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Crisis Management and The Impact of Pandemics on Religious Tourism

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Crisis Management and The Impact of Pandemics on Religious Tourism

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The spread of the novel coronavirus (COVID-19) has caused a worldwide shockwave of fear and much misinformation leaving chaos in its wake. Holy shrines and other religious sites have a special place in the hearts and minds of many people. For example, the mosques in Makkah and Medina, Saudi Arabia typically accommodate over one hundred thousand Muslims daily. Due to the spread of COVID-19, both mosques were forced to shut their doors to pilgrims for health and safety reasons. This situation has saddened millions of Muslims all over the globe. The same situation applies to Qom City in Iran, Bethlehem on the West Bank, and the Vatican City. Precautionary actions have caused religious shrines to remain closed until further notice. The methodology used in this study is descriptive and multi-disciplinary. In this paper, the issue of COVID-19 is addressed from the perspective of medical science, chemistry, management science, economics, and religious sociology. This paper sheds light on the history of the virus, its effect on the global economy and crisis-management measures involving sacred places. The paper investigates how faith can expedite the recovery strategies of religious tourism, and consequently the tourism sector will follow suit. The paper elaborates on the potential impact of the pandemic on the future of religious tourism and how the psychological impact of closing Holy Shrines to pilgrims can be a strong driving force for a speedy recovery once the pandemic trickles off.

Key Words: COVID-19, pandemic, food, crisis management, religious tourism, recovery

COVID-19: An overview

The novel coronavirus (COVID-19) is a previously unknown pathogen that has become highly contagious for humans. In late 2019, this coronavirus had mutated just enough to start causing human disease. It quickly spread around the world and has caused a global pandemic. The impact of COVID-19 has been medically severe. The public health threat it presents is profound. The pandemic is rapidly escalating and for many it is deadly. The COVID-19 virus is unique among human coronaviruses in its combination of high transmissibility and the substantial number of fatalities that occur in

high-risk populations. COVID-19 is now a major health threat to the global community. The global spread has been rapid, with over 215 countries now having reported cases. As of 27 October 2020, there have been over 43.7 million confirmed cases and over 1.16 million deaths worldwide. The estimated mean death rate of 2.66 percent (Anderson, Heesterbeek, Klinkenberg, & Hollingsworth, 2020; Google, 2020).

To reduce the intensity of the epidemic and to slow down the increase in cases, the focus must remain on preventing the spread of the disease and controlling negative outcomes. Containment of the pandemic can

be successfully operationalised with the appropriate intervention measures. A risk-based prevention and control approach to strengthen epidemiological investigation, case management and epidemic prevention for high-risk populations is essential to defeating this pandemic (Gaythorpe, Imai, & Cuomo-Dannenburg, 2020). Recognising that COVID-19 is a life-threatening disease, this outbreak can be managed with a response that ensures most infected individuals will recover (Verity *et al.*, 2020).

Coping with the COVID-19 Pandemic is not a one-dimensional issue. This worldwide phenomenon must be addressed from several perspectives simultaneously, so that solutions provided to manage this crisis are operational and feasible. Without addressing the health and medical issues, without understanding the chemical structure of the virus, without knowledge of disease management and without understanding the behaviour of society, this problem cannot be addressed in a practical way.

In this study, the issue of COVID-19 is addressed from the perspective of medical science, management science, economics, and religious sociology. The study sheds some light on the history of the virus, its relation to consumption of certain meat. Moreover, a brief account of the food factor and its impact on virus formation and spread have been presented. The paper attempts to investigate and evaluate the crisis-management measures in sacred places, actions taken, and degree of success in light with the World standard measures. This study also addresses the impact of the pandemic on the future of religious tourism and the psychological influence of closing Holy Shrines on believers who make pilgrimages to sacred places. Such psychological impact can be a strong driving force for speedy recovery once the pandemic trickles off. Moreover, the paper investigates how faith can expedite the recovery strategies of religious tourism, and consequently the tourism sector will follow suit.

Methodology

We have designed and implemented a descriptive qualitative approach to answer questions about Covid-19 crisis management and the impact of the pandemic on religious tourism. We have found experimental and qualitative methods to be useful on their own in explaining the phenomenon we wish to study. As a result, we have employed qualitative research as a mode

of inquiry. Qualitative research is a scientific method of observation to gather non-numerical data (Babbie, 2013). Qualitative research has been recurrently used in sociology. This type of research attracts researchers because it allows them to investigate the meanings that people attribute to their behaviour, actions, and interactions with others. While quantitative research is useful in determining relationships between variables, for example, the relationship between COVID-19 and economic recession, qualitative research can shed light on the reasons for this association by moving directly to the source - that is, the people themselves.

The study also utilises participant observation (Spradley, 2016). With this method, the researcher participates in the event not only to observe others but to gain direct experience in the pilgrimage setting. It is important to mention here that three of the researchers have performed hajj and Umrah several times, and in so doing, have observed and examined the hajj experience within the Muslim community.

This study also embraces textual analysis methods to examine the prevailing and published research, in particular literature in the areas of religion and religious tourism. A number of scholars have approved the textual analysis method as a tool to study religious texts particularly their contextual meanings and associations with a particular issues, for instance, in the case of this study it is religious tourism recovery (Karcic, 2006; Martin, 1982).

What is COVID-19?

Coronaviruses in humans are not uncommon. They are a large group of viruses that range widely in the severity of symptoms that humans experience. The spiked (crown-like) protein armatures on the outside of the virus that are used to grab and penetrate the outer walls of human and animal cells is what gives the virus its name. The coronaviruses that typically circulate among humans tend to be relatively benign. In fact, they account for about a quarter of all the seasonal 'cold' viruses in humans. Influenzas typically cause a fatality rate of 0.1%. However, COVID-19 is at least 8 times more virulent than the typical flu virus. COVID-19 is a close relation to the severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (WHO, 2020). COVID-19 derives its name from being, genetically, like the SARS coronavirus that was responsible for the SARS epidemic in 2002 (WHO, 2009).

