. 349–375.

Bidandi, F. (2018) Understanding refugee durable solutions by international players: Does dialogue form a missing link? *Cogent Social Sciences*, 4 (1), pp. 1–15.

Biggerstaff, M., Cauchemez, S., Reed, C., Gambhir, M. and Finelli, L. (2014) Estimates of the reproduction number for seasonal, pandemic, and zoonotic influenza: a systematic review of the literature, *BMC Infectious Diseases*, 14 (1), pp. 1-20.

Biryabarema, E. (2021) Uganda suspends work of 54 NGOs, increasing pressure on charities | Reuters, *Reuters*. Available from: https://www.reuters.com/world/africa/uganda-suspends-work-54-ngos-increasing-pressure-charities-2021-08-20/ [Accessed 23 November 2024].

Black, R. (2001) *Fifty Years of Refugee Studies: From Theory to Policy*, *Source: The International Migration Review*, 35 (1), pp. 57-78.

Böhme, C. and Schmitz, A. (2022) Refugee's agency and coping strategies in refugee camps during the coronavirus pandemic: ethnographic perspectives, *Comparative Migration Studies*, 10 (34), p. 1-20.

Brankamp, H. (2022) Feeling the refugee camp: Affectual research, bodies, and suspicion, *Area*, 54 (3), pp. 383–391.

Broadbent, A., Walker, D., Chalkidou, K., Sullivan, R. and Glassman, A. (2020) Lockdown is not egalitarian: the costs fall on the global poor, *The Lancet*, 396 (10243), pp. 21 – 22.

Brown, C. and Chiavaroli, C. (2023) Duplicitous Trust: Village Health Work in the Wake of Humanitarian Protection Failings in Uganda, *Medical Anthropology Quarterly Online, Theorizing Trust from Anthropological Perspectives*. Available from: https://medanthroquarterly.org/critical-care/2023/10/duplicitous-trust-village-health-work-in-the-wake-of-humanitarian-protection-failings-in-uganda [Accessed 31 July 2024].

Brown, C. and Torre, C. (2024) *Key Considerations:* Food Assistance Prioritisation in Refugee Settlements in Uganda and its Impacts. *Social Science in Humanitarian Action (SSHAP)*. www.doi.org/10.19088/SSHAP.2024.054.

Brown, P. (2020) Studying COVID-19 in light of critical approaches to risk and uncertainty: research pathways, conceptual tools, and some magic from Mary Douglas, *Health, Risk & Society*, 22 (1), pp. 1–14.

Bryce, C., Ring, P., Ashby, S. and Wardman, J. (2022) Resilience in the face of uncertainty: early lessons from the COVID-19 pandemic, *Journal of Risk Research, 23 (7–8),* pp. *880–887*.

Buguzi, S. (2021) Covid-19: Counting the cost of denial in Tanzania, *BMJ*, 373: n1052, p. 1-2.

Butler, N. and Tullock, O. (2020) Considerations and principles for shielding people at high risk of severe outcomes from COVID-19. *Social Science in Humanitarian Action (SSHAP)*.

Butter, M. and Knight, P. (2023) *Covid Conspiracy Theories in Global Perspective*, Butter, M. and Knight, P. (eds.). London and New York: Routledge.

Bwire, G., Ario, A. R., Eyu, P., Ocom, F., Wamala, J. F., Kusi, K. A., *et al.* (2022) The COVID-19 pandemic in the African continent, *BMC Medicine,* 20 (1), pp. 1–23.

Caduff, C. (2015) *The Pandemic Perhaps: Dramatic Events in a Public Culture of Danger*. Oakland, California: University of California Press.

Caduff, C. (2020) What Went Wrong: Corona and the World after the Full Stop, *Medical Anthropology Quarterly*. 34, pp. 467-487.

Calhoun, C. (2010) The Idea of Emergency: Humanitarian Action and Global (Dis)Order, in: Fassin, D. and Pandolfi, M. (eds.) *Contemporary States of Emergency: the Politics of Military and Humanitarian Interventions*. New York: Zone Books, pp. 29–58.

Callaway, E. (2021) Mix-and-match COVID vaccines trigger potent immune response, *Nature*, 593(7860): 491.

Carstensen, N. (2016) Understanding and supporting community-led protection, *Forced Migration Review*, (53), pp. 4-7.

Centers for Disease Control and Prevention (2023) Lesson 1: Introduction to Epidemiology , *CDC Archive*. Available from: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html [Accessed 11 December 2024].

Centre for Epidemic Preparedness and Response, L. (2022) Centre for Epidemic Preparedness and Response | LSHTM. Available from: https://www.lshtm.ac.uk/research/centres/centre-epidemic-preparedness-and-response?utm_medium=email&utm_campaign=2022%209%20Briefing%20session%20on%20London%20building%20return%20war%20in%20Ukraine%20COVID-19%20research%20in%20action%20and%20more&utm_content=2022%209%20Briefing%20session%20on%20London%20building%20return%20war%20in%20Ukraine%20COVID-19%20research%20in%20action%20and%20more+CID_8712e91d783245a67558e5317409b4af&utm_source=E%20newsletter&utm_term=Centre%20for%20Epidemic%20Preparedness%20%20Response [Accessed 24 September 2022].

Checchi, F., Testa, A., Warsame, A., Quach, L. and Burns, R. (2013) *Estimates of Crisis-Attributable Mortality in South Sudan, December 2013-April 2018: A Statistical Analysis*. London.

Cheeseman, N. (2021) *Managing Elections under Covid-19 Pandemic Conditions: The Case of Uganda*. Stockholm: International Institute for Democracy and Electoral Assistance.

Chimni, B. S. (1999) *New Issues in Refugee Research. Working Paper No. 2. From resettlement to involuntary repatriation: towards a critical history of durable solutions to refugee problems*. Available from: https://www.unhcr.org/sites/default/files/legacy-pdf/3ae6a0c50.pdf.

Christensen, A. and Harild, N. (2009) *Forced Displacement: The Development Challenge*. Conflict, crime and violence issue note. Washington, D.C: World Bank.

Clements, K. P. (2014) What is legitimacy and why does it matter for peace? *Accord*, 25, pp. 13–16.

Clements, K., Shoffner, T. and Zamora, L. (2016) Uganda's approach to refugee self-reliance, *Forced Migration Review, 52, pp. 49-51*.

Clifford, J. (1997) *Routes: Travel and Translation in the late Twentieth Century*. Cambridge, Massachusetts and London, England: Harvard University Press.

Clifford, J. and Marcus, G. E. (1986) *Writing Culture: The Poetics and Politics of Ethnography*. Berkeley; Los Angeles; London: University of California Press.

Closser, S., Rosenthal, A., Maes, K., Justice, J., Cox, K., Omidian, P. A., *et al.* (2016) The Global Context of Vaccine Refusal: Insights from a Systematic Comparative Ethnography of the Global Polio Eradication Initiative, *Medical Anthropology Quarterly*, 30 (3), pp. 321–341.

Coggon, D., Rose, G. and Barker, D. (2003) Chapter 1. What is epidemiology? in: *Epidemiology for the uninitiated*. Fifth edition. London: BMJ books.

Collier, S. j. and Lakoff, A. (2015) Vital Systems Security: Reflexive Biopolitics and the Government of Emergency, *Theory, Culture & Society*, 32 (2), pp. 19–51.

Collins, R. (2007) Civil Wars in the Sudan, *History Compass*, 5 (6), pp. 1778–1805.

Colson, E. (1971) *The social consequences of resettlement: the impact of the Kariba resettlement upon the Gwembe Tonga*. Manchester: Manchester University Press for the Institute for African Studies, University of Zambia.

Comaroff, J. and Comaroff, J. L. (2001) Millennial Capitalism: First Thoughts on a Second Coming, in: Comaroff, J. and Comaroff, J. L. (eds.) *Millennial Capitalism and the Culture of Neoliberalism*. Durham and London: Duke University Press, pp. 1–56.

Connolly, M. A., Gayer, M., Ryan, M. J., Salama, P., Spiegel, P. and Heymann, D. L. (2004) Communicable diseases in complex emergencies: Impact and challenges, *Lancet*, 364 (9449), pp. 1974–1983.

Convention and Protocol relating to the Status of Refugees (2007). Available from: https://www.unhcr.org/uk/media/convention-and-protocol-relating-status-refugees

Cooper-Knock, S.-J. and Long, K. (2020) Camps, in: Allen, T., Macdonald, A., and Radice, H. (eds.) *Humanitarianism. A Dictionary of Concepts*. 1st Edition. New York: Routledge, pp. 52–67.

Crisp, J. (1999) *New Issues in Refugee Research: 'Who has counted the refugees?' UNHCR and the politics of numbers. Working Paper No. 12.* Available from: https://www.refworld.org/reference/research/unhcr/1999/en/87381

Dagens, A., Sigfrid, L., Cai, E., Lipworth, S., Cheng, V., Harris, E., Bannister, P., Rigby, I. and Horby, P. (2020) Scope, quality, and inclusivity of clinical guidelines produced early in the covid-19 pandemic: rapid review, *BMJ*, 369 (m1936), pp.1-10.

Dahab, M., van Zandvoort, K., Flasche, S., Warsame, A., Ratnayake, R., Favas, C., Spiegel, P. B., Waldman, R. J. and Checchi, F. (2020) COVID-19 control in low-income settings and displaced populations: what can realistically be done? *Conflict and Health*, 14 (54), pp. 1-6.

Daly, M. W. (1991) *Imperial Sudan: the Anglo-Egyptian Condominium: 1934-1956*. Cambridge: Cambridge University Press.

Davis, A. and Sharp, J. (2020) Rethinking One Health: Emergent human, animal and environmental assemblages, *Social Science and Medicine*, 258(113093), pp.1-8.

De Lauri, A. (2016) *The Politics of Humanitarianism. Power, Ideology and Aid*. London; New York: I.B.Tauris.

de Waal, A. (2003) How will HIV/AIDS transform African Governance? *African Affairs*, 102 (406), pp. 1–23.

de Waal, A. (2021) *New Pandemics, Old Politics: two hundred years of war on disease and its alternatives*. Cambridge: Polity.

de Waal, A. (2022) Paradigm-breaking pandemics, old academic politics, *Africa*, 92 (3), pp. 411–413.

Dionne, K. Y. and Turkmen, F. F. (2020) The Politics of Pandemic Othering: Putting COVID-19 in Global and Historical Context, *International Organization*, 74(S1), pp. E213–E230.

Dolan, C. (2011) *Social Torture: The Case of Northern Uganda, 1986-2006*. New York: Berghahn Books.

Douglas, M. (1992) *Risk and Blame: Essays in Cultural Theory*. London: Routledge.

Dubois, M. (2009) *Protection: Protection: The New Humanitarian Fig Leaf*. Discussion Paper, Refugees Studies Centre, University of Oxford. Available from: https://www.rsc.ox.ac.uk/files/files-1/dp-protection-fig-leaf-2009.pdf

Duclos, D. and Palmer, J. (2020) COVID-19 in the Context of Forced Displacement: Perspectives from the Middle East and East Africa. *Briefing*: Brighton: Social Science in Humanitarian Action Platform (SSHAP).

Duff, C. (2014) *Assemblages of Health. Deleuze's Empiricism and the Ethology of Life*. London: Springer.

Durback, N. (2005) *Bodily Matters: The Anti-Vaccination Movement in England, 1853-1907*. Durham and London: Duke University Press.

Edwards, A. (2013) A numbers game: Counting Refugees and International Burden Sharing, *University of Tasmania Law Review*. Available from: https://classic.austlii.edu.au/au/journals/UTasLawRw/2013/1.html

Enria, L. (2020) Unsettled authority and humanitarian practice: reflections on local legitimacy from Sierra Leone's borderlands, *Oxford Development Studies*, 48 (4), pp. 387–399.

Erikson, S. (2019) Faking global health, *Critical Public Health*, 29(4), pp. 508-516.

Erikson, S. L. (2012) Global Health Business: The Production and Performativity of Statistics in Sierra Leone and Germany, *Medical Anthropology: Cross Cultural Studies in Health and Illness*, 31 (4), pp. 367–384.

European Commission (2024) Forced displacement - European Commission. Available from: https://civil-protection-humanitarian-aid.ec.europa.eu/what/humanitarian-aid/forced-displacement_en# [Accessed 23 November 2024].

Evans-Pritchard, E. (1939) Nuer Time-Reckoning, *Journal of the International African Institute*, 12 (2), pp. 189–216.

Evans-Pritchard, E. (1976) Witchcraft, oracles, and magic among the Azande. Oxford: Clarendon Press.

Fairweather, I. S. (1997) Crisis Anthropology and The New Dialogue, *Anthropology Today*, 13 (4), pp. 19–19.

Farmer, P. (2001) *Infections and Inequalities: The Modern Plagues*. Berkley; Los Angeles; London: University of California Press.

Fassin, D. (2012) *Humanitarian Reason. A Moral History of the Present*. Berkley; Los Angeles; London: University of California Press.

Fassin, D. (2023) Afterword, *Social Anthropology/Anthropologie Sociale*, 31 (1), pp. 103–105.

Fassin, D. and Pandolfi, M. (2010) *Contemporary States of Emergency: The Politics of Military and Humanitarian Interventions*. New York: Zone Books.

Fast, L. (2018) *Crossing boundaries in protecting civilians Mapping actors, insights and conceptual spaces. HPG Working Paper.* London: Humanitarian Policy Group, Overseas Development Institute.

Favas, C., Abdelmagid, N., Checchi, F., Garry, S., Jarrett, P., Ratnayake, R. and Warsame, A. (2020) Guidance for the prevention of COVID-19 infections among high-risk individuals in camps and camp-like settings, *London School of Hygiene and Tropical Medicine*, (March), pp. 1–15. Available from: https://www.lshtm.ac.uk/sites/default/files/2020-04/Guidance for the prevention of COVID-19 infections among high-risk individuals in camps and camp-like settings.pdf

Feldman-Savelsberg, P., Ndonko, F. T. and Schmidt-Ehry, B. (2000) Sterilizing Vaccines or the Politics of the Womb: Retrospective Study of a Rumor in Cameroon, *Medical Anthropology Quarterly*, 14 (2), pp. 159–179.

Feyissa, D. and Hoehne, M. V. (2010) *Borders and Borderlands as Resources in the Horn of Africa*. Suffolk: James Currey.

Fiddan-Qasmiyeh, E., Loescher, G., Long, K. and Sigona, N. (2014) The Oxford Handbook of Refugee and Forced Migration Studies., in: Fiddan-Qasmiyeh, E., Loescher, G., Long, K., and Sigona, N. (eds.) *The Oxford Handbook of Refugee and Forced Migration Studies*. Oxford Handbook Online.

Finnström, S. (2008) *Living with Bad Surroundings*. London: Duke University Press.

Fisher, D. A., Carson, G. and Steering Committee, G. (2020) Back to basics: the outbreak response pillars, *The Lancet*, 396, pp. 598. DOI:10.1126/science.abc9004.

Foucault, M. (1994) Governmentality, in: Faubion, J. D. (ed.) *Power: The Essential Works of Michel Foucault 1954-1984*. London: Penguin Books Ltd, pp. 201.

Gagro, S. F. (2014) The Responsibility to Protect (R2P) Doctrine, *International Journal of Social Sciences*, III (1), pp. 61-77.

Gan, E. and Tsing, A. (2018) How things hold: A diagram of coordination in a satoyama forest, *Social Analysis*, 62 (4), pp. 102–145.

Dinyo, D.G.A., Ahmadi, A., Okereke, M., Yasir Essar, M. and Lucero-Prisno III, D.E. (2020) South Sudan: a young country's fight against COVID-19, *Pan African Medical Journal*, 37 (1): 49.

Garoon, J. P. and Duggan, P. S. (2008) Discourses of disease, discourses of disadvantage: A critical analysis of National Pandemic Influenza Preparedness Plans, *Social Science and Medicine*, 67 (7), pp. 1133–1142.

