

Health profile 2015

Qatar



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Foreword

The Government of Qatar and WHO are working together to effectively improve the public health situation in the country with special emphasis on the five key regional priorities:

- health security and prevention and control of communicable diseases;
- noncommunicable diseases, mental health, violence and injuries, and nutrition;
- promoting health through the life-course;
- health systems strengthening; and
- preparedness, surveillance and response.

The strategic directions to address these priorities are broadly in line with WHO's 12th General Programme of Work, the Programme Budget 2016–2017 endorsed in May 2015 by the 68th World Health Assembly and the five strategic areas of work endorsed by the WHO Regional Committee for the Eastern Mediterranean in 2012.

Reliable and timely health information is essential for policy development, proper health management, evidence-based decision-making, rational resource allocation and monitoring and evaluation of the public health situation. While the demand for health information is increasing in terms of quantity, quality and levels of disaggregation, the response to these needs has been hampered because of fragmentation and major gaps and weaknesses in national health information systems.

The strengthening of health information systems is a priority for WHO in the Region. Intensive work with Member States since 2012 has resulted in a clear framework for health information systems and 68 core indicators that focus on three main components: 1) monitoring health determinants and risks; 2) assessing health status, including morbidity and cause-specific mortality; and 3) assessing health system response. In order to successfully achieve this important goal, concerted and aligned action at national and international level are required to address the gaps and challenges in the health information systems of all countries. This will ensure the generation of more effective evidence to monitor improvement in the health situation, nationally, regionally and globally.

This comprehensive health profile is intended to serve as a tool to monitor progress in the health of the population. WHO's collaboration with its Member States will strengthen the national health information systems, and enable the generation of timely and reliable evidence to assess the health situation and trends, and the health system response. Most important, it will provide the information needed by health policy and decision-makers.

Qatar's national health strategy 2011–2016 aims to achieve a comprehensive and international standard health care system. Much has already been accomplished through its implementation, such as the development of national strategies on mental health and on diabetes, and work is on track to achieve an integrated and unique health care system. Significant and notable progress has also been made with respect to cancer services through the national cancer strategy, which aims to put Qatar's cancer services at the forefront of international best practice. The country continues to undertake diverse measures to reduce the prevalence of communicable and noncommunicable diseases and to promote health across the life course.

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Introduction

The population of the country has increased by 79.7% in the past 25 years, reaching 2.4 million in 2015. It is estimated that 1.1% of the population live in rural settings (2012), 2.1% of the population is between the ages of 15 and 24 years (2015) and life expectancy at birth is 79 years (2012). The literacy rate for adolescents (15 to 24 years) is 99.1%, for total adults 96.7% and for adult females 95.8% (2012).

The burden of disease (2012) attributable to communicable diseases is 7.7%, noncommunicable diseases 69.0% and injuries 23.3%. The share of out-of-pocket expenditure is 8.4% (2013) and the health workforce density is 77.4 physicians, and 118.7 nurses and midwives, per 10 000 population (2009).

The public health issues facing the country are presented in the following sections: communicable diseases, noncommunicable diseases, promoting health across the life course, health systems strengthening and preparedness, surveillance and response. Each section focuses on the current situation, opportunities and challenges faced and the way forward. In addition, several trends in population dynamics and in selected health indicators are analysed to provide policy-makers with evidence and forecasts for planning.

Communicable diseases

HIV

Tuberculosis

Malaria

Neglected tropical
diseases

Vaccine-preventable
diseases

Communicable diseases

- A prevention of mother-to-child transmission of HIV programme has been implemented in all hospitals, testing 100% of women before, during and after pregnancy, with no HIV positive cases observed during the current reporting period.
- Tuberculosis control is integrated into the national health strategy 2011–2016.
- The country has been a pioneer for the introduction of new lifesaving vaccines in the Region.

HIV

The HIV prevalence is low. Routine testing is administered on 100% of blood collected (1). There is no national strategic plan on HIV/AIDS in place.

There are no voluntary counselling and testing centres, but extensive testing is carried out at several sites including for premarital testing and migrant worker testing. In addition, a prevention of mother-to-child transmission programme has been implemented in all hospitals, testing 100% of women before, during and after pregnancy, and no HIV positive cases have been observed during the current reporting period. The identified mode of HIV transmission is heterosexual intercourse and there continues to be a lack of data regarding most-at-risk groups.

As part of the national health strategy 2011–2016, the communicable disease control unit is planning to conduct research on most-at-risk groups in order to tailor the programme response accordingly.

Tuberculosis

The tuberculosis-related mortality rate (2013) is estimated at 0.1 per 100 000 population (2). Drug-resistant tuberculosis is estimated at 1.2% among new cases and 0.0% among previously treated cases (2).

Tuberculosis in children and the elderly is minimal. Tuberculosis control is in place and includes: planning, monitoring and evaluation; human resources capacity-building; provision of diagnostic and treatment services; community mobilization; and health education. The Gulf Cooperation Council procedures for the screening of visitors are followed and treatment is provided free of charge for all national and non-national residents. Diagnosis and treatment services are in line with WHO standards, with high rates of contact tracing. Community-based tuberculosis activities include community mobilization for prevention, diagnosis, improved treatment adherence and care services.

