

Layers of epidemic: Present pasts during the first weeks of COVID-19 in western Kenya

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SPOTLIGHT ISSUE

Histories of epidemics in the time of COVID-19

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Abstract

The epidemic of COVID-19 appears to be reshaping the world, separating before and after, present and past. Its perceived novelty raises the question of what role the past might play in the present epidemic and in responses to it. Taking the view that the past has not passed, but is present in its material and immaterial remains, and continuously emerging from these, we argue that it should not be studied as closed narration but through the array of its traces, which constitute the texture of the present. To that end, and building on long-term ethnographic research on past and present epidemics in western Kenya, we assemble here some preliminary observations on the first weeks of COVID-19 in Kenya. We explore how the acute epidemic crisis currently unfolding is intertwined with layered fragments of earlier epidemic events, attending to material infrastructures, institutional practices, and ritual responses, to the presence of virally loaded bodies, pharmaceuticals, and their residues, and to the resurgence of often painful memories and emotions. People in this region have experienced a long century of epidemics and anti-epidemic measures of varying duration and intensity, from colonial and postcolonial sleeping sickness and smallpox to HIV/AIDS and more recently cancer, alongside actual or anticipated outbreaks of cholera and Ebola. This local perception of one

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long epidemic qualifies the notion of a radical temporal break that the COVID-19 pandemic is often associated with in European conversations.

KEYWORDS

Africa, anthropology, COVID-19, epidemics, history and/or postcolonial, HIV, Kenya, traces

1 | INTRODUCTION: EPIDEMIC REMAINS

The epidemic of COVID-19 is often described as radically new, an event that is reshaping the world and triggers fantasies of unknown futures, separating before and after, present and past. Its perceived novelty raises the question of what role the past might play in the present epidemic and responses to it. In a recent post on *History Workshop*, Lachenal and Thomas challenge the common-sense hope that one can draw “lessons” from the past, such as concerning how a pathogen, its victims, or wider publics might behave, or the success and failure of interventions.¹ They emphasise “the capacity of present crises [maybe of the present as such] to resist historical interpretation,” and warn against the “comfort of comparison” that foregrounds narrative structures and temporal patterns and tends to uncritically reify stereotypical categories, instead of critically examining the process of their reiteration.

Rather than discrediting all historiographical understanding of the ongoing crisis, however, Lachenal and Thomas call for “alternative strategies for enquiring into the uncanny trade between past and present.”² Elsewhere, we have jointly engaged this “uncanny trade”—moving between history, social anthropology, Science and Technology Studies, and contemporary archaeology—by “tracing” the past in the present, through its remains and residuals, routines and habits, memorials and memories.³ In this way, the past does not emerge as ordered narration (which could serve as foil of comparison or lesson for the present) but through encounters with its fragmented remains.⁴ These in turn texture ongoing events, and retain unpredictable potential for future emergence.⁵

This paper assembles our preliminary notes on the first weeks of COVID-19 in western Kenya, where we have conducted ethnographic research on and off for the past 25 years.⁶ The Kenyan government’s response to COVID-19 forced us to return to Europe a few months into fieldwork on the mutual entanglements of 20th-century epidemics, spanning from sleeping sickness and river blindness to HIV/AIDS and cancer. We were thus focusing on the remains of epidemics and anti-epidemic measures and their material and affective residuals in landscape, architecture, bodies and ecologies, sedimented technologies and institutional practices, and in the memories and visual and administrative records they left behind—just as the new epidemic arrived.

2 | THE EBOLA KIT

Less than 1 week after the first COVID-19 case was diagnosed in an international traveller in faraway Nairobi, preparations for a potential epidemic commenced in a small hospital in Siaya district, on the shore of Lake Victoria. Based on the previous year’s international Ebola preparedness exercise, those in charge improvised a local protocol

¹Lachenal & Thomas (2020).

²Lachenal & Thomas (2020).

³Geissler, Lachenal, Manton, & Tousignant (2016); Lachenal (2017).

⁴See Manton (2015).

