Research Article

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"More than an intensive care phenomenon": Religious communities and the WHO Guidelines for Ebola and Covid-19

„Mehr als ein Phänomen der Intensivpflege": Religiöse Gemeinschaften und die WHO Richtlinien für Ebola und Covid-19

Abstract: This article draws on anthropological fieldwork conducted during the West African Ebola outbreak (2014-2016) and reports of the ongoing Covid-19 crisis to discuss the role played by religion in infectious disease control. While much separates Ebola and Covid-19, the religious practices prevalent in both contexts produce similar challenges to hospital staff and caregivers. In West Africa, at least 20 % of all infections were suspected to be related to the burial of deceased Ebola victims; yet at the same time, local communities at times reacted very negatively to infectious disease control measures. This article discusses how, based on this recognition, a systematic exchange began between anthropologists, faith-based organisations (FBOs) and humanitarian organisations active in the provision of healthcare, culminating in a WHO protocol for the "safe and dignified" burial of Ebola victims. The model of 'contactless' adaptations of religious practices it put forth may have significantly contributed to the control of the epidemic. In the second part, this article turns to the Covid-19 pandemic to show how religious communities have responded to the risks associated with many religious practices, and how the WHO, drawing on its experience with Ebola, developed comparable guidelines aimed at religious leaders and faith communities. As the experience in West Africa has shown, it is argued, the active involvement of religious actors in the formulation of public health measures may not only help to provide safe comfort in the midst of a profoundly alienating experience, but significantly reduce the spread of the virus.

Zusammenfassung: Dieser Beitrag bezieht sich auf anthropologische Feldforschung während der Ebola-Krise in Westafrika (2014-2016) und Berichte der gegenwärtigen Covid-19 Pandemie. Obwohl sich die Ebola-Krise und die Covid-19 Pandemie in vielem unterscheiden, werden Gesundheitsfachpersonen vor ähnliche Herausforderungen gestellt. Während der Westafrikanischen Ebola-Krise wurden mindestens 20 % aller Infektionen mit Begräbnissen in Verbindung gebracht; zugleich reagierten örtliche Gemeinschaften zum Teil äußerst negativ auf Maßnahmen der Infektionskontrolle. Dieser Artikel diskutiert wie, aufgrund dieser Erkenntnis, ein systematischer Austausch zwischen Anthropologen und Glaubens-basierten Organisationen (FBOs) und im örtlichen Gesundheitswesen tätigen humanitären Organisationen erfolgte. Diese Konsultation mündete in einem WHO-Protokoll zur "sicheren und würdevollen" Beerdigung von Ebola-Opfern; das darin enthaltene Modell der Entwicklung "kontaktloser" religiöser Praktiken trug scheinbar maßgeblich zur Eindämmung der Ebola-Epidemie bei. Im zweiten Teil wendet sich der Artikel der Covid-19 Pandemie zu und zeigt, wie religiöse Gemeinschaften auf die mit ihren Praktiken verbundenen Risiken reagiert haben und wie die WHO, aufbauend auf ihrer Erfahrung mit Ebola, vergleichbare Richtlinien für die Covid-19 Pandemie erstellte. Es wird argumentiert, dass die Erfahrung in West Afrika gezeigt hat, dass die aktive Involvierung religiöser Akteure in der Formulierung öffentlicher Gesundheitsmaßnahmen nicht nur hilft sicheren Komfort in einer zutiefst verstörenden Erfahrung zu ermöglichen, sondern die Verbreitung des Virus vermindern kann.

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In face of the unprecedented crisis wrought by Covid-19, it pays to be reminded of the most recent infectious disease epidemic to dominate international headlines: The West African Ebola-crisis. The epidemiology of the Ebola crisis in many ways differs from the current Covid-19 pandemic. Like SARS-CoV-2, the virus which causes Covid-19, the Ebolavirus has been suspected to have originated in bats and jumped to human hosts. First identified in 1976 in South Sudan and the DR Congo, the virus flared up periodically until a large outbreak occurred in Sierra Leone, Liberia and Guinea between 2014 and 2016. With a reproductive rate of 1.5, it spread more slowly than the Coronavirus. But with a mortality rate of 25 % to 90 %, Ebola was far more deadly than Covid-19 (World Health Organization 2020 c, 2020d). In the three-year period of the epidemic, barely 30,000 suspected cases and just over 10,000 deaths were counted. (Boisen et al. 2016).