Malaria

Qatar is considered a low burden and low risk country for malaria. Total confirmed malaria cases increased from 79 in 2003 to 708 in 2012, of which 100% were imported (3). In 2013, of the confirmed cases, 9.3% were *Plasmodium falciparum* and 90.7% were *P. vivax* (3).

The country is free from local malaria transmission and there was no malaria-associated mortality in 2013. The number of imported cases has mainly increased due to an increasing number of expatriate workers from India and Pakistan. All cases are parasitologically confirmed. All malaria patients received anti-malarial treatment. Vector control activities are the responsibility of the Ministry of Municipal Affairs. The Department of Health Affairs of Doha Municipality exercises overall supervision of municipalities and renders technical and logistic support to the peripheral network of municipalities. Health services of the Hamad Medical Corporation are provided free to nationals and are subsidized for expatriate residents. Emergency services are provided free to everyone, including treatment for severe malaria cases. Drugs for treatment and prophylaxis for malaria are also given free of charge. The Hamad Medical Corporation recently procured artemisinin-based combination therapies for treating uncomplicated falciparum malaria and Malarone for chemoprophylaxis; both drugs have been available since 2012. The laboratory of the Hamad Medical Corporation is considered the reference laboratory, where slides from primary health care centres are sent and results then communicated to facilities for provision of treatment. Screening for Glucose-6-phosphate dehydrogenase (G6PD) deficiency is done before treatment with primaquine for *P. vivax* malaria. In such cases chloroquine is given alone without radical treatment.

The main priorities for the country are strong vigilance and disease surveillance and ensuring the availability of quality malaria diagnosis and effective treatment in all health facilities.

Neglected tropical diseases

The country was certified free of dracunculiasis in 1998 and no autochthonous cases have been reported for cutaneous and visceral leishmaniasis (4). There have been no reported cases of lymphatic filariasis or schistosomiasis.

The prevalence of both helminth and protozoan parasites increased during 2005–2008, with helminth infection prevalence increasing. Helminth infections are probably acquired abroad when immigrants visit their home villages, whilst protozoan infections are reinforced by transmission within the country.

Vaccine-preventable diseases

Immunization coverage among 1-year-olds improved between 1990 and 2013 for BCG from 97.0% to 98.0%, DTP3 from 82.0% to 99.0%, measles from 79.0% to 99.0% and poliomyelitis from 82.0% to 99.0% (5). In 2013, hepatitis B (HepB3) vaccination coverage among 1-year-olds was 99.0% (5).

The country has been a pioneer in the introduction of new lifesaving vaccines in the Region. *Haemophilus influenzae* type B vaccine was introduced in 1996, pneumococcal conjugate vaccine in 2005 and rotavirus vaccine in 2009. Qatar has maintained interruption of poliomyelitis transmission and neonatal tetanus elimination for many years. However, the country is facing recurrent measles outbreaks that necessitate intensive efforts to be eliminated. The high measles incidence contradicts the reported high vaccination coverage. A vaccination coverage survey is therefore necessary. Hepatitis A vaccine was introduced in 2010 for children aged 1 year and 18 months and was added to the adult immunization schedule in 2012. The children's schedule for routine immunization has been updated due to the current situation in the Region; it is recommended to administer the hexavalent vaccine dose at 4 months of age instead of the pentavalent vaccine at 2 months of age. Also, quadrivalent polysaccharide meningococcal (ACYW135) vaccine against meningitis was introduced for adults during the Hajj season 2014 together with the tetravalent seasonal influenza vaccine. A zero incidence of neonatal tetanus cases has been maintained. The cost of vaccines in 2013 for governmental vaccination services was covered from the government budget. The incidence of measles has decreased in the resident population; the government's target is less than 5 per 1 000 000 by 2016 in order to achieve country measles elimination. Continuous monitoring and evaluation is done for measles and there is an elimination strategy including mandatory case based surveillance and laboratory confirmation. Cases of hepatitis B are also reported.

Noncommunicable diseases

Noncommunicable diseases

Mental health and substance abuse

Violence and injury

Disabilities and rehabilitation

Nutrition

Noncommunicable diseases

- The Supreme Council of Health has developed National Vision 2030 to address noncommunicable diseases risk factors.
- A national mental health strategy has been launched.
- A national road safety multisectoral strategy 2013–2022 has been developed.
- A social protection sector strategy and family cohesion strategy are in place, covering persons with disabilities and other vulnerable groups.
- The National Food Safety Committee has banned the sale of energy drinks to children under 16 years of age and enforced a warning sign at retail shops.

