INTEGRATING HUMAN RIGHTS WITH LOCAL NORMS: EBOLA, BURIAL PRACTICES, AND THE RIGHT TO HEALTH IN WEST AFRICA

JULIE FRASER & HENRIKE PRUDON*

While international rights are intended to apply universally, their interpretation is culturally dependent and implementation contextually defined. Scholars have therefore advocated culturally sensitive approaches to human rights that include local norms in programs for effective implementation. This paper examines such approaches by scholars including Celestine Nyamu-Musembi (2000), Erika George (2008), and Tom Zwart (2012), and explores their application in a case study on the right to health, Ebola, and burial practices in West Africa. As these approaches aim to integrate local norms with universal human rights, their application in a case study enables a critical assessment of whether the coexistence and interaction of different normative orders may help to more effectively implement human rights standards in a given context.

Introduction

While the issue of human rights universalism and relativism has existed for several decades, a more sophisticated and less dichotomous debate has slowly emerged.[1] Rather than debating the origin of particular norms or the global foundations of human rights, it is now generally accepted that the universality of rights does not

* Julie Fraser (B.A., LL.B., LL.M.), Ph.D. Candidate at SIM, Utrecht University, The Netherlands; and Henrike Prudon (B.A., LL.B.), M.Sc. Cultural Anthropology, Utrecht University, The Netherlands. The authors would like to thank Professor Dr. Tom Zwart, Dr. Michael Odhiambo, Dr. Marc Simon Thomas, and Dr. Katrien Klep for their valuable input. We would also like to thank Professor Dr. Cheikh Niang, an expert in the field, for introducing us to this subject-matter. All errors remain with the authors.

[1] *See* Marie-Bénédicte Dembour, *Following the Movement of a Pendulum: Between Universalism and Relativism*, *in* CULTURE AND RIGHTS: ANTHROPOLOGICAL PERSPECTIVES 56, 56 (Jane K. Cowan et al. eds., 2001).

mean their uniformity in implementation. When implementing international human rights obligations, more emphasis is given to the need for and the extent to which States can consider and accommodate their local circumstances, such as legal tradition, culture, politics and economics.[2] More attention is increasingly paid to the user's perspective of human rights, and the variety of contexts and norms relevant to human rights enjoyment. As such, scholars and practitioners have advocated approaches to human rights that include local norms in programs for effective implementation. While several different theoretical approaches have been formulated, their distinct contributions in practical application are yet to be analyzed.

It is contended that such theoretical approaches are necessary both from a normative perspective (emphasizing the value of diversity and cultural rights) and from a practical one (legitimacy and efficacy). This paper examines how so-called "culturally sensitive approaches to human rights" can assist in the acceptance, implementation and enjoyment of rights. Using the example of the right to health and the recent Ebola outbreak in West Africa, this paper submits that such approaches can be indispensable to human rights protection. As these approaches aim to integrate local norms with universal human rights, their application in a case study enables a critical assessment of whether the coexistence and interaction of different normative orders may help to more effectively implement human rights in a given context. The paper explores culturally sensitive approaches to the right to health in a case study considering how cultural practices regarding death and burial can assist or undermine the implementation of the right to health. The main question is: how do culturally sensitive approaches to human rights operate in practice to enhance the enjoyment of the right to health?

While numerous scholars have written on culturally sensitive approaches to human rights, this paper considers specifically the pragmatism/capabilities approach by Erika George; critical

[2] David Kinley, *Bendable Rules: The Development Implications of Human Rights Pluralism*, *in* LEGAL PLURALISM AND DEVELOPMENT: SCHOLARS AND PRACTICE IN DIALOGUE (Brian Tamanaha et al. eds., 2012); *see also* Sally Engle Merry, *Transnational Human Rights and Local Activism: Mapping the Middle*, 108 AM. ANTHROPOLOGIST 38, 38-51 (2006).

pragmatism advocated by Celestine Nyamu-Musembi; and Tom Zwart's receptor approach.[3] The paper considers the opportunities and challenges of these culturally sensitive approaches, including their potential to increase the legitimacy and effectiveness of human rights measures in local settings. Further, comparing the various methods facilitates the identification of the constitutive elements of a practically useful contextual approach. The topic of Ebola in West Africa was selected because it serves as a contemporary and well-known example of the right to health, which also has a prominent cultural dimension. Information regarding the relevant traditional burial practices in West Africa has been drawn from existing ethnographic research.

This paper is divided into three sections. The first section sets out the right to health under international law with a focus on its cultural dimension. The second section presents an overview and comparative analysis of the three selected culturally sensitive approaches to human rights. The third section introduces the case study of the recent Ebola outbreak in West Africa, and applies the culturally sensitive approaches to the right to health in context. It focuses on how the approaches can highlight the user's perspective and integrate various cultural norms into effective human rights protections. The paper concludes by analyzing the insights gained from the application of the culturally sensitive approaches to the right to health in the case study, and considers their potential for further integration of the human rights project.

---

[3] Erika R. George, *Virginity Testing and South Africa's HIV/AIDS Crisis: Beyond Rights Universalism and Cultural Relativism Toward Health Capabilitie*s, 96 CAL. L. REV. 1447, 1517 (2008); Celestine Nyamu-Musembi, *How Should Human Rights and Development Respond to Cultural Legitimization of Gender Hierarchy in Developing Countries?*, 41 HARV. INT'L L.J. 381, 418 (2000); *see also* Tom Zwart, *Using Local Culture to Further the Implementation of International Human Rights: The Receptor Approach*, 34 HUM. RTS. Q. 546 (2012).

I. The Right to Health

The right to health is one of the broadest and most complex of international human rights.[4] First articulated on the global level in 1946, the World Health Organization's (WHO) Constitution provides that the "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."[5] The right was subsequently included in the 1948 Universal Declaration of Human Rights and the WHO Declaration of Alma-Ata of 1978.[6] The right to health is legally protected in several international instruments, including Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[7] It is also protected regionally, *inter alia*, in Article 16 of the African Charter on Human and Peoples' Rights.[8]

Article 12(1) of the ICESCR defines the right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12(2) of the ICESCR sets out the necessary steps for States Parties to take in order to achieve the full realization of the right, including in the case of epidemics. The

---

[4] Paul Hunt (Special Rapporteur of the U.N. Human Rights Council), *Report of the Special Rapporteur the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 24, U.N. Doc. A/HRC/4/28 (Jan. 17, 2007).

[5] World Health Organization [WHO] [CONSTITUTION] Jul. 22, 1946, at Preamble.

[6] G.A. Res. 217 (III) A, Universal Declaration of Human Rights, at art. 25 (1) (Dec.10, 1948) [hereinafter UDHR]; *see also generally* International Conference on Primary Health Care, *Declaration of Alma-Ata*, (Sept. 6-12, 1978), *available at* http://www.euro.who.int/__data/assets/pdf_file/0009/113877/E93944.pdf [hereinafter Declaration of Alma-Ata].

[7] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3, [hereinafter ICESCR]. It is also protected in several other international and regional documents. *See also International Standards -- Right to Health*, U.N. OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS ("U.N. OHCHR"), http://www.ohchr.org/EN/Issues/Health/Pages/InternationalStandards.aspx (last visited Nov. 12, 2016).

[8] African (Banjul) Charter on Human and Peoples' Rights, art. 16, Jun. 27, 1981, 1520 U.N.T.S. 217; *see also* African Charter on the Rights and Welfare of the Child, art. 14, Jul. 11, 1990, OAU Doc. CAB/LEG/24.9/49.

U.N. Committee on Economic, Social and Cultural Rights (CESCR), which monitors the implementation of ICESCR, has elaborated much of the right to health, particularly in its General Comment No. 14.[9] This Comment has provided much needed clarity to the right to health and its various elements. The U.N. Special Rapporteur on the right to health noted, while not legally binding and imperfect in places, the General Comment is both "compelling and groundbreaking."[10] This section addresses some elements of the right to health under ICESCR, with a focus on the right's cultural dimensions.[11]

A. What is the Right to Health?

Rather than the right to be healthy, the CESCR has interpreted the right to health "as a right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health."[12] These health facilities, goods, services, and conditions must be of good quality as well as available, accessible, and acceptable to the relevant people in each State.[13] As such, the right to health is made up of several connected and complex aspects, and its enjoyment relies upon the cooperation of numerous actors. It is best understood as the right to a health system that creates conditions for everyone to enjoy

---

[9] U.N. Committee on Economic, Social and Cultural Rights [CESCR], *General Comment No. 14: The Right To the Highest Attainable Standard of Health (Art. 12)*, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14].

[10] Hunt, *supra* note 4, at ¶ 9. While not legally binding, the Committee's interpretations are the most authoritative views on the ICESCR.

[11] This paper does not intend to give a full analysis of the right to health and as such many aspects of the right are not discussed, including issues regarding justifiability, territoriality, health indicators, or health jurisprudence from around the world. For more information on the right to health *see* Ben Saul et al., *Chapter 14: Article 12 The Right To Health*, *in* THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMMENT, CASES, AND MATERIALS (2014).

[12] General Comment No. 14, *supra* note 9, at ¶ 9.

[13] *Id*. at ¶ 12.

the highest attainable standard of health.[14] By nature, such a health system is very broad, comprises all healthcare actors[15], and addresses both healthcare as well as the underlying determinants of health.[16]

1. The Obligation to Implement

Under the ICESCR, the right to health is legally binding upon States Parties, which are obliged to respect, protect and fulfill that right. Article 2(1) provides that States are required to progressively achieve the full realization of Covenant rights, thereby recognizing the resource constraints States may face and the time it will necessarily take to implement these rights.[17] It also allows for a differentiated standard between developed and less developed States.[18] In this way, some aspects of the right to health are immediately enforceable, while in relation to other aspects, a State must show that it is making every possible effort, within available resources, to continuously better protect and promote the right.[19] For

---

[14] ICESCR, art. 12.2(d); U.N. OHCHR, *supra* note 7, at ¶ 8; Paul Hunt (Special Rapporteur of the U.N. HRC), *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 4, U.N. Doc. E/CN.4/2006/48 (Mar. 3, 2006).

[15] "A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation." *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, WORLD HEALTH ORGANIZATION ("WHO"), (2007) http://who.int/healthsystems/strategy/everybodys_business.pdf.

[16] The underlying determinants of health include adequate sanitation, safe drinking water and health education. Hunt, *supra* note 14, at ¶ 5.

