

Death and Funerary Practices in the Context of Epidemics: Upholding the Rights of Religious Minorities

Santiago Ripoll

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Summary

This working paper explores the challenges that emerge when public health measures to mitigate the risk of infection during an epidemic infringe on the rights of religious communities to say a final farewell to their loved ones according to their custom. The paper aims to answer these questions: how does epidemic response in the context of death and burials frame and impact religious minority rights? And in turn, how do sectarian dynamics reposition themselves in the context of epidemic response?

I explore the conflict between biomedical understandings of death and funerary practices within epidemic responses, and religious minorities' freedom of belief and practice. I show how epidemic response is a secular project, and how its latent religious values linked to the creation of the nation-state generate particular dominant discourses of what is appropriate in death-related policies during epidemics. I also explore how relationships between dominant and minority religions, and other social dimensions, may shape the negotiation of 'safe and dignified burials'.

I draw on the experiences of religious and ethnic minorities in different epidemics in the past (Ebola and plague) when faced with emergency funerary measures that were against their religious practice. I also include Covid-19 as a case study, as evidence is emerging not only of competition between public health goals and religious rights, but also about positionings of power between ethnic and religious majorities and minorities.

The objective of this working paper is to further shed light on the processes that link epidemic response in the context of death and funerary practices to religious minority rights, to show how the response is politicised and to point to the sectarian inequalities as a result of the response. To do so, I will review three case studies: (i) the case of Ebola amongst Muslims and Christians in Liberia in the epidemic of 2014–15, illustrating the conflict between the secular epidemic response and religious priorities in its resolution; (ii) the case of pneumonic plague in Madagascar in 2017, showcasing a similar conflict, but highlighting the impediments to its resolution, and (iii) the case of religious inequalities and Muslims in Sri Lanka in the context of the ongoing Covid-19 pandemic.

In each case study, I will briefly (i) introduce the socio-political context, including the interfaith or sectarian politics, (ii) explore the different strategies for epidemic response

that were attempted in the context of death and burials, as well as their impact on religious minorities, and outline how the 'public health' objectives were negotiated, (iii) describe the response of these communities, and (iv) reflect on the politicisation of the response along religious lines (particularly so in the Covid-19 case study).

This comparison will shed light first on the ways that epidemic response has impacted on religious communities (by attempting either coercive or aligned approaches or both), and secondly on the role of the secularised public health response and the politicisation of the response along sectarian lines in the context of funerary practices. It will give insights into what kind of policy interventions regarding the care of the dead can be useful in respecting religious minority rights, but, unlike other literature in this field, it will highlight the limitations and challenges that these interventions may face as a result of problems of incommensurability between public health priorities and other priorities.

Keywords: epidemics; secularism; religious minorities; funerary practices; humanitarian response; freedom of religion or belief; Madagascar; Liberia; Sri Lanka.

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Acronyms

BMH	Bureau Municipal d'Hygiene (Municipal Office of Hygiene)
CODESRIA	Council for the Development of Social Science Research in Africa
SSHAP	Social Science in Humanitarian Action
UNICEF	United Nations Children's Fund

1 Introduction

Epidemics with high mortality rates place a heavy burden on societies, increasing the number of dead people to be dealt with over a short period of time, as well as raising concerns about how the preparation of the body and the conduct of the funeral might affect the transmission of the disease. The number of deaths may be high enough to overwhelm the capacity of communities or funeral organisers and prevent them from following the funerary practices that are customary. In turn, depending on the disease and its transmission pathways, certain practices may facilitate transmission more than others. For example, in the case of Ebola, the blood and other bodily fluids remain infectious for days after death, and therefore the people who prepare the body are at risk of infection (Abramowitz and Omidian 2014; Ripoll *et al.* 2018). On the other hand, those who handle the bodies of people who have died of Covid-19 or cholera are less likely to be infected (Malvy *et al.* 2019).

When declaring an outbreak, governments and other responders, such as international aid organisations (donors, UN agencies, NGOs, and so on), enact legislation or develop policy and guidelines to enable community or professional funeral practices to be adapted to an increase in mortality, as well as to 'mitigate the risk' of transmission. These policies, based on biomedical and epidemiological knowledge and shrouded in technical language, are often portrayed as neutral. A variety of measures to ensure 'safe burials' may be introduced; for example, banning particular practices, such as the preparation of the body, enforcing one kind of 'disposal' over another (e.g. cremation over burial) or banning ceremonies and funeral gatherings, etc. (Moore, Tullock and Ripoll 2020).

The achievement of 'risk reduction' through these measures may clash with the customary practices of religious communities. As shown below, epidemic response as a secular project prioritises biomedical and epidemiological knowledge and treats it as if it were devoid of religion and culture. Culture and religion thus become residual, a world of meaning and practices outside the 'real world' of disease to be either overcome, subverted, or harnessed. Conflict or tensions with religious communities often emerge when their public health needs are pitted against other needs. In the case of the care of the dead, conflict emerges as the symbolic, social, and emotional aspects of mortuary and funerary practices which included caring for the dead, may be jeopardised by response guidelines on 'safe burials'.

This has on occasion, as we shall see in the case studies below, generated resistance from communities to an epidemic response. Funeral practices have particular meanings

for the grieving family and friends, and the kinship and community networks, as well as playing a role in channelling and unravelling the emotional energy of loss and bereavement. Customary practices are not set in stone or unmoveable and they do not necessarily emerge from a fixed tradition. The evidence from previous epidemics is that religious communities can adapt their practices, provided that their symbolic, social, and emotional needs are met. Below, I explore two case studies in which the outcomes differed: the Ebola response and its impact on Muslims in Liberia and efforts to combat plague in Madagascar. In the Sri Lanka case study, however, such efforts to accommodate the needs of religious communities were not attempted in the first place.

