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IDENTITY, INFECTION AND FEAR: A PRELIMINARY ANALYSIS OF COVID-19 DRIVERS AND RESPONSES IN SRI LANKA

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Contents

Abbreviations

ADB	=	Asian Development Bank
ASEAN	=	Association of Southeast Asian Nations
ACJU	=	All Ceylon Jam'iyyathul Ulema
BBC	=	British Broadcasting Corporation
COVID-19	=	Corona Virus Disease 2019
ICES	=	International Centre for Ethnic Studies
NOCPC	=	National Operation Centre for Prevention of COVID-19
PHI	=	Public Health Inspector
SAARC	=	South Asian Association for Regional Cooperation
SEARO	=	WHO Southeast Asia Regional Office
TJ	=	Tablighi Jamaat

Introduction

It is well known by now that certain religious movements unknowingly played a crucial role in the onset of COVID-19 in certain countries. The serious Covid-19 epidemic in South Korea started with the controversial Shincheonji Church of Jesus with a personality cult centred around 88-years-old Lee Man-hee, identified as the messianic saviour of his followers. This cult facilitated the transmission of the virus from Wuhan to South Korea as well as its incubation within a close group of cult members in South Korea. During the first two weeks of the epidemic, over 50 % of all confirmed COVID-19 patients was among these cult members who merely comprised a tiny fraction (less than one percent) of the total population in South Korea. Similarly, the initial hub of transmission of corona virus in Iran was Qom, a leading pilgrimage centre for Shiite Muslims from all over the world. The role of religious festivals and pilgrimage in epidemic history is well known through research in medical history as well as in medical anthropology.[1] For instance, my own research on history of malaria in Sri Lanka points to many instances of popular Hindu-Buddhist rituals and related patterns of human movement, including pilgrimages contributing to the continuation of the annual cycle of disease transmission in the country[2]. What is perhaps unique to the current COVID-19 pandemic is how large-scale, transnational religious congregations specific to certain religious movements of the current era triggered regional and cross-border transmission of a newly evolved viral disease within a short span of time such as two weeks.

This paper seeks to identify and explore drivers of and responses to the COVID-19 epidemic in the island nation of Sri Lanka. Initially my interest was in the impact of any Sri Lankan participation in three large Islamic religious gatherings (congregations) elsewhere in South and Southeast Asia which have already received some attention from the angle of triggering the virus in several countries in the region. This religious driver of the epidemic in the larger South and Southeast Asian region

[1] . P. Gautret and R. Steffan. Communicable diseases as health risks at mass gatherings other than Hajj: what is the evidence? International Journal of Infectious Diseases 47, 2016: 46-52; P. Gautret. Religious Mass Gatherings: Connecting People and Infectious Agents. Clinical Microbiology and Infection 21 (2)), 2015: 107-108; M.C. Inhorn and P.J. Brown. Anthropology of Infectious Disease. Annual Reviews of Anthropology 19 1990: 89-117.

[2]. K.T. Silva. Decolonisation, Development and Disease: A Social History of Malaria in Sri Lanka. Delhi: Orient Blackswan, 2014.

constitutes the primary focus of the first part of this paper. While the role of conventional agents of globalisation such as tourism, trade and international labour migration in triggering epidemics is already well established, the role of international religious movements as disease carriers across national borders is less well known. As the paper developed I became more interested in the issue of identities of who is infecting whom within the context of Sri Lanka where blaming the ethnic and religious other for one's ailments, irrespective of the nature of the ailment, has been an established practice for some years now at least from the time the country's ethnic problem came into being in its current form since the 1950s. The second part of the paper deals with the issue of identity and infection, in this instance infection with COVID-19 in the Sri Lankan context and the resulting process of scapegoating and demonising the ethno-religious other as part of the COVID-19 response on the part of the state, media including social media and the public in Sri Lanka. The morbidity and mortality data and the disease response in Sri Lanka are examined using limited information available in order to understand the impact of larger processes at the country level.

This preliminary investigation relies largely on media reports and secondary data relating to the epidemic, related drivers and the epidemic response, as primary data collection is not feasible in the current situation which, however, requires urgent social science inputs in order to assess, inform and guide viable collective responses to the epidemic. The time span covered is March 1 to April 15, 2020, encompassing the early phase of an unfolding epidemic, the course of which is uncertain and not totally predictable in the light of global experiences at the time of compiling this report. In terms of its conceptual approach the paper uses globalisation as a framework for understanding both the global spread of the pandemic itself and the role of global religious mobilisation in triggering the epidemic in specific countries in the region under consideration. Following Arjun Appadurai, I understand globalisation in terms of flows, especially enhanced cross border movement of people, commodities, technology, ideas and infections as an outcome of this process operating at higher

levels above the level of nation states.[3] I also see this as an unpredictable destabilising situation producing a 'runaway world' as elaborated by Anthony Giddens.[4]

Globalisation and Religion

The relationship between religion and globalisation is a contested one. Secularisation thesis which is contained within modernisation theory argues that with globalisation, religion will decline in importance both as an ideology and a set of institutions driven by a doctrine. This, however, was proved incorrect as religious reform and revitalisation became important side by side with modernisation and globalisation.[5] Religion was then seen as a kind of social fossil associated with conservative social sectors that will nevertheless disappear with processes of progressive social change. The view too was problematised as religions actually became a driver of progressive social change and democratisation in countries so radically different such as Poland, the Philippines and several Latin American countries with dictatorial regimes.[6]

What is important for our discussion here is how religions themselves became globalised in terms of new religious movements, which are transnational in organisation, and participation in ritual activities and their implications for transmission of infectious diseases from one country to another and from one cluster to another within the same country. This is, however, not to argue that religions merely serve to transmit disease across regional and national borders.[7] On the contrary, religions also help overcome the psychological stresses and humanitarian crises resulting from health emergencies as have been shown by many faith-based organisations engaged in charity and philanthropy and community services in such calamities. [8]

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[3]. Arjun Appadurai. Modernity at Large: Cultural Dimensions of Globalization. Minneapolis: University of Minnesota Press, 1996.

[4] . Anthony Giddens. Runaway World: How Globalisation is Reshaping our Lives. London: Profile Books, 1999.

[5] . Brian R. Wilson. Religion in Secular Society. London: C.A. Watts, 1966.

[6] . Jeffrey Haynes. Religion and Democratization: An Introduction. Journal of Democratization 16 (6) (2009): 1041-1057.

[7] . For a discussion on the larger role of religion in the conflict setting of Sri Lanka, read Spencer, Jonathan et al. Checkpoint, Temple, Church and Mosque. London: Pluto Press, 2015.

[8] . Osela, F. & Widger, T. You can Give even if You have Ten Rupees: Muslim Charity in a Colombo Housing Scheme. Modern Asian Studies 52 (1) 2018: 297-324.

Religions, especially new religious movements, help articulate existential uncertainties in the current era of globalisation.[9] Therefore, one's insecurities and health threats may often be seen as outcomes of deliberate action or inaction of rival ethno-religious groups due to irrational tendencies or malicious intent. In this conceptualisation, disease is not merely a matter of personal vulnerability, risk perception or a public health hazard affecting everyone, but a conspiracy of one group intent on harming or eliminating another. This is indeed how COVID-19 is understood by some people affected by the current global crisis not just in the global South. For instance, Shincheonji was openly blamed for the COVID-19 epidemic in South Korea in the public consciousness of certain other religious groups and by secular commentators.

Tablighi Jamaat as a Regional and Global Religious Movement

In this context the possible ways in which certain large religious congregations in South-East Asia, all connected with the mainstream reformist Islamic religious movement of Indian origin called, Tablighi Jamaat, may have triggered the spread of COVID-19 in several countries in the region has received public health and media attention. The first is a massive religious congregation of about 16,000 people in Sri Petaling mosque just outside Kuala Lumpur, Malaysia from February 27 to March 1, 2020. The second is a series of different congregations in Nizamudin mosque in New Delhi, India between March 3 and 24, 2020. Apart from many locals, religious leaders and preachers from some countries in the region who participated in these events with some participants who picked up the disease in Kuala Lumpur may have carried it with them and transmitted it to a wide range of Indian and South Asian participants in the Delhi congregations held almost immediately after. These are transcultural religious gatherings with a potential impact on cross border flows of infections at a critical juncture in the global COVID-19 pandemic.

The reformed TJ is a devotional religion dating back to 1920s modelled after the bhakti cult in Hinduism with missionary and congregational appeal aimed at cultivating faith in Allah and piety.[10] Extreme devotion to god is common to many forms of Islamic

[9] . C, Kinnvall. Globalization and Religious Nationalism: Self, Identity, and the Search for Ontological Security. Political Psychology 25 (5) 2004: 741-765.

[10] . S. Ma'mun. Tabliqui Jamaat: An Islamic Revivalist Movement and Radicalization Issues. Islamic Realitas: Journal of Islamic and Social Studies 5 (2) 2019: 145-159.

reform, but unlike in forms of militant Islamism, Tablighi Jamaat is completely preoccupied with moral purification and spiritual upliftment to the deliberate neglect of anything social, political or economic, left to other players in its effort to shape piety and faith according to their own convictions.[11]

Adherence to a particular dress code and growing a particular style of beard symbolises an inner purification and a total devotion to god. Massive devotional gatherings (see photo 1) are interspersed with private missionary tours of small groups of about ten people (*jilla)* throughout the year. These involve 'mouth to mouth propaganda' at the periphery designed to motivate ordinary Muslims, who in the eyes of the Jamaats, have moved away from the central doctrine to become better Muslims. "The emphasis has never been on book learning, but rather on first-hand personal communication".[12] For the most part, morally and spiritually inspired religious action in Islam at the ground level in Islamic and non-Islamic countries in South and Southeast Asia is passionately pursued by Tablighi Jamaats. They have been instrumental in infusing a deep religious fervour and spiritual awakening in Islamic society.[13] At the practical level, the movement offers social capital and religious dignity and access to local and international Muslim networks.

