

# The End of Life Accompanied by COVID-19: A Qualitative Study on Grief During the First Outbreak In Peru (Part I)

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## Abstract

Due to the massive deaths and high level of contagion brought about by COVID-19, burial practices and the way we bury our dead are being affected by SARS-CoV-2 confinement and control measures. Here, we aimed to examine the changing of death, dying, and mourning during the first wave and quarantine applied in Peru with the arrival of COVID-19 in 2020. Using a qualitative approach, 15 participants who lost a family member because of COVID-19 were interviewed by telephone and video call. Our results revealed that death in isolation, the loss of rituals, and the farewell to relatives have dramatically affected family members. Peruvian funeral practices were altered by health provisions, making it a challenge to accompany relatives at the end of life. This way of coping with death can affect family wellbeing, for which no interventions have yet been proposed to improve the quality of life during bereavement.

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**Introduction**

On 11th March 2020, the World Health Organisation (WHO) declared the COVID-19 outbreak as a pandemic, and as a consequence of its spread, the world is currently experiencing the biggest health crisis in a long time ([World Health Organization, 2020](#)). To reduce the spread of COVID-19, governments have introduced intervention measures and policies of social distancing and restriction. Consequently, substantial social changes have affected many aspects of our daily lives, especially mourning, how we die and mourn our dead ([Eisma & Tamminga, 2020](#)).

Grief is inevitable and multidimensional for bereaved people. Furthermore, the grieving process reflects a unique convergence of responses (affective, cognitive, behavioural, physical and spiritual adjustments) where grief depicts the normal reaction to the death of a loved one. Consequently, most bereaved people usually adjust over six to twelve months and eventually develop a new sense of normality in their lives ([Shear, 2012](#)). However, the pandemic has created a context in which the sorrow experienced by surviving family members of people who died because of COVID-19 is amplified by several coincident factors. These factors include social isolation, financial hardship, health problems, concerns about other family members, the death of friends, and anxiety about one's mortality ([Eisma et al., 2020](#)). The social isolation mandated by governments during the SARS-Cov-2 pandemic plays a great role in the realisation of bereavement, so, although many people understand the need for home isolation and confinement, the sadness of not being able to visit loved ones increases episodes of grief during COVID-19 deaths ([Guevara, 2021](#)).

The study by [Hamid & Jahangir \(2020\)](#) describes these feelings in several cases of patients dying not only alone but away from their families, and how families feel helpless for going through these difficult moments with their loved ones, providing them calm and reassurance at the time of their departure. These situations have become very common in families of people who have died from COVID-19, and it is clear to see how they can affect the bereaved in the immediate future, becoming a public health problem. Psychologically, the lack of funeral rituals makes it harder to realise the loss. Additionally, sudden and unexpected deaths prevent mourners from preparing to cope with the loss, considering that physical decease does not accompany social and psychological death, leading people to experience difficulties when facing the grieving process. When intense, these barriers can lead to so-called complicated grief, characterised by lasting disorganisation that hinders or prevents psychological reorganisation and resumption of life. There may also be exacerbated symptomatic manifestations, such as expressing intense feelings, somatisation, social isolation, depressive episodes, low self-esteem and self-destructive impulses. These mental health impacts caused by COVID-19 are a problem that not only affects the individual who suffers but also has a multidimensional influence on their environment, so it is

crucial to understand how the various grief processes are occurring during SARS-CoV-2 outbreaks (Mortazavi et al., 2020).

Peru, a middle-income country in Latin America, has implemented the longest and most inefficient quarantine in the region to control the spread of the first SARS-CoV-2 outbreak during political, economic and social crises in 2020. It is possible that during this period, social restriction policies such as strict isolation, lack of public transport mobilisation, fear and lack of information played a significant role in the mourning process (Hamid & Jahangir, 2020; Mortazavi et al., 2020; Carr et al., 2020).

Our main objective was to learn about changes in bereavement practices during the first outbreak of SARS-CoV-2 in Peru. Due to the length of the results, we divided this study into two publications, the first presented in this paper (Part I) details the characteristics of death and funeral practices. The second paper (Part II) reports on personal and social changes linked to bereavement, hygiene practices and unresolved grief.