[17] CESCR, *General Comment No. 3: The Nature of States Parties Obligations*, U.N. Doc. E/1991/23 (Dec. 14, 1990) [hereinafter General Comment No. 3].

[18] Hunt, *supra* note 4, at ¶ 59.

[19] However, the Special Rapporteur has noted that "progressive realization does not mean that a State is free to choose whatever measures it wishes to take so long as they reflect some degree of progress. A State has a duty to adopt those measures that are most effective, while taking into account resource availability and other human rights considerations." Hunt, *supra* note 4, at ¶ 50.

example, a State's health system must have, *inter alia*, a comprehensive national plan; a minimum "basket" of health-related facilities and services; and ensure public participation as well as respect for cultural difference.[20]

States Parties are obliged under ICESCR to implement the right to health via various complementary approaches such as through laws, action plans, community consultation and international cooperation.[21] The CESCR has indicated a preference for legislative implementation,[22] but also recognizes the importance of other measures (administrative, financial, educational, and social measures).[23] Crucially, the CESCR acknowledges that the implementation measures adopted by States will vary significantly, and that each State enjoys certain discretion in determining the measures most suited to its circumstances.[24] While it is vital for measures to be tailored not just to national but also local settings to be effective, the CESCR supervises a State's exercise of this discretion.[25] To avoid violating the ICESCR, States must take *all* necessary steps to ensure the right to health is realized, including regulating third party activities to prevent them violating the right of others.[26]

Furthermore, the right to health implies that States are not only individually obliged to realize the right to health, but they are also required to cooperate internationally to realize the right.[27] This applies in times of emergency and also due to the fact that some diseases (such as HIV/AIDS and Ebola) are easily transmissible

---

[20] *Id*. at ¶ 66; General Comment No. 14, *supra* note 9, at ¶¶ 43-44.

[21] General Comment No. 14, *supra* note 9, at ¶ 1.

[22] *See* Hunt, *supra* note 4, at ¶ 105. "First, the right to the highest attainable standard of health should be recognized in national law. This is very important because such recognition gives rise to legal accountability for those with responsibilities for health systems. … It should be recognized in the national law of all States."

[23] General Comment No. 3, *supra* note 17; General Comment No. 14, *supra* note 9, at ¶¶ 33, 36.

[24] *Id*. at ¶ 4; *Id*. at ¶ 53.

[25] General Comment No. 3, *supra* note 17, at ¶ 4.

[26] General Comment No. 14, *supra* note 9, at ¶¶ 51-53.

[27] General Comment No. 3, *supra* note 9, at ¶ 14.

across borders. The CESCR envisages the involvement of international non-state actors in the realization of the right to health, including the WHO, UNICEF and the World Bank.[28]

2. Public Participation

An essential element of the right to health is public participation in all health-related decisions at the local, national, and international levels.[29] More importantly, the CESCR has identified public participation as one of the core minimum obligations that is immediately enforceable.[30] This is arguably so because the provision of health services can only be effective if States ensure public participation.[31] Special Rapporteurs have identified active and informed participation on issues including identifying the overall strategy, policy, implementation, and accountability,[32] as a public entitlement rather than privilege.[33] Access to health information[34] is a key aspect of an effective health system, which "enables individuals and communities to promote their own health, participate effectively, claim quality services, monitor progressive realization, … [and] hold

---

[28] *See generally* General Comment No. 14, *supra* note 9, at Section V; *see also* Manisuli Ssenyonjo, *Non-State Actors and Economic, Social and Cultural Rights*, *in* ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN ACTION 109–135 (Baderin & McCorquodale eds., 2007).

[29] General Comment No. 14, *supra* note 9, at ¶¶ 11, 17.

[30] Anand Grover (Special Rapporteur of the U.N. GAOR), *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical & Mental Health*, ¶ 19, U.N. Doc. A/HRC/17/25 (Apr. 12, 2011).

[31] General Comment No. 14, *supra* note 9, at ¶ 54.

[32] Hunt, *supra* note 4, at ¶ 41; General Comment No. 14, *supra* note 9, at ¶ 54.

[33] Grover, *supra* note 30, at ¶ 51.

[34] "Individuals are entitled to a full range of health information that bears upon them and their communities. This includes information on preventive and health-promoting behaviour, as well as how to access health services." Paul Hunt (Special Rapporteur of the U.N. GAOR), *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical & Mental Health—Addendum—MISSION TO UGANDA*, ¶ 33, U.N. Doc. E/CN.4/2006/48/Add.2 (Jan. 19, 2006).

those responsible to account."[35] In this way, obligations regarding the right to health relate both to the processes and outcomes.[36]

It is clear while States are accountable under international treaties, all members of society have responsibilities regarding the right to health, including individuals, families, communities, civil society organizations, intergovernmental organizations and the private sector.[37] This is supported by the Declaration of Alma-Ata,[38] Article 29 of the UDHR,[39] and the U.N.G.A. Declaration on the Rights and Responsibilities of Individuals, Groups, and Organs of Society.[40] As such, States should create institutional arrangements and conditions conducive for such actors to discharge their responsibilities *vis-à-vis* the right to health.[41] Participating stakeholders can play important roles supporting implementation by providing, *inter alia*, "technical expertise and communicating the interests of affected communities."[42]

B. The Cultural Dimension of the Right to Health

As drawn out by the CESCR, Special Rapporteurs, and scholarship, a key aspect of the right to health is its relationship with culture. While an agreed definition remains elusive, "culture" can generally be seen to encompass the complex features that characterize a society/social group, including modes of life, value

---

[35] Hunt, *supra* note 4, at ¶ 40.

[36] "It is not only interested in what a health system does (e.g., providing access to essential medicines and safe drinking water), but also how it does it (e.g., transparently, in a participatory manner, and without discrimination)." *Id.* at ¶ 39.

[37] General Comment No. 14, *supra* note 9, at ¶ 42; *see also* Ssenyonjo, *supra* note 28, at 126.

[38] Declaration of Alma-Ata, *supra* note 6, ¶ IV.

[39] Ssenyonjo, *supra* note 28, at 123; UDHR, *supra* note 6, at art. 29.

[40] G.A. Res. 53/144 (Mar. 8, 1999).

[41] General Comment No. 14, *supra* note 9, at ¶ 42.

[42] U.N. Secretary-General, *Note on Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 33, U.N. Doc. A/69/299 (Aug. 11, 2014).

systems, traditions, and beliefs.[43] What is agreed upon is that culture is not static or inert, but dynamic and continuously (re)invented. Rather than a product, culture is a process with no well-defined boundaries and multiple influencers.[44] As a society's norms and values make up part of its culture, human rights cannot be detached from culture,[45] as it constitutes a normative order that human rights will necessarily interact with. Lenzerini's analysis demonstrates that culture is an essential element of human rights, necessarily influencing "[its] structure, perceptions, adjudication, and enforcement."[46]

On this basis, scholars have noted that almost all human rights have a "cultural dimension."[47] This has been recognized by the CESCR in relation to economic and social rights, including the right to health.[48] This is crucial as it acknowledges that culture impacts upon our perceptions of sickness and health, our understanding of

---

[43] *See* UNESCO, Universal Declaration of Cultural Diversity preamble, UNESCO Doc. 31C/Res 25, Annex 1 (Nov. 2, 2001); *see also* UNESCO, World Conference on Cultural Policies, *Mexico City Declaration on Cultural Policies* (Aug. 6, 1982), [*available at* http://portal.unesco.org/culture/en/files/12762/11295421661mexico_en.pdf/mexico_en.pdf.]. The latter also includes human rights. *See also* CESCR, *General Comment No. 21: The Right of Everyone to Take Part in Cultural Life (Art. 15(1)(a))*, ¶ 13, U.N. Doc. E/C.12/GC/21 (Dec. 21, 2009).

[44] Yvonne Donders, *Inaugural Lecture Delivered upon Appointment to the Chair of Professor of International Human Rights and Cultural Diversity at the University of Amsterdam*, HUMAN RIGHTS: EYE FOR CULTURAL DIVERSITY (Jun. 29, 2012), http://www.oratiereeks.nl/upload/pdf/PDF-6449weboratie_Donders.pdf; FEDERICO LENZERINI, THE CULTURALIZATION OF HUMAN RIGHTS LAW 220-221 (2014).

[45] *Universality of Human Rights and Cultural Diversity*, ADVISORY COUNCIL ON INTERNATIONAL AFFAIRS TO THE DUTCH FOREIGN MINISTRY (Jun. 4, 1998), http://aiv-advies.nl/download/d610af2e-eb72-454c-a238-8a061f99a088.pdf [hereinafter Advisory Council].

[46] Lenzerini, *supra* note 44, at 213.

[47] Donders, *supra* note 44, at 17; Lenzerini, *supra* note 44, at 123, 152; *see also* Melville Herskovits, *Statement on the Human Rights', submitted to the U.N. Commission on Human Rights by the American Anthropological Association Executive Board*, 49 AM. ANTHROPOLOGY 539-543 (1947) (regarding the concept of human rights as cultural).

[48] General Comment No. 14, *supra* note 9, at ¶ 12(c).

them and our responses to them. Furthermore, the CESCR held that the rights to food, water, and housing must also be culturally appropriate, which is important as they are underlying determinants of health.[49] The CESCR has specifically stated that all health facilities, goods and services must be "culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities."[50]

The Special Rapporteur has also acknowledged the need for cultural sensitivity in the right to health, noting that while necessary as a matter of principle, cultural respect also "makes sense as a matter of practice."[51] Special Rapporteurs have stated that the national health plan must be "responsive to national and local priorities"[52] and that both the drafting process and the plan itself must respect cultural difference.[53] For example, the national "health system is required to take into account traditional preventive care, healing practices and medicines."[54] In addition, health workers should be sensitive to ethnicity and culture,[55] and community health workers should be trained as they are best placed to understand and respond to their communities' health needs and priorities.[56]

Despite these statements in the General Comment and elsewhere requiring health goods and services to be culturally appropriate, the CESCR has rarely elaborated on its meaning. In her research, Donders found no further specification of what "culturally

---

[49] CESCR, *General Comment No. 12, The Right to Adequate Food (Art. 11)*, U.N. Doc. E/C.12/1999/5, ¶¶ 8, 11 (May 12, 1999) [hereinafter General Comment No. 12]; CESCR, *General Comment No. 15, The Right to Water (Arts. 11 & 12)*, U.N. Doc. E/C.12/2002/11, ¶ 12(c)(i) (Jan. 20, 2003) [hereinafter General Comment No. 15]*;* U.N. OHCHR, *General Comment No. 4, The Right to Adequate Housing (Art. 11(1))*, U.N. Doc. E/1992/23, ¶ 8(g) (Dec. 13, 1991) [hereinafter General Comment No. 4].