[11] . For a nuanced understanding of the piety movement in Tabliqhi Jamaat and its relation to secularism see Humeira Iqtidar. Secularism and Secularization: Untying the Knots. Economic and Political Weekly 47 (35) 2012: 50-58.

[12] . de Rooij, L. Tablighi Jamaat. Islam: A Worldwide Encyclopaedia. 2016.

[13] . For a sociological account of Tablighi Jamaat read Barbara Metcalf. Travelers' Tales in the Tablighi Jamaat. Annals of the American Academy of Political and Social Science 588 (1) 2003: 136-148.

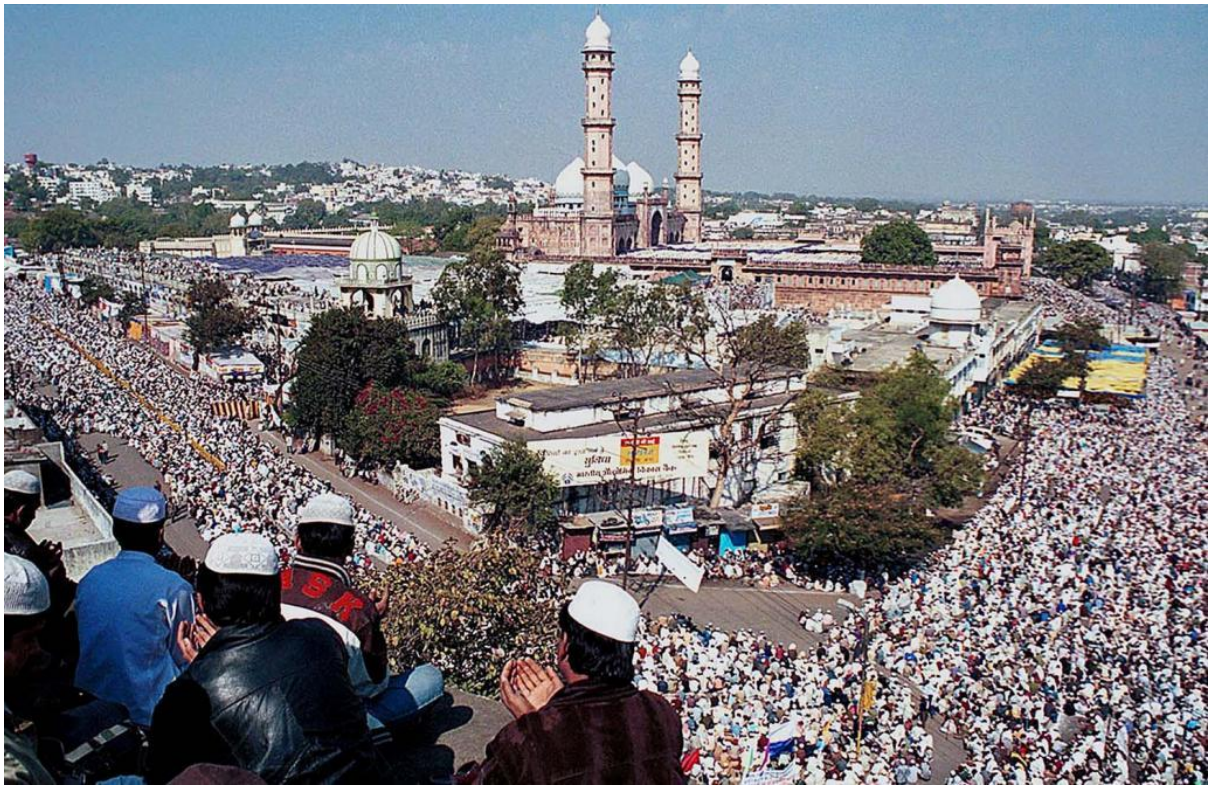


Photo 1: Jamaats gather around the Taj ul Masjid Mosque to offer prayers on the final day of a Tablighi religious gathering in Bhopal, India, 2017. (AFP)

The sheer size of Tablighi Jamaat (TJ) presence in South and Southeast Asia, the domestic and international mobility of Tablighi Jamaats, faith as a key driver of their intense participation in the days long congregations and missionary work, and close interactions among participants from different countries may have contributed to rapid disease transmission. Further, the failure of religious leaders and organisers as well as political leaders and health authorities in Malaysia and India, one a predominantly Islamic country and the other a Hindutwa dominated country where Muslims have been increasingly pushed to the social margin, having failed to prevent or monitor these potential public health hazards at a critical juncture of the global pandemic, point to the complex ways in which the combined effect of faith, mobility and popular religious mobilisations and congregations contribute to the global COVID-19 pandemic. In both countries countrywide lockdowns were introduced immediately after the religious gatherings were concluded, with the result that stables were closed only after horses have run away in all directions. The blame game has been at work in both countries, but more particularly in India, where in Hindutwa

worldview, Muslims have been treated often unfairly as a scapegoat for many problems affecting the Hindu majority.[14]

Another Tablighi Ijtema, planned to be conducted in Sulawesi, Indonesia from March 19 to 22, got cancelled at the last minute due to pressure from the Indonesian government, but by that time the visitors had gathered in big numbers perhaps causing some adverse public health impact by the time the gathering dispersed. [15]

The Annual Gathering of Tablighi Jamaat in Kuala Lumpur, February 27 to March 1

The annual gathering (Ijtema) in Kuala Lumpur was a massive gathering of about 16,000 people that included about 1500 foreign participants from a total of thirty countries, including India and Sri Lanka.[16] Apparently social distancing or wearing of safe masks were not practised (see Photo 2), even though by this time the relevant safety protocols had been introduced globally as COVID-19 containment measures. Shared eating of food in the Islamic style (*Sunnah*) appears to have been practised at least by some participants. "During the event, the attendees prayed together and slept alongside one another inside a mosque, with many others camping in tents pitched outside."[17] Three days of intensive interaction among each other did provide ample opportunities for the virus to spread freely among the participants as some of them also came from countries already with advanced COVID-19 outbreaks such as China, South Korea and Iran. In the short run, the biggest impact was in Malaysia itself. Almost 2/3 of the total caseload of about 675 COVID-19 patients in Malaysia by mid-March was attributed to disease transmission triggered by the event. [18] In a total caseload of 56 patients in Brunei by the third week of March, 50 were attributed to the Ijtema in Kuala Lumpur.[19] During contact tracing in the same period in Cambodia, Singapore and Thailand, 13, 5 and 2 cases detected respectively had been identified

[14] . Alam, Javeed. The Contemporary Muslim Situation in India: A Long-term View. Economic and Political Weekly 43 (2) 2008: 45–53.
[15] . https://www.straitstimes.com/asia/se-asia/indonesia-muslim-tablighi-jamaat-event-postponed-amid-coronavirus-fears. Accessed on April 8, 2020.
[16] . https://www.benarnews.org/english/news/malaysian/conservative-group-03202020181010.html. Accessed on April 8, 2020.
[17]. https://www.aljazeera.com/news/2020/03/coronavirus-philippines-seeks-215-attended-islamic-event-200321143247350.html. Accessed on March 31, 2020.
[18]. https://www.benarnews.org/english/news/malaysian/conservative-group.03202020181010.html. Accessed on April 8, 2020.
[19]. https://www.nst.com.my/news/nation/2020/03/575560/how-sri-petaling-tabligh-became-southeast-asias-covid-19-hotspot. Accessed on March 31, 2020.

among Muslims who participated in the ritual gathering in Malaysia. [20] How travel to and from Malaysia for this event actually affected the COVID-19 transmission in India, Indonesia, Bangladesh and the Philippines is yet to be established empirically.

Photo2: Worshippers at the Seri Petaling Mosque, where hundreds of cases of coronavirus have been linked to a mass prayer event. Photo: Reuters

Given the ethnic makeup and the political ideology of the Malaysian state, the religious gathering in Kuala Lumpur did not receive as much adverse publicity as in some neighbouring countries. For instance, in the Philippines contact tracing focused on the 215 Muslim Filipinos who reportedly participated in the event in Kuala Lumpur. [21] It was claimed on March 22 that a significant spike in reported number of cases in the preceding week was attributable to Muslim devotees returning from Kuala Lumpur event, some of whom had travelled secretly to the religious event through the country's "backdoor" meaning southern islands close to the Malaysian border. [22]

The Tablighi Jamaat Gatherings in Delhi Headquarters, March 3 to 24

Nizamudin area of Delhi houses the world headquarters of the Tablighi Jamaat movement and the spiritual hub of this global religious foundation. It had gatherings

[20] . Ibid.
[21] . https://www.aljazeera.com/news/2020/03/coronavirus-philippines-seeks-215-attended-islamic-event-200321143247350.html. Accessed on April 2, 2020.
[22] Ibid.

from March 3 onwards culminating in two main events from March 8 to 10 and March 23 to 24. It appears that there was no one continuous programme throughout March but many Jamaats passed through the Centre as they do throughout the year before and after completing their preaching tours (*jilla)* in various parts of India. The Ijtema annual gathering *(Aalami Mashwara)* was held in Banglewali Masjid, the international headquarters of the Tablighi Jamaat from March 8 to 10. This was perhaps instrumental in disease transmission in capital territory and beyond.

There is no reliable information about the actual number of participants in the annual gathering. Apparently, TJ has no practice of keeping records of how many people actually participated in its roster of events. Estimates of the total number of participants in the main event by participants and media range from 3000 to 9000.[23] They came from all over India and from other countries. The reported number of foreign participants from March 8 to 10 vary from 300 to 600 with delegates from Indonesia and Malaysia reportedly leading the pack. This event got wider publicity in India when some 10 Indonesian participants in the Delhi event had subsequently travelled to Hyderabad and were found positive for COVID-19 a week later. This, prompted health authorities throughout India to deliberately look for participants in the Ijtema in Delhi and screen them for the disease.

