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1 **Clinical respiratory infections and pneumonia during the Hajj pilgrimage: A systematic**
2 **review**

3

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22

23 **Running title:** Syndromic surveillance of respiratory infections among Hajj pilgrims

24 **Keywords:** Hajj; Pneumonia, Pneumococcal; Respiratory Tract Infections; Syndromic
25 Surveillance

26

27 **Abstract**

28 **BACKGROUND:** The Islamic Hajj pilgrimage to Mecca is one of the world's largest annual
29 mass gatherings. Inevitable overcrowding during the pilgrims' stay greatly increases the risk
30 of acquiring and spreading infectious diseases, especially respiratory diseases.

31 **METHOD:** The MEDLINE/PubMed and Scopus databases were searched for all relevant
32 papers published prior to February 2018 that evaluated the prevalence of clinical symptoms of
33 respiratory infections, including pneumonia, among Hajj pilgrims, as well as their influenza
34 and pneumococcal vaccination status.

35 **RESULTS:** A total of 61 papers were included in the review. Both cohort- and hospital-based
36 studies provide complementary data, and both are therefore necessary to provide a complete
37 picture of the total burden of respiratory diseases during the Hajj. Respiratory symptoms have
38 been common among Hajj pilgrims over the last 15 years. In cohorts of pilgrims, cough
39 ranged from 1.9% to 91.5%. However, the prevalence rates of the most common symptoms
40 (cough, sore throat, and subjective fever) of influenza-like illness (ILI) varied widely across
41 the included studies. These studies have shown variable results, with overall rates of ILI
42 ranging from 8% to 78.2%. These differences might result from differences in study design,
43 study period, and rates of vaccination against seasonal influenza that ranged from 1.1% to
44 100% among study participants. Moreover, the definition of ILI was inconsistent across
45 studies. In hospitalized Hajj pilgrims, the prevalence of pneumonia, that remains a major
46 concern in critically ill patients, ranged from 0.2% to 54.8%.

47 **CONCLUSIONS:** Large multinational follow-up studies are recommended for clinic-based
48 syndromic surveillance, in conjunction with microbiological surveillance. Matched cohorts
49 ensure better comparability across studies. However, study design and data collection
50 procedures should be standardized to facilitate reporting and to achieve comparability
51 between studies. Furthermore, the definition of ILI, and of most common symptoms used to

52 define respiratory infections (e.g., upper respiratory tract infection), need to be precisely
53 defined and consistently used. Future studies need to address potential effect of influenza and
54 pneumococcal vaccine in the context of the Hajj pilgrimage.

55

56 **Introduction**

57 The yearly "*Hajj*" (also known as the pilgrimage to Mecca) in the Kingdom of Saudi Arabia
58 (KSA) is the "Fifth Pillar of Islam" and is mandatory once in a lifetime for all adult Muslim
59 who are physically and financially able. The Hajj is one of the world's largest annual mass
60 gatherings. In 2016, around 1.3 million foreign visitors, from more than 180 countries,
61 gathered in the KSA to complete the Hajj, in addition to over 500,000 domestic Hajj pilgrims
62 [1]. Also, about 5-6 million pilgrims perform the "*Umrah*" (also known as the lesser
63 pilgrimage) each year.

64 The Hajj and its rituals are physically demanding for Hajj pilgrims, the majority of whom are
65 elderly [2], with chronic conditions. Although the Hajj rituals only take one week, pilgrims
66 usually stay in the KSA for several weeks throughout the month-long Hajj season, presenting
67 a major public health and infection control concern, and a challenge both for the Saudi
68 authorities, as well as for the national authorities of the countries of origin of the pilgrims. In
69 addition to physical exhaustion, sleep deprivation [3], and heat stress [4], inevitable
70 overcrowding, both in housing and ritual sites, especially in Mina encampment (this is
71 approximately a 3-kilometer square area where pilgrims are accommodated in air-conditioned
72 semi-permanent tents, some with up to 50-100 people) and inside the Sacred Mosque in
73 Mecca (with up to six pilgrims per square meter) [5], greatly increases the risk of acquiring
74 and spreading infectious diseases [6-8], especially respiratory diseases [9,10]. To minimize
75 the spread of infections during the pilgrimage or in the pilgrims' home countries upon their
76 return, vaccination and non-pharmaceutical interventions are thus recommended by national
77 and international public health agencies [11,12].

78 We carried out a systematic review of cohort and hospital studies that reported the prevalence
79 of clinical symptoms of respiratory infections and pneumonia among pilgrims during the Hajj,
80 and both their influenza and pneumococcal vaccination status, with the aim to provide data

81 allowing the investigation of the impact of this large mass-gathering event on public health
82 policies and services and to identify potential targets for preventive measures.

83 **Search Strategy and Selection Criteria**

84 This review was performed according to Preferred Reporting Items for Systematic Reviews
85 and Meta-Analyses (PRISMA) guidelines (<http://www.prismastatement.org>).

86 The MEDLINE/PubMed and Scopus databases were searched for all relevant papers
87 published prior to February 2018, using the terms:

88 #1: Hajj OR hadj OR pilgrim OR pilgrims OR pilgrimage

89 #2: Respiratory

90 #3: Infection OR infections

91 #4: ILI OR URTI OR URTIs OR URI OR URIs OR LRTI OR LRTIs OR LRI OR LRIs

92 #5: Pneumonia OR *Streptococcus pneumoniae* OR pneumococcus OR pneumococcal

93 #6: #1 AND ((#2 AND #3) OR (#4) OR (#5))

94 In addition, the Saudi epidemiology bulletin (<http://seb.drupalgardens.com/>) was hand
95 searched for additional papers for inclusion. Finally, the reference lists of reviewed articles
96 were searched for additional relevant papers.

97 For inclusion, the article had to meet the following criteria: (1) Original study involving Hajj
98 pilgrims; (2) detailed description of the study population, including influenza and
99 pneumococcal vaccination status when available; (3) clinical or self-reported respiratory
100 symptoms and diseases. Only articles published in English were included for review. We
101 excluded cohort studies with less than 50 participants and case reports. We also excluded
102 studies conducted among selected groups of individuals suffering from respiratory tract
103 infections, due to lacking denominator data.

104 The two authors independently performed the searches, screened titles/abstracts for eligibility,
105 selected papers that appeared to be relevant according to the review's inclusion criteria, and

106 reviewed each of the selected manuscripts in full. The data were extracted from the included
107 papers by one reviewer (SB) and collected in the summary table that was included in the
108 review. The extracted data were checked by the two authors (SB and PG) for accuracy. Minor
109 discrepancies were resolved by the authors' discussion.

110 **Results**

111 **Included studies**

112 The search strategy initially yielded 391 records, of which 143 were duplicates. Twenty-nine
113 additional papers were identified through manual searches. Of the 277 papers identified 183
114 records were excluded after screening the title and abstract. Of the 94 full text articles
115 reviewed, 61 were deemed suitable for inclusion in this review according to the
116 inclusion/exclusion criteria. The results of the search strategy are shown in Figure 1.

