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Country Cooperation Strategy for WHO and the United Arab Emirates 2012–2017

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1. INTRODUCTION

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS process, in consideration of global and regional health priorities, has the objective of bringing the strength of WHO support at country, Regional Office and headquarters levels together in a coherent manner to address the country's health priorities and challenges. The CCS, in the spirit of Health for All (HFA) and primary health care, examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies that have a major bearing on health.

The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to have stronger impact on health policy and health system development, strengthening the linkages between health and cross-cutting issues at the country level. This medium-term strategy does not preclude response to other specific technical and managerial areas in which the country may require WHO assistance.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's contribution to Member States for achieving the Millennium Development Goals (MDGs).

The CCS for the United Arab Emirates is the result of analysis of the health and development situation and of WHO's current programme of activities. During its preparation, key officials within the Ministry of Health, the Health Authorities of Abu Dhabi and Dubai and the national health syndicate were consulted. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed.

2. COUNTRY HEALTH AND DEVELOPMENT CHALLENGES AND NATIONAL RESPONSE

2.1 Government and geography

The United Arab Emirates is a federal state established in December 1971 and consisting of seven emirates: Abu Dhabi, Dubai, Sharjah, Umm al Qaywayn, Ajman, Al Fajayrah and Ras al Khaymah. The Supreme Council, comprising the rulers of the seven emirates, is the highest constitutional authority. It is also the highest legislative and executive authority; it draws up the general policies and approves federal legislation. The Cabinet, or Council of Ministers headed by the Prime Minister, is the executive authority for the country. Under the control of the President and the Supreme Council, it manages all internal and foreign affairs of the country under its constitution and federal laws. Corresponding to the federal institutions are the local governments of the seven emirates. Varying in size, they have evolved along with the country's growth. However, their mechanisms differ among emirates depending on factors such as population, area and degree of development. The largest and

most populous emirate, Abu Dhabi, has its own central governing organ, the Executive Council, under which tare a number of separate departments, equivalent to ministries. Abu Dhabi also has a National Consultative Council, chaired by a speaker, with 60 members selected from among the emirate's main tribes and families. The Dubai Executive Council, established in 2003, has similar functions for the country's second largest emirate. Sharjah and Ajman also have Executive Councils.

The total area of the United Arab Emirates is 83 600 sq km[1], most of which is desert. It is situated in a strategic location along the southern approaches to the Strait of Hormuz, a vital transit point for world crude oil, bordering on Oman and Saudi Arabia. The country has a long coastline and is endowed with rich reserves of petroleum and natural gas. In 2009, over 70% of the total water withdrawal was primary groundwater (including fossil water), 24% was desalinated water and around 6% was treated wastewater.[2]

2.2 Population

The population was 8.2 million in 2010.[1] Nationals of the United Arab Emirates comprise 11% of the population and about 8% of the workforce (Table 1). Indians comprise the largest proportion of population, estimated at 36%, followed by Pakistanis at 14%.[3] The remaining expatriate population comprises mainly nationals of Sri Lanka, Bangladesh, Philippines, North America and Europe, Islamic Republic of Iran, and other Arab countries (especially Egypt and Palestine).

Table 1. Demographic indicators

Indicator	Value	Year
Population, total	8 264 000	2011
Population ages 0–14 (% of total)	19.1	2008
Population ages 65 and above (% of total)	0.9	2008
Population growth (annual %)	6.1	2008
Birth rate, crude (births per 1000 population)	9.6	2010
Death rate, crude (deaths per 1000 population)	.9	2010
Life expectancy at birth, total (years)	77.4	2008
Fertility rate, total (births per woman)	2.4	2009
Urban population (% of total)	81.0	2008
Percentage of population recognized as a national*	11	2010
Percentage of population recognized as a non-national*	89	2010

Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.

*derived from data from the National Bureau of Statistics, United Arab Emirates (http://www.uaestatistics.gov.ae, accessed 6 December 2012)

[1] *Demographic, social and health indicators for countries of the Eastern Mediterranean 2011*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2011.

[2] United Nations Environment Programme. *State of the environment and policy retrospective 1972–2002*. London, Earthscan Publications, 2002.

[3] *Country profile 2008: United Arab Emirates*. London, Economist Intelligence Unit, 2008.

2.3 Social determinants of health

The economy is primarily derived from oil and gas. Oil reserves are estimated at around 98 billion barrels, the fifth largest in the Organization of Petroleum Exporting Countries (OPEC). Natural gas reserves are estimated to be the fifth largest in the world.[3] Per capita income has fluctuated in recent years as a result of unstable oil prices and the global economic crisis. The country is successfully diversifying its economy away from the hydrocarbon sector, with the non-oil sector having grown by 54% in 2003–2007 in nominal GDP terms.[3]

The United Arab Emirates has the highest Human Development Index in the Eastern Mediterranean Region, and is ranked at 30 out of 187 countries globally. The country has invested heavily in educating its citizens (Table 2), with good progress in mainstreaming girls and women's education at all levels, including the tertiary level.[4] In its education strategy of 2010–2020, the Ministry of Education emphasizes teacher training and development, focusing on the nationalization of the teaching pool and lessening the dependence on foreign skills.