Perhaps due to the relatively few cases and the geographic and cultural distance between sub-Saharan Africa and Europe, the Ebola crisis had a relatively small impact on global pandemic preparedness, and the Coronavirus outbreak caught European and American governments off-guard. The U. S. response came in mid-March, woefully unprepared after the virus had been downplayed as a 'hoax' for weeks by the Trump administration and right-wing media, and in the wake of two high-profile departures of national security officials tasked with biodefense (Dawsey et al. 2018; Sun 2018). Initially, leading health authorities, including the WHO and the U. S. surgeon-general, did not recommend the general public to wear facemasks. Though essential hygienic articles in every hospital ward, microbes seemed to play by different rules in public spaces, and the prevalence of facemasks in East Asia – where supplies are relatively abundant – was typecast as "local cultural habits" (World Health Organization 2020 e: 1).

While the time will come to learn the political lessons of the Coronavirus pandemic, the Ebola crisis offers several valuable precedents which may inform the institutional response to the current crisis. Covid-19, wrote a group of intensive care physicians at Papa Giovanni XXIII Hospital in Bergamo – by far the hardest-hit region of Italy – is the "Ebola of the rich". And like Ebola, it is "more than an intensive care phenomenon". It requires not patient, but community-centred care, and the collaboration of social scientists, psychologists, social workers, and so on (Nacoti et al. 2020: 3). It is in response to this call that this article reviews the challenges faced in West Africa and points out the role social scientists and spiritual care workers played in the Ebola outbreak, and have begun to play in the present Covid-19 pandemic.

'Cultural mediation' during the Ebola outbreak

In September 2014, Ebola cases were doubling every month, with Guinea, Liberia and Sierra Leone at the epicentre of the outbreak. "As soon as a new Ebola treatment facility is opened", WHO reported that month, "it immediately fills to overflowing with patients, pointing to a large but previously invisible caseload." In Monrovia, the capital of Libera, "taxis filled with entire families, of whom some members are thought to be infected with the Ebola virus, crisscross the city, searching for a treatment bed. There are none." Sent away at every turn, the sick "have no choice but to return to their communities and homes, where they inevitably infect others". As the medical crisis began to turn into an unmitigated humanitarian catastrophe, calls within WHO for "non-conventional interventions" became louder (World Health Organization 2014 b: paras 6, 18).

In response to a growing awareness that lack of cultural knowledge rendered ineffective much of the international humanitarian response, a group of anthropologists in the UK founded the "Ebola Response Anthropology Platform" and began to analyse the cultural complexities involved in the global Ebola-response. Similar initiatives emerged in the U. S. (American Anthropological Association 2014a), and among scholars from Holland, Belgium and France, as well as through the West African Network for the Anthropology of Emerging Epidemics (RAEE). A major conference was held in Dakar in mid-2015 (Desclaux & Anoko 2017). The findings of anthropologists were taken seriously. In the UK, the Department for International Development (DFID), the Ministry of Defence and the Government Office for Science established formal relationships with the Platform (Martineau et al. 2017). The data shared in this way soon pointed to the importance of burial and bereavement practices, in particular those which included touching, kissing and washing of bodies. The first confirmed case in Sierra Leone was traced to the burial of a traditional healer, a "super spreader" in Guinea which had led to 365 Ebola deaths. Local authorities suspected traditional burials to be connected to 60 % of all cases (World Health Organization 2014a), while a former WHO expert on Ebola suggested a more conservative but still remarkably high 20 % of all infections to have occurred during burial (World Health Organization 2014c).