## Methods

### *Study Design and Participants*

A qualitative study was designed with semi-structured online interviews to fifteen Peruvian volunteers who lost a family member due to COVID-19 during the first outbreak (March–June 2020). Participants were randomly selected through online social networks and were invited to participate. Participants were of both sexes and over 18 years of age. Participant characteristics are summarised in Table 1. Before each interview, an informed consent form was provided, explaining the aims and the researchers' handling of the recordings.

### *Interviews*

The interviews were conducted online between November 20, 2020 and June 30, 2021. The meeting links were sent by WhatsApp (Meta Platforms, California, USA) and the video calls were made on the open-access platform Google Meet (Google, Mountain View, USA). The interviews were in Spanish language and lasted about 32 minutes approximately. Also, the recordings were necessary for further analysis and interpretation of the responses. The “Questionnaire on unsolved grief and dying practices during the COVID-19 pandemic” (QUGDyP-C19) was designed, validated and used. This 20-item questionnaire was validated based on characteristics governing grief during the pandemic, grief practices and rituals, and changes associated with COVID-19 grief. This instrument was reviewed and validated by three experts following the recommendations for quality qualitative studies (Creswell, 1998).

**Table 1.** Summary of Baseline Characteristics of Participants.

No	Age	Sex	Place of Birth	Profession	Deceased Relative	Death Time (months)	Responsible for the Deceased
1	41	Woman	Arequipa	Housewife	Dad	3	She and her four sisters
2	40	Male	Oxapampa	Nurse technician	Dad	8	Partner of the deceased
3	21	Woman	Ayacucho	Student	Grandpa	3	Children of the deceased
4	22	Woman	Lima	Student	Grandpa	4	Social secure
5	28	Woman	Lima	Pharmacy technician	Dad	8	Her
6	21	Male	Lima	Chef	Uncle	16	Him and the neighbors
7	52	Woman	Pachacamac	Independent	Husband	9	Her
8	30	Woman	Lima	Nurse technician	Grandpa, couple, father	a	Her and brothers
9	42	Woman	Pachacamac	Promoter	Dad	10	Uncle and brothers
10	20	Woman	Lima	Student	Aunt	2	Husband of the deceased
11	36	Male	Pachacamac	Independent	Dad	7	He and his brothers
12	72	Male	Pachacamac	Cabbie	Sister	8	He and his 9 brothers
13	31	Woman	Callao	Nurse	Dad	10	Her
14	32	Male	Jesús María	Administrator	Dad	4	He and his brothers
15	62	Woman	Lima	Housewife	Politic father	7	Her

<sup>a</sup>Grandparents (1 year), Dad (8 months), and Couple (7 months).

### *Interview Handling, Data Analysis and Ethical Issues*

Interviews were recorded and transcribed independently by two authors (JMS and NZ). The transcripts were reviewed by the entire team in two meetings in order to find typographical errors. All responses from each participant were coded and entered into NVivoO 12 (QSR International, Melbourne, Australia) for pooled analysis. Each interview was analysed by following [Braun & Clarke's \(2006\)](#) techniques for qualitative studies. This study had IRB approval from Wiener University (Exp. No. 1188-2021).

## Results

### *How COVID-19 Arrived in Peru*

Since COVID-19 has arrived in Peru, it has caused around 2.27 million infections and 202,000 deaths in 21 months (by the end of December 2021) (Ministerio de Salud, 2020b). On March 6, the first case was reported, and on March 15, the Peruvian government declared a state of emergency under Decree No. 044-2020-PCM, which established pandemic control measures (Presidencia del Consejo de Ministros, 2020). These measures were: a 15-day strict lockdown, social immobilisation (from 17:00 to 5:00), complete immobilisation on Sundays, flights and transport restrictions among provinces and international access. It also included mass screening with rapid tests for SARS-CoV-2 and confirmation with molecular tests, the implementation of ICUs and first-level care, the adaptation of the sports centre created for the Lima 2019 Pan American Games (Sports Village) as a centre for hospitalisation of patients and health professionals with 24 h of work and 15 days of stay, the creation of oxygen supply centres, as well as the financing of rapid response projects in science and technology (Barrutia et al., 2021; Moya-Salazar et al., 2021a, 2021b; Pan-American Health Organization, 2020).