[50] General Comment No. 14, *supra* note 9, at ¶ 12(c).

[51] Hunt, *supra* note 19, at ¶ 44.

[52] Hunt, *supra* note 16, at ¶ 4.

[53] *Id*., *supra* note 19, at ¶ 44.

[54] *Id.*

[55] *Id.*

[56] *Id*., *supra* note 16, at ¶ 7.

appropriate" means in practice.[57] She found very few explicit references, and that the Concluding Observations of the ICESCR, CRC and CEDAW Committees do not often, nor consistently, refer to the right to health's cultural dimensions.[58] It appears that the CESCR delegates the determination of what is "culturally appropriate" in context to the States, who are also required – albeit without clear instructions - to consult with the relevant cultural communities.[59] In this way, differences or conflicts may arise between the State and the community's view of what is or what is not appropriate, potentially giving rise to a conflict between the right to health and the right to participate in cultural life.[60]

In the Concluding Observations, Donders found that most of the discussion focused – as it tends to in human rights discourse – on culture as an *obstacle* to the enjoyment of the right to health, such as the practice of female genital mutilation/cutting (FGM/C).[61] Therefore, Donders differentiated between two types of cultural dimensions regarding the right to health: 1) the need to ensure the cultural appropriateness of health goods and services; and 2) the need to protect against certain cultural approaches/practices that negatively impact upon the right to health. The second aspect implies that the right to health requires the eradication of cultural patterns and stereotypes that present obstacles to the enjoyment of the right to health, as well as cultural practices that are detrimental to health.[62] The requirement for health goods and services to be culturally appropriate should not be interpreted as permitting unjustifiable limitations on the enjoyment of the right to health.[63]

---

[57] Yvonne Donders, *Exploring the Cultural Dimension of the Right to the Highest Attainable Standard of Health*, 18 POTCHEFSTROOM ELECTRONIC L.J. 197 (2015).

[58] *Id.* at 192.

[59] Donders, *supra* note 57 at 197-198.

[60] ICESCR, at *supra* note 7, at art. 15; *see also* General Comment No. 21, *supra* note 43.

[61] Donders, *supra* note 57, at 192, 198, 203-204; Sally Engle Merry, *Human Rights Law and the Demonization of Culture (and Anthropology Along the Way)*, 26 POL. & LEGAL ANTHROPOLOGY REV. 60 (2003).

[62] Merry, *supra* note 61, at 192.

[63] *Id*. at 210; Ben Saul, David Kinley & Jaqueline Mowbray, *Chapter 17: Art.*

States should implement the right to health, taking into account the local cultural context and in consultation with the relevant communities. As can be seen in the case study below, public participation is crucial as it assists in the State's determination of the cultural appropriateness of goods and services, in the identification of cultural obstacles to the enjoyment of the right to health (if any) as well as its remedy. While States undoubtedly have discretion in this determination, it is subject to international supervision by United Nations monitoring bodies, which have already ruled on some practices such as FGM/C and child marriage.[64] Finally, it should be noted that given culture's dynamism, what is deemed culturally appropriate may change over time and space, and assessments of such appropriateness may need to be kept up to date through consultation.

C. Conclusion: The Right to Health

Under Article 12 of the ICESCR, State Parties are legally bound to progressively realize the right to health and must take all necessary steps to implement a national health system. This includes the adoption of legal and other measures, and the State must determine in its discretion those measures best suited to be effective in its national context. States are obliged to involve public and private actors as well as cultural communities in the design and implementation of health measures. States are furthermore obliged to ensure health services and goods are culturally appropriate. This is an implicit recognition of the substantive role of culture in human rights. However, States are not required to respect all cultural practices and should in fact ameliorate practices that present

---

15: Cultural Rights, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: COMMENT, CASES, AND MATERIALS 1210-1211 (2014).

[64] *See* Committee on the Elimination of Discrimination Against Women ("CEDAW") and Committee on the Rights of the Child ("CRC"), *Joint General Recommendation No 31. of Committee on the Elimination of Discrimination Against Women/General Comment No 18 of the Committee on the Rights of the Child on Harmful Practices*, ¶¶ 19-22, U.N. Doc. CEDAW/C/GC/31-CRC/C/GC/18 (Nov. 14, 2014).

obstacles to the enjoyment of the right to health. This should also be done in a culturally sensitive way and in consultation with the relevant communities. As reiterated by the Special Rapporteur, "[i]nclusive, informed and active community participation is a vital element of the right to health."[65]

II. Culturally Sensitive Approaches to Human Rights

Given the cultural dimension of the right to health, as well as of other rights, scholars have increasingly advocated the use of culturally sensitive approaches to human rights. This is because in order to be accepted as legitimate and effective in practice, human rights need to be informed by local communities.[66] A community's values and norms will shape individual/communities' perception of human rights.[67] As such, human rights measures should be tailored to local settings rather than transplanted from above/abroad. Crucially, the universal application of international human rights does not imply their uniform implementation.[68] Culturally sensitive approaches emphasize the user's perspective, recognizing that "rights make very little sense unless they are alive among the people."[69] It is on this basis that academics and practitioners have increasingly called for more culturally sensitive approaches to human rights, and greater respect for cultural diversity in the interpretation, implementation and adjudication of rights.[70] This is often done both

---

[65] Hunt, *supra* note 16, at ¶ 7.

[66] *See* Michael Freeman, *Universalism of Human Rights and Cultural Relativism*, *in* ROUTLEDGE HANDBOOK OF INTERNATIONAL HUMAN RIGHTS LAW 56 (Scott Sheeran & Sir Nigel Rodley eds., 2013); and FEDERICO LENZERINI, THE CULTURALIZATION OF HUMAN RIGHTS LAW 218 (2014).

[67] Advisory Council, *supra* note 45.

[68] Cees Flinterman, *The Universal Declaration of Human Rights*, 26 NETH. Q. HUM. RTS. 482 (2008); Eva Brems, *Reconciling Universality and Diversity in International Human Rights: A Theoretical and Methodological Framework and Its Application in the Context of Islam*, 5 HUM. RTS. REV. 13 (2004).

[69] Eva Brems, *Reconciling Universality and Diversity in International Human Rights Law*, in HUMAN RIGHTS WITH MODESTY: THE PROBLEM OF UNIVERSALISM 223 (Andras Sajo ed., 2004).

[70] *See, e.g.*, ABDULLAHI AHMED AN-NA'IM, *Toward a Cross-Cultural*

from a normative perspective (emphasizing the value of diversity and cultural rights) and from a practical one (legitimacy and efficacy).

This second section addresses some of the culturally sensitive approaches to human rights advocated in the literature. While numerous scholars have written on this topic – pre-eminent among them Sally Engle Merry[71] – , George, Nyamu-Musembi, and Zwart were selected for this study for several reasons. First, in contrast to Merry, these scholars have not been as extensively reviewed. Second, all three are recent contributions that aim for a wider theoretical frame but tend to focus on Africa. Finally, and importantly, these scholars do not merely seek to provide an academic lens for understanding the translation of the global to the local, but have a normative basis and programmatic intent. This section presents a comparative analysis of these three scholars, focusing on their approach to implementation, solutions to human rights problems and effectiveness in practice.

A. Culturally Sensitive Approaches to Implementation

Human rights, including the right to health, can be implemented via legal and other measures. The CESCR held that the requirement in Article 2 of the ICESCR for States to use "all appropriate means" to implement the right to health must be given its full and natural meaning.[72] Those advocating culturally sensitive approaches to human rights tend to emphasize measures including awareness raising, education, and social development, as merely implementing legal measures can be ineffective in practice. For example, if a culturally insensitive law is enacted, it is likely to be under- or un-implemented, and therefore, unsuccessful in protecting

---

Approach to Defining International Standards of Human Rights: The Meaning of Cruel, Inhuman, or Degrading Treatment or Punishment, *in* HUMAN RIGHTS IN CROSS-CULTURAL PERSPECTIVES: A QUEST FOR CONSENSUS 37 (1992); Herskovits, *supra* note 47, at 539-543; LENZERINI, *supra* note 44; Brems, *supra* note 69, at 223.

[71] *See* Merry, *supra* note 2, at 265-302.

[72] General Comment No. 3, *supra* note 17, at ¶ 4.

the right in question. Legal anthropologists have acknowledged this, commenting that legislative efforts can be especially ineffective where external legal norms compete with a community's internal norms in a "social field."[73] Numerous examples of this can be drawn from legislative measures to criminalize FGM/C that do not in fact reduce its practice.[74] Acknowledging this issue also implies the recognition of several normative orders that impact an integrated approach to human rights.

George, Nyamu-Musembi and Zwart recognize these plural normative orders and advocate the use of non-legal measures of implementation, highlighting the opportunity that exists in local customs and social institutions. Nyamu-Musembi has argued that it is possible to realize rights through local practice and custom, rather than relying solely on national legislation or the international human rights system.[75] Taking a pragmatic approach, she promotes the use of these informal systems based also on the inaccessibility of many formal judicial institutions for people, which can be expensive and/or absent in rural areas.[76] While Nyamu-Musembi argues that primary efforts should be made to work with local customs and practices, she recognizes the additional need to also amend domestic administrative institutions, legislation, and constitutions to achieve structural change.[77]

In contrast, Zwart elevates non-legal measures and questions the need for legislative efforts. He argues that the International Bill

---

[73] George, *supra* note 3, at 1485 (citing Sally Falk Moore, *Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study*, 7 L. SOC. REV. 721, 723 (1973)).

[74] For example, despite criminalization, the practice continues to affect Tanzanian women. *See* Camilla Yusuf & Yonatan Fessha, *Female Genital Mutilation as a Human Rights Issue: Examining the Effectiveness of the Law Against Female Genital Mutilation in Tanzania*, 13 AFR. HUM. RTS. L.J. 374-375 (2013).

[75] Celestine Nyamu-Musembi, *Are Local Norms and Practices Fences or Pathways? The Example of Women's Property Rights*, *in* CULTURAL TRANSFORMATION AND HUMAN RIGHTS IN AFRICA 126 (Abdullahi Ahmed An-Na'im ed., 2002).

[76] *Id.* at 143.