⁵See also Tousignant (2013); Droney (2014); Hunt (2016)

⁶E.g., Geissler & Prince (2010).

for patient screening (using fever, cough, and international travel as a case definition). Meanwhile, the nursing officer found several boxes of unused, disposable Ebola equipment in the hospital stores. “We are lucky, because we are close to the border” (with Uganda and beyond it, Congo, the epicentre of last year's Ebola epidemic), she said, while spreading the components out on the table, “other hospitals didn't get such equipment.” One of the N95 masks was used at once by a Community Health Volunteer (CHV), anticipating the viral threat, to spray the designated “Corona Holding Area” against a long-standing bat infestation.

In the absence of clear scientific knowledge, proven strategies and technological resources—the leftovers of a previous epidemic (or of the anticipation of one that never came)—offer the next best tools to prepare for a new, unknown viral threat. Such epidemic recycling carries with it particular images and feelings. They evoke horrors one heard about from elsewhere, but also convey the power of medical commodities and global anti-epidemic action. Some associations are fleeting and coincidental, while others are intentionally evoked or actively performed for public health or political purposes. Two days after our visit to the hospital, the front page of the national broadsheet featured public health staff, dressed in the same full-body Ebola protection kit, as they disinfected a minibus and “street dwellers” in Nairobi.⁷ These scary images served to underline the gravity of the threat, recall the heroism of West African Ebola warriors, and stage the potency of a state concerned to prove it had the disease under control.

3 | TRACING SUSPECTS

Some weeks later, the county announced its first COVID-19 victim, a man in his 50s who had travelled, with several stopovers and a vehicle breakdown, from his workplace in Mombasa to his home village, where he died.⁸ According to social media posts, the county's “Corona Security Team” pursued his contacts in guesthouses and car workshops, “arresting two fugitive mechanics,” and “raided Kisumu ... and nabbed 4 people,” who were forcibly quarantined. The decisive tone of this message, sent to health workers, resembled the vocabulary of the CHVs who were “tracing” the contacts of another COVID-19 carrier, a priest who, 1 week earlier, had travelled from Rome at the height of the Italian epidemic and celebrated mass and a funeral before he was diagnosed.⁹

In both cases, moral judgement was passed on the allegedly “reckless” travellers, who had “irresponsibly” endangered others. This stereotype recalled the stigmatisation of AIDS “risk groups” like sex workers and truck drivers, whose mobility was blamed for spreading HIV; although in the current case, the culprits were not vulnerable groups but privileged individuals bringing disease to innocent villagers. Meanwhile, CHVs were instructed to “identify suspects” in their villages, based on symptoms, histories of travel, or participation in the funeral. “Visitors” from town were particularly suspect, as were, by default, the “high risk groups” inherited from HIV-prevention campaigns in the 1990s: sex workers and commercial motorbike drivers.

Suspicion also met the CHVs as they were looking for suspects. Coming from town and hospital, they posed an infection risk, and above all they could force suspects into 14-day hospital isolation, causing economic hardship and risking exposure. The ambivalent position of these “middlemen” between state and “community” runs through the area's epidemic history.¹⁰ Since the transnational HIV/AIDS interventions that began in the 2000s, CHVs have been trusted helpers, but also envied as better-paid NGO staff, and feared as “defaulter tracers,” seeking out patients who had not collected their anti-retroviral medicines (ARVs), often due to stigma.¹¹

In the 1960s, a previous generation of CHVs, still wearing colonial uniforms, had “combed” the same area for “suspects” of then-rampant sleeping sickness.¹² Suspects were taken for screening and long, toxic treatment, from

⁷Omulo (2020).

⁸Wasonga & Okeyo (2020).

⁹Daily Nation Team (2020e).

¹⁰Hunt (1999).

¹¹Mwai et al. (2013).

¹²Wijers (1969); Geissler & Prince (2010, pp. 54–56).

which many did not return. Today's Corona Isolation Ward—for now, the only one in Siaya County—was established in the same place as the carceral sleeping sickness “Camp.” Old people still remember the time when “screening,” “mopping up of suspects,” and “camps” carried connotations of colonial, anti-Mau Mau atrocities. Now, younger people learn anew that anti-epidemic measures can be as violent as the epidemic itself, when they encounter police coercion during the current anti-COVID-19 “curfew” and witness even nurses being assaulted when they come home from a late shift. “Lockdown” measures prohibiting movement, as well as forced isolation, are having devastating effects on livelihoods and triggering confrontations with the security forces, especially in towns, where many depend on “tarmacking” in search of their day-to-day income.¹³ Reports from the second day of curfew in Kenya thus note “four killed by the police and one death by Corona.”¹⁴