This tension between the guidelines for the epidemic and the practices of religious minorities can be hijacked by the social groups in power. Epidemics layer themselves on longstanding historical, political, and religious fault-lines, and as the disease unfolds, actors reposition themselves politically, exacerbating those divides. During past epidemics, different social groups (based on class, ethnicity, party politics, religion, or other things) have made accusations about who caused or transmitted the disease, and have established who can be trusted to respond to the disease, and what policies (e.g. lockdown, quarantining) are deemed acceptable. For example, recent cholera outbreaks in Mozambique highlighted the neglect and demonisation of the poor by the ruling party, and the distrust, on the part of the poor, of the ruling party's response, as a result of longstanding neglect of the one by the other (Chigudu 2019).

Politicisation of the response is a common occurrence in epidemics. Powerful actors can attack minorities while veiling it as part of the response to the epidemic. For example, in the ongoing Covid-19 pandemic, the Filipino government has attacked political dissidents and union activists in the Philippines by accusing them of 'spreading misinformation', and the Malaysian authorities rounded up and detained migrants, citing Covid-19 as the reason (Sane-Schmidt, Ripoll and Wilkinson 2020). As is shown below, targeting funerary practices has been used in previous epidemics as a way of targeting and 'othering' vulnerable populations (Ripoll *et al.* 2018; Ripoll and Wilkinson 2018). In particular contexts, pinning the risk of transmission on funerary practices has been used by groups belonging to majority religions to further marginalise and stigmatise minority religious groups. The case studies outlined highlight here those interfaith dynamics.

The research questions I set myself to answer in this paper are as follows: how does epidemic response in the context of death and burials frame and impact religious minority rights? And, in turn, how do sectarian dynamics reposition themselves in the context of epidemic response? In order to answer these questions, I develop three case studies, allowing for a deeper qualitative illustration of the multi-dimensional dynamics of

such a 'complex issue in its real-life context' (Crowe *et al.* 2011: 1). The case studies draw on (i) historical and anthropological literature exploring the socio-political context and the origin and meanings assigned to funeral practices, (ii) the grey literature on epidemic response (guidelines, policies, programme evaluations, and so on), including guidelines on 'the management of bodies' and on necessary modifications to (or banning of) funerary practices, (iii) the social science and grey literature relating to the community responses – including those of religious minorities – to public health interventions and prohibitions, and lastly (iv) political science and media articles exploring state–citizen and intersectorian relations.

The structure of this paper is as follows. In the next section, I show how epidemic responses assign meanings to death and the afterlife that are different to those attributed to them by religious communities, and I analyse the strategies governments and health organisations pursue to ensure that funerary practices are aligned with public health goals. I also show how these interventions may infringe on the rights of religious minorities to their own beliefs and forms of worship. The three case studies follow: first, the case study of the Ebola pandemic in Liberia in 2014–15 and the conflict that arose between the secular epidemic response and the religious priorities of Muslims and Christians regarding funerary practices, as well as the way this conflict was resolved. Secondly, there is the case study of the pneumonic plague epidemic in Madagascar in 2017, in which a similar conflict arose between the health authorities and those who practise the ancestral funerary practice of *famadihana*. In this case study, I analyse why the conflict was not resolved. The third and last case study describes an attack on the rights of Muslim minorities to worship as they choose, through policies of enforced cremation during the current Covid-19 response. I conclude the paper by reflecting on the implications for future epidemic responses if governments are to uphold people's right to freedom of religion.

2 Epidemic response secularism, minority rights, and the afterlife

2.1 Epidemic response as a secular project

What is death, and where is it placed in the broader journey of our individual and communal existence? And what role does the preparation of a body and the conduct of a funeral play in this journey? These are questions that elicit different answers, depending on people's beliefs or the religious or philosophical traditions they belong to. Very often in an epidemic with high mortality, as we are experiencing with Covid-19 globally, policymakers' concerns around death and burials emerge as an afterthought. Governments and health agencies involved in the response prioritise saving people's lives, ensuring their health systems are not overwhelmed, and preventing infection. Within the conventional epidemic response guidelines, which are dominated by biomedical and epidemiological approaches (Dry and Leach 2010), the dead are bodies to be 'managed' and 'processed', to be 'disposed of' as quickly as possible. See, for example, the relevant WHO guidelines for Covid-19 (WHO 2020).

In this light, care after death – preparing the dead person for burial or cremation, transporting them, and commemorating them through ceremonies – is constructed by health authorities as a locus for contagion, and thus the different steps are regulated and policed (Lynteris and Evans 2018). There is an underlying secular position here, according to which, the end of our individual life on earth is the end of life itself: nothing of importance happens to the person beyond death, and at the moment of death, the person as a subject becomes an object, a body. How one's body is 'disposed of' becomes a pragmatic decision based on logistics and infection prevention.

However, this clashes with alternative narratives of life, death, and the afterlife (often within religious traditions, though not necessarily). For example, religions that include ancestor worship emphasise the importance of holding funerals which enable the spirit of the dead person to travel safely to the world of ancestors and make a successful transition into an ancestor (Ripoll and Jones 2019). In the Abrahamic monotheistic religions, this safe passage into an afterlife is also salient. For example, the Russian Orthodox Church allows interment but not cremation. This is because in life, the body and the soul are deeply integrated and form a temple for the Holy Spirit, and after death, the sacred nature of the body after the soul departs is maintained by interment. The afterlife in heaven, hell, or purgatory, finishes at the End of Days, when resurrection occurs, and the body is reunited with the soul (Lardas 2015).

Similarly, in Islam, the integrity of the body, preserved through interment, is necessary for the resurrection on the Last Day (Di Palma 2016). Conservative and Orthodox Jews also perceive cremation as defilement, and according to them, the dead need to be returned to God, and this is achieved by returning them to the earth from whence they came (Donin 2019). Within these religious understandings, contrary to the secular biomedical model, death becomes a crucial step in the longer journey of the afterlife.