These regulations did not include a scheduled protocol for death management, funeral practices and family support. For this, at the beginning of the lockdown (March 20th, 2020), the dead bodies were stored in black bags in the morgue and then, due to the overload of the deceased, offices, consulting rooms, and corridors of the health centres were full of them. Relatives were informed of the death by telephone. A relative could recognise the deceased only by the identification card on the bag, as it was forbidden to open the bags to identify the individual. Once the family member gave his consent, the dead body was cremated and the ashes kept in custody because it was unknown whether SARS-CoV-2 could be spread through the air, whether it was perennial in the dead body or whether it could even be transmitted in the ashes.

Sometimes, this funeral flow did not occur, as patients were referred from the Peruvian provinces to Lima (capital of Peru) or because there were no direct relatives in this region, the deceased was secretly cremated, and the relative was informed of the death by telephone. This process took 1–2 days, thus violently closing the life cycle and opening a new ICU bed for another critically ill patient. This dramatic scenario started when after presenting the typical symptoms of COVID-19 (cough, fever, anosmia, dysgeusia and lung pain), health professionals were contacted (call 115) to test the suspects and take them to the nearest health centre to meet the patient's needs (i.e. mechanical ventilation). Family members were only informed about their relative condition by telephone during the hospitalisation. However, many family members were not satisfied with the information provided by the health staff and went to the hospital to wait for news from their relatives. This information could arrive at any time of the day. For this reason, relatives had to camp outside the hospital waiting for “good news” and the indications of the health staff (i.e. to buy medicines that the Seguro

Integral de Salud (SIS) did not cover, to stock up on oxygen cylinders for daily use, etc.).

### *Dying Alone and Away From the Family*

Biological death can be understood as the state of an individual who has undergone irreversible cessation of circulatory and respiratory functions or irreversible cessation of all brain functions, including brainstem functions (Tomasini, 2017). The common notion of this process is characterised as the final event of life. Therefore, the events accompanying the dying process must preserve the idea of a “good death.” That is, to safeguard the dignity, maintain open communication within the family and give the necessary time to the closest relatives to integrate the loss and thus avoid the suffering of both actors (Meier et al., 2016). However, 6 weeks into the SARS-CoV-2 multinational state of emergency, the world changed dramatically, and fear of death and uncertainty gripped people as the virus ravaged the earth (Goveas & Shear, 2020).

Currently, death during the COVID-19 pandemic represents the “Bad Death” since patients are isolated from their families, have physical pain and psychological anguish, are treated without respect or dignity, and receive unwanted medical interventions, depriving them of their right to choose and autonomy (Meier et al., 2016; Wakam et al., 2020). All of this and the ambiguous and scarce communication from the health staff towards the families triggered emotional distress, as Silvia’s account demonstrates: “My dad was a very macho person and did not like to be bathed or to have his nappy changed by someone, and for this someone to be a woman, is quite strong, so it was one of the things that made me feel powerless” (P13), in the same way, Blanca recalled: “Every day the doctors communicated with us just to tell us to be prepared because my relative was serious, but the nurses we spoke to told us that he was stable, as his saturation had risen, and the truth is, I don’t know who was lying.” (P5). The stories of two other participants also demonstrate the improvisation of the health system in the handling of deaths: Julia, who says, “We were at home (...), and my mother just called to know how my grandfather was, but they just told her that he had died” (P08). Also, Milagros says: “They called me 2 h after my husband died” (P10).

The fear of dying alone is almost universal. For this reason, health workers make efforts to give patients enough time for their relatives to say a proper goodbye to them (Wakam et al., 2020). An awkward topic during the COVID-19 pandemic is that communication has not been direct as it used to be before the pandemic. In most situations, due to distancing policies and visit restrictions, the death or clinic evolution of the patients was given by phone calls or in front of the hospital, causing anguish in families and health professionals (Erazo-Muñoz et al., 2021). The following account is a clear example of this occurrence: “The only thing you had to do during the day was to settle for the medical report given by phone in 10 minutes. You had no more. There were days when no one called; then I phoned, so they called my attention and told me that I was doing call traffic and that I could not continue doing that” (P13). Because of this, some sought ways to communicate with their loved ones, infringing some rules

provided by the hospitals. Here is an example: *“I did not have much communication because when he was hospitalised, I was not allowed to leave with him his mobile phone, but through a friend who works there, in a hidden way, we gave him a mobile phone and only at certain moments I could talk to my husband”* (P7). Many of the patients could not say goodbye because they were far from their families. Few, probably in despair, were able to find a way and enough clarity to say their last words, as Linda mentioned: *“We hoped that he would get better, that is why we did not say goodbye. But when they gave me his mobile phone, I read on it a message where he wrote that he loved us very much and that we should take care of each other. That is the only way he said goodbye”* (P7).