117 **Cohort studies addressing the prevalence of respiratory tract infections among Hajj** 118 **pilgrims**

119 A total of 45 publications were identified. These studies were conducted among cohorts of
120 pilgrims from the 1999 through the 2015 Hajj seasons. The results of these studies are
121 presented in Table 1. Various study designs were used, including cross-sectional studies, case-
122 control studies, and prospective cohort studies with follow-up of pilgrims, before, during and
123 after the Hajj. Participants were from different countries and continents (Africa, North
124 America, Asia, Europe, as well as from Australia), with the majority from Iran, and they were
125 recruited from different settings, including travel medicine clinics, vaccination centers, Hajj
126 travel agencies, international airports and transit zones, Mecca's city and Mina encampments.
127 Their numbers varied widely in these studies, ranging from 106 to 107,074.
128 Respiratory symptoms were common during the Hajj. Overall, the prevalence of cough
129 ranged from 1.9% in domestic and international pilgrims in 1999 [13] to 91.5% in Malaysian
130 pilgrims in 2007 [14,15] (Table 3). More recent studies, conducted in different populations of

131 pilgrims during the 2011-2014 Hajj seasons, reported prevalence of cough ranging from
132 46.3% to 86.8% [16-24]. These studies also reported a comparable prevalence of sore throat
133 ranging from 34.7% to 91% among pilgrims [16-23].

134 In addition, many of these studies have investigated the epidemiology of respiratory tract
135 infections among pilgrims by estimating the common prevalence of upper respiratory tract
136 infection (URTI), acute respiratory infection (ARI) or influenza-like illness (ILI), which were
137 inconsistently defined across studies by a combination of general symptoms (e.g. cough, sore
138 throat and fever). Overall prevalence of ILI varied in these studies from 8% to 78.2% [14-
139 16,18-23,25-45] (Table 3). In large studies conducted among Iranian pilgrims between 2003
140 and 2005, the prevalence of ILI was, respectively, 70.1% and 35.8% in 2003 and 2004
141 [41,42], but 19.6% in 2005 [46]. In another large 5-year (2004-2008) follow-up study
142 conducted among 254823 Iranian pilgrims, only 10.7% of pilgrims complained of ILI during
143 the Hajj [47,48]. However, the ILI syndromic case definition used in the 2003-2004 study (ILI
144 was defined as cough and fever of more than 38°C with or without the coryzal symptoms and
145 myalgia) [41,42] was different with that used in the 2004-2008 study (ILI was defined as
146 symptoms and signs such as sudden headache, dry cough, high grade fever, myalgia, coryza,
147 malaise and loss of appetite with an abnormal general appearance) [47,48]. Also, it is unclear
148 from the 2005 study [46] if the definition used was consistent with those used in the two
149 previous studies [41,42,47,48]. In a recent large study, conducted among 3364 Egyptian
150 pilgrims between 2012 and 2015, the prevalence of ILI was 30.4% (ILI was defined according
151 to the World Health Organization definition as the presence of measured fever of $\geq 38\text{ C}^\circ$, and
152 cough; with onset within the last 10 days) [45]. Other studies of different sizes (from 129 to
153 468) and design were conducted from 2007 through 2014 among different populations of
154 pilgrims using a common ILI definition (the association of cough, sore throat, and subjective
155 fever). These studies have shown variable results, with overall rates of ILI ranging from 8% to

156 78.2% [14-16,18,19,21-23,25-26,31,35,37]. Thus, during the 2013 Hajj season, while the
157 highest prevalence of ILI was observed among Malaysian pilgrims, with a prevalence
158 estimated at 78.2% [25], a lower prevalence was observed among French pilgrims (47.3%)
159 [18,21].

160 Coverage of seasonal influenza vaccination among pilgrims was evaluated in many studies,
161 which have yielded varying results, with reported rates of influenza vaccination ranged from
162 1.1% to 100% [14,15,18,21-23,25,26,28,29,31-34,36,37,41-51,53-56]. A variation over time
163 in influenza vaccination coverage was observed, as exemplified by a rate of 10.5% observed
164 in a survey of pilgrims from Riyadh in 2003 [43], but 94.4% in a similar survey in 2010
165 [32,33,36]. During the 2013 Hajj season, influenza vaccination rates also varied according to
166 pilgrims' country of origin [29], with 20% observed among Saudi pilgrims, 80% among
167 Qatari pilgrims, and 87% among Australian pilgrims, while a study involving French pilgrims
168 interestingly reported that none of them had received the 2013 influenza vaccine before
169 departing for the Hajj because the vaccine was not available at this time [18,21]. The majority
170 of the studies reported influenza vaccination coverage among pilgrims, but only 13 [18,19,21-
171 23,25,27,28,31,46-48,55] reported their pneumococcal vaccination status, with rates ranging
172 from 1.2% among a multinational cohort of 1676 pilgrims from 13 countries (from Africa,
173 Asia, USA and Europe) in 2013 [28] to 51.2% among a small study of 129 French pilgrims in
174 2013 [18,21].

175 **Hospital-based studies addressing the prevalence of respiratory tract infections among** 176 **ill Hajj pilgrims**

177 Of the 61 publications that were included in this review, 16 specifically addressed ill Hajj
178 pilgrims at health care facilities from 1993 through 2014 Hajj seasons. Medical facilities
179 included primary health care centers (PHCCs) and different specialized wards in tertiary care
180 hospitals, including ear, nose and throat (ENT) departments, intensive care units, emergency

181 units, infectious disease units and unspecified medical units. Pilgrim participants were
182 included either as inpatients or outpatients. The results of these studies are summarized in
183 Table 2.

184 Overall, the prevalence of upper respiratory tract infections (URTI) ranged from 1.4% to
185 42.1% (Table 3). This prevalence was 1.4% among 141 Pakistani pilgrims who attended the
186 King Abdul Aziz hospital in Medina during the 1992 Hajj [57] and 42.1% among 3087 Saudi
187 and non-Saudi patients (47.5% of them were pilgrims) who attended the ENT clinic at Al-
188 Noor Specialist Hospital in Mecca during the 2009 Hajj [58]. Pharyngitis was also frequently
189 reported among ill pilgrims. Thus, in this study of 3087 pilgrims during the 2009 Hajj, the
190 overall prevalence of pharyngitis was 45.7% [58]. More recently, in 2008, the prevalence of
191 pharyngitis in a large cohort of 4136 outpatients patients from 82 nationalities who attended
192 13 randomly selected Mina PHCCs (94.9% of whom were pilgrims) was found to be 23.7%
193 [59,60], and 61% in a study of 1047 Saudi and non-Saudi patients (2.3% of them were
194 inpatients) [61]. However, in this second study of 1047 patients, only 34.5% were pilgrims.

