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‘The Disease of the Rich’: Containment Measures and Cashing in on Covid-19 in Kenya from March 2020 to March 2021

Claire Médard

1 Territorial control as a means of combating Covid-19 is the prevailing approach around the world today: containment has replaced prevention based on individual responsibility. The terminology of territorial control, as used here, refers to government intervention to restrict the movement of people, making use of boundaries and other spatial demarcations, and also increasingly through the use of advanced technologies and data gathered from digital surveillance. Supported by some and fiercely criticised by others, this new security order, which has both moral and territorial aspects, is controversial.

2 The territorial control model is generally presented as being systematic and applicable to all. In fact, in both its design and application, it is the result of choices guided by different political, economic and social considerations. It is never neutral, and practical control measures are based on simplifications of reality with a view to staging an intervention. In the particular case of Covid-19, containment as a means of “prevention” was introduced as an emergency measure. However, this approach is not an effective response to the complexity and diversity of the demographic, economic and social circumstances that characterise contagion patterns and the relative likelihood of developing serious illness; nor does it provide a response to the consequences of restricting people’s movement and the decline in economic activity. Territorial measures are presented as a solution that avoids scrutiny. The treatment of the pandemic through territorial control, characterised both by the closure of national borders and by restricting internal movement, conveys a new moral order, ultimately designed to provide reassurance rather than taking responsible action.

3 Compared to other countries, and taking into account the difficulties of collecting statistics about Covid-19 (Gastineau et al. 2020), the pandemic has had a lower incidence in Kenya, which is demographically more youthful than Europe. The vast majority of people do not feel that they have had first-hand experience of the disease, except perhaps via their screens. There was talk of a bad "fever" (*homa*) in Kakamega, in rural Western Kenya, in November 2020, during a spike in the pandemic in that area. In contrast, the increasingly restrictive territorial control measures that were imposed between March and August 2020 paralysed the country (for at least 3.5 months domestically, 4-6 months internationally, and 6-9 months scholastically) and undermined the socio-economic integrity of ordinary people (those now being called "hustlers" by politicians campaigning for the 2022 presidential election). In October 2020, in Eldoret, the capital of the Rift Valley Province and the political stronghold of Ruto's "hustler" party, as opposed to the "dynasties" (name given by Ruto to the alliance between U. Kenyatta and Raila Odinga), those wearing masks were denounced as pro-government and Covid-19 was seen as the disease of the rich. The "preventive" measures, based on restricting individual movement, became, for a time, the main source of income for unscrupulous public officials. More broadly, a whole business flourished in underhandedly awarding Covid-related professional private- and public-sector contracts.

4 Territorial control contributes to the creation of a dominant moral order, transforming social relationships and contributing to othering by accentuating differences of class, race, ethnicity and age (in Kenya the youth and the poor are viewed as being too casual about the pandemic). Mechanisms of control induce a climate of tension, which becomes embedded in everyday relationships, where each person watches and distrusts the other. The escalation of containment measures highlights how the means can be mistaken for the end, how control of movement ends up being conceived as an end in itself, obscuring the primary public health objective. The territorial strategy of "prevention," adopted with variations around the world, has led to an absurd situation where prevention is discussed mainly in terms of the effectiveness of territorial control. The conflation of public health prevention measures with public order measures, which the case of Kenya illustrates well, is explored here. We will first present the way in which events are linked, and then discuss more precisely how the issues of public health, security, and public order overlap. We will then discuss the corruption and rent-seeking strategies which resulted from increased control over movement in the name of promoting public health. Finally, the standardisation and trivialisation of controls will be discussed.

Brief Chronology

5 The alert was sounded at the end of February and government-led interventions to control the pandemic within the country were quickly put in place. The President took the initiative: on 28 February 2020 he set up the National Environment Response Committee on Coronavirus (NERCC) to enable national coordination (ROK, Executive Order No. 2, 2020). The Public Health Act (ROK 2017) specifies the government's responsibility to prevent the spread of infectious disease, particularly when it comes from outside the country. On 3 March 2020, Covid-19 was declared to be "a formidable

epidemic disease" (ROK, 27/03/2020, LG n°37). As Eboko and Schlimmer (2020) pointed out, these measures predated the first occurrence of the disease.

6 The first case was identified on 13 March 2020, with border control implemented on 15 March 2020. On the same day, the Minister of Health banned all gatherings, including religious assemblies. All schools were to be closed. Movement throughout Kenya was restricted by the introduction of a curfew. From 6 April, quarantine was imposed on the inhabitants of the two main urban areas, Nairobi and Mombasa, as well as those living in certain coastal and border areas. A month later, additional measures were taken within these conurbations, with the Eastleigh district of Nairobi and the old town of Mombasa being sealed off from 6 May to 7 June. The quarantine periods in the coastal counties also ended on 7 June, with the exception of Mombasa municipality.