Biomedicine considers death to be mostly an individual affair, rather than a social and communal one. In the examples above, the grief of the community secures safe passage for the departed person and avoids leaving the spirit or alternatively the body in limbo. In ancestor worship, obstacles to this passage caused by breaches in funeral practice may lead to ancestors cursing the community. Death is a communal affair, with the determination of the cause of death and the burial practices being vehicles on occasion for gift-giving and for settling accounts (Ripoll *et al.* 2018). Funerals can reaffirm the commitment to family, community, God, and ancestors.

2.2 Epidemic response and the framing of religion and funerary practices

Conventional epidemic response, as a secular project, constructs itself as separate from all religion. Yet to do so, as in the broader secular project within biomedicine, it needs to 'craft "the religious" as its object, asserting itself as equally positioned vis-à-vis all religions' (Whitmarsh and Roberts 2016: 203). This reconstruction and recrafting of religion, in order to separate it from the secular, implies the confinement of religion to the ideational realm as beliefs (Langford 2016), and moving it from a holistic totalising cosmology to a separate sphere of 'the religious' outside public life in liberal democracies, mostly centred around ritual and ceremony, and solely relevant to the spiritual (*ibid.*). Secular medicine portrays itself as opposed to this set-up and as a rational and pragmatic alternative that focuses on the materiality of the individual body and its wellbeing. Within this epidemic response secularism, religion is only awarded the space not already covered by medicine and epidemiology.

How has the response to the epidemic positioned itself vis-à-vis religion? Governments, international organisations, and health agencies leading the response have mostly done so in different ways: either by confronting religion, or in its more benign form, epidemic response has aligned itself with religion through the adaptation or modification of practices. In the context of death and burials, a confrontational approach can mean that particular practices have been enforced, for example, compulsory cremation instead of burial, or alternatively banned, for example, by forbidding certain ways of preparing the body, or transporting it, or by banning ceremonial gatherings. This approach has led to

much grief and psychological distress when people have not been able to care for their loved ones beyond death. This stress is magnified when not following customary burials can lead to negative consequences: ancestor curses on the community or punishment by God. Depending on the level of trust towards government authorities and respondent organisations, overt resistance to these measures may occur.

Alignment, on the other hand, in its most benign form, is the approach that anthropologists like me have taken via platforms such as the Ebola Anthropology Response Platform or Social Science in Humanitarian Action (SSHAP). In these cases, governments and humanitarian health agencies have aimed to bring communities 'on board'. They have opened spaces of dialogue with affected communities and have designed guidelines with their participation (and input from social scientists knowledgeable about the context). They have also devolved services and their design to local communities and have enrolled religious leaders in response activities and as interlocutors with local groups. Modified burial practices emerge as a result of this alignment and negotiation, as occurred with 'safe and dignified burials' in the latter half of the Ebola response in West Africa (see case study below).

Building on the capacity of customary practices to evolve and adapt, communities with support from the epidemic response decided to modify burials to meet both symbolic and ritual needs *and* public health priorities. This alignment approach, desirable as it is, assumes that funeral practices are commensurable and interchangeable, and that public health priorities are at least equivalent and comparable to religious priorities. The assumption behind conventional community engagement with reference to religious practices is that these can be made comparable through a single frame of reference, within which the biomedical and religious can relate to each other and can in a way be translated and exchanged. Yet this is not always true. Eva Spies highlighted this problem of incommensurability amongst different religious 'traditions' and in turn with customary practices (Spies 2013). I argue that the problem of incommensurability can emerge between epidemic response public health goals and the role of funeral practices, despite efforts in adaptation. I explore this in the case study on *famadihana* funerals in Madagascar.

2.3 Interfaith relations and the politicisation of epidemic response

Talal Asad (2003) described how the conceptual separation between secular and religious spaces is a problematic one. Conducting a genealogy of the secular sheds light on the religious logic that underpins it. Asad indicated that contemporary framings of the secular emerged as a result of the incorporation of Christian theologies into Enlightenment thinking. These original theologies separated the domain of 'the rational'

from themes such as myth, magic, witchcraft, possession, and taboo (Asad 2003: 22). From this perspective, 'religion, whose object is the sacred, stands in the domain of the nonrational' (*ibid.*). This applies to modern medicine, in which 'the "secular" self' of the health practitioner 'carries latent religious logics' (Whitmarsh and Roberts 2016: 204). The foundation of nation-states may be underpinned by religious projects that become incorporated into the states' construction of secularity (Fernando 2014).

This applies also to biomedicine and to infectious disease response when policymakers assess the different interventions to address transmission. The acts of framing what medical or public health techniques are in the realm of the possible, which ones are preferable, and the ethical criteria to choose certain interventions over others when there are trade-offs, are underpinned by a particular dominant worldview. Practices that contradict those underlying theologies are reallocated to the category of 'the religious'. As Whitmarsh and Roberts (2016: 203) put it: 'biomedicine's claim to secularity helps to produce the figure of the liberal political subject itself by restricting to the sphere of the "religious" those practices that a medical establishment's implicit religious commitments disavow'. We will see in the case studies below how particular funeral practices are deemed 'necessary' while others are considered non-essential, and how this prioritisation can be shaped by the underlying theologies dominant in the nation-state, and, as I indicate below, through the politicisation of the response.

It is important to note that the construction of the secular in medicine is what frames it as pitted against the 'religious' (Anderson 2014). Yet this constructed opposition between medicine and 'the religious' counters the holistic nature of religious belief and practice. The evidence is that in many contexts medical pluralism is the norm, with people including both biomedical and alternative health providers in their health-seeking practices, and models of disease and wellness including spiritual and material causes (including germ theory) (Baer 2018), and religious healers relying on elements of biomedicine for diagnosis or treatment (Carruth 2014). Customary practices around sanitation can often be aligned with public health goals in the context of epidemics, such as local concepts of purity or contamination (Ripoll and Wilkinson 2018). In turn, religious discourse and practice have shown themselves in several contexts to be flexible and adaptable to emerging challenges, including epidemics (Richards 2016).