195 On the contrary, lower prevalence rates of bronchitis were reported during the Hajj (1.4%-
196 9.6%) [59-63]. A recent retrospective cross-sectional multicenter study of 185 Turkish
197 inpatients (87.5% were pilgrims) who returned to Turkey from the Arabian Peninsula
198 countries between 2012 and 2014 reported a slightly higher prevalence of acute
199 tracheobronchitis (13.6%) [64]. In addition, in this study, pneumonia was among the most
200 common clinical diagnosis among the hospitalized Hajj patients and represented about half of
201 diagnoses [64]. As pneumonia remains a major concern in critically ill patients, most of them
202 reported the prevalence of pneumonia among pilgrims [57,59,60,62-71], with reported rates
203 ranging from 0.2% in 2008 in 13 randomly selected Mina primary health care centers [59,60]
204 to 54.8% in 2004 in two ICU in Mecca [68] (Table 3). The prevalence of pneumonia was not
205 reported in 3 papers [58,61,72]. Pneumonia was the second most common admitting diagnosis

206 (22%) in a study of 140 patients admitted to the ICUs in four hospitals in Mina during the
207 2004 Hajj [68]. This result is further confirmed by a recent study of 452 critically ill Hajj
208 patients, of over 40 nationalities, admitted to 15 hospitals in 2009 and 2010. In this study,
209 pneumonia was defined as the primary cause of critical illness (27.2%) of all ICUs admissions
210 during the Hajj [65]. Also, in another prospective study of pilgrims admitted in two major
211 ICUs in Mecca for the 2004 Hajj season, community acquired pneumonia (CAP) was the
212 commonest source of sepsis, 54.8% [66].

213 **Discussion**

214 The purpose of this review was to provide syndromic surveillance data that may be useful, in
215 conjunction with microbiological data that will be presented in further papers, for the
216 surveillance of respiratory infections and pneumonia during the Hajj. Despite the fact that
217 some of the included studies in our review were performed among small numbers of pilgrims
218 and cannot be extrapolated, it is clear from this work that respiratory symptoms have been
219 common among Hajj pilgrims over the last 15 years, as evidenced by the high prevalence of
220 cough (over 90%) among Malaysian pilgrims during the 2007 Hajj [73]. Cough is a common
221 symptom among pilgrims [16,74] and likely results from crowded conditions during the Hajj.
222 This close contact among such individuals may increase the risk of the transmission of
223 respiratory pathogens, and therefore may contribute to respiratory disease outbreaks. Climatic
224 conditions and air pollution in Mecca and surrounding holy sites during the Hajj [75] may
225 also play a role. Recent follow-up studies thus evidenced a significant acquisition of
226 respiratory viruses, particularly rhinovirus, influenza virus, and coronaviruses other than
227 Middle East Respiratory Syndrome Coronavirus (MERS-CoV), and of bacteria, including
228 *Streptococcus pneumoniae*, *Hemophilus influenzae*, *Staphylococcus aureus* and *Klebsiella*
229 *pneumoniae* by Hajj pilgrims upon their return from the Hajj [76,77]. Respiratory diseases are
230 the most common diseases observed among pilgrims attending Mina primary health care

231 centers [59] and a major cause of hospital admission during the Hajj [70], with pneumonia a
232 leading cause of admission to intensive care units [62,68], where they are responsible for
233 about half of the cases of sepsis [66]. Unfortunately, while numerous articles on Hajj pilgrims
234 were retrieved from our literature search, relatively few recent articles specifically addressed
235 ill pilgrims in the context of hospital settings. The use of cohort studies allows investigators to
236 evaluate the actual incidence of clinical events in Hajj pilgrims since it provides a
237 denominator, but may not identify and capture the prevalence of some underlying conditions
238 and of severe forms of respiratory tract infections, which are more likely to be evidenced in
239 hospital patient populations. Conversely, hospital studies use data that may be biased,
240 frequently lacking denominator values, and so probably overestimating the occurrence of
241 severe illness. Moreover, a hospital-based study will, by definition, not capture some minor
242 illness cases that do not require hospitalization.

243 The prevalence rates of cough, sore throat and subjective fever varied widely across the
244 included studies. These differences may result from differences in study design that may lead
245 to potential biases (for example bias related to the method of data collection, using either self-
246 report questionnaires or telephone interview), study period (with regards to the seasonality of
247 respiratory viral infections), and rates of vaccination against seasonal influenza among study
248 participants which may widely vary from one study to another, as described in this review.
249 Thus, all data regarding the pilgrims, including demographic data, medical history, clinical
250 data and information on vaccination status and compliance with non-pharmaceutical
251 preventive measures, should be carefully collected by using standardized questionnaires. In
252 addition, in the context of syndromic surveillance for respiratory pathogens, data regarding
253 the pilgrim's symptoms should be collected prospectively during face-to-face interviews by
254 trained medical investigators who travel with the pilgrims. One important result of this review
255 is the finding of a lack of consistency ILI syndromic case definitions across included studies.

256 Thus, in a 2003 study (that did not fulfill the inclusion criteria for this review) [78], of 1310
257 Malaysian pilgrims who had a clinic visit for upper respiratory tract symptoms at five clinics
258 during the 2000 Hajj, with the aim of determining influenza vaccine effectiveness against
259 clinically defined ILI, 63% had ILI (defined as sore throat in combination with either
260 temperature $\geq 38^{\circ}\text{C}$ or cough) and 14% had influenza by the CDC definition (defined as
261 measured fever [$\geq 100^{\circ}\text{F}$ (37.8°C)] and a cough and/or a sore throat). Only one of the studies
262 reported here used the CDC definition of ILI or the WHO definition (an acute respiratory
263 infection with measured fever of $\geq 38^{\circ}\text{C}$ and cough, with onset within the last 10 days) [45].
264 In his paper, Rashid et al. demonstrated the low sensitivity of the CDC criteria and proposed
265 therefore the use of the triad of ‘cough, sore throat and subjective fever’ to clinically define
266 ILI at the Hajj or other mass gatherings, since this new simple clinical case definition is more
267 specific and sensitive than the CDC definition [79]. This definition was used over the last
268 years by French [16,18,19,21-23,31,37], Malaysian [14,15,25], Indian [26] and Afghan [35]
269 investigators leading cohort studies among Hajj pilgrims, thus allowing more reliable
270 comparisons of findings between studies (Table 1).

271 Respiratory diseases are a major concern during the Hajj. Non-pharmaceutical interventions
272 (e.g., hand hygiene, wearing face masks, social distancing) are known to reduce the spread of
273 respiratory viruses from person to person and are therefore recommended to pilgrims by
274 public health agencies. Although hand hygiene compliance is high among pilgrims, face mask
275 use and social distancing remain difficult challenges. Data about the effectiveness of these
276 measures for preventing acute respiratory infections at the Hajj are limited, and results are
277 contradictory, highlighting the need for future large-scale studies [80].