Garrett, L. (1994) *the Coming Plague: Newly Emerging Diseases in a World Out of Balance*. New York: Farrar Straus Giroux.

Geertz, C. (1998) Deep Hanging Out. *The New York Review of Books*. Available from: https://www.nybooks.com/articles/1998/10/22/deep-hanging-out/?srsltid=AfmBOop0lp_bhpqz3Bv8QFCmUpk3JEMME5zasIBK1eQgy03DMOQSnr3S/

Geissler, P. (2013) Public secrets in public health: Knowing not to know while making scientific knowledge, *American Ethnologist*, 40 (1), pp. 13–34.

Geschiere (2013) *Witchcraft, Intimacy, and Trust: Africa in Comparison*. Chicago and London: The University of Chicago Press.

Geschiere, P. (2019) Shifting Figures of the Witch in Colonial and Postcolonial Africa, in: Dillinger, J (ed), *The Routledge History of Witchcraft*. London: Routledge, pp. 299–316.

Gidron, Y. (2022) *Mobile Livelihoods: Borderland dynamics between Uganda and South Sudan*. Rift Valley Institute.

Glasman, S. J. (2017) Seeing Like a Refugee Agency: A Short History of UNHCR Classifications in Central Africa (1961-2015), *Journal of Refugee Studies*, 30 (2), pp. 337–362.

Global Preparedness Monitoring Board (2019) *A world at risk. Annual report on global preparedness for health emergencies*. Available from: http://apps.who.int/iris

Goodhand, J. (2013) Epilogue: The View from the Border. In: Korf, B., and Raeymaekers, T. (eds.), *Violence on the Margins. States, Conflict, and Borderlands*. New York: Palgrave Macmillan, pp 247-264.

Goodwin-Gill, G. S. (2017) *'International Refugee Law – Yesterday, Today, but Tomorrow?'* Available at: https://www.blackstonechambers.com/documents/GSGG-PastPresentFuture.pdf

Gorsky, M. and Sirrs, C. (2017) World health by place: The politics of international health system metrics, 1924-c. 2010, *Journal of Global History*. 12(3), pp. 361–385.

Gostin, L. O., Tomori, O., Wibulpolprasert, S., Jha, A. K., Frenk, J., Moon, S., *et al.* (2016) Toward a Common Secure Future: Four Global Commissions in the Wake of Ebola, *PLOS Medicine*, 13 (5): e1002042.

Gouglas, D., Christodoulou, M., Plotkin, S. A. and Hatchett, R. (2019) CEPI: Driving progress toward epidemic preparedness and response, *Epidemiologic Reviews*, 41, pp. 28-33.

Government of Uganda (2018) *Uganda's Revised CRRP Road Map 2018-2020. The Comprehensive Refugee Response Framework (CRRF)*. Available from: https://data.unhcr.org/en/documents/details/93337

Government of Uganda (2019) *Uganda's Refugee Response. Our Story. Based on the Facts and Experiences*. Available from: https://data.unhcr.org/en/documents/details/74396

Government of Uganda, UNHCR, UNICEF and WFP (2018) *Food Security and Nutrition Assessment in Refugee Settlements Final Report*. Available from: https://reliefweb.int/report/uganda/food-security-and-nutrition-assessment-refugee-settlements-final-report-data-collected

Government of Uganda and UNICEF (2018) *Child Poverty and Deprivation in Refugee-Hosting Areas. Evidence from Uganda*. Available from: https://reliefweb.int/report/uganda/child-poverty-and-deprivation-refugee-hosting-areas-evidence-uganda

Grant, C. (2018) *Ebola preparedness and traditional healers in South Sudan*.K4D Helpdesk. Report. Brighton, UK: Institute of Development Studies.

Grant, C. (2023) The centrality of (mis)trust in pandemic preparedness in Sub-Saharan Africa: a conceptual framework, *Journal of the British Academy*, 11(s6), pp. 137–161.

Guardian (2020) First case of coronavirus confirmed in London – as it happened | Coronavirus | The Guardian. Available from: https://www.theguardian.com/world/live/2020/feb/12/coronavirus-live-updates-deaths-infections-symptoms-transmission-wuhan-china-cruise-ship-quarantine-cases-latest-update-news [Accessed 14 November 2024].

Habibzadeh, F. (2023) Malaria and the incidence of COVID-19 in Africa: an ecological study, *BMC Infectious Diseases*, 23 (66), pp. 1-7.

Handyman, J. (2000) *Managing Displacement: Refugees and the Politics of Humanitarianism*. Minneapolis: University of Minnesota Press.

Hansen, R. (2018) The comprehensive refugee response framework: A commentary, *Journal of Refugee Studies*, 31 (2), pp. 131–151.

Hardy, A., Manton, J., Lafferty, E. and Blanchet, K. (2016) Blog: The Evolution of Humanitarianism Throughout Historical Conflict | LSHTM, *Humanitarian Crisis Centre, LSHTM*. Available from: https://www.lshtm.ac.uk/research/centres/centre-history-public-health/news/2017-2 [Accessed 12 November 2024].

Harman, S., Erfani, P., Goronga, T., Hickel, J., Morse, M. and Richardson, E. T. (2021) Global vaccine equity demands reparative justice-not charity, *BMJ Global Health*, 6(e006504), pp. 1-4.

Harper, I. and Parker, M. (2014) The Politics and Anti-Politics of Infectious Disease Control, *Medical Anthropology*, 33 (3), pp. 198–205.

Harrell-Bond, B. E. (1986) *Imposing Aid: Emergency Assistance to Refugees*. Oxford: Oxford University Press.

Harrell-Bond, B., Voutira, E. and Leopold, M. (1992) Counting the refugees: gifts, givers, patrons and clients, *Journal of Refugee Studies*, 5 (3–4), pp. 205–225.

Hartley, K. and Jarvis, D. S. L. (2020) Policymaking in a low-trust state: legitimacy, state capacity, and responses to COVID-19 in Hong Kong, *Policy and Society*, 39 (3), pp. 403–423.

Hashim, A., Jean-Gilles, L., Hegermann-Lindencrone, M., Shaw, I., Brown, C. and Nguyen-Van-Tam, J. (2012) Did pandemic preparedness aid the response to pandemic (H1N1) 2009? A qualitative analysis in seven countries within the WHO European Region, *Journal of Infection and Public Health*, 5 (4), pp. 286–296.

Haskell, T. (1985) Capitalism and the Origins of the Humanitarian Sensibility, Part 1, *The American Historical Review*, 90 (2), pp. 339-361.

Haydarov, R., Anand, S., Frouws, B., Toure, B., Okiror, S. and Bhui, B. R. (2016) Evidence-Based Engagement of the Somali Pastoralists of the Horn of Africa in Polio Immunization: Overview of Tracking, Cross-Border, Operations, and Communication Strategies, *Global Health Communication*, 2 (1), pp. 11–18.

Headrick, D. R. (2014) Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900–1940, *PLoS Neglected Tropical Diseases*, 8 (4), pp. e2772.

Herbert, S. and Idris, I. (2018) *Refugees In Uganda: (in)stability, conflict, and resilience. Rapid Literature Review*. Birmingham, UK: GSDRC, University of Birmingham.

Hewlett, B. S. and Amolat, R. P. (2003) Cultural contexts of Ebola in Northern Uganda, *Emerging Infectious Diseases*, 9 (10), pp. 1242–1248.

Hewlett, B. S. and Hewlett, B. L. (2008) *Ebola, Culture and Politics: The Anthropology of an Emerging Disease*. Belmont, CA: Thomson.

Heyman, B. (2010) The concept of risk, in: Heyman Bob, Alaszewski, A., Shaw, M., and Titterton, M. (eds.) *Risk, Safety, and Clinical Practice*. Oxford: Oxford University Press, pp. 15–36.

Heymann, D. L., Chen, L., Takemi, K., Fidler, D. P., Tappero, J. W., Thomas, M. J., *et al.* (2015) Global health security: the wider lessons from the west African Ebola virus disease epidemic. *Lancet* 385, pp.1884–1901.

Hickel, J. (2012) *South Sudan's ultimate goal should be to phase out its petroleum industry.* Blog, *LSE*. Available at: https://blogs.lse.ac.uk/africaatlse/2012/07/04/south-sudans-ultimate-goal-should-be-to-phase-out-its-petroleum-industry/ [accessed 15th December 2024].

Ho, K. (2012) "Studying up" wall street: Reflections on theory and methodology. in L Aguiar & C Schneider (eds.), *Researching Amongst Elites: Challenges and Opportunities in Studying up*. Farnham: Ashgate Publishing Ltd., pp. 29-48.

Hopwood, J. (2015) *Elephants Abroad and in the Room: explicit and implicit security , justice and protection issues on the Uganda / S Sudan border*, The Justice and Security Research Programme, Paper 22.

Hopwood, J. (2022) An inherited animus to communal land: the mechanisms of coloniality in land reform agendas in Acholiland, Northern Uganda, *Critical African Studies*, 14 (1), pp. 38–54.

Hopwood, J. and Atkinson, R. (2015) *Developing a Land Conflict Monitoring and Mapping Tool for Acholi Sub-Region of Northern Uganda*. The Justice and Security Research Programme, Paper 28.

Horst, C. (2006) *Transnational Nomads: How Somalis Cope with Refugee Life in the Dadaab Camps*. Oxford; New York: Berghahn Books.

Horton, R. (2020) *The COVID-19 Catastrophe What's gone wrong and how to stop it happening again*. Cambridge: Polity Press.

Hovil, L. (2018) *Uganda's Refugee policies: The history, the politics, the way forward*, *International Refugee Rights Initiative*. Rights in Exile Policy Paper. International Refugee Rights Initiative.

Human Rights Watch (2018) Uganda: Attacks on Opposition Figures, Media. Available from: https://www.hrw.org/news/2018/08/21/uganda-attacks-opposition-figures-media [Accessed 23 November 2024].

Hunter, M. A. (2009) The Failure of Self-Reliance in Refugee Settlements, *POLIS*, 2, pp. 1–46.

Idris, I. (2017) *Effectiveness of various refugee settlement approaches. K4D Helpdesk Report 223*. Brighton, UK: Institute of Development Studies.

Ilcan, S. and Rygiel, K. (2015) 'Resiliency Humanitarianism': Responsibilizing Refugees through Humanitarian Emergency Governance in the Camp, *International Political Sociology*, 9 (4), pp. 333–351.

Initiative for Social and Economic Rights (2021) *Where Did COVID 19 Money Go? International Finance Institutions' Funding to Uganda. Report Summary. June 2021*. Kampala.

Integrated Food Security Phase Classification (2021) *Uganda (Refugee). Overview of the IPC Acute Malnutrition Analysis of the Refugee Settlements in Uganda. IPC Acute Malnutrition Analysis. November 2020 - September 2021*.

International Committee of the Red Cross (ICRC) (2024) International Red Cross and Red Crescent Movement | ICRC. Available from: https://www.icrc.org/en/international-red-cross-and-red-crescent-movement# [Accessed 12 November 2024].

International Organization for Migration (2021) *DTM South Sudan — Flow Monitoring Registry — Trends in cross-border return flows and impact of COVID-19 restrictions (Feb – Dec 2020). IOM, South Sudan*.

International Organization for Migration (2024) *IOM Emergency Manual. Emergency Preparedness*.

Iskander, J., Strikas, R. A., Gensheimer, K. F., Cox, N. J. and Redd, S. C. (2013) Pandemic influenza planning, United States, 1978-2008, *Emerging Infectious Diseases*, 19 (6), pp. 879–885.

Islam, S. N. E., Mookherjee, N. and Khan, N. (2022) 'Medicine in Name Only': Mistrust and COVID-19 Among the Crowded Rohingya Refugee Camps in Bangladesh, *Medicine Anthropology Theory*, 9 (2), pp. 1–32.

Jackson, M. (2005) Storytelling events, violence, and the appearance of the past, *Anthropological Quarterly*, 78 (2), pp. 355–375.

Jacobsen, K. L. and Fast, L. (2019) Rethinking access: how humanitarian technology governance blurs control and care, *Disasters*, 43 (S2), pp. S151–S168.

James, M. (2022a) From Rebel to Humanitarian: Military Savoir Faire and Humanitarian Practice in Eastern DR Congo, *Development and Change*, 53 (1), pp. 166–189.

James, M. (2022b) Humanitarian Shapeshifting: Navigation, Brokerage and Access in Eastern DR Congo, *Journal of Intervention and Statebuilding*, 16 (3), pp. 349–367.

James, M., Kasereka, J. G., Kasiwa, B., Kavunga-Membo, H., Kambale, K., Grais, R., *et al*. (2023a) Protection, health seeking, or a laissez-passer: Participants' decision-making in an EVD vaccine trial in the eastern Democratic Republic of the Congo, *Social Science and Medicine*, 323(115833), pp. 1-8.

James, M., Mansaray, A., Thige, F. O., Mafinda, M., Kasonia, K. K., Paluku, J. K., *et al*. (2023b) Continuity and Rupture in Crisis: from Ebola to COVID-19 in Sierra Leone and the eastern Democratic Republic of the Congo, *Global Public Health*, 18 (1): 2259959.

James, M. V. and Lees, S. S. (2022) "Are You Sure It's Not the Corona Vaccine?" An Ebola Vaccine Trial During COVID-19 in DRC, *Medical Anthropology*, 41 (5), pp. 503–517.

Janmyr, M. (2022) Ethnographic Approaches and International Refugee Law, *Journal of Refugee Studies*, 00(0): feac042.

Jarvis, L. (2021) Covid-19 and the politics of temporality: constructing credibility in coronavirus discourse, *Critical Studies on Security*, 9 (1), pp. 72–75.

Johns Hopkins University (2022) GitHub - CSSEGISandData/COVID-19: Novel Coronavirus (COVID-19) Cases, provided by JHU CSSE. Available from: https://github.com/CSSEGISandData/COVID-19 [Accessed 4 June 2022].

Johnson, C., Jones, R., Paasi, A., Amoore, L., Mountz, A., Salter, M. and Rumford, C. (2011) Interventions on rethinking 'the border' in border studies, *Political Geography*, 30 (2), pp. 61–69.

Johnson, D. H. (2014) The political crisis in South Sudan, *African Studies Review*, 57(3), pp. 167 -174.

Jones, L. and Schmidt-Sane, M. (2020) 'Key Considerations: COVID-19 RCCE strategies for cross-border movement in the Eastern and Southern Africa region. *A briefing*. Brighton: Social Science in Humanitarian Action (SSHAP)

Jose, B. and Medie, P. A. (2015) Understanding why and how civilians resort to self-protection in armed conflict, *International Studies Review*, 17(4), pp. 515-535.

Juma, C. A., Mushabaa, N. K., Salam, F. A., Ahmadi, A. and Lucero-Prisno, D. E. (2020) COVID-19: The Current Situation in the Democratic Republic of Congo, *The American Journal of Tropical Medicine and Hygiene*, 103 (6), pp. 2168.

Kaiser, T. (2005) Participating in development? Refugee protection, politics and developmental approaches to refugee management in Uganda, *Third World Quarterly*, 26 (2), pp. 351–367.

Kaiser, T. (2006) Between a camp and a hard place: rights, livelihood and experiences of the local settlement system for long-term refugees in Uganda, *Journal of Modern African Studies*, 44 (4), pp. 597–621.

Kaiser, T. (2010) Dispersal, division and diversification: Durable solutions and Sudanese refugees in Uganda, *Journal of Eastern African Studies*, 4 (1), pp. 44–60.

Kaiser, T. (2011) Researching social life in protracted exile: Experiences with sudanese refugees in Uganda 1996-2008, in: Mazurana, D., Jacobsen, K., and Gale, L. A. (eds.) *Research Methods in Conflict Settings: A View from Below*. Cambridge: Cambridge University Press, pp. 106–126.

Kamradt-Scott, A. (2016) WHO's to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa, *Third World Quarterly*, 37 (3), pp. 401–418.