Longstanding sectarian inequalities can be exacerbated by the politicisation of epidemic response. Reviews conducted by the SSHAP as part of the 'Social Science in Epidemics' portfolio¹ show that the impact of the epidemic and the strategies of the response layer themselves on already existing social, economic, and political fault-lines. Powerful groups

¹ See the relevant evidence reports here: www.socialscienceinaction.org/about/social-science-lessons/.

reposition themselves to prioritise particular framings of the cause and transmission of the disease, and in turn, deliver responses that discriminate against competing or marginalised groups. The poor, opposition parties, indigenous groups, racial or ethnic minorities, LGBT+ communities, etc. can be accused of causing or transmitting the disease. In turn, the epidemic response can be made to benefit particular groups over others, channelling resources to particular groups and marginalising others.

Historically, religious minorities have on occasion been accused of causing or transmitting epidemics or zoonotics: from Jewish people in Europe being accused of spreading the plague in the Middle Ages (Cohn 2012), and Egyptian Christians of spreading the 2009 H1N1 influenza virus (Leach and Tadros 2014), to Muslim minorities (amongst others) being blamed in several countries for the ongoing Covid-19 pandemic (Werleman 2020).

Epidemics thus shape interfaith and intersectoral relations and can mean religious inequalities are exacerbated by the disease and how the response is defined and implemented. Powerful social groups adhering to majority religions, and avowedly secular groups define what funeral preparations and ceremonies are deemed 'essential' and which ones are unacceptable, and decide what trade-offs are necessary to achieve the goal of containing the epidemic. It is important to understand religious differences as part of an intersectional approach, as they cannot be separated from other social dimensions. I explore these interfaith and intersectoral dimensions in the case studies, especially in the Sri Lanka case study.

2.4 Undermining the rights of religious minorities

The rights of religious minorities are guaranteed by the 1948 Declaration of Universal Human Rights (United Nations 1948: 5), including Article 18:

Article 18. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Further, the Human Rights Committee general comment 22 focuses on the explicit entitlement to perform 'a series of ceremonies and religious customs that often have cultural and traditional connotations' including customary practices after death and funeral rites and ceremonies (UN Human Rights Committee 1993).

This freedom is subject to be limited by the protection of other rights, established in the 1981 Declaration to the General Assembly:

Art. 1 (3): Freedom to manifest one's religion or belief may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

(United Nations General Assembly 1981)

It is according to national law that these competing rights need to be evaluated and prioritised. It is in the national context that very often the rights of religious minorities can be vulnerated. By deciding that particular religious practices need to be limited in the name of public health, the state can justify the banning of religious practices, including funerary practices. Cloaked in the language of public health, the banning of particular practices may discriminate against particular religious minorities, thereby exacerbating religious inequalities in the country, or in some contexts it may be used to repress minority religions. There are other forms of religious discrimination that can occur in epidemics, including discrimination in access to health care and social protection, blaming religious minorities for spreading the disease, inciting violence or discrimination against minorities, or using epidemic surveillance mechanisms to identify and repress minorities (Ochab 2020).

Case study 1. Muslim and Christian religious freedoms regarding burials in Liberia during the West African Ebola pandemic (2014–15)

Liberia's Muslims make up 12.2 per cent of the population, whilst Christians represent 85.5 per cent of it. Both Muslims and Christians still practise several elements of indigenous religions in parallel to their official worship, such as 'ancestor worship, membership in secret societies, witchcraft, polygyny, and trial by ordeal' (Redd 2015). When the Ebola pandemic was declared in Liberia in August 2014, the country was being ruled by the Unity Party, the president being Ellen Johnson Sirleaf. She had been at the helm since the 2005 elections, which followed the end of the civil war in 2003 and the ousting of Charles Taylor. The rise of Johnson Sirleaf embodied the resurgence of the Americo-Liberian English-speaking elite, which makes up 5 per cent of the population (Sesay *et al.* 2009) and building alliances with members of other parties, civil society, and ethnic groups (such as the Mandingo) in a culture of neopatrimonialism (Gerdes 2015). The Unity Party succeeded in demilitarising the conflict and bringing donor money (notably World Bank and International Monetary Fund support) as well as international public health advisors into the country (Falola and Oyebade 2016: 65–66).

When Ebola hit Liberia, high mortality overwhelmed its funerary systems. Burial teams were overburdened, which led to full mortuaries and bodies not being removed from people's homes. In Liberia, as a result of pressure to respond to the epidemic, strict measures were implemented in terms of funeral practices. These occurred in tandem with other restrictive measures, such as quarantining and curfew in Monrovia, rolled out by the Liberian military. At first, spiritual leaders, who were influential in the affected communities, were not consulted (Pellecchia *et al.* 2015). It was made a criminal offence to hide bodies, and cremation was mandatory in the Monrovia region between August and December 2014. Outside the capital at the onset of the epidemic, dead bodies were taken by 'safe burial' teams, put in body bags, and were buried out of necessity in unmarked graves.

The government defined customary funeral practices as a problem in order to respond to high mortality and the infectious nature of Ebola victims. Cremation was mandated, to avoid, in Johnson Sirleaf's words, 'tampering with the dead and contaminating water sources' (Snyder 2014, unpaginated). The Minister of Information blamed the 'traditional' nature of Liberian society and the way Ebola attacked 'traditional practices like how we prepare bodies for burial' (*ibid.*).

Cremation was resisted by many Muslims and Christians. In both cases, their freedom of belief and worship was being violated. Many Liberian Christians and Muslims combine ancestor worship with their monotheistic faith and many practise 'traditional' burials. According to these beliefs, appropriate care of the body and interment through the necessary funerary rites is necessary to send the spirit of the loved one off to the afterlife appropriately and to enable them to join the ancestors (Featherstone 2015). Fulfilling these duties also protects the family and community from harm, as improper burial may be a cause of misfortune (Ripoll *et al.* 2018). Those who opposed cremation felt that burial was the right way of commemorating the dead, and a burial site was necessary so that they would have a place to visit and remember the deceased. In turn, for those who resisted cremation, there was also a rejection of the state's intervention in a family and community affair (Abramowitz and Omidian 2014). Also, the lack of organisation meant that people in charge of cremation were unable to separate the ashes of those who had been cremated (*ibid.*).