How such a large number of foreign delegates entered India for this event was also problematic with media claiming that some overseas delegates actually came on tourist visa rather than missionary visa applicable in this instance. Some media also reported that certain participants may have actually entered India illegally using local connections and visas to neighbouring countries.[24]

The second event from March 22 to 24 appears to have been cancelled in the last minute but large numbers had already gathered in the Centre by that time.[25] Any large gatherings after March 16 was clearly in violation of a Delhi government ruling outlawing any congregation of over 50 people. The restrictions imposed by the Indian state leading to a Janata Curfew on March 22 and countrywide lockdown for 21 days

[23] . https://thewire.in/government/delhis-nizamuddin-hotspot-coronavirus. Accessed on March 31, 2020.
[24] . These reports may or may not be correct. They have to be assessed in the light of the anti-Muslim stance of much of mainstream and social media in India. The same media culture has been extended to Sri Lanka, particularly after the havoc caused by Easter Sunday attacks by suspected Thawheed Jamaat bombers.
[25]. https://swarajyamag.com/news-brief/before-delhi-there-was-indonesia-tablighi-jamaat-rejected-indonesian-govt-request-to-postpone-ijitema-went-ahead-with-congregation-despite-corona-fears. Accessed on April 8, 2020.

from March 24 perhaps led to the cancellation of the event planned from 23 to 24. Some 2500 participants had arrived in the centre by that time, but only about 1000 were able to leave the centre by the time travel restrictions were imposed. What instructions were given to the participants by the organisers for personal protection and prevention of COVID-19 are not known. These issues have been subjected to much speculation and possible misinterpretation in an environment replete with Islamophobia and overt and covert maltreatment of Muslims in the public domain. The photographic evidence at the time of evacuation indicated that wearing face masks was common at that point in time, but social distancing was conspicuous by its absence (see Photo 3). Many participants continued to stay inside the mosque premises until after a nationwide lockdown was introduced from March 24 onwards.

Photo 3: Participants are waiting to be evacuated from Markaz Nisamuddin on March 24 (photo BBC).

In an interview with BBC, one of the participants stated that many delegates left before the national lockdown that came into effect on March 24th, but a large number, including some foreign delegates, was stranded in the Centre due to lockdown and cancellation of trains and flights.[26] After the lockdown came into effect, the police

[26] . https://www.bbc.com/news/world-asia-india-52131338. Accessed on March 31, 2020.

cleared all remaining people in the hostel and moved all of them to quarantine centres set up outside for the purpose. As of 30 March 2020 the entire Nizamuddin West area has been cordoned off by the Police and medical camps have been set up.[27] After evacuation of over 1000 remaining participants from the Markaz Nizamuddin, some 167 Jamaat attendees were quarantined in a railway facility in southeast Delhi amid concerns over their safety and transmission of the virus. There were further complications after the staff at the quarantine facility reported that the TJ followers "misbehaved" with the staff and disobeyed them. Delhi government ordered an FIR against Muhammad Saad Kandhlawi, the head of Nizamuddin Centre. On 31 March 2020, an FIR was filed against the group by Delhi Police under the Epidemic Diseases Act of 1897 and related provisions.

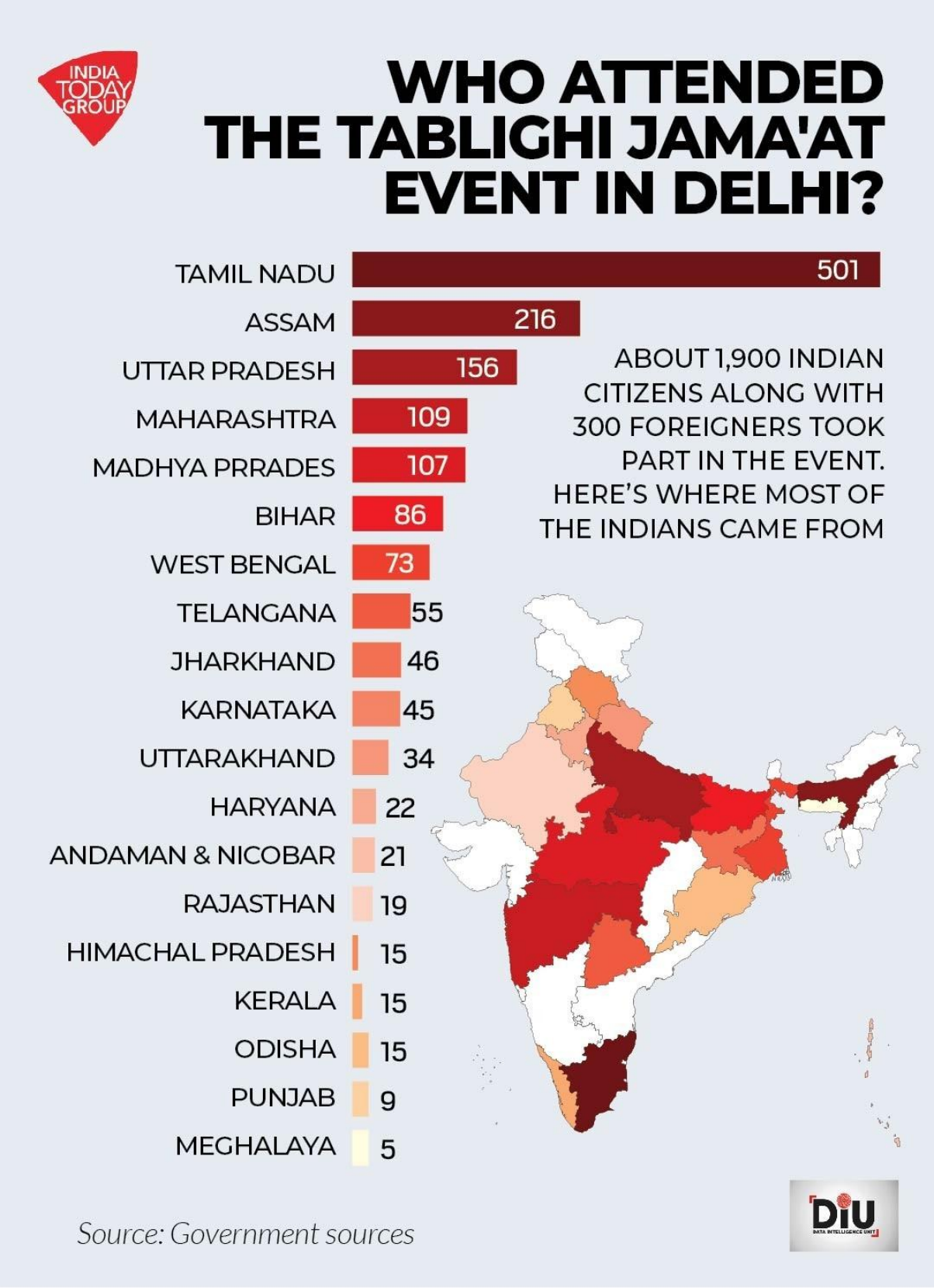
The health authorities in India quickly became concerned about the religious gatherings in Markaz Nizamuddin as a potential source of infection of COVID-19 throughout India.[28]The data relating to the number of participants from different states in India and from overseas and the subsequent detection of COVID-19 among them are scattered and widely contested by different parties at this stage.[29] Conspiracy theories were in circulation in print, electronic and social media. Antagonistic terms such as 'corona-jihad' were used in tweets, social media and even print media in a clear display of Islamophobia over the issue.[30] TJ leaders denied the charge that TJ gathering was part of a deliberate move to hurt the pandemic control work in India by pointing to similar gatherings planned by other religious groups in the same period but eventually got cancelled due to Janata curfew and lockdown. For instance, on March 18, the chief minister of UP insisted that a large mela to be held in Ayodhya from March 25 to April 2 in order to celebrate Ram Navami will go ahead as planned in spite of warnings by health authorities. Acharya Paramhans, the spiritual advisor to the CM, stated that "Lord Ram would protect devotees from the corona virus". The next day, UP government changed its position when the central government declared imposition of a Janata curfew on March 22 and urged the public to celebrate Ram

[27] . https://en.wikipedia.org/wiki/Tablighi_Jamaat. Accessed on April 6, 2020.
[28] . https://www.firstpost.com/health/coronavirus-outbreak-delhi-police-books-tablighi-jamaat-head-as-nizamuddin-centre-emerges-as-hotspot-1339-workers-quarantined-says-mha-8211721.html. Accessed on March 31, 2020.
[29] . https://www.indiatoday.in/india/story/hunt-for-nizamuddin-event-participants-bigger-than-whats-known-1661943-2020-04-01. Accessed on March 31, 2020.
[30] . https://www.aljazeera.com/news/2020/04/tablighi-jamaat-event-india-worst-coronavirus-vector-200407052957511.html, Accessed on April 11, 2020.

Navami at home.[31] So clearly TJ was not the only religious mobilisation with potentially harmful gatherings planned at the time. What is obvious is lack of conformity between the political centre and TJ perhaps as a consequence of preceding developments.

We summarise here some of the available information without having a means to verify them at this juncture.

[31] . https://science.thewire.in/politics/government/delhis-nizamuddin-hotspot-coronavirus/



Map 1: State-wise distribution of the Reported Number of Participants in TJ event in Delhi. March 8 to 10.

Thus the reported number of participants in the Ijtema gathering in Delhi from March 8 to 10 varied from state to state but the important point is that the participants came from all over India with potential impact for disease transmission throughout the country. The reported number of participants was highest from Tamil Nadu although according to some media reports the actual number of participants was much higher from the capital territory in New Delhi though not indicated in the map. The central health ministry issued a directive to all state-level health authorities to check if they attended the meetings in Markaz Nizamuddin as part of their regular contact tracing. [32] This, in turn, became an important source of information for surveillance of the disease by health authorities, media personnel and all other agencies.