4 | RAPID DISPOSAL

Immediately after the first Kenyan COVID-19 case was announced, the government closed public mortuaries and decreed that all bodies were to be buried within 48 hrs, with less than 15 mourners.¹⁵ Since funerals in western Kenya usually comprise hundreds of participants and involve viewing the body, this triggered debates about the social-cultural impact of the epidemic.¹⁶ Counterintuitively, the “Luo Council of Elders,” a respected assembly that had taken an advisory role during the international HIV/AIDS prevention campaigns around 2000, defended the draconian measures.¹⁷ Referring back to the cultural adaptations they had overseen in relation to HIV, male circumcision, and widow inheritance, they stated flatly that “culture [is] not static.” When some of the closed mortuaries were emptied of unclaimed bodies to make room for anticipated COVID-19 victims, the reports of the interment of unclaimed corpses in public mass graves recalled the traumata of the time of AIDS, when some families, overwhelmed by healthcare and burial costs, had abandoned deceased relatives' bodies.¹⁸

Deep memories of AIDS were further stirred when, 1 month later, a video clip from the hasty burial of the first local COVID-19 victim circulated on social media, and later on a national newspaper website.¹⁹ The shaky footage, lit by flickering flashlights, shows a rural homestead by night and an open grave. A white pickup truck backs out of the darkness into the frame, with several people in white protective suits and facemasks on its open back. They pull a white body bag off the back of the truck, which drops on the ground, is dragged to the grave, and, after short hesitation and intensified wailing by the women in the background, swung into the hole. This undignified, and indeed violent, midnight burial drew the rage of the local CHVs who had shared the video. Going viral on WhatsApp and other social media, it provoked strong emotions across a wide range of people. Even disease control experts, medical professionals, and epidemiologists privately expressed grief and anger. The national outrage forced the Ministry of Health to issue a statement defending the government's actions and propose a protocol for “dignified” burials.²⁰

The brutal treatment of a deceased's body would have offended any human observer, and the involvement of masked strangers contradicted fundamental ideas about burial, kinship, and funerary dignity.²¹ The footage's raw immediacy—the confused, jerky movements and the darkness, the sound of the heavy body hitting the bottom of the grave, and the wailing of the mourners—took our conversations with CHVs and villagers to the beginning of the AIDS epidemic. Then, people recalled, bodies were buried hurriedly, “thrown away” in black polythene bags (body bags were then still a military privilege). An elderly CHV, shocked by the video, which brought back memories of her

¹³Prince (2013).

¹⁴Kimari (2020).

¹⁵Makokha & Wamasebu (2020).

¹⁶Kabale & Achuka (2020).

¹⁷Prince (2011); Ndegwa (2001, p. 33, n. 9).

¹⁸Shiloya (2020).

¹⁹Daily Nation Team (2020a; 2020b; 2020d).

²⁰Kimuyu (2020).

²¹See also Lee & Vaughan (2008).

son's early death, warned: "Then [when we experienced similar funerals in the 1990s], we did not want to listen to government," implying that this time, the younger people should adhere to advice and change their behaviour to prevent a return of past collective suffering. The suffering endured by bereaved parents and by children who had lost parents and siblings, teachers and role models in the 1990s "time of AIDS"—pains that are obscured by the successes of HIV campaigns and everyday "living with HIV"—suddenly flared up in people's responses to the short video clip.²²

5 | VULNERABLE GROUPS

Due to therapeutic and preventive successes, the AIDS epidemic of the 1990s, when untreated infections caused death on an unprecedented scale, has become an historical era. AIDS is no longer experienced as the catastrophic epidemic event that (belatedly) triggered billion-dollar aid programmes; indeed, it is scarcely visible in western Kenya today. However, it is very much present, as many remain infected with HIV and receive free anti-retroviral (ARV) medicines at government and NGO clinics.²³ While "the time of death" associated with HIV infection before anti-retrovirals is not often spoken of, the epidemic has left material debris that anchors memories and exerts effects in the present: graves and abandoned homes, donor-funded clinics, bureaucratic routines and laboratory infrastructures that serve international research but also clinical care, discarded apparatus and pharmaceutical residuals. It has also left behind quasi-professional health groups like "peer counsellors" and trained CHVs, some of whom have been "absorbed" as CHVs or casual workers, while others are now looking for jobs. Meanwhile, AIDS activists and self-help groups adapt impressively quickly to COVID-19 community work, switching from promotion of condoms to homemade facemasks.