Physical distancing imposed by governments was the best alternative to avoid contagion. However, it had psychological repercussions for many people who saw their families die alone and far from home (Montauk & Kuhl, 2020). Phrases such as *“He was hospitalised for a week, but there was no contact”* (P4) or *“After they took him away in the ambulance, we never spoke to him again”* (P9) were important characteristics shared by twelve of the fifteen participants in this study. Anxiety, anger, and guilt are recurrent and complex issues in natural death and were not the exception regarding COVID-19 deaths. Each participant showed deep grief in phrases like *“It is something I do not know how to express, it hurts to remember that”* (P12), *“There were several mixed feelings, the pain of not being able to save him”* (P09) or *“It was like a roller coaster of emotions... When he was in the hospital... Every day, I cried. I talked to my grandfather by video call, and you could notice that he was getting weaker (...) I was already crying because I was afraid that the worst would happen, that my dad would end up in a bad way”* (P04). As well as feelings of denial such as *“It hurt me and it hurts me a lot to talk about it, sometimes I think that he is still in Lima and I will see him when I come back”* (P03).

Many families begged to see their loved ones before they died to show them that they were either alone or abandoned. That was a simple request in the past, but nowadays, it has become an ethical and health dilemma that has triggered sadness and despair in many people (Erazo-Muñoz et al., 2021; Montauk & Kuhl, 2020; Wakam et al., 2020) *“I felt so sad to know that he was gone without being able to say goodbye, that is when I understood the worth of having a father and a mother”* (P11).

## Missing the Farewell

During the grieving process, the mourner usually experiences physical and emotional reactions. The memories, the experiences and the relationship with the loved one will directly affect his social and family environment. Therefore, the funeral process acquires great importance, as it allows establishing family ties, facing reality and sharing with others the pain of the loss (Pereira, 2013).

Due to the large number of deaths caused by the pandemic, the principal biosecurity measure implemented in Peru at the hospital level was isolation in special wards for patients who were diagnosed positive and had moderate symptoms (Montauk & Kuhl, 2020). Poor

communication between the bereaved and their families due to isolation can be a huge barrier during the consolidation of death and affect the normal grieving process (Feder et al., 2020). Liana and Rosmery's story are a clear example of this: "They took him to the emergency hospital and from then on we had no communication with my grandfather" (P03), and "We were not allowed to talk to him where my father was, neither my brother nor I could. After they took him away in the ambulance, we have not been able to talk to him" (P09).

This loss of contact caused the families to assume with impotence that they could not do anything for their loved ones during his illness and death. "What would have happened if I had gone out to see him? What would have happened if I had had the opportunity to help my father? I think that the remorse of all children and relatives of people who have died will always be with us" (P02). Thus, many of the families who suffer the invaluable loss of their loved ones during the pandemic must face not being able to say goodbye or good riddance. In this study, 14/15 participants reported not being able to say goodbye to their family members, and only one was able to say goodbye through a phone call. "On phone call, I said goodbye to him and told him he had to be strong because we were waiting for him" (P05).

Several studies describe the emergence of pathological grief worldwide due to COVID-19 deaths and people's exposure to the constant loss of life (Killikelly et al., 2021). Thus, Julia's situation is a special case, as she lost her grandparents, her father and her husband during the pandemic, being the loss of her husband the most painful. At the last moment, he told me: "I'm going to overcome this, I'm not going to abandon you" he told me that before he was hospitalised (...) I wanted to go and see my husband off, but because of my state of health, they wouldn't let me go" (P08). Accepting the loss of a family member is very complicated in the context of a pandemic because the process is unexpected and sudden. Relatives of people with illnesses grieve in anticipation. They are mentally ready for the departure of their loved ones, as the death of a person in a critical health condition is expected. In contrast, many relatives of COVID-19 patients are not aware of the severity of the disease and do not accept the fact that they are no longer part of this world (Kent & McDowell, 2004). "It's all been very quick... We decided to operate on my dad's eyes... But they asked us for the COVID-19 test, and the result was positive, but he hadn't had any symptoms, we've done the quarantine and all that. In June, he was supposedly discharged because he was no longer positive. Suddenly, he got sick on July 19th, and that's what triggered all this" (P01). Another story also provides insight into this phenomenon: "I think we have not yet entered that stage of acceptance, we are still assimilating it, I would say that we are in a state of denial, where we still deny that my dad has died and that he is travelling, we even try to pile up his things and put them away. His room is intact, but we have stored his books and stuff from his office" (P14).