Standard procedures for the "safe management" of a dead Ebola body were deeply distressing for many communities: a team wearing full protective gear arrived at

the scene, sometimes escorted by armed military personnel, disinfected domestic spaces, burned all personal effects and removed the body for cremation. At times this process was understood as a form of "persecution" (Desclaux & Anoko 2017: 479). The account of James Fairhead, an anthropologist of West Africa at Sussex, of the Kissi people in Guinea's Forest Region is illustrative of the disruptive effect this had in many communities. According to Fairhead (2016), improper burials had grave repercussions for those left behind, threatened the sacred order of a community and attracted the wrath of ancestors (Paulme 1954). Unsurprising in this context is the considerable resistance encountered by medical workers – the Red Cross recorded an average of ten attacks per month, verbal and physical, on its workers; hostages were taken; vehicles and health centres were torched; the spraying of a market with disinfectant triggered a riot which left ten people wounded, and in September 2014 a delegation of eight physicians, politicians and journalists were murdered (Fairhead 2016). Afraid of not finding a person again once they had been taken to a hospital and losing the opportunity to say farewell and conduct a proper burial, the infected and the dead were sometimes hidden from visiting health workers. The threat of being quarantined themselves, the stigma of infection which extended into their community through contact tracing, as well as the loss of income further contributed to the underreporting of cases and the death of people in the homes of relatives (Allen et al. 2015; Desclaux & Anoko 2017).

An important way forward identified by anthropologists working on the ground was adjusting the manner in which Ebola control teams interacted with local communities. Consider the following example documented by Julienne Anoko, an anthropologist employed to assist WHO and UNICEF during the Ebola outbreak. Faced with the task of burying a pregnant woman, a Red Cross team encountered strong resistance from the community. Because of the strict ordering of the reproductive cycles of life and death in Kissi culture, the burial of a pregnant body implied a major transgression of the sacred order. Extraction of the fetus was considered too dangerous, and even members of the burial team refused to look at the body or transfer it into a bag. Left in the open, it began to decompose. Through a negotiation between the health workers and a village elder mediated by Anoko, an agreement was reached that a ritual could be conducted to repair the transgression and "appease the anticipated wrath of the dead". The WHO paid $660 for a cleansing and burial ritual, and the team was permitted to continue contact tracing (Fairhead 2015: 5-6; Anoko 2014).

Successful cases of such "cultural mediation" (Desclaux & Anoko 2017) were rare, but pointed to the possibility of meeting the needs of both Ebola control teams and local communities. Premised on work such as that of Anoko – who was awarded the "Research And Innovation Award" by the French Red Cross for her work during the Ebola epidemic (World Health Organization, n.d.) – the Platform suggested health authorities and humanitarian organisations to take seriously and actively engage with the religious practices of local communities. The Institute for Development Studies at the University of Sussex, for example, advised the All Party Parliamentary Group for Africa – a group of parliamentarians in the House of Commons and House of Lords – on matters such as mistrust and exclusion, and the critical importance community ownership of control measures (Institute for Development Studies 2015).

Knowledge of the spiritual needs of local populations helped to adjust humanitarian aid. An evaluation co-funded by DFID and the Wellcome Trust, for instance, provided detailed recommendations on the operation of community-based care centres, including the consultation of elderly to facilitate appropriate burials (Oosterhoff et al. 2015). A separate DFID briefing advised that humanitarian interventions must consider that

> the approach to village communities in such traumatic circumstances should be to ally with them in expressions of grief, concern and solidarity, and then to recognize that cultural and behavioural change will come most effectively if they are offered space in which to exercise their own collective understanding of ways to mitigate the moral and societal risks (Richards & Fairhead 2014: 1).

In other words, not carrying out funerals was not an option:

> Not attending a funeral, or not carrying out procedures deemed to be correct or necessary creates a huge burden of guilt among the negligent. They have sinned. No amount of "health education" about risks of EVD [Ebola Virus Disease] will alter this burden of guilt. [...] Enforcement of little understood sanitation rules by strangers with no connection to the deceased are likely to be resented and resisted. No authority stands above what people consider to be a moral imperative (Richards & Fairhead 2014: 2).

Instead, communities should be advised on how to modify burial practices to reduce the risk of infection. The custom of placing of money on the ground of the burial was instructive. The laying of a stone or other item at the grave and moving this stone to the native village of the deceased, so that the person could be returned to her ancestors by 'proxy', was cited as a further example of an exist-

Fig. 1: Selected illustrations from the WHO guideline created for the West African Ebola outbreak. Reprinted from World Health Organization, "How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola or Marburg virus disease – Interim Guidance". Copyright (2017).

ing practice which could be used to avoid infection without inflicting distress on the relatives, effectively increasing their willingness to cooperate with Ebola control measures.

