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**COMPARING COVID-19 POLICIES: AN ANALYSIS OF COVID-19
RESPONSE IN QATAR AND THE UNITED ARAB EMIRATES**

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Comparing COVID-19 Policies: An Analysis of COVID-19 Response in Qatar and the United Arab Emirates

Abstract:

The novel coronavirus, COVID-19, first appeared in early 2020 and has since been able to spread rapidly across the globe. The rapid government response to the growing public health crisis created a unique opportunity to analyze and compare the COVID-19 related public health policies as enacted by various nations.

Having dealt with the impact of MERS and SARS prior to the COVID-19 pandemic, the Middle East provides a distinct perspective into the question of whether prior exposure to public health crises prepared governments in the region to respond to COVID-19. Utilizing news sources reporting on public health policies in the region, as well as public health data as reported by the World Health Organization and the Coronavirus resource center: COVID-19 dashboard by the Center for Systems Science and Engineering at Johns Hopkins University, I compare policies and subsequent health outcomes in Qatar and the United Arab Emirates.

Were prior public health crises advantageous to countries within the Middle East in terms of their ability to respond to the COVID-19 pandemic? Based on regional evidence of national and subnational public health policy responses taking place during the period of COVID-19 pandemic onset, which can be defined as winter to spring of 2020, in addition to regional morbidity and mortality rate, this paper concludes that the data suggests otherwise. The COVID-19 pandemic emphasized the importance of political actors having the capacity to offer effective public health policy responses, thus this paper offers a theoretical framework for why Qatar and the United Arab Emirates, despite their unique advantages, were equally unable to significantly lessen the number of confirmed cases and reported deaths due to COVID-19.

Keywords: COVID-19, Qatar, United Arab Emirates, public health policies, immigrant workers

Comparing COVID-19 Policies: An Analysis of COVID-19 Response in Qatar and the United Arab Emirates

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1.0 Background

As of December 15th, 2020, there have been more than 73 million reported cases, and more than 1.5 million reported deaths¹ as a result of the novel coronavirus, COVID-19. Since its first appearance in early 2020, COVID-19 has been able to spread rapidly across the globe through human-to-human viral transmission². The severity of the disease in combination with its rapid virality required governments across the globe to react swiftly in enacting public health policies that would reduce the spread of the virus. The COVID-19 pandemic provides a unique opportunity to analyze and compare public health policies across nations with similar characteristics. This essay compares the policies enacted by Qatar and the United Arab Emirates in response to the pandemic. In both countries, policies were primarily enacted at the national level. The comparison of these two countries allows for some insight into public health policy and the preparedness of public health systems in the Middle East.

Qatar reported its first case of COVID-19 on February 29th, 2020³. As of July 2020, Qatar, with a case per capita rate of 3.929 per 100,000 people⁴, was found to have the highest rate of COVID-19 cases per capita in the entire world. Currently, the total amount of confirmed cases in Qatar stands at 141,121 with a total of 241 deaths¹. What makes the country particularly unique is its population demographics. Out of Qatar's 2.8 million residents, 88 percent of the population is comprised of expatriate workers who are primarily males between the ages of 20 and 50 years old^{2,4}. Medical research has shown that males and those within older age groups are disproportionately susceptible to COVID-19². From February to April non-Qatari patients tested positive for COVID-19 at significantly higher numbers than Qatari patients (see Figure 1). High

proportions of non-native groups such as these expatriate workers can affect the transmission of viruses due to high levels of population influx and efflux, thus potentially worsening the epidemiological situation. It is a factor that requires addressing by the government of Qatar and by its fellow countries in the Middle East also with large expatriate populations.

The United Arab Emirates reported its first case of COVID-19 on January 29th, 2020, and was the first Middle Eastern country to do so⁵. The country reported its first two COVID-19 related deaths on March 20th, 2020. There are currently 186,041 reported confirmed cases and 618 reported deaths in the country¹. That number has grown dramatically since the start of the summer: from 25,063 confirmed cases and 227 deaths reported as of May 20th, 2020⁶. Two observations stand out regarding the country's approach towards the pandemic. Scholars have commented on the lack of concern and awareness⁵ amongst the United Arab Emirates' citizenry. Another interesting aspect is the role played by the competing and sometimes overlapping authorities between two major cities, Abu Dhabi and Dubai⁷, which may be the reason behind the subnational policies enacted in the United Arab Emirates, which is in stark contrast to the lack of subnational policies in Qatar.