[77] Nyamu-Musembi, *supra* note 3, at 417.

of Rights does not dictate a domestic legal response, and that States are not required to meet their international obligations via legislative and judicially enforceable means.[78] Zwart's receptor approach works from the premise that human rights may be more fully implemented through non-legal measures, including social institutions such as women's associations, religion, extended families, and traditional medicine.[79] He relies on such non-state actors who, where necessary, can be facilitated and supported in their role by the State.[80] His approach thus ties in with the CESCR's General Comment No. 14, which focuses on the responsibilities of groups and individuals.[81] Using ethnographic data, the approach looks for human rights "receptors" within communities that provide a gateway through which treaty obligations can be understood, translated, and delivered for the right's holders' enjoyment.[82] The receptor approach encourages States to meet their treaty obligations with the help of existing social arrangements rather than law.[83]

As an example of the receptor approach, Zwart gives the system of traditional healers in South Africa, which may be mobilized to ensure HIV patients have access to the necessary anti-retrovirals, contributing to the right to health.[84] George also uses an example regarding HIV/AIDS in South Africa, contending that the (predominantly Zulu) practice of virginity testing could be used to fight the spread of the disease.[85] While she does not appear to be

---

[78] Zwart, *supra* note 3, at 549-551.

[79] Social institutions are sets of patterned strategies, consisting of norms, values, and role expectations, which people develop and pass on to succeeding generations for dealing with important social needs.

[80] Zwart, *supra* note 3, at 554.

[81] General Comment No. 14, *supra* note 9, at ¶ 33.

[82] Zwart, *supra* note 3, at 548.

[83] *Id*. at 558.

[84] Zwart, *supra* note 3, at 563-564; *see also* Rachel King, *Collaboration with Traditional Healers in HIV/AIDS Prevention and Care in Sub-Saharan Africa: A Literature Review*, JOINT U.N. PROGRAMME ON HIV/AIDS ("UNAIDS") (2000), *available at* http://data.unaids.org/Publications/IRC-pub01/JC299-TradHeal_en.pdf.

[85] Virginity testing is a prenuptial custom that involves the examination of female genitalia to ascertain whether or not they are sexually chaste. George, *supra*

opposed to legislative measures *per se*, she submits that such measures may not be effective, particularly where they are counter to cultural practices.[86] Advocating an approach based on capabilities theory[87] and pragmatism, George would be unlikely to privilege any particular measures. Instead, she would prioritize those measures that are effective in practice and increase the capability and freedom for people to choose the type of life they want and to become the person they desire.[88]

B. Homegrown Solutions to Human Rights Problems

Those advocating culturally sensitive approaches to human rights commonly emphasize the need for homegrown solutions to human rights problems. This is because changes to cultural practices are most likely to be successful if they arise from within the cultural community rather than being imposed from the outside - by either the law or the State.[89] Advocates of homegrown solutions, including George, Nyamu-Musembi, and Zwart, highlight the agency and strength of communities and the variety of tools and resources at their disposal. In particular, Nyamu-Musembi relies on culture's contested and dynamic nature to find local solutions.

Zwart promotes homegrown remedies and mobilizing local social institutions to protect human rights.[90] For example, the *senga* institution among ethnic groups in Uganda, which places aunties in the social role of sexual educator, can be mobilized as a social pathway to ensure young people's awareness of HIV/AIDS

---

note 3, at 1454-1457.

[86] *Id.* at 1451, 1513. George positively reviews domestic jurisprudence by the South African Constitutional Court. *Id.* at 1495-1500.

[87] *See generally* AMARTYA SEN, INEQUALITY RE-EXAMINED (1992); MARTHA NUSSBAUM, WOMEN AND HUMAN DEVELOPMENT (2000).

[88] George, *supra* note 3, at 1489.

[89] Donders notes that this does not, however, "relieve states from the responsibility to find ways to promote such changes." Donders, *supra* note 44, at 23.

[90] Zwart, *supra* note 3, at 560-561.

prevention techniques.[91] According to the receptor approach, if there is a full match between the social institution and the relevant human right, then the State can be deemed as meeting its international obligations.[92] If there is only a partial match, amplification is required and the State has to extend/reform social arrangements to meet its human rights obligations.[93] It is important that such amplification also be a community-based reform that works from the bottom up. The receptor approach opposes the introduction of foreign notions (including laws) into local contexts if remedies exist that fit within the existing social structure.[94] By relying as much as possible on locally embedded remedies, the receptor approach aims to respect and uphold local culture while enhancing human rights protection.[95]

In contrast, George argues that such a culturally embedded practice like virginity testing may be successful in reducing HIV infection rates where other measures by the South African Government have failed.[96] Essentially an "abstinence only" mechanism, virginity testing has re-emerged as a traditional public health measure in response to the HIV/AIDS epidemic.[97] George argues that those opposing the practice "fail to appreciate the opportunities that culture may present for positive change."[98] Exploring pragmatically how culture can be mobilized to better promote health, she advocates "creative compromises or alternative solutions" to address the criticism of virginity testing, but that retain

---

[91] H. Muyinda, J. Nakuya, R. Pool & J. Whitworth, *Harnessing the Senga Institution of Adolescent Sex Education for the Control of HIV and STDs in Rural Uganda*, 15 AIDS CARE: PSYCHOLOGICAL AND SOCIO-MEDICAL ASPECTS OF AIDS/HIV 159 (2003).

[92] Zwart, *supra* note 3, at 554.

[93] *Id.* at 558.

[94] *Id.* at 559.

[95] Zwart, *supra* note 3, at 548.

[96] George, *supra* note 3.

[97] *Id.* at 1450, 1458.

[98] The practice is opposed by, *inter alia*, feminists, AIDS activists, and medical experts, who argue that the practice is unhygienic, scientifically unproven and violates the human rights of those tested (as it is discriminatory, a violation of privacy and bodily integrity). *Id.* at 1460-1463, 1469-1474.

its beneficial aspects.[99] For example, by adapting the practice to focus on education by having testers provide girls with information about sexual health, the "problem" of cultural practices could in fact "become an effective part of the solution."[100]

With a different emphasis than George, Nyamu-Musembi focuses on utilizing culture's dynamism and diversity to move away from non-compliant human rights positions. She advocates a critical pragmatic approach, in which those seeking to shift dominant cultural positions generate empirical evidence of alternative local practices.[101] Among others, she gives the example of the Akamba in Kenya, where despite prevailing notions that daughters are not entitled to inherit, cases can be found where fathers provide for their daughters' inheritance.[102] Such examples illustrate the need to examine alternative positions and actual practices within a cultural community, rather than simply relying upon normative statements. Such statements often present cultural norms as rigid, and fail to reflect the whole social reality where variation is present but perhaps not acknowledged.[103] Evidence of the flexibility and variety of local practice "serves as a powerful counter to rigid any absolutist statements" on custom and culture.[104]

Key to Nyamu-Musembi's critical pragmatism approach is that culture is not deterministic and that people can be, and are, agents of change.[105] As such, human rights compliance advocates must appropriate the positive openings offered by cultural and religious traditions.[106] Through such openings, advocates can demonstrate that a certain dominant perspective is not absolute, with deviations both possible and permissible. These alternatives can potentially shift to become the new norm – in closer compliance with international human rights standards. In this process, Nyamu-

---

[99] *Id*. at 1491-1492.
[100] George, *supra* note 3, at 1510.
[101] Nyamu-Musembi, *supra* note 3, at 413.
[102] *Id*., *supra* note 75, at 133-134; *supra* note 3, at 414-415.
[103] Nyamu-Musembi, *supra* note 3, at 405.
[104] *Id.* at 413, 417-418.
[105] Nyamu-Musembi, *supra* note 75, at 134.
[106] Nyamu-Musembi, *supra* note 3, at 382.

Musembi encourages reiterating "the general principles of fairness and justice in a community's value system," which "often results in flexible application of what may at first appear to be rigid rules."[107] She argues that failing to engage with the politics of culture or to challenge the purported/dominant view of culture is the same as its implicit endorsement.[108] As Zwart and George do not explicitly engage with the politics of culture, Nyamu-Musembi contributes here an important layer of understanding the negotiation of culture as a political process revolving around questions of power.

While stressing that cultural change needs to be initiated and promoted by those within a community, all of these approaches generally foresee a role for outside actors. George emphasizes that human rights proponents should seek to cooperate with community members wishing to change their societies from within.[109] Nyamu-Musembi agrees, noting that while outside actors can support and/or influence internal discourse, they must not undermine it.[110] Interventions by outsiders may not be effective or – worse – be counterproductive. Another scholar in the field, Eva Brems, suggests that outsiders should not campaign directly in a community, but instead support local, internal pro-human rights forces as only such "insiders can accurately grasp the complex situation."[111] Zwart seems to agree with Brems, but includes an important role for anthropologists as possible mediators.

C. Effectiveness in Practice

The common reason given for why culturally sensitive approaches to human rights are necessary is effectiveness. After all, States are obliged by the international treaties to "give effect" to the rights therein.[112] It has been reiterated that the quest to promote

---

[107] *Id.* at 413.

[108] Nyamu-Musembi, *supra* note 3.

[109] George, *supra* note 3, at 1514.

[110] Nyamu-Musembi, *supra* note 3, at 394.

[111] Brems, *supra* note 69, at 229.

[112] *See* International Covenant on Civil and Political Rights art. 2(2), Dec. 16,

human rights is more likely to succeed if it builds on, rather than challenges, local cultural traditions. Broad public support – or community "buy-in"[113] – is essential for human rights to operate effectively in practice.[114] This is because local level actors best understand how to proceed in their community, what changes can be made, and in what time period.[115] Bell submits that building human rights practices on local cultural traditions "is more likely to lead to long term commitment to human rights ideas and practices."[116] All three culturally sensitive approaches endorse this view, with Nyamu-Musembi and George explicitly doing so in terms of pragmatism.[117]

Zwart's approach works from the premise that "human rights will be most effective if they are able to lock on to socio-cultural receptors in diverse cultures."[118] Where amplification is necessary, reforms that add to the existing social arrangements have a better chance of being supported and carried out by the community than those enforced top-down.[119] Zwart refers to An-Na'im, who argues that human rights are more likely to be implemented if they are viewed as legitimate by the various cultural traditions.[120] People are

---

1966, 999 U.N.T.S. 171; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 2(1), Dec. 10, 1984, 1465 U.N.T.S. 85; International Convention on the Elimination of All Forms of Racial Discrimination arts. 2(1)(c), 6, 7, Dec. 21, 1965, 660 U.N.T.S. 195.