Noncommunicable diseases

The burden of noncommunicable diseases causes 69.0% of all deaths: cardiovascular diseases account for 24.0%, cancers 18.1%, respiratory diseases 1.6% and diabetes mellitus 8.9% of all deaths (6). As a result, 14% of adults aged between 30 and 70 have a probability of dying from one of the four main noncommunicable diseases (7). More than 15.7% of youth (13–15 years of age, 22.8% boys, 8.8% girls) have ever smoked cigarettes, while 24.2% of youth have been affected by passive smoking (8) and per capita consumption of alcohol is 1.5 litres of pure alcohol (9). The prevalence of insufficient physical activity in adolescents is 90.1% (11–17 years of age, 88.3% boys, 91.6% girls) and the age-standardized prevalence is 33.3% (29.9% males, 46.9% females) (10). Raised blood pressure,¹ in adults between 18 and 64 years of age, affects 32.9% of the population (28.0% males, 37.7% females), while obesity affects 41.4% (39.5% males, 43.2% females).² All 11 essential medicines required for treatment of noncommunicable diseases are available in the public health sector.³

The Supreme Council of Health has developed National Vision 2030 that includes a component addressing noncommunicable disease risk factors. Based on the National Vision 2030, the Supreme Council of Health developed the nation health strategy 2011–2016 to address noncommunicable diseases risk factors and conducted a STEPwise approach to noncommunicable disease risk factor surveillance survey in 2012.

¹ Systolic blood pressure ≥ 140 mmhg and/or diastolic blood pressure ≥ 90 mmhg or currently on medication for raised blood pressure.

² Qatar Stepwise report 2012: chronic disease risk factor surveillance. Doha: Supreme Council of Health; 2015 (<http://www.sch.gov.qa/publications/publications>, accessed 24 December 2015).

³ WHO Regional Office for the Eastern Mediterranean, unpublished data, 2013.

Mental health and substance abuse

Neuropsychiatric disorders are estimated to contribute 20.8% of the burden of disease (11) and the suicide rate is 4.6 per 100 000 per year (12).

A national mental health strategy was launched in December 2013 to develop a system that will provide the best possible mental health services and change attitudes towards mental illness. A national mental health committee oversees implementation of the strategy, which is supported by a detailed implementation plan (2013–2018) that describes a series of milestones and key performance indicators. An inclusive, multisectoral approach is being adopted regarding stakeholder collaboration with a broad spectrum of organizations including the governmental, private and nongovernmental sectors being encouraged to contribute to the implementation of the strategy. Patients and families will also be encouraged to participate and engage with the implementation of the strategy and service developments.

A major part of the system transformation will see a shift in the balance of care from hospitals to the community and integrating mental health care into mainstream primary health care. New clinical guidelines for depression and anxiety have been introduced with the aim of creating an integrated care pathway between primary and secondary care. Most frontline primary care physicians and general practitioners' have now been trained in foundation level mental health and another cohort trained to an advanced level. Pilot sites have been established in three primary care health centres with new clinical guidelines to support people with mild to moderate depression and anxiety. A new community-based specialist mental health service opened recently providing new settings for child and adolescent and female adult services. For people with more severe mental health problems, the Hamad Medical Corporation is improving and developing new specialist inpatient facilities and has just opened the first of four new specialist community hubs. A new treatment and rehabilitation centre is now fully operational and offers residential and day care services to people with substance misuse problems.

Further developments during 2015 include preparations to implement a new mental health law, identify research priorities, implement a new minimum mental health dataset, and develop a website and new campaigns to support prevention and promotion programmes. The Naufar Wellness Centre will open in the near future with state of the art facilities for outpatients and in-patients with chronic pain and addictive disorders. A further priority is to address stigma and improve public understanding about mental health and substance misuse.

Violence and injury

The percentage of deaths caused by injuries in 2012 was 23.3%; of this, unintentional injuries accounted for 81.4% (of which 40.3% was due to road traffic injuries and 14.9% as a result of falls) and 18.6% were due to intentional injuries (80.5% as a result of self-harm and 19.5% interpersonal violence) (6). In 2010, the estimated road traffic fatality rate was 14.0 per 100 000 population (13). For post-injury trauma care, there is a universal emergency access telephone number and more than 75% of the seriously injured are transferred by ambulance (13).

There is specialized emergency care training for medical doctors and nurses. A national road safety multisectoral strategy 2013–2022 has been developed, with the health component included in the national health strategy 2011–2016. Laws exist on most road safety risk factors but need to be made more comprehensive. Challenges include inadequate information systems.

There is a need to set up a more comprehensive and updated injury surveillance system and strengthen vital registration with cross-validation with other data sources including the Ministry of Interior. The current road traffic legislation needs to be made more comprehensive. Formal emergency medicine training for all concerned medical personnel needs to be put in place.

Disabilities and rehabilitation

The disability prevalence is 0.4%, and is lower among males (0.3%) than females (0.8%) (14). Age-specific disability prevalence is highest in the above 65 age group (13.1%) and lowest among those aged 25–44 years (0.2%) (14). Of the different types of disability and difficulty, those related to movement account for 44.5%, speech 39.3%, sight 31.7%, self-care 30.8%, memory 29.6% and hearing 21.0% (14).