This occurred against a backdrop of fear and chaos, where the authorities failed to remove bodies from people's homes, and people resorted to abandoning them in the street. Further, information about when your family member had died in an Ebola treatment unit was unavailable, and many outside Monrovia were not able to find out where their loved one was buried. This situation was perceived by citizens and

community leaders as inhumane, and it generated suspicion and discontent towards the response and the government. This resistance was echoed by Muslim and Christian leaders in the country. Interviews in Monrovia showed that some of the population would be willing to accept cremation, provided that family members were able to attend the ceremony, be fully informed of the whereabouts of sick or dead family, and receive a guarantee that the bodies would be treated with respect (*ibid.*).

Out of necessity for sanitary purposes or in a bid to resist burial policies that were deemed inappropriate, illegal 'secret burials' were conducted, and on occasion, the teams conducting official burials were attacked. These 'secret burials' were conducted because the family had been waiting for days for the 'safe burial team' to arrive, or because cremation would have meant that a 'proper' burial would be impossible. Despite prohibitions by the government to handle bodies, Muslims who conducted secret burials emphasised the importance of 'righteous washing', a practice in which the body was made pure for God and the person was honoured and respected by the family (Roth Allen and Lacson 2015: 24). Christians also practised the washing of the body. People of higher status, such as religious elders, were more likely to receive secret burials (27). Other reasons for secret burials included fear of stigma and quarantining (24).

The top-down punitive measures to prevent Ebola proved counterproductive: cremation created secret burials, as it was based purely on the fulfilment of biomedical needs but failed to meet the social, emotional, and psychological needs of communities. The policy of cremation 'crudely defined the transition from life to death as a simple biomedical passage of state, wiping out deep social links, and endangering the credibility of the measure itself'. (Pellecchia *et al.* 2015: 10). Liberia's case shows how coercive measures, inadequate communication about and organisation of new funerary procedures, and the implementation of new funerary measures without consultation with communities and their trusted leaders, lead to mistrust and non-compliance.

As the end of 2014 approached, the 'safe and dignified burial teams' were trained, with their training incorporating elements of community engagement, and the Liberian government called off the cremation decree. As the burial teams became more established, they progressively adapted burial practices to community needs through dialogue, maintaining those elements that did not contravene public health needs. Religious leaders were recruited to support the response (Featherstone 2015). For example, the epidemic response worked with local leaders, such as the Mandingo community leaders, to conduct a consultation and recruit local volunteers, including an imam, to form the burial teams, which received training (WHO Africa 2015).

Religious leaders communicated to their followers the importance of following the 'safe and dignified burial' guidelines. These guidelines were produced in collaboration with faith-based organisations and medical anthropologists that had identified meaningful alternative ways of touching and bathing the body (Moran 2017). It included separate guidelines for Muslims and Christians on how to prepare the body before putting it into the body bag and then into a coffin. Guidelines for Muslims covered elements like dry ablution (cleaning with sand), and shrouding, which would not require direct contact with the body. Family members or religious elders were allowed to perform dry ablution (WHO 2017b). Guidelines for Christians included the option of viewing the body and washing it by sprinkling water on it, or reading verses from the Bible and adding cloth or similar items such as clothing to the body bag as a symbol of dignity (*ibid.*). The guidelines also emphasised the importance of the acquiescence of the family, and the presence of a religious leader during the body preparation and burial, whenever relevant.

Responders realised that death created a social rift which needed to be managed by the bereaved through ritualised expressions of grief and loss. This social participation was enabled through permitting socially distanced attendance at funerals. Only close family members would be near the interment site and would be allowed to throw the first handful of soil. Priests or imams would lead the burial ceremony and the event would close with the ritual washing of hands by all involved but using disinfectant (*ibid.*). These alliances with communities and customary and religious leaders, together with a more efficient management of the caseload, resulted in a lowering of resistance by people to the new funerary practices.

The adapted practices were indeed followed, showing that religious communities were able to adapt if they were consulted and their inputs were incorporated into the new definition of 'safe and dignified' funeral practices. Moran, however, in her study of burials in Liberia, highlights the tension that exists between biomedical goals and freedom of religion or belief, using as an example the potentially contradictory nature of the text of the guidelines: "[There are] two consecutive sentences that underscore the contradictions embedded in the protocol: "The handling of human remains should be kept to a minimum. Always take into account cultural and religious concerns"" (Moran 2017: 414).

Moran raises the question, are these always reconcilable? Is it always possible to align the secular aspects of biomedicine and the public health needs of the community with the community's spiritual or religious needs? Moran highlighted the problem of incommensurability, pointing out how anthropologists had focused solely on 'ritual' and ignored the fact that there were other psychological and emotional aspects of burials that were equally important to consider (Moran 2017). Freedom of religion or belief goes

beyond 'practices'; it is not only about conducting socially sanctioned rites, but also about fulfilling spiritual needs. I will consider the problem of commensurability further in the Madagascar case study below.

Case study 2. *Famadihana* funerals in Madagascar and the plague response

The boundaries between the 'religious' and the 'customary' within monotheistic religions is blurred in Madagascar (as is the case in many other contexts). According to the latest census in Madagascar (in 1993), 41 per cent of the population are Christian, 52 per cent follow indigenous religion, and 7 per cent are Muslim (Southall *et al.* 2020). Indigenous or traditional religion is centred around ancestors. Whilst there is a God, called *Zanahary* (Creator) or *Andriamanitra* (the Fragrant), the ancestors (*razana*) play a direct role in everyday affairs. The living are seen as extensions of the dead (Metz 1994). The ancestors are the sources from which the life-force flows and generate norms and customs, including taboos, to be observed. The key to happiness and success is keeping the ancestors satisfied (Astuti and Harris 2008).