Since mourning does not only take place post mortem but it can begin with the diagnosis of the disease, and as COVID-19 is a pathology that does not yet have a specific treatment and has a variable evolution, many of the patients diagnosed were subject to anxiety and depressive states, affecting their state of health and the



doctor-patient relationship (Díaz et al., 2021). This was Linda's situation. Her husband had COVID-19. Because of the fear and anxiety of being intubated, he died of a cardiorespiratory arrest, despite the improvements. *"He was fine every day. He called and was calm, he was also very nervous, and when the doctors decided to intubate him, he had a cardiorespiratory arrest. That's what they told us. The problem is that he refused his mother being intubated, and wanted to take her out of the hospital. I think that's why he got nervous and went into cardiac arrest"* (P07). Other participants also recounted similar stories in which their family members appeared to be getting better but unexpectedly died *"The last time I saw him, he was still fine, delicate, but he was fine"* (P02), *"The day before he died, I had communication with him. He told me he was fine, he was eating, nothing else. That was the last time I spoke to my dad"* (P05), *"He came to my house to get two shots, and I asked him: daddy, why did you walk here? Why didn't you come by car? He came on a Friday," and I asked him, "Daddy, do you feel good?" and he said, "yes, I feel good, I get two shots, and that's it." He died the next day at 7:00 a.m."* (P15).

Although 14/15 of interviewees mentioned that their relatives died in hospitals or private clinics, the Peruvian Government established that a maximum of five relatives could attend the burial or cremation of their relative's body. (Ministerio de Salud, 2020a) *"Yes, of course, five people were allowed, and I went with my brother, my mother, and my two aunts"* (P14). So, in this study, 8/15 interviewees did manage to attend the burial or the casket of ashes of their relative, and 5/15 interviewees determined that, despite not having said goodbye, it would have been worse not to be present at the burial. These are the five accounts of the farewell practices experienced by the interviewees: *"It would have been worse, not seeing him, not knowing anything about him, it was emotional and painful to be there"* (P15), *"Seeing him was the best thing(...) because I felt calmer since I felt that I did the last thing for her and so I feel calm"* (P12), *"It was bad in itself, but I didn't want to stop being there"* (P05), *"It was better this way, because we were in her last moments"* (P07), *"I always thought it would have been worse if I wasn't there, to be with my brothers, with my mother, and to be able to accompany her"* (P11).

### Changes in Death Rituals and Practices

Because the loss of a family member involves intense mourning, farewell rituals are key to completing the process and coming to terms with the loss of a loved one (Pietkiewicz, 2012; Van Gennep, 1960). Death rituals are millennia-old among populations. For example, the Egyptians performed mummification while the "Papu" practised endocannibalism. In the West, a wake and a burial filled with relatives is a tradition (Doughty, 2017). In addition, Peruvian families which are mostly Catholic, usually accompany this ritual with masses and wakes, speeches about the wellbeing of the deceased in "paradise" in the company of God, and usually serving food and drink. *"We practice the wake at home where we serve coffee, for those who stay all night we give*

soup (aguadito or chicken broth), or there are some people who bring liquor, and begin to drink. They watch the coffin accompanied by many people. It is the custom” (P15).

In Peru, even the Andean populations hold the fifth wake 2 days after the burial, where the clothes, bedding and jewellery are washed in the river to free the remains of the soul that still lives with the family. A burial and wake provide emotional support, comfort to the relatives (Bahar et al., 2012), acceptance, condolences (condolences for close friends and relatives), recommendations and remembrance of the deceased’s good deeds, which help to ease the pain of the relatives and help them to reorganise their lives by accepting the loss of the relative.