278 In addition to non-pharmaceutical interventions, vaccination against influenza is
279 recommended for all Hajj pilgrims by the Ministry of Health of Saudi Arabia [11,12].

280 Differences in study design and heterogeneity in the ILI definition across studies make it

281 difficult to compare findings from different studies and inhibits the drawing of conclusions
282 regarding the potential effects of this vaccination on related clinical symptoms of influenza
283 disease. However, recent papers by Alqahtani et al. and Alfelali et al. found the influenza
284 vaccine to be effective, respectively, against both laboratory-confirmed influenza [81] and
285 clinical influenza [82]. As influenza vaccination is generally considered effective in reducing
286 influenza-related infections, the Scientific Committee for Influenza and Pneumococcal
287 Vaccination guidelines (SCIPV) thus recommends, in its recent guidelines, an influenza
288 vaccination for all people, especially those at high risk, at least 2 weeks before the Hajj [83].
289 It also recommends, for the next Hajj seasons that will take place from June to September, the
290 administration (prior to the Hajj) of the Southern Hemisphere influenza vaccine for pilgrims
291 from the Southern Hemisphere (where influenza positivity rates are higher during this period).
292 Furthermore, as the influenza vaccine is not expected to be available for pilgrims from the
293 Northern Hemisphere before these next Hajj seasons, the SCIPV also recommends the
294 administration of the Southern Hemisphere influenza vaccine for those pilgrims from the
295 opposite hemisphere before the Hajj [83]. Because of the mismatching between circulating
296 and vaccine strains that has frequently occurred since 2003 [84], Alfelali et al. recommends,
297 when the composition of influenza vaccines differs and whenever logistically feasible, taking
298 into consideration the dual vaccination of Hajj pilgrims with both the Southern and Northern
299 Hemispheres' vaccines. However, such strategy is impaired by the frequent unavailability of
300 the Southern Hemisphere influenza vaccine in the Northern Hemisphere. The issue of
301 influenza vaccine availability to match Southern and Northern hemispheres was discussed by
302 the Saudi Ministry of Health in consultation with the WHO and it was recommended to use
303 the available hemisphere strain as long as there is a match in circulating strains [85]. Despite
304 the risk of acquisition of *S. pneumoniae* during the Hajj, there is currently no consistent
305 guideline on the use of pneumococcal vaccine for Hajj pilgrims across pilgrim countries of

306 origin [86,87]. Thus, and because many of the Hajj pilgrims are elderly and have chronic
307 illnesses and underlying risk conditions for which pneumococcal vaccination is recommended
308 [86], the SCIPV also recommended, in its 2016 pneumococcal vaccination guidelines,
309 pneumococcal vaccination of the at-risk population at the appropriate time before the Hajj,
310 using the 2 types of pneumococcal vaccines that are currently available: the 23-valent
311 polysaccharide pneumococcal vaccine (PPSV23) and the 13-valent conjugate vaccine
312 (PCV13) [88]. However, it did not recommend providing a pneumococcal vaccine routinely
313 to healthy persons aged less than 50 years, because of lack of evidence. In addition, it has
314 been well demonstrated that the conjugate vaccine against *S. pneumoniae* targets the most
315 virulent serotypes associated with Invasive Pneumococcal Diseases (IPD) that are also
316 associated with antibiotic resistance [89]. These arguments reinforce the need for compliance
317 with current recommendations for vaccinating at-risk Hajj pilgrims against IPD and influenza
318 [89].

319 Respiratory tract infections, including influenza, continue to be a major concern during the
320 Hajj. Both cohort- and hospital-based studies provide complementary data and potentially
321 useful information, and both are therefore necessary to provide a complete picture of the total
322 burden of respiratory diseases during this mass gathering. Large multinational follow-up
323 studies are thus recommended for clinic-based syndromic surveillance, in conjunction with
324 microbiological surveillance. Matched cohorts ensure better comparability across studies,
325 particularly in terms of origin of pilgrims and possible travelling conditions. However, the
326 study design and data collection procedures should be standardized, to facilitate reporting and
327 to achieve comparability between studies. Furthermore, the definition of ILI, and of most
328 common symptoms used to define respiratory infections (e.g., URTI), needs to be precisely
329 defined and consistently used. Future studies need to address the potential effects of influenza
330 and pneumococcal vaccine in the context of the Hajj pilgrimage. Moreover, because of the

331 mismatching between circulating and vaccine strains that has frequently occurred since 2003
332 [84], Alfelali et al. recommends, when the composition of influenza vaccines differs and
333 whenever logistically feasible, taking into consideration the dual vaccination of Hajj pilgrims
334 with both the southern and northern hemispheres' vaccines. However, such strategy is
335 impaired by the frequent unavailability of the southern hemisphere influenza vaccine in the
336 northern hemisphere. Despite the risk of acquisition of *S. pneumoniae* during the Hajj, there is
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338 pilgrim countries of origin [86,87]. Thus, and because many of the Hajj pilgrims are elderly
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357 and pneumococcal vaccine in the context of the Hajj pilgrimage.

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363 **Conflicts of interest**

364 The authors have no conflicts of interest to declare.

365

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Table 1. Studies conducted among cohorts of Hajj pilgrims

| Hajj season | Study population | Study design | Global prevalence of respiratory symptoms (%) | Vaccination coverage (%) | Study | Ref. |
|-------------|------------------------|---|---|---|---|------|
| 2013-2015 | 847 Chinese pilgrims | Longitudinal survey conducted in returning Hajj pilgrims arriving at Xinjiang and Gansu airports, China | Fever: 1.9% Sore throat or cough: 1.9% | Influenza: 100% | Ma <i>et al.</i> , 2017 (BMC Infectious Diseases) | [50] |
| 2014 | 148 Iranian pilgrims | Follow-up seroepidemiological study among Hajj pilgrims returning to Yazd province, Iran | Cough: 63% | Not specified | Rahimian <i>et al.</i> , 2017 (Respiratory Medicine) | [24] |
| 2012-2015 | 3364 Egyptian pilgrims | A cross-sectional survey among Hajj pilgrims at Cairo Airport, Egypt. Study based on face-to-face interview | ILI ¹ : 30.4% | Influenza: 19.7% | Refaey <i>et al.</i> , 2017 (Influenza Other Respi Viruses) | [45] |
| 2013 | 468 Malaysian pilgrims | Cross-sectional survey conducted in pilgrims recruited at a Hajj course at Universiti Sains Malaysia (USM), Kelantan, | ILI ² : 78.2% | Influenza: 37.4% Pneumococcal: 31.6% | Hashim <i>et al.</i> , 2016 (J Travel Med) | [25] |

