

Key considerations: dying, bereavement and mortuary and funerary practices in the context of COVID-19 (April 2020)

This brief sets out key considerations for events related to death, burial, funerals (rites, ceremonies and practices) and mourning in the context of the global outbreak of the COVID-19. Further participatory inquiry should be undertaken, but given ongoing transmission, conveying key considerations for adapted end-of-life, mortuary, burial and funeral practices and related community engagement have been prioritised. The brief aims to provide practical considerations for partners working in the COVID-19 response. It is based on a rapid review of existing published and grey literature including insight and learning from other epidemics and infectious disease outbreaks. It should be read in conjunction with related SSHAP briefs on quarantine, physical distancing, and information in the online media.

The brief was developed for the Social Science in Humanitarian Action Platform (SSHAP) by Anthrologica and the Institute of Development Studies (IDS) with input from colleagues from York University, and Bath University. It was reviewed by colleagues at Colgate University, University of Sussex and L'Institut de recherche pour le développement (IRD). The brief is the responsibility of the SSHAP.

The experience of death is a defining human event in every culture. Specific rituals and customs may vary, but all cultures place importance on marking the passage of loved ones. Burial and funerals symbolise the connection between the deceased person and their socio-cultural networks, and for many societies, failing to conduct these appropriately can result in social and spiritual repercussions for families and communities.¹

The COVID-19 pandemic has had a profound impact on many aspects of dying, death, burials, cremation and funerals. Concerns about disease transmission have led to restrictions on visits to the dying person. High levels of mortality have overwhelmed hospital morgues and mortuaries, and uncertainties about posthumous transmission have raised concerns about how to safely manage the deceased. Physical distancing measures have limited the numbers of mourners allowed to attend funerals and other burial rites; in some cases, these gatherings have been prohibited altogether. Such changes to customary practices can have profound psychosocial and wider cultural impact. The brief outlines issues relating to (1) the experience of death and dying; (2) caring for the deceased; (3) mourning and funeral practices; (4) community reactions; (5) psychosocial impacts; and (6) media coverage.

Developing the response to dying, death, burials, cremation and funerals in the context of COVID-19 is complicated and various agencies may have responsibility and authority for different components within a country. The following key considerations are therefore intended to be broadly applicable but recognising that there may be great variation in who can be expected to implement them.

Key considerations

- When important processes related to death and dying are denied, there can be significant impact at both individual and societal levels, however, people are generally pragmatic and adaptable and will change practices if the need is understood and acceptable alternatives are agreed. The measures and restrictions adopted and the means of communicating them must be appropriate to the specific cultural context, and involvement of the wider community in their formulation and dissemination is essential.
- Beliefs and practices regarding death and dying vary widely across settings and timeframes for appropriate mourning are culturally variable. In order to fully understand the local context, assessments should be made of how funerary practices are being modified in relation to policy measures implemented in response to COVID-19. A tool to help gather information rapidly on burial practices, death and mourning in epidemics has been developed by SSHAP.²

Death and dying

- Measures that restrict people visiting dying patients may have significant psychosocial impact on patients, health workers, family members and communities. The idea of dying alone is particularly upsetting and it is important to explore ways of enabling interaction between a patient and loved ones and/or spiritual advisors in a manner consistent with distancing guidelines. Approaches will vary by context and should be developed in consultation with the wider community, including local leaders, religious leaders and influential organisations and associations, but may include the facilitation of virtual visits or the use of personal protective equipment (PPE) for in-person visits.
- If arrangements cannot be made for virtual or other visits, healthcare workers or other care staff should be present to provide end-of-life companionship and family members should be informed of this. Adequate psychosocial support systems should be in place for health and care staff involved in the COVID-19 response and particularly those who are exposed to high mortality.

Appropriate management after death

- Speed and safety in caring for the deceased must be balanced with a sense of propriety. Adapted measures should ensure that the deceased are cared for in a timely manner but must avoid being perceived as hasty or dehumanising.
- Capacity of local mortuaries should be assessed and increased and adapted where necessary. This may include the safe employment of additional staff, access to PPE equipment, arrangements for the collection of the deceased, cold storage facilities for the deceased, acquisition of land for burials and increased cremation capacity (if appropriate). The capacity of registering and recording deaths must be maintained to ensure timely death certification.