The U. S. Center for Disease Control and Prevention was similarly advised on a wide range of persistent problems in Liberia, including denial of the existence of the disease, extreme opposition to cremation deemed abhorrent by some Muslims, the importance of washing bodies, the prevalence of secret burials, and the creeping "public health emergency order fatigue", which was diminishing the effectiveness of Ebola control measures (cf. the report of the American Anthropological Association 2014, and the "briefings and guides"-section of the Ebola Response Anthropology section on ebola-anthropology.net). The cooperation of local religious leaders was identified as critical to sanctioning public health advice and changing burial practices – for instance, when an Imam via radio broadcast permitted burial without washing (Allen et al. 2015). Such cooperation with affected communities and their religious leaders was widely recognised as a key factor in halting the Ebola

epidemic. As David Nabarro, UN Special Envoy on Ebola put it,

> [t]he local community organisations, neighbourhood watch committees, churches, mosques and other groups, they are really, really important [...] if they are part of the response, if they own the response, then everything is okay. If they are not part of the response, then we get problems (Feig 2015).

A "game-changer" in this respect was the WHO's guideline on how to conduct "safe and dignified" burials for Ebola victims, developed in September 2014 in collaboration with the Red Cross and Red Crescent, the World Council of Churches, Islamic Relief, Caritas Internationalis and World Vision (Marshall 2017: 631; Marshall & Smith 2015: 25; World Health Organization 2014c). Since 2003, WHO had included anthropologists in its response teams for haemorrhagic fevers in Central Africa in an attempt to "adapt" and "humanise" health interventions, and anthropologists were again consulted in the creation of these guidelines (Desclaux & Anoko 2017: 478; World Health Organization 2014c). Last updated in 2017 (World Health Organization 2017), the guidelines described

twelve steps intended to arrive in the family home in a non-threatening manner, establish consensus concerning the removal of the body and the manner of its burial, sanitising the home and the victim's personal belongings, and so on. As the guidelines recognised,

> [t]he burial process is very sensitive for the family and the community and can be the source of trouble or even open conflict. Before starting any procedure the family must be fully informed about the dignified burial process and their religious and personal rights to show respect for the deceased. Ensure that the formal agreement of the family has been given before starting the burial. No burial should begin until family agreement has been obtained (World Health Organization 2017: 1).

The guidelines stipulated that every burial team should be accompanied by a "communicator" and a "religious representative" not wearing any personal protective equipment to act as a bridge between biomedical and religious worlds, as had Anoko. The burial team should offer condolences upon arrival and arrange to meet a "local faith representative" at the place of collection for the burial (World Health Organization 2017: 4). It was expected to carry a list of religious representatives who could be called for families who did not have any such contacts. Religious considerations were made at every step of the process. Thanks for the life of the deceased should be given. Separate instructions were provided for the burial of Christian and Muslim patients. For Christians, it was advised that "non-contact" adaptations were found and agreed on by the community:

> Give the family opportunity to view and an alternative to touching and bathing the body – e.g. sprinkling of water over the body or reading a scripture – placing the written scripture verse on the body before closing the body bag… their needs to be locally adapted and discussed (World Health Organization 2017: 6).

For Muslims, detailed instructions for "dry ablution", proven to be acceptable in many cases, were provided:

- A short Arabic prayer of intention is said over the deceased.
- The hand of the Muslim Burial team member carrying out the dry ablution (in PPE [Personal Protective Equipment]), softly strikes their hands on clean sand or stone and then gently passes over the hands and then the face of the deceased. This symbolically represents the ablution that would normally have been done with water.
- A short Arabic prayer is said over the deceased.
- The body bag is closed if no request for shrouding has been made (World Health Organization 2017: 8).

A further non-contact adaptation included instructions for the appropriate use of a burial shroud for Muslims, and the possibility to obtain permission from an Imam to use a body bag to represent a shroud.