This novel SARS-CoV-2 coronavirus (now called COVID-19) was first identified in Wuhan, China, in December of 2019. COVID-19 is responsible for the global pandemic we are currently experiencing. This virus is the product of a naturally occurring adaptation that the virus has made to use humans as a host. Contrary to internet gossip, analysis of the genome sequence data from this virus and other related viruses has found no evidence that the virus was engineered (human made). Rather, it is a product of naturally occurring mutations, similar to how a 'cold virus' mutates from one year to the next (Riou & Althaus, 2020). The first known severe illness caused by a coronavirus was identified in China, in 2003 and since that time has been referred to as Severe Acute Respiratory Syndrome (SARS). Based on genomic sequencing analysis, the most likely origins for COVID-19 (SARS-CoV-2) is that the virus evolved to its present state of virulence through natural selection in a non-human host and then migrated to humans (in the same way that the SARS coronavirus epidemic occurred in 2003). It is claimed that humans contracted the SARS virus after direct exposure to civets; small nocturnal mammals native to tropical Asia, Africa, and Columbia (WHO, 2009). Structural analyses of the proteins in that virus have been carried out to enable research for prevention and therapeutic interventions to combat the virus. Another, similar coronavirus, the Middle East Respiratory Syndrome (MERS) caused an outbreak, in 2012 in Saudi Arabia. In the case of MERS, camels were the animal host for the virus before it migrated to humans (WHO, 2009).

Using Illumina and nanopore sequencing, the whole genome sequences of the virus have been identified. There is a coronavirus that lives in bats. Alignment of the genome sequence of the COVID-19 virus and similar genomes of Beta coronavirus show that the closest host relationship is to the bat SARS-like coronavirus strain BatCov RaTG13. This strain is a 96% match with COVID-19. Genome sequencing analysis of 104 strains of the COVID-19 virus isolated from patients between the end of December 2019 and mid-February 2020 showed 99.9% homology of the virus, without statistically significant mutation (Andersen, Rambaut, Lipkin, Holmes, & Garry, 2020).

At its origin, COVID-19 is a zoonotic virus. Phylogenetic analyses and genome sequencing suggest that bats are the most probable reservoir for the COVID-19 (SARS-CoV-2) virus. However, there are no documented cases

of direct bat-human transmission. Therefore, this would suggest an intermediate host was involved in the spread from animals to humans. The virus most probably mutated enough to be able to stay alive in an intermediate host that lives in the caves where bats reside. The most probable intermediate host is a pangolin. The pangolin looks like a cross between an armadillo and an anteater (Andersen *et al.*, 2020). The chance that a coronavirus that was not pathogenic when it first entered the human population evolved the properties of COVID-19 while a human was serving as host is a slight possibility; however, that is less likely as a possible origin of the disease (Kucharski *et al.*, 2020).

How is COVID-19 being addressed to minimize the impact of the pandemic?

Two potential strategies for responding to the pandemic have been considered. The first is mitigation. This approach focuses on slowing down the spread of the epidemic. Mitigation focuses resources on protecting those most at-risk of death from the virus. This approach does not attempt to interrupt transmission of the disease. Its primary focus is on reducing the impact of the disease with medical interventions, such as treating those individuals who have life-threatening symptoms. The second potential strategy for responding to this pandemic is suppression. Suppression attempts to reverse the progression of the epidemic. The goal of this strategy is to reduce the number of active cases until an effective vaccine is available. However, it is estimated that it will be 18 months before a vaccine against COVID-19 becomes available. Furthermore, there is no guarantee that initial vaccines will have high levels of efficacy (Bootsma & Ferguson, 2007).

Both approaches to intervention have significant challenges when implemented alone. The optimal mitigation approach combines at-home isolation of suspected individuals, home quarantine of all household members of the individuals suspected of having the disease, and social distancing of the elderly and others most at-risk of severe disease symptoms. With mitigation, the population will eventually evolve a herd immunity leading to a decline in disease transmission. Mitigation could decrease the death rate by half. However, the epidemic would still likely result in many more millions of deaths.

Statistical analysis of the current trajectory of the pandemic is that about 80% of the population will eventually be infected with the virus through human-to-human transmission. Therefore, the most realistic and practical intervention strategy would be to implement both mitigation and suppression interventions (Ostermann *et al.*, 2014). The use of social distancing of the entire population, case isolation, household quarantine and closure of schools is predicted to have significant impact on slowing down the pandemic. Studies suggest that effective suppression of the virility of the virus would best occur from population-wide social distancing. To avoid rebound transmission, this would need to be maintained until an effective vaccine becomes available. However, this might not be a realistic option due to the realities of the global economy. Since social distancing would at best need to be in place for up to a year, until a vaccine becomes available, such an extended social distancing requirement would doubtfully be tolerated by the public. Therefore, a 3-month mitigation is more feasible. This would significantly reduce deaths, but without the more austere measure of continued social distancing until a vaccine is available (Halloran *et al.*, 2008). The value of implementing household quarantine during a pandemic is well-established as a principle of preventive medicine. The WHO China Joint Mission Report (2020) drew the conclusion that 80% of virus transmission occurred from family member to family member (The importance of school closure is not to protect children, but rather to slow down transition of the virus from children to older adults). School closures support epidemic suppression when combined with population-wide social distancing.

The principle of early identification, early isolation, early diagnosis and early treatment is crucial to overcoming this pandemic (Mossong *et al.*, 2008).

Who is at-risk?