Table 2. Socioeconomic indicators

Indicator	Value	Year
GDP growth (annual %)	1	2010
GDP per capita, PPP (current international $)	47 213	2010
GNI per capita, PPP (current international $)	50 580	2009
Labour force, female (% of total labour force)	15	2009
Unemployment, female (% of female labour force)	12	2008
Unemployment, male (% of male labour force)	2	2008
Unemployment, total (% of total labour force)	4	2008
Unemployment, youth female (% of female labour force aged 15–24)	22	2008
Unemployment, youth male (% of male labour force aged 15–24)	8	2008
Unemployment, youth total (% of total labour force ages 15–24)	12	2008
Adult literacy rate, female 15+ years (%)*	93	2008
Adult literacy rate, male 15+ years (%)*	92	2008
Adult literacy rate, total 15+ years (%)*	92	2008
Population with sustainable access to improved water source (%)*	100	2008
Population with sustainable access to improved sanitation (%)*	100	2008

Source: *World Development Indicators 2012*. World Bank, 2012.
* Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.

[4] Al-Suwaidi A. The United Arab Emirates at 40: a balance sheet. *Middle East Policy*, 2011, 18(4):44–58.

2.4 Health profile

2.4.1 Health overview

Health care is provided for all nationals, as mandated by Article 19 in the constitution. Total expenditure on health as a percentage of GDP was 4.0 in 2010 and translated into an average per capita expenditure of US$ 1078 (Table 3).[1] The population is growing quickly, but almost one third is below the age of 15 years. The number of pensioners is forecast to reach only 1.4 million, or just over 15% of the population, by 2020.[5] There is an increasing demand on health care services: by 2015 the demand is estimated to rise by 16%, and the government has already begun to explore public–private partnership in the health sector.

The United Arab Emirates has managed to eradicate many of the communicable diseases still present in much of the Region; however, due to the increasingly sedentary lifestyles, some of the highest incidences of noncommunicable diseases in the world are found in the country, with high prevalence rates.

National health care indicators are equivalent to those in high-income countries (Table 4). Fully 25% (US$2 billion) of total health care expenditure in 2010 was spent sending patients for treatment abroad.[5] The absence of local expertise, expensive treatment and a general lack of confidence in medical facilities are the main driving forces behind this.

Table 3. Health expenditure indicators 2010

Indicator	
Total expenditure on health as % of GDP	4.0
Total expenditure on health (per capita) (average US$ exchange rate)	1450.0
Per capita government expenditure on health (average US$ exchange rate)	1078.0
General government expenditure on health as % of total health expenditure	74.0
Out-of-pocket expenditure as % of total health expenditure	19.0

Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.

Table 4. Health status indicators 2010

Neonatal mortality rate (deaths per 1000 live births)	4.9
Infant mortality rate (deaths per 1000 live births)	7.1
Under five mortality rate (deaths per 1000 live births)	9.8
Maternal mortality ratio (deaths per 100 000 live births)*	12
Births attended by skilled health personnel (%)	100

Source: *Demographic, social and health indicators for countries of the Eastern Mediterranean 2012*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2012.
* United Nations Maternal Mortality Estimation Inter-Agency Group estimate

[5] *Industry report: healthcare United Arab Emirates 2011*. London, Economist Intelligence Unit, 2011.

2.4.2 Health systems

Governance

The health sector is administered by different authorities. At the federal level there are two entities: the Ministry of Health (responsible for regulating the public health sector) and the Emirates Health Authority (responsible for service delivery). At the emirate level there are also two: the Health Authority Abu Dhabi and the Dubai Health Authority. The Ministry of Health and health authorities have developed policies and strategies for health development with the aim of further improving quality of health care and access to required primary, secondary and tertiary care. A primary concern is the expatriate community, whose members are not entitled to universal care and must pay for health insurance. In 2008 Abu Dhabi made health insurance mandatory for expatriates, a policy that at the federal level is being encouraged for the rest of the emirates.[5] While a number of policies and strategies for different health programmes exist at the Ministry of Health and health authorities, there is a need for a consolidated national health policy and strategy at Ministry of Health level as well as health authorities level to assist in harmonizing health development at all levels. Similarly, many health laws are in place at national and health authority levels. Activities are under way to amalgamate such legislation as a part of a consolidated public health law.

The establishment of harmonized rules and regulations, norms, standards and managerial practices in health is a major priority for the health sector. In addition, there is need to re-examine intersectoral collaboration and partnership to optimize the contribution of other sectors, ministries and local authorities in applying a rights-based public health approach addressing the social determinants of health.

The national health strategy is based on the overall government strategy of 2011–2013, focusing on a comprehensive and effective health system for communal health. The strategic objectives are as follows: [6]

- Enhance and strengthen the Ministry of Health's role in setting and applying policies, regulations and governance guidance at federal level;
- Develop and improve the Ministry of Health infrastructural facilities;
- Enhance and develop the health care safety system to counter health hazards;
- Promote public health care standards and raise public health care awareness among the