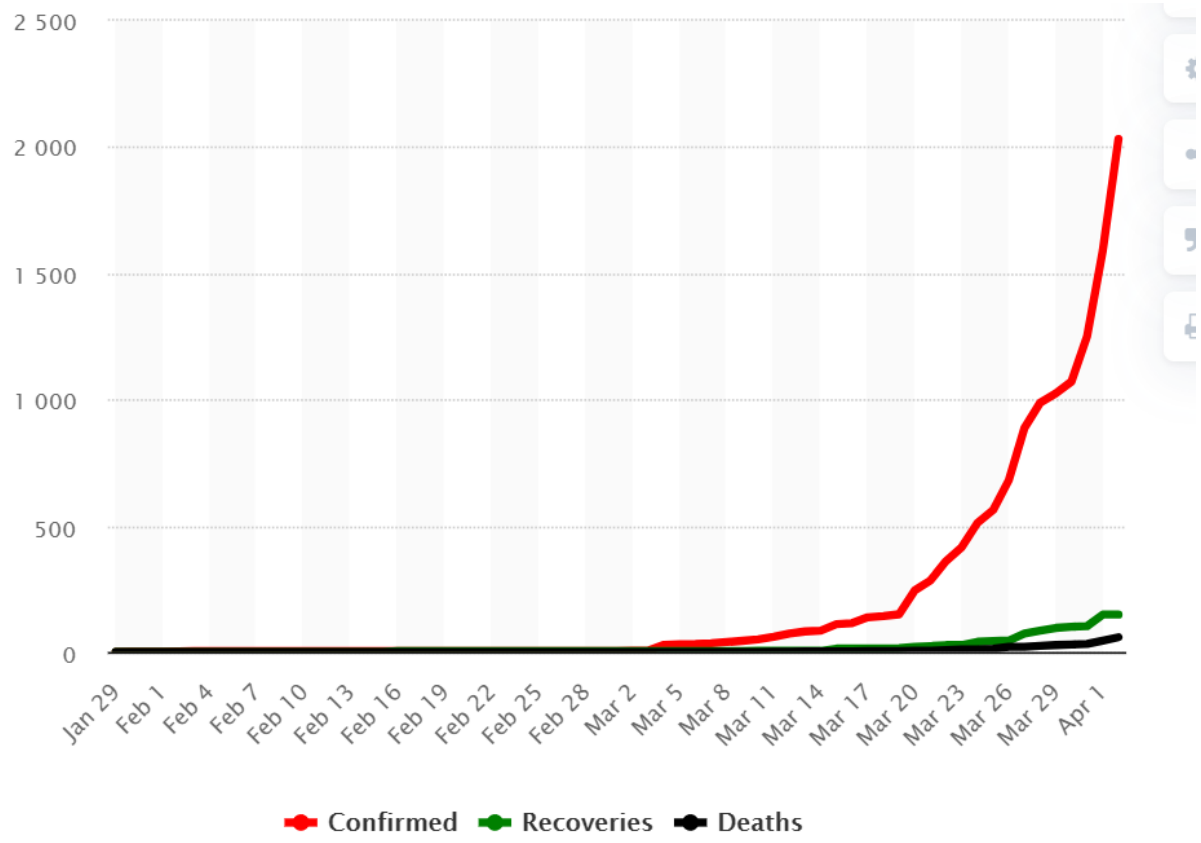


Figure 1: Number of Confirmed COVID-19 patients, deaths and recoveries in India from January 29 to April 1, 2020

Source: Ministry of Health and Family Welfare India[33]

[32] . https://www.mohfw.gov.in/ Accessed on April 2, 2020.
[33] . Ibid.

The evidence on COVID-19 morbidity and mortality in India points to a clear spike from March 20 onwards. This is despite the fact that Janata curfew was introduced in India on March 22 and it was converted to a 21-day continuous countrywide lockdown affecting the entire country from March 24 onwards. How far this spike can be attributed to the mass gatherings of potential infectors and vulnerable receptors of the virus is not clear from the available data. At least some medical observers saw the event as a veritable "biological bomb" that triggered the unhindered flow of the virus throughout India, even though the TJ establishment denied this claim.[34]

Media statement issued by the Union Ministry of Health in India on April 1, however, claimed that 128 COVID-19 cases and 7 COVID-19 deaths across India as of March 31, are linked to Markaz Nizamuddin gatherings in March.[35] Further, the ministry advised the health workers to check whether people had actually participated in the TJ congregations in Delhi in contact tracing along with reported symptoms and overseas travel history. Times of India reported on April 3rd that as of April 2nd, there was a total of 295 COVID-19 confirmed cases among delegates of TJ congregations and their contacts and as many as 65% of new cases detected on April 2nd were attributable to infections triggered by TJ gatherings in March.[36] Another report in early April claimed as many as one-third of all COVID-19 confirmed cases in India by that time had been triggered by TJ gatherings in Delhi. [37]

In response to the allegations made and legal action initiated by the state, TJ issued a media statement on March 31 claiming that they have not violated any laws of the land and some delegates were stranded in the centre by March 24 as permission was not granted to them by the authorities to hire private vehicles for their travel despite applications made and reminders were sent.[38] These exchanges clearly indicated that the central authorities and TJ are mutually suspicious towards each other, making it difficult for them to collaborate in a coordinated public health campaign centred around the control of COVID-19 pandemic in India. While TJ events have clearly

[34] . https://www.deccanherald.com/international/covid-19-india-follows-us-to-remind-the-world-a-1975-treaty-against-bio-weapons-818359.html. Accessed on April 8, 2020.
[35] . https://www.ndtv.com/india-news/coronavirus-nizamuddin-centres-warning-to-states-on-tablighi-jamaat-members-over-covid-19-cases-2204038. Accessed on March 30, 2020.
[36] . https://timesofindia.indiatimes.com/india/covid-19-in-india-nearly-65-of-544-new-all-india-cases-linked-to-tablighi-jamaats-event-in-city/articleshow/74958094.cms. Accessed on March 30, 2020.
[37] . https://science.thewire.in/politics/government/delhis-nizamuddin-hotspot-coronavirus/
[38] . https://www.aljazeera.com/news/2020/03/india-links-dozens-coronavirus-cases-muslim-gathering-200331095417048.html. Accessed on April 8, 2020

contributed to the escalation of the epidemic, the gap between the central authorities and TJ is both ideological and institutional, each blaming the other for failure to prevent the epidemic. TJ has sought to resort to its faith-based movement character and global contacts in responding to attacks by the central government while the central government has identified and blamed the same traits for triggering the epidemic. The response to the epidemic is clearly politicised and ethnicised as noted by various other observers commenting on similar disasters.[39] TJ's single-minded preoccupation with faith and piety to the neglect of public health concerns and maintenance of law and order, has compromised the health of Indian citizens in general and their own followers in particular. On the other hand, the state action has served to alienate TJ further and failed to win the trust and conformity of this global movement in the national campaign against COVID-19.

It has to be pointed out at this juncture that within Islamic tradition itself there have been much larger religious gatherings such as Haj and previous examples of Ijtema (photo 1) with no epidemic transmissions reported on those occasions. So zeroing in on and essentialising Islam as the cause of the pandemic would be untenable even in the case of South and Southeast Asia. That said it has to be acknowledged that the timing of these congregations, their transnational character, participation of devotees from countries at different levels of disease transmission, lack of coordinated application of precautions and containment measures during congregations and post-congregation long distance travel would have certainly contributed to increased transmission of COVID-19 within the South and Southeast Asia region. What is evident from India is that the epidemic has already set off a blame game with Muslims as the main carriers of the virus with some evidence drawn from TJ events in Delhi perhaps exaggerating them way beyond their actual role in triggering the epidemic throughout India.

[39]. https://theconversation.com/coronavirus-is-not-the-great-equalizer-race-matters-133867. Accessed on April 8, 2020.

COVID-19 Profile in Sri Lanka

The onset of COVID-19 epidemic in Sri Lanka was triggered by infections associated with tourism, followed by Sri Lankans becoming exposed to the virus overseas either during short visits abroad or as resident workers overseas, with Sri Lankan workers returning from Italy largely triggering the epidemic in the early phase. Contact tracing until March 27 carried out by the Ministry of Health indicated that infections among tourists, tour guides and Sri Lankans returning from overseas including local contacts of these different groups comprised 82 percent of all infections (102) detected in Sri Lanka by that time. Sri Lankan workers returning from Italy and their family members and local contacts made up 42 percent of all infections. Thus, in the first month since the detection of the first confirmed case in Sri Lanka, the Sri Lankan COVID-19 epidemic was largely triggered by return labour migration from Italy even though Sri Lanka has multiple connections with China and South Korea where the pandemic in the Asian region started. The observed pattern of disease transmission in Sri Lanka was closely connected with tourism and worker migration to overseas, two well-known frontiers of globalisation in the country.[40] By March 31 a notable number Sri Lankan visitors returning from India too was diagnosed with the disease triggering fears of a potential Indian impact on escalation of the epidemic in Sri Lanka.

Table 1: A Breakdown of Confirmed COVID-19 Patients in Sri Lanka, 27 March, 2020

Category of Patient	**Number**	**%**
Foreign tourists	3	2.9
Tourist guides and their contacts	17	16.7
Sri Lankan workers returning from Italy and their contacts	43	42.2
Returnees from India	4	3.9
Sri Lankans returning from other countries and their contacts	17	16.7
Exposure in airport or quarantine centre	3	2.9
Possible local transmission	10	9.9
Uncertain exposure	5	4.9
TOTAL	102	100.1

[40] . It has to be noted here that income from tourism and remittances by Sri Lankans employed abroad, who comprise nearly 25 percent of the entire work force in Sri Lanka, drive the Sri Lankan economy damaged heavily by the war, tsunami, Easter Sunday attacks and years of mismanagement under various regimes.