7 Quarantine for the inhabitants of Nairobi and Mombasa ended later, on 7 July 2020. The ban on gatherings and the closure of bars were further extended, month by month. In August, international air traffic resumed, subject to travellers presenting a negative Covid test. Mandatory Covid testing for truck drivers had already been in place along the land borders since May, but truck drivers remained subject to strict controls. Bars reopened on 28 September 2020 and the curfew hour was pushed back to 11pm. During a new wave or contagion, on 4 November the curfew hours were changed again and extended (from 10pm to 4am). On 3 January 2021, the President announced that the curfew would be extended until 12 March 2021.

8 Two periods can be distinguished: during the first phase, from March to early July 2020, internal movement was highly restricted; thereafter, in the second phase, movement within the country's borders was again permitted. After an initial phase characterised by the sometimes excessive use of public force, physical distancing measures became normalised and were subject to controls during the whole period.

The Conflation of Public Health Interventions and Public Order Measures

9 At the beginning of the crisis, various measures converged to control the movement of people. In Kenya, the territorial framework for sanitary control (containment) was established more than a century ago under colonial rule and concerned both human and non-human populations. The history of Kenya provides a good illustration of territorial sanitary control interventions: quarantining livestock, forced population displacement due to the localised prevalence of diseases, and segmentation through urban planning, isolating Indian or African working-class neighbourhoods from European areas, and separating the rich from the poor. Historically, the control of internal migration played an important role in Kenya. In particular, under colonial rule it served to regulate access to the city for African populations from the homelands or "reserves." Beyond the reference to racial and ethnic categorisations that served as the basis for internal boundaries within Kenya, the territorial framework for sanitary control was also interpreted in terms of the limited medical and veterinary knowledge at the time. With the emergence of a new "unknown" disease, Covid-19, quarantining came back into focus. In this new context, the impetus was on preventing urban dwellers from leaving the major cities and areas considered to be contagious. In 2020, an arsenal of both public health (ROK 2017) and public order (ROK 2012) legislation transformed measures to control the movement of people into public health measures.

The curfew was one of the very first measures to be introduced, on 27 March 2020 (ROK, Public Order No. 1, 2020). It falls within the framework of law enforcement. It was complemented by measures under public health legislation that define "infected areas" and "carriers" (ROK, LG No. 49 and No. 50 2020), with the stated aim of limiting the spread of the disease. In this context, quarantine locations were specified and carriers defined: at one point during the crisis, this meant all people arriving from abroad were considered as potential carriers. Reporting the sick or those suspected of being sick with the disease became a legal obligation for doctors, landlords and employers, and this amounted to institutionalising a form of denunciation. On another scale, some quarantine locations covered entire regions. The declaration of an infected area resulted in the lockdown of Greater Nairobi (ROK, LG 51, 6 April 2020, and LG 89, 19 May 2020), Mombasa County (ROK, LG 52, 8 April 2020), Kilifi and Kwale counties on the Indian Ocean coast (ROK, LG 53 and LG 54, 8 April 2020), as well as Mandera county, which borders Somalia and Ethiopia (ROK, LG 71, 22 April, and LG 85, 13 May 2020). Precise maps were provided in these official publications outlining the target areas: the Greater Nairobi area extended far beyond Nairobi County.

10 The "security" escalation, from 6 May 2020, was reflected in the intensification of measures targeting specific areas within regions already subject to quarantine. The new measures were introduced via the Public Order Act (ROK, Public Order No. 2, 2020, 6 May 2020), under the authority of the Minister of the Interior. These highly localised containment measures were subsequently extended under the Public Health Act (ROK, LG No. 83, 13 May 2020). The neighbourhoods targeted were the Somali neighbourhood of Eastleigh in Nairobi, and Mombasa Old Town, with five and 24 Covid cases reported respectively. It should be noted that these two heavily Muslim neighbourhoods have, on several occasions in the recent past, been suspected of harbouring radicalised networks, and are therefore subject to increased surveillance.

11 Due to the territorial nature of the selected containment measures, it is difficult to separate prevention objectives from security objectives. In the end, one might ask whether other interests are served by upholding territorial measures in the name of prevention.

The Excesses of Rent-Seeking and Control

12 In the early days, with fear in the air, the Kenya-wide curfew and the containment measures in Greater Nairobi and the coastal counties were aggressively implemented. The police made arrests on the grounds of non-compliance with physical distancing measures, which led to people being crammed into detention facilities, thereby exacerbating the contagion.