Approximately 70% of individuals who become infected with the virus are between the ages of 30-69 years. In spite of what is miscommunicated by the media, transmission of the disease within health care settings and even among health care workers does not seem to be a major feature of COVID-19. Data on individuals under the age of 19 suggests that this population is at a relatively low risk of having a severe response to the virus. It accounts for only 2.4% of all reported cases, so far. Likewise, pregnant women do not appear to be at a higher risk of having severe symptoms in response to the virus. The mortality

rate among young children (birth-age 9) is being disputed because the records of the recorded deaths in young children are disputed (Ferguson, Laydon, & Nedjati-Gilani, 2020).

Symptoms and severity

Most individuals who become infected with the COVID-19 virus have mild symptoms and recover with no sequelae. Symptoms of COVID-19 are quite non-specific. The disease can even be present in an individual who is asymptomatic. The individuals who are labelled asymptomatic probably do develop symptoms of the disease, but these may be so mild that they go unnoticed. In a minority of individuals the disease can lead progressively from pneumonia to organ failure and death. The typical symptoms include: fever (87.9%), dry cough (67.7%), fatigue (38.1%), sputum production (33.4%), shortness of breath (18.6%), myalgia or arthralgia (14.8%), sore throat (13.9%), headache (13.6%), chills (11.4%), nausea or vomiting (5.0%), and nasal congestion (4.8%) (Gaythorpe *et al.*, 2020). Mild respiratory symptoms of COVID-19 typically occur within 5 days of becoming infected with the virus. However, there are reports of some individuals not noticing symptoms until day 14 of their exposure to the virus. Approximately 80% of laboratory confirmed cases will experience mild to moderate symptoms from the virus. This statistic even includes most of the individuals whose symptoms progress to pneumonia. Roughly, only 13.8% of individuals have a life-threatening response to the disease. Of that percentage only about half will not respond adequately to treatment. Those who die will not die directly from the virus, but rather from respiratory failure, septic shock, or kidney failure as an aftermath of severe lower lobe pneumonia. Individuals at the highest risk of dying from the virus are those over 60 years of age who have an underlying health condition such as diabetes, cardiovascular disease, chronic respiratory disease, or cancer (Gaythorpe *et al.*, 2020).

Acute respiratory distress syndrome (ARDS) and shock are the main cause of death for individuals unable to recover from the infection and this is most likely to occur in individuals over the age of 60 who are cigarette smokers or individuals with an underlying medical condition that weakens their immune system. Critical cases are defined as individuals who develop pneumonia that leads to respiratory failure requiring mechanical ventilation or individuals who, due to their underlying

medical conditions, go into shock or organ failure that requires intensive care. About a quarter of severe cases require mechanical ventilation while the remaining 75% only require oxygen supplementation. Although the crude fatality ratio (CFR) is currently estimated at 3.8%, this is drawn from the number of confirmed cases, not from the total number of individuals who may have contracted the virus. So, it is possible that the fatality rate is closer to 2.5% of infected individuals. The CFR is twice as high in men than in women (4.7% vs. 2.8%); possibly due to the higher incidence of cigarette smoking among men. The highest mortality rate is in people over 80 with a CFR of 14.2 to 21.9%. Among patients who have died, the time from symptom onset to death has ranged from 2-8 weeks (Linton *et al.*, 2020).

Disease progression

Approximately 30% of those that are hospitalised require critical care (invasive mechanical ventilation or ECMO). Fifty percent of those in critical care may die. This percentage tends to be age dependent. Older individuals with underlying health issues are at greatest risk and require more intensive intervention. Duration of stay in a hospital for individuals with severe symptoms is 8 days, if critical care is not required, and 16 days (with 10 days in ICU) if critical care is required. This is consistent with estimates for typical hospital admissions for pneumonia of any origin (Ferguson *et al.*, 2020). In spite of the higher-risk for individuals over 65-years of age, a 107-year old woman in Istanbul, Turkey recovered from the virus in April, after a week-long stay in the hospital and there have been other centenarians, worldwide, who have tested positive for COVID-19 who also survived the infection with a full recovery (Associated Publishers Limited, 18 April, 2020).

Knowledge gap

Although the effectiveness of the public health control measure of social distancing will prove to be extremely effective in slowing the aggressive spread of the virus, the wearing of protective masks and using gloves by the general public may prove to have limited value in controlling the spread of the virus (since the masking is not to protect the individual with the mask from others with the infection but to protect others from the individual wearing the mask (Li *et al.*, 2020).

The relationship between Covid-19 and food

The human body needs food for energy, proper growth, body maintenance and functioning. However, substances that people eat can also be a source of illness. Food can also be used to treat diseases and protect the body from diseases (Whitney & Rolfes, 2010). Foods contaminated with hazardous chemical substances or infected with bacteria, viruses and parasites can be life-threatening. Substances used as foods cause more than 200 diseases. Eating contaminated food causes illness in about 600 million people a year worldwide (10% of the world's population) and 420,000 people die from infected foods every year (Franz *et al.*, 2018). Food choices impact our health. What we eat can affect our health years later. Carelessness about food choices may even lead to the spread of disease (Whitney & Rolfes, 2010).

In general, people's decisions about what they eat, when they eat, and how much they eat is based on a complicated interaction between genetic, behavioural, and social factors (Higgs & Thomas, 2016). Most people select their food based on factors such as taste, habit, convenience, economics, ethnic heritage, social interactions, emotions, religious dogma, positive and negative associations, or an item's nutritional and health benefits.

Food choice based on ethnic heritage is the most influential factor and has a powerful impact on eating behaviour. People commonly prefer to eat foods that remind them of their childhood. In fact, every country has its own food preferences and regions within a country often have unique cuisine that reflects the local culture in terms of ingredients and cooking styles (Savage, Fisher, & Birch, 2007).