| | | | | | | |
|------|----------------------|---|--|-----------------|---|------|
| | | Malaysia, at Hajj Building Complex, Malaysia and in Mecca, Saudi Arabia. Study based on post-Hajj self-questionnaires collected on return | | | | |
| 2013 | 839 African pilgrims | Cross-sectional survey conducted in returning pilgrims recruited at the "Hajj village" special area at Kotoka International Airport, Ghana. Study based on face-to-face interview | Cough: 70.7% Sore throat: 40.9% Elevated temperature: 18.4% Runny nose or sneezing: 18.13% Breathing difficulty: 14.8% | Not specified | Annan <i>et al.</i> , 2015 (Trop Med Int Health) | [17] |
| 2014 | 270 Indian pilgrims | Cross-sectional survey conducted in pilgrims recruited at departure from Kempegowda International Airport, Bangalore, India. Study based on telephone interview on return | ILI ² : 66.3% | Influenza: 1.1% | Fatema <i>et al.</i> , 2015 (IJPMN) | [26] |

| | | | | | | |
|---------------|---|---|--|--|--|------|
| 2012- 2014 | 382 French pilgrims | Longitudinal survey conducted in pilgrims recruited at a specialized Hajj travel agency, Marseille, France. Study based on medical evaluation during travel | ILI ² : 46.2% Cough: 80.9% Sore throat: 91.0% Rhinitis: 78.7% Hoarseness: 63.0% Myalgia: 48.3% Subjective fever: 47.3% | Not specified | Gautret <i>et al.</i> , 2015 (Travel Med Infect Dis) | [16] |
| 2007 | 106 Malaysian pilgrims | Longitudinal survey conducted in pilgrims enrolled in the National Pilgrim Management and Fund Board, Malaysia. Study based on follow-up during travel | Cough (average of the 6 weeks of stay): 39.5% Runny nose (average of the 6 weeks of stay): 25.5% Sore throat (average of the 6 weeks of stay): 18.5% Fever (average of the 6 weeks of stay): 7.1% | Influenza: 61.3% | Hasan <i>et al.</i> , 2015 (J Immigr Minor Health) | [51] |
| 2013 | 1676 pilgrims (Paired cohort: 692 pilgrims/ Nonpaired cohort: 514 pilgrims at arrival and 470 | Cross-sectional survey (unpaired cohort) and longitudinal survey (paired cohort) conducted in | ILI: 61.9% | Influenza: 21.9% Pneumococcal: 1.2% | Memish <i>et al.</i> , 2015 (Clin Microbiol Infect) | [28] |

| | | | | | | |
|---------------|---|---|---|---|---|------|
| | pilgrims at Mina) from 13 countries (Africa/Asia/USA/Europe) | pilgrims recruited on arrival at Jeddah airport. Study based on post-Hajj face-to-face interview conducted at Mina | | | | |
| 2011 and 2012 | 3203 pilgrims (1590 pilgrims at the beginning of the Hajj and 1613 pilgrims at the end of the Hajj) from 18 countries in Africa or Asia | Cross-sectional survey conducted in pilgrims recruited at Mecca for the beginning-Hajj cohort and Mina for the end-Hajj cohort. Study based on face-to-face interview | URTI during Hajj (for the end-Hajj cohort): 29.2% | Influenza or pneumococcal ⁴ (beginning-Hajj cohort versus end-Hajj cohort): 45.8% versus 76.7%, respectively | Memish <i>et al.</i> , 2015 (Clin Microbiol Infect) | [27] |
| 2011 | 164 Australian pilgrims | Cross-sectional survey conducted in pilgrims recruited at Mina encampment. Study based on post-Hajj face-to-face interview | ILI ³ : 63.4% Cough: 46.3% Sore throat: 34.7% Fever: 23.8% Runny nose: 23.8% Sputum: 12.8% Muscle pain: 9.7% | Not specified | Barasheed <i>et al.</i> , 2014 (Infect Disord Drug Targets) | [20] |

| | | Headache: 8.5% | | | | |
|------|--|---|---|---|---|--------------|
| | | Shortness of breath: 2.4% | | | | |
| 2013 | 1038 pilgrims from Saudi Arabia, Australia and Qatar | Cross-sectional survey conducted in pilgrims recruited at Mina encampment. Study based on post-Hajj face-to-face interview | ILI ⁴ : 11% Sore throat: 59% Cough: 40% Runny nose: 34% | Influenza (Australian versus Qatari versus Saudi pilgrims): 87% versus 80% versus 20%, respectively | Barasheed <i>et al.</i> , 2014 (Virolog Sin) | [29] |
| 2013 | 129 French pilgrims | Longitudinal survey conducted in pilgrims recruited at a specialized Hajj travel agency, Marseille, France. Study based on medical evaluation during travel | ILI ² : 47.3% Cough: 86.8% Sore throat: 82.9% Rhinorrhea: 72.1% Myalgia: 50.4% Fever: 49.6% Dyspnea: 21.7% | Influenza: None in 2013 and 44.2% in 2012 Pneumococcal: 51.2% | Benkouiten <i>et al.</i> , 2014 (Emerg Infect Dis) Gautret <i>et al.</i> , 2014 (Emerg Infect Dis) | [18, 21] |
| 2012 | 169 French pilgrims | Longitudinal survey conducted in pilgrims recruited at a specialized Hajj travel agency, Marseille, | ILI ² : 47.3% Cough: 83.4% Sore throat: 79.7% | Influenza: 45.6% Pneumococcal: 35.9% | Benkouiten <i>et al.</i> , 2014 (Clin Infect Dis) | [19, 22, 23] |

| | | | | | | |
|------|----------------------|--|---|--|--|------|
| | | France. Study based on medical evaluation during travel | Rhinorrhea: 68.5% Myalgia: 46.5% Feverishness: 45.4% Dyspnea: 19.6% | | 2013 (Clin Infect Dis) Gautret <i>et al.</i> , 2013 (Clin Microbiol Infect) | |
| 2006 | 295 Iranian pilgrims | Longitudinal survey conducted in pilgrims recruited at a Hajj caravan. Study based on medical evaluation during travel | Runny nose: 51.7% Dry coughs: 51.7% Hoarseness: 47.7% Yellowish-greenish sputum: 42.8% Nose congestion: 38.8% Purulent Post-Nasal Discharge: 35.5% Sore Throat: 34.2% Painful swallowing: 23.8% Throat itch: 28.6% Fever: 26.8% Myalgia: 24.6% Feeling chills: 17.8% | Influenza and pneumococcal: 63.7% Influenza or pneumococcal: 26.4% Neither: 6.4% Incomplete information: 3.5% | Dabiran <i>et al.</i> , 2014 (Health) | [55] |