Kansiime, M. K., Tambo, J. A., Mugambi, I., Bundi, M., Kara, A. and Owuor, C. (2021) COVID-19 implications on household income and food security in Kenya and Uganda: Findings from a rapid assessment, *World Development*, 137 (105199), pp. 1-10.

Kao, A. (2001) Viewpoint. Matthew Lukwiya, MD, *AMA Journal of Ethics*, 3 (2), pp. 60-61.

Keck, F., Kelly, A. K. and Lynteris, C. (2019) Introduction. The anthropology of epidemics, in: Kelly, A. K., Keck, F., and Lynteris, C. (eds.) *The Anthropology of Epidemics*. 1st ed. New York: Routledge, pp. 1–24.

Keck, F. and Lachenal, G. (2019) Simulations of epidemics: techniques of global health and neo-liberal government, in: Kelly, A. H., Keck, F., and Lynteris, C. (eds.) *The Anthropology of Epidemics*. London and New York: Routledge,

Kelly, A. H. (2018) Ebola vaccines, evidentiary charisma and the rise of global health emergency research, *Economy and Society*, 47 (1), pp. 135–161.

Kelly, A. H., Keck, F. and Lynteris, C. (2019) *The Anthropology of Epidemics*. New York: Routledge.

Kennedy, E. (2011) Emergency and Exception, *Political Theory*, 39 (4), pp. 535–550.

Kentikelenis, A. and Seabrooke, L. (2021) Organising knowledge to prevent global health crises: A comparative analysis of pandemic preparedness indicators, *BMJ Global Health*, 6(e006864), pp.1-12.

Khadiagala, G. M. (2010) Boundaries in eastern africa, *Journal of Eastern African Studies*, 4 (2), pp. 266–278.

Kindersley, N., Majiek, P., Othur, S., Barjok, D., Luga, E., Nyibol, E., Miskin, A., Madut, C. and Majok, J. D. (2021) *Community Approaches to Epidemic Management in South Sudan: Lessons from local healthcare systems in tackling COVID-19*. Rift Valley Institute.

Kinganda-Lusamaki, E., Whitmer, S., Lokilo-Lofiko, E., Amuri-Aziza, A., Muyembe-Mawete, F., Makangara-Cigolo, J. C., *et al.* (2024) 2020 Ebola virus disease outbreak in Équateur Province, Democratic Republic of the Congo: a retrospective genomic characterisation, *The Lancet Microbe*, 5 (2), pp. e109–e118.

Kleinman, A. (1995) *Writing at the Margin. Discourse Between Anthropology and Medicine*. Berkley; Los Angeles; London: University of California Press.

Laing, N., Mylan, S. and Parker, M. (2024) Does epidemiological evidence support the success story of Uganda's response to COVID-19? *Journal of Biosocial Science*, 11, pp. 1–8.

Lakoff, A. (2007) Preparing for the Next Emergency, *Public Culture*, 19 (2), pp. 247-271.

Lakoff, A. (2008) The Generic Biothreat, or, How We Became Unprepared, *Cultural Anthropology*, 23 (3), pp. 399–428.

Lakoff, A. (2017) *Unprepared. Global Health in a Time of Emergency*. First edition. Berkeley: University of California Press.

Lakoff, A. (2019) What is an epidemic emergency, in: Kelly, A. H., Keck, F., and Lynteris, C. (eds.) *The Anthropology of Epidemics*. London and New York: Routledge.

Lamarque, H. (2022) *Key Considerations: Cross-Border Dynamics between Uganda and Rwanda in the Context of the Outbreak of Ebola 2022*. Social Science in Humanitarian Action (SSHAP). DOI: 10.19088/SSHAP.2022.044

Lamarque, H. and Brown, H. (2022) *Key Considerations: Cross-Border Dynamics between Uganda and Kenya in the Context of the Outbreak of Ebola, 2022*. Social Science in Humanitarian Action (SSHAP). DOI: 10.19088/SSHAP.2022.043

Lancaster, K., Rhodes, T. and Rosengarten, M. (2020) Making evidence and policy in public health emergencies: lessons from COVID-19 for adaptive evidence-making and intervention, *Evidence & Policy*, 16(3), pp. 447-490.

Law, J. (2004) *After method: Mess in social science research*, *After Method: Mess in Social Science Research*. London and New York: Routledge.

Law, J. and Singleton, V. (2000) Performing Technology's Stories: On Social Constructivism, Performance, and Performativity, *The John Hopkins University Press*, 41 (4), pp. 765–775.

Leach, M. and Fairhead, J. (2007) *Vaccine anxieties: global science, child health and society*. London: Earthscan.

Leach, M., MacGregor, H., Ripoll, S., Scoones, I. and Wilkinson, A. (2022a) Rethinking disease preparedness: incertitude and the politics of knowledge, *Critical Public Health*, 32 (1), pp. 82–96.

Leach, M., MacGregor, H., Akello, G., Babawo, L., Baluku, M., Desclaux, A., *et al*. (2022b) Vaccine anxieties, vaccine preparedness: Perspectives from Africa in a Covid-19 era, *Social Science and Medicine*, 298 (114826), pp. 2-10.

Leach, M. and Tadros, M. (2014) Epidemics and the Politics of Knowledge: Contested Narratives in Egypt's H1N1 Response, *Medical Anthropology*, 33 (3), pp. 240–254.

Lees, S., Enria, L. and James, M. (2023) Contesting the crisis narrative: epidemic accounts in Sierra Leone, Tanzania, and Democratic Republic of the Congo, *Disasters*, 47 (1), pp. 78–98.

Leonardi, C. (2015) *Dealing with Government in South Sudan: Histories of Cheifship, Community and State*. Woodbridge, Suffolk: James Curry.

Leonardi, C., Storer, E. and Fisher, J. (2021) Geographies of unease: Witchcraft and boundary construction in an African borderland, *Political Geography*, 90(102442), pp. 1-11.

Leonardi, Cherry. and Santschi, Martina. (2016) *Dividing communities in South Sudan and Northern Uganda: boundary disputes and land governance*. Rift Valley Institute.

Lomo, Z., Naggaga, A. and Hovil, L. (2001) *The Phenomenon of Forced Migration in Uganda: An Overview of Policy and Practice in an Historical Context. Refugee Law Project Working Paper No.1*. Kampala.

Ludlow, D. L. (1999) Humanitarian Intervention and the Rwandan Genocide, *Journal of Conflict Studies*, 19 (1), pp. 22–47.

Lumu, I. (2020) COVID-19 Response in Sub-Saharan Africa: Lessons from Uganda, *Disaster Medicine and Public Health Preparedness*, 14 (3), pp. e46–e48.

Lynteris, C. (2014) Introduction: The Time of Epidemics, *The Cambridge Journal of Anthropology*, 32 (1), pp. 24-31.

Lynteris, C. and Poleykett, B. (2018) The Anthropology of Epidemic Control: Technologies and Materialities, *Medical Anthropology, 37(6), p. 433-441*.

MacDonald, N. E., Eskola, J., Liang, X., Chaudhuri, M., Dube, E., Gellin, B., *et al.* (2015) Vaccine hesitancy: Definition, scope and determinants, *Vaccine*, 33 (34), pp. 4161–4164.

MacGregor, H., Leach, M., Akello, G., Sao Babawo, L., Baluku, M., Desclaux, A., *et al.* (2022) Negotiating Intersecting Precarities: COVID-19, Pandemic Preparedness and Response in Africa, *Medical Anthropology*, 41 (1), pp. 19–33.

MacGregor, H., Ripoll, S. and Leach, M. (2020) Disease Outbreaks Navigating uncertainties in preparedness and response, in: Scoones, I. and Stirling, A. (eds.) *The Politics of Uncertainty Challenges of Transformation*. 1st Edition. London: Routledge, pp. 113–126.

Mackenzie, J. S., Drury, P., Arthur, R. R., Ryan, M. J., Grein, T., Slattery, R., Suri, S., Domingo, C. T. and Bejtullahu, A. (2014) The Global Outbreak Alert and Response Network, *Global Public Health*, 9 (9), pp. 1023–1039.

Malkki, L. H. (1995a) Refugees and Exile: From 'Refugee Studies' to the National Order of Things, *Annual Review of Anthropology*, 24 (1), pp. 493–523.

Malkki, L. H. (1995b) *Purity and exile: Violence, Memory and National Cosmology among Hutu Refugees in Tanzania*. Chicago: University of Chicago Press.

Malkki, L. H. (1996) Speechless Emissaries: Refugees, Humanitarianism, and Dehistoricization, *Cultural Anthropology*, 11(3), pp. 377-404.

Manderson, L., Burke, N. J. and Wahlberg, A. (eds) (2021) *Viral Loads: Anthropologies of urgency in the time of COVID-19*. London: UCL Press.

Marabello, S. and Parisi, M. L. (2020) "I Told You the Invisible Can Kill You": Engaging Anthropology as a Response in the COVID-19 Outbreak in Italy, *Human Organization*, 79 (4), pp. 250–258.

Marcus, G. E. (1995) Ethnography in / of the World System: The Emergence of Multi-Sited Ethnography, *Annural Review of Anthropology*, 24, pp. 95–117.

Martineau, F., Wilkinson, A. and Parker, M. (2017) Epistemologies of ebola: Reflections on the experience of the Ebola Response Anthropology Platform, *Anthropological Quarterly*, 90 (2), pp. 475–494.

Mathieu, E., Ritchie, H., Ortiz-Ospina, E., Roser, M., Hasell, J., Appel, C., Giattino, C. and Rodés-Guirao, L. (2021) A global database of COVID-19 vaccinations, *Nature Human Behaviour*, 5 (7), pp. 947–953.

Mbiti, J. S. (1990) *African Religions & Philosophy*. Oxford: Heinemann.

McConnachie, K. (2016) Kirsten McConnachie Camps of Containment: A Genealogy of the Refugee Camp, *Humanity*, 7(3), pp. 397-412.

McKay, G. and Parker, M. (2018) Epidemics, in: Allen, T., MacDonald, A., and Radice, H. (eds.) *Humanitarianism A Dictionary of Concepts*. New York: Routledge, pp. 81–95.

McKibbin, W. and Fernando, R. (2023) The global economic impacts of the COVID-19 pandemic, *Economic Modelling*, 129 (106551), pp. 1-18.

Mehand, M. S., Al-Shorbaji, F., Millett, P. and Murgue, B. (2018) The WHO R&D Blueprint: 2018 review of emerging infectious diseases requiring urgent research and development efforts, *Antiviral Research*, 159, pp. 63-67.

Mellish, T. I., Luzmore, N. J. and Shahbaz, A. A. (2020) Why were the UK and USA unprepared for the COVID-19 pandemic? The systemic weaknesses of neoliberalism: a comparison between the UK, USA, Germany, and South Korea, *Journal of Global Faultlines*, 7 (1), pp. 9-45.

Merry, S. E. (2016) *The Seductions of Quantification: Measuring Human Rights, Gender Violence, and Sex Trafficking*. Chicago and London: University of Chicago Press.

Migdal, J. S. (2004) Boundaries and Belonging States and Societies in the Struggle to Shape Identities and Local Practices Edited by, in: Migdal, J. S. (ed.) *Boundaries and*

Belonging. States and Societies in the Struggle to Shape Identities and Local Practices. Cambridge: Cambridge University Press, pp. 3–26.

Momodu, S. (2019) Migration. Uganda stands out in refugees hospitality, *Africa Renewal, United Nations*. Available at: https://www.un.org/africarenewal/magazine/december-2018-march-2019/uganda-stands-out-refugees-hospitality [Accessed 15th December 2024].

Moon, S., Sridhar, D., Pate, M. A., Jha, A. K., Clinton, C., Delaunay, S., *et al.* (2015) Will Ebola change the game? Ten essential reforms before the next pandemic. the report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola, *Lancet*, 386, pp. 2204 -2221.

Moro, L. N. (2019) What is means to be a 'refugee' in South Sudan and Uganda, *London School of Economics and Political Science*. Available from: https://blogs.lse.ac.uk/africaatlse/2019/05/28/what-it-means-to-be-a-refugee-in-south-sudan-and-uganda/ [Accessed 6 October 2020].

Moro, L. and Robinson, A. (2022) *Key Considerations Concerning Cross-Border Dynamics between Uganda and South Sudan in the Context of the Outbreak of Ebola 2022*. Social Science In Humanitarian Action (SSHAP). DOI: 10.19088/SSHAP.2022.045.

Moyo, K., Sebba, K. R. and Zanker, F. (2021) Who is watching? Refugee protection during a pandemic - responses from Uganda and South Africa, *Comparative Migration Studies*, 9 (1), pp. 1–19.

Mukumbang, F. C. (2022) How the COVID-19 pandemic is shifting the migrant-inequality narrative, in: Nico, M., Pollock, G. (eds), *The Routledge Handbook of Contemporary Inequalities and the Life Course*. Abingdon: Routledge.

Mullen, L., Mullen, L., Potter, C., Potter, C., Gostin, L. O., Cicero, A., Cicero, A. and Nuzzo, J. B. (2020) An analysis of International Health Regulations Emergency Committees and Public Health Emergency of International Concern Designations, *BMJ Global Health*, 5 (6), pp. e002502.

Müller, M. and Schurr, C. (2016) Assemblage thinking and actor-network theory: conjunctions, disjunctions, cross-fertilisations, *Transactions of the Institute of British Geographers*, 41 (3), pp. 217–229.

Murphy, E. M., Greene, M. E., Mihailovic, A. and Olupot-Olupot, P. (2006) Was the "ABC" Approach (Abstinence, Being Faithful, Using Condoms) Responsible for Uganda's Decline in HIV?, *PLOS Medicine*, 3 (9), pp. e379.

Mylan, S. (2024) Suspicious business: COVID-19 vaccination in Palabek refugee settlement, northern Uganda, *Social Science & Medicine*, 346(116695), pp. 1-9.

Nakueira, S. (2020) Chapter 7: Unpacking Vulnerability: An Ethnographic Account of the Challenges of Implementing Resettlement Programmes in a Refugee Camp in Uganda, in: Foblets, MC., Leboeuf, L. (eds), *Humanitarian Admission to Europe: The Law Between Promises and Constraints*. Baden-Baden, Germany: Nomos Verlagsgesellschaft, pp. 239–270.

Nari, Mr. T. J. (2024) Epistemological Implications of John Mbiti's Conception of African Time, *International Journal of Social Science and Human Research*, 07 (03), pp. 1579-1585.

Commission on a Global Health Risk Framework for the Future; National Academy of Medicine, Secretariat. (2016) *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*. Washington, D.C.: National Academies Press.

Neiman, S. and Titeca, K. (2023) EXCLUSIVE: How a WFP food aid revamp has gone wrong for refugees in Uganda, *The New Humanitarian*. Available from: https://www.thenewhumanitarian.org/investigations/2023/12/15/exclusive-investigation-wfp-food-aid-revamp-gone-wrong-refugees-uganda [Accessed 26 November 2024].

Nguyen, V.-K. (2014) Ebola: How We Became Unprepared, and What Might Come Next, *Society for Cultural Anthropology*. Available from: https://culanth.org/fieldsights/ebola-how-we-became-unprepared-and-what-might-come-next [Accessed 19 November 2020].

Nguyen, V.-K. (2019) Of what are epidemics the symptom? Speed, interlinkage, and infrastructure in molecular anthropology, in: Kelly, A. H., Keck, F., and Lynteris, C. (eds.) *The Anthropology of Epidemics*. Abingdon and New York: Routledge.

Nichter, M. (1995) Vaccinations in the Third World: A consideration of community demand, Social *Science & Medicine*, 41 (5), pp. 617–649.

Niehaus, I. (2007) Death before Dying: Understanding AIDS Stigma in the South African Lowveld, *Journal of Southern African Studies*, 33 (4), pp. 845–860.

Njenga, M. K., Dawa, J., Nanyingi, M., Gachohi, J., Ngere, I., Letko, M., Otieno, C. F., Gunn, B. M. and Osoro, E. (2020) Why is There Low Morbidity and Mortality of COVID-19 in Africa?, *The American Journal of Tropical Medicine and Hygiene*, 103 (2), pp. 564.