During the past two decades, several viral respiratory infections with pandemic potential have been detected that have been linked to animal sources. As previously mentioned, in 2002 an infection transmitted from animals to humans is linked to the Severe Acute Respiratory Syndrome coronavirus (SARS-CoV) detected in China. This was transmitted from swine to humans. A similar virus was detected in Mexico in 2009, and the Middle East Respiratory Syndrome coronavirus (MERS-CoV) was detected in Saudi Arabia in 2012, and again in 2017 in Guangdong, China (El Zowalaty & Jarhult, 2020; Trilla, 2020). Historically, animal hosts such as avian, bovine, swine, canine, phocine or wild animals have transmitted different varieties of coronaviruses to humans (El

Zowalaty & Jarhult, 2020; Lu, Stratton, & Tang, 2020; Sohrabi *et al.*, 2020). However, unlike SARS-CoV and MERS-CoV, the SARS-CoV-2 (COVID-19) has spread outside the epicenter of the original infection outbreak area, much more readily and rapidly than has occurred with the other coronaviruses (El Zowalaty & Jarhult, 2020).

Traditional medicine

Since the development of a vaccine against COVID-19 could take a year or more, traditional medicine could be considered as an adjunctive treatment, alongside conventional medicine, to fight against COVID-19. In 2003, Chinese patients suffering from SARS-CoV who were treated with traditional medicine, spent shorter time in hospital and suffered milder symptoms. Accordingly, the Chinese government has advised medical staff during the current pandemic to use a combination of traditional Chinese medicine alongside conventional western medicine for treating patients with COVID-19 (Ling, 2020). Along with these medicines, infected individuals must be provided with a continuous source of healthy food supplies.

Based on experience of the SARS-CoV outbreak in 2003, many people are expected to suffer from psychological stress related to the fear of the COVID-19 pandemic (Jiang *et al.*, 2020). Mental health issues should also receive significant attention within the first six months after the outbreak. Authorities in Shanghai, China initiated a psychological crisis intervention (PCI) to help all affected people, including medical workers to overcome any psychological difficulties during the pandemic. Two approaches are being used: using the telephone or internet to assist individuals suffering from psychological stress and; onsite mental health services at medical centres. Psychological crisis intervention aims mainly at minimising the negative psychological effects stemming from stress-related mental health issues (Jiang *et al.*, 2020).

Coronavirus threatens global supply chain

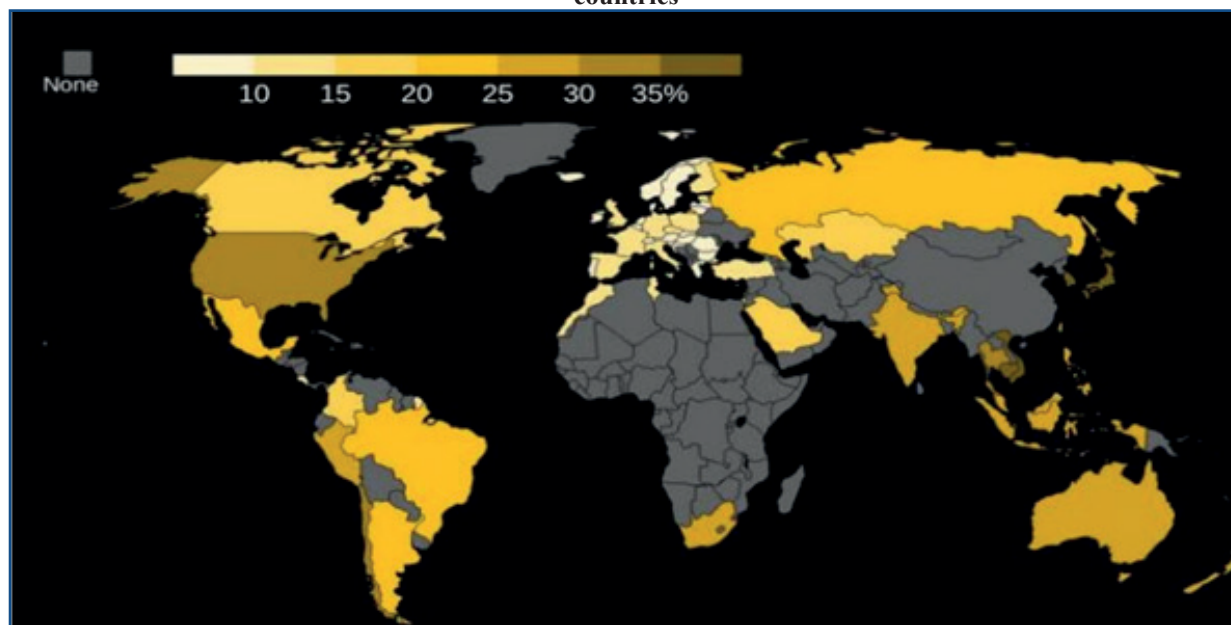
It is quite clear that due to the spread of the COVID-19 the world economy has suffered. There has been a widespread disruption of industry and the global supply chain. This disruption may well have many irreparable consequences for businesses and the global economy (Park, Kim, & Roth, 2020). Many business

executives are struggling to find solutions to support their employees, ensuring security of supply, mitigating negative financial impacts, identifying potential threats, and managing and guiding market uncertainty that has driven down demand for goods and services. The global value chains are the engine of economic development and gross domestic product (GDP) growth in the world. The spread of COVID-19 has reinforced the need for businesses to focus more on crisis management. The pandemic has had a significant negative impact on global markets. Fear of the virus has affected world oil prices, and factories in China have reduced their production due to falling demand (C-Y Park, Kim, & Roth, 2020). The slowdown in demand has distorted suppliers' prospects. According to Reuters, China's economic growth is only expected to reach 5.4% in the first quarter of 2020, which is the lowest since the world financial crisis of 2008. The cost of slowing China's economic growth to the world economy is estimated at 1.1 trillion dollars.

