



Managing contingency planning during the Hajj

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Abstract

This essay focuses on crisis management and planning processes with reference to healthcare planning for the annual mass pilgrimage to Saudi Arabia exploring the linkages between leadership and team processes through the lens of contingency approaches to leadership coupled with shared governance.

As far as is currently known, the outcome of all these multi-agency actions and precautions taken co-operatively by the Saudi authorities and other bodies and agencies is that no cases of Ebola emerged in Saudi Arabia during the 2014 Hajj and there is no evidence of the spread of the disease elsewhere by pilgrims returning to their own countries. This successful attempt to obviate the threat of a potential Ebola outbreak among Hajj pilgrims provides an appropriate example of how the contingency approach to leadership and the management of risk coupled with a determination to share ownership of activity and responsibility among stakeholders, both within and without the country directly involved, can make a practical contribution to health care and also offer important guidelines for dealing with risks or unforeseen situation that might present themselves in the future.

Introduction

This essay focuses on crisis management and planning processes with reference to healthcare planning for the annual mass pilgrimage to Saudi Arabia exploring the linkages between leadership and team processes through the lens of contingency approaches to leadership coupled with shared governance.

Background

Religious celebrations bring together vast numbers of pilgrims from all over the world and constitute a potential infection risk both for pilgrims and for the host population. Saudi Arabia has long-term experience of this through the annual Muslim religious pilgrimage to



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Mecca and Medina called the “Hajj” which can attract more than two million people from close to 200 countries and where many potential health hazards exist, amplified by the extreme congestion of people all together in the same place at the same time (Memish, 2002). Since the Hajj is dictated by the lunar calendar, which is shorter than the Gregorian calendar, it falls at a different time each year and so presents public-health policy planners with a moving target, demanding constant preparedness, especially as any emerging infectious diseases could have the potential to turn quickly into epidemics (Memish, Ventakesh & Ahmed, 2003). To combat these risks and to allow access to health services to pilgrims, therefore, Saudi Arabia undertakes extensive public health planning and surveillance systems. Part of this is its collaboration with outside health organisations, such as the World Health Organisation (WHO) Centre for Mass Gatherings Medicine, the Gulf Co-operation Council, UK universities and other public health institutions, with which bodies it recently set up a partnership organisation, the Global Center for Mass Gathering Medicine (Memish, Zumla & Al-Tawfiq, 2014).

The large number of major health risks that exist where pilgrims from abroad gather in large numbers have been well known for a long time to the Saudi authorities, some of the most common ones being influenza, malaria, invasive meningococcal disease and gastro-intestinal infections. Other less common diseases with potential for outbreak during the Hajj have included SARS, with its global spread in 2003, and MERSCoV, a serious respiratory disease. It has dealt with these risks over the years by means of detailed advance planning, public health preparedness, vaccination requirements, and, in most recent years, by significant electronic health surveillance (Memish et al., 2014). During the latest pilgrimage, in October 2014, it had to employ all these techniques and also a number of new ones to deal effectively with the potential for the spread of the Ebola virus, from Africa in particular. In so doing it firmly cemented its commitment to the practice of shared governance of health care already manifested by its part in the setting up in Riyadh two years earlier of the aforementioned Global Center for Mass Gathering Medicine, a virtual research network of academic and public health institutions in partnership with the WHO Collaborating Centre on Mass Gatherings Medicine and WHO Global Capacity Alert and Response, which, through



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provision of a scientific evidence base, has as its aim to drive the best health promotion, prevention guidelines and practice, and health education for those who attend the Hajj and other mass gatherings.

Contingency leadership

As Hartley & Bennington (2010, 3) state, ““Better leadership” is seen as central to improving the quality of healthcare and the improvement of organisational processes. But the question invariably is ‘What kind of leadership’? One volume on health care organisation refers to the various approaches leading to a ‘pattern of perpetual revolution minus evidence of desired impact’ (McKee, Ferlie & Hyde, 2008). Yet it does seem that contingency approaches to leadership coupled with shared practices provide an appropriate and productive fit for the scenario of planning for potential outbreaks of disease at mass gatherings - events which may be as diverse as international sporting competitions or religious celebrations such as the Hajj. During the European Football Championship Finals (Euro 2012), for example, the WHO piloted new mechanisms to distribute messages about travel health with a view to sharing this experience and the best practice arising from it with subsequent organisers (Smallwood & Arbuthnott, 2014). In the same way, as we shall see, in the 2014 Hajj sharing best practice and the leadership associated with it were important in safeguarding against the potential spread of Ebola in Saudi Arabia.