The UN Convention on the Rights of Persons with Disabilities was signed in 2007 and ratified in 2008 with its Optional Protocol. The Constitution does not include articles on disability. A law on persons with special needs has been in place since 2004 and is being amended. A social protection strategy and a family cohesion strategy have been in place since 2011 and cover persons with disabilities among other vulnerable groups. A national programme for early detection of hearing loss was launched in 2003. Although there is continuous medical education for audiology staff, a tertiary-level training resource centre for skilled cadres does not exist. Other key challenges are inadequate data sharing, inadequate coverage for primary eye care, maldistribution of eye care cadres, inequitable eye care coverage especially in the west and north of the country, and a lack of school eye health services in private schools.

The adoption of the WHO global disability action plan 2014–2021 provides an opportunity for strengthening health sector disability action within a broader multisectoral framework, building on existing national efforts. The proposed national eye health plan 2013–2019 emphasizes the improvement of health outcomes through adopting a public health approach, addressing avoidable and irreversible blindness as part of the noncommunicable diseases programme.

Nutrition

The estimated prevalence of various conditions due to malnutrition in children under 5 years of age is: 4.8% underweight, 2.1% wasting, 11.6% stunting and 10.4% overweight (15). The estimated prevalence of anaemia in women of reproductive age (15–49 years) is 24.7%.⁴ Initiation of breastfeeding within one hour after birth is 33.5% (Qatari nationals 42.0%, non-Qatari nationals 30.0%), while 29.3% (Qatari 18.6%, non-Qatari 35.0%) of children under 6 months are exclusively breastfed; low birth weight is 10.6% (Qatari 10.2%, non-Qatari 11.0%) (16).

According to the STEPwise survey, nearly 91% of the population consumes fewer than five servings of fruit and vegetables per day. The government is in the process of launching national dietary guidelines. The National Food Safety Committee has banned the sale of energy drinks to children under 16 years of age and is enforcing a warning sign at retail shops. A final draft of a marketing breast milk substitutes law and regulations has been drawn up. Implementation is underway of the WHO salt reduction initiative in bread products with a 20.0% reduction. A national physical activity guideline has been developed. Challenges include an increase in over-nutrition, obesity and noncommunicable diseases, a lack of nutrition expertise and the capacity required to implement and monitor nutrition programmes and policies, and the lack of a sustainable nutrition surveillance system.

There is a need for capacity-building at the academic and professional levels.

⁴ WHO Regional Office for the Eastern Mediterranean, unpublished data, 2014.

Promoting health across the life course

Reproductive,
maternal, newborn,
child and adolescent
health

Ageing and health

Gender, equity
and human rights
mainstreaming

Social determinants
of health

Health and the
environment

Promoting health across the life course

- There has been a consistent reduction in maternal mortality attributable to improved immunization coverage and improvements in antenatal, postnatal and delivery care.
- the National Association for Elderly Care was established in 2003, bringing together policy-makers from most concerned ministries, as well as representatives of civil society and associations providing health and social services, academia and the private sector.
- The government has endorsed the WHO regional strategy on health and the environment and framework for action 2014–2019, and implementation has been initiated to lower the burden of environmental risks on health.

Reproductive, maternal, newborn, child and adolescent health

The maternal mortality ratio declined by 55.2% between 1990 and 2015 from 29 to 13 per 100 000 live births (17), and the under-five mortality rate decreased by 61.9% (from 21 to 8 deaths per 1000 live births) (18). The leading causes of under-5 mortality are acute respiratory infection (4.0%), prematurity (30.0%), intrapartum-related complications (9.0%) and congenital anomalies (27.0%) (19). The proportion of women receiving antenatal care coverage (at least one visit) is 90.8% (96.2% Qataris, 88.7% non-Qataris) and (at least four visits) 84.5% (Qataris 92.3%, non-Qataris 81.4%) (16).

The reduction in maternal mortality is consistent with changes in key determinants of mortality due to improved immunization coverage and improvements in antenatal, postnatal and delivery care.

Ageing and health

Life expectancy at birth rose by 5.3% between 1990 and 2012 (from 75 years to 79 years) (19). In 2010, the ageing population, above 60 years, represented 1.9% of the total population (20).

Government retirees over 60 years of age and senior citizens may apply for assistance from the Ministry of Social Affairs and the Higher Council for Family Affairs, which has a National Committee for Ageing. In 2003, the National Association for Elderly Care was

established, bringing together policy-makers from most concerned ministries, as well as representatives of civil society and associations providing health and social services, academia and the private sector. The Association offers health and social care services for the elderly, citizens and residents alike, including nursing services, advice on diet, medication, physiotherapy, and counselling for older people and their families. The Association also sends social workers to assess individual cases and provide assistance. The government organizes regular activities for the elderly to promote social integration. A national strategy and plan of action on ageing has been developed, and a mechanism for cooperation and coordination is being set up.

The momentum created by the 2015 *World report on ageing and health* and the related global strategy and plan of action provides an opportunity to align the national strategy and national efforts. Capacity-building is also needed to strengthen elderly-friendly services provided through the primary health care system.

Gender, equity and human rights mainstreaming

The country falls among the high human development index countries, but ranks low at 113 among 152 countries in terms of gender inequality (21). Female adult (above 15 years of age) literacy was 95.8% in 2012 (22) and participation in the labour force is 50.8% (21).