The consequences of the outbreak are not yet completely known, but the devastating effects are likely to be far greater than those experienced in the past. From a supply-chain perspective, the lessons learned from previous crises such as the 2003 SARS outbreak cannot be used for the present situation, as the Chinese economy is now much more developed and more intertwined with the world economy. In recent years, the Chinese economy has made significant progress in upgrading its transportation network. Besides, today's global value chains are broader and more complex than in 2003. China's share of the value-added of the world manufacturing industry in 2003 was about 9%. It climbed to 28% in 2018 (Haren & Simch-Levi, 2020).

According to the latest Fortune magazine ranking, out of 1,000 active businesses worldwide, 938 have been affected by the current pandemic in the first or second tiers of their supply chains. The automotive industry was affected by the pandemic faster than other industries because of its Just in Time (JIT) supply chain and the global supply network. Production rates in the Chinese auto industry reached less than 50 percent of production before the virus spread, and since that time parts suppliers in China are virtually inactive. For example, in February 2020, AG Volkswagen's joint venture with Chinese Group FAW had begun production at 4 units, though they were not targeted to reach full production capacity until May 2020. These delays have had a bullwhip effect on suppliers of internal and external components that halt

Figure 1. Global percentage share of Chinese intermediate goods imports, of total commodity imports in other countries



(Cousin, 2020)

or delay production. The trend that has already caused the market to decline will further reduce sales volumes by 2 to 5 percent. Manufacturers of electronics have also been directly affected by the virus. Apple, for example, lost more than 12 percent of its market value in the first week of the COVID-19 outbreak, due to the inability to supply parts needed by its suppliers in 43 countries that have contracted with Chinese factories (OECD, 2020). Another negative consequence of the Coronavirus is restricted access to workers due to quarantine conditions in factories and workforce casualties (Sim, 2020). The Bloomberg Economic Sector, based on available data from the OECD Commercial Value Added, has drawn a map of the extent to which the economies of the world rely on imports of intermediate goods from China. Figure 1 indicates that the share of imported goods from China to the US (for example) is more than 35% of total imports in the country.

Five different patterns in the face of the COVID-19 crisis

An overall pattern of actors and decision-makers faced with this pandemic is viewed in five different categories based on two components of their political decision-making ability and their health infrastructure. Suggested solutions to the problems are provided.

Countries with strong crisis management and strong health systems

The first group of countries to be considered are those that have strong political management in the face of crisis, and in principle, the possibilities and resources for decision-making during crisis are also much broader for them than many other countries. These countries have very strong health infrastructures that reinforce their political management and decision-making at this critical juncture. In this category, regardless of their health capability in the face of crisis, they decided to protect citizens' health by entering a full quarantine and accepting its economic consequences. The most prominent actors in this category are South Korea and Singapore. With strong crisis management, they developed strategies and infrastructure to maintain preparedness for dealing with widespread crises following the 2003 SARS disease. South Korea had predicted that a crisis larger than SARS could become a major threat. So, they provided all the necessary facilities to manage the crisis. Citizens of these two countries, their political, social networks, and health system will be less negatively impacted by the pandemic in the long-term.

Countries with strong crisis management and a strong health system but delayed decision making

This category includes actors who, while having strong political management to make decisions during a crisis and having a very robust and efficient health

infrastructure, have largely delayed the appropriate crisis decision-making. These countries postponed quarantine and imposed the heavy burden of delaying political decision-making on the country's health system. The increase in the number of people affected, as well as the increasing number of deaths in these countries (the largest death toll from this disease), is a consequence of this mistake. This category includes the US, UK, France, and Germany. Despite early delays, these governments are highly capable of responding to the crisis and the consequences of the self-imposed delays. The strong infrastructure of these actors will give them a great opportunity to manoeuvre through a recovery. Even if the death rates are high, they will eventually be able to respond to the crisis with relative efficiency.

Countries with poor crisis management and strong health systems

These actors lacked strong political management to take decisions in a crisis. They experience a greater financial crisis than first and second-tier players, but they have a favourable and robust health care system. In management and decision-making, they may not have initially taken the disease seriously enough, on the other hand, they were very optimistic about their health system and did not know that this disaster would add to the depth of their economic and political crises. These countries are now facing the crisis of high numbers of new infections and deaths per day. Italy and Spain are examples of this category. Their health care system is now in shock and the health system will face many problems during the pandemic. These actors will see profound damage from the pandemic to the social, economic, health and political sectors of their societies.

Countries with strong crisis management and poor health systems

In this classification, the actors were aware of the situation from an *a priori* as well as a *posteriori* economic damage to their infrastructure resulting from their decision to enter compulsory quarantine. They were also aware of the weakness of their health care infrastructure that would be greatly stressed in the face of the pandemic. They quickly enforced heavy and compulsory quarantine (faster than the Group 1, 2, and 3 countries). An actor in this category is the Kurdistan Regional Government of northern Iraq (The Kurdistan Regional Government (sometimes called Kurdistan) is the official ruling body in northern Iraq). The Kurds were aware of the importance of decision-

making in times of crisis. Rather than increasing the burden that the disease would have on the poor health care system of the region, they attempted to implement a preventative scenario with timely decision-making, accepting the damage it would cause to the economy. The Kurdistan Region has now attracted regional and global attention in crisis management, and the World Health Organisation has officially declared their efforts a success. In the medium to long term, this actor will face problems with the economic consequences of the continuing pandemic. However, many lives will be saved. In this category, instead of relying on the limited ability of their financial resources, decision-making relied on 'charitable organisations' and 'capital groups'. The groups raised millions of dollars in aid for the poor and under-privileged citizens, as well as the health care system in the Kurdistan region. Currently, about six hospitals are being built in Iraqi Kurdistan, that are being equipped with all the necessary facilities to address the health crisis caused by the pandemic.