[113] Radhika Coomaraswamy, *The Contemporary Challenges to International Human Rights*, *in* ROUTLEDGE HANDBOOK OF INTERNATIONAL HUMAN RIGHTS LAW 133 (Scott Sheeran & Sir Nigel Rodley eds., 2013).

[114] Advisory Council, *supra* note 45, at 10.

[115] Coomaraswamy, *supra* note 113, at 132.

[116] Daniel A. Bell, *The East Asian Challenge to Human Rights: Reflections on an East West Dialogue*, 18 HUM. RTS. Q. 641, 657 (1996).

[117] While both George and Nyamu-Musembi explicitly use a pragmatic approach, they endeavor to counter pure pragmatism, which looks only to the consequences of certain actions and promotes whatever works best in practice. George does this by incorporating the normative perspective of the capabilities theory, and Nyamu-Musembi by taking a critical approach that also seeks structural reform. *See* George, *supra* note 3, at 1494, 1506; Nyamu-Musembi, *supra* note 3, at 416-417.

[118] Zwart, *supra* note 3, at 548.

[119] Zwart, *supra* note 3, at 558.

[120] ABDULLAHI AHMED AN-NA'IM, *Introduction*, *in* HUMAN RIGHTS IN CROSS-CULTURAL PERSPECTIVES: A QUEST FOR CONSENSUS 3 (1992).

more inclined to observe normative propositions they believe to be endorsed by their own traditions.[121] Standards imposed by outsiders or not accepted as culturally legitimate will, inevitably, remain ineffective.[122] An-Na'im maintains that one of the chief underlying causes of human rights violations is their lack or insufficiency of cultural legitimacy.[123] Recalling the sentiment of the Special Rapporteur above, An-Na'im concludes that dictating standards to a society is in principle unacceptable, and also unlikely to succeed in practice.[124]

D. Conclusion: Culturally Sensitive Approaches to Human Rights

George, Nyamu-Musembi, and Zwart, among others, advocate the need for culturally sensitive approaches to be used in human rights conceptualization and implementation. In doing so, they reject universalist/relativist dichotomies and seek to maintain cultural integrity and legitimacy alongside human rights enjoyment. Scholars adopt broad anthropological definitions of culture - rejecting its portrayal as static or ancient - and rely on its dynamic nature and multiple influencers. Key to all three approaches is culture's intrinsic role in human rights, and viewing culture as an opportunity rather than an obstacle to human rights enjoyment. Not only can culture inform human rights, as recognized in the requirement for health goods and services to be culturally appropriate, but it can also provide implementation mechanisms, for example through the role of traditional healers. When faced with human rights problems, George, Nyamu-Musembi, and Zwart look to homegrown solutions pre-existing within or developed by the community itself. While Zwart especially rejects legal means for ensuring human rights, all three tend to de-emphasize national

---

[121] An-Na'im, *supra* note 70, at 20.

[122] ABDULLAHI AHMED AN-NA'IM, *Conclusion*, *in* HUMAN RIGHTS IN CROSS-CULTURAL PERSPECTIVES: A QUEST FOR CONSENSUS 431 (1992).

[123] Abdullahi Ahmed An-Na'im, *supra* note 70, at 19.

[124] *Id.* at 37.

human rights legislation and policies.

This reliance upon local individual and group actors also reflects current international law, which has recognized these actors' responsibilities in relation to human rights. As noted above, the CESCR has held that States should facilitate individuals, groups, and local actors to discharge their responsibilities regarding the right to health. Despite this focus on cultural communities, George, Nyamu-Musembi, and Zwart all see a (secondary) role for outside actors – whether the government, NGOs or international actors. Such actors can, for example, assist local actors by providing financial and other kinds of support, including education. This acceptance of outside intervention may in part be due to the fact that George, Nyamu-Musembi, and Zwart all have reform agendas, which seek to bring the status quo more into line with international human rights norms.

Finally, culturally sensitive approaches are important as they seek to integrate a variety of normative orders relevant to human rights. In this way, they can be seen as recognizing, embracing and employing the realities of pluralism to promote human rights enjoyment. This is crucial, not only for respect of cultural diversity, social cohesion, and continuity, but also for the most effective implementation of human rights standards. It is their link to effectiveness that makes culturally sensitive approaches to human rights particularly compelling.

III. Culturally Sensitive Approaches to Ebola and Burial Practices in West Africa

Having established the inherent relationship between culture and human rights, as well as the normative and practical reasons for adopting culturally sensitive approaches to human rights, this section considers these approaches in a case study. This section assesses to what extent culturally sensitive approaches to the right to health can be usefully applied to the recent Ebola outbreak in West Africa. This case study was chosen as culturally sensitive approaches are particularly relevant to the right to health, which, as stated in first section, requires culturally appropriate health goods and services; on-

going public participation and consultation in health matters; for health systems to take into account traditional preventative care, treatment and medicines; and also requires health workers sensitive to culture. The purpose of this section is to examine how culturally sensitive approaches to human rights can make vital and effective contributions in practice. The first part describes the 2014-2015 Ebola outbreak and the second part outlines an anthropological understanding of some traditional West African burial practices. Finally, the third part describes specific burial practices identified as being a contributing factor in the spread of Ebola, and the benefits of applying culturally sensitive approaches to such issues.

A. West African Ebola Outbreak and Containment 2014-2015

On March 23, 2014, the WHO received its first report of a possible outbreak in Guinea of the Ebola virus disease (Ebola).[125] Outbreaks of Ebola have occurred in Sub-Saharan Africa since the 1970s, but remained reasonably contained; as Ebola transmission initially occurs from animals to humans, earlier outbreaks were largely in tropical, low-populated areas.[126] By comparison, the latest outbreak in Upper West Africa took on a completely new character. Rapidly spreading throughout urban areas, Ebola in West Africa became the center of global attention and was recognized as a major health epidemic with potentially disastrous outcomes.[127] The disease quickly spread across borders and predominantly affected three countries – Guinea, Liberia, and Sierra Leone.

In December 2014, the estimated new cases of Ebola *per week* went up to 154 in Guinea, 138 in Liberia, and 537 in Sierra Leone.[128] Up until October 19, 2015, the total number of reported

---

[125] Team WHO Ebola Response, *Ebola Virus Disease in West Africa—the First 9 Months of the Epidemic and Forward Projections*, 371 NEW ENG. J. MED. 1481 (2014).

[126] WHO, *Ebola Virus Disease Fact Sheet*, http://www.who.int/entity/mediacentre/factsheets/fs103/en/index.html (last visited Oct. 19, 2016).

[127] *Id.*

[128] Team WHO Ebola Response, *West African Ebola Epidemic After One*

cases was 28,477.[129] Not coincidentally, the two countries that have suffered the most – Liberia and Sierra Leone – maintain a recent history of violent civil wars, which exacerbated the problems faced by health workers in the area. Considering that there is a high probability of underreporting in these countries, combined with the fact that Ebola has a survival rate of around fifty percent, one can imagine the extent to which the epidemic has further disrupted and traumatized those countries now struggling to contain it and deal with its aftermath. As of October 2015, no new cases of Ebola have been reported to the WHO, and as of June 9th 2016, the Ebola epidemic is officially contained in the last country to report victims, Liberia.[130]

Never before has Ebola containment proven so problematic. To compare, the 1976 Sudan outbreak led to 284 infections,[131] while the 1995 Zaire (now the Democratic Republic of Congo) outbreak infected 315.[132] The rapid urbanization of West Africa since the 1990s has greatly increased population density in a few cities, facilitating an expedited spread of the disease. However, this cannot exhaustively account for the severity of the outbreak. Other explanations include: inadequate existing health infrastructures;[133] widespread distrust of the government;[134] a failure of WHO

Year-Slowing but Not Yet Under Control, 372 NEW ENG. J. MED. 584 (2015).

[129] WHO, *Ebola Data and Statistics*, WHO (Oct. 19, 2015), http://apps.who.int/gho/data/view.ebola-sitrep.ebola-summary-latest?lang=en>.

[130] WHO, *Ebola Situation Report*, WHO (Oct. 14, 2015), http://apps.who.int/ebola/current-situation/ebola-situation-report-14-october-2015; WHO, *End of the most recent Ebola virus disease outbreak in Liberia – 9 June 2016*, www.who.int/mediacentre/news/releases/2016/ebola-liberia/en/ (last visited Apr. 14, 2017).

[131] *Ebola hemorrhagic fever in Sudan, 1976*, 56 BULL WORLD HEALTH ORG. 247 (1978).

[132] Tara Waterman, *Ebola Zaire Outbreaks*, STANFORD UNIVERSITY (1999), https://web.stanford.edu/group/virus/filo/eboz.html.

[133] Sharon Abramoitz et al., *Community-Centered Responses to Ebola in Urban Liberia: The View from Below*, 9 PLOS NEGL. TROP. DIS. 5 (Apr. 9, 2015); *Factors that Contributed to Undetected Spread of the Ebola Virus and Impeded Rapid Containment*, WHO (January 2015), http://www.who.int/csr/disease/ebola/one-year-report/factors/en/.

[134] This is a significant problem complicating containment efforts. Given the

leadership;[135] lack of healthcare professionals and burial teams;[136] and local beliefs and practices that interfere with containment efforts.[137]

This last category of explanation has led to several media accounts positing "culture" as a culprit in the spread of Ebola.[138]

---

recent civil and ethnic conflicts and weak state institutions, people often do not trust the government and are suspicious of its interventions. In relation to Ebola, several rumors were prevalent that the government had either invented the disease to secure international donations or, as the disease progressed, was taking the bodies of the sick and diseased to sell their blood and body parts. As Helen Epstein notes: "When the epidemic occurred, many ordinary Liberians were so profoundly estranged from their government that they assumed it was lying to them and actively disbelieved the warnings that Nyenswah and others were desperately broadcasting to the nation and the world." This mistrust does not necessarily extend to international organizations, but does impact all efforts in which the state is involved. *See* Helen Epstein, *Ebola in Liberia: An Epidemic of Rumors*, N.Y. BOOKS REVIEW (Dec. 18, 2014), http://www.nybooks.com/articles/2014/12/18/ebola-liberia-epidemic-rumors; *The Human Factor*, 93 BULL. WORLD HEALTH ORG. 72-73 (2015) [hereinafter Cheikh Niang Interview]; James Fairhead, *Understanding Social Resistance to the Ebola Response in the Forest Region of the Republic of Guinea: An Anthropological Perspective* 59 AFR. STUD. REV. 7-31 (2016); Sara Jerving, *Why Liberians Thought Ebola Was a Government Scam to Attract Western Aid*, THE NATION (Sept. 16, 2014), https://www.thenation.com/article/why-liberians-thought-ebola-was-government-scam-attract-western-aid; Terrence McCoy, *The Major Liberian Newspaper Churning Out Ebola Conspiracy After Conspiracy*, WASHINGTON POST (Oct. 17, 2014), https://www.washingtonpost.com/news/morning-mix/wp/2014/10/17/the-major-liberian-newspaper-churning-out-ebola-conspiracy-after-conspiracy/?utm_term=.036e09265145.