Source: Adapted from published data, Epidemiological Unit, Ministry of Health. Available at http://www.epid.gov.lk/ Accessed on March 26, 2020

There has been slow but steady increase in the number of confirmed cases detected in Sri Lanka as evident from Figure 2:

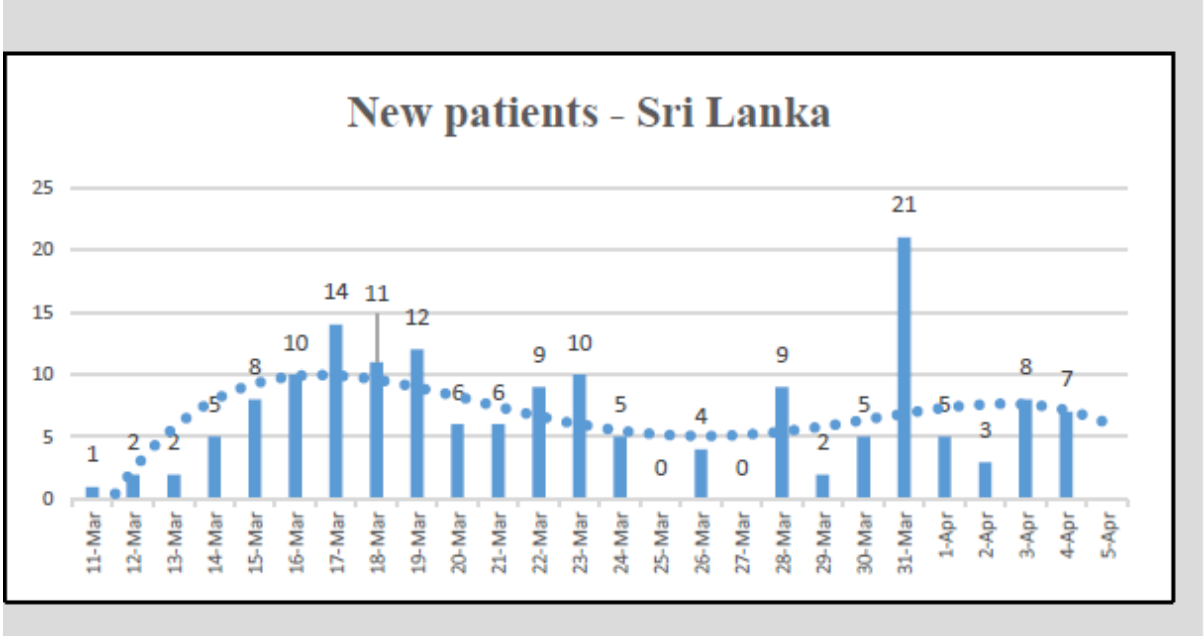


Figure 2: Changes in Number of Confirmed COVID-19 Patients Diagnosed in Sri Lanka from March 11 to April 5

Source: Epidemiological Unit, Ministry of Health and Indigenous Medical Services

http://www.epid.gov.lk/web/images/pdf/corona_virus_report/sitrep-sl-en-05-04_10.pdf Accessed on April 6, 2020.

The quarantine process facilitated active case detection with passive case detection through the hospital system serving to catch those who fall through the quarantine procedures as well as infected among the general public. In terms of WHO categorization, Sri Lanka is currently in Stage 3, sub-category 3A, known as Home Cluster, probably in the threshold of entering Stage 3B, known as Village Cluster. Stage 4 is where community transmission occurs on a large scale as evident in Italy, Spain and USA at present. Sri Lanka also may be important from the angle of recent discussions about genetic mutations of the virus in Asian, European and American contexts.[41] Given the possibility that Asian strains of the virus possibly blended with

[41]. P. Forster, L. Forster, C. Renfrew and M. Forster. Polygenetic Network Analysis of SARS-COV 2 Genomes. Proceedings of the National Academy of Sciences, USA, 2020 April 8.

European strains in Sri Lanka due to the heavy influence of the Italian epidemic during the early phase of the epidemic in Sri Lanka and the influx of Asian strains from surrounding countries subsequently, potential genetic mutation of the virus in Sri Lanka requires further attention from relevant specialists.

COVID-19 Response

Sri Lanka's response to COVID-19 outbreak was swift and comprehensive. A 22-member National Operation Centre for Prevention of COVID-19 (NOCPC) was established on March 17 under the leadership of the army chief. This facilitated the establishment of a mandatory quarantine process mediated by the security forces targeting Sri Lankan and international travellers arriving from selected countries. Rescuing Sri Lankan students trapped in Wuhan through intervention of the state and their successful completion of the quarantine process was one of the important landmarks of success in an initial response to the global pandemic (See Photo 5). With a view to contain the epidemic, countrywide national public holidays were announced from March 10th onwards. Continuous curfew with short breaks in between was introduced as a measure for containing the epidemic from March 18th. This in turn affected the supply of essential commodities and delivery of services. On March 26, the president appointed a special task force under the leadership of his brother, Basil Rajapaksa to coordinate provision of essential services and supply of goods.

It is important to point out here that civil society was not represented in these two national committees either as members or observers, launching a military-led statist response to COVID-19 in Sri Lanka. Sri Lanka's advanced health infrastructure built over several decades covering many emergencies ranging from war to tsunami, inclusive of emergency, curative and preventive services helped launch a satisfactory response to the pandemic. Side by side with public health officials, the security forces were fully mobilised in developing and implementing quarantine services, including contact tracing of those exposed. Some 45 health facilities were reportedly established in carefully selected locations for COVID-19 testing and treatment, with required protection for staff and patients. This ensured the availability and accessibility of appropriate health services and drugs.

Photo 4: A Media Briefing by the National Operation Centre for Prevention of COVID-19 in Sri Lanka (Photo Pradeep Pathirana, Ceylon Daily Mirror)

The quarantine services mostly established and run by the armed forces themselves were mandatory rather than voluntary with force being applied where participants resisted. No choice was offered to the participants as to place of quarantine or type of service providers with all costs involved being covered by the state as part of its public health services. In the case of mandatory two-week institutional quarantine imposed on persons travelling from countries severely affected by the epidemic and first-level contacts of infected persons, some Sri Lankan workers returning from Italy and South Korea initially refused to participate due to preference for paid services in some cases, long distance travel to quarantine centres, fear of isolation in faraway places and possible fear of cross infections. In a typical illustration of the paradoxical impulses of the moment, the very same people thanked the government and the military profusely in front of television cameras on completion of the quarantine process. There were also some local community protests against the establishment of quarantine centres due to fear of infection from the already infected from outside.

Photo 5: Sri Lankan students rescued from Wuhan complete their quarantine process in a quarantine centre in the Diyatalawa army camp. (Picture themoming.lk)

These protests were suppressed by the security forces, sometimes using curfew restrictions. Home quarantine was imposed on persons in contact with other exposed individuals and with public health inspectors conducting periodic surveillance on people in home quarantine. Homes going through quarantine were isolated with a public notice pasted by health officials on the walls indicating the quarantine process for the benefit of others. Those who successfully completed the quarantine process (institutional or home-based) were issued a certificate by public health inspectors for proving their disease-free status. As the epidemic unfolded and more and more cases were detected, a community quarantine was also introduced, with a complete lockdown of designated areas by the police as a means to prevent community transmission of the disease. Public compliance to these measures was variable. In a meeting with newly appointed members of NOCPC, the president referred to "Irresponsible citizens" who obstruct the country's fight against COVID-19.[42] Authorities did not point to any particular individuals or groups, but social media was replete with references to particular ethno-religious groups identified as public enemy number one.

[42] . https://economynext.com/sri-lanka-president-angry-at-irresponsible-citizens-in-fight-against-covid19-59645/

Religion and Infection

The authorities considered religion a too sensitive subject to be investigated in relation to the epidemic and perhaps an unnecessary diversion given their pressing challenges. The blessing and support of religious actors, however, were sought as and when necessary. Possible adverse impact of large religious gatherings from the angle of social distancing was recognised as a casual observation during the response to the epidemic. For instance, in a rare recognition of Buddhist ritual as a potential driver of the epidemic, the President of Sri Lanka criticised continuing pilgrimage to Sri Pada at the time of public concern about the epidemic. In response, the chief incumbent of the Sri Pada temple refused to cancel the ritual identifying it as a time-tested remedy rather than a trigger for the epidemic, echoing a similar view by religious authorities worldwide planning religious activities at the time. A specific ruling to stop the festival, however, was not issued in spite of an official request to that effect from the District Secretary for the local area. The countrywide curfew introduced later made it difficult for people to go on pilgrimage, settling a potential dispute between the state and Sripada temple.

On the other hand, the Buddhist establishment in Kandy provided both spiritual and material backing for the COVID-19 response by the state. A week-long chanting of Rathana Sutta was conducted from March 18th onwards by Buddhist monks within the Temple of the Tooth premises to bless the country and contain the epidemic. When the President established a COVID-19 Health Care and Social Security Fund (CHCSSF) on March 23rd, the Temple of the Tooth and Malwatta and Asgiriya chapters jointly contributed Rs. 20 million to this fund. [43] It has to be pointed out here that All Ceylon Jam'iyyathul Ulema (ACJU) also advised its members to make contributions to this fund and accordingly some Muslim business establishments made substantial contribution to this fund. For instance, Akbar Brothers donated Rs. 50 million to this fund through the Prime Minister, Mahinda Rajapakse (See Photo 6).

[43] . http://www.pmdnews.lk/large-contributions-for-covid-19-healthcare-and-social-security-fund/

Photo 6: Akbar Brothers Donate Rs. 50 million to the COVID-19 Health Care and Social Security Fund (photo businessnews.lk).

