A few days into the coronavirus lockdown, my 85-year-old mother called me sounding very worried. She wanted to discuss her concerns over the bats in her ceiling. Bats can be a real nuisance; they invade houses, hide in that space between the roof and the ceiling and not only make really annoying screeching sounds, but also have a tendency to deposit their acrid-smelling droppings and urine up there. These discolour the ceiling boards and, under the Western Kenya sun, can emit a really foul odour. If you are not used to them, bats can give you a real fright when they exit their dark hiding places at dusk and it wouldn’t help at all if you are not a Dracula fan and have issues with these upside down mammals that are associated with vampires.

Bats are very difficult pests to get rid of but this time, my mother’s concern was whether they could infect her with the coronavirus. She is elderly, and like many her age, has a litany of “underlying conditions” that make her a prime candidate for COVID-19. Apparently, my mum had listened to a series of discussions on FM Radio—in her first language, mark you—that associated the coronavirus with bats, and warned that the aged and the infirm were most at risk.

The panellists also informed listeners that the virus originated in China. In the playful manner of our folk, the contagion had been named Akkori nyar China, nyar Wuhan, Akkori daughter of China, daughter of Wuhan. Anybody familiar with Luo culture knows that a woman who joins the
community, especially through marriage, is known by her father’s name or her place of origin. Nyar China had wormed her way into our community like a newlywed. But affection for this miaha—this newly married woman—was not great.

The lethal infectiousness of nyar China was emphasised, and my mother was grappling with the recommendation to maintain social distance which meant that the stream of village friends and relatives who normally come by to check on her would need to keep off. She was told not shake hands or hug; how was she to greet her children or grandchildren? How does a grandmother show affection from a distance?

But what mum found most confounding was that she had to wear a mask covering her mouth and nose because the coronavirus comes out of the nose or mouth of an infected person and infects others through the same route. So the breathing that keeps one alive was now the route through which death could enter the body? Handwashing and sanitising were easy for her to understand; mum has always been very particular about clean hands and even though she thought the regularity was a trifle exaggerated, she was ok with having to spend more on soap.

At her age, my octogenarian mother has lived through many disease outbreaks. As we spoke, she recalled measles, smallpox, mumps and others, but confided that she had not seen this kind of thing before. “This one is different”, she said. “We have had Ayaki with us all these years, but this?” Then her voice went a little lower and she asked, “They have also said that anyone who dies now will be buried on the same day. No mourning, no mourners?”. My initial reaction to mum’s queries was one of joy and satisfaction; at least the coronavirus message was getting out there in mashinani where it is most needed. I was no longer sceptical about the survey that reported that knowledge about the virus was almost universal, that close to ninety per cent of respondents knew of the importance of handwashing and wearing a mask. The only message that did not seem to have been well received was about social distancing.

This was exciting news; I am a veteran of the HIV public awareness, education and mobilisation trenches. In all the years that we have been speaking about the ABC of HIV prevention—abstinence, being faithful to one partner whose status you know, consistent and correct condom use and acceptance of medical male circumcision—we have not had close to universal awareness let alone compliance with the recommendations.

The proliferation of FM stations broadcasting in local languages helped to take the coronavirus message to the grassroots, and to domesticate the measures of prevention. The discussions were hosted by individuals who could contextualise the prevention measures in the local language. This ensured that the message percolated to the remotest parts much faster than the virus itself could travel.

Three distinct messages about the virus were heard loud and clear: that it was a deadly, highly contagious virus, that the symptoms of the COVID-19 disease it causes are flu-like and that those who catch it die a rather sudden and painful death. Mum told me that they described it as “drowning in a well full of mucus”, the fright and disgust in her voice palpable.

Without going into details, they also communicated that the aged and those with underlying illnesses were most vulnerable. So my mum, with her high blood pressure, arthritis and cardio-vascular issues, was worried out of her wits. At the same time that these messages were circulating—and as if to reinforce them—stories from Italy and other parts of Europe were streaming in. When the illness was first reported in China it seemed too distant, but Europe is just next door even in village terms. It seems as if the strategy used to communicate information about the coronavirus was mainly based
on scare tactics.