13 Opposition to the containment measures was poorly organised. The curfew was opposed by the Law Society of Kenya, but the High Court upheld it. Civil society actors spoke out against police brutality and the way poor neighbourhoods were being targeted (Amnesty International, 20/08/2020). The situation became untenable in poor neighbourhoods due to this violence and the curfew, which was absurd given the importance for people to remain outdoors due to overcrowded housing and modes of livelihoods within these areas. It is particularly in this context that the drift towards securitarianism, facilitated by the measures taken in the name of public health, was condemned (Mutahi and Wanjiru, 23/11/2020). The control measures were immediately

misused by some state officials. Threats of all kinds, based on the anti-Covid legal arsenal, were used as a lever for corruption. Quarantine measures, in particular those targeting returning Kenyans, were quickly interpreted as a racket. Kenyans became accustomed to saying that Covid-19 had become a “business,” particularly in relation to the renewed potential for territorial control, referring both to an authoritarian legacy and to the systemic practices of corruption linked to it. Population control leads to racketeering: when it intensified during this period, it became a source of income for some in positions of power. Specific and exceptional travel authorisations had to be endorsed by officials, giving them additional authority, which could be monetised. For example, specific measures were put in place for funerals (gatherings were limited to 15 people, exceptional travel permits were issued), leading to actions combining intransigence and corruption. In the hospital setting, the more specific treatment of Covid-19 deaths (burial within 48 hours, in specific locations and under specific conditions) has had wider repercussions, as the threat of non-return of the body was also used as a lever to put additional financial pressure on families, including for deaths not attributed to Covid-19.

The Standardisation and Normalisation of Control

14 Over time, the restrictions on movement were lifted and the focus of surveillance by police officers shifted to physical distancing measures. For international travellers, a technological monitoring device was introduced, allowing them to be kept under surveillance for the first 14 days of their stay in Kenya.

15 Throughout Kenya, people were required to wear a mask as soon as they left their homes. The obligation to wear a mask everywhere outside led to a particular wearing style, on the chin, immediately raised when a police officer approached. There were very few homemade masks. Reusable nylon masks and surgical masks were sold at the roadside or near bus stations. FFP2 masks were also used by the more affluent who sometimes chose to double up on protection by combining a surgical mask with an FFP2 mask. The wearing and non-wearing of masks became a clear marker of social differentiation.

16 Hand-washing stations and mandatory temperature-taking at the entrance to all public places became standard. These stations, which were set up at the beginning of the health crisis, were provided for by law and were located at the entrance to all public administration buildings, supermarkets and shops. Hand-washing stations operated by the knee or foot were improvised. Private security arrangements are widespread in Kenya, and prevention measures fitted comfortably within this framework. Temperature checks at the entrance to public places were carried out by networks of private security guards. The thermometer was pointed at the visitor’s temple or wrist and then turned over to show the result to the person concerned. This new security measure was added at the entrance of gated properties and communities. This practical measure met a private demand. Electronic thermometers generally displayed temperatures far below normal temperatures without creating any alarm. The temperature was registered, and the provision of contact details often completed the process.

17 After the initial wide-scale restrictions, the possibilities for extortion of the wider public became much more limited and restricted to bribes and official fines for failing

to wear a mask or breaking the curfew. Once again, these pecuniary measures penalised the poorest: those who work in the informal sector, on the roadside, or in transport. In December 2020, the increased scrutiny could be explained both by the increase in travel during the festive period and by the targets set by civil servants seeking to supplement their income. The people being checked preferred to pay the equivalent of a €50 bribe, rather than receive a summons and be placed with others in crowded detention facilities to escape the €200 fine or prison.

Conclusion

18 Using the example of Kenya, this paper draws attention to the overlap between public health "prevention" measures and public order interventions. This so-called prevention is based on territorial control mechanisms that are part of a long tradition of monitoring internal movement within the country and maintaining public order. Renewed opportunities for territorial control with Covid-19 prevention measures fit well within this tradition, as do systemic practices of corruption through the creation of "private" benefits stemming from territorial control for state officers. Territorial surveillance, which is theoretically neutral and equitable, seems, on the contrary, to be designed to allow for the creation of exceptions for financial gain. It might have been possible to excuse the conflation of public health control measures with territorial control measures on the basis of fear and ignorance, but it would be difficult to exonerate the system of power that generated abuses based on the establishment of territorial measures in the fight against Covid-19.

19 The growing securitarian agenda, which is a throwback to an old territorial model and consists of routine and recurrent practices of surveillance over people's movements within the country, has acquired legitimacy on the basis of a new fear. In Kenya, this legitimacy has nevertheless been undermined by widespread practices turning territorial control into money-making opportunities for officials, combined with real concerns about an economic crisis which have challenged the dominant moral order.

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NOTES

On the subject of quarantine see the numerous works of historians such as R. Waller (2004), David M. Anderson (2002) and Roger Van Zwanenberg (1975).

ABSTRACTS

This article analyses the political construction in Kenya of the confusion between health prevention and law enforcement during the COVID-19 pandemic. Kenya's security approach to the management of the COVID-19 situation went along with extortion mechanisms—the numerous exceptions to containment indeed made it possible to extract rent. The fear of the virus initially legitimised coercive measures which have now declined; but deviant practice linked to territorial control are now challenging the moral order.

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Geographical index: Kenya
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