It is important to note that despite conversion to Christianity, many have kept traditional religious practices, particularly with regard to funeral practices and the key role of ancestors. I will explore the interaction between the different world religions and the Malagasy consideration for ancestors further below, when considering the funeral practices of *famadihana*, the turning of the bones (also known as the turning of the dead), which involves exhuming the bodies of relatives.

Plague is endemic in Madagascar, with a small number of cases emerging nearly every year, often between September and April. An epidemic occurred between August and November 2017 and affected non-endemic areas (it affected almost half of the country's districts) and major cities. There were 2,417 cases and 209 deaths (WHO Africa 2017). The plague is a zoonosis transmitted from rodents to humans via fleas, and human to human transmission can occur through flea bites, or in the case of the pneumonic plague (77 per cent of cases), through air droplets. If the illness is detected early, treatment with antibiotics is effective.

The epidemic response was led by the Ministry of Public Health, with the support of WHO and the Institut Pasteur in Madagascar.² Activities included epidemiological surveillance, testing, contact tracing, and isolating, treatment with antibiotics, rodent and vector control, risk communication, screening at ports and lastly, 'safe and dignified burials'

² For a review of the fraught relationship between public health authorities like the Pasteur Institute and Malagasy communities in the context of plague, see Poleykett (2018).

(WHO 2017a). The Minister of Health identified the funeral practice of *famadihana* as one of the causes of plague transmission (AFP News 2017b). Whilst there is no study determining the survival of the bacteria in corpses, there is an understanding that 'the handling of potentially plague infected corpses may reactivate the disease' (Andrianaivoarimanana *et al.* 2013: e2382).

The response was initially to perform 'safe burials', where the members of the family could not touch their loved ones after death or clean their bodies, nor could they bury them in the family tomb (Imazpress 2018). The Malagasy government issued a ruling that plague victims could not be buried in tombs that could be reopened. Exhumation was forbidden until seven years after the death (Andrianaivoarimanana *et al.* 2013: e2382).

Famadihana is a funeral practice carried out mostly by Malagasys in the central highlands (such as the Merina and Betsileo), including by people living in cities. In the winter, between July and October, families gather in their ancestral land (*tanindrazana*), and congregate with their extended family of that descent group in the family burial vaults.

Famadihana is sometimes called 'second burial'. The first burial is a mostly a family affair, in which the family member is buried, often in an individual grave. After at least two years, the body of the person is exhumed, shrouded in silk, and taken to the communal tomb (McGeorge 1974). The traditional explanation for this is that humans are made of ancestral matter and people cannot leave the world of the living and become ancestors until their bodies are completely decomposed (Bo 2015). This second burial is more of a joyous communal affair, in which the whole group of descendants participates, with relatives travelling to the ancestral land. *Famadihana* is called the 'turning of the bones' because it is also an occasion in which the ancestors in the communal tomb are taken out of the communal tomb and spoken to and honoured by their family members, and their silk shrouds are replaced. The family then dances with their ancestors before returning them to their family grave. This occurs every five to seven years. To signal the need for *famadihana*, ancestors who are in the communal family tomb communicate through dreams with their live descendants and declare that they are 'cold', and they need their shrouds to be replaced. An astrologer or *ombiasy* determines the ideal time for the ceremony to occur.

Despite the practice not being of Christian origin, but rather an adaptation of an ancestral Southeast Asian practice of double funerals, a great proportion of those who practise *famadihana* are Christian. In a survey conducted in the capital, Antananarivo, 71.6 per cent of those who stated they were Christians said they practised the tradition of 'turning

of the dead' (Roubaud 1998). Yet the different Christian churches as organised institutions have very different attitudes towards the practice, depending on whether they consider it to be a customary practice or a religious one. The Catholic Church considers it a customary practice that can be subsumed within and incorporated into Christian burials, understanding the ancestors as transmitting God's grace, rather than being a life-force themselves. The Protestant churches, however, consider it a religious ritual, and hence reject it, as they perceive it to be ancestor worship. Much stronger is the repudiation by Christian revivalist movements and Pentecostalist movements, which see it as demonic and corrupting Christian worship (Spies 2013). Conflict between tradition and the different Christian denominations vis-à-vis *famadihana* is longstanding, regardless of prohibitions related to plague.

Despite the fact that burying plague victims in a tomb that can be reopened has been banned and the time allowed before exhumation has been extended to seven years, and despite the risk communication campaigns carried out by the authorities, *famadihana* has continued unabated. There have been reports of covert exhumation (AFP News 2017a), of people refusing to part with their loved ones, and of police having to seize the bodies of plague victims (Matthews 2017).

In response to this resistance by communities, social scientists urged the international community to transfer the lessons learnt about community engagement during the West African Ebola pandemic to Madagascar, and to 'conduct in-depth qualitative research to complement the rapid knowledge, attitudes, beliefs, and practices surveys proposed by many public health programmes; and adapting public health measures to local contexts' (Sams *et al.* 2017: 2624).

Mirroring that Ebola experience, the WHO and UNICEF carried out a consultation with community leaders and focus groups to determine what changes would be acceptable in Madagascar (Heitzinger *et al.* 2018). As a result, the 'safe and dignified burials protocol' was produced, presented to the Red Cross and adopted by the government. This included over 30 restrictions, including compulsory washing and disinfection of plague victims by specialised burial teams, incineration of their clothes, use of a body bag, and a ban on *famadihana* for seven years (*ibid.*). A pilot test carried out by the Red Cross and a subsequent survey indicated that people would be willing to accept modified burials. In the words of the Minister of Health, '[N]ow, the novelty is the word "dignified". That means habits and customs are respected, but also all that is health security' (Imazpress 2018, unpaginated).

The assumption behind this was that people, provided they knew what caused plague transmission, would accept modified burials, which were safer, and provided that they *also* had meaningful elements of respect. The assumption that burial practices can be broken down into components with meaning and that these components are commensurable and interchangeable with biomedically proposed practices is countered by the continuation of *famadihana*.