As with communication about HIV, there were a lot of half-truths and outright falsehoods doing the rounds. My mum had heard that the coronavirus was associated with the “strange” meats eaten by the Chinese—bats and other creatures in “wet markets” came up. It was also said that the Chinese had deliberately manufactured the virus with the intention of killing everyone (especially Africans) and taking over our continent to find a place for their ballooning population.

These conspiracy theories were actually competing with public health messages at the grassroots. When HIV first arrived it was discussed in hushed tones. Stories filtered in from Uganda where they had nicknamed the disease “slim” because of how it wasted those it afflicted. The cause was not clear, or possibly the connection to sexual intimacy made it uncomfortable to discuss the cause. HIV soon acquired local names—ayaki, mukingo, biitya, live-wire... all names that suggested devastation.

The association of HIV with promiscuity, prostitution and homosexuality soon followed. Those who were infected were pointed at and their supposed sins discussed in hushed tones. In Luoland, the term chira was used to explain the origin of the disease. Now, chira is an amorphous term used to describe an unending malady resulting from one having committed a grave taboo. Chira was not new, but in the past, an afflicted person would be given some manyasi—herbs—and the taboo would be managed. But Ayaki was unrelenting and soon people started dropping like flies. The combination of sexual transmission and death attached a stigma to HIV.

In the early days, the bodies of those who succumbed to AIDS-related illnesses were wrapped in hideous- black polythene bags and a closed-casket funeral was held. Relatives were not allowed to hold wakes; burials were conducted quickly and funeral gatherings were forbidden. Those who survived the deceased were stigmatised and shunned. Before dying, those who were HIV-positive endured being shunned, discriminated against and condemned. Parents refused to allow their children to be taught by HIV-positive teachers, landlords drove HIV-positive people from their houses and those selling goods would discriminate against any known HIV-positive individual.

The response to the coronavirus was following the exact same trajectory. Soon after the first death was announced in Kenya, the state responded by locking down certain localities and declaring a dusk-to-dawn curfew. The announcement of the night-time lockdown was greeted with humour, and CNN mocked Kenya for allegedly having discovered that the virus is spread by darkness. On the ground, law enforcement agencies doubled their zeal in punishing and arresting curfew breakers, those not wearing masks and individuals not obeying social distancing.

The response to the coronavirus was weaponised and in the first few days more people died from police brutality than from the virus. Photos of burials being conducted in the dead of night by public health officials dressed like space explorers and bodies wrapped in polythene being sprayed with disinfectant did the rounds on social media.

People were angry, maybe even defiant, because of the high-handedness. With regards to the social distancing rules in particular, how practical are they when people live in crowded housing where residents pass each other along narrow passageways (and woe unto you if you are plus-sized)? Many engage in wage labour, selling their muscle power shoulder to shoulder. Saying they should “work from home” is as insulting as Marie Antoinette asking Parisians who could not find bread to eat cake instead.

There are many Kenyans who are faced with the choice between buying a mask and a tin of maize meal for their families. In most areas, the state failed to provide face masks yet unleashed police on those who did not wear them even as the media was reporting that free masks had been donated to
The Ministry of Health holds daily briefings on the coronavirus, led by the Cabinet Secretary backed by a posse of clinicians, with the head of state occasionally chiming in to emphasise the seriousness of the COVID-19 situation and deepen the measures aimed at managing the crisis. We are stuck in crisis mode and as the number of confirmed cases grows, and given the head start before the much anticipated “peak”, should the state not be providing reassuring messages of our state of preparedness?