These traces of HIV/AIDS return in the COVID-19 epidemic not only in tools and practices, but also the memories attached to them. The virus itself continues to be present in the bodies of many people, dormant and mutating towards drug resistance. Together with concomitant infectious diseases such as TB, HIV creates dangerous comorbidities with COVID-19, and compromised immunity and lung diseases might lead to increased mortality from COVID-19.²⁴ However, the fact that most HIV-positive people in Kenya today are on ARV treatment might also offer protection against the new virus.²⁵ Apart from these (as yet unproven) fears and hopes about the combination of the old, contained epidemic and the emerging one, COVID-19 control measures severely affect people living with HIV, as hospitals become more difficult to access (and are feared for the risk of virus transmission and of forced isolation), and because scarce laboratory capacities are suddenly turned from HIV-related testing to COVID-19.²⁶ The impact anti-COVID-19 measures are having on people's livelihoods is another echo of the economic devastation wrought by AIDS among earlier generations, which many families are still grappling with. However, at the time of writing, it is the anti-epidemic measures that are affecting livelihoods rather than the disease itself.

6 | EPIDEMIC CHRONICITY

Similarly, COVID-19 intersects with the latest Kenyan epidemic—that of cancer. Twenty-five years ago, cancer was invisible in the villages where we worked. The few deaths that may have occurred due to cancer were masked by high rates of infectious diseases, and cancer diagnosis, let alone treatment, was available to very few. In the last decade, a cancer epidemic has emerged in Kenya, as in the rest of Africa, driven in part by a combination of HIV infection and treatment.²⁷ It is probably also linked to exposure to carcinogenic toxicants accumulated in soil, water,

²²On this "unresolved grief," see Kane (2020).

²³Prince (2012); see Hardon & Moyer (2014).

²⁴Bearak & Slater (2020).

²⁵AFP (2020).

²⁶Muchangi (2020a).

²⁷Mulemi (2008; 2013); Prince (2020); Livingston (2012).

and local foods over the course of a century. Some inhabitants, ironically, point to the large-scale use of DDT and organic insecticides in the control of diseases like sleeping sickness, river blindness, and malaria.²⁸ The visibility of cancer has been enhanced by the growing availability of diagnostic and treatment facilities and the novel insurance mechanisms that have increased access to these, albeit unevenly.

The impact of COVID-19 on those with cancer and other non-communicable, chronic conditions such as diabetes and heart conditions (also rising steeply in this region) will be serious.²⁹ And even if the virus does not spread as dramatically as in Europe, the anti-epidemic measures anticipating the pandemic will have dramatic effects for them. Livelihoods are being severely curtailed, affecting not only particular families but also the wider social networks on which patients and families rely for financial support, especially during health crises. Cancer treatment becomes harder to access due to strains on health system resources that are already very limited, and the immunosuppressant effects of chemotherapy pose a lethal risk.³⁰ The recent, modest achievements of the health system in its struggle with cancer and non-communicable diseases and the tremendous efforts of cancer patients and their families are therefore jeopardised by COVID-19.

7 | A LONGER EPIDEMIC

The intertwining of the acute epidemic crisis with layered fragments of earlier epidemic events, which we began to sketch in the notes above, qualifies the notion of a radical temporal break that the COVID-19 pandemic is often associated with in Europe. Indeed, even during the last large epidemic that western Kenya endured, HIV/AIDS, many perceived the omnipresence of death less as a rupture than as a continuation of suffering, as the outcome of a century of physical weakening, through epidemics and declining nutrition, that commenced with colonial occupation and had progressively reduced fertility, bodily growth, and strength, and spread disease.³¹ AIDS was accordingly called “the death of today”—extending from that of yesterday, and preceding that of tomorrow. Over the century or so since colonial occupation, epidemics and anti-epidemics (both with often equally painful outcomes and long-term sequelae) have come and gone, or lingered on.