- Up-to-date and accurate information regarding risk associated with handling those who have died from COVID-19 should be clearly communicated to people who care for the deceased. Misinformation regarding the danger of posthumous infection is widespread and risks creating an atmosphere of unnecessary fear as well as mistrust of government and response teams once accurate information is conveyed.
- Changes in mortuary and funerary practice can cause distress. Families should be informed in a careful, timely and compassionate manner about what will happen with the remains of their relative and expectations must be sensitively managed. Community and faith leaders can support this process. Families should understand the different steps that will be followed, and be assured that they that they will be able to retrieve their loved ones' ashes or identify the burial site. Time should be provided for family members to ask questions and to fully participate in decisions regarding the deceased as appropriate.

Mourning and funeral practices

- Changes to established funerary practices as a result of an epidemic response have sometimes elicited community opposition. It is important not to frame 'resistance' to emergency funerary measures as coming from fixed traditions. Evidence from previous epidemics demonstrates that people are willing to adapt practices, provided (i) the new practices meet the symbolic, social and emotional needs of the original ceremonies and practices, and (ii) affected communities themselves are involved in the formulation of any proposed changes.
- Often, it is necessary to only change the medically unsafe components of caring for the deceased. When possible, as many elements of the normal practice must be preserved. When practices cannot be followed, their modification must safeguard religious freedom and incorporate spiritual and cultural values of the deceased and their family, within the limits of safety. Again, is important that family members are consulted throughout.
- In places where customary gatherings are not allowed, mourners may be encouraged to explore alternatives. During COVID-19 there have been numerous examples of rituals and ceremonies taking place remotely (e.g., memorials held over online platforms such as Zoom) and of individual participation (e.g., lighting a candle in a window). In many settings, the bereaved are being encouraged to plan a ceremony or memorial to be held once restrictions are lifted. The act of planning such an event may provide some immediate support. Practices that are chosen and managed by the family, that have personal meaning and that are aligned with personal values will be most beneficial. Families should also be reassured that they are under no pressure to explore alternatives, that there is no right or wrong, and that grieving is a process of which a funeral or other ritual is just one part.

Media reporting on COVID-19 deaths

- Reporting death and dying must be communicated with sensitivity. Statistics are important to understand the pandemic, but people should not be reduced to data points. Balanced media reporting that respects people's dignity, privacy and humanity is important. Similarly, as mortuary and funeral practices change, these must not be sensationalised but details about new measures and the reasons they are necessary reported accurately and with compassion.

The experience of death and dying in the context of COVID-19

Policies relating to death and dying. The importance of having loved ones, and often spiritual advisors, present at death is found across all cultures.^{3,4} In an effort to limit the spread of COVID-19, however, hospitals, long-term care facilities and hospices around the world have restricted or prohibited visitors.^{5,6,7,8,9,10,11,12,13} Difficult discussions about care, such as decisions about life-prolonging measures, may have to be conducted without personal interaction between the patient/doctor and the patient's family.¹⁸ In many countries, strict quarantine policies prevent people from traveling to visit a dying person.⁶ Some policies allow exceptions for end-of-life visits, usually only for one person, and require the visitor to wear PPE.^{14,15} even so, necessary protocols to screen visitors for the virus may mean that the family member does not arrive in time or cannot be allowed in.¹⁶ These restrictions mean that many critically ill patients are dying alone, or with a health care worker at their side or nearby.¹⁷

Mitigation measures. In response to concerns about the psychosocial impact of measures limiting visits to hospitals and other care facilities, private and public sector actors in many countries have implemented approaches that facilitate a level of connection between the dying person and their loved ones. In the Republic of South Korea, the Center for Disease Control and Prevention (CDC) guidelines allow family members to enter the patient's room to say goodbye, provided that PPE is worn.¹⁵ In Thailand, many hospitals have closed circuit television for relatives to see and talk with patients, and most patients also have mobile phones to communicate with their relatives.¹⁵ In Italy and the UK, patients are also able to communicate with friends and family over video-link using mobile phones or tablets.^{30,5} Donated tablet devices have made it easier for coronavirus patients at hospitals around the world to communicate with their loved ones.^{31,32,33} It has been reported that priests are giving the last rite virtually or by phone.³⁴ In many cases, health workers are themselves standing vigil for dying patients, to ensure that they do not die alone.¹⁹ The level of formal psychological intervention needs to be carefully considered and provided to the right people at the appropriate time. A major role of psychologists in this context is to support health care staff, particularly management, to create a protective and humanised environment for themselves, the patient and their family.^{29,36}