All these rituals have been dramatically affected by the pandemic. The increase in deaths and confinement has made it impossible to say goodbye to those who have died of COVID-19. This situation is not exclusive to COVID-19 because all families who lost a family member have been affected by the national lockdown (Hamid & Jahangir, 2020). The families of patients who died of COVID-19 have been more damaged as they have lived through a progressive drama mixed with fear, uncertainty and grief. Thus, all the participants in this study emphasised, between tears and lamentations, that they had not developed post-death rituals. In hospitals, dead bodies were in bags (initially in black bags, but later because of the large number of deceased, they used black rubbish or moving ones). Dead bodies were stored throughout the hospital because the morgue had collapsed on its capacity. Almost all bodies were cremated with no consent of the relatives (due to government provision and fear of airborne SARS-CoV-2 contagion). A family member could recognise the body at the hospital without opening the bag, which created uncertainty and great concern for the relatives. “They gave me the body all in plastic, and I was not allowed to see it. I wondered if the person who was inside was my grandfather. Maybe my grandfather is still inside, but they got confused, and he is still alive and hospitalised. Luckily, an uncle of mine had contacts inside the hospital, so they allowed him to see my grandfather and take a picture of him” (P3). Another participant also told a similar story “We fought for many days to get the body and have it cremated, to take it to a temple and keep the ashes, but we could see neither the body nor the ashes” (P2).

Fear of contagion and carrying the disease were barriers to saying goodbye to family members. “We always watch over and bury the deceased, but this time we were not able to enjoy any of these because the protocols did not allow us to do so, and we were not in any condition because my sisters were infected” (P1). At the beginning of the pandemic, the cremated bodies were stored by the government and were not handed over to relatives months later. Peru was one of the countries with the strictest and longest quarantine in Latin America (Leaders League, 2020). Every fifteen days, it was reported that some other fifteen days were necessary to expire COVID-19, and so on for the first 4 months. After the first quarter in quarantine, some family members were able to bury their relatives without performing previous funeral practices such as the wake. Although this did not complete all the dying practices, it was the best that the relatives of the deceased clung to. “There was no wake, but from the hospital, we took him straight to burial. We don’t believe in cremation, so we buried him” (P13). When the

central government of Peru delegated a function to each regional and provincial government, the situation turned out different for everyone, each *hospital* and each city imposed their own rules. A participant who has had three losses simultaneously is a clear example of this. *“For my grandmother, there was no wake, they buried her. We were able to hold a wake for my father in a centre where he was president of a club, where we held a wake for 2 days. We didn’t hold a wake for my couple either, her was buried (P8).*

The situation in the Peruvian provinces was different, as they were marked in principle by a shortage of health personnel, which led to a lack of patient care and a high mortality rate (CEPAL, 2020). The inefficiency of health care support has led to funeral practices often occurring without distance and control after the first trimester of quarantine. *“We took him to Arequipa. We had to pay the police at the checkpoints to pass. We watched over him 1 day. Then we took him out of the case. The orchestra (band of musicians) came, and a few people accompanied us. We carried the coffin around the block in the neighbourhood where he was born. He was born and grew up here. He spent all his childhood, adolescence, and old age here” (P11).* On the other hand, most of the population living in Lima are migrants from the provinces (Horton, 2021). This population has migrated to peri-urban areas (conurbanos) and have brought their funeral rituals and practices. After months of strict confinement, many relatives have sought to practise their traditional customs (from the Andes or the jungle) in the capital’s neighbourhoods. A step by step continuation of their traditions in the middle of the city of Lima. *“As my grandmother was from Arequipa, my grandfather has always followed her customs when someone dies. We leave my grandfather’s clothes (his t-shirt and trousers) in a vigil, and every Monday, we light a candle for him. My grandmother does that every day. She lights the candle with his favourite rose or flowers” (P4).*