[135] L.O. Gostin & E.A. Friedman, *Ebola: A Crisis in Global Health Leadership*, 384 LANCET 1323 (2014).

[136] *Improving Burial Practices and Cemetery Management During an Ebola Virus Disease Epidemic – Sierra Leone, 2014*, CENTER FOR DISEASE CONTROL AND PREVENTION ("CDC") (Jan. 16, 2015), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a6.htm.

[137] *Factors that Contributed to Undetected Spread of the Ebola Virus and Impeded Rapid Containment*, WHO (Jan. 2015), http://www.who.int/csr/mdisease/ebola/one-year-report/factors/en.

[138] *See, e.g., Ebola Conflict: Guinea's Battle to Change Culture*, BBC NEWS (Jan. 19, 2015) http://www.bbc.com/news/world-africa-30874966; Dick Thompson, *Ebola's Deadly Spread in Africa Driven by Public Health Failures, Cultural Beliefs*, NATIONAL GEOGRAPHIC (Jul. 2, 2014), http://news.nationalgeographic.com/news/2014/07/140702-ebola-epidemic-fever-world-health-guinea-sierra-leone-liberia.

While these types of reports reveal a very limited and archaic notion of culture, some cultural practices have been recognized by the WHO as contributing to the spread of Ebola.[139] For example, the WHO identified burial rites for the dead, involving physical contact and washing, as being a contributing factor in the disease's spread.[140] This is because the disease can be communicated human-to-human through direct contact with the bodily fluids of infected people,[141] and can also be communicated indirectly – through bedding, syringes, or gloves. Even after death, the disease remains contagious in the corpse. Because of this, burial rites and practices became a pathway for contamination.[142]

B. West African Burial Rites

The application of burial rites or mortuary rituals is one of the few universal, pan-cultural practices, all providing evidence for an inherently human resistance to accepting biological death as a self-contained fact.[143] Instead, death constitutes a wider social event that transitions through several phases before the departure of the deceased is final. These phases vary greatly across cultures. It expresses not merely different variations on the same theme, but show a remarkable range of views on life, death, and the afterlife. Mortuary rites are deeply seated in these basic understandings or worldviews, and can therefore seem unintelligible to those outside of

---

[139] *Fact Sheet: Ebola Virus Disease*, WHO (Jan. 2016), http://www.who.int/entity/mediacentre/factsheets/fs103/en/index.html.

[140] Although this paper focuses on the cultural aspects of burial rights in the transmission of Ebola, the authors acknowledge that this is only one element among many. The significance of this element has not been sufficiently scientifically documented, and as such we do not seek to overstate its contribution. For the WHO identification of burial practices as a site of transmission, s*ee id.*

[141] *Id.*

[142] Paul Richards et al., S*ocial Pathways for Ebola Virus Disease in Rural Sierra Leone, and Some Implications for Containment*, 9 PLOS NEGL. TROP. DIS. 4 (Apr. 17, 2015).

[143] ANTONIUS C.G.M. ROBBEN, *Death and Anthropology: An Introduction, in* DEATH, MOURNING, AND BURIAL: A CROSS-CULTURAL READER 9 (2004).

the cultural community.[144] These rites are highly dependent on cultural belief systems and, as such, are fertile soil for cross-cultural misunderstanding.

The fact that knowledge varies across cultural systems yet appears to be self-evident within systems contributed to misunderstandings between the local population and those intervening both on behalf of the State and the international community. In the case of Ebola, different world-views conflicted, bringing previously invisible and "common sense" knowledge into focus. The biomedical approach to health, often taken for granted in the West, is actually steeped in some very specific cultural views on bodies, life, illness, death, and individuality.[145] For example, it embraces a notion of death as constituting an irreversible and final event. However, many other ideas about life and death are cyclical, rather than final,[146] such as in the case of reincarnation or entry to the afterlife.

In these contexts, burial and mourning practices have a fundamentally different function. In addition to paying respect and providing closure for those who remain, culturally established burial practices may be necessary to help the deceased pass the liminal phase between this stage of life and the next.[147] The imprecise execution of these mortuary rites can have real consequences for both the deceased as well as the community responsible for burial. For example, if a deceased person is not interred according to the tradition, they will not pass into the afterlife with their ancestors and may punish the community.[148] Fears of witchcraft can also increase the urgency of dealing with the dead in specific, ritualistic manners

---

[144] Robben, *supra* note 143, at 10.

[145] Margret Lock & Nancy Scheper-Hughes, *A Critical-Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent*, *in* READINGS FOR A HISTORY OF ANTHROPOLOGY 480-503 (Paul A. Erickson & Liam D. Murphy eds., 2013).

[146] Robben, *supra* note 143, at 4.

[147] *Id.* at 10 (discussing Van Gennep).

[148] James Fairhead, *The Significance of Death, Funerals and the After-Life in Ebola-Hit Sierra Leone, Guinea and Liberia: Anthropological Insights into Infection and Social Resistance*, INSTITUTE OF DEVELOPMENT STUDIES (Oct. 9, 2014) http://opendocs.ids.ac.uk/opendocs/handle/123456789/4727.

to ensure that the witch no longer wields power from the afterlife.[149] Here, the application of proper mortuary rites may be considered of utmost importance to ensure the future health and stability of the community. From the perspective of those adhering to this worldview, neglecting these rites can have consequences as real or even more salient than the threat of Ebola.

If the WHO and other health workers trying to contain Ebola fail to understand and appreciate the affected communities' need to care for their dead in a particular way, it can rupture the trust necessary for communication, cooperation, and effective implementation of preventative measures. In the recent Ebola outbreak in West Africa a lack of trust in government and health officials was certainly an important factor, creating chaos that put both local communities and health workers at risk.[150] As such, the next part looks at specific burial practices in West Africa that were seen as interfering with containment efforts, and considers how culturally sensitive approaches to the right to health may have provided solutions to the problems these practices posed for containment.

C. Ebola, Burial Practices and Culturally Sensitive Approaches to the Right to Health

This part examines from an anthropological perspective several burial practices identified as contributing factors in the spread of Ebola: 1) preparing the corpse; 2) modifying the corpse;

---

[149] *Helpdesk Report: Ebola – Local Beliefs and Behaviour Change*, HEALTH EDUCATION ADVICE AND RESOURCE TEAM (Oct. 22, 2014), http://www.heart-resources.org/2014/11/ebola-local-beliefs-behaviour-change/ [hereinafter HEART Report] (quoting Marianne Ferme, email communication, 2014).

[150] In a well-known example, an EVD response team of 8 was killed in Guinea. *Ebola Outbreak: Guinea Health Team Killed*, BBC NEWS (Sept. 19, 2014), http://www.bbc.com/news/world-africa-29256443; Cheikh Niang Interview, *supra* note 134; Kai-Lit Phua, *Meeting the Challenge of Ebola Virus Disease in a Holistic Manner by Taking into Account Socioeconomic and Cultural Factors: The Experience of West Africa*, 8 INFECTIOUS DISEASES: RESEARCH & TREATMENT 39-44 (Nov. 19, 2015).

and 3) burial location. It contextualizes these practices in its cultural settings and analyzes them through the lens of culturally sensitive approaches to the right to health. The examples are taken from ethnographic literature and practitioner's reports on the region, and are presented here as being related to certain ethnic groups. In reality, however, practices may vary even in different villages of the same ethnic background, or may be more widely practiced across ethnicities. For the purposes of this study, these examples were selected with an eye towards the specific problem of Ebola transmission and are not intended to be exhaustive.

1. Preparing the Corpse

There are many reasons why touching the corpse may be deemed necessary before burial, such as confirming the death or closing the eyes of the deceased.[151] A common way of caring for a corpse and preparing it for burial in West Africa is washing and oiling the body.[152] Often done by close family members, washing and oiling has been one of the sources of Ebola contamination that the WHO and West-African States quickly identified and sought to prevent.[153] This mode of familial care can be deemed very important and, as such, it has proven difficult to force abandonment of this practice in favor of safer burial practices that prevent and reduce Ebola contamination.[154] A series of focus groups with communities in the affected area illustrated that "widespread acceptance of the need for "safe burial" does not make the actual procedures any more acceptable to grieving families."[155] This shows that more than just education based on biomedical principles is necessary in order to

---

[151] Fairhead, *supra* note 148, at 6.

[152] CDC, *supra* note 136; Fairhead, *supra* note 148.

[153] Fairhead, *supra* note 148; HEART Report, *supra* note 149; Cheikh Niang Interview, *supra* note 134.

[154] CDC, *supra* note 136, at 20-27.

[155] Paul Richards et al., *Village Responses to Ebola Virus Disease in Rural Central Sierra Leone*, SMAC (Jan. 12, 2015), http://www.ebola-anthropology.net/case_studies/village-responses-to-ebola-virus-disease-in-rural-central-sierra-leone.

dissuade practitioners of traditional burial rituals.

Suspicions of witchcraft can also require another type of preparation that involves touching the corpse. In order to ensure that the cause of death was natural, the corpse has to be physically interrogated. While there is great variance in techniques to do so, it usually includes further handling of the corpse, which increases the risk of Ebola contamination. Fairhead notes that this practice is unlikely to disappear as it is deemed "very important to identify witches prior to their burial, as a witch must be buried in a special way 'to render the spirit innocuous, or they will continue after their death to cause miscarriages, crop failures, and other misfortunes.'"[156] If medical teams responding to Ebola disregard the importance of such practices and their purposes, they may be perceived as making an already volatile situation of disease and death in a community even worse by contributing to further misfortune.[157]

2. Modifying the Corpse

In some cases, the corpse is not only touched or treated, but modified to be deemed appropriate for burial. For example, burying a pregnant woman is highly problematic among the Kissi. As the Kissi worldview is predicated upon the separation of natural cycles, the woman and her fetus have to be interred separately; otherwise the community will have intentionally disrupted the natural order by not separating the reproductive cycle from the transition to death.[158] The complicated ritual of separating the fetus is executed by the women's society and is performed in secret. Women carry the corpse into the bush and remove the fetus from the mother, burying them separately.