Nordling, L. (2020) *The pandemic appears to have spared Africa so far. Scientists are struggling to explain why*, Science. Available at: https://www.science.org/content/article/pandemic-appears-have-spared-africa-so-far-scientists-are-struggling-explain-why [accessed 06th October 2022].

Nuruzzaman, M. (2015) Rethinking foreign military interventions to promote human rights: Evidence from Libya, Bahrain and Syria, *Canadian Journal of Political Science*, 48 (3), pp. 531–552.

O'Byrne, R. (2015a) *Safety at the Margins: perceptions of justice and (in) security from South Sudan's southern border.* The Justice and Security Research Programme, Paper 23.

O'Byrne, R. (2015b) *Deities, Demons and Outsiders: The cosmological dimensions of (in)security and (in)justice in Pajok, South Sudan*, The Justice and Security Research Programme, Paper 21.

O'Byrne, R. (2016) *Becoming Christian: Personhood and Moral Cosmology in Acholi South Sudan*, PhD Thesis, Department of Anthropology, UCL.

O'Byrne, R. J. (2021) Occult economies, demonic gifts, and ontological alterity: An evangelical biography of evil and redemption in rural South Sudan, *The Journal of Religion in Africa*, 50 (1–2), pp. 137–155.

O'Byrne, R. J. (2022) Resistant Resilience: Agency and Resilience Among Refugees Resisting Humanitarian Corruption in Uganda, *Civil Wars*, 24 (2–3), pp. 328–356.

O'Byrne, R. J. (2023) Understanding the Everyday Movements of South Sudanese Refugees in Uganda, in: Karunaratne, G. (ed.) *Informal Settlements of the Global South*. Abingdon: Routledge,

O'Byrne, R. J. and Ogeno, C. (2021) Pragmatic Mobilities and Uncertain Lives: Agency and the Everyday Mobility of South Sudanese Refugees in Uganda, *Journal of Refugee Studies*, 33 (4), pp. 747–765.

OCHA (2022) *OOHA on Message: Humanitarian Principles*. Available from: https://www.unocha.org/publications/report/world/ocha-message-humanitarian-principles-enar

Ogeno, C. and O'Byrne, R. J. (2018) The Illegal Economy of Refugee Registration: Insights into the Ugandan Refugee Scandal, *London School of Economics and Political Science*. Available from: https://blogs.lse.ac.uk/africaatlse/2018/03/08/the-illegal-economy-of-refugee-registration-insights-into-the-ugandan-refugee-scandal-publicauthority/ [Accessed 7 October 2020].

Oleribe, O. O., Taylor-Robinson, S. D. and Taylor-Robinson, A. W. (2024) COVID-19 post-pandemic reflections from sub-Saharan Africa: what we know now that we wish we knew then, *Public Health in Practice*, 7(100486), pp.1-5.

Oliver-Smith, A. (1996) Anthropological Research of Hazards and Disasters, *Annual Review of Anthropology*, 25 (1), pp. 303–331.

Omaswa, F. G., Okware, S. I. and Kiguli-Malwadde, E. (2015) Strategies from the 2000–01 Ebola outbreak in Uganda, *The Lancet Global Health*, 3 (S29), pp. 29.

Omata, N. (2023) The role of developmental 'buzzwords' in the international refugee regime: Self-reliance, resilience, and economic inclusion, *World Development*, 167(106248), pp. 1-11.

Ong, Aihwa. and Collier, S. J. (2005) *Global assemblages: technology, politics, and ethics as anthropological problems*. Malden, MA: Blackwell.

OPM and UNHCR (2021) *Uganda - Refugee Statistics March 2021 - Palabek*. Available at: https://reliefweb.int/report/uganda/uganda-refugee-statistics-march-2021-palabek.

OPM and UNHCR (2022a) *Inter-Agency Uganda Country Refugee Response Plan (UCRRP) 2022-2025*. Available at: https://data.unhcr.org/en/documents/details/92447.

OPM and UNHCR (2022b) *Uganda - Refugee Statistics June 2022 - Palabek*. Available at: https://reliefweb.int/report/uganda/uganda-refugee-statistics-june-2022-palabek.

Oppenheim, B., Gallivan, M., Madhav, N. K., Brown, N., Serhiyenko, V., Wolfe, N. D. and Ayscue, P. (2019) Assessing global preparedness for the next pandemic: Development and application of an Epidemic Preparedness Index, *BMJ Global Health*, 4 (1), pp. 1–9.

Oxfam (2020) *Protecting Refugees From Coronavirus,* Oxfam in Action. Available from: https://www.oxfam.org.uk/oxfam-in-action/impact-stories/moury/ [Accessed 29 August 2024].

Pacciardi, A. (2023) Viral bodies: racialised and gendered logics in the securitisation of migration during COVID-19 in Italy, *Critical Studies on Security*, 11 (3), pp. 176–193.

Palmer, J. J. (2019) Sensing Sleeping Sickness: Local Symptom-Making in South Sudan, *Medical Anthropology*, 39(6), pp. 457-473

Palmer, J. J. and Kingsley, P. (2016) *Controlling sleeping sickness amidst conflict and calm: remembering, forgetting and the politics of humanitarian knowledge in Southern Sudan, 1956-2005*. Working Paper. London, UK: Overseas Development Institute.

Parashar, S. and Schulz, M. (2021) Colonial legacies, postcolonial 'selfhood' and the (un)doing of Africa, *Third World Quarterly*, 42 (5), pp. 867–881.

Park, S. J. and Akello, G. (2017) The oughtness of care: Fear, stress, and caregiving during the 2000–2001 Ebola outbreak in Gulu, Uganda, *Social Science & Medicine*, 194 (Oct), pp. 60–66.

Parker, M. and Allen, T. (2011) Does mass drug administration for the integrated treatment of neglected tropical diseases really work? Assessing evidence for the control

of schistosomiasis and soil-transmitted helminths in Uganda, *Health Research Policy and Systems*, 9 (3), pp. 1-20.

Parker, M., Baluku, M., Ozunga, B. E., Okello, B., Kermundu, P., Akello, G., MacGregor, H., Leach, M. and Allen, T. (2022) Epidemics and the Military: Responding to COVID-19 in Uganda, *Social Science & Medicine*, 314 (115482), pp. 1-9.

Parker, M., Fergus, C. A., Brown, C., Atim, D., Ocitti, J., Atingo, J. and Allen, T. (2021) Legacies of humanitarian neglect: long term experiences of children who returned from the Lord's Resistance Army in Uganda, *Conflict and Health*, 15 (43), pp. 2-19.

Parker, M., Hanson, T. M., Vandi, A., Sao Babawo, L. and Allen, T. (2019a) Ebola and Public Authority: Saving Loved Ones in Sierra Leone, *Medical Anthropology*, 38 (5), pp. 440–454.

Parker, M., Hanson, T. M., Vandi, A., Babawo, L. S. and Allen, T. (2019b) Ebola, community engagement, and saving loved ones, *The Lancet*, 393 (10191), pp. 2585.

Parker, M., Macgregor, H. and Akello, G. (2020) COVID-19, Public Authority and Enforcement, *Medical Anthropology*, 39 (8), pp. 666–670.

Parkhurst, J. O. (2002) The Ugandan success story? Evidence and claims of HIV-1 prevention, *The Lancet*, 360 (9326), pp. 78–80.

p'Bitek, O. (1966) *Song of Lawino*. Nairobi: East African Publishing House.

p'Bitek, O. (1971) *Religion of the Central Luo*. Nairobi: East African Literature Bureau.

p'Bitek, O. (1986) *Artist, the Ruler: Essays on Art, Culture, and Values, Including Extracts from Song of Soldier and White Teeth Make People Laugh on Earth*.Nairobi: East African Publishers.

p'Bitek, O., Girling, F. K. and Allen, T. (2019) *Lawino's People: The Acholi of Uganda*, Allen, T. (ed.). Berlin: LIT Verlag.

Pendle, N., Marko, F., Gercama, I. and Bedford, J. (2019) *Key considerations: cross-border dynamics between South Sudan and DRC*. Social Science in Humanitarian Action Platform (SSHAP).

Peters, R. W. (2016) Local in Practice: Professional Distinctions in Angolan Development Work, *American Anthropologist*, 118 (3), pp. 495–507.

Picardo, A. and Ndung'u, J. (2017) Elimination of sleeping sickness in Uganda could be jeopardised by conflict in South Sudan, *The Lancet Global Health*, 5 (1), pp. E28–E29.

Pietrabissa, G. and Simpson, S. G. (2020) Psychological Consequences of Social Isolation During COVID-19 Outbreak, *Frontiers in Psychology*, 11(2201), pp. 1-4.

Piot, P., Muyembe, J. J. and Edmunds, W. J. (2014) Ebola in west Africa: From disease outbreak to humanitarian crisis, *The Lancet Infectious Diseases*, 14(11), pp. 1034-1035.

Porter, H. (2017) *After Rape: Violence, Justice and Social Harmony in Uganda*. Cambridge: International African Institute and Cambridge University Press.

Porter, H. (2019) Moral Spaces and Sexual Transgression: Understanding Rape in War and Post Conflict, *Development and Change*, 50 (4), pp. 1009–1032.

Porter, H. E. (2012) Justice and rape on the periphery: the supremacy of social harmony in the space between local solutions and formal judicial systems in northern Uganda, *Journal of Eastern African Studies*, 6 (1), pp. 81–97.

Porter, H. E. (2013) *After rape: justice and social harmony in northern Uganda*, PhD Thesis, London School of Economic and Political Science.

Public Health England (2020) *Disparities in the risk and outcomes of COVID-19*. Available from: www.facebook.com/PublicHealthEngland

Public Health England (2021) JCVI advises on COVID-19 vaccine for people aged under 40. Available from: https://www.gov.uk/government/news/jcvi-advises-on-covid-19-vaccine-for-people-aged-under-40#:~:text=As%20COVID%2D19%20rates%20continue,delays%20in%20having%20the%20vaccine.

Quarantelli, E. (2006) *Catastrophes Are Different from Disasters: Some Implications for Crisis Planning and Managing Drawn from Katrina* – Items, Social Science Research Council. Available from: https://items.ssrc.org/understanding-katrina/catastrophes-are-different-from-disasters-some-implications-for-crisis-planning-and-managing-drawn-from-katrina/ [Accessed 10 December 2024].

Ramsay, G. (2020) Time and the other in crisis: How anthropology makes its displaced object, *Anthropological Theory*, 20 (4), pp. 385–413.

Rashedi, R., Samieefar, N., Masoumi, N., Mohseni, S. and Rezaei, N. (2022) COVID-19 vaccines mix-and-match: The concept, the efficacy and the doubts, *Journal of Medical Virology*, 94(4), pp.1294–1299.

Ratnayake, R., Tammaro, M., Tiffany, A., Kongelf, A., Polonsky, J. A. and Mcclelland, A. (2020) People-centred surveillance: a narrative review of community-based surveillance among crisis-affected populations, *Lancet Planet Health*, 4, pp. e483-495.

Redfield, P. (2013) *Life in crisis: the ethical journey of Doctors without Borders*. Berkely: University of California Press.

Rhodes, T. and Lancaster, K. (2022) Making pandemics big: On the situational performance of Covid-19 mathematical models, *Social Science & Medicine*, 301(114907), pp. 2-10.

Richards, P. (2016) *Ebola. How a people's science helped end an epidemic*. London: Zed Press.

Richardson, E. T. (2020) Pandemicity, COVID-19 and the limits of public health 'science', *BMJ Global Health*, 5(e002571), pp. 1-3.

Richardson, E. T., Barrie, M. B., Kelly, J. D., Dibba, Y., Koedoyoma, S. and Farmer, P. E. (2015) Biosocial approaches to the 2013-2016 Ebola pandemic, *Health and Human Rights*, 18 (1), pp. 115–128.

Richardson, E. T., McGinnis, T. and Frankfurter, R. (2019) Ebola and the narrative of mistrust, *BMJ Global Health*, 4(e001932), pp. 1-4.

Roach, S. C. (2023) *Slave Soldiers, British Colonial Rule, and Armed Resistance*, *South Sudan's Fateful Struggle*. New York: Oxford University Press.

Rödlach, A. (2006) *Witches, Westerners, and HIV AIDS and Cultures of Blame in Africa*. First. Walnut Creek, California: Left Coast Press.

Rogge, J. R. (1977) A geography of refugees: Some illustrations from Africa, *The Professional Geographer*, 29 (2), pp. 186–193.

Rolandsen, Ø. H. (2011) A false start: Between war and peace in the Southern Sudan, 1956-62, *Journal of African History*, 52 (1), pp. 105–123.

Roth, E. (2020) Epidemic temporalities: A concise literature review, *Anthropology Today*, 36 (4), pp. 13–16.

Rottenburg, R. and Merry, S. E. (2015) A world of indicators: the making of governmental knowledge through quantification, in: Rottenberg, R., Merry, S. E., Park, S.-J., and Mugler, J. (eds.) *The World of Indicators. The Making of Governmental Knowledge through Quantification*. Cambridge: Cambridge University Press, pp. 1–33.

Rubenstein, J. C. (2015) Emergency Claims and Democratic Action, *Social Philosophy and Policy*, 32 (1), pp. 101–126.

Samimian-Darash, L. (2022) Scenarios in a Time of Urgency, *Social Anthropology/Anthropologie Sociale*, 30 (4), pp. 90–109.

Samimian-Darash, L. and Rotem, N. (2019) From Crisis to Emergency: The Shifting Logic of Preparedness, *Ethnos*, 84 (5), pp. 910–926.

Schmidt, A. (2003) FMO Thematic Guide: Camps versus settlements, *Forced Migration Online*. Available from: http://www.unhcr.org/cgi-bin/texis/vtx/research/opendoc.pdf?tbl=RESEARCH&id=3ae6a0c22 [Accessed 15th December 2024].

Schmidt, M. (2020) *Key Considerations: Emerging Evidence On Shielding Vulnerable Groups During COVID-19*. Social Science in Humanitarian Action Platform (SSHAP).

Schmidt-Sane, M. M., Nielsen, J. O., Chikombero, M., Lubowa, D., Lwanga, M., Gamusi, J., Kabanda, R. and Kaawa-Mafigiri, D. (2020) Challenges to Ebola preparedness during an ongoing outbreak: An analysis of borderland livelihoods and trust in Uganda, *PLoS ONE*, 15 (3): e0230683.

Searcy, K. (2019) Sudan in Crisis, *Origins. Current Events in Historical Perspective. Available at: https://origins.osu.edu/article/sudan-darfur-al-bashir-colonial-protest*. [Accessed 15th December 2024].

Slutkin, G., Okware, S., Naamara, W., Sutherland, D., Flanagan, D., Carael, M., Blas, E., Delay, P. and Tarantola, D. (2006) How Uganda Reversed Its HIV Epidemic, *AIDS and Behavior*, 10 (4), pp. 351-361.

Somparé, A. W. and Somparé, E. B. (2019) Mistrust During the Ebola Epidemic in Guinea, in: Mühlfried, F. (ed.) *Mistrust: Ethnographic Approximations*. Bielefeld: Transcript Verlag, pp. 129–145.

Soudan, N. (2024) *The Politics of Food and the Myth of the Self-Reliant Refugee in Uganda*. Available from: https://www.unhcr.org/

South African Government (2022) COVID-19 / Coronavirus. Available from: https://www.gov.za/Coronavirus [Accessed 5 December 2024].

Sparke, M. and Williams, O. D. (2022) Neoliberal disease: COVID-19, co-pathogenesis and global health insecurities, *Environment and Planning A*, 54 (1), pp. 15–32.

Spengler, B., Espinoza Garrido, L., Mieszkowski, S. and Wewior, J. (2021) Introduction: Migrant Lives in a State of Exception, *Parallax*, , 27(2), pp. 115-158.

SSHAP (2020) Social Science in Humanitarian Action Platform. Available from: https://www.socialscienceinaction.org/ [Accessed 15 July 2020].