Experiences in past pandemics may also inform approaches to COVID-19 visitor restrictions. During the West Africa Ebola outbreak, biosecurity measures were adapted to enable patients admitted to treatment centres to see and communicate with family members and to allow the family to continue logistical and emotional support for the patient.¹ Visiting areas were established in 'green zones' where patients and families could interact at a safe distance. This interaction and support was particularly important at the end of life. Local religious leaders provided spiritual and moral guidance to patients and family members and played an important role in supporting culturally-appropriate shifts in burial practices.³⁵ More formal psychological service networks may also be helpful to address the psychosocial aspects of the COVID-19 response. During the Ebola outbreak in Uganda in 2000, the response recruited grief counsellors who had supported dying HIV/AIDS patients and their families before the advent of anti-retrovirals.³⁵ Somali immigrants in the US and Netherlands have past experience conducting Muslim purification rituals with family members using disinfectant, mask and gloves;⁷⁷ this might be possible in the COVID-19 context.

Caring for the deceased

While the impact of an individual's death on their family, community and health care professionals is perhaps the most immediate concern in the context of a 'usual' death, death in the context of COVID-19 presents additional, practical, difficulties. In even the most conservative models, there is an expectation that COVID-19 mortality levels may overwhelm the capacity of mortuary services. To date, there is no evidence of posthumous transmission of COVID-19,³⁷ yet concerns about and restrictions on caring for the deceased persist and may have a profound effect on families of the deceased as well as mortuary staff. As countries face rapidly increasing numbers of deaths mandatory cremations and restrictions on embalming may become more widespread. In turn, such measures can have potentially severe psychosocial impacts. The following table sets out some of the measures affecting care for the deceased that are in effect at the time of writing:

Measure	Country example
Viewing the body is allowed	Hong Kong, ³⁸ Indonesia (with precautions) ³⁹ New Zealand (only for those in the same isolation bubble as the deceased) ⁴⁰
Viewing the body is prohibited	Italy, ⁴¹ Iran, ⁴² Ireland, ⁴³ Ecuador ⁴⁴
Preparation of the body is allowed with protective guidelines	Hong Kong (PPE for mortuary staff), ³⁸ Ireland (facemask for the body while moving it), ⁴⁵ Turkey (washing and shrouding following proper precautions), ⁴⁶ Pakistan ⁴⁷
Preparation of the body is prohibited	China, ⁴⁸ Italy, ⁴¹ Iran, ⁴² Ecuador, ⁴⁴ India ⁴⁹
Contact with the body is prohibited	China, ⁴⁸ Israel, ⁵⁰ Indonesia, ³⁹ India ⁴⁹
Mandatory cremation	China, ⁴⁸ South Korea ¹⁵
Recommended cremation	Hong Kong, ³⁸ Philippines (bodies cremated within 12 hours unless religion forbids cremation) ⁴⁹
Embalming is prohibited	Hong Kong, ³⁸ Indonesia, ³⁹ Ecuador, ⁴⁴ India ⁴⁹
Body can be transported across regions/countries	US (cremated or embalmed in a hermetically sealed casket) ⁵¹ Turkey (in a "soldered" coffin to prevent leakage) ⁴⁶
Cremated ashes only permitted to be transported	China ⁴⁸

Increased mortality and response capacity of mortuary services. The high number of fatalities from COVID-19 have put mortuary systems under intense strain. A number of consequences have already been seen in the current pandemic, and past experience suggests others are likely to arise. These include:

- **Surpassing the capacity of local morgues, crematoriums and burial sites.** In the current pandemic, the crematorium in Bergamo, Italy, reached maximum capacity and the local government sought help from the military to transport bodies to crematoria in other Italian cities.⁵² In Madrid, Spain, an ice rink has been established as a temporary mortuary⁵³ and in New York City, 45 "mobile morgues" have been deployed to handle the excess mortality.⁵⁴ In parts of the UK, burial land is scarce and some local authorities anticipated the need for burial and cremation services would rapidly exceed capacity.^{55,56} There have been widespread reports of insufficient material resources, both in terms of keeping mortuary workers safe (e.g., PPE equipment) and other items (e.g., coffins).^{57,58,59} According to associations of funeral directors in the UK, the supply of adequate PPE has been insufficient to comply with COVID guidelines.⁵⁸
- **Risk of bodies not being collected.** In the present outbreak, there have been reports from Ecuador that the death toll outpaced the country's ability to handle the deceased and bodies were left on the street.⁶¹ In Spain, the bodies of dozens of elderly people were left in nursing homes for days before the military was deployed to collect them.⁵⁶ The surge capacity of countries where death, bereavement and coronial services were already under-resourced will be significantly compromised.⁵⁶ In countries recently affected by mass mortalities (due to natural disasters, conflict or epidemics) it may be possible to call on established burial teams expand capacity.
- **Delayed documentation.** High mortality places a burden on state, local and national registries as they struggle to provide death certificates. These delays can have implications for life insurance and other death benefits in locations where those are available, and should be mitigated. For example, in the UK, response measures have been updated to streamline the death management system so it can more efficiently handle the increased demand. The changes have enabled electronic transmission of required documents for death registration to support physical distancing measures and make provisions for local governments to take control of components of the death management process in the event that the death toll from COVID-19 significantly exceeds capacity.⁶²

Concerns regarding caring for the deceased. Preparing the deceased (washing, dressing and/or shrouding the body) has great significance in many parts of the world. International guidelines indicate no serious risk of posthumous transmission of COVID-19,^{63,64,37,65} although some reports do suggest the virus may survive on clothes in the immediate hours after a person's death.⁶⁶ Such inconsistencies have led to confusion about what constitutes safe procedures, despite the low risk of transmission after death.⁶⁷ In response, countries have introduced a wide range of policies and recommendations for caring for the deceased by mortuary personnel and family members, some of which are outlined in the summary table above. A number of countries, including the UK and Australia⁶⁸ discourage any familial contact with the deceased to eliminate all risk of transmission. Under the European CDC guidelines, family members are allowed to view and touch the deceased provided that PPE is used and disinfection protocols are in place.⁶⁴ In Italy, bodies are sealed in body bags at the location of death (e.g., in hospital or at home) so funeral directors are unable to prepare or dress the body as they would normally. They can lay clothes on the body in the coffin, but cannot add personal possessions that may have been provided family members.⁶⁶ Mortuary workers have described feeling deeply distressed following encounters with relatives trying to hand over drawings, heirlooms and personal notes in the hope that they would be placed in the coffin with deceased.⁶⁶ It is important to note that in many cultures, seeing the face and viewing the body of the deceased are key for both social and emotional reasons. For example, in recent Ebola epidemics in the Democratic Republic of Congo (DRC), when kin were unable to see the face of their loved ones or congregate around the body, it impeded confirmation of death, raised concerns about witchcraft and body snatching, led to negative rumours about the ulterior motives of the response, and delayed emotional closure.^{1,69}

Many countries have implemented procedures to ensure that the deceased are managed as quickly as possible in the context of COVID-19.⁴⁵ Consistent with WHO and the US CDC recommendations, guidelines in many countries require that funeral and mortuary staff treat the body as potentially infectious and use appropriate PPE, ventilation and disinfectant protocols.^{48,41,15,42,66,51} Other COVID-specific measures include placing a face mask on bodies before moving them (Ireland),⁴⁵ disinfecting remains bags (China),⁴⁸ use of temporary caskets for transportation to mortuary (Italy),⁴¹ and wrapping bodies in hospital plastic and delivering them to cemeteries within 24 hours (Iran).⁴² The WHO guidelines discourage embalming of bodies (implemented in Canada, Ireland and France).^{37,70,67} The US CDC states that embalming can be conducted following standard precautions with PPE and respiratory protection.⁵¹ Some countries, including the US, have suspended autopsies due to the potential for high viral load and increased risk.⁷¹

Mandatory/recommended cremation policies. Countries in Asia and elsewhere have enacted policies either encouraging or requiring cremation rather than burial to allow more rapid care for the deceased. In China, cremation of victims of COVID-19 is compulsory and the family's agreement is not necessary provided a medical professional agrees.⁴⁸ The Republic of South Korea has also implemented mandatory cremations as a component of their response measures.¹⁵ Both China and South Korea introduced mandatory cremation during the SARS epidemic. This precedent may impact the acceptability of mandatory cremation in these populations, although more research is needed. It can be expected that mandatory measures will be received more positively by cultures and religions that generally accept cremation, including Hinduism and Buddhism, rather those which do not routinely practice it, such as Islam and Judaism.