There is need for an analysis of the discrepancy between the human development and gender inequality indexes from a health perspective. In addition, assessment of the institutionalization of the right to health and a gender analysis of the health system are required. These should aid efforts to sustain the achievements made, from a gender, equity and rights perspective, in all components of the health system including data collection, capacity-development, programmes, policies, strategies and action plans.

Social determinants of health

The *Human development report 2014* ranked the country at 31 out of 187 countries across the world on the human development index (21). The urban population increased by 6.2% between 1990 and 2012 from 92.8% to 98.9%, while access of the rural population to improved water sources increased by 5.4% from 92.0% to 97.0% (23). In 2010, the age group 0–24 years accounted for 28.1% of the total population (20). Adult literacy rates in 2012 were 96.4% (24), while overall unemployment was 0.6% and youth unemployment (15–24 years) 1.7% (23).

Challenges include a lack of clarity within the health sector on its role in addressing social determinants of health and a perception that this is not a priority in affluent societies. An opportunity exists in the use of WHO tools, strategies and indicators for operationalization of social determinants of health in health planning and ongoing programmes.

There needs to be a focus on identifying social determinants of health in the context of economic affluence and for key public health issues such as noncommunicable diseases and road traffic injuries and their related risk factors. This will enable the design and implementation of effective prevention and control interventions within the health sector and in coordination with other sectors.

Health and the environment

It is estimated that 252 people die a year as a result of environmental factors and the percentage of disability-adjusted life years attributable to the environment is estimated at 14.0% (25). Access to improved sanitation facilities and to improved drinking-water is 100.0% (19). It is estimated that 0.01% of the population uses solid fuels (biomass for cooking, heating and other usages) (26).

The main environmental risk factors include air pollution, chemical exposures, and housing and environmental determinants of injuries. These contribute significantly to the burden of noncommunicable diseases and injuries. Outdoor air pollution is monitored and reported; available ground/satellite data and global models have shown high levels of particulate matter concentration in the environment. The government has been working on strengthening national capacity related to air quality, environmental health impact assessment and waste management. It has endorsed the WHO regional health and the environment strategy and framework for action 2014–2019.

The focus now is to initiate a national multistakeholder process to develop a strategic environmental health framework for action 2015–2016. WHO is providing technical support in this.

Health systems

National health
policies, strategies
and plans

Integrated people-
centred health
services

Access to medicines
and health
technologies

Health systems,
information and
evidence

Health systems

- There is a national health strategy with the following key objectives: a comprehensive and accessible world class health care system, integrated services, highly skilled national workforce, evidence-based policy, affordable and effective health services, and high-calibre research activities directed at improving the quality, quantity, efficiency and effectiveness of health care services.
- The government's National Vision 2030 focuses on three pillars: system expansion, system adaptation and overall quality and access improvement.
- The use of effective online pharmacy management systems has had a major impact on promoting access to medicines.

National health policies, strategies and plans

The country's national health planning cycle is addressed in the national health strategy 2011–2016. Total expenditure on health per capita at the international exchange rate increased between 2005 and 2013 from US\$ 1084.0 to US\$ 2504.0, of which general government expenditure on health increased during the same period from US\$ 1374.8 to US\$ 2200.0 (27). General government expenditure on health as a percentage of total expenditure on health decreased during the same period from 62.0% to 87.9%. However, total expenditure on health as a percentage of gross domestic product decreased during the same period from 2.2% to 2.5% (27). The share of out-of-pocket expenditure in 2013 was 8.4% (27).

The government's national health strategy 2011–2016 is among the 14 sectoral strategies that form the national development strategy. The key objectives of the national health strategy are a comprehensive and accessible world class health care system, integrated services, a highly skilled national workforce, evidence-based policy, affordable and effective health services, and high-calibre research activities directed at improving the quality, quantity, efficiency and effectiveness of health care services. The strategy's guiding principles are that services should be people-centred, sustainable, evidence-based and of high quality. In recent years, efforts have been made to split financing from provision to enhance efficiency in the system. This has culminated in the establishment of a new national health insurance system, which started with coverage of the national female population for maternal and child health-related services and has been extended to all nationals for basic services. Comprehensive public health care is also available for the entire population against a nominal annual fee.

Integrated people-centred health services

Human workforce density increased between 2005 and 2009 for physicians from 26.5 to 77.4 per 10 000 population, and for nurses and midwives from 60.0 to 118.7; in 2005 there were 8.5 dentists and 13.5 pharmacists per 10 000 population (28). Health service delivery data showed the number of mental health hospitals in 2011 averaged 0.07 per 100 000 population, while there were 1.66 psychiatrists working in the mental health sector per 100 000 population (29).