| | | | | | | |
|-----------|--|---|--|---|---|--------------|
| 2004-2008 | 254823 Iranian pilgrims (30037 pilgrims in 2004, 75676 in 2005, 48678 in 2006, 71595 in 2007, and 28837 in 2008) | Longitudinal survey conducted in pilgrims recruited at 1352 Hajj caravans. Study based on medical evaluation during travel | Common cold like illness (total): 47.1% ILI ⁵ (total): 10.7% | Influenza (2004 versus 2005): 75.2% versus 88.3%, Pneumococcal (2004 versus 2005): 2.5% versus 8.9%, respectively | Razavi <i>et al.</i> , 2014 (Med J Islam Repub Iran) Razavi <i>et al.</i> , 2013 (Med J Islam Repub Iran) Meysamie <i>et al.</i> , 2006 (Saudi Med J) | [47, 48, 46] |
| 2010 | 1507 pilgrims | Longitudinal survey conducted in pilgrims recruited at primary health care centers in Riyadh, Saudi Arabia (for the mandatory pre-Hajj meningococcal vaccination). Study based on telephone interview on return | URTI ⁶ : 53.1% | Influenza: 94.4% | Al-Jasser <i>et al.</i> , 2013 (East Mediterr Health J) Al-Jasser <i>et al.</i> , 2012 (Saudi Med J) Al-Jasser <i>et al.</i> , 2011 (Saudi Epidemiology Bulletin) | [32, 33, 36] |
| 2009 | 274 French pilgrims | Longitudinal survey conducted in | ILI ² : 8.0% | Influenza: 97.4% | Gautret <i>et al.</i> , 2013 | [31, 37] |

| | | | | | | |
|------|-------------------------|---|--|---|---|------|
| | | pilgrims recruited at a travel medicine clinic of a university hospital, France (for the mandatory pre-Hajj meningococcal vaccination). Study based on telephone interview on return | Cough: 48.5% Sore throat: 36.1% Rhinorrhea: 23.7% Sputum: 13.5% Subjective fever: 10.9% Myalgia: 9.5% Shortness of breath: 2.9% Voice failure: 2.9% | Influenza A(H1N1): 5.8% Pneumococcal: 31.4% | (Travel Med Infect Dis) Gautret <i>et al.</i> , 2011 (J Travel Med) | |
| 2006 | 338 Iranian Pilgrims | Longitudinal survey conducted in pilgrims recruited at a Hajj and pilgrimage organization at Chaharmahal va Bakhtiari Province, Iran. Study based on post-Hajj face-to-face interview | Cough: 70.0% Hoarseness: 53.6% Sore throat: 49.7% Coryza: 43.8% Wheezing: 43.5% Myalgia: 30.8% Dyspnea: 17.8% | Not specified | Imani <i>et al.</i> , 2013 (International Journal of Travel Medicine & Global Health) | [52] |
| 2012 | 541 Australian pilgrims | Cross-sectional survey conducted in pilgrims recruited at Mina encampment. Study based on post-Hajj face-to-face interview | AFRI ⁷ : 9% | Not specified | Rashid <i>et al.</i> , 2013 (Med J Aust) | [30] |

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|------|----------------------|--|--|--|--|------|
| 2009 | 186 US pilgrims | <p>Longitudinal survey conducted in pilgrims recruited at pretravel clinic for Hajj travelers in Minnesota, US, and Arab Community Center for Economic and Social Services at multiple settings, including mosques, community health clinics, and the Detroit Wayne County International Airport, in Michigan, US. Study based on post-Hajj face-to-face and telephone interview</p> | <p>Cough: 30.1% Sneezing: 25.8% Sore throat: 15.6% Fever: 13.4% Congestion: 8.6% Breathing problems: 2.1% ‘‘Bronchitis’’⁸: 1.1% ILI⁹: 9.7%</p> | <p>Influenza: 63.0% Influenza A(H1N1): 38.7%</p> | <p>Balaban <i>et al.</i>, 2012 (J Travel Med)</p> | [34] |
| 2010 | 1659 Afghan pilgrims | <p>Longitudinal survey conducted in pilgrims recruited at four transit areas located next to the Kandahar, Balkh, Hirat and Kabul airports, Afghanistan. Study based on post-Hajj telephone interview</p> | ILI ² : 37.8% | Not specified | <p>Saeed <i>et al.</i>, 2012 (J Epidemiol Glob Health)</p> | [35] |

| | | | | | | |
|------|------------------------|--|--|------------------|---|----------|
| 2009 | 305 Iranian pilgrims | Cross-sectional survey conducted in returning pilgrims recruited Shiraz Airport, Iran | Fever: 11.1% Cough: 48.2% Sore throat: 46.2% Nasal symptoms: 60.6% Myalgia: 31.8% | Influenza: 97.7% | Ziyaeyan <i>et al.</i> , 2012 (Influenza Other Respir Viruses) | [53] |
| 2010 | 1717 pilgrims | Cross-sectional survey conducted in returning pilgrims recruited at King Abdulaziz International Airport, Jeddah | Cough: 72.2% | Influenza: 52.4% | Maslamani <i>et al.</i> , 2011 (Saudi Epidemiology Bulletin) | [54] |
| 2007 | 387 Malaysian pilgrims | Cross-sectional survey conducted in returning pilgrims recruited at transit centers at Jeddah and Medina | ILI ² : 40.1 Cough: 91.5% Runny nose: 79.3% Fever: 59.2% Sore throat: 57.1% | Influenza: 72.9% | Deris <i>et al.</i> , 2010 (J Travel Med) Deris <i>et al.</i> , 2010 (Trop Biomed) | [14, 15] |
| 2007 | 394 Malaysian pilgrims | Cross-sectional survey conducted in returning pilgrims recruited at transit centers at Jeddah and Medina | Cough: 90.1% Runny nose: 78.2% Fever: 58.4% Sore throat: 56.3% | Not specified | Deris <i>et al.</i> , 2009 (Saudi Med J) | [73] |
| 2006 | 580 French pilgrims | Longitudinal survey conducted in | Cough: 60.6% | Influenza: 34.3% | Gautret <i>et al.</i> , 2009 | [49] |

| | | | | | | |
|------|------------------------|---|--|---------------|--|------|
| | | pilgrims recruited at a travel medicine clinic of a university hospital, France (for the mandatory pre-Hajj meningococcal vaccination). Study based on telephone interview on return | Fever: 16.6% | | (Clin Microbiol Infect) | |
| 2004 | 170 Iranian pilgrims | Longitudinal survey conducted in pilgrims recruited to departure from Iran (details not provided). Study based on medical follow-up at Mina encampment | Common cold ¹⁰ : 57.0% ILI ¹¹ : 10.9% | Not specified | Razavi <i>et al.</i> , 2007 (IJCID) | [38] |
| 2002 | 1027 domestic pilgrims | Longitudinal survey conducted in pilgrims recruited at primary health care centers in Riyadh, Saudi Arabia (for the mandatory pre-Hajj meningococcal vaccination). Study based on telephone interview on return | ARI ¹² : 39.8% | Not specified | Choudhry <i>et al.</i> , 2006 (East Mediterr Health J) | [39] |