By March 21, the quarantine process identified an evangelical Christian Church in Jaffna as a potential source of infection. The senior pastor in the Philadelphia Missionary Church reportedly tested positive for COVID-19 and, thereafter, went to Switzerland with his wife for medical treatment under circumstances not clear at this stage. He had held a congregation in Jaffna on Sunday, March 15 where some 240 people reportedly participated. It was revealed that the pastor hugged and blessed participants during the prayers. Several of the Pastor's contacts later presented with COVID-19 symptoms to Jaffna Teaching Hospital and three were confirmed positive during the investigations. Twenty other participants who were in close contact with the pastor were transferred to a quarantine centre in the army and the remaining participants in the congregation were asked to go for home quarantine under the supervision of the army and local PHIs. This also brought in a lockdown under curfew of the entire Northern Province for a number of days. Later another 200 families in Hatton Dickoya area in Nuwara Eliya District who participated in a service by the same pastor in a local church were identified and put on home quarantine under the supervision of local PHIs.

Islam and the Corona Epidemic in Sri Lanka

Islam has become an important flashpoint in the COVID-19 control activities in Sri Lanka due to a number of factors. First, the COVID-19 epidemic unfolded in Sri Lanka at a time of growing marginalisation of the Muslim minority in Sri Lanka following a series of mob attacks on Muslims from 2012,[44] Easter Sunday attacks by suspected Islamist terrorists in April 2019 and the total exclusion of Muslim politicians from the new government formed in December 2019, for the first time in the political history of post-independent Sri Lanka.[45] In other words, this was a time when Muslims were particularly vulnerable to social exclusion, scapegoating and negative stereotyping in media in general and social media in particular.[46]

Second, as of April 15, 2020, Muslims may have been actually overrepresented among COVID-19 patients in Sri Lanka even though we do not have any reliable official information of confirmed patients by their ethnicity or religion. Three of the seven COVID-19 related deaths in Sri Lanka as of April 15, were identified implicitly or explicitly as Muslims during the summary funerals held in front of television cameras in order to dispose the dead bodies.[47] This identification was confirmed by local Muslims I spoke to. If reported mortality is any index of morbidity, 43 percent of cases being Muslim at this particular juncture in a still unfolding epidemic would certainly over-represent them in COVID-19 morbidity and mortality compared to their relative size in the total Sri Lankan population, namely 10 percent.

Whether this rather crude assumption is indeed correct must be verified through further research. But for now, we can treat it as a plausible assumption to make about the social epidemiology of COVID-19 at a given period of the natural history of the epidemic in Sri Lanka, even though this is not consistent with figures quoted by some other sources. For instance, a public statement issued by Independent Professional Alliance on April 14, 2020 referred to an unpublished survey conducted by the government on an unspecified date that interestingly determined that only 6.3% of 191

[44] . Farzana Haniffa, Harini Amarasuriya, Vishakha Wijenayake and Gehan Gunatilleke. Where have all the Neighbours Gone? Aluthgama Riots and its Aftermath. Colombo: Law and Society Trust. 2018.

[45] . A.R.M. Imtiyaz. The Easter Sunday Bombings and the Crisis Facing Sri Lanka's Muslims. Journal of Asian and African Studies 2019:1-14.

[46] . Secretariat for Muslims. Anti-Muslim Sentiments in Sri Lanka: Hate Incidents of 2014. Colombo: Secretariat for Muslims, 2015.

[47] . In justification of this procedure it has to be stated here that all three Muslim persons who died of KOVID-19 in Sri Lanka as of April 10 were admitted to hospitals when ill and they are not an outcome of a possible over quarantine of suspected Muslims as claimed by some critics of the COVID-19 response in Sri Lanka.

COVID-19 confirmed corona patients at that point in time was Muslim.[48] The methodology used in this survey, however, was not specified. Further, it failed to recognise possible ramifications of TJ regional gatherings in the local spread of corona virus. In any case the ethnoreligious make up of patients is not fixed and it is likely to change with ebbs and flows in the epidemic and the emergence of new foci of infections in time to come.

Third, funeral arrangements for the dead Muslim COVID-19 patients led to a serious controversy, as mandatory cremation of COVID-19 deaths advocated by health authorities in Sri Lanka, was not acceptable to Muslim leaders considering that burial, preferably in a mosque or a designated Muslim cemetery, is the religiously sanctioned practice prescribed by the Koran. In a letter addressed to the President and other authorities dated April 2, 2020, a group of civil society actors representing different communities noted that compulsory cremation went against Clinical Practice Guidelines on COVID-19 patients issued by the Ministry of Health on March 27th allowing for either cremation or burial. These guidelines, however, were abrogated by a subsequent circular that made cremation compulsory even though burial is culturally and religiously prescribed in Islam.[49]

Protesting against the cremation of the first Sri Lankan Muslim who died of the virus, Rauff Hakeem, the leader of the Sri Lanka Muslim Congress, noted in his Facebook that it is "unfortunate, regrettable and of course reprehensible that the Janaza of the Negombo Victim of the COVID-19 virus had been cremated without permitting the burial as is ordained in our faith."[50] In a subsequent intervention at an all party conference regarding COVID-19, he produced a WHO document that permitted both cremation and burial but this was rejected by local health authorities on the grounds of high underground water levels in several areas in Sri Lanka rendering the second option potentially hazardous and unacceptable. Further, Hakeem claimed perhaps with valid reason that mandatory cremation might discourage Muslim patients to come forward in the fear that if they eventually die of the disease they will be required to go against the religiously sanctioned method of disposal of dead bodies. Many

[48] . https://srilankabrief.org/2020/04/status-statement-ii-sri-lankas-response-to-covid-19-alliance-of-independent-professionals/

[49]. Letter of April 4, 2020 addressed to the President of Sri Lanka and other authorities by civil society actors titled 'Disposal of Bodies of Deceased Persons Who were Infected with or Suspected of Being Infected with COVID-19".

[50] . https://economynext.com/hakeem-calls-cremation-of-muslim-covid19-victim-reprehensible-63220/

critiques of Rauff Hakeem in political debates and in social media echoed the need for common standards and a common law affecting all communities at a time of national disaster, downplaying cultural diversity and the need to compromise majority and minority perspectives within a functioning democracy.

Fourth, shutdown of a number of entire Muslim towns where confirmed patients were diagnosed led to media surveillance on these communities. Some of the COVID-19 hotspots identified by the authorities in late March were Muslim bazaar settlements such as Etulgama, Beruwala and Akurana and settlements of war-displaced Muslims from the North in Puttalam, who are presently often split between Puttalam and their original home areas in Mannar and elsewhere.[51]

In some instances, while briefing the media, the authorities referred to the confirmed patients by their Islamic identity contrary to the standard official practice of maintaining the anonymity in respect of all patients except where occupation and travel history (e.g. gem merchant returning from Germany) was mentioned in public. If Muslim persons are in fact overrepresented among COVID-19 patients in Sri Lanka, it is perhaps inevitable that some Muslim communities will be subjected to disease surveillance because of the compact nature of these communities and close social bonds among them.

What is problematic, however, is the wide publicity given to case detection in these communities resulting in increased surveillance of these communities by a combination of security forces, television cameras and health authorities. This is particularly problematic in view of the wave of anti-Muslim violence targeting such communities in recent years. In most instances, no effort was made to establish rapport with the community leaders and explain to them why isolation of their communities and community quarantine would be necessary.

In some instances, the entire communities were temporarily shifted to some quarantine centres situated far away during night time or early hours of the morning, giving no chance for the affected families to make prior arrangements for the visit.

[51]. For an ethnographic account of this community see Thiranagama, S. In My Mother's House: Civil War in Sri Lanka. Philadelphia: University of Philadelphia Press, 2011. Surenthiraraj and de Mel identified them as people with "two homes and refugees in both". See Esther Surenthiraraj and Neloufer de Mel. 'Two Homes and Refugees in Both': Contrasting Frameworks- the Case of Northern Muslims of Sri Lanka'. Journal of Social and Political Psychology 7 (2), 2019: 1044-1054.

Another deeply problematic development from the angle of public health and human rights has been the reported use of curfew introduced as a public health intervention for various other purposes. For instance, there has been a flurry of arrests of persons reportedly connected with the Easter Sunday attacks apparently using the lockdown imposed on Muslim communities.[52] Further, there was a roundup of beggars in Colombo claiming that they have been in contact with a drug ring reportedly linked with the spread of COVID-19 in low income neighbourhoods in Colombo. A similar roundup of brewers of illicit liquor who apparently tried to cash in on closure of liquor shops during public screening was also reported in media.

While the relevant illegal operations do require thorough investigations in their own right, mixing up of public health interventions with a broad range of questionable security operations carried out under the façade of public health screening, is likely to confuse the public and interfere with public compliance with COVID-19 containment measures. Apart from everything else, the members of the security forces themselves may be put in undue risk if they are unsure of the specific nature of the operations they are assigned to. In a way this can be seen as an inevitable outcome of an over reliance on security forces for carrying out public health interventions that require a different training, different mind-set and different tool kits, including effective protective gear.

Within the resulting environment of mistrust and blatant lack of cultural sensitivity and regard for human rights, contact tracing itself may have suffered due to the fear of exposure, fear of arrest and potential public denigration of the potentially infected and their family members. Even though Sri Lanka has had many outstanding successes in public health, successful eradication of malaria by September 2016 being one such achievement , these public health initiatives relied on persuasion and efficient delivery of services by technically competent health workers rather than application of force as such.[53]

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[52]. In a clear illustration of a potential misuse of COVID-19 contact tracing for security operations, when human rights lawyer Hejaas Hisbullah from COVID-19 affected Puttalam area, was arrested by the security forces on April 14, 2020 reportedly in connection with Easter Sunday attacks, he was apparently told in a telephone call that he will be visited by public health officials to get information about his potential exposure caused by the use of an ATM machine previously used by a COVID-19 infected person. Instead he was visited by police officers and was arrested without clarifying under what charges he was being arrested. See https://www.colombotelegraph.com/index.php/cid-abuses-covid-19-surveillance-to-detain-top-lawyer-habeas-corpus-petition-reveals-terrifying-details/. Accessed on April 19, 2020.

[53]. Margaret Jones. Health Policy in Britain's Model Colony: Ceylon 1900-1948. New Delhi: Orient Blackswan, 2004.