Funeral and mourning practices

In many countries (e.g., China, Turkey) the central or national government has enacted laws and policies regarding aspects of mortuary and funeral practices in the context of COVID-19. In some, authority may be vested, in whole or in part, in local or regional government entities, as is the case in the United States. In other countries, the government may make recommendations, but it is left to institutions (both public and private) to decide whether and how to implement them (e.g., hospital visiting policies in Ireland).

Funerals and other death rituals such as wakes and *shiva*, as well as the act of mourning itself, have been profoundly affected by physical distancing measures introduced globally in response to COVID-19. Measures differ by country and range from discouraging funerals and related rituals to the outright prohibition of funerals. Some countries have limited any funeral or related gathering to family members only. In many locations, a two meter (six foot) distance must be maintained between attendees. The table below outlines some measures implemented at the time of writing.

Measure	Country examples
Prohibited/postponed funerals and related ceremonies	China, ⁷⁸ Ghana, ⁷⁹ Brazil, ⁸⁰ Ecuador ⁴⁴
Discouraged funerals	Brazil ⁸⁰
Limited funerals and ceremonies	Italy, ³¹ Botswana (funerals to be no more than two hours), ⁸¹ Turkey ⁴⁶
Physical distancing in funerals	South Korea, ¹⁵ Ireland, ⁴³ Iran, ⁴² Pakistan ⁸²
Limitations to size of funeral gatherings	France (10), ⁴⁹ South Korea, ¹⁵ Ireland (close family members), ⁴³ Eritrea (max. 10), ⁸³ India (max. 20) ⁴⁹
Encouraged postponement of funerals	South Korea ⁴⁵
Restricted travel to attend funerals	South Africa (only immediate family members and those closely affiliated who live outside a province of metropolitan area can travel in to attend a funeral) ⁸⁴
Prohibited placement of personal items in coffins	Italy ⁶⁶

Community reactions

Community acceptance is essential to the successful uptake of any policy related to death and burials, particularly in an emergency context. Opposition to funeral practices may result as part of broader resistance to epidemic response measures, particularly when there is lack of trust in central authorities or government. Epidemics can exacerbate political fault lines and inequalities between social groups, and response activities (including changes in funeral practices) can contribute and further magnify these.⁹⁵ During the 2008-2009 cholera epidemic in Zimbabwe for example, the lack of understanding about changes in funeral policies fuelled increased resentment against the authorities.⁹⁶

Opposition to changes in funeral practices during a pandemic may also result from the failure of response agencies to fully understand local customary practices, to involve community members (including leaders and local community associations) in planning alternative practices, or to fully explain modifications and why they are needed. In Liberia, as elsewhere in West Africa and beyond, burial is an important component of becoming an ancestor, linking generations and heritage.⁹⁷ In response to limited burial plots and concerns about the rising water table during the early phase of the 2014-2016 Ebola outbreak, the government introduced mandatory cremation, a practice not widely conducted in the country. The population was deeply troubled by this, particularly as an individual's ashes could not be identified or returned to their family. In light of increased opposition, the government made it a criminal offense to hide bodies to prevent cremation⁹⁴, yet communities continued to frequently conducted local burials (which were deemed illegal). Similar opposition was encountered in Sierra Leone and Guinea. However, as the epidemic continued, response agencies, most notably the International Federation of the Red Cross and national Red Cross and Red Crescent Societies, modified their standard protocols to ensure burials were both safe and dignified. Working with community members, they progressively adapted burial practices to balance community needs and public health priorities and to create acceptable guidelines. Similarly steps are now accepted as good practice and are essential in the context of COVID-19.