Reports on the final months of the response indicated continuing resistance to Ministry of Health guidelines. Several clashes occurred in October 2017 between relatives of victims and officers from the Municipal Office of Hygiene (BMH), the institution in charge of burial teams, when the teams were taking away the bodies. They were often accompanied by law enforcement officials. In Toamasina, bodies buried in mass graves were dug up and stolen (*L'express de Madagascar* 2019). Given the context and the visibility and spread of the disease, religious priorities could not, for many, be balanced with health priorities. In the words of a person attending a *famadihana* ceremony, 'I don't want to imagine the dead like forgotten objects. They gave us life - I will always practise the turning of the bones of my ancestors – plague or no plague.' (AFP News 2017a, unpaginated).

Since the end of the epidemic, the government has decided to incorporate most of the guidelines into law, taking a more punitive approach. The draft law, under discussion in August 2019, forbids people to touch the remains of a plague victim, to organise a funeral vigil, or to bury the corpse of anyone who has died of the plague in the family vault (*L'express de Madagascar* 2019).

This case study shows how there can be irreconcilable tensions between epidemic response secularism and freedom of belief, as a result of the incommensurability of the biomedical–epidemiological objectives and spiritual objectives. Those who practise *famadihana* are under attack as an indirect result of epidemic response secularism.

Case study 3. Covid-19: Compulsory cremation and Muslim minorities in Sri Lanka

The ongoing Covid-19 pandemic has been driven by a narrative of urgency and blame across the world (Morthorst 2020). Measures have been rolled out swiftly and with little consultation, and very rarely have they been based on adequate emergency preparedness pandemic protocols or capacities.

Covid-19 victims are, compared to those who have been ill with other diseases, such as Ebola, a relatively low risk for those who care for them after death. To date, there is no evidence of post-mortem transmission, and the evidence shows that the person can be handled safely if basic hygiene practices are observed (CDC 2020; WHO 2020). Despite

this, many countries have banned one or more care practices, such as the viewing of the dead person, the preparation of the body (washing, dressing, etc.), transport, or embalming. Several countries have enforced cremation or have legislated for cremation as a measure of last resort. The objective of cremation can be to prevent transmission or, alternatively, to ensure that the mortuary capacity of the country is not overwhelmed. An important concern regarding transmission is funerary ceremonies, at which mourners can congregate and transmit the virus amongst themselves. For that reason, many of the public health interventions related to death and burials have included banning funerals or related rituals, limiting their size or imposing social distancing on them. For an extensive analysis of death and burial policies during Covid-19, see Moore *et al.* (2020).

In this case study, I wish to explore the politicisation of the epidemic response, and how social or political actors can use the response to further the interest of religious majorities and discriminate against religious minorities. There have been examples of authoritarian governments instrumentalising Covid-19 and response measures – lockdown and quarantining, exposure to infection by lack of protection, transport bans, accusations of misinformation – to discriminate against marginalised populations: the poor, migrants, opposition workers, or unionised workers. In some countries (India, Iraq, Pakistan, and others), the response has been hijacked to discriminate against religious minorities. For a summary of emerging religious discrimination in the light of Covid-19, see IDS (2020).

Sri Lankan politics is dominated by emergent authoritarian Sinhalese nationalism under the Presidency of Mahinda Rajapaksa. Having won the presidential elections with a sweeping majority in November 2019, Rajapaksa has been undermining the judiciary and the legislative and media controls on the executive (International Crisis Group 2020). Rajapaksa worked for the Minister of Defence during the final years of the civil war against the Tamil Tiger independentists, thus in charge during a period in which rights violations were carried out by the military. The current government has resisted giving ethnic minorities, such as the Tamils, the autonomy agreed in the peace accords, and has not awarded Muslims a voice, despite their having been targeted by both the Sinhalese and the Tamil Tigers during the conflict (McGilvray and Raheem 2007).

According to the 2012 Census (Department of Census and Statistics of Sri Lanka 2012), the Sinhalese make up 75 per cent of the population and are predominantly Buddhist, living in the centre and southwest of the country. The Sri Lanka Tamils, mostly Hindu, make up 11.1 per cent of the population, living mostly in the north and east of the island. Some Sinhalese and Tamils converted to Christianity – mostly Roman Catholicism. Christians make up 8 per cent of the population. Moors, the descendants of Arab traders, make up 9.3 per cent of the population, and are mostly Muslim. They mostly live in urban

centres in the south and are also prevalent in the centre and east of the country. Other minorities include the Indian Tamils (4.7 per cent) and the Malays (0.22 per cent). In this case study, I will focus on the impact of religious discrimination on Muslim communities (9.66 per cent). In recent times, the importance of ethnic identity has declined in favour of a religious source of identity (Imtiyaz *et al.* 2015).

Muslims had lived in both Tamil- and Sinhalese-controlled areas during the civil war. Muslim elites and politicians chose to support the Sinhalese side and successive regimes to win their rights and positions but have always portrayed themselves as a separate group, defined by religion, in Sri Lanka. This has meant Muslims have been perceived as traitors by the Tamil, and at the same time have been the emerging enemy of Sinhalese ethno-nationalism (*ibid.*). Muslim political representation is fragmented, with no dominant party competing in the elections (Fazil 2009).

In the years following the end of the war, starting in 2009, Islamophobic attacks were carried out by extremist Sinhalese Buddhist organisations. Attacks, led by Buddhist monks, targeted mosques, halal certifications and slaughter-houses, and Muslim women (International Crisis Group 2013). This occurred with the tacit support of the government (Imtiyaz and Mohamed-Saleem 2015). Note that Christians have also been subject to attacks (Wickremesinhe 2016). This has continued unabated, and this repression played a part in causing the radicalisation of some Muslim groups, such as the group that perpetrated the Easter Sunday Bombings in April 2019. Sinhalese politicians have used anti-minority slogans to mobilise Sinhalese voters, and the security forces did not prevent mobs from attacking Muslims and their property in May 2019 (while the police sometimes supported it). These attacks by Buddhist militants on Muslim religious sites and businesses have continued through to the start of the pandemic (Imtiyaz 2020).