As these cases demonstrate, through mediation between the biomedical logic of public health interventions and the religious cosmologies inhabited by local communities, burial and bereavement practices could be adapted to satisfy both the needs of Ebola control teams and the bereaved families. Pioneered by anthropologists associated with the Ebola Response Platform, this model was taken up by health workers and became institutionalised through the development of the WHO guidelines on "safe and dignified" burials. According to a recent study, the Red Cross' use of this protocol reduced the epidemic between 4.9 % and 36.5 % (Tiffany et al. 2017). The employment of these mediators moreover may have not only decreased the risk of infection from dead and dying Ebola patients, but reduced the suffering wrought by feelings of transgressing a sacred order; the stigmatisation and ostracism of infected individuals blamed for such transgressions; rumours and attacks on Ebola control teams, and the abandonment or 'stealing' of the dead. By developing trust in medical authorities, they may have increased the reporting of cases, hospitalisation rates and cooperation with contact tracing.

Spiritual needs and institutional responses to Covid-19

Media accounts and the response of many governments to the Ebola crisis fit well into prevalent perceptions of African 'backwardness'; as a sample of over 300 media reports on Ebola suggested, beliefs such as those of the Kissi people were often subtly characterised as "exotic and mystifying", and Doctors Without Borders, the U. S. Center for Disease Control and Médecins Sans Frontières insisted on the clear subordination of local practices to biomedical expertise (Moran 2017: 407). Much like during the Ebola outbreak, public health responses to Covid-19 were delayed by months until the crisis fit the "outbreak narrative" ("a disease emerges in a remote location and spreads across a world highly connected by globalisation and air travel to threaten 'us all'"), at which point it was taken seriously as a 'global security' concern, and major Western powers deployed the military to 'combat' the outbreak (Wilkinson & Leach 2015: 138; Wald 2008). As in the West African Ebola crisis, subtle implications of irrationality – such as relating to the draconian Chinese quarantine measures or the pervasive East Asian "cultural habit" of wearing facial masks – potentially delayed and compromised public health responses in Europe and the U. S.

As far as local faith communities are concerned however, the experience in West Africa has been increasingly recognised as a valuable lesson by leading scholars of religion and global health (Marshall et al. 2020) and in some instances has begun to inform public health policy. In Tanzania, WHO and other UN agencies began working with the ministry of health to repurpose Ebola healthcare workers, rapid response teams and isolation units for the Covid-19 pandemic (World Health Organization, Regional Office for Africa 2020). According to the WHO Regional Director for Africa, an "important lesson" from the Ebola outbreak was to begin work at the community level early, to actively engage community groups and to listen to them – "not just to send radio messages, but to talk to people and hear them"(United Nations Africa Renewal 2020). Similarly, the Human Rights Watch deputy director for Africa has stressed community engagement and -communication and the involvement of locally respected individuals and institutions as key to building trust in, and cooperation with, infectious disease control measures (Sawyer 2020).

Both Ebola and Covid-19 are "diseases of social intimacy" spreading through migration, marriage, funeral, family ties and markets (Richards et al. 2015). And, like in West Africa, in the Covid-19 pandemic religious communities played a decisive role in the spread of the virus. In early March, over sixty percent of all confirmed Covid-19 cases in South Korea were linked to a funeral of an influential member of the Shincheonji Church of Jesus in Daegu, and the church was heavily criticised for not complying with health authorities (Rashid 2020). Religious practices presented ready pathways for the rapid spread of the virus. In Georgia, Romania, and Greece, the Eastern Orthodox tradition of using a single spoon to distribute wine to the congregation was continued weeks into the Covid-19 pandemic (Roth et al. 2020). Kissing, touching and washing of bodies is practiced in Orthodox Judaism (kissing the phylactery), Roman Catholicism (kissing the cross in the hand), and is permissible for and at times practiced by Muslims. Anointment of the sick is commonly practiced in the Catholic tradition, and ablution has historically been a part of Islamic traditions and continues to be observed to this day. Finally, both in West Africa and the global North, the seeking of physical intimacy at times of departure is a human need regardless of creed, and is sanctioned by palliative care guidelines such as those of the German Society for Palliative Medicine (Deutsche Gesellschaft für Palliativmedizin 2015).