Psychosocial impacts

Psychosocial impact of hospital restrictions. Prohibiting visits to hospital can be distressing for the patient, relatives and the wider community. The fear of loved ones dying alone is widespread and a cause for concern.¹⁹ In many countries, particularly those with fragile health systems, family members are an integral part of patient care and support. In West Africa, for example, illness is regarded as a collective problem involving family and community. Family members accompany patients to health facilities and support them emotionally and logistically, providing food and negotiating treatment with health workers.¹ Past experiences (e.g., during the West Africa Ebola outbreak) have also shown that preventing visitors can adversely affect trust in response teams and can be a major deterrent to engagement with response actions.^{20,21,22} Previous disease outbreaks have also highlighted the intense emotional strain that working with elevated mortality can have on health workers^{23,24,25} and this has already been seen in the current pandemic.^{26,7,8,27} The emotional impact may be magnified when difficult choices need to be made about who to prioritise for medical intervention, such as ventilation, when resources are limited,^{28,29} or when the deaths are particularly unexpected, such as those involving children and younger people, and those without co-morbidities.²⁶

Psychosocial impact of changes in mortuary practices and mitigation strategies. In times of grief, people expect and rely on a degree of certainty regarding what will happen to their loved ones. Changes in mortuary practices during the COVID-19 pandemic have altered normal and predictable care for the deceased. In China, Spain, Italy and other countries it has been reported that changes have not always been made clear to grieving families and there has been uncertainty as to whether their loved one would be cremated, where and when, and how to receive their ashes. Engagement with communities and good communication are essential and will encourage acceptance of changes in mortuary practices. Given the serious psychosocial impact and distress caused by uncertainty associated with care for the deceased, it is important that communication between the family and those caring for the deceased be ongoing, open and detailed to remove as much uncertainty as is possible. Acceptable care for the deceased may differ according to religious, ethnic and cultural group and it is essential to guard against actions that may be perceived as disrespectful or contrary to existing traditions. Mandatory cremation, in particular, may be very disturbing for families who would not normally choose this for their loved one. In Sri Lanka, authorities have cremated casualties of COVID-19 against their families' wishes.⁷² In India⁷³ and the UK,⁷⁴ Muslim, Jewish and Christian communities have resisted mandatory cremation policies, and it is expected that opposition will be encountered in other multi-ethnic countries. Parliamentary ministers in the UK have argued that principles of religious freedom should be safeguarded⁷⁵ and exemptions to proposed legislation on religious grounds have been allowed.⁷⁴ As part of Israel's response, Tahara, the Jewish purification rite, was prohibited. Members of the Chevra Kadisha, the country's religious burial society, challenged the national guidelines, arguing that preventing people from being buried as a 'human being' would destroy community morale at a time when it was most needed. The recommendation was subsequently revoked.⁷⁶ Beyond the deceased's family, acceptable care has implications for the wellbeing of staff, including those working in healthcare settings, nursing homes and funeral homes. Individuals often have ideas about what constitutes a 'good death', and psychological harm can result when staff feel they would have wanted the deceased to have been treated differently.²⁸

Psychosocial impact of changes in mourning and funeral practices and mitigation strategies. Funerals rites are a well-documented means by which communities express emotion, say goodbye and heal. Mourning and funeral practices are being substantially reshaped due to COVID-19.⁴⁵ Changing policies around burial and funeral rites may exacerbate feelings of uncertainty, loss and desperation, and new guidelines may affect the family's ability to process loss. Having no personal proof of death and not being able to bury a person in an acceptable way may make families and communities vulnerable to 'ambiguous loss' in which the experienced loss is not verified, the grieving process is frozen and the natural human need for meaning, sense, knowledge, connection and ritual is denied.⁸⁵ This void can have a continuing and devastating impact on everyday life and long-term mental health. During previous outbreaks (such as during the Ebola outbreak in West Africa) physical distancing and separation measures compounded feelings of grief, loss, distress, guilt and helplessness amongst family members.^{24,86}

Maintaining a compassionate approach to burial and funeral rites is difficult in outbreak situations where relatives cannot be present.¹ In China, funerals were forbidden in early February, and mourners have been unable to perform the Taoist and Buddhist burial rituals that would comfort them and help to ensure the deceased a peaceful passage to the afterlife. In the many countries where funeral rites are an entrenched part of social life the strict measures banning funeral ceremonies may have severe psychological consequences for the family and community of the deceased who are unable to perform burials in their accustomed and correct manner.