Countries with poor crisis management and poor health systems

Actors in this category show that they are not capable of making decisions in a crisis because they do not have an integrated decision management system, and their health system is not capable of sustaining the damage caused by mismanagement. The health system of these actors is fragile and suffers from a lack of resources and facilities. As a result, the long-term human, social, psychological, economic, and cultural damage caused by the pandemic will be far greater for these actors in the future. The inability of the health care system to withstand parallel or future damage before re-recovering from COVID-19 will be profound. At the same time, a crisis of trust in the relationship between the people and the government will emerge. This could lead to serious political damage. This situation can only be remedied by being responsible, accepting mistakes, and making quick efforts to prevent more victims. Pakistan is the most prominent example of this group.

Crisis management in the face of COVID-19

In managing this crisis, one must consider two important issues: the business market and the community. This section outlines ways to reform the value chain of global production and strategies to manage the social crisis in the aftermath of the pandemic.

Response to the threat of COVID-19 on the global supply chain

In the context of the pandemic, how to replace a global value chain is an important issue. Production is now very limited in many supply chains so that organising the chain in a way that maintains global equilibrium becomes a critical issue. The outbreak of COVID-19 has increased uncertainties in the global economy. How should firms respond to long-term disruption to supply and what should their response to this risk look like?

During the pandemic firms urgently need to adopt short-term strategies to boost their resilience, while anticipating longer-term considerations for re-configuring supply chains to counter emerging threats. The principles of the framework for dealing with threats are summarised below:

- Enhance the visibility of the entire supply chain across all levels to primary, secondary, and third-party players. Which suppliers produce the key and critical components? Are there any alternative sources? How is the stock situation of the supply warehouse? In this situation, it is advisable to double the critical supply sources or increase the available buffers to insulate against damage.
- Evaluate and re-evaluate closer options periodically to shorten distances with suppliers and get closer to customers.
- Use the leverage of advanced manufacturing technologies to increase the ability to withstand threats and maintain flexibility.
- Use scenario-writing techniques to systematically evaluate the entire supply chain and deploy operational units for rapid adaptation.

Managing the unpleasant consequences of this global pandemic is an important issue for the world economy and every business. All business leaders and governments around the world need to cooperate to use leading-edge approaches to problem-solving and accelerate the implementation of shared responses. Through cooperation, stakeholders will be better able to take action to find the most effective solutions to contain global economic threats.

Social crisis management

Crisis-management protocols are always divided into 'physical and environmental elements' and 'psychological management and group behaviour.' Environmental and physical management includes the following:

- Limiting the spread of the virus
- Providing optimal patient care
- Maintaining stability of the physical health of the entire community (Zhang, Wu, Zhao, & Zhang, 2020)

Crisis management during this pandemic must include:

- Preventing lawlessness in society-at-large
- Enhancing law enforcement's ability to 'lead group behaviours and engage communities'
- Equipping the community with positive psychological tools
- Confronting misinformation
- Averting catastrophe
- Supporting benevolent interventions and heroism,

It is the duty of the government during crisis management of a pandemic to create and broadcast positive and entertaining initiatives that can:

- Reduce mental stress
- Reduce anxiety
- Increase positivism and positive thinking in society
- Avoid mass panic

Although health warnings are crucial, without an equally strong positive messaging, the warnings only accelerate and exacerbate the psychological crises of society during a pandemic (KPMG, 2020).

Crisis management in religious tourism

With the emergence of the novel coronavirus (Covid-19) and its spread all over the world, countries have taken social distancing measures that heavily impact on religious practices and rituals. This is expected and predictable when one realizes that COVID-19 has infected over forty million people across the globe. On 30 January 2020, the World Health Organization (WHO) declared COVID-19 a public health emergency on an international scale. On 11 February they gave the virus the name novel coronavirus (COVID-19). On 12 March 2020, they declared the outbreak to be a pandemic. The scale of the outbreak has sparked terror around the world.

Impact on Pilgrimage

Here we review the most prominent actions and reactions taken by countries and religious bodies concerning religious practices as a part of strategies to manage

the crisis created by this pandemic. The secretary-general of the International Union of Muslim Scholars Ali Qara Daghi issued the ruling that it is permissible to temporarily stop the performance of Umrah and Hajj pilgrimage rituals due to the pandemic. This decision was based on the fear that pilgrims may become infected with COVID-19 due to the crowded conditions at the pilgrimage sites. The official ruling states that since the pandemic is so dangerous, it is permissible to prevent Umrah or Hajj pilgrimages temporarily to avoid the spread of the virus. He added that most Muslim scholars have agreed that it is permissible to stop Hajj if there is a lack of safety on the pilgrimage journey (Alrub, 2020).

Medical authorities have stressed that there is a serious fear of spreading the disease due to Hajj and Umrah and a decision has been issued in this regard from Saudi Arabia. The Saudi authorities decided to suspend Umrah temporarily in the Kingdom, for fear of a viral outbreak at the Grand Mosque in Makkah and the Prophet's Mosque in Medina. Makkah and Medina receive hundreds of thousands of pilgrims every month from all parts of the world. If the virus was transmitted within such a large group the global pandemic would be intensified once infected individuals returned to their countries. It is noteworthy that the safety of people is considered to be more important than performing Umrah. This ruling is based on Islamic teaching which represents the best strategy to fight this pandemic. Q2:195 declares the verdict that we should not expose ourselves to dangers and bear our responsibility of maintaining our safety.