The theory underlying such approaches emphasises that nothing is set in stone, in the sense that different contexts may require adaptations of leadership style (Mullins, 2013: 780). The contingency approach involves, as Paton and McCalman (2008, 4) put it, ‘knowledge of the circumstances surrounding a situation’ as well as an ‘understanding of the interactions’ and reflection on ‘the potential impact of associated variables’. So even if the initial picture is likely to be a blurred one, the meeting of goals and effective and progressive management of possible scenarios that might arise will still be possible. Mullins (2013, 60) sees the contingency approach as not seeking to ‘suggest one best way to manage the structure ... but should provide insights into the situational and contextual factors’. In a similar way, the words of one commentator on management of some 20 years ago seem to be particularly



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applicable here: ‘Increasingly a winning strategy will require information about events and conditions outside the institution [to] prepare for new changes and challenges arising from sudden shifts’ (Drucker, 1997). More recently, Osborne & Browne (2005, 218) used the term ‘change readiness’ to describe ‘the ability and propensity of organisational members to engage in behaviours that offer support to a change effort’.

The contingency approach in the case of Saudi Arabia’s preparations for the Hajj also fits well with the idea of shared ownership of decision-making processes, both at an international level with other governments and agencies and locally with those on the ground who are putting into effect the policies and procedures being followed. This tends to be especially the case in the medical sector where good outcomes are often dependent on a whole group of different people with completely different skill sets and areas of expertise working together in order to achieve successful outcomes (Ferlie & Shortell, 2001: 285). The other important effect of shared ownership is to enhance the value of the staff contribution and so make it more effective as people develop a sense of ownership of the work they are carrying out (Scott & Caress, 2005: 5). This is inherent in the various contingency approaches to decision-making which have been theorised and seems to tally in particular with the ‘maturity of followers’ variety, which lays emphasis on the ‘readiness’ of the individual to be able and willing to carry out the necessary tasks successfully (Mullins, 2013: 379-85). As Paton and McCalman (2008, 13) put it: Those who have to work through the change process need to be converted to the concepts and ideas and to own them’... ‘everyone involved in making change work has to feel part of it and accept the reasoning for the vision and how this is to be realised.’ The way Mullins (2013, 3) puts it is as ‘essentially an integrating activity concerned with organisational processes through which members of the organisation are co-ordinated, directed and guided towards objectives’. However one describes it, it seems undoubtedly the case that successful outcome is more likely to happen if those involved see themselves as having ownership of the process, within a framework of interaction within the group, with group members having a significant say in implementation of systems and procedures (Chambers, 2011; Palfrey, Thomas & Phillips, 2004).



The challenge of emergent phenomena at the Hajj

How then has Saudi Arabia utilised the contingency approach to leadership coupled with shared governance in recent years in order to minimise the health risks to its visiting pilgrims? It has of course its own proactive, well established system of advanced planning, based on long experience. For a number of years, pilgrims arriving from countries in the so-called 'African meningitis belt', comprising 16 countries, have been given ciprofloxacin tablets at the port of entry to reduce the prevalence of carriers of neisseria meningitides and quadrivalent vaccination has been given to pilgrims from within Saudi Arabia and residents of Makkah and Medina as well as Saudi government staff who work during the Hajj. In 2006 an article in the Lancet on 'Health risks at the Hajj' (Ahmed, Arabi & Memish, 2006) pointed to SARS, avian influenza, and haemorrhagic fever as continuing hazards among others associated with the Hajj and concluded: 'Hajj management, even for a nation as well-resourced as Saudi Arabia, is an overwhelming task. International collaboration by planning vaccination campaigns, developing visa quotas, and arranging rapid repatriation are integral to managing health hazards at the Hajj'. Here we see how adept the country has been at handling what one writer, arguing about leadership and management more generally, termed 'the triggers of change' (Kanter, 1983). At the same time the Lancet article pointed out that management of the Hajj was improving year on year as the authorities learned from experience and it is clear that, over the last decade, there has undoubtedly been a significant advance in public health measures focused on sanitation, provision of safe water and food supplies, and provision of free clinic and hospital care as necessary. There has in this area seemed to be, as Walshe and Smith (2011, xxiii) put it: 'evidence-based management, visionary leadership and exceptionally robust and rigorous governance'.

Part of this has been achieved by the country's multidisciplinary group of experts from various government sectors in the advance planning of health services, logistical support, and communications for the Hajj. In addition to this, however, Saudi Arabia has also, importantly, begun to liaise ever more closely with the authorities from all countries from which pilgrims come communicating to them health requirements, including advice about public health guidelines to prevent the spread of respiratory and gastrointestinal infections. For the 2012



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and 2013 Hajj in particular, the Saudi Ministry of Health had three main planning considerations for communicable disease alert and response during the pilgrimage. These were based on the WHO's recommendations for mass gatherings and comprised risk assessment of what might happen during the Hajj, proactive surveillance for communicable diseases, especially because of outbreaks of MERS-CoV (Middle East respiratory syndrome) and other viral diseases, and ways of responding and taking necessary action. The WHO also supplied information and advice about outbreak management and emerging diseases, as did the European Centre for Disease Prevention and Control, Public Health England in the UK, and the Center for Disease Control and Prevention in the US. This constituted a major shared effort to maintain the necessary highest level of public health services and increased risk awareness of infectious diseases during the Hajj. Such an effort is well described by one writer as 'a dynamic process of pursuing a vision of change in which the leader is supported by two main groups: followers within the leader's own organisation, and influential players and other organisation's in the leader's wider, external environment', the leader in this case being the Saudi health authorities (Goodwin, 2006: 22).