As a result of the Covid-19 pandemic, Rajapaksa declared a state of exception, and dissolved Parliament, postponing the general election for the legislature first to April and then to August 2020. The Covid-19 measures have been strict: lockdown, bans on gatherings, quarantine centres, and curfews. The military have been deployed and have arrested up to 55,000 people as 'curfew violators'. Income and food support have been insufficient, and certain populations, particularly in the Tamil areas, are reported to have been bypassed (Jayanth 2020). Muslims have been racially profiled as 'high risk' by surveillance mechanisms aimed at assessing the risk of spread in each district (Amnesty International 2020a). Two Muslim figures vocal against discrimination against Muslims have been detained without due process (Human Rights Watch 2020).

On 11 April, the Sri Lankan government made cremation compulsory for all deaths suspected of being due to the Coronavirus. This has occurred despite WHO guidelines stating that burial can be practised safely, and against the appeal of the UN Special Rapporteur on Freedom of Religion or Belief. Amnesty International sees it as an attack on Muslims on the anniversary of the Easter Bombings and in the run-up to the elections (Amnesty International 2020b). Sinhalese Buddhists are customarily cremated, but this goes against the religious traditions of Muslim and Christian communities in the country. Other measures imposed have included forbidding the touching of the body (hence *ghusl* – Muslim ritual washing is *de facto* forbidden) and banning mass gatherings and functions.

On 20 April, three Muslims were forcibly cremated in Sri Lanka, with the military, police, and surveillance mechanisms being deployed to enforce the cremation and force family members into quarantining centres (Shehadi 2020). A lawyer has presented the case to the Sri Lankan supreme court, who reviewed the mandatory cremation in July 2020.

This case study shows how a government's response to Covid-19 can exacerbate sectarian tensions and be instrumentalised to promote discrimination against religious minorities in favour of exclusivist nationalist agendas. The imposition of cremation despite the recommendations of the WHO to the contrary is one of the ways in which minorities are being attacked. Authoritarian governments can fuel ethnic and religious tensions and use fear related to the pandemic to harness political power and justify it as part of meeting public health objectives.

3 Conclusion

Different social groups, in their exercise of freedom of belief, worship, and spirituality, assign very different meanings to life, death, and the afterlife, as well as the role that the care of the dead – including the funeral and other related practices – plays in the transition to the afterlife. Particularly in fast-moving, high-mortality epidemics, the responses of the authorities often sideline or ignore the importance of mourning, of caring for the dead, and of funeral ceremonies to people in general and to religious communities in particular. Epidemic response secularism constructs itself as separate from (a reductive idea of) religion. Yet it still carries with it an unspoken and taken-for-granted ‘sense of propriety’ (Schoch-Spana 2000) regarding how people must be treated after death. Epidemic response secularism thus carries within it a latent religious morality, but one linked to modernisation, state-building, and the establishment of medical institutions. The effect is that supposedly ‘technical’ and secular policy regarding death and burials in an epidemic, when it is devised without the participation of minority groups or without due consideration, may discriminate against religious minorities. This is particularly salient when policymakers consider the trade-offs between public health goals and the continuation of customary religious practices.

Epidemic responses have often failed to achieve their goal of containing a disease through coercion. When social or religious minorities face compulsory measures in a top-down response, the result is mistrust and, on occasions, resistance. This is particularly so when people feel that they have not been able to do their duty towards their family members, God, or their ancestors, as we have seen in the case studies of compulsory cremation in Liberia and the banning of funerals in Madagascar. These dynamics of trust/mistrust are inevitably linked to historical, social, and political inequalities, which the epidemic exacerbates. These inequalities between social groups include power imbalances between majority and minority religions.

The lessons from the West Africa Ebola epidemic show that an adaptive strategy can increase trust in the response. Such a strategy can include engaging people in the design and roll-out of response activities, consulting religious leaders, decentralising care, introducing participatory forms of community engagement and communication, and so on. In terms of burials, the Liberian guidelines on ‘safe and dignified burials’ are a good example of consultation with religious communities and leaders. Through the consultation process, communities adapted their burial practices in ways that they deemed culturally appropriate. Meaning was sustained, but those practices that transmitted the disease were removed or modified. These are all positive moves that

show that religious tradition is not a fixed entity: people may be willing to change their practices.

However, as the Malagasy example highlights, one assumption behind 'safe and dignified burials' is that, if you have anthropologists and communities at the table, public health needs and symbolic needs can be reconciled. Yet the Madagascar case study highlights the issue of commensurability, and the fact that funeral practices cannot be broken down into interchangeable pieces to exchange between the realms of health and religion, 'removed from their symbolic context where they have their own efficacies and affordances' (Poleykett 2018). Malagasy funerals illustrate how people 'do not measure traditions against each other, look for equivalents and strive to resolve differences – they live with them' (Spies 2013). And this has meant living with plague in order to preserve *famadihana*. This does not mean that through further participatory dialogue with communities, these practices may not change. What needs to be acknowledged is that it may be impossible to translate concepts or practices from the realm of public health into that of religion. Therefore, the negotiation of trade-offs between epidemic risk and religious priorities must be understood as a political process, rather than a process of translation or mediation.

Epidemic response as a secular project carries with it a vulnerability to the politicisation of the response along sectarian lines. The construction of an 'emergency', to which extraordinary actions must be directed, creates a space that can be occupied by authoritarian regimes, who channel people's fear and create stigmatisation. Exacerbating ethnic and religious outlines, the epidemic response has in many countries been hijacked by authoritarian regimes to break down opposition, and, for ethnic and religious nationalist projects, to discriminate further against religious minorities. Denying Muslims their right to conduct burials, wash the body or conduct other ceremonies safely as part of the Covid-19 pandemic is a concerted attack on them. Correct checks on the executive by the legislature and the judiciary are necessary, and donors, global health institutions, and international epidemic responders have a clear duty to denounce sectarian and other forms of politicisation of the response and hold governments accountable.

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