Stein, B. N. and Tomasi, S. M. (1981) Foreword, *International Migration Review*, 15 (1/2), pp. 7.

Stellmach, D., Beshar, I., Bedford, J., Du Cros, P. and Stringer, B. (2018) Anthropology in public health emergencies: What is anthropology good for? *BMJ Global Health*, 3 (2): e000534.

Storer, E., and Anguyo, I. (2023) “These people are lying to us”: Mutating Vaccine Fears and Colonial Histories in Arua, North-West Uganda, *Medical Anthropology Quarterly Online*. Available from: https://medanthroquarterly.org/critical-care/2023/03/these-people-are-lying-to-us-mutating-vaccine-fears-and-colonial-histories-in-arua-north-west-uganda/ [accessed 15th December 2024].

Storer, E., Dawson, K. and Fergus, C. A. (2022) Covid-19 Riskscapes: Viral Risk Perceptions in the African Great Lakes, *Medical Anthropology,* 41 (4), pp. 387–403.

Storer, E., O’Byrne, R. J. and Reid, K. (2017) Poisoning at the periphery: allocating responsibility across the Uganda/South Sudan borderlands, *Third World Thematics: A TWQ Journal*, 2 (2–3), pp. 180–196.

Streefland, P., Chowdhury, A. and Ramos-Jimenez, P. (1999) Patterns of vaccination acceptance, *Social Science & Medicine*, 49 (5), pp. 1705–1716.

Suarez, C. (2017) Living between Two Lions: Civilian Protection Strategies during Armed Violence in the Eastern Democratic Republic of the Congo, *Journal of Peacebuilding and Development*, 12 (3), pp. 54–67.

Summers, C. (1991) *Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925*, *Signs*. Vol. 16 (4), p. 787-807.

Tankwanchi, A. S., Jaca, A., Larson, H. J., Wiysonge, C. S. and Vermund, S. H. (2020) Taking stock of vaccine hesitancy among migrants: a scoping review protocol, *BMJ Open*, 10 (5): e035225.

Taussig, M. (1999) *Defacement*. California: Stanford University Press.

Tazzioli, M. and Stierl, M. (2021) ‘We closed the ports to protect Refugees.’ Hygienic borders and deterrence Humanitarianism during Covid-19, *International Political Sociology*, 15 (4), pp. 539–558.

Telford, J., Gibbons, L. and Van Brabant, K. (1997) *Counting and identification of beneficiary populations in emergency operations: registration and its alternatives*. London. Available from: http://www.oneworld.org/odi/rrn/

Thakur, R. (2016) The Responsibility to Protect at 15, *International Affairs*, 92 (2), pp. 415–434.

The Global Fund to Fight AIDS, T. and M. (2021) Uganda’s Remarkable Response to COVID-19 - Blog. Available from: https://www.theglobalfund.org/en/blog/2021-03-23-ugandas-remarkable-response-to-covid-19/ [Accessed 24 May 2022].

The Lancet COVID-19 Commissioners, Task Force Chairs and Commission Secretariat (2020) Lancet COVID-19 Commission Statement on the occasion of the 75th session of the UN General Assembly, *Lancet*, 369, pp. 1102–1124.

Thomas, C. M., Osterholm, M. T. and Stauffer, W. M. (2021) Critical Considerations for COVID-19 Vaccination of Refugees, Immigrants, and Migrants, *The American Journal of Tropical Medicine and Hygiene*, 104 (2), pp. 433–435.

Thompson, E. P. (1967) Time, Work-Discipline, and Industrial Capitalism, *The Past and Present Society*, 38(Dec), pp. 56–97.

Tichenor, M. (2017) Data Performativity, Performing Health Work: Malaria and Labor in Senegal, *Medical Anthropology*, 36 (5), pp. 436–448.

Tilley, H. (2016) History of Medicine: Medicine, Empires, and Ethics in Colonial Africa, *AMA Journal of Ethics*. Vol. 18(7), pp. 743-753.

Titeca, K. (2021) Who depends on whom? Uganda's refugee 'success story', corruption and the international community, *Third World Quarterly*, 43 (1), pp. 55–73.

Titeca, K. (2022) *Who paid the price for Uganda's refugee fraud scandal (and who didn't)?* The New Humanitarian. Available from: https://www.thenewhumanitarian.org/investigation/2022/12/07/Uganda-UNHCR-refugee-fraud-corruption [Accessed 23 November 2024].

Titeca, K. (2023) *Exclusive: Uganda's refugee programme hit by fresh fraud concerns,* The New Humanitarian. Available from: https://www.thenewhumanitarian.org/news/2023/04/21/uganda-refugee-programme-fraud-concerns [Accessed 23 November 2024].

Torre, C. (2023a) "Think Positive, Save a life"? Resilience and Mental Health Interventions as Political Abandonment in a Refugee Settlement in Northern Uganda, *Civil Wars*, 25 (4), pp. 708–734.

Torre, C. (2023b) *Throwing therapy at the problem Mental health and humanitarian intervention in Palabek refugee settlement, northern Uganda*. PhD Thesis, London School of Economics and Political Science.

Torre, C., Mylan, S., Parker, M. and Allen, T. (2019) Is promoting war trauma such a good idea? *Anthropology Today*, 35 (6), p. 218-227.

Torre, C. and Storer, E. (2023) COVID-19 vaccines, mobility, and pandemic bureaucracies: Undocumented migrants' perspectives from Italy's Alpine border, *Journal of Migration and Health*, 7 (100189), p.2-9.

Tumushabe, J. (2006) *The Politics of HIV/AIDS in Uganda*. Social Policy and Development Programme Paper, Number 28. United Nations Research Institute for Social Development.

Uganda Bureau of Statistics (2024a) *Multidimensional Child Poverty In Uganda. Volume 1: The Extent and Nature of Multidimensional Child Poverty and Deprivation - 2024*. Available from: https://www.ubos.org

Uganda Bureau of Statistics (2024b) *Multidimensional Child Poverty in Uganda - 2024. Volume 1 Key Summary Report*. Available from: https://www.ubos.org

UK Influenza Pandemic Preparedness Strategy 2011 (2011). Available from: http://www.dh.gov.uk/publications

UNHCR (2000) *The state of the world's refugees, 2000: fifty years of humanitarian action*. Available from: https://archive.org/details/stateofworldsref0000unse

UNHCR (2003) *Framework for Durable Solutions for Refugees and Persons of Concern*. Available from: https://www.unhcr.org/sites/default/files/legacy-pdf/3f1408764.pdf

UNHCR (2015) *Guidelines on International Protection No. 11: Prima Facie Recognition of Refugee Status*. Available from: https://www.unhcr.org/uk/media/guidelines-international-protection-no-11-prima-facie-recognition-refugee-status-5-june-2015

UNHCR (2017) *Comprehensive Refugee Response Framework Uganda - The Way Forward*. Available from: https://data.unhcr.org/en/documents/details/63266

UNHCR (2018a) *New York Declaration: UNHCR Quick Guide*. Available from: https://www.unhcr.org/uk/media/new-york-declaration-quick-guide

UNHCR (2018b) Briefing Notes: Uganda starts biometric verification of refugees. Available from: https://www.unhcr.org/uk/news/briefing-notes/uganda-starts-biometric-verification-refugees [Accessed 23 November 2024].

UNHCR (2019) *Uganda Country Refugee Response Plan January 2019-December 2020*. Available from: https://reporting.unhcr.org/sites/default/files/Uganda%20Country%20RRP%202019-20%20%28January%202019%29.pdf

UNHCR (2020) Uganda Comprehensive Refugee Response Portal. Available from: https://data2.unhcr.org/en/country/uga [Accessed 6 October 2020].

UNHCR (2021a) COVID-19 socioeconomic impact worsens for refugees in Uganda | UNHCR Blog. Available from: https://www.unhcr.org/blogs/https-www-unhcr-org-blogs-covid-19-socioeconomic-impact-worsens-for-refugees-in-uganda/ [Accessed 27 August 2024].

UNHCR (2021b) PRESS RELEASES COVID-19 poses a major threat to the life and welfare of refugees in Uganda, *UNHCR Global Website*. Available from: https://www.unhcr.org/uk/news/news-releases/covid-19-poses-major-threat-life-and-welfare-refugees-uganda [Accessed 23 November 2024].

UNHCR (2022a) *South Sudan Regional Refugee Response Plan. January - December 2022*. Available from: https://data.unhcr.org/en/documents/details/91497

UNHCR (2022b) *Underfunded* Report, *September 2022*. Available from: https://reliefweb.int/report/world/underfunded-report-september-2022

UNHCR (2022c) UNHCR *COVID-19 Vaccine Access Report 2021*. Available from: https://www.unhcr.org/uk/media/unhcr-covid-19-vaccine-access-report-2021

UNHCR (2022d) *Country - Uganda, Uganda Comprehensive Refugee Response Portal*. Available from: https://data.unhcr.org/en/country/uga [Accessed 3 September 2022].

UNHCR (2022e) *Uganda Country Refugee Response - Emergency Appeal - April - December 2022*. Available from: https://data.unhcr.org/en/documents/details/95441

UNHCR (2023a) *Emergency Handbook. Health in camps*. Available from: https://emergency.unhcr.org/emergency-assistance/health-and-nutrition/health-care-contexts/health-camps-and-settlements

UNHCR (2023b) South Sudan Refugee Crisis Explained. *USA for UNHCR*. Available from: https://www.unrefugees.org/news/south-sudan-refugee-crisis-explained/#:~:text=The%20vast%20majority%20(over%2083,parents%20and%20are%20traveling%20alone [Accessed 15th December 2024]/

UNHCR (2024a) Who we protect: Refugees. Available from: https://www.unhcr.org/uk/about-unhcr/who-we-protect/refugees [Accessed 9 December 2024].

UNHCR (2024b) Asylum-seekers | UNHCR. Available from: https://www.unhcr.org/uk/about-unhcr/who-we-protect/asylum-seekers [Accessed 9 December 2024].

UNHCR (2024c) Who we protect: Internally Displaced People. Available from: https://www.unhcr.org/uk/about-unhcr/who-we-protect/internally-displaced-people# [Accessed 9 December 2024].

UNHCR (2024d) *Informal settlements: Key points. Emergency Handbook*. Available from: https://emergency.unhcr.org/emergency-assistance/shelter-camp-and-settlement/settlements/informal-settlements

UNHCR (2024e) What is a Refugee Camp? Definition and Statistics | USA for UNHCR. Available from: https://www.unrefugees.org/refugee-facts/camps/ [Accessed 23 November 2024].

UNHCR (2024f) Refugee Data Finder - Key Indicators. Available from: https://www.unhcr.org/refugee-statistics [Accessed 23 November 2024].

UNHCR (2024g) Country - Uganda. Available from: https://data.unhcr.org/en/country/uga [Accessed 21 October 2024].

UNHCR (2024h) *South Sudan Regional Refugee Response plan. January - December 2024*. Available from: https://reliefweb.int/report/uganda/south-sudan-regional-refugee-response-plan-january-december-2024

UNHCR and Government of Uganda (2018) *Comprehensive Refugee Response Framework: Review of Practical Applications in Uganda*. Available from: https://reliefweb.int/report/uganda/comprehensive-refugee-response-framework-review-practical-application-uganda-november-2018

UNHCR Regional Representation in Rome (2007) *The Detention of Refugees and Asylum-Seekers by Reason of Their Unauthorised Entry or Presence*. Available from: https://www.unhcr.org/sites/default/files/legacy-pdf/4d9488f49.pdf

UNHCR UK (2020) UNHCR - South Sudan emergency. Available from: https://www.unhcr.org/uk/south-sudan-emergency.html [Accessed 6 October 2020].

UNHCR UK (2024) Uganda's open-door policy for refugees strained by arrivals from Sudan, DRC, and South Sudan | UNHCR UK. Available from: https://www.unhcr.org/uk/news/briefing-notes/ugandas-open-door-policy-refugees-strained-arrivals-sudan-drc-and-south-sudan [Accessed 23 November 2024].

UNHCR and WFP (2023) *Support to UNHCR and WFP country operations in Uganda*. Available from: https://reporting.unhcr.org/uganda#toc-populations

United Nations (2016) *Protecting humanity from future health crises: Report of the High-level Panel on the Global Response to Health Crises*. Available from: https://digitallibrary.un.org/record/822489?ln=en&v=pdf

United Nations (2021) COVID cases surging in Africa at fastest rate this year, but deaths remain low, *UN News*. Available from: https://news.un.org/en/story/2021/12/1107882 [Accessed 24 May 2022].

United Nations (2023) Uganda: UN experts condemn egregious anti-LGBT legislation | OHCHR. Available from: https://www.ohchr.org/en/press-releases/2023/03/uganda-un-experts-condemn-egregious-anti-lgbt-legislation [Accessed 23 November 2024].

United Nations (no date) History of the United Nations | United Nations. United Nations. Available from: https://www.un.org/en/model-united-nations/history-united-nations [Accessed 12 November 2024].

United Nations Development Programme (2022) *Socio-Economic Update of Uganda*. Available from: https://www.undp.org/sites/g/files/zskgke326/files/2023-

01/Socio%20Economic%20Update%20of%20Uganda-First%20Edision%20Oct%202022.pdf

US Centre for Disease Control and Prevention (CDC) (2024) Outbreak History | Ebola | CDC. Available from: https://www.cdc.gov/ebola/outbreaks/index.html [Accessed 21 November 2024].

Van Boetzelaer, E., Chowdhury, S., Etsay, B., Faruque, A., Lenglet, A., Kuehne, A., *et al*. (2020) Evaluation of community based surveillance in the Rohingya refugee camps in Cox's Bazar, Bangladesh, 2019, *PLoS ONE*, 15 (12): e0244214.

Victor, L. (2019) Those who go underwater: Indignation, sentiment, and ethical immanence in northern Uganda, *Anthropological Theory*, 19 (3), pp. 385–411.

Victor, L. and Porter, H. (2017) Dirty things: spiritual pollution and life after the Lord's Resistance Army, *Journal of Eastern African Studies*, 11 (4), pp. 590–608.

Vigh, H. (2008) Crisis and chronicity: Anthropological perspectives on continuous conflict and decline, *Ethnos*, 73 (1), pp. 5–24.

von Weichs, R. (2009) Uganda, protests against British colonialism and occupation, In: Ness, I., (ed), *International Encyclopedia of Revolution and Protest*. New Jersey: Wiley & Blackwell, pp. 3369–3373.

Wachira, L. J., Arena, R., Sallis, J. F., Lambert, E. V., Ong'wen, O. M., Laddu, D. R., Onywera, V. and Oyeyemi, A. L. (2022) Why are COVID-19 effects less severe in Sub-Saharan Africa? Moving more and sitting less may be a primary reason, *Progress in Cardiovascular Diseases*, 71 (Mar-April), pp. 103-105.

Wainman, N., Whyte, S. R. and Meinert, L. (2022) Textures of precarity: Repurposing in a Ugandan refugee settlement, *Anthropology Today*, 38 (4), pp. 19–22.

Weissman, F. (2010) 'Not in our name': Why Medecins sans frontières does not support the 'Responsability to protect', *Criminal Justice Ethics*, 29 (2), pp. 194–207.

Welsh, M. (2014) Resilience and responsibility: governing uncertainty in a complex world, *The Geographical Journal*, 180 (1), pp. 15–26.

White, A. I. R. (2020) Historical linkages: epidemic threat, economic risk, and xenophobia, *The Lancet*, 395 (10232), pp. 1250–1251.

White, L. (2000) *Speaking with Vampires: Rumour and History in Colonial Africa*. First Edition. Berkeley and Los Angeles: University of California Press.

Whyte, S. (1997) *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda*, *Cambridge University Press*. Cambridge: Cambridge University Press.

Wiegratz, J., Martiniello, G. and Greco, E. (2018) *Uganda: The Dynamics of Neoliberal Transformation*. London: Zed Books.