The burial and rituals were expensive for families since they had limitations to work daily during confinement. The pandemic has generated an unprecedented economic impact that has mainly affected low- and middle-income populations (Baldwin & Weder di Madurom, 2020). Most participants did not have the finances to cover the costs of hospital transfers and burial, graveside and wake costs (Long, 2021). If the family member died from COVID-19, the “corpse collectors” were the only ones in charge of removing the bodies from the houses at an additional cost. The relatives directly responsible for the burial were those in charge of the deceased: husbands (P10), their lovers (P2), children (P8), and other relatives (P12). *“I didn’t take the money out of my pocket, we all took it out of our resources, we don’t have good jobs, but everyone put in what they had, they came to us, we made a “chanchita”, and that’s how we held the wake. Each of my siblings contributed from their own pockets. I liked that, getting everything done” (P11).*

When the person responsible for the family member could not pay for all the funeral expenses, they had to resort to a bank loan. *“I got into debt after another, it’s something I’m paying until now, but at that moment you don’t expect that. My dad was the support of the house. I worked, I helped with food or some household expenses, but the one who covered the general expenses of the whole house was my dad, so when my dad left, I had*

to cover the expenses because I am the one who lives with my mum, but yes I had to get into debt to cover both things” (P13). Other families opted to carry out quick activities in their neighbourhoods through social networks to be able to cover the cost of the funeral. “My neighbours helped me to organise a pollada” (P6). The pollada is an activity where chicken is prepared, along with potatoes and salad to be sold at a modest price by selling tickets to friends and relatives, to sell as much as possible and raise to three times their investment. This activity takes place in Peru for many purposes, such as covering the medicines of a sick relative, finishing the construction of a house, raising funds for a graduation trip, among others.

Many families have also had relatives who had pre-paid for their niche. This interest in buying their tomb began in the mid 90’s in Peru, promoted by the funeral agencies that have given facilities to the families and the interested parties themselves. Thus, one could buy the grave of a relative and pay for it in up to 15 years. Many families could bury their relatives because they had bought the graves with anticipation and at a low cost. “Thank God for his brother, the one who passed away in March, in 2015, bought four niches, nobody knew about that, only my dad. He distributed one niche for my dad, mum, one for me and one for any of his siblings who need it. That is why we only covered the funeral expenses” (P9).

In this sense, Liana’s case is noteworthy because her grandfather had bought his grave several years earlier and finally used it during the pandemic. “My grandfather secretly paid for his grave, he told me about it when he was still alive, and I asked him: “Daddy, but why are you buying this?” and he responded: “Dear, so as not to generate expenses, I am buying one for me and another for your grandmother, too” and I said to him: “That’s fine, daddy.” He had already paid a part, the rest had to be completed by all the siblings, and he could be buried in the grave he was paying” (P3).

## Discussion

COVID-19 has changed funeral practices due to restrictions taken to curb the spread of SARS-CoV-2. To the best of our knowledge, this is the first in Peru to describe how the practices of farewell, burial, and burial have been progressively lost and can impact family well-being during confinement.

During the jolt of COVID-19 at the beginning of 2020, the deaths of family members from COVID-19 have had a greater impact than other deaths, not only due to the context of restrictions but also because of the precariousness in which they occurred. Similar to our findings, [Eisma & Tamminga \(2022\)](#) have shown that COVID-19 deaths produced higher levels of bereavement than natural deaths and were more frequently parental deaths and fewer deaths of children cared for in intensive care. Interestingly, the low frequency of bereavement linked to children with COVID-19 found by [Eisma & Tamminga \(2022\)](#) is consistent with our results in the Peruvian population, where a low frequency of these deaths has been reported in part due to the epidemiological development of COVID-19 worldwide ([Pan-American Health Organization, 2020](#)).

Since the disruption in mourning practices at the beginning of the pandemic in each community, the undying changes have been increasing. Research by [Mitima-Verloop et al. \(2022\)](#) shows that the pandemic has had a very negative impact on bereavement among Dutch adults compared to the pre-COVID-19 situation. This dramatic experience of grief, which can lead to prolonged grief, may be due to a set of circumstantial social determinants in the context of death. In Peru, there is an inequitable social and economic reality that generates unequal support for the family member who has lost a family member to COVID-19 among communities, that is, while in the cities contact with the family member who was hospitalized or died of COVID-19 was restricted through case monitoring, in certain rural and indigenous regions there was a lack of multilevel support to deal with illness, death and bereavement. This phenomenon has also been experienced in other countries, for example, the study by [Skalski et al. \(2021\)](#) in Poland has shown that a correlation between resilience and perceived social support with dysfunctional grief due to a death by COVID-19.