| | | | | | | |
|-----------|--|--|--|---|--|----------|
| 2004 | 995 pilgrims from Riyadh | Longitudinal survey conducted in pilgrims recruited from randomly selected Hajj groups in Riyadh, Saudi Arabia. Study based on post-Hajj telephone interview | ARI ¹³ : 25.6% | Not specified | Abdin <i>et al.</i> , 2005 (Saudi Epidemiology Bulletin) | [40] |
| 2003-2004 | 51100 Iranian pilgrims (32370 pilgrims in 2003 and 18730 pilgrims in 2004) | Longitudinal survey conducted in pilgrims recruited at 180 Hajj caravans in 2003 / 110 caravans in 2004. Study based on medical evaluation during travel | ILI ¹⁴ in 2003: 70.1% ILI ¹⁴ in 2004: 35.8% | Influenza (2003 versus 2004): 10.7% versus 75.2%, respectively | Razavi <i>et al.</i> , 2005 (Acta Medica Iranica) Razavi <i>et al.</i> , 2004 (Acta Medica Iranica) | [41, 42] |
| 2003 | 115 UK pilgrims | Longitudinal survey conducted in pilgrims recruited at East London Mosque, London, UK. Study based on medical evaluation after travel | Respiratory symptoms: 80.9% | Influenza: 26.1% | El Bashir <i>et al.</i> , 2004 (Emerg Infect Dis) | [56] |
| 2003 | 1027 pilgrims from Riyadh | Longitudinal survey conducted in pilgrims recruited at 10 randomly selected primary health care centers in Riyadh, Saudi Arabia | ARI ¹⁵ : 39.8% | Influenza: 10.5% | Al-Mudameigh <i>et al.</i> , 2003 (Saudi Epidemiology Bulletin) | [43] |

| | | | | | | |
|------|---|--|--|----------------|--|------|
| | | (for the mandatory pre-Hajj meningococcal vaccination). Study based on telephone interview on return | | | | |
| 1999 | 412 domestic and international pilgrims | Cross-sectional survey conducted in pilgrims recruited at Mina. Study based on post-Hajj self-administered questionnaires | Runny nose: 18.0% Cough: 14.0% Sore-throat: 12.0% | Not specified | Fatani <i>et al.</i> , 2001 (Saudi Epidemiology Bulletin) | [13] |
| 1999 | 2070 Pakistani pilgrims | Longitudinal survey conducted in pilgrims recruited in organized groups in Pakistan. Study based on medical evaluation during travel | ILI ¹⁶ : 47.9% Documented fever $\geq 38.8^{\circ}\text{C}$: 29.8% URTI ¹⁷ : 72.2% | Influenza: 54% | Qureshi <i>et al.</i> , 2000 (Vaccine) | [44] |

¹ILI was defined according to the presence measured fever of $\geq 38^{\circ}\text{C}$, and cough; with onset within the last 10 days.

²Influenza-like illness (ILI) was defined according to the presence of the triad of cough, subjective fever and sore throat.

³ILI was defined as subjective (or proven) fever plus one respiratory symptom (e.g. dry or productive cough, runny nose, sore throat, shortness of breath).

⁴ILI was defined as subjective (or proven) fever and at least one respiratory symptom such as cough, sore throat and rhinorrhea.

⁵ILI was defined as symptoms and signs such as: sudden headache, dry cough, high grade fever, myalgia, coryza, malaise and loss of appetite with an abnormal general appearance.

⁶Upper respiratory tract infections (URTI) was defined as any person who reported having developed at least one of the constitutional symptoms (fever, headache, myalgia) and one of the local symptoms (running nose, sneezing, throat pain, cough with /or without sputum) after reaching Mecca for the Hajj or within 2 weeks from return to Riyadh.

⁷Acute febrile respiratory infection (AFRI) was defined as the presence of subjective fever plus at least one respiratory symptom (cough, sore throat, runny nose or breathlessness).

⁸Two travelers who reported “bronchitis” as a symptom were also included.

⁹ILI was defined as fever plus sore throat and/or coughing.

¹⁰Common cold was defined as sore throat with coryzal symptoms, and low grade fever.

¹¹ILI was defined as fever $>38.5^{\circ}\text{C}$, myalgia, low back pain, coryzal symptoms and cough.

¹²Acute respiratory infection (ARI) was defined as one of the constitutional symptoms (fever, headache, myalgia) along with one of the local symptoms (running nose, sneezing, throat pain, cough with/without sputum, difficulty breathing).

¹³ARI was defined as any person suffering from at least one of the constitutional symptoms (fever, headache, myalgia) along with one of the local symptoms (runny nose, sneezing, throat pain, cough with/without Sputum, difficulty in breathing) developing after reaching Makkah for the Hajj.

¹⁴ILI was defined as cough and fever $>38^{\circ}\text{C}$ with or without the coryzal symptoms and myalgia.

¹⁵ARI was defined as any person suffering from at least one of the constitutional symptoms (fever, headache, myalgia) along with one of the local symptoms (runny nose, sneezing, throat pain, cough with/without Sputum, difficulty in breathing) developing after reaching Mecca for the Hajj.

¹⁶ILI was defined as sore throat with either temperature $\geq 38.8^{\circ}\text{C}$ or cough.

¹⁷Cough or sore throat or rhinorrhea or muscle ache or headache.

Table 2. Studies conducted among ill Hajj pilgrims at health care facilities

| Hajj season | Study population | Recrutement | Proportion of ill patients with respiratory symptoms globally (%) | Proportion of ill patients with pneumonia (%) | Study | Ref. |
|-------------|---|---|---|---|---|----------|
| 2012-2014 | 185 Turkish patients (87.5% were pilgrims) returning to Turkey from the Arabian Peninsula countries | 15 referral Turkish centers with infectious diseases departments (inpatients) | URTI ¹ : 33.1% Acute tracheobronchitis ² : 13.6% Acute exacerbation of COPD ³ : 8.9% | 50.3% | Erdem <i>et al.</i> , 2016 (Eur J Clin Microbiol Infect Dis) | [64] |
| 2008 | 4136 patients (94.9% were pilgrims) from 82 nationalities | 13 randomly selected Mina primary health care centers (outpatients) | Common cold: 20.6% Pharyngitis: 23.7% Bronchitis: 9.6% Tonsillitis: 4.2% | 0.2% | Alzahrani <i>et al.</i> , 2012 (J Infect Public Health) Alzahrani <i>et al.</i> , 2009 (Saudi Epidemiology Bulletin) | [59, 60] |
| 2009-2010 | 452 pilgrims from over 40 nationalities | Intensive care unit of 15 hospitals in Mecca, Mina, Arafat, and Medina (inpatients) | Not specified | 27.2% | Mandourah <i>et al.</i> , 2012 (BMC Infect Dis) | [65] |
| 2009 | 3087 Saudi and non-Saudi | Ear, nose, and throat clinic at Al- | Pharyngitis: 45.7% | Not specified | Alherabi <i>et al.</i> , | [58] |