Wiertz, T. (2021) Biopolitics of migration: An assemblage approach, *Environment and Planning, Politics and Space 39(7), pp.1375:1388.*

Wilder-Smith, A., Chiew, C. J. and Lee, V. J. (2020) Can we contain the COVID-19 outbreak with the same measures as for SARS?, *The Lancet Infectious Diseases*, 20, pp. e102–e107/

Wilkinson, A. and Fairhead, J. (2017) Comparison of social resistance to Ebola response in Sierra Leone and Guinea suggests explanations lie in political configurations not culture, *Critical Public Health*, 27 (1), pp. 14–27.

Wilkinson, A., MacGregor, H., Scoones, I., Schmidt-Sane, M., Leach, M., Taylor, P., *et al*. (2023) *Pandemic Preparedness for the Real World: Why We Must Invest in Equitable, Ethical and Effective Approaches to Help Prepare for the Next Pandemic*. Brighton: Institute of Development Studies.

Wilkinson, A., Parker, M., Martineau, F. and Leach, M. (2017) Engaging 'communities': anthropological insights from the West African Ebola epidemic, *Philosophical Transactions B*, (372), pp. 1–7.

Williams, L. (2022) Building an Ecology of Resilience through Religious Practice and Community in Northern Uganda, *Civil Wars*, 24 (2–3), pp. 305–327.

Wolf, M. and Hall, K. (2018) Cyborg Preparedness: Incorporating Knowing and Caring Bodies into Emergency Infrastructures, *Medical Anthropology: Cross Cultural Studies in Health and Illness*, 37 (6), pp. 486–498.

World Bank (2017) *Forcibly Displaced. Towards a Development Approach Supporting Refugees, the Internally Displaced, and Their Hosts*. Washington, DC: World Bank.

World Bank (2022) The World Bank Data. Available from: https://data.worldbank.org/indicator/SP.POP.DPND?end=2020&locations=UG-KE-RW-TZ-SS-CD&start=2007&view=chart [Accessed 18 July 2022].

World Food Programme (2024) *Strategic evaluation of WFPs' approaches to Targeting and Prioritization for Food and Nutrition Assistance. Final Terms of reference*. Available from: https://www.wfp.org/publications/strategic-evaluation-wfps-approaches-targeting-and-prioritization

World Health Organization (1948) Constitution, Available from: *https://www.who.int/about/governance/constitution*

World Health Organization (2005) *International Health Regulations*. Third edition. *Available from: https://www.who.int/publications/i/item/9789241580496*

World Health Organization (2009) WHO information on tuberculosis and pandemic influenza A (H1N1), *WHO News*. Available from: https://www.who.int/news/item/12-11-2009-who-information-on-tuberculosis-and-pandemic-influenza-a-(h1n1) [Accessed 4 December 2024].

World Health Organization (2015) *Anticipating Emerging Infectious Disease Epidemics. Meeting Report. WHO Informal Consultation*. Available from: https://apps.who.int/iris/bitstream/handle/10665/252646/WHO-OHE-PED-2016.2-eng.pdf

World Health Organization (2017) *Vaccination and trust*. Available from: https://www.who.int/publications/i/item/vaccination-and-trust

World Health Organization (2019a) *Emergencies: International health regulations and emergency committees: Q&A*. Available at: https://www.who.int/news-room/questions-and-answers/item/emergencies-international-health-regulations-and-emergency-committees

World Health Organization (2019b) *Ten threats to global health in 2019*. Available from*: https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019*

World Health Organization (2021a) *WHO Guidance on Preparing for National Response to Health Emergencies and Disasters*. Geneva. Available from: https://iris.who.int/bitstream/handle/10665/350838/9789240037182-eng.pdf;sequence=1#:~:text=The%20guidance%20suggests%20mechanisms%20countries,through%20a%20participatory%20process%20that

World Health Organization (2021b) *COVID-19 immunization in refugees and migrants: principles and key considerations*. Available from: https://www.who.int/publications/i/item/covid-19-immunization-in-refugees-and-migrants-principles-and-key-considerations-interim-guidance-31-august-2021

World Health Organization (2023a) Trypanosomiasis, human African (sleeping sickness). Available from: https://www.who.int/news-room/fact-sheets/detail/trypanosomiasis-human-african-(sleeping-sickness)# [Accessed 15 November 2024].

World Health Organization (2023b) *Preparedness and resilience for emerging threats Module 1: planning for respiratory pathogen pandemics*. Geneva. Available from: https://www.who.int/publications/i/item/9789240084674.

World Health Organization (2024a) WHO Health Emergencies Programme | WHO | Regional Office for Africa. Available from: https://www.afro.who.int/about-us/programmes-clusters/who-health-emergencies-programme [Accessed 14 November 2024].

World Health Organization (2024b) Health emergencies. Available from: https://www.who.int/our-work/health-emergencies [Accessed 14 November 2024].

World Health Organization (2024c) Pandemic prevention, preparedness and response accord. Available from: https://www.who.int/news-room/questions-and-answers/item/pandemic-prevention--preparedness-and-response-accord [Accessed 21 November 2024].

Appendix: SSHAP Policy Brief

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

London School of Hygiene & Tropical Medicine
Keppel Street, London WC1E 7HT

T: +44 (0)20 7299 4646
F: +44 (0)20 7299 4656
www.lshtm.ac.uk

RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	lsh457909	**Title**	Dr
First Name(s)	Sophie Katherine Hardman		
Surname/Family Name	Mylan		
Thesis Title	Re-thinking epidemic preparedness in refugee settings: An ethnographic exploration in Palabek Refugee Settlement, northern Uganda, during COVID-19		
Primary Supervisor	Melissa Parker		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Social Science and Humanitarian Action Platform		
When was the work published?	September 2024		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	N/A		
Have you retained the copyright for the work?*	**No**	Was the work subject to academic peer review?	**Yes**

*If yes, please attach evidence of retention. If no, or if the work is being included in its published format, please attach evidence of permission from the copyright holder (publisher or other author) to include this work.

SECTION C – Prepared for publication, but not yet published

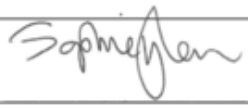
Where is the work intended to be published?	
Please list the paper's authors in the intended authorship order:	

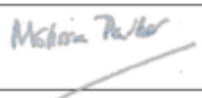
Stage of publication	Choose an item.

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	n/a.

SECTION E

Student Signature	
Date	12th December 2024

Supervisor Signature	
Date	13th December 2024

Key considerations: Balancing epidemic preparedness and response with humanitarian protection in Ugandan refugee settlements

SSHAP
Social Science in Humanitarian Action Platform

Humanitarian actors in Ugandan refugee settlements face the dual challenge of preparing for and responding to epidemics, while providing essential humanitarian assistance. They must balance their international mandate to protect refugees and uphold human rights with a variety of public health measures to safeguard refugees, humanitarian workers and Ugandan host communities from epidemic threats. This complex task also involves addressing broader regional, national and international public health implications of uncontrolled epidemic spread.

Previous SSHAP briefs have described specific considerations regarding cross-border dynamics between Uganda and neighbouring countries in the context of epidemics.[1,2] The brief *Key Considerations: Cross-Border Dynamics Between Uganda and South Sudan in the Context of the Outbreak of Ebola, 2022*[1] highlights the complex movement of people across the highly porous – and sometimes contested – South Sudan-Uganda border, which cuts through multiple ethnic groups. It describes mobility as related to networks of kin, livelihoods, trade, education, healthcare, and the search for safety and security. The brief suggests that Ebola preparedness and response activities need to be locally appropriate, paying specific attention to the livelihoods of people in this region. Another brief[3] specifically highlights the need to consider the context specific vulnerabilities of refugees in Uganda in relation to epidemics.

This brief builds on these insights and presents considerations for **five areas of epidemic preparedness and response** in Ugandan refugee settlements, drawing on the experience of COVID-19 and its implications for **humanitarian protection.** It focuses on refugee settlements in north Uganda, drawing on ethnographic data collected during COVID-19 in Palabek refugee settlement, Lamwo district. This is combined with insights from published research, grey literature, and discussions with government employees and humanitarian actors engaged in the Ugandan refugee response.

Key considerations

- **Enabling cross-sectoral strategies amongst humanitarian sectors is essential for effective epidemic preparedness and response efforts.** Epidemic preparedness and response must include livelihoods, food security, protection, environment and education in addition to health, and water, sanitation and hygiene (WASH).
- **Facilitating flexible funding is critical to meet refugees' needs.** Epidemic preparedness and response policies need to be flexible so that activities can be tailored to the unique needs and priorities of refugees, informed by refugees' lived experiences. This requires flexibility in funding streams.
- **Acknowledging that refugees' priorities during epidemics vary greatly and are shaped by economic, political and social influences is a prerequisite to engaging refugees.** Successfully engaging refugees in epidemic preparedness and response requires consideration of these wider influences. For example, experiences of fraud in food distrubution[4] or inadequate basic provisions, directly impact the success of public health measures.
- **Addressing the context-specific priorities of refugees is critical to the effectiveness of epidemic response and humanitarian protection activities**. Epidemic response activities are shaped by international and national priorities that frequently overlook the lived realities of refugees. This has the potential to render epidemic response and humanitarian protection activities ineffective, as refugees circumvent official policies to ensure their ongoing survival in contexts of high precarity.

Epidemic preparedness and response in Ugandan refugee settlements, September 2024,
www.doi.org/10.19088/SSHAP.2024.042

- **Considering refugees' mobility in relation to livelihood needs during epidemics is essential.** Surveillance and isolation activities need to consider refugees' mobility in relation to essential livelihood activities, especially in the context of significant food insecurity. Movement of refugees in and out of refugee settlements may not cease during epidemics despite formal restrictions, including at international borders.
- **Focusing epidemic preparedness plans on reception centres as key entry points for early detection of outbreaks helps minimise the spread of disease.** Reception centres are sites of intensive protection activities but are also highly prone to infectious disease outbreaks due to congestion and inadequate facilities. However, they are not separate from the wider settlement, as new arrivals mix with other refugees, host communities and humanitarian personnel.
- **Acknowledging that public health policies are shaped by political narratives as well as public health rationale helps humanitarian actors navigate policies effectively.** Registration and infectious disease screening of refugees is shaped by district, national and international political discourse. Humanitarian actors must navigate political narratives regarding refugees – including the perception of new arrivals as a health security threat – whilst providing basic humanitarian protection.
- **Collecting context-specific data helps understand how a vaccine is perceived by refugees and how it compares to other priorities, supporting effective campaigns.** Uptake of vaccines during epidemics is shaped by previous vaccination campaigns and wider geopolitical dynamics. These include the relationship of refugees to government and humanitarian actors, and inequalities related to displacement.
- **Specific attention should be paid to ensuring practitioners have regular contact with their personal support network.** Balancing humanitarian protection and epidemic activities places a strain on humanitarian practitioners. If this is overlooked, it can compromise the effectiveness of activities, as practitioners face 'burn out'.

Humanitarian protection and epidemics

The provision of humanitarian aid to refugees revolves around the term 'protection'. The UN Refugee Agency (UNHCR) has a mandate to protect refugees and coordinate humanitarian responses.[5] This encompasses a wide range of interventions to protect forcefully displaced and separated persons from violence and conflict in line with international refugee law, but also to ensure refugees receive access to basic human rights.[6] The Refugee Coordination Model outlines the roles and responsibilities of those providing assistance to refugees.[5] This includes a specific Refugee Protection Group encompassing working groups for child protection and sexual and gender-based violence. In addition, however, the seven sectors constituting the Multi-Sector Group (refugee emergency telecommunication; food security; health and nutrition; shelter; WASH; education; and livelihoods/ self-reliance) are also key elements of humanitarian protection.

Infectious disease outbreaks and epidemics in refugee settings add an additional dimension to conceptualisations of protection that need to be considered by humanitarian practitioners. The regulated and unregulated movement of refugees is understood to be a health security threat, as refugees may carry the disease in question across international borders.[7,8] During COVID-19 in Uganda, the government considered certain groups to be the focus of disease transmission, and therefore the greatest threat to health security. These groups included truck drivers[9] and new arrivals of refugees.[10] This posed challenges to maintaining the health and safety of refugees residing in settlements and nationals living in the areas hosting refugees, whilst also providing essential services to new arrivals of refugees.

Refugees are also considered a vulnerable group when it comes to infectious disease outbreaks and epidemics and are in need of health protection. Refugee settlements are at risk of disease outbreaks due to overcrowding, inadequate WASH facilities, and high fatality rates

driven by pre-existing malnutrition and limited healthcare access.[11] Ugandan refugee settlements also receive refugees from areas particularly susceptible to zoonotic epidemics, such as the Congo Basin.[12] Furthermore, COVID-19 has demonstrated that consideration needs to be given to the effects of global pandemics within refugee settings,[13] with refugees experiencing disproportionally negative socio-economic consequences.[14]

Uganda's refugee response

Uganda is Africa's largest refugee-hosting nation, accommodating approximately 1.7 million refugees.[15] Refugees are primarily located in settlements in northern, western and south-western districts[16] – some of the poorest areas in the country.[17] The largest refugee population in Uganda comes from South Sudan, and they are granted refugee status on a prima facie basis. However, refugees also come from a variety of other countries including the Democratic Republic of the Congo, Rwanda and Burundi.[15] The Ugandan Office of the Prime Minister (OPM) oversees all settlements, supported by UNHCR and partnering non-governmental organisations (NGOs) delivering services across the sectors of humanitarian response. A Refugee Welfare Committee comprises elected refugee leaders and mirrors the local council structure of Uganda. Each refugee settlement is divided into zones and blocks, and Refugee Welfare Committee leaders come from the settlement, zone and block levels.

Uganda's approach to refugees has received international attention, and in 2017 the Comprehensive Refuge Response Framework (CRRF) was launched.[18] This confirmed Uganda's 'open door policy' to refugees who live side by side with Ugandan nationals in settlements that enable free movement. The CRRF builds on Uganda's longstanding refugee policy, which has a 'development approach', with the long-term goal of reducing reliance on humanitarian assistance. This development approach includes the 1999 Self-Reliance Strategy;[19] the Development Assistance to Refugee-Hosting Area Program (2004); and more recently, in 2015, the Settlement Transformative Agenda.[20] The latter advocated for refugee settlements rather than encampments and included refugees in Uganda's broader development plans.[21]

There are, however, significant shortfalls in international funding for Uganda's refugee response. UNHCR's 2024 South Sudan Regional Refugee Response Plan states:

> 'Funding for the Uganda Country Refugee Response Plan (UCRRP) has dwindled in the past years, and the capacity of Refugee Response Plan (RRP) partners to provide life-saving support and protection services to new arrivals and basic assistance to refugees has diminished. This has manifested as significant reductions in food rations, with over 80 per cent of the population receiving USD 3 per person per month, which is barely enough to survive'.[15]

Furthermore, there is evidence that policies promoting self-reliance and resilience fail to provide adequate assistance to refugees.[22–25]

Health services to refugees

In line with the CRRF, the OPM and the Ugandan Ministry of Health (MOH) produced the Health Sector Integrated Refugee Response Plan in 2022. The plan outlines a vision for integrated and coordinated health services for both refugees and Ugandan host communities, operating as an addendum to the Health Sector Development Plan 2015-2020.[26] This document describes the Ugandan Minimum Health Package to refugees, which includes specific attention to the needs of new arrivals, as well as emergency and epidemic preparedness and response, facility based and community health services, and quality assurance.

The Government of Uganda write clearly that refugees are associated with challenges concerning Water, Sanitation and Hygiene (WASH), disease outbreaks, and the re-emergence of eliminated diseases. Although new or re-emerging outbreaks cause minimal burden in comparison to other more commonly found medical concerns, outbreaks of cholera, measles,

polio and Ebola have led to significant resource implications.[26] Rather than being delivered through the national Ugandan health delivery system, health services to refugees are usually provided by NGOs through UNHCR funding. These NGOs are also required to provide care to Ugandans living in the vicinity of refugee settlements. The government of Uganda, however, has advocated for a paradigm shift towards more integrated services.[26]

Epidemic preparedness and response involves the coordination of refugee agencies such as UNHCR; NGOs providing refugee services; and the Ugandan government, including state command, OPM, district government and MOH. Support from additional international agencies such as the World Health Organization (WHO), UNICEF and Médecins Sans Frontières is obtained when epidemics reach pre-determined disease-specific thresholds.