On the other hand, reported problems relating to public health uptake and compliance by the Muslims and their inclination to use private medical care, at least partly due to real or perceived discrimination at the point of health care delivery in the public sector,[54] language and cultural barriers experienced by Muslim women in particular in accessing health services in the public sector, have affected the health-seeking behaviour of Muslims as pointed out in some prior public health literature.[55] These tendencies of ethno-racial profiling in health services and the resulting difficulties encountered by the Muslim community in accessing health services are likely to be further reinforced by any real or perceived Muslim over representation among COVID-19 infected. Muslim response to the epidemic must be seen in the light of this complex scenario where they were under contradictory pressures and onslaughts from diverse sources.

Finally, following a pattern already well established in social media during the episodes of anti-Muslim violence and reports on Easter Sunday attacks, Muslims were overtly or covertly blamed for triggering the epidemic by virtue of their hiding of information including travel history when presenting themselves for medical treatment, being carriers of the disease from place to place (Figure 3) and irresponsible behaviour such as moving from one health care service to another without revealing their travel history and contacts, exposing others to infection. This also led to certain protests against dead bodies of Muslims being cremated in non-Muslim areas in front of certain public cemeteries designated for the task.[56] Similarly, a motor-vehicle that

[54]. In a graphic illustration of potential prejudices in government health services, a director of a leading cancer hospital in Colombo described a particular patient who entered the hospital without revealing his travel history etc. and later died of COVID-19 related complications as "a veritable suicide bomber" targeting health workers and cancer patients with compromised immunity levels. Later it came to light that the patient concerned was a Muslim. Obviously the health administrator concerned implied that the relevant COVID-19 patient was akin to a suicide bomber involved in Easter Sunday attacks. The same medical administrator had been previously engaged in a face book onslaught in Sinhala against a Muslim philanthropist who actually provided a PET scanner for the hospital through funds generated by him. So far no action has been taken against this blatantly racist medical administrator by the state or Sri Lanka Medical Council. For details see Prasanna Cooray. Maharagama Cancer Hospital Director Undermines the Fight against the Cancer Menace in Sri Lanka. February 3, 2020. http://dbsjeyaraj.com/dbsj/archives/67588.

[55]. D.D. Siriwardhana, A. Pathmeswaran and A.R. Wickremasinghe. Socioeconomic inequality and determinants of postnatal home visits made by public health midwives: An analysis of the Sri Lanka Demographic and Health Survey. PLOS one, April 24, 2019.

[56]. It has to be noted here that there were public protests against cremation of COVID-suspected or COVID-confirmed dead bodies of Sinhala persons as well. For instance, there was a protest by a few local people (Sinhalese) in Dadalla Cemetery when a COVID-suspected dead body of a Sinhala person was cremated objecting to possible spread of germ from the dead body to nearby Sinhala communities. By this time, it had been confirmed through a PCR test that the dead person was actually free of the virus and this was, in turn, revealed to the protestors by the health authorities, but they did not believe it. The Police arrested two protestors and

reportedly transported a Muslim from Akurana who later tested positive for COVID-19 was burnt in Nawalapitiya by unknown persons following the vehicle with the number plate being shown in TV news.

An example of a powerful Facebook post composed in pungent Sinhala mischievously attributing an uncomplimentary role to Muslims in the propagation of the corona epidemic in Sri Lanka is given in Figure 3. Importantly, Muslim traders, the same people who were subjected to anti-Muslim violence as well as communal-minded shop boycott campaigns in Sri Lanka, lately carried out concomitantly with violence, are the targets of this Facebook post which is composed deploying the neoliberal language of mass production, marketing and consumption and attributed figuratively to the Chinese, Muslim traders and the Sinhala consumers respectively.[57] There is pun intended in the rhyming words such as cheena, nana and corona, all identified as inevitable neoliberal evils confronting "we the Sinhalese". Even though the actual social history of the epidemic in Sri Lanka is far more complex with multiple factors contributing to the epidemic outbreak, this stereotypical formulation is likely to find many acceptors among people because they already have a prejudiced mind set shaped by popular culture and mass media.

went ahead with the cremation. The protests, however, were bigger in the case of cremation of COVID-19 Muslim dead bodies. For instance, when a dead body of a Muslim person who died of COVID-19 was planned to be cremated in Kotikawatta Cemetery in Colombo on April 2, a large gathering of protestors from the area gathered near the cemetery in violation of curfew, but authorities went ahead with the cremation in spite of the public protests. .

[57]. In spite of its seemingly innocuous appearance, this post constitutes 'hate speech' in terms of UN definition. "… any kind of communication in speech, writing or behaviour, that attacks or uses pejorative or discriminatory language with reference to a person or a group on the basis of who they are, in other words, based on their religion, ethnicity, nationality, race, colour, descent, gender or other identity factor." United Nations Strategy and Plan of Action on Hate Speech, 2019: 2.

Figure 3: A Facebook Post in Sinhala

Source:https://www.facebook.com/photo/?fbid=120994422874508&set=a.100605868246697) Accessed on April 2, 2020.

Translation

Made in China

Brand Name Corona

Distribution throughout Sri Lanka

By none other than Nana

(Nana is a Sinhala slang word for the ubiquitous Muslim trader in the distribution chain)

Composition and Art Work by

'Athal Fun Lovers'

Local Impact of Participation in TJ Events Overseas

Against this background it is rather surprising that health authorities in Sri Lanka did not pay attention to possible ramifications of TJ events in Kuala Lumpur, New Delhi or Sulawesi for escalation of the epidemic in Sri Lanka. In spite of the heightened media publicity given to these events in the respective countries and elsewhere, they were obviously not configured or monitored by Sri Lankan authorities from the angle of triggering or responding to infections in Sri Lanka. By comparison, health authorities in India have closely monitored the impact of the Delhi TJ gatherings on the evolving COVID-19 trends in India as noted earlier. Media reports in Malaysia and India did refer to Sri Lankan participation in these events, even though the number of participants and their level of exposure could not be established through these reports. If indeed there is overrepresentation of Muslims among the infected in Sri Lanka at a particular juncture in the history of the epidemic as is implied by community isolations by health authorities and as was speculated earlier in this report, it is quite likely that these TJ events did make some contribution depending on who and how many participated from Sri Lanka. It is, however impossible to determine the actual impact of Sri Lankan participation in the TJ events in the overall epidemic trends in the country with no official monitoring of Sri Lankan participation in these events and the resulting lacuna in reliable information.

There was, however, one glaring instance, where travel history to Indonesia for possible participation in a religious event was mentioned by the Army commander in public, following the detection of one confirmed COVID-19 patient from Puttalam. The person concerned, who was reportedly in compulsory home quarantine following his return from Indonesia, was found positive for COVID-19. Later, the authorities found that this person had many contacts in the area upon his return from Indonesia, including participation in a wedding ceremony in Mannar, and this led to a quarantine centre being quickly established in Zahira College in Puttalam. A total of 10 people who were in contact with the first patient were diagnosed with the disease by the end of March, resulting in the highest number of confirmed cases detected per day (21) up to that time on March 31 (see Figure 2). This nucleus of corona infection came to be known as “the Puttalam Cluster” in media and public health circles. Akurana cluster established later was attributed to a shoe trader who returned from a business trip to Chennai, but it also included at least one person who had returned from an Islamic

religious event in Indonesia.[58] Later, four other people who also reportedly participated in a religious event in Indonesia were identified in Badulla and they were sent to the quarantine centre in Kahagolla. No COVID-19 infection, however, has been detected in this group as at this point in time.

On March 31 the commander of the armed forces announced over TV that a person diagnosed with COVID-19 has travelled in a Malaysia Airlines flight from Kuala Lumpur on March 17th and 37 other people too have travelled with him. The government wanted them to come forward and register with the police as their identities were not known at the time. It is quite possible that the person identified and some others who travelled with him had returned from the Ijtema in Kuala Lumpur even though this was apparently not known or not recognised by the authorities in Sri Lanka at the time.

Surprisingly, no participants in the Delhi TJ gatherings have been detected in either the quarantine process or case detection up to now. This is indeed surprising as these events have been recognised as one of the most important drivers of the epidemic in India in general and Tamil Nadu in particular. Although a flurry of infections from India has been of serious concern to health authorities in Sri Lanka and a quarantine process was set up for Buddhist pilgrims returning from India in late March and the Sri Lankan navy was placed on high alert for possible escapees from India in the light of the escalating epidemic in South India, returnees from TJ gatherings in India have not been followed up on in Sri Lanka in spite of much media attention and official state recognition given to the impact of these events in understanding and responding to the COVID-19 pandemic in India. One possibility is that some of the COVID-19 infections in Sri Lanka attributed to other infections from India are in fact due to participation in TJ gatherings in Delhi. An alternative possibility is that TJ gatherings in Delhi did not make any impact on the epidemic in Sri Lanka in spite of potentially exaggerated claims in India. As of now, we have no empirical evidence to support either of these assumptions.

As for the apparent overrepresentation of Muslims in COVID-induced mortality and by implication COVID-19 morbidity in Sri Lanka at this point in time, while we cannot rule out the possible impact of TJ events in the region, it does not appear to be a lead

[58]. Personal communication with a medical practitioner in Akurana.

factor accounting for the current situation in Sri Lanka. Perhaps the cancellation of all public events by the state by mid-March, subsequent imposition of curfew and the corresponding ACJU directive to all mosques not to hold any public prayers within the mosque premises may have served to neutralise potential passing on of the virus to a large number of fellow Muslims by the participants returning from overseas TJ events who are religiously motivated and likely to play a key role in mosque activities in their home areas.

In addition to the possible impact of participation in TJ events overseas, the extent to which the Muslim livelihoods depended on spatial mobility within and outside Sri Lanka and the congested settlement pattern in Muslim commercial centres and bazaars may also be compelling reasons for their greater exposure to the virus.[59] In any case, this is a subject that requires well designed collaborative research involving health researchers and social scientists.