---

[156] Fairhead, *supra* note 148, at 12 (quoting Carol MacCormack, *Dying as Transformation to Ancestorhood: The Sherbro Coast of Sierra Leone*, *in* STERBEN UND TOD. EINE KULTURVERGLEICHENDE ANALYSE, VERHANDLUNGEN DER VII. INTERNATIONALEN FACHKONFERENZ ETHNOMEDIZIN IN HEIDELBERG 117-126 (Dorothea Sich et al. eds., 1986).

[157] HEART Report, *supra* note 149, at 4 (quoting Annie Wilkinson, *Ebola: Identifying the True Game-Changers*, STEPS CENTRE (Sept. 10, 2015), http://steps-centre.org/blog/ebola-identifying-the-true-game-changers).

[158] Fairhead, *supra* note 148, at 3.

Disregarding these rites amounts to sorcery and creates a "fault" in the natural order, subsequently leading to more illness, failing crops, or droughts. However, separating the fetus from the mother after death poses a very high risk of further Ebola transmission and, in some cases, the woman handling the corpses in the bush is subsequently sent to the villagers to cleanse them from the misfortune and re-establish the natural order, creating new nodes of Ebola transmission.[159]

3. Burial Location

In addition to touching the corpse, the location for interment can be considered closely connected to ensuring one's undisturbed passage into the afterlife - but has impeded efforts to quarantine certain villages.[160] Although not universal in West Africa, some large ethnic groups have prescribed burial places.[161] For example, the preferred place of burial for the Kissi relates to ideas about the nature of the afterlife. In Kissi culture, the afterlife is where the dead live in a mirror image of their home village. Mortuary rites aim to transfer the deceased to the "village of the ancestors" where they can join those previously deceased and continue to exert influence on the living. Therefore, when a member of the community is not buried within the appropriate confines of the village, their spirit is doomed to wander, with negative consequences for the living as well as the dead.[162]

Among the Mende, the appropriate place of burial is related to the village of the deceased's lineage.[163] Mende villages tend to be exogamous, with women marrying men from other villages and

---

[159] Fairhead, *supra* note 148, at 8.

[160] Richards et al., *supra* note 142.

[161] FELIX I. IKUOMOLA, THE EBOLA VIRUS AND WEST AFRICA: MEDICAL AND SOCIOCULTURAL ASPECTS 14, 33 (2015).

[162] Fairhead, *supra* note 148, at 5.

[163] Richards et al., *supra* note 142, at 7; Paul Richards & Alfred Mokuwa, *Village Funerals and the Spread of Ebola Virus Disease*, CULTURAL ANTHROPOLOGY (Oct. 7, 2014), http://www.culanth.org/fieldsights/590-village-funerals-and-the-spread-of-ebola-virus-disease.

moving to live in those villages. Women who have married out into another village have to be returned to their own community of origin for burial if they die before the marriage is considered "complete."[164] However, marriage among the Mende is not a state but a process, predicated upon the continued exchange of gifts and services and the payment of the bride price. In a June 2014 study of three Mende villages, a random sample found that in sixty-two point two percent of cases the marriage was considered incomplete, and therefore the woman a "stranger" in that village.[165] As such, upon her death, the woman's corpse must be returned to her village of origin. For these reasons, the Mende might be reluctant to comply with Ebola quarantine orders preventing the movement of corpses between villages.

4. Combatting Ebola in West Africa: Culturally Sensitive Approaches to the Right to Health

Conflicting with these traditional burial practices is the necessity for the safe burial of Ebola victims in order to reduce or eliminate further infection. So-called "safe burials" are done by special burial teams and are designed to minimize direct physical contact to reduce the chances of transmission. Burial measures include wearing protective gear, putting corpses into plastic body bags, and either cremating or burying them in a two-meter deep grave.[166] As is evident, washing, oiling, and modifying the corpses by family members according to traditional rites are not accommodated in this process. In fact, the President of Liberia, Ellen Johnson Sirleaf, mandated cremation for all corpses in August 2014 via a national policy, despite the fact that cremation is not culturally acceptable in the region.[167] This part of the paper considers how

---

[164] *Id.*

[165] Richards & Mokuwa, *supra* note 163.

[166] CDC, *supra* note 136; *Families Left Haunted By Liberia's Ebola Crematorium*, THE GUARDIAN (Jan. 23, 2015) http://www.theguardian.com/world/2015/jan/23/-sp-liberia-ebola-crematorium.

[167] *Liberia: Ellen Enforces Cremation - As Measure Against Ebola*, ALL

culturally sensitive approaches to the right to health may have intervened in order to find culturally appropriate solutions to this impasse.

It is commonly accepted - especially by those advocating culturally sensitive approaches - that law alone cannot solve all human rights issues.[168] Such top-down national laws and policies as the one introduced by Sirleaf regarding cremation, would be specifically denounced under Zwart's receptor approach in favor of local measures. This may be an apt example of how measures such as national dictates are not always successful in forcing a change in behavior, especially where public participation is not well-developed enough to ensure State awareness of culturally appropriate/inappropriate measures. While these measures may have been necessary in Liberia to quickly reduce transmission, such a top-down mandate also further fuelled the mistrust pre-existing between the population and those seeking to intervene.[169] Top-down laws and policies that prescribe culturally inappropriate ways of handling the dead have been counterproductive, leading to resistance, underreporting, and unsafe burial practices.[170] In some cases, local populations blocked roads and even attacked and killed members of medical teams.[171]

Recognizing this need for cultural appropriateness, health workers are increasingly negotiating between the wants and needs of the relevant populations and the requisite health interventions. For example, some intermediate, culturally sensitive practices were negotiated in urban Sierra Leone that relieved the need for the family to touch the corpse.[172] Official burial teams agreed to shroud Muslims safely, to clothe the bodies in garments provided by the

---

AFRICA (Aug. 5, 2014), http://allafrica.com/stories/201408051276.html; Ikuomola, *supra* note 161, at 38-39; HEART Report, *supra* note 149, at 8.

[168] Donders, *supra* note 44, at 23.

[169] THE GUARDIAN, *supra* note 166.

[170] *WHO Strategic Response Plan: West Africa Ebola Outbreak*, WHO (2015), http://apps.who.int/iris/bitstream/10665/163360/1/9789241508698_eng.pdf.

[171] BBC NEWS, *supra* note 150; Fairhead, *supra* note 148.

[172] CDC, *supra* note 136.

family and, if the family could afford one, to put corpses in coffins. Families are allowed to be near the burial and practice modified rites or pray from a distance while the corpse is interred.[173] To mitigate not being able to show the proper care to a loved one, mourners adopted a new funeral rite in which they seek forgiveness from the deceased.[174]

This negotiation and modification of traditional burial practices can be seen as an element of culturally sensitive approaches to the right to health. For instance, George's pragmatic capabilities approach would ask: what increases one's capability to be free from Ebola infection and will work in practice? As with George's proposed modifications to virginity testing, it would mean retaining the non-harmful aspects of traditional burial (prayers and shrouding), while modifying the harmful elements (extensive and unprotected physical contact). Those promoting culturally sensitive approaches to human rights highlight that it is not always necessary to abolish completely a traditional practice deemed harmful, but rather those aspects detrimental to health.[175] A similar example can be found in recent efforts to retain the ceremony of FGM/C, while removing the physical cutting.

While a positive step, a negotiated new practice may have questionable or unsustainable legitimacy or be rejected by some not part of the negotiation. Therefore, negotiation must be done with the right partners who enjoy broad based community support and who have cultural capital. In order to change a practice, the appropriate change agents within a cultural community must first be properly identified. Moreover, in the culturally sensitive approaches discussed, full implementation goes beyond negotiation and all three look towards communities themselves for recourse. While the WHO appears to have realized the importance of abandoning top-down approaches in favor of a more community-based model,[176] George, Nyamu-Musembi, and Zwart call not only for negotiation between

---

[173] *Id.*

[174] Cheikh Niang Interview, *supra* note 134.

[175] Donders, *supra* note 57, at 211.

[176] WHO, *supra* note 170.

the necessities of Ebola containment and cultural practices, but for actively identifying local solutions from existing cultural resources. The focus is therefore not only on modifying existing practices, but on finding and mobilizing pre-existing local solutions. This is because any pre-existing alternative practices already enjoy cultural legitimacy and, as such, may be more readily implemented by the community.

An interesting case of identifying useful pre-existing alternative traditions relates to the burial of a pregnant Kissi woman as described above. As the ritual separating the mother and fetus creates many moments of contact with the corpse, it was strongly discouraged by the WHO to prevent transmission. In one documented case, the villager's reticence to bury a pregnant woman with the fetus meant that, in the interim, the corpse had started decomposing, posing an even larger risk of contamination.[177] The WHO contacted an anthropologist with regional expertise who, from her experience, assessed that there must be rituals still known in the region to "repair" the natural order in alternative ways. In Zwart's approach, qualitative experts like anthropologists are envisioned as a useful intermediary for navigating local beliefs and practices.[178]

In this case, the anthropologist found an elderly man who had inherited from a family member a reparation ritual that could be used in this situation.[179] This type of solution is consistent with Nyamu-Musembi's call to focus on local diversity for alternative pathways that may not be the dominant norm.[180] While the dominant cultural position of a community may be antagonistic towards a human right, cultural norms are often internally contested and other views and

---

[177] Sylvain Landry Faye, *How Anthropologists Help Medics Fight Ebola in Guinea*, WHO (Sept. 24, 2014), http://www.scidev.net/global/cooperation/feature/anthropologists-medics-ebola-guinea.html; Amy Maxmen, *How the Fight Against Ebola Tested a Culture's Traditions*, NATIONAL GEOGRAPHIC (Jan. 30. 2015), http://news.nationalgeographic.com/2015/01/150130-ebola-virus-outbreak-epidemic-sierra-leone-funerals.

[178] Zwart, *supra* note 3.

[179] Maxmen, *supra* note 177.

[180] Nyamu-Musembi, *supra* note 3, at 416-17.

practices exist within a community.[181] Such alternatives, which already enjoy cultural legitimacy, could be employed and, on the basis of culture's dynamism, potentially shift to become the new norm. More of these "alternatives" are sure to exist, especially in countries like Liberia, where the practice of burial rites has been severely disrupted by civil war for many years.