The government's national health reforms focus on three pillars: system expansion, system adaptation, and overall quality improvement. Over the past few years, the Supreme Council of Health has transformed the country's health system through evidence-based policies. A network of hospitals, health care centres and primary health care facilities provides high quality primary, secondary and tertiary health care that is accessible and affordable to the entire population. Mandating international hospital accreditation by organizations accredited by the International Society for Quality in Health Care between 2010 and 2014 could have improved the quality of health care management. Primary health care facilities have a defined catchment population averaging 11 000 persons and maintain registration of the entire catchment population with individual health folders. The Primary Health Care Corporation is implementing family practice in all primary health care facilities and plans to implement an electronic clinical information system, in partnership with the private sector, enabling implementation of specific quality measures for monitoring standards of service delivery. Challenges include the rapid growth of an unregulated private sector with variable quality of care and the lack of indigenous human resources, making the country heavily reliant on a foreign health workforce, with implications for the impact of the policy of Qatarization on the sufficiency of the health workforce.

The key priorities for health care delivery are: establishing a comprehensive world class health care system; promoting an integrated system of health care, with preventive health care and affordable services; cultivating a skilled national workforce; developing a national health policy; and promoting a culture of high-quality research. Strengthening and developing norms, standards and accreditation systems for health facilities is another priority. The Supreme Council of Health is establishing a national licensing and accreditation programme for health facilities, building on existing facility licensing requirements. The priorities for primary health care services delivery are the full implementation of the family practice approach, integration of community-based mental health and control of noncommunicable diseases. Another focus is on sustaining and managing a skilled health workforce-mix capable of providing high-quality health services. Strengthening public-private partnerships in health is another important priority.

Access to medicines and health technologies

The national health strategy 2011–2016 is a far-reaching national plan with universal access to the needed levels of health care as its cornerstone. The government covers the majority of the total cost of health care, with out-of-pocket health expenditure being one of the lowest in the world. As noted above, a network of hospitals and health care centres provides accessible and affordable high-quality primary, secondary and tertiary health care to the entire population. Challenges include a heavy reliance on a foreign health workforce, ensuring a sustainable health care financing system, the rapid growth of the private sector, the lack of an updated national medicines policy and low access to controlled medicines, and insufficient postgraduate training.

Long-term human resource planning is under way to ensure a sustainable and highly skilled health workforce.

Health systems, information and evidence

The Supreme Council of Health has a national health information and statistics team within the public health department and a national e-health and data management system strategy. The Supreme Council of Health has invested in electronic data-capturing systems and has an e-Health and Information Technology Department to ensure that facilities are linked and information flow is efficient and timely. The Council collects cause-specific mortality from all sectors and produces an annual statistical report. Technical support is provided by several international agencies including WHO. Extensive training has been undertaken for physicians on death notification and the International Classification of Diseases.

Although the country reports causes-specific mortality by age and sex on a regular basis, additional efforts are needed to improve the quality of causes of death data to reduce the level of ill-defined causes. An e-health and data management strategy has been developed to ensure that the health sector has appropriate and secure access to accurate information for planning, measuring and monitoring the quality, safety and effectiveness of the health care system and population health outcomes.

Preparedness, surveillance and response

Alert and response
capacities

Epidemic and
pandemic-prone
diseases

Emergency risk and
crisis management

Food safety

Poliomyelitis
eradication

Outbreak and crisis
response

Preparedness, surveillance and response

- A health emergency programme has been established within the Supreme Council for Health.
- Efforts are being made to achieve accreditation for the microbial and chemical analytical work done in the public health laboratory.

Alert and response capacities

The government declared itself as having met all International Health Regulations (IHR) 2005 requirements by June 2014.

The country continues to work on the quality and functionality of IHR capacities, including areas related to coordination, points of entry and IHR-related zoonosis, food safety, and chemical and radiation hazards. Existing agreements with other Gulf Cooperation Council countries have facilitated the country in meeting its IHR requirements, particularly those related to cross-border surveillance, enhanced regional capacity in infection prevention and control, and conducting regional risk assessment on potential hazards, and helped in the updating of the national preparedness and response plans.

Epidemic and pandemic-prone diseases

The emergence of Middle East respiratory syndrome (MERS) as a public health problem in the country indicates that the country's public health system needs to be effective, responsive and resilient in the timely detection of any emerging health threat, though the country has remained reasonably free from major outbreaks. The absence of a national infection control programme remains a major gap given the potential threat from novel zoonotic infections.

The country's priorities should be in the areas of enhancing surveillance, particularly for severe acute respiratory infections, developing evidence-informed policies and plans for the prevention and control of epidemic- and pandemic-prone diseases, and building a public health workforce capable of implementing the prevention and control strategy. A national infection prevention and control programme is under development.

Emergency risk and crisis management

Increased political support for emergency preparedness and response is reflected in the establishment of a health emergency programme within the Supreme Council of Health. This programme coordinates the preparedness and response functions of the whole health sector.

An all-hazards approach has been adopted in updating the country's hazards profile. A multisectoral response plan, involving the whole health sector and its partners, will be developed based on this. Work is underway on integrating response plans within the health sector in light of multisectoral all-hazards principles and IHR 2005.