Finally, the lack of any civil society participation, minority representation or critical social science thinking at the level of policy formulation, a general malady in Sri Lanka irrespective of the political regime in power, has apparently contributed to a situation where COVID-19 response is guided by a narrowly demarcated set of technical, security and operational considerations designed by a cohort of security personnel and health professionals to a relative neglect of social and political issues involved and the possible impact of the COVID-19 policies and interventions on trust building, community development and long-term peace and stability in the country. In the letter to the authorities by civil society actors referred to earlier, this issue was indeed highlighted.

> "At present, the religious identity of certain victims has been highlighted due to which, in both mainstream and social media, we have seen outpourings of vitriol, and hate speech against Muslims for their actions or inactions in not preventing or causing the spread of COVID-19".[60]

[59] . It has to be noted here that, according to media reports, none of the three Muslims who died of Corona virus in Sri Lanka as at this point in time reported of a travel history to TJ events reported in this essay. Their infections were attributable to business travel or exposure to family members who travelled abroad for work or business. On the other hand, the impact of participation in the religious gatherings is likely to show up later because of the timing of the events in Delhi and Sulawesi in particular.

[60] . Letter of April 4, 2020 addressed to the President of Sri Lanka and other authorities by civil society actors titled 'Disposal of Bodies of Deceased Persons Who were Infected with or Suspected of Being Infected with COVID-19".

A similar opinion was expressed by the Alliance of Independent Professionals as well.

> "The military and intelligence services remain in charge of the government's effort against Covid-19 … health authorities have expressed their disappointment in the intelligence services leaking information of the patients to media and politicians in the government". [61]

Conclusion

Even though identity issues were completely ignored at one level by health authorities in Sri Lanka and several other countries in the region in understanding or responding to the epidemic, as evident from targeting of particular communities in the contact tracing process, it is quite clear that identity issues did play an important role in the mind-set of the media personnel, health workers, security establishment and the public at large as well as to the yet to be precisely established possible Muslim trigger in the epidemic. In media accounts, in social media in particular, 'who is infecting whom' has been a major preoccupation in this era of globalisation where uncertainties and existential insecurities are often attributed to the minorities and socially marginalised as has been pointed out by many observers on epidemics in different countries.[62] As has been noted by previous commentators, the global COVID-19 epidemic has also triggered a 'pandemic of hate', with various parties, including the state, military, social media, TV and print media, knowingly or unknowingly contributing to the dissemination of this parallel and equally harmful germ.[63] In the case of Sri Lanka, the military-led COVID-19 response has been clearly insensitive to minority rights and the need for recognising cultural diversity. At the same time, it has failed to understand and satisfactorily respond to the potential religious drivers of the epidemic in ways that do not stigmatise particular communities and secure their participation in addressing complex disease control and related humanitarian issues.

It is indeed critically important to know that different communities, including different religious groups, relate to the epidemic differently because of their differences in faith, differences in forms of greeting (for instances handshakes,

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[61] . https://srilankabrief.org/2020/04/status-statement-ii-sri-lankas-response-to-covid-19-alliance-of-independent-professionals/

[62] . R. Dingwall, L.M. Hoffman and K. Staniland. Introduction: Why Sociology of Pandemics? Sociology of Health and Illness. 35 (2) 2013: 167-173.

[63] . https://www.newframe.com/a-pandemic-of-hate/ Accessed on April 8, 2020.

hugging and kissing), differences in lifestyle (for instance bazaar life in some communities), differences in worship practices such as physical proximity in congregations, differences in funeral arrangements and disposal of dead bodies and the degree of congestion and crowdedness often linked to poverty and resource limitations. The civil society responses so far appear to be as ignorant as the state about and equally oblivious to potential social, cultural and religious drivers and consequences of the epidemic. An unbiased analysis of the social epidemiology of the pandemic free of the blame game and the effort to find scapegoats, is needed for this purpose. It is important to note here that epidemics such as HIV/AIDS became manageable when the affected communities began to make responsible decisions and took up risk minimisation behavioural change.

Disease control ideas such as social distancing, lockdown and quarantine do not always work smoothly in the expected manner because they are not based on a realistic assessment of the social world in different contexts, whether we are talking about subsidised public transport services, urban low-income (*watta*) communities, plantation labour quarters (line rooms), bazaar townships or even in military barracks in Sri Lanka. We may not have an escape from these life-saving strategies in a rapidly expanding global pandemic like COVID-19, but for their effective implementation they need community participation, trust, acceptance of and mutual respect for cultural diversity and leading from below as much as leading from above. While Islam in general has been a conformist religion supportive of the status quo with ACJU, for instance, immediately cancelling all collective prayers in mosques until further notice once Sri Lankan state cancelled all public events, religious movements such as Tablighi Jamaat may not always conform to directives just because they are legally and administratively enforced by external authorities whose authority and legitimacy may be questioned by the movements.

We do have to admit that there is human complicity in epidemic flows, whether we are talking about those involved in organising the live animal market in Wuhan, possible contribution of TJ events in epidemic flows in South and Southeast Asia or possible disease transmission via the Royal - Thomian match in Colombo. However, blaming one community as 'the superspreader' of the epidemic either by political authorities at the top or other agents such as media or rumour is certainly not justified and it does

not help in disease control and prevention interventions to the extent that control efforts will be misdirected and not geared to effective community participation.

At the same time, the disease response must be informed and guided by an unbiased and nuanced understanding of the social and political context of public mobilisation and exposure to risk as against politically charged distorted notions such as "our unblemished faith will protect us", "we the blessed people of Sri Lanka will be saved" or Islamophobia and stereotypical popular ideas of who is infecting whom.[64] For a nuanced understanding of how social factors indeed contribute to epidemics, well designed social epidemiological research that situates viruses and microbes within the larger social, political and environmental context is necessary. This is particularly relevant for understanding the rapid global spread of deadly corona virus within a specific socio-political global context.

The gender dimensions of the epidemic, not addressed in this essay, also require closer attention. The epidemiological data published by the Ministry of Health is not gender segregated. In a TV discussion, one health official in Sri Lanka noted that about 25 to 33% of all confirmed cases are women and this also appears to be the case in the epidemiological profile in other countries. All COVID-19 deaths reported so far in Sri Lanka are among males. The religious gatherings discussed in this paper are all male gatherings by definition and this together with the fact that much of business travel is done by males may partly account for this situation. On the other hand, risk behaviours such as smoking and alcohol consumption, more common among males in the broader Asian context, may also make them more vulnerable to the disease and complications caused by the disease once infected. On the other hand, according to media reports, most of the infected women, children and elderly people in Sri Lanka appear to have been infected by their male counterparts who became exposed to the disease during travels abroad or business activities outside home and also because of the failure to practise social distancing in many household contexts in Sri Lanka, particularly in poorer over-crowded settings.

A significant epidemic outbreak involving some 62 confirmed COVID-19 patients as of April 20th in Kesellwatta, a low-income community in Colombo, was traced to a Sinhala woman, a potential superspreader like patient 31 in South Korea. The person

[64]. This is of course by no means unique to Sri Lanka. Donald Trump's calling the virus "Chinese virus" or "Wuhan virus" is another blatantly racist take on the pandemic.

concerned, who had reportedly travelled to India for a combination of business and pilgrimage, came under media scrutiny in mid-April, fortuitously diverting attention away from Muslims as a source of infections at least temporarily. A gender, social class and culture sensitive approach is certainly needed in trying to understand the exposure to the disease, risk of infection and risk of facing life-threatening situations as well as in disease response in matters such as home quarantine, institutional quarantine, community lockdowns and funeral practices.

Globally, the COVID-19 response has been designed and implemented within a country framework where authorities in each country seek to contain the epidemic within its own territory. This is perhaps the only available framework to respond to a fast spreading epidemic of this nature, but the analysis in this paper points to serious lapses in this approach when responding to a fast spreading epidemic that does not recognise national borders. In so far as TJ events in Malaysia, India and Indonesia impacted the disease burden in each country and in neighbouring countries, country-level COVID-19 responses can only respond once the disease has already caused irreparable damage at the higher level (upstream). Social undercurrents like the TJ movement operate in transnational spaces and openings using online communication and virtual engagements, giving states limited potential for intervention.

This is where bipartisan or multilateral engagements such as WHO Southeast Asia Regional Office (SEARO), South Asian Association for Regional Cooperation (SAARC) and Association for Southeast Asian Nations (ASEAN) can do serious preventive, monitoring and mopping up operations perhaps in collaboration with civil society initiatives at the regional level, like South Asian Collective. This effort should not only seek to minimise religions' potential contribution to disease transmission, but also mobilise religions' capacity for healing and promoting public action in domains such as charity, philanthropy and mutual concern in terms of risk reduction and not passing on the virus to others, irrespective of who they are.

Finally, in reporting disasters and pandemics, media has a great deal of responsibility to raise public awareness and highlight resource constraints when it comes to serving the pandemic victims. However, media, especially social media not subjected to any public scrutiny, appear to add to the fear psychosis, blame game and panic responses in place of educating the public and shaping a well-informed public opinion. Hate mongering and dissemination of unfounded fears and prejudices targeting Muslims in

particular have been freely circulating in social media and in some measure in regular print and electronic media as well. Just like the larger macro-level response to the pandemic itself, media response to the pandemic in Sri Lanka has been state-centric, minority and social underclass insensitive and unreflective and unresponsive especially when it comes to a plethora of public grievances, human right violations, livelihood insecurities and difficulties caused by state-imposed restrictions as reflected in the arrest of a large number of curfew breakers as well as suspects for various other offenses, including those reportedly connected with national security, throughout the period. As some farmers whose livelihood was paralysed due to the epidemic response reported to media "we may die of hunger before the corona virus takes us". This is an issue that requires further reflection as we in South and Southeast Asia prepare for the next phase of the pandemic in whatever shape or benign or threatening forms it will come.

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