National ministries of health have responded to the relatively high risks associated with these practices by requiring strict sanitary rules, particularly in the treatment of dead bodies. Irish health authorities, for instance, advised mortuaries to place face masks on dead bodies, while in Israel, bodies were recommended to be twice wrapped in plastic, ritual washing to be performed wearing full protective equipment, and for burial again wrapped in plastic instead of the traditional burial cloth (Amante et al. 2020). However, unlike haemorrhagic fevers such as Ebola, bodies of those who have passed away from Covid-19 are generally not infectious and do not require cremation (World Health Organization 2020f). The widespread use of guidelines for safe and dignified practices comparable to those for burial of Ebola-victims, then, appears incumbent in order to ensure that public health measures are based on the available medical evidence and accompanied by suitable arrangements to increase the likelihood of community cooperation.

During the Covid-19 pandemic, mediation between spiritual needs and medical institutions is often conducted by chaplains and spiritual care givers working as part of clinical care teams. Professional associations, such as the American Association of Professional Chaplains and the National Association of Catholic Chaplains, have worked to disseminate best practices, particularly regarding non-contact adaptations of prayer and blessing rituals. In German-speaking Europe, guidelines for dealing with Covid-19-related issues were created in mid-March, with the intention of facilitating the rapid implementation of rules regulating visits by relatives, and safe and dignified access to the dead. Researchers based at the University of Münster and the University of Zürich began to consult with a team of medical professionals, theologians and academics of spiritual and pastoral care to further refine these guidelines. On this basis, a platform was launched which, much like the Ebola Response Anthropology Platform, requested submissions from the wider German-speaking community of spiritual and medical care professionals. Its website (covid-spiritualcare.com), co-founded by the present author, was soon flooded by reports and inquiries from physicians, Catholic and Protestant spiritual care workers, hospital chaplains and graveyard employees. Through a recursive process of data gathering and -analysis, several subsequent iterations of the guidelines were produced, and sections on prayers and rituals appropriate for isolation units, videos on the correct use of personal protective equipment, theological discussions and experience reports were added to the website (see the editorial of this issue).

Similar initiatives emerged in the U.S.: The Chaplaincy Innovation Lab, a network of U.S.-based scholars and chaplains, for instance, soon began to offer webinars on telechaplaincy, virtual prayer sessions and town-hall

meetings, and resources on topics like professional self-care, loneliness, and so on. The Emory University Interfaith Health Program and the Institute for Spirituality & Health at George Washington University began to aggregate and disseminate resources, ranging from prayers to inter-disciplinary work spanning theology, public health and religious studies. Globally, UNICEF in partnership with Religions For Peace – a coalition founded in 1970 to promote multi-religious cooperation – launched the "Global Multi-Religious Faith-in-Action COVID-19 Initiative". It aims to leverage its partnerships to adapt religious practices and so reduce the risk of infection with the Coronavirus, promote the voice of local faith communities, inter-generational dialogue and "religious teachings and sacred texts that emphasize cleanliness as an element of holiness"; counter stigma and discrimination, and provide voluntary services including spiritual care (UNICEF & Religions for Peace 2020).

Lastly, the Berkley Center for Religion, Peace & World Affairs at Georgetown University in Washington, D.C., conducts webinars and consultations and maintains a vast and continually updated resource repository in co-operation with the Joint Learning Initiative on Faith & Local Communities, an international collaboration collecting evidence of the work of faith-based organisations. One consensus reached during a consultation held in mid-March between leading academics, medical specialists and directors of major faith-based humanitarian agencies was that both national and international public health officials "quite well appreciated" the importance of involving religious communities, but that "specific measures" were lacking to "translate that awareness into practice". Again, the experience with Ebola informed the discussions – for instance, through a successful collaboration with churches to send text messages with health advice signed by local bishops, which has been replicated during the Covid-19 crisis by using a WhatsApp group to disseminate messages "on the authority of bishops worldwide" (Berkley Center for Religion, Peace and World Affairs & World Faiths Development Dialogue 2020: 1, 2, 4).

In late March, the World Health Organization followed with guidelines aimed at healthcare facilities, families, and religious and public health authorities concerning the appropriate handling of Covid-19 bodies. "The dignity of the dead, their cultural and religious traditions, and their families", it recommended, "should be respected and protected throughout"; "hasty disposal of a dead from Covid-19 should be avoided", and

authorities should manage each situation on a case-by-case basis, balancing the rights of the family, the need to investigate the cause of death, and the risks of exposure to infection (World Health Organization 2020f: 1).