Efforts can be made to alleviate the pain caused by modified regulations for burials and mourning rituals. Examples of this have occurred in other epidemics, for example during the Ebola outbreak in DRC families have planted trees as a way to remember their loved ones. Alternative rituals are underway in many places in the current pandemic too, the Madrid regional government has proposed daily observation of a minute of silence and flying flags at half-mast;⁸⁷ in Italy, police officers have been seen saluting vehicles carrying the deceased.⁸⁸ In Italy and France, undertakers and funeral directors have assumed the responsibility for the deceased and for ensuring, in the absence of family and friends, that bodies are buried with dignity and empathy.^{66,89} Families in the Netherlands have asked friends and relatives to send postcards, letters and photos of the deceased to be included in a later ceremony. In the UK, people have put candles in their windows to memorialise friends and family who have died. Jewish mourning *shiva* calls and funerals in many contexts are being conducted through online platforms.⁹⁰

How acceptable these approaches are to family members as an alternative means of honouring the dead is uncertain, but it should be remembered that previous outbreaks have shown people to be generally pragmatic, adaptable and willing to change practices if the need is understood and acceptable alternatives are agreed.⁹¹ It may be helpful to encourage families to think about available alternative rituals and ceremonies without putting pressure on them, emphasising that there is no right or wrong.^{92,93} However, as was flagged by anthropologists in the wake of the West Africa Ebola outbreak,⁹⁴ the importance of one-off rituals need not be overemphasised, as mourning is a long and complex process.

Media coverage of death in the context of COVID-19

Credible journalism and reporting is critical during a public health crises when increased and intense media influence has the potential to affect the outbreak and its response both positively and negatively.¹¹¹ How the media discuss death and dying is particularly important during an infectious disease outbreak. In Ebola preparedness and response activities in West and East Africa, dramatic and oversimplified media messages like 'Ebola Kills' increased fear and may have fuelled community opposition to response activities.^{98,99} To date, media reporting of COVID-19 has shown similar tendencies to emphasise the dramatic, including focusing on statistical models predicted wide ranging death rates presented in a stark numerical form.¹⁰⁰ From the early days of COVID-19, people around the world have been closely following the number of actual and projected deaths on a daily basis.^{101,102}

Given the global nature of the pandemic, press coverage has far reaching impact, particularly as it often includes powerful images related to death. For example, images of coffins in Italy have circulated in media across sub-Saharan Africa (e.g. DRC, South Sudan, Uganda) resulting in widespread fear with people asking "if people in Europe with such good healthcare are dying, what about us?"¹¹⁰ This genuine concern must be recognised. Any approach to modified death, mortuary and burial practices will be viewed against this backdrop, and directly addressed with sensitivity by responders.

More recently, media outlets have started to put a human face on the pandemic, with accounts of survivors^{103,104} and tributes to those who have died.^{93,105,112} These stories, largely from reporters in Europe and the United States, have developed, at least in part, as a reaction to the threat of COVID-19 becoming more immediate and personal as it spread beyond Asian countries. The European media has described the pandemic as "making us consider our own mortality and that of our families".¹⁰⁶ Most societies are reluctant to talk about death, although it has been suggested that Western societies may be further along the 'death anxiety' spectrum¹⁰⁷, yet media sources are now reporting recommendations that families begin to talk about death in order to know the wishes of their loved ones.^{108,109} Being open about final wishes may be particularly important in the current context, as COVID-19 related illness can progress quickly and family contact in formal care environments is limited.

Related SSHAP COVID-19 briefs

Key considerations: Quarantine in the context of COVID-19.

<https://www.socialscienceinaction.org/resources/february-2020-social-science-humanitarian-action-platform/>

Compliance with physical distancing measures for COVID-19 and implications for RCCE in Eastern and Southern Africa.

<https://www.socialscienceinaction.org/resources/compliance-physical-distancing-measures-covid-19-implications-rcce-eastern-southern-africa-april-2020/>

Key considerations: Online information, mis- and disinformation in the context of COVID-19.

<https://www.socialscienceinaction.org/resources/key-considerations-online-information-mis-disinformation-context-covid-19/>

A range of additional social science resources related to COVID-19 are available through SSHAP at www.socialscienceinaction.org/update-novel-covid-19-outbreak/

Contact

If you have a direct request concerning the response to COVID-19, regarding a brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Olivia Tulloch (oliviattulloch@anthrologica.com) and Santiago Ripoll (s.ripoll@ids.ac.uk). Key Platform liaison points include: UNICEF (nnaqvi@unicef.org); IFRC (ombretta.baggio@ifrc.org); and GOARN Research Social Science Group (nina.gobat@phc.ox.ac.uk).



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