| | | | | | | |
|------|--|---|--|---------------|--|------|
| | patients (47.5% were pilgrims) | Noor Specialist Hospital, Mecca (mostly outpatients) | URTI ⁴ : 42.1% | | 2011 (Saudi Med J) | |
| 2008 | 1047 Saudi and non-Saudi patients (34.5% were pilgrims) | Ear, nose, and throat clinic at Al- Noor Specialist Hospital, Mecca (mostly outpatients) | Pharyngitis: 61.0% URTI ⁴ : 18.6% Tonsillitis: 5.5% Otitis media: 2.2% | Not specified | Alherabi <i>et al.</i> , 2009 (Saudi Med J) | [61] |
| 2004 | 165 pilgrims | Two intensive care units (King Faisal Hospital and King Abdul Aziz Hospital) in Mecca (inpatients with sepsis) | Not specified | 54.8% | Baharoon <i>et al.</i> , 2009 (Travel Med Infect Dis) | [66] |
| 2007 | 2411 patients | Emergency room of Al-Anssar Hospital and 4 primary health care centers in Medina (in and outpatients) | Not specified | 1% | Al-Quwaidhi <i>et al.</i> , 2008 (Saudi Epidemiology Bulletin) | [67] |
| 2007 | 248 pilgrims | Two randomly selected Mina hospitals (Mina al Tawarri & Mina El-Jesser) (outpatients) | Cough: 28.2% Dyspnea: 27.4% Fever: 25.0% Running nose: 16.5% Chest pain: 15.3% | Not specified | Khamis <i>et al.</i> , 2008 (J Egypt Public Health Assoc) | [72] |

| | | | | | | |
|------|------------------------------------|--|---|-------|--|------|
| 2004 | 140 patients (97.9% were pilgrims) | Intensive care units in Mina and Arafat hospitals (inpatients) | Respiratory failure: 5.0% Upper airway obstruction: 0.7% | 22.1% | Madani <i>et al.</i> , 2007 (Ann Saudi Med) | [68] |
| 2005 | 689 pilgrims from 49 countries | Tertiary care hospital in Mina (inpatient medical departments) | Dyspnea: 38.3% Chest pain: 24.8% Cough: 22.1% Fever: 19.2% | 26.0% | Khan <i>et al.</i> , 2006 (Saudi Med J) | [69] |
| 2003 | 575 patients (97.4% were pilgrims) | Seven hospitals in Mina and Arafat (inpatient medical wards) | URTI ⁴ : 4.7% Acute bronchitis: 1.7% | 29.4% | Madani <i>et al.</i> , 2006 (Ann Saudi Med) | [62] |
| 2002 | 160 patients | Two hospitals in Arafat and two hospitals in Mina (in patient medical wards) | URTI ⁴ : 3.1% Dyspnea: 53.0% Cough: 49.0% Fever: 47.0% Chest pain: 12.5% | 39.4% | Al-Ghamdi <i>et al.</i> , 2003 (Saudi Med J) | [70] |
| 1993 | 7676 pilgrims | Emergency Department of Al-Noor Hospital in Mecca (in and outpatients) | Sore-throat: 6.8% Common cold: 6.0% URTI ⁴ : 4.4% Bronchitis: 3.7% | 2.0% | Al-Harbi <i>et al.</i> , 2000 (J Family Community Med) | [63] |

| | | | | | | |
|------|------------------------|--|--|-------|---|------|
| | | | Headache: 1.6% | | | |
| | | | Cough: 1.2% | | | |
| 1993 | 773 pilgrims | King Abdul Aziz hospital in Medina (inpatient medical wards) | URTI ⁴ : 7.1% | 45.8% | Yousuf <i>et al.</i> , 1995 (Ann Saudi Med) | [71] |
| 1992 | 141 Pakistani pilgrims | King Abdul Aziz hospital in Medina (inpatient medical wards) | URTI ⁴ : 1.4% Acute bronchitis: 1.4% | 29.1% | Yousuf <i>et al.</i> , 1993 (PJMR) | [57] |

¹Upper respiratory tract infection (URTI) was defined as an acute infection that includes tonsillitis, pharyngitis, laryngitis, sinusitis, otitis media, and the common cold.

²Acute tracheobronchitis was defined as a patient with dry cough and/or low-grade of fever (< 38 °C), sub-sternal pain, and fatigue in the absence of opacities on chest X-ray.

³Acute exacerbation of chronic obstructive pulmonary disease (COPD) was defined as an association with increased frequency and severity of coughing and/or shortness of breath and wheezing, increased amount of sputum production, and/or a change in appearance of sputum in a patient with COPD.

⁴Was not defined.

Table 3. Prevalence of cough, influenza-like illness, upper respiratory tract infection and pneumonia reported in the included studies

| Symptoms | Prevalence (%) | Range (%) |
|--|----------------|-----------|
| Cough (in cohorts of Hajj pilgrims) | 1.9 | 1.9-91.5 |
| | 14.0 | |
| | 30.1 | |
| | 39.5 | |
| | 40.0 | |
| | 46.3 | |
| | 48.2 | |
| | 48.5 | |
| | 51.7 | |
| | 60.6 | |
| | 63.0 | |
| | 70.0 | |
| | 70.7 | |
| | 72.2 | |
| | 80.9 | |
| 83.4 | | |
| 86.8 | | |
| 90.1 | | |
| 91.5 | | |
| Cough (in ill Hajj pilgrims at health care facilities) | 1.2 | 1.2-49 |
| | 22.1 | |
| | 28.2 | |
| | 49.0 | |
| ILI ¹ (in cohorts of Hajj pilgrims) | 8.0 | 8.0-78.2 |
| | 9.7 | |
| | 11.0 | |

| | | |
|--|------|-----------|
| | 10.7 | |
| | 10.9 | |
| | 30.4 | |
| | 35.8 | |
| | 37.8 | |
| | 40.1 | |
| | 46.2 | |
| | 47.3 | |
| | 47.3 | |
| | 47.9 | |
| | 61.9 | |
| | 63.4 | |
| | 66.3 | |
| | 70.1 | |
| | 78.2 | |
| URTI ² (in cohorts of Hajj pilgrims) | 29.2 | 29.2-72.2 |
| | 53.1 | |
| | 72.2 | |
| URTI ² (in ill Hajj pilgrims at health care facilities) | 1.4 | 1.4-42.1 |
| | 4.4 | |
| | 4.7 | |
| | 7.1 | |
| | 18.6 | |
| | 33.1 | |
| | 42.1 | |
| Pneumonia (in ill Hajj pilgrims at health care facilities) | 0.2 | 0.2-54.8 |
| | 1.0 | |
| | 2.0 | |
| | 22.1 | |
| | 26.0 | |

27.2

29.1

29.4

39.4

45.8

50.3

54.8

¹Influenza-like illness

²Upper respiratory tract infection

Figure 1. Flow diagram