In early April, this was followed by a detailed, six-page "interim guidance" (World Health Organization, 2020g) developed by the WHO's Information Network for Epidemics (EPI-WIN) established during the Coronavirus outbreak to counter an "infodemic" of "mis- and disinformation" (World Health Organization 2020a). Initiated in response to the rapid spread of the virus in faith communities such as those in South Korea and Iran, it aimed at religious leaders and their communities, and was developed in consultation with well over sixty individuals and FBOs, including among others, World Vision International, the World Council of Churches, the ACT alliance, Islamic Relief USA, the Lutheran World Federation, Caritas Internationalis and current and former scholars and UN programme executives of faith-based initiatives and community engagement. The consultation built on a WHO-internal structural review which had followed the Ebola-crisis, and many of the contributors had already been involved in the earlier guidelines on "safe and dignified" burials of Ebola victims (interview with a former UN programme executive, April 2020).

The document identified religious leaders and faith-based organisations as playing a "major role in saving lives and reducing illness related to COVID-19" by providing a "primary source of support, comfort, guidance, and direct health care and social service, for the communities they serve." It portrayed religious leaders as "a critical link in the safety net for vulnerable people", particularly in the dissemination of "health-saving practices" and the reduction of "fear and stigma". Rather than hindrances to public health policy, as religious practices have often figured in public health discourse, the WHO thus acknowledged the positive contribution of faith communities and addressed them as valuable partners. It offered practical suggestions regarding possible non-contact adaptations: ceremonial foods should be served in individually pre-packaged containers rather than shared communally; hugs, kisses and handshakes should be replaced with a "bow or peace sign"; worship services should be joined via recording or broadcast and pastoral care visits conducted via phone, video call or social media; embalming, burial and cremation should be permitted for Covid-19 victims; public health messages should be "woven into sermons and prayers to be shared with communities", and so on (World Health Organization 2020g: 1, 2, 3, 5). Special guidelines were provided for the safe conduct of Ramadan (World Health Organization 2020h), and a flow

chart and risk assessment tool was provided to evaluate the risk of mass gatherings (World Health Organization 2020b). Taken together, these guidelines likely represent the most detailed consideration of the specific needs of religious communities produced in the seven decades of WHO's institutional history.

Discussion

Ebola, anthropologists consulted on the West African crisis had argued, is a disease that "attacks the social body" (Fairhead 2014, cited in Martineau et al. 2017: 484). Likewise, Covid-19 has turned out to be much more than an affliction of the lungs. It is a 'sickness', to build on Arthur Kleinman (1988), not merely in its macrosocial (institutional, social and political) dimensions, but in a sense that might be described as 'spiritual' – it erodes the ties of social fabric which bind humans to each other and to something greater than themselves. While the rapid spread of streaming-technology has produced new, virtual and disembodied forms of sociality and has been met with considerable creativity – note the drive-by confession booth in Maryland which has turned out surprisingly popular (Ramirez 2020) – for many, Covid-19 is a sickness of solitude thrust unto woefully unprepared medical staff (Bagnasco et al. 2020). In this context, the integrity of religious rituals which serve the cohesion and well-being of communities becomes even more important. At the same time, if the explosive spread of Ebola in West Africa is indicative, religious communities also become ready vectors for the transmission of infectious diseases, and at times are reluctant to accept medically safe non-contact adaptations.