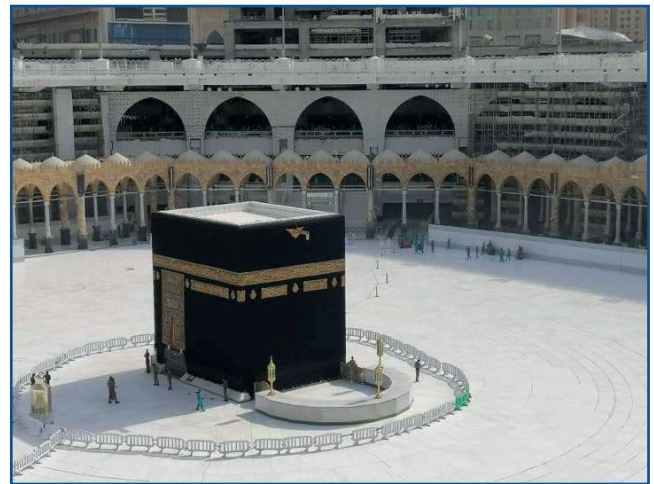
Usama bin Zaid: The Prophet (PBUH) said: If you hear of the plague in a land, then do not enter it, and if it outbreaks out in a land while you are in it, do not leave that land (Al-Bukharai, 2003).

Do not throw yourselves into destruction (Q2:195).

Umrah attracts millions of Muslims annually from different countries of the world, and the decision to suspend its performance came just two months before Ramadan, when the number of pilgrims doubles. 18.3 million people performed Umrah in 2018. Last year, Hajj attracted about 2.5 million people, before the spread of the virus the authorities had expected that the number of pilgrims would reach 2.7 million in 2020.

Social networking websites are now filled with pictures and videos of how these sites now appear completely empty of people in a scene that has not happened for

Figure 2: Photograph of an 'empty' Makkah, as shared on Twitter, April 2020



decades (Figure 2). Social media is full of believers echoing sadness seeing the mosques 'closed 'till further notice'. These restrictions on entering holy sites are without precedent. Many people wonder if the new measures will cause extended damage to the Hajj season, if the virus continues to spread.

In Iran, the pandemic sparked great controversy between clerics and the government over measures to curb the spread of the virus in the Islamic Republic. At one point, Iran was recording the largest number of deaths outside of China, however, religious shrines were still open in Qom, which was believed to be the epicenter of the virus in Iran. Millions of Shi'a pilgrims visit the tomb of Fatima, the daughter of Musa al-Kazim, the seventh imam of the Twelver Shiites every year in Qom. The authorities advised citizens to avoid unnecessary gatherings and asked them not to travel to Qom. Initially they did not close the shrines in the city, however, eventually Qom was closed to curb the spread of the pandemic (Gandhara, 2020).

All mosques and churches were closed in the Palestinian territories in an effort to contain the spread of COVID-19. The authorities announced this decision to limit the prayers of citizens to their homes and not to go to mosques and churches in all regions of Palestine, until further notice. The Islamic Endowments Department decided to close the roofed chapels inside the blessed Al-Aqsa Mosque as a preventive measure against the spread of COVID-19. The director of Al-Aqsa Mosque, Sheikh Omar Al-Kiswani, said that all prayers would be held in the arenas of the blessed Al-Aqsa Mosque, and all doors would remain open to worshippers.

The city of Bethlehem, which is a religious destination for Christians, has witnessed unprecedented inactivity in the past few months. It is usually filled with tourists and pilgrims from various countries of the world throughout the year. The Palestinian Ministry of Tourism states that 1.5 million visitors typically enter 'Bethlehem' over the Christmas period (Amouri, 2020). The yard of the Church of the Nativity, which, to some, is considered the most important Christian religious site in the world is believed to have been built on the cave where Jesus (PBUH) was born. This site closed its doors by agreement of all Christian denominations, in response to the recommendations of the Palestinian Ministry of Health. The city's streets appear empty, shops and all mosques are closed, even for Friday prayers through the duration of the pandemic. Bethlehem hotels are closed to tourists, and all reservations were cancelled.

St. Peter's square in Rome is usually crowded with visitors during Easter, which is considered the most important holiday for Christians. This year the Vatican celebrated the holiday alone (Figure 3), stating that in 2020, all Easter prayers in St. Peter's Square would take place without the participation of worshippers due to the outbreak of COVID-19. Social media circulated a picture of Pope Francis, alone in the square, in a scene that reflects the bitter reality of the country most affected by Corona in Europe. In response to that, the papal office announced in a statement that

against the background of the current international health situation, all liturgical celebrations of the Holy Week will take place without the presence of worshippers in person.

The Vatican also clarified that

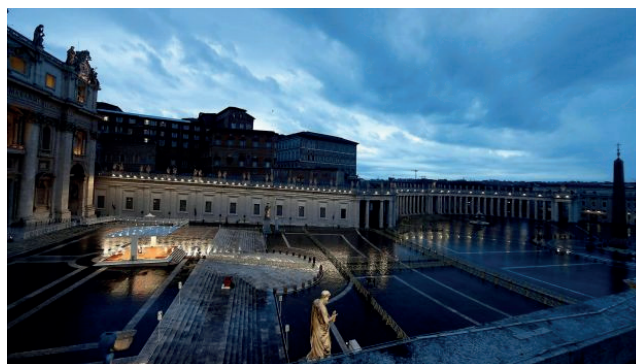
all public gatherings, as well as preaching and prayers of the Pontiff will be available via live broadcast on the official Vatican News website (Vatican, 2020).

The pandemic has also negatively impacted religious pilgrimages in Buddhism, Hinduism, Confucianism, and even visits to the four sacred mountains of Taoism.