Local cultural resources can also be widely employed, such as the Kissi use of an empty house in which to keep the deceased, a custom that can be helpful in preventing Ebola transmission from the deceased to other members of the family. Furthermore, after the burial, the room in which the death occurred has to be purified - a custom that can well be adapted to include the disinfection necessary following a case of Ebola.[182] Zwart would look to these purification practices as potential "receptors" that could be "amplified" to address the problem of Ebola transmission.[183] Another important "receptor" Zwart mentions are the cultural brokers, such as traditional figures of power.[184] In Sierra Leone's national response, traditional leaders and Paramount Chiefs were involved in the effort to convince communities of the need for safe burials and to ensure community leadership in organizing them.[185] Engaging traditional leaders is a key aspect of both George's and Zwart's approaches, as they are considered gatekeepers to the community practices and norms.[186]

Traditional leaders in West Africa include religious leaders, traditional healers, secret society elders, community elders, and griots. Such people may be especially well placed to negotiate, identify, and mobilize local resources and alternatives to existing burial practices to help combat Ebola. Furthermore, they are often directly involved in the execution of burial rites. For example, Ferme reports that in the Mende-speaking part of Sierra Leone, several

---

[181] An-Na'im, *supra* note 120, at 4.

[182] Fairhead, *supra* note 148 at 4.

[183] Zwart, *supra* note 3, at 564.

[184] *See* Merry, *supra* note 2, at 38 (discussing cultural brokers as "translators").

[185] CDC, *supra* note 136.

[186] *See* Zwart, *supra* note 3, at 564; George, *supra* note 3, at 1485-1486.

community elders privately wash the corpses. When the corpse is presented for burial, it is shrouded in clean cloth, leaving only the eyes uncovered. Mourners only touch the cloth.[187] Especially in villages where these procedures carry strong cultural significance and elimination is unlikely,[188] providing elders with training and the necessary equipment to ensure their own safety may be the most appropriate way forward. Secret society leaders and traditional healers also hold great power in West Africa and should be engaged to seek alternatives to achieve the goals of mortuary rites without risking Ebola transmission. These cultural brokers are especially well positioned to identify possible symbolic substitutes where corpses would normally be physically interrogated on suspicion of witchcraft.[189]

The same rationale can be applied to the issue of moving the deceased to the prescribed place of burial. Flexibility in these rituals has been noted before the outbreak of Ebola, where families would pragmatically accept some alterations.[190] For example, a small place of worship could be set up in the location where burial was supposed to take place (but does not), which avoids actually moving the corpses.[191] New homegrown solutions that have arisen to deal with Ebola can also be scaled up in communities; some villages have started building external shelters to care for suspected Ebola patients on their own,[192] and can be encouraged in their efforts by State and international actors. As mentioned above, George, Nyamu-Musembi, and Zwart all foresee such a role for external actors, despite their emphasis on community actors.

---

[187] HEART Report, *supra* note 149, at 4.
[188] Fairhead, *supra* note 148, at 9.
[189] Fairhead, *supra* note 148, at 20.
[190] Richards et al., *supra* note 142, at 13.
[191] Fairhead, *supra* note 148, at 9.
[192] Richards et al., *supra* note 142, at 13.

D. Conclusion: Culturally Sensitive Approaches to Ebola and Burial Practices

All of this local cultural knowledge and productivity was mostly ignored at the start of the Ebola outbreak,[193] despite the obligation on States as well as international actors to provide culturally appropriate health care. In the meantime, the need for cultural sensitivity has been better acknowledged as not only a normative but also a pragmatic tool to combat Ebola.[194] This case study demonstrates one of the main principles of culturally sensitive approaches to human rights: that modifications to cultural practices are most successful if they arise within the cultural community and are not imposed from above or abroad. It also demonstrates cultures' dynamism and rich resources from which to draw alternatives or conceive of new practices. Furthermore, it shows that cultural communities can and should play a vital role in making health policies, goods, and services culturally sensitive or appropriate,[195] as this can be a matter of life and death. The right to health is complex by nature. In the case of Ebola, the exacerbating role of poverty, underdevelopment, lack of education, and poor nutrition and sanitation are clearly highlighted. These underlying determinants of health also point to the indivisibility of human rights.

---

[193] Rosie Wigmore, *Contextualizing Ebola Rumours from a Political, Historical, and Social Perspective to Understand People's Perceptions of Ebola and the Responses to It* (2015), http://www.ebola-anthropology.net/key_messages/contextualising-ebola-rumours-from-a-political-historical-and-social-perspective-to-understand-peoples-perceptions-of-ebola-and-the-responses-to-it; Dariusz Dziewanski, *How Traditional Leaders Helped Defeat Ebola*, AL JAZEERA (Nov. 5, 2015) http://www.aljazeera.com/indepth/features/2015/10/traditional-healers-helped-defeat-ebola-151028114811599.html.

[194] Indeed, the WHO is now actively focusing on involving local communities and traditional leaders, and has written a protocol on safe and respectful burial in the village. *See* WHO, *Field Situation: How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola virus disease* (Oct. 2014), http://apps.who.int/iris/bitstream/10665/137379/1/WHO_EVD_GUIDANCE_Burials_14.2_eng.pdf?ua. It must also be noted, however, that this protocol still "does not allow enough local input" to deal with the wider socio-cultural implications of a death. *See* Richards et al., *supra* note 142, at 13.

[195] Donders, *supra* note 57, at 212.

The case study also demonstrates the various and complementary roles of local and external actors in achieving the right to health, as envisaged by the culturally sensitive approaches as well as by the CESCR. It also demonstrates the role to be played by non-state actors (such as traditional spiritual leaders and elders) in protecting the right to health, and why such actors are recognized internationally as having human rights responsibilities. Local populations require trust to work with, and not against, unfamiliar or "foreign" medical interventions. This trust can come from dialogue, consultation, and engagement on the topic of health care[196] – which is part of the public participation obligation on States under ICESCR.[197] Of course, the chaos of the emergency situation and the lack of healthcare infrastructure exacerbated the problems of implementing the right to health with an eye to culture in this case study. Epidemics are difficult by nature, but even in emergency times this study shows that culturally sensitive approaches are crucial and cannot be suspended or disregarded as something only relevant for general practice.

This assessment implies that States, in consultation with the public, should create health plans that deal with emergency situations and build trust. Community health workers should be trained in advance – including traditional healers. Similarly, health education should be sensitive to cultural and traditional knowledge, as well as encouraging practices that promote health.[198] This case study demonstrates the need to build in culturally sensitive approaches to the whole health system, so it is not just *ad hoc* procedures. As an example of this, Brazil set up Health Councils to advise on health matters that are comprised half of civil society and half health workers and government officials.[199] Something like this could be done to ensure public consultation is ongoing and that avenues for dialogue are already in place *before* emergency situations arise.

This case study furthermore demonstrates the inherent links

---

[196] Cheikh Niang Interview, *supra* note 134.

[197] General Comment No. 14, *supra* note 9, at ¶¶ 11, 17.

[198] George, *supra* note 3, at 1508.

[199] Saul et al., *supra* note 11, at 1054.

between culture and human rights, and the necessity for human rights solutions to be culturally appropriate. Culture cannot be legislated over or dismissed as immaterial. Culturally sensitive approaches such as those advocated by George, Nyamu-Musembi, and Zwart are therefore highly valuable. The case study highlights their reformist nature, seeking the delicate balance between upholding and respecting culture while progressively pursuing human rights protection. Such approaches provide a crucial lens for approaching the right to health, as culture and context are more than buzzwords in the universalist/relativist debate - it constitutes the lived experience of people, an integral part of the right to health.

Conclusion

The evolution of the universalist/relativist debate since the turn of the century has ushered in a new understanding of culture's relationship with human rights. This creates the space to reflect positively on culture's role and to see it as an opportunity rather than (just) an obstacle to human rights. Furthermore, culturally sensitive approaches such as those formulated by George, Nyamu-Musembi, and Zwart, employ a more sophisticated notion of culture than the old dichotomies allowed for, by acknowledging that people are products of their culture but also agents in creating it. Greater emphasis is placed on the user's perspective and the variety of contexts and interacting norms relevant to human rights enjoyment. Acknowledging and engaging with this pluralistic setting – which exists in virtually all societies – is important for effective human rights implementation. As reiterated by scholars and practitioners, this is necessary both from a normative and a practical perspective.

The culturally sensitive approaches to human rights formulated by George, Nyamu-Musembi, and Zwart converge on acknowledging the limited power of legal solutions, the need to identify resources in existing social mechanisms, and the importance of homegrown solutions. All three share a reform agenda, with George and Nyamu-Musembi emphasizing a pragmatic approach to

human rights implementation. For practices incompatible with human rights standards, Zwart and George seek to modify current practices, while Nyamu-Musembi promotes identifying pre-existing alternative local practices. While Zwart sees a diminished role for legal measures, Nyamu-Musembi envisions a more complementary one. Nyamu-Musembi also advocates critically engaging with the politics of culture. Unraveling these approaches in the case study shows that while they start from different ideological angles and employ a different vocabulary, they share the similar goal of ensuring respect for cultural diversity and furthering human rights enjoyment. The various principles of these approaches may be selected and tailored in order to be most effective in a specific context.

The case study discussed here shows that such culturally sensitive approaches can be indispensable – rather than just preferable - to human rights protection. In this case, including the user's perspective to ensure cultural appropriateness of health goods and services is not only an essential element, but a precondition for more effective implementation. On this basis, and as seen in the case study, States should focus more on facilitating the role of non-state actors and enabling them to contribute to the realization of human rights. This could be done through dialogue, media, art, education, and formal as well as informal institutional arrangements. Crucially, communities must be part of identifying the issues and solutions to human rights problems impacting them. In relation to the right to health, such non-state actors are specifically entitled to participate in health planning and delivery with the State.

Culturally sensitive approaches are important for the right to health as demonstrated here, and also for other human rights given culture's pervasive role. Culture cannot be de-linked from human rights, which exist as one normative system among a plurality. Under international law, States must take all necessary steps to ensure rights are effective and can use a diversity of implementation measures to do so. Culturally sensitive approaches assist in this endeavor as it facilitates the recognition of other relevant normative orders and their integration with human rights norms. On this basis, and given

that human rights are not one size fits all,[200] culturally sensitive approaches can and should inform human rights considerations.

[200] Kinley, *supra* note 2, at 58.