In this article, I have argued that mediation between religious and medical communities is thus key to a comprehensive institutional response to Covid-19. Yet, in most clinical settings, religious experts are found at or near the bottom of the institutional hierarchy. Nonetheless, in the field of global health, this situation has slowly advanced over the past decades (Peng-Keller et al., forthcoming). Since the 1970s, the World Health Organization has understood that traditional health-related beliefs are not merely an obstacle, but a necessary ally in the provision of primary healthcare (Winiger, forthcoming a). In the 1980s, the recommendation of the World Health Assembly to ministries of health to consider a 'spiritual dimension' in primary healthcare provision (Peng-Keller, forthcoming) opened the door to local faith leaders, who in some of the WHO's regional offices hold much more sway over local populations than public health officials (Winiger & Rauch,
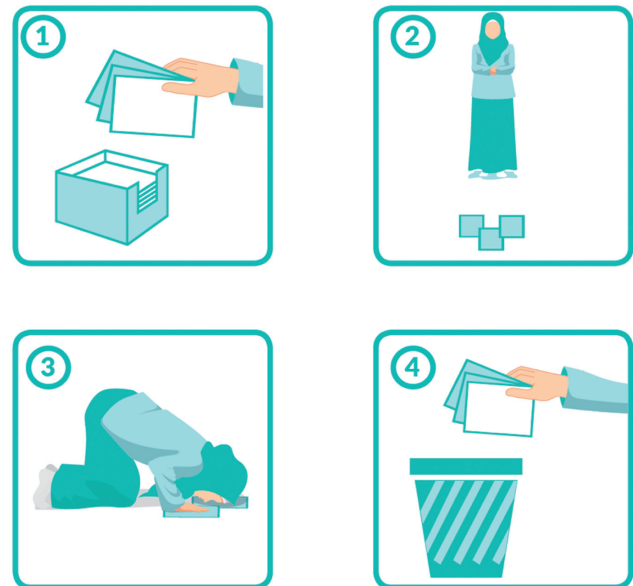

Fig. 2: Flyer circulated by the association for Quality Assurance of Islamic Spiritual Care. Reprinted from Verein Qualitätssicherung der Muslimischen Seelsorge in öffentlichen Institutionen, "Preventive measures in prayer during the coronavirus pandemic" Copyright (2020)

forthcoming), and in the 1990s, the relationship between spirituality, religion and personal beliefs on subjective quality of life began to be recognised (Winiger, forthcoming b). The WHO's guidelines on "safe and dignified" burial practices for Ebola victims, and the guidelines for religious leaders and faith communities may be understood as the most recent milestone in this this long and circumlocutory rapprochement between religious communities and the world's leading public health authority.

Notwithstanding spreading distrust of public health institutions, the brittle state of multilateral organisations and the Trump administration's threat to defund WHO (Shear & McNeil 2020), the organisation's guidelines continue to figure as an important factor for local religious communities caught between medical and spiritual needs. Consider the Swiss association for "Quality Assurance of Islamic Spiritual Care" (Qualitätssicherung Muslimische Seelsorge) in Zurich, which operates a website (islam-seelsorge.ch) and a 24-hour spiritual care hotline. During the Covid-19 pandemic, it has disseminated recommendations to Muslim spiritual care givers, such as the substitution of prayer rugs provided to Muslim with disposable sheets of A4 paper in public rooms of silence (Verein Muslimische Seelsorge Zürich 2020b). Although the Swiss federal ministry of health requires the deceased not to be touched, the association refers to the WHO guidelines for the appropriate handling of Covid-19 bodies and asks not to place dead bodies in plastic

bags or to force cremation. Instead, while burials should be both conducted "according to the appropriate hygiene- and protection measures", they may also be washed, dressed, made to lie in repose, and "as far as possible" treated like any other death (Verein Muslimische Seelsorge Zürich 2020 a: 1). As this illustrates, the difficult and at times contradictory accommodation of religious, national and international regulations is often resolved by reference to the WHO's normative statements. As the heads of forensics and the legal advisor on Islamic law at the International Committee of the Red Cross wrote in a detailed discussion of Islamic burials of Covid-19 victims: the WHO's guideline "shines a clear light on the debate" (Al-Dawoody & Finegan 2020).

In sum, the Covid-19 pandemic ravaging health systems and economies across Europe and the U.S. is shaping up to become one of the most significant social, medical and economic challenges of the post-war era. Perhaps the greatest novelty of this crisis however is not its scale, but the plain fact that it has catapulted into collective consciousness a fear of systemic precarity not familiar to populations of the global North, which have enjoyed decades of relative – if steadily declining – prosperity and stability. Key to turning this crisis into an opportunity, I suggest, is to take heed of the advice sounded by the group of intensive care physicians in Bergamo mentioned at the outset: Covid-19 is not an "intensive care phenomenon". Rather, it requires a model of community-centred care informed by social scientists, psychologists, social workers – and, I have argued, thoughtful mediation between the demands of medical institutions and the spiritual needs of the population.

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