Food safety

At present there is little systematic exchange of data between the various ministries involved with the different aspects of food safety. Recent efforts have intensified to achieve accreditation of the microbial and chemical analytical work done in the public health laboratory. The upgrading of the capacity and efficiency of the central food laboratory is in progress and the laboratory has obtained ISO accreditation. Laboratory quality assurance programmes have been developed and implemented. The following initiatives are in progress: updating guidelines for food poisoning outbreak investigations; strengthening the food inspection system and enforcement mechanisms; and developing a training programme for newly promoted or hired food inspectors and veterinarians. Food safety awareness campaigns have been undertaken and workshops held for the public and stakeholders on good food hygiene and handling practices. Instructions and standard operating procedures have been drafted and regular training provided to support health inspectors in their auditing duties of food premises. A food safety authority is soon to be established as the sole regulator for managing food safety from “farm to table”, and the roles and responsibilities of the different authorities and stakeholders will be clarified.

The government is planning a thorough overhaul and reorganization of its food safety system. Although many of the components of the system function well, there is a need to focus on the way these components work together. Priorities include strengthening the foodborne disease surveillance systems to allow the early detection, management and prevention of spread of foodborne diseases, and strengthening food safety control and prevention measures.

Poliomyelitis eradication

The country reported the last case of poliomyelitis in September 1990. The polio-free status has been maintained since then due to high immunization coverage: routine immunization against polio has been mandatory since 1980 and coverage is estimated to have reached 100% with national immunization days carried out on a regular basis from 1995 to 2000, in coordination with other member countries of the Gulf Cooperation Council. Since 1994, there has been national reporting on acute flaccid paralysis surveillance and virological classification of cases. The country has achieved and maintained certification standards since 1997. In 2014, the non-polio acute flaccid paralysis rate in children below the age of 15 years was 2.3 per 100 000 and the rate for adequate stool collection was 100% (30).

The basic national documentation for certification and the final national document for regional certification have been accepted by the Regional Committee for Certification of Poliomyelitis Eradication. Abridged annual updates are submitted regularly to the Committee and a plan for preparedness for importation has been developed and endorsed by it. The main challenge is the presence of a large resident population from polio-endemic countries.

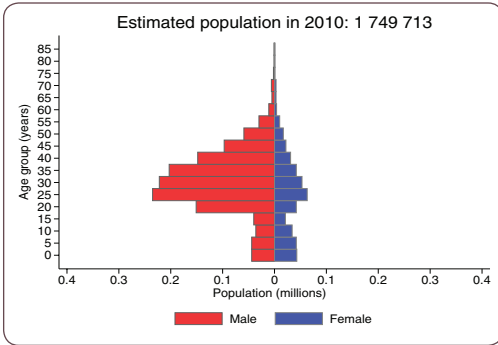
The immunization status of high risk groups, particularly immigrants, must be maintained at a high level and the preparedness and response plan should be tested for its appropriateness in field conditions.

Outbreak and crisis response

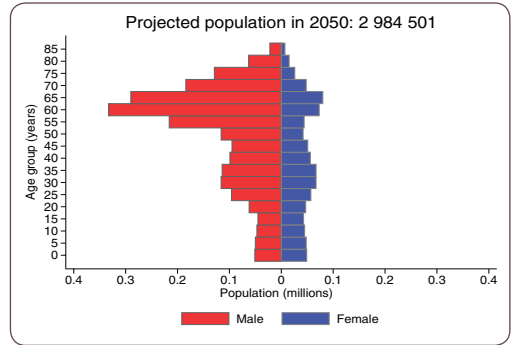
In late 2014, the government began scaling up its preparedness for Ebola virus disease by assessing and measuring its level of preparedness and readiness, using the WHO assessment checklist, and accordingly identifying critical gaps for improvement.