Five areas of epidemic preparedness and response

The following sections outline **five areas of epidemic preparedness and response** in Ugandan refugee settlements, drawing on the experience of COVID-19 and its implications for humanitarian protection. These areas are: **learning from COVID-19 lockdowns**; **quarantine and isolation**; **disease surveillance**; **vaccination**; and **integration and coordination**.

Learning from COVID-19 lockdowns

In March 2020, Uganda instigated a national lockdown in response to COVID-19. Scholars have described how 'Uganda's response, though quick and decisive, by restricting movement and social interactions, has negatively impacted the social protection for refugees.'[20] Over the following two years, various measures were taken to 'loosen' and 'tighten' COVID-19 containment measures, commonly known as lockdowns.[27] These periods of containment had significant implications for travel and business within the country; schools were essentially closed for two years and the economic consequences for Ugandan citizens and refugees were severe.[28]

Food and mobility

Prior to the COVID-19 pandemic, refugees in Ugandan settlements experienced significant food insecurity.[4,25,29] Most recently this was compounded by insufficient donor funding which led to a reduction in food rations from the World Food Programme[22] (the implementation of which coincided with the pandemic). Research has also described corruption within food distribution.[4] Prior to the pandemic, refugees relied on other sources of income to generate funds for additional food and other essential items. This included working as casual labour in nearby farms, villages and towns; selling produce at markets; running small shops; or becoming motorcycle taxi drivers. Circular movement to borderlands and neighbouring countries provided access to farmland.[30]

Many refugees attributed the increase in food insecurity to COVID-19. This aligned with a reduction in overseas funding from countries in the Global North, whose attention turned inwards towards their national COVID-19 policies.[31] In the context of reduced food rations and the loss of additional sources of income during lockdowns, refugees continued to travel back to borderlands to farm or search for other economic opportunities,[32] crossing officially closed yet porous borders.[10]

This circular movement of refugees across international borders, e.g., the Uganda-South Sudan border, has been well documented as essential to survival – both prior to and during the COVID-19 pandemic.[1,4,30,33] During COVID-19, this unregulated movement of refugees through porous borders challenged humanitarian services in refugee settlements in terms of disease surveillance and isolation, as discussed in the sections below. However, efforts to restrict such movement risks undermining a critical aspect of refugee self-protection,[10] in the absence of adequate humanitarian funding to protect against the wider detrimental effects of lockdowns.

The movement of adults described above left children unaccompanied within settlements, creating significant child protection concerns. This was noted by many NGOs in Palabek, including those in the health facilities who noted an increasing number of unaccompanied children attending the outpatient departments.

Settlement COVID-19 taskforce

A specific success reported by refugees and humanitarian actors in Palabek was the formation of a settlement-level COVID-19 taskforce during the first lockdown. This success was attributed to a strong commitment from formal authorities to ensure a coordinated response through Refugee Welfare Committee leaders and Village Health Teams in the settlement, ensuring clear and consistent messaging.

However, this success was not replicated during the second lockdown, as Refugee Welfare Committee leaders noted a significant decline in communication quality from OPM and other agencies in the settlement.

Suicide and violence

Lockdowns coincided with a notable increase in suicide and sexual and gender-based violence across many refugee settlements. In June 2021, UNHCR published a press release documenting a worrying rise in attempted and completed suicides amongst refugees in Uganda, with a 129% increase in 2020 compared to 2019. UNHCR states that 'most cases concern young women affected by gender-based violence'.[14]

In 2021, the International Rescue Committee, with support from UNHCR and the European Union Civil Protection and Humanitarian Aid, conducted focus group discussions in Palabek refugee settlement to investigate the concerning increase in suicidal behaviours. The report collated community perspectives on why people attempt or commit suicide.

These were summarised as: having no means to support oneself; gender-based or domestic violence; chronic diseases and the associated stigma; alcoholism and drug abuse; bereavement; unemployment; and loss of property.[34] 'No means to support oneself' is likely to reflect the inseparable nature of food insecurity and mental health that has been documented amongst refugees in Ugandan settlements prior to COVID-19.[35]

In contrast, the violent enforcement of national COVID-19 policies reported in other areas of Uganda by police, soldiers, and local defence units[36] was considered to be less severe in settlements, at least in part attributed to settlements as a site of international humanitarian protection.

Humanitarian activities

Following national Ugandan COVID-19 policies, NGOs providing direct services across multiple sectors in refugee settlements had to significantly adjust their operations to comply with restrictions on gatherings and social distancing. In response to the unknown risks of a new pathogen, many NGOs withdrew their staff from in-person work in the settlements. This made the delivery of many services to refugees impossible.

However, some activities managed to utilise alternative methods of communication. For example, 'road drives' became a common practice for disseminating information to refugees without the need for gatherings. This involved a large speaker being placed on a vehicle with messages conveyed loudly as the vehicle drove around the different areas of the settlement.

Nevertheless, the significant reduction in humanitarian presence in the settlements was experienced by refugees as a failure to provide adequate protection during a time of increased precarity.

Healthcare services

Access to basic healthcare was significantly disrupted by COVID-19 lockdowns. Restrictions on transportation, such as motorcycle taxis, hindered access to health facilities, especially for those with physical disabilities.

Additionally, fear of contracting COVID-19 directly from healthcare workers made refugees hesitant to visit health centres. Community outreach activities in the health sector were also halted during lockdown. This had an impact on the management of other diseases. For instance, in Palabek refugee settlement, weekly 'community outreach' sessions targeting high malaria zones stopped with lockdowns, as gatherings and community activities by implementing partners could not take place due to government restrictions. Even when allowed, healthcare staff were hesitant to engage directly with refugees for fear of contracting COVID-19.

These insights from COVID-19 lockdowns are highly relevant to preparedness plans for future epidemics. They demonstrate that the socio-economic consequences of epidemics, such as reduced livelihood opportunities, food insecurity and restricted access to healthcare services directly impact the engagement of refugees with – and thus the success of – containment policies. There is a higher likelihood of success for preparedness plans that can incorporate these considerations and actively involve refugees through inclusive taskforces.

Quarantine and isolation

When Uganda closed its borders in March 2020 it also halted asylum processes, shutting down transit points and reception centres. Although these measures were temporarily lifted for a large influx of refugees from the DRC in July 2020, borders largely remained closed.[20] Despite this national policy, refugees continued to arrive using unofficial porous borders,[10] directly entering settlements. Humanitarian actors were required to provide humanitarian protection to these individuals in line with international refugee law, with additional COVID-19 measures.

New arrivals

During COVID-19, the Government of Uganda mandated quarantine for all new refugees entering settlements until they tested negative for COVID-19. This policy acknowledged that despite the official closure of international borders, refugees continued to arrive. This required a significant allocation of resources and was not always feasible due to the closure of processing sites at border points.

Refugees arriving directly into settlements mixed with established refugees, host community and humanitarian staff prior to COVID-19 testing. This mixing was influenced by pre-existing relationships with family and friends within settlements who often offered support to new arrivals. Those arriving also frequented shops in the settlement trading centres. Additionally, the suspension of new refugee registrations required humanitarian practitioners to seek specific permission from government authorities, delaying registration processes and allowing further mixing within settlements.

In contrast, during an Ebola outbreak in 2022, with an epicentre in Mubende district (Western Uganda) the closest refugee settlements in neighbouring districts temporarily diverted new arrivals to alternative settlements to be registered. These decisions, however, are usually based on settlement capacity rather than disease outbreaks.

Quarantine and isolation facilities

During the initial wave of COVID-19, refugees already residing in settlements were required to visit health centres for testing if they had any symptoms or signs of COVID-19, or if returning from another location. If they tested positive, they were isolated in specific facilities. In Palabek, this created a socially monitored border to the settlement, with anyone entering the settlement escorted to a health centre for quarantine and testing, regardless of symptoms. These policies

were generally supported by those in refugee leadership positions, and generally had great adherence from refugees.[10]

Similar engagement was reported in other settlements such as Rhino. However, the additional quarantine and isolation requirements posed significant challenges for refugee services, including the need for extra funding for food and WASH facilities. Refugees reported inadequate food provision in quarantine and isolation units, whilst humanitarian professionals struggled to secure additional funding for these services. In Palabek, challenges were partially overcome by repurposing closed reception centres for COVID-19 facilities.

Home-based care

At the start of the second wave of COVID-19, Uganda shifted its policy to focus on home-based care for mild and moderate cases,[37] including in refugee settlements, though this posed unique challenges. Isolating infected individuals from other family members was often unfeasible due to limited space, and maintaining isolation was difficult given the economic pressures refugees faced to secure income. Officially, home-based isolation ended when individuals tested negative, but delays in result processing meant isolation periods could extend for weeks or months. The likelihood of refugees maintaining isolation during these extended periods diminished as time went on.

Coordinated response

Whether isolated remotely or at home, these measures affected refugees' engagement with livelihood activities, increasing pressure on humanitarian services to provide additional support. To put it simply: expecting refugees to stay at home when they had no source of food, or engage with infection prevention strategies such as hand washing without soap, was impossible. In this way, epidemic response efforts directly overlapped with livelihood opportunities and WASH services, requiring humanitarian practitioners to work across different sectors. Healthcare professionals had to seek support from alternative sectors to address concurrent social and economic issues, to ensure the success of public health interventions.

Disease surveillance

Disease surveillance in Ugandan refugee settlements incorporates both community-based disease surveillance and facility-based surveillance. Community-based disease surveillance utilises the Village Health Teams (VHTs) in refugee settlements, which receive training in epidemic preparedness and response (see SHHAP Brief, *Key Considerations: Community Based Surveillance in Public Health*).[38]

Surveillance includes passive and active components. **Passive surveillance** involves the monitoring of weekly and monthly surveillance reports that are submitted via Uganda's Health Management Information System[26] directly to the Ugandan MOH. Diseases are categorised[39] variously as **diseases targeted for elimination** (e.g., bacterial meningitis, lymphatic filariasis); **epidemic-prone diseases** (e.g., cholera, measles); **diseases of public health importance** (e.g., viral hepatitis, trachoma); and **diseases or events of international concern** (e.g., acute viral haemorrhagic fever, SARS). See Uganda MOH's *National Technical Guidelines for Integrated Disease Surveillance and Response* for the full list.[40]

Active surveillance consists of targeted activities in response to specific concerns, such as alerts from VHTs or member of the refugee leadership, about unusual cases.

Mobility

Uganda's refugee response allows freedom of movement, and this poses challenges for disease surveillance. When refugees are highly mobile, surveillance becomes more challenging, as following up on cases of concern becomes difficult. This was evident during a measles outbreak in 2022 in Palabek.

The outbreak originated among refugees who had recently travelled from South Sudan. The disease spread across Palabek settlement to Kiryandongo settlement. It was first detected in Palabek through routine (passive) surveillance. Three positive cases from the same sub-county were found in laboratory testing, reaching the threshold for the declaration of an outbreak at the district level. Healthcare practitioners followed up the individuals who had tested positive but were not able to locate them. Successful contact tracing by healthcare workers across the settlements helped to mitigate this challenge.

Village Health Teams

Individuals make up Village Health Teams (VHTs), which represent specific regions of the settlement, in line with the Ugandan VHT Strategy.[41] VHTs are a central element of epidemic preparedness and response and provide an essential bridge of communication between humanitarian practitioners and refugees. They are responsible for 'health promotion, health education, identification and referral of sick/malnourished individuals and follow-up in the community'.[26] Members of VHTs provide weekly reports that are analysed by healthcare professionals, who are looking out for signs of potential outbreaks. Concerning trends are monitored closely.

Despite the challenges of funding VHTs, their work remains an essential dimension of disease surveillance. COVID-19 posed additional challenges, with increased pressures placed on VHTs in the delivery of healthcare and disease surveillance. In some settlements, VHTs felt they were not being adequately recognised for the personal risk involved in providing face-to-face care – especially whilst other NGO services withdrew. In Rhino settlement, partner organisations such as the Youth Social Advocacy Team responded to this challenge by working to secure additional funding for VHTs.

Funding challenges

The funding of VHTs has been challenged by the shortfalls in UNHCR's budget.[42] Members of VHTs previously had no stipends but were paid on an activity basis. This fragmented approach was harmonized by introducing a stipend of 50,000 Ugandan Shillings (approx. GBP 10) per month for each VHT member. With reduced funding, the role of Hygiene Promoter was further combined with the VHT role.

Healthcare facilities

Surveillance at healthcare facilities relies on the healthcare-seeking behaviour of refugees and Ugandan nationals. This is essential not only for providing health services but also for collecting routine disease surveillance data. During COVID-19, health facilities became a focus of concern regarding disease transmission. This not only prohibited individuals from receiving medical assistance, but also challenged the collection of accurate surveillance data.

This presented a constant challenge for healthcare workers in settlements, who had to reduce their contact with refugees in line with national policy, whilst also encouraging refugees to seek medical care if symptomatic. Preventive measures to reduce COVID-19 transmission were introduced at health facilities. This included screening at entrances, social distancing for patients attending the outpatient department, and providing longer courses of medical prescriptions for those receiving chronic care management. For example, those with diabetes, hypertension, and those receiving antiretroviral therapy.

New arrivals

In line with the health service package for new arrivals of refugees, initial activities are meant to include screening for epidemic-prone diseases and malnutrition, completed in the 'acute phase of refugee influx'.[26] Timely screening for epidemic-prone diseases, including COVID-19, is not always feasible due to wider political constraints. For example, during COVID-19, humanitarian practitioners had to wait for permission to be granted to authorise the movement of new arrivals

of refugees by the Resident District Commissioner (representative of the president and central government) in consultation with OPM. Additionally, there was not always a supply of COVID-19 test kits, so screening was not performed regularly, further compromising efforts to interrupt disease transmission.

Vaccination

Routine vaccinations are administered to new arrivals of refugees (e.g., measles and polio). Schedules for routine childhood immunisations are also followed.[26] Epidemics may require additional vaccination campaigns. For example, outbreaks of measles, cholera and Ebola would require specifically designed vaccination strategies for those considered to be at increased risk. During the COVID-19 pandemic, all refugees were invited to get vaccinated. However, vaccination campaigns during epidemics can have particular challenges, such as those described below.

Supply

During COVID-19, inconsistent supply and changes in the type of vaccine available created logistical difficulties in delivering a continuous vaccination campaign. Furthermore, the wider dimensions of vaccine availability reflected geopolitical dynamics and failures of COVAX (a global initiative focused on equitable access to COVID-19 vaccines).[43] This directly shaped refugees' perspectives on the vaccine in Palabek refugee settlement, where social, economic, political and spiritual dimensions combined to shape vaccine uptake.[31]

Competing priorities

COVID-19 vaccination occurred in a context in which COVID-19 related illness and death was perceived by refugees to be minimal in comparison to other more pressing health concerns, as well as the wider challenges of food insecurity outlined above. Refugees therefore questioned why such emphasis was being placed on COVID-19, as opposed to other more pressing concerns. When competing priorities were not addressed, the vaccination campaign lost legitimacy among refugees.[31] This is challenging for humanitarian actors, whose activities are dictated by international funding flows that do not necessarily reflect the priorities of the beneficiaries of international aid.

Vaccine legacies

Healthcare professionals working with refugees in Uganda have described COVID-19 vaccination among refugees as remaining fairly low, but believe this has not had significant consequences given the minimal COVID-19 morbidity and mortality amongst refugees in comparison to other health threats such as malaria and other respiratory infections (Uganda's Health Management Information System data reporting these trends are not freely available to reference). However, each vaccination campaign has consequences for the next.