Should they not be speaking about an increase in the number of fully kitted out health care providers, increased bed capacity in High Dependency Units and Intensive Care Units, and an increased number of ventilators and other equipment? Would that not be more reassuring? Right now, the message is reminiscent of the pre-ARV HIV message that “AIDS kills”. Every day there is talk about the “peak” that is expected and we are being prepared for the crash, but if we cannot apply brakes to the vehicle, can we at least reassure the ill-fated passengers that the facilities are in a state of readiness to deal with the injuries? What we need to know is the state’s capacity to cope with that peak and not whether it will come or not.

After we had climbed over the “AIDS Kills” hurdle and abandoned images of emaciated figures and burial caskets, we began to communicate how to live positively. Campaigns centred on the benefits of knowing one’s HIV status and voluntary counselling and testing (VCT) were aggressively promoted, together with the assurance that HIV is not a death sentence and that there is life after HIV.

Healthy living included focusing on nutrition and mental health. This was mainly to reduce self-stigma and discrimination. This is the direction the COVID-19 communication needs to take; we must now respectfully engage with Kenyans on the meaning and implication of the “new-normal”. This is the time for persuasive, logical yet emotional communication that will appeal to the head and the heart about the “new normal”.

Communication needs to separate myth from fact; my mother needs to understand the connections between the bat and this new disease because the bats are not moving in a hurry. She needs non-stigmatising information that clarifies to her why her age group is more vulnerable so that she knows how to relate to her grandchildren and fellow villagers. The public needs to understand that handwashing and sanitising is good hygiene that also reduces cases of dysentery, cholera and other illnesses transmitted in unhygienic environments. The public must also be helped to understand that any contagious disease can spread in crowded places and hence the need for physical distancing.

Communication on prevention and management needs to focus on normalising and building self-efficacy in the “new normal”. The communication now needs to logically challenge each one of us to find the self-motivation to wear a mask when in public much as we did with HIV; wearing condoms when having sex, being faithful to one partner whose status we knew and abstaining where it was possible.

Communities must reconsider such long-held cultural practices like hugging and handshaking. In those communities where it is taboo to shake hands with in-laws, there are other ways in which they show love, affection and recognition. We can start from there to explain that Akkori nyar China is like a mother-in-law who needs to be treated with reverence and not fear.

And where the public health message insists on immediate interment of the dead, a more acceptable and convincing logic must be provided. If the problem is the crowding among mourners, then the focus needs to shift away from stigmatising the remains of the deceased. It is possible for
communities to manage the numbers at a funeral and bury their kin with dignity in order to achieve closure. Besides, there should not be contradictions where a high-ranking Ministry of Health official attends a funeral with 400 other people, or politicians hold a meeting with hundreds of people in attendance while elsewhere in the same country police tear-gas and clobber and scatter mourners at a funeral.

Away from illness and death, there is the one-metre distance that should also be observed while queuing at the bank, the matatu stop, or while receiving sacrament in church or offering prayer at the mosque. The community must also be challenged to find ways to avoid or manage gatherings at weddings, political rallies or other mass events because these must go on in the “new normal”. We must find ways of fitting in soap and water into our daily activities even as we adopt as routine and normalise handwashing with soap literally every hour of every day. And from now onwards, we must adopt a new etiquette when sneezing, coughing, laughing and speaking.

The public must be given the correct, scientifically proven facts about the virus and the disease it causes, and what to do when it strikes so that they can separate the wheat from the chaff that social media throws at everyone. And while applying all these measures, we must yet engage in those activities that will transform our country and our people, moving forward from poverty through work (at home or elsewhere) and leading ourselves into a dynamic state of economic growth that will bring greater social equity and the fulfilment of the human potential.

As happened with smallpox and rinderpest—and soon polio— science will eventually will find a way to eradicate COVID-19. The development of a vaccine will help manage COVID-19 as happened with measles. And just like we did with HIV, which called for social and behaviour change to get us to where we are today, development communication professionals need to ease into the driving seat of normalising COVID-19 and life after COVID-19 while the clinicians return to their primary role of tending to the sick.

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