Demographic profile

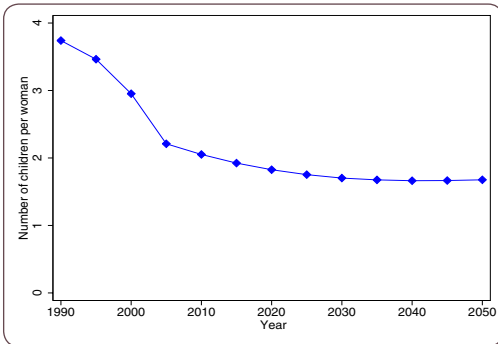
Population pyramid 2010



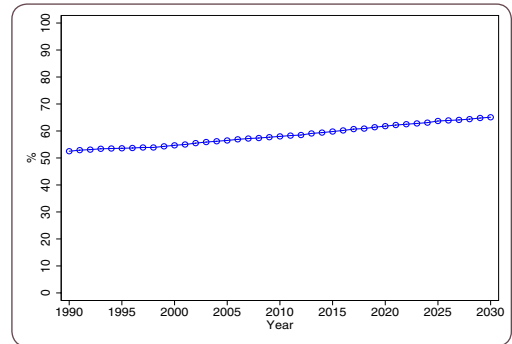
Population pyramid 2050



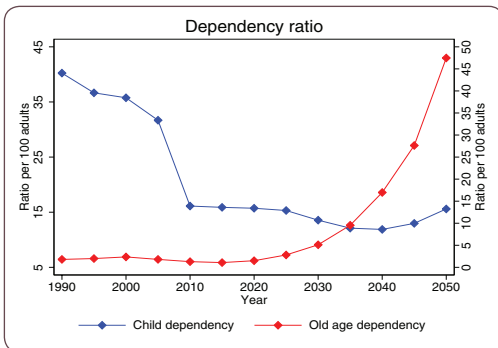
Total fertility rate



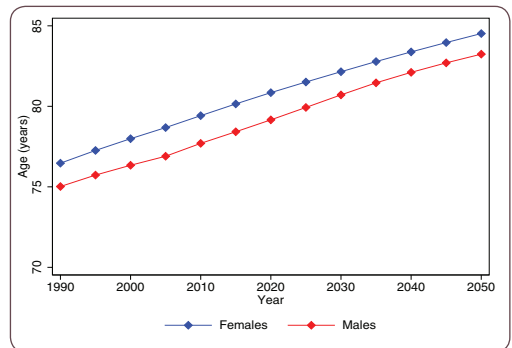
Need for family planning satisfied



Dependency ratio



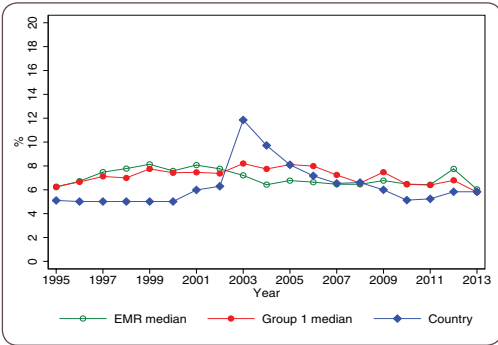
Life expectancy at birth



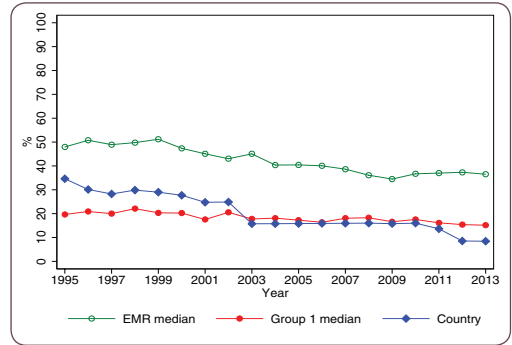
Sources for all graphs: (20)

Analysis of selected indicators

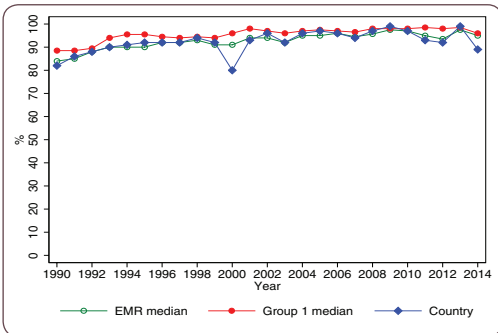
General government expenditure on health as % of general government expenditure (31)



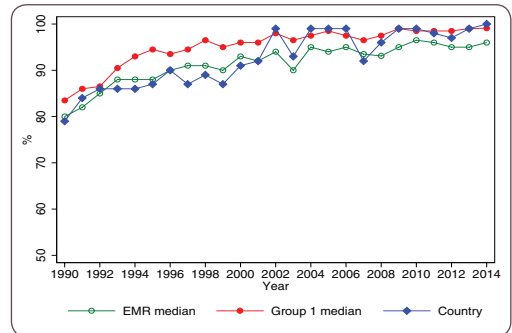
Out-of-pocket expenditure as % of total health expenditure (31)



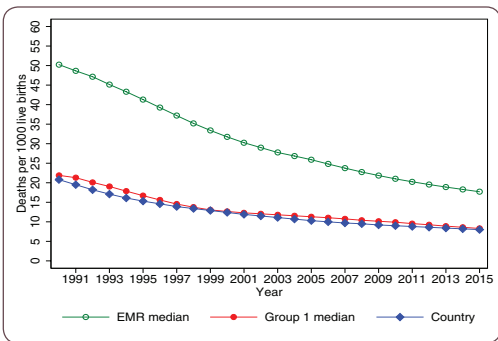
DPT3/pentavalent coverage among children under 1 year of age (%) (5)



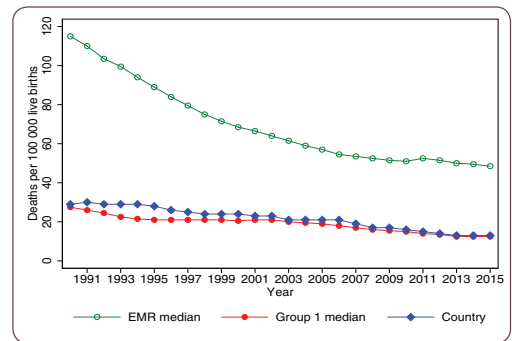
Measles immunization coverage (%) (5)



Under-5 mortality (per 1000 live births) (18)



Maternal mortality ratio (per 100 000 live births) (17)



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