This local perception of one long epidemic was reflected in persistent rumours about the European origins of ill-health and the nefarious aims of disease control agents, which were told and retold in western Kenya as well as elsewhere in Africa.³² Three decades after the anti-sleeping sickness “campaigns” during decolonisation, Geissler surveyed the area's children for worm diseases and was accused of stealing blood or body parts for selfish gain.³³ After the arrival of COVID-19, similar rumours circulated, this time much faster and more widely, drawing on global sources, through social media, about white scientists either spreading the virus or testing “toxic vaccines” on African “guinea pigs.” White people, including the anthropologists, were now perceived as infection risk and addressed (sometimes jokingly) as “Corona.”³⁴ The continued historical experience of colonial epidemy was condensed in the vision of COVID-19 as a “white disease.”

8 | RECOURSE TO OLDER REMEDIES

While today's rumours about COVID-19 combine scientific jargon and global black consciousness with memes from transnational anti-vaccination activists and social media figures, other responses to the epidemic seek help from

²⁸E.g., Saoko (2005).

²⁹Herrick (2020); Daily Nation Team (2020c).

³⁰Muchangi (2020b).

³¹Geissler & Prince (2010).

³²White (1995); Graboyes (2015).

³³Geissler (2005).

³⁴Geissler and Prince (2020).

explicitly local or cultural sources as appropriate African remedies for a European affliction. Herbal remedies for the virus are propagated by inventive, urban healers, using familiar plants in novel ways, tying official information on COVID-19 symptoms and transmission to older logics of disease and healing, and utilising elements of pharmaceutical packaging and marketing—just as was done during the height of the HIV/AIDS epidemic.³⁵ Like then, public opinion on these attempts is split, with some hoping for “African solutions” for the new “white disease”—harking back to the expectations placed on African scientists’ idiosyncratic AIDS treatments—and others pointing to the dangers of “quacks” and religious healers seeking private gain.³⁶

A spontaneous collective attempt to harness the forces of the past against the new affliction was the return, in April 2020, of *nyawawa*, the spirits of dead people, who occasionally move down, in an invisible, nightly procession, from the hills above Kisumu to the open lake, their abode, many miles away. When passing, they call after people, and leave disease in their wake, unless one makes deafening noise with pots and pans. This sound travels slowly downwards through the night, from homestead to homestead, into the lake. Two weeks into the Kenyan epidemic, inhabitants of the region “defied the lockdown” to perform this collective ritual.³⁷ *Nyawawa* are associated with children’s diseases like measles and chicken pox (*nundu*), and with other outbreaks of infectious disease. It is remembered from the 1969 cholera epidemic and around the smallpox epidemics of 1934 and 1943.³⁸ The practice possibly originated in colonial outbreaks of infectious disease. When we lived in a village on the lakeshore in the early 2000s, *nyawawa* sometimes passed, but people say it is a rare event these days. The April 2020 *nyawawa* triggered lively debates. Newspapers celebrated it (maybe half-ironically and reviving older ethnic stereotypes) as a “local means” to counter the epidemic, “saved Christians” condemned it as “satanic,” while others suggested that the ritual might indeed chase away the “satanic” virus, or at least affirm a sense of community and solidarity in the face of affliction.³⁹

9 | CONCLUSION

Attention to epidemic traces and their place in a social landscape familiar to us relativises the novelty of COVID-19. Rather than a break between past and present, the recent epidemic arrival, its reception, and actions taken against it are at least partially made up from bits and pieces left behind by previous ones. Traces of epidemics may be manifest (in buildings and graves, in disabled or diseased bodies, in rituals discarded then remembered) or they may be invisible (like mutated pathogens, residual pharmaceuticals, or narratives and lexica). They can be memorialised, overlooked, or hidden, recognised by some but not others, in some moments but not others.⁴⁰ They defy chronology and closure, and persist as dispersed fragments and folded sediment. It is their overlapping, sometimes fleeting and contradictory, often unexpected presence that accounts for much of their effects on the present. Earlier epidemics and anti-epidemic measures hence do not “determine” the new epidemic, but continue to emerge in mutual entanglements with it. Attending to epidemic traces, we do not learn *from history* but *within* the presence of history, not in order to draw “lessons” from previous, closed episodes of epidemics, but to probe their layered and folded deposits in the present.

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³⁵See e.g., Iliffe (2006); Langwick (2010).

³⁶E.g., Elliott (2018).

³⁷Oudia (2020).

³⁸See MacGoye (1977, p. 59); Schneider (2009).

³⁹Oudia (2020).

⁴⁰See e.g., Roth (2019).

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