Although these differences between the communities are very marked, the restrictions have also led to similar experiences on death and mourning. The study by [Patel et al. \(2022\)](#) in an urban area in the center of Gujarat, India showed that the community restrictions imposed have been necessary in the current situation despite the emotional crisis that they have had to live through. In other words, despite being affected by the changes in funeral rituals and the sudden loss of family members due to COVID-19, they understand that it is better not to carry them out in order to avoid contagion. However, missing the farewell ceremony makes death seem like an unreal event, and also creates a psychological crisis that leads to their denial ([Biancalani et al., 2022](#)).

Among us Peruvians, we note the pain, remorse and impotence caused by the death of family members and the lack of a proper funeral farewell. In fact, [Biancalani et al. \(2022\)](#) noted that, due to the lack of funeral ceremonies, mourners were not able to say a final goodbye to their loved ones, or to recognize their dead and have the opportunity to face the event. Although, as in the study by [Mitima-Verloop et al. \(2022\)](#) facing mourning has not yielded a real solution. They showed that viewing funerals (from the construction of the site to the immediate farewell) as consolation was inversely associated with symptoms of chronic grief. This is partly due to the fact that the duel is incomplete, as all events of the deceased's dismissal roadmap have not been completed and relatives have not achieved a proper farewell.

Various studies have been characterizing changes in farewell rituals during COVID-19 in various parts of the world ([Aguiar et al., 2022](#); [Hamid & Jahangir, 2020](#)). In the Muslim population, several death rituals absent in those who died from COVID-19 (such as the physical and spiritual purification of the body) have been succinct, impacting the respectful encounter of the deceased with God. This situation has explained the refusal of sick Muslims to be hospitalized, to die in their natural environment and with their traditional death rituals ([Gabay & Tarabeih, 2022](#)). The study by [Hack et al., \(2022\)](#) in Australians has shown that the blocking of mourning rituals has generated feelings of denial, anger, and discouragement, as well as emotional pain and the longing

to be with the, loved one during the last hours. Changes in this practice were highlighted when grief was acknowledged and sympathy was expressed, but their absence led to the disappointment of the family that sentimental possessions, such as photos or clothes, were not available after death. In the Portuguese population, the change in the habit of dying was evidenced in the perceived insufficiency of the funeral ritual without a complete farewell (Aguilar et al., 2022). In addition, being unable to see the corpse in person created feelings of grief, fear, and loneliness, as was the case with our participants in Peru.

This study presents the limitations and future implications described in the second part. However, we mentioned two limitations in this regard, one is that we did not segment the analysis by profession or occupation, and the other is that we did not fully delve into the economic factors of each participant. Health professionals, police officers, journalists and politicians have had greater mobility during the pandemic in Peru and this could impact the practices of visiting relatives with COVID-19 and bereavement. High incomes, on the other hand, can maintain protocols for easier and safer funeral activities and the transfer of the deceased, while low-income residents are governed by government decisions about dead bodies.

## Conclusions

The COVID-19 breakthrough has led to unprecedented change throughout the world. Every country has been shaken by this virus that has caused millions of deaths and economic, social and mental crises. Our findings suggest that COVID-19 has impacted the way we die and farewell rituals during the first wave, strict protocols were set to limit the spread of SARS-CoV-2. The lack of access to do the follow-up on infected family members has had a transgressive impact on the understanding of the health-disease process. When family members have died, the common stages of farewell have been lost, from the news that a loved one has died to the burial or cremation of the body. Contingency measures have affected the mourning process and may have consequences that could affect the quality of life of the bereaved for a long time. Many participants have shown feelings of grief during the interviews by crying and regretting the death of the relative, commenting on what they would have done to avoid the deaths, how they understand the loss today, and how they still mourn their dead.

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## Interview Handling, Data Analysis and Ethical Issues

Interviews were recorded and transcribed by two authors (JMS and NZ). All responses from each participant were coded and entered into NVivoO 12 (QSR International, Melbourne, Australia) for pooled analysis. Each interview was analysed by following [Braun & Clarke's \(2006\)](#) techniques for qualitative studies. This study had IRB approval from Wiener University (Exp. No. 1188-2021).

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