Religious Tourism

Religious Tourism is one of the oldest types of tourism (Rogerson, 2019) and its aim is to perform religious rituals, as is the case for Muslims' pilgrimage to perform Hajj and Umrah, as well as recreation and enrichment of family, as mentioned in the teachings of Islam:

Figure 3: Pope Francis delivering a blessing to an empty St Peter's Square



Source: The Irish Times Newspaper, 4th April 2020

There is no blame upon you for seeking bounty from your Lord [during Hajj]. But when you depart from Arafat, remember Allah at al-Mash'ar al-Haram. And remember Him, as He has guided you, for indeed, you were before that among those astray (Q2:198).

Hajj differs from most other types of journeys because it is primarily a religious act in its own right, it is made for a specific (spiritual) purpose and represents a path to certain holy places. Unlike other types of tours, the pilgrimage usually involves social, economic, or physical difficulties or sacrifices for pilgrims who usually accept these sacrifices willingly as part of the spiritual nature of Hajj (C. Park, 2004). We shouldn't go without saying that many Christians are also concerned about undertaking similar pilgrimages to sites such as Jerusalem, Rome, Lourdes in France, and the Camino de Santiago in Spain. In the same vein

it is extremely important that people use their beliefs in a way that makes them feel empowered and hopeful.

Thus, says Thomas Plante, PhD, a professor of psychology at Santa Clara University (Goodman, 2020).

Religious tourism is a multifaceted activity but is a type of tourism that can deeply incite tourists to achieve religious awakening (Albayrak *et al.*, 2018). Pilgrimage, however, represents the main physical expression of the power of attraction of Holy places and sometimes involves large numbers of people travelling by various means from all walks of life (C. Park, 2004). Motives that drive millions of pilgrims to embark on their pilgrimage should not be underestimated.

The future of religious tourism and pilgrimage depends to some extent on those strong motives to restore its recovery force. Positive religious restructuring can help people survive difficult times by enabling them to see the tragedy as an opportunity to approach a higher power or to improve their lives as seen live online in Friday rituals from mosques throughout the world. Nearly 100 mosques in Germany and the Netherlands ring out the call to prayer, as a sign of support for Muslims amid the COVID-19 pandemic (Sajid, 2020).

Religion has always played an important role in many aspects of society, including travel and the behaviour of travellers. The global growth of pilgrimage to religious sites in recent decades has changed people's thinking and belief regarding secular public space and has introduced new forms of thinking to find spirituality and develop alternative religious movements (Raj, 2012). Indeed, throughout most of human history, religion has been one of the main reasons for people traveling, and it still remains a main driving force for many journeys. These trips are referred to as pilgrimage or religious tourism (or Hajj), which have become relatively common phrases within the tourism sector.

Religion has always been a part of people's ritual routine and one of these routines is travel. Working on boosting religious motives and faith beyond religious tourism could accelerate the normalisation of not only religious tourism but the whole tourism sector. Religion has retained a significant place within the global political environment over the last 100 years despite emerging secularism and related functions, which pervade cultures and traditions (Raj, 2012). Faith is a strong motive which affects people's insights, decisions, norms, social culture, and behaviour. Religious travel in quite a number of places is a cornerstone of people's culture and is the foundation of community values and the specific practices of their daily routine, businesses, economy revenues, development projects, and their welfare. Therefore, strategies for raising the awareness of religious tourism can be a substantial plan for religious tourism recuperation post COVID-19.

Religious tourism is characterised as a travel niche that targets both the broad consumer market in addition to the more limited fervent religious one. The population of religious tourists constitutes those who seek to fulfil their high-dimensional desires, such as spirituality, meditation,

composure and enlightenment. Millions of people travel annually to holy places in such capacity. Both these followers of faith and those who identify themselves in holy places as religious tourists, focusing on more secular motives, demonstrate remarkable loyalty to these sites and destinations (Andriotis, 2009; Rodrigues & McIntosh, 2014).

Conclusion

The measures taken to manage the coronavirus pandemic are important to minimise loss of life. The effectiveness of the public health control measure of social distancing will prove to be extremely effective in slowing the aggressive spread of the virus. In order to manage the current crisis, traditional medicines should be considered as adjunctive treatment against the virus because of the effectiveness of these compounds found during the SARS-CoV in 2003. Chinese patients suffering from SARS-CoV who were treated with traditional medicine, spent less time in hospital and suffered milder symptoms. In addressing this pandemic, crisis-management protocols must balance concern over the global economy and global markets with the health and safety of individuals.

The negative effect on religious tourism might take quite a toll on religious pilgrimages in the future. Due to health and safety concerns, travellers might feel reluctant to resume pilgrimages if they believe the health risks remain even after the pandemic has officially ended. The impact is potentially grave for Islam because the most important pilgrimage is the heavily populated pilgrimage to Makkah which occurs annually. It is unclear whether the pilgrimage will be cancelled in 2021. The same uncertainty befalls the Christian pilgrimages to Bethlehem, The Vatican, the Camino to Santiago de Compostela in Spain and many other religious sites throughout the world in the coming months. Fears surrounding the COVID-19 pandemic could have a long-lasting impact on religious tourism and make believers more hesitant to go on pilgrimages.

On the other hand, the COVID-19 pandemic seems to have rekindled spirituality and a willingness by many to have greater respect for individual differences and see the essential oneness of all humans. Motives that drive millions of pilgrims to embark on their pilgrimage should not be underestimated. The future of religious tourism depends to some extent on these strong motives as its

recovery force. Positive religious restructuring can help people through difficult times by enabling them to see the tragedy as an opportunity. Eventually, faith instilled into the minds and hearts of pilgrims will act as a gripping force to bring religious tourism gradually back to normal.

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