The fear of a MERS-CoV outbreak is worth pointing to in particular as an example of the success of an infectious disease alert and response planning at the Hajj. In 2013 international media attention focused on MERS-CoV after the detection of fatal cases in France, Germany, and the UK, all of which had a connection with the Arabian Peninsula. A WHO emergency committee on MERS-CoV was formed which included a Global Center for Mass Gathering Medicine board member. In view of the impending Hajj in November 2013, during which well over a million pilgrims were expected to visit Saudi Arabia, the possibility that MERS-CoV could occur in pilgrims and then spread as they returned home, causing an epidemic worldwide, was a major concern. Research carried out by the Global Center MERS-CoV study group led to the rapid definition of hospital outbreaks, identification of the mode of transmission and the formulation of specific recommendations for the Hajj. The Ministry of Health in Saudi Arabia actually recommended that people at high risk for contracting MERS cancel their participation in the pilgrimage. Although a French study found that all its 179 survey takers with conditions that put them at high risk for contracting MERS still planned to



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participate even after pre-travel educational consultations (Gautret, P., Benkouiten, S. & Salaheddine, I, 2013), the measures devised by the shared group were so effective that no MERS-CoV cases were detected at the 2013 Hajj, and none were reported from the pilgrims' own countries when they returned (Memish, 2014). Using this example the Saudi government would clearly rate high on the scale of responsiveness (defined as 'the speed or accuracy with which a service provider reacts to a request for action or information') discussed by Paton and McCalman (2008, 94) as an evaluative criterion for contingency leadership.

A further measure the Saudi authorities have taken in collaboration with other countries' governments has been to begin issuing permits to foreign pilgrims to visit rather than allow an entirely free flow. The effect of this over the last three years has been to reduce considerably the number of people able coming to attend the Hajj. It is clear that a reduction from 1,752,932 international pilgrims in 2012 to 1,343,995 in 2013 and even fewer in 2014 does in itself constitute a significant step in reducing the potential for the incidence and spread of disease (Memish et al., 2014). The issuing of permits has been part of a wider liaison system the Saudi Ministry of Health has established with stakeholders (travel agents, Muslim councils, and tour organisers) in the countries where the pilgrims travel from. This has included the development of material for education and information (in various languages) and requirements for vaccinations and precautions to be taken before travel and during the pilgrimage.

For all their experience of dealing with the potential for the outbreak and spread of disease via the Hajj, the Saudi authorities could not have foreseen the additional challenge they would face in safeguarding the 2014 pilgrimage. This took the form of having to contemplate the possibility of the Ebola virus, rampant in some parts of Africa, spreading to Saudi Arabia, and then of course potentially more widely. Already in 2001, Saudi Arabia banned all Ugandan residents from attendance at the Haji because of the threat of Ebola, which had resulted in the deaths of close to 200 Ugandans in 2001 (Memish, 2002). But at that time the spread of the disease was contained to a relatively small area of Africa, while in the summer of 2014 Ebola had, through a convergence of factors, spread much more widely in the



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continent (in Guinea, Liberia, Sierra Leone and Nigeria) and many governments throughout the world had begun to take public health steps to try and prevent the often deadly disease from entering their country (Fauci, 2014).

To attempt to meet the threat of pilgrims bringing the Ebola virus to Saudi Arabia and then spreading it to the home countries of other pilgrims so far unaffected, it was clear that an enhancement of the already existing effort of shared leadership was necessary. The WHO's Global Health Workforce Alliance and Integrated Disease Surveillance programs, which leads international efforts to improve health workforce capacity and training in developing nations, liaised with the Saudi authorities, who were already aware that they needed to develop detailed but rapid planning for this prospective emergency. In co-ordination with the WHO, other international health bodies and the governments of the countries where Ebola had struck, the Saudi government took various measures. It announced that it would not issue visas to pilgrims from Sierra Leone, Liberia and Guinea due to the spread of Ebola in those countries. It deployed hundreds of health officials in international airports and more than 22,000 general practitioners were assigned to deal with the pilgrims. At home it set up 24 isolation units were set up in case of an outbreak as well as emergency rooms, surgery units and other facilities needed to treat patients. Finally at airports officials checked foreign planes with special care, double-checking the papers that proved the aeroplanes had been sprayed twice before taking off to their destinations. Most of these measures were widely reported in the world's press (in the UK, for example, broadsheets such as the Guardian (2014) carried the story prominently) and demonstrated the ability of Saudi Arabia and its partners to use the contingency approach to react to an example of what have been called 'emergent phenomena', i.e. events that public service managers cannot foresee and which arise because of unexpected changes of one kind or another in the environment (Osborne & Brown, 4).

Conclusion

As far as is currently known, the outcome of all these multi-agency actions and precautions taken co-operatively by the Saudi authorities and other bodies and agencies is that no cases of Ebola emerged in Saudi Arabia during the 2014 Hajj and there is no evidence of the spread of



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(2908 words)



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