In the event of a new epidemic posing a threat to refugee health, vaccination could become increasingly critical. In this instance, a vaccination campaign will need to overcome the histories of problematic vaccination for COVID-19. For example, if a vaccination campaign was to be required for mpox in Ugandan refugee settlements, detailed qualitative investigation would need to examine what refugees understand about the disease and its perceived threats in relation to wider socio-economic challenges, such as food insecurity. It would also be important to explore if any aspect of vaccination raises specific suspicions amongst refugees, and why.

Integration and coordination

The ability to provide humanitarian protection to refugees depends on the effective coordination of multiple actors. Epidemic preparedness and response within Ugandan refugee settlements also requires attending to the needs of Ugandan nationals and humanitarian staff as well as refugees.

Integration of health services

The Health Sector Integrated Refugee Response Plan emphasises the goal of integrating services for refugees and Ugandan nationals, including during outbreaks.[26] There have been significant steps taken to integrate services. Since 1 July 2024, health facilities in Palabek have officially been run by the Ugandan MOH. This follows on from refugee settlements in the West Nile and south-western regions of Uganda, which have already made the transition to integrated health services.

It was anticipated that there would be full integration and transition of all refugee health and nutrition services by the time of writing, but this has not yet been achieved. The government of Uganda remains committed to integration but requires further support to actualise full transition. The move towards an integrated system responds to challenges associated with parallel systems, including concerns that large and unpredictable numbers of refugees can overwhelm Ugandan healthcare systems.[44] This would have significant ramifications for epidemic response capacity.

Furthermore, humanitarian agencies providing refugee-specific services in settlements need to balance the needs of Ugandan host communities living in the vicinity of the settlement with the needs of refugees. This can be a delicate balance, with both Ugandan nationals and refugees reporting inadequate attention to their respective needs.

Areas of integration that have been considered particularly successful include vaccination campaigns coordinated by humanitarian and national health services. These campaigns simultaneously targeted refugee and host communities, as was the case for a measles outbreak in Palabek in 2022. Additionally, health campaigns and monitoring exercises are frequently planned jointly by humanitarian agencies and government services.

However, integrated health services for refugees and host populations in the West Nile region are reported to have inadequate infrastructure and persistent shortfalls in medicines, essential supplies and healthcare workers.[45] This has significant impacts for epidemic preparedness and response activities, since the provision of essential health components of humanitarian protection are not being met.

Speed of response

Epidemics can spread rapidly, and the effectiveness of response efforts is directly influenced by the speed of action. However, response activities often involve sign-off from multiple different organisations and individuals, across district and national political landscapes, in addition to international humanitarian actors. This can significantly impede the speed of response, as response actors await the allocation of funding.

Protection of humanitarian actors

Caring for the physical and mental health of humanitarian practitioners is required in order for these individuals to work effectively within epidemic and refugee response efforts.

Those delivering services within settlements are at risk of contracting infectious diseases, due to the proximity of contact while providing a variety of services to protect refugees. For example, humanitarian practitioners have developed symptoms during outbreaks of cholera, Ebola, dysentery and COVID-19 in Ugandan refugee settlements. This could be partially mitigated through adequate provision of personal protective equipment (PPE), in conjunction with infection prevention and control training. However, the adequate stockpiling of PPE has been mixed. On occasion, inadequate stores were available. In other contexts, such as during COVID-19, staff reported that adequate supplies were available, with a surplus of PPE that had been acquired in preparation for previous outbreaks of Ebola.

There are also wider psychological effects on humanitarian practitioners that need to be considered. During COVID-19, humanitarian practitioners spent prolonged time away from their families, working under highly pressurised conditions, with reports of significant ‘mental strain and fatigue’. High levels of stress, with reduced ability to spend time with family and friends, risked ‘burn out’ amongst humanitarian practitioners.

References

1. Moro, L., & Robinson, A. (2022). *Key Considerations: Cross-Border Dynamics between Uganda and South Sudan in the Context of the Outbreak of Ebola, 2022*. Institute of Development Studies. https://doi.org/10.19088/SSHAP.2022.045
2. Lamarque, H., & Brown, H. (2022). *Key Considerations: Cross-Border Dynamics Between Uganda and Kenya in the Context of the Outbreak of Ebola, 2022*. Institute of Development Studies. https://doi.org/10.19088/SSHAP.2022.043
3. Kaawa-Mafigiri, D., Kato, F., & Schmidt-Sane, M. (2020). *Tackling Deadly Diseases in Africa: Key Considerations for Epidemic Response and Preparedness in Uganda* (TDDA Briefing). IDS, DAI Global Health.
4. O'Byrne, R. J. (2022). Resistant Resilience: Agency and Resilience Among Refugees Resisting Humanitarian Corruption in Uganda. *Civil Wars*, *24*(2–3), 328–356. https://doi.org/10.1080/13698249.2022.2092686
5. UNHCR. (2019, July 11). *Refugee Coordination Model (RCM)*. UNHCR. https://emergency.unhcr.org/coordination-and-communication/refugee-coordination-model/refugee-coordination-model-rcm
6. UNHCR. (n.d.). *Protection*. UNHCR UK. Retrieved August 16, 2024, from https://www.unhcr.org/uk/what-we-do/safeguard-human-rights/protection
7. Tazzioli, M., & Stierl, M. (2021). "We Closed the Ports to Protect Refugees." Hygienic Borders and Deterrence Humanitarianism during Covid-19. *International Political Sociology*, *15*(4), 539–558. https://doi.org/10.1093/ips/olab023
8. Pacciardi, A. (2023). Viral bodies: Racialised and gendered logics in the securitisation of migration during COVID-19 in Italy. *Critical Studies on Security*, *11*(3), 176–193. https://doi.org/10.1080/21624887.2023.2248437
9. Storer, E., Dawson, K., & Fergus, C. A. (2022). Covid-19 Riskscapes: Viral Risk Perceptions in the African Great Lakes. *Medical Anthropology*, *41*(4), 387–403. https://doi.org/10.1080/01459740.2022.2047675
10. Mylan, S. (n.d.). *Protection and Containment: Surviving COVID-19 in Palabek refugee settlement, northern Uganda*. Glob Policy.
11. Shannon, K., Hast, M., Azman, A. S., Legros, D., McKay, H., & Lessler, J. (2019). Cholera prevention and control in refugee settings: Successes and continued challenges. *PLoS Neglected Tropical Diseases*, *13*(6), e0007347. https://doi.org/10.1371/journal.pntd.0007347
12. Caron, A., Jori, F., de Nys, H., Herbinger, I., Liégeois, F., Mouinga-Ondémé, A., & Ratiarison, S. (2022). Emergence/Re-emergence of Infectious Agents and Epidemic Risks in Central African Forests. In R. Eba'a Atyi, F. Hiol Hiol, G. Lescuyer, P. Mayaux, P. Defourny, N. Bayol, F. Saracco, D. Pokem, R. Sufo Kankeu, & R. Nasi (Eds.), *The Forests of the Congo Basin: State of the Forests 2021* (pp. 265–288). Center for International Forestry Research (CIFOR).
13. Oxfam. (2020). *Protecting refugees from coronavirus*. Oxfam in Action. https://www.oxfam.org.uk/oxfam-in-action/impact-stories/moury/
14. UNHCR UK. (2021). *COVID-19 poses a major threat to the life and welfare of refugees in Uganda*. https://www.unhcr.org/uk/news/news-releases/covid-19-poses-major-threat-life-and-welfare-refugees-uganda
15. UNHCR. (2024). *South Sudan Regional Refugee Response Plan: January-December 2024*.
16. UNHCR, & OPM. (2024). *Uganda Comprehensive Refugee Response Portal*. https://data.unhcr.org/en/country/uga
17. Government of Uganda, & UNICEF. (2018). *Child Poverty and Deprivation in Refugee-Hosting Areas: Evidence from Uganda*.
18. UNHCR. (2017). *Comprehensive Refugee Response Framework Uganda—The Way Forward*. http://library.health.go.ug/leadership-and-governance/refugees/comprehensive-refugee-response-framework-uganda-way-forward
19. Clements, K. T., Shoffner, T., & Zamora, L. (2016). Uganda's approach to refugee self-reliance. *Forced Migration Review*. https://www.fmreview.org/clements-shoffner-zamore/
20. Moyo, K., Sebba, K. R., & Zanker, F. (2021). Who is watching? Refugee protection during a pandemic - responses from Uganda and South Africa. *Comparative Migration Studies*, *9*(1), 37. https://doi.org/10.1186/s40878-021-00243-3
21. Government of Uganda. (2020). *Third National Development Plan (NDPIII) 2020/21 – 2024/25*. https://www.health.go.ug/wp-content/uploads/2020/08/NDP-3-Report.pdf
22. Soudan, N. (2024). *The Politics of Food and the Myth of the Self-Reliant Refugee in Uganda* (No. 346; Egmont Policy Brief). https://www.egmontinstitute.be/app/uploads/2024/06/Nina-Soudan_Policy_Brief_346_vFinal.pdf?type=pdf
23. Kaiser, T. (2005). Participating in Development? Refugee protection, politics and developmental approaches to refugee management in Uganda. *Third World Quarterly*, *26*(2), 351–367. https://doi.org/10.1080/0143659042000339155
24. Hunter, M. (2009). The Failure of Self-Reliance in Refugee Settlements. *POLIS Journal*, *2*, 1–46.
25. Torre, C. (2023). *Throwing therapy at the problem mental health and humanitarian intervention in Palabek refugee settlement, northern Uganda* [PhD, London School of Economics and Political Science]. https://etheses.lse.ac.uk/4557/
26. Government of Uganda. (2022). *Health Sector Integrated Refugee Response Plan 2019-2024*.
27. Parker, M., Baluku, M., Ozunga, B. E., Okello, B., Kermundu, P., Akello, G., MacGregor, H., Leach, M., & Allen, T. (2022). Epidemics and the Military: Responding to COVID-19 in Uganda. *Social Science & Medicine*, *314*, 115482. https://doi.org/10.1016/j.socscimed.2022.115482
28. Laing, N., Mylan, S., & Parker, M. (2024). Does epidemiological evidence support the success story of Uganda's response to COVID-19? *Journal of Biosocial Science*, 1–8. https://doi.org/10.1017/S0021932024000117
29. Kamugisha, F., Komakech, H., Kisakye, A. N., & Bukenya, J. (2024). Prevalence of food insecurity and associated factors among refugee households in Rhino Camp Refugee Settlement, Arua District, Uganda. *Journal of Interventional Epidemiology and Public Health*, *7*(1), 1–15.
30. Gidron, Y. (2022). Mobile Livelihoods: Borderland dynamics between Uganda and South Sudan. *Rift Valley Institute*.
31. Mylan, S. (2024). Suspicious business: COVID-19 vaccination in Palabek refugee settlement, northern Uganda. *Social Science & Medicine (1982)*, *346*, 116695. https://doi.org/10.1016/j.socscimed.2024.116695
32. International Organization for Migration (IOM). (2021). *DTM South Sudan—Flow Monitoring Registry—Trends in cross-border return flows and impact of COVID-19 restrictions (Feb – Dec 2020)*. IOM.
33. O'Byrne, R. J., & Ogeno, C. (2020). Pragmatic Mobilities and Uncertain Lives: Agency and the Everyday Mobility of South Sudanese Refugees in Uganda. *Journal of Refugee Studies*, *33*(4), 747–765. https://doi.org/10.1093/jrs/feaa085
34. International Rescue Committee, & UNHCR. (2021). *Report on Suicide Detection, Prevention and Response*.

35. Torre, C. (2023). "Think Positive, Save a Life"? Resilience and Mental Health Interventions as Political Abandonment in a Refugee Settlement in Northern Uganda. *Civil Wars*, *25*(4), 708–734. https://doi.org/10.1080/13698249.2023.2209485
36. Parker, M., MacGregor, H., & Akello, G. (2020). COVID-19, Public Authority and Enforcement. *Medical Anthropology*, *39*(8), 666–670. https://doi.org/10.1080/01459740.2020.1822833
37. Nakireka, S., Mukunya, D., Tumuhaise, C., Olum, R., Namulema, E., Napyo, A., Serwanja, Q., Ingabire, P. M., Muyinda, A., Bongomin, F., Musaba, M., Mutaki, V., Nantale, R., Akunguru, P., Ainembabazi, R., Nomujuni, D., Olwit, W., Nakawunde, A., Nyiramugisha, S., … Kiguli, S. (2023). "I thought I was going to die": Experiences of COVID-19 patients managed at home in Uganda. *PLOS ONE*, *18*(12), e0295113. https://doi.org/10.1371/journal.pone.0295113
38. Palmer, J., & Duclos, D. (2023). *Key Considerations: Community-Based Surveillance in Public Health*. Institute of Development Studies. https://doi.org/10.19088/SSHAP.2023.010
39. Nansikombi, H. T., Kwesiga, B., Aceng, F. L., Ario, A. R., Bulage, L., & Arinaitwe, E. S. (2023). Timeliness and completeness of weekly surveillance data reporting on epidemic prone diseases in Uganda, 2020–2021. *BMC Public Health*, *23*(1), 1–12. https://doi.org/10.1186/s12889-023-15534-w
40. Ministry of Health, Government of Uganda. (2021). *National Technical Guidelines for Integrated Disease Surveillance and Response, Third Edition*.
41. Ministry of Health, Government of Uganda. (2010). *VHT-Village Health Team: Strategy and Operational Guidelines*.
42. UNHCR. (2023). *Ugandan refugee operation: Impact of underfunding in 2023 (September-December)*.
43. Usher, A. D. (2021). A beautiful idea: How COVAX has fallen short. *The Lancet*, *397*(10292), 2322–2325. https://doi.org/10.1016/S0140-6736(21)01367-2
44. Government of Uganda. (2018). *Uganda's Revised CRRP Road Map 2018-2020: The Comprehensive Refugee Response Framework (CRRF)*.
45. Komakech, H., Nyachwo, E. B., & Lubogo, D. (2024). Integrated health services for refugee and host populations in Uganda: A qualitative study of stakeholder's perspectives. *Global Public Health*, *19*(1), 2387445. https://doi.org/10.1080/17441692.2024.2387445

Authors: This brief was written by Sophie Mylan (London School of Hygiene and Tropical Medicine – LSHTM), whose ethnographic fieldwork in Palabek refugee settlement was conducted for her PhD. Ethical clearance was obtained from LSHTM, Gulu University and UNCST (Uganda). Doctoral funding was provided by the ESRC (ES/P000592/1), plus fieldwork support from the Parkes Foundation, and LSE through the AHRC Safety of Strangers grant (AH/T007524/1).

Acknowledgements: Oversight for this brief was provided by Melissa Parker (LSHTM). Contributions and reviews were made by Emmanuel Kerukadho (UNHCR), Byasali Kabi Yoab (Office of the Prime Minister, Uganda), Afema Erick (International Rescue Committee), John Jal Dak (Youth Social Advocacy Team), Leben Nelson Moro (University of Juba). Editorial support provided by Georgina Roche. This brief is the responsibility of SSHAP.

Suggested citation: Mylan, S. (2024). Key considerations: Balancing epidemic preparedness and response with humanitarian protection in Ugandan refugee settlements. Social Science in Humanitarian Action (SSHAP). www.doi.org/10.19088/SSHAP.2024.042

Published by the Institute of Development Studies: September 2024

Contact: If you have a direct request concerning the brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or Juliet Bedford (julietbedford@anthrologica.com).

About SSHAP: The Social Science in Humanitarian Action is a partnership between the Institute of Development Studies, Anthrologica , CRCF Senegal, Gulu University, Le Groupe d'Etudes sur les Conflits et la Sécurité Humaine (GEC-SH), the London School of Hygiene and Tropical Medicine, the Sierra Leone Urban Research Centre, University of Ibadan, and the University of Juba. This work was supported by the UK Foreign, Commonwealth & Development Office and Wellcome 225449/Z/22/Z. The views expressed are those of the authors and do not necessarily reflect those of the funders, or the views or policies of the project partners.

@SSHAP_Action
info@socialscience.org
www.socialscienceinaction.org
SSHAP newsletter