2.0 Policies during the Period of Pandemic Onset

Defining the period of pandemic onset in the Middle Eastern region as the time from the initial case in the United Arab Emirates till the end of April, there is a clear trend of policy severity growing in response to the growing numbers of confirmed positive COVID-19 cases.

Qatar initially started by mandating that those arriving from Iran and South Korea were required to quarantine upon arrival⁸. However, following their initial first reported case at the end of February, restrictive policies started to become enacted more frequently. At the beginning of March travel suspensions from Egypt⁹ and Italy¹⁰ were enacted. A more extreme travel suspension, stopping all travel from Bangladesh, China, India, Iran, Iraq, Lebanon, Nepal,

Pakistan, Philippines, South Korea, Sri Lanka, Syria, and Thailand was then announced on March 8th, 2020¹¹. On the other hand, exit travel was not heavily restricted aside from where other countries banned entrance to visitors². The following day, Qatar announced that it would shut down its schools and universities on the 10th of March until further notice¹². About a week later all shops, bank branches, and shopping centers were closed under new government regulations, and the closure of restaurants, cafes, and food trucks at common social sports clubs and parks soon followed^{13, 14}. Also in early March, the government implemented standard protocols as outlined by the World Health Organization in terms of testing, contact tracing, social distancing guidelines, and eventually the shut-down of all non-essential businesses and business activity⁴. Around the same time, the government also locked down the capital city of Doha by deploying the cordon sanitaire around the Industrial Area⁴. The Industrial Area is home to the worker barracks for many of the expatriate migrant workers who find themselves working in the many factories and warehouses in the area. To mark the cordon the government established roadblocks and concrete barriers around most of the area's perimeter. On April 1st, Qatar ordered its private sector companies to have 80 percent of their workforce working from home¹⁵. Policies issued in May mainly saw the continuations of previously announced policies as the number of positive cases continued to grow as depicted in Figure 2. The only additional restrictive policy was a controversial mandatory contact tracing app which went into effect on May 22nd, 2020¹⁶.

Following the confirmation of its first cases in January, the United Arab Emirates began implementing preventative measures in line with the rules and regulations put forth by the World Health Organization¹⁷. The United Arab Emirates' government began screening all passengers arriving from China on January 23rd, 2020. This included all incoming passengers coming in through Dubai International airport and Abu Dhabi International airport⁵. About a month later

the United Arab Emirates' Ministry of Foreign Affairs and International Cooperation imposed a travel ban on all travel from Iran and Thailand⁵, which coincided with Qatar's first confirmed cases among the travelers returning from Iran. Like in Qatar, as the number of confirmed cases and reported deaths began to increase (see Figure 3), the severity of public health policies grew. In the beginning of March, the government announced the closure of all schools and universities until further notice which was then followed by the temporary closure of all places of worship⁵. Towards the end of the month, the United Arab Emirates placed restrictions on flights, suspending all passenger flights but allowing cargo flights carrying essential goods. Malls were shut down and the government acknowledged that many citizens would be remaining in isolation for long periods of time. The Telecommunications Regulatory Authority unblocked Skype and Google Hangouts so that citizens could use these services⁵. On the 25th of March, the government announced the National Disinfection Program with a purpose of completely sterilizing all public utilities, metro services, and public transportation during the weekends. Nonetheless, the Dubai Metro and the Dubai Tram were suspended at the end of March. Curfews were also put in place, in addition to a fine of AED 50,000 for anyone caught violating any COVID-19 related measures⁵. Further restrictive measures in April included the suspension of inter-city buses in Sharjah. The government also launched a mobile app to ensure that people directed to self-quarantine were complying with mandatory quarantine requirements⁵. May saw the United Arab Emirates moving towards a hopeful "recovery" phase as the government began to lift restrictions⁶. Understanding possible factors that influenced the rise in restrictive policies, as well as the rollback of these same policies, is vital to understanding what gaps may exist in each country's level of preparedness and effectiveness in dealing with viral diseases of COVID-19's caliber.

3.0 Discussion

The region has a history with other strains of coronavirus, having been plagued by episodes of Middle East respiratory syndrome coronavirus (MERS-CoV) beginning in 2012^{7, 18}. These experiences combined with having dealt with other outbreaks such as the Ebola virus contribute to the theory that Qatar and the United Arab Emirates would be better prepared for the COVID-19 pandemic than countries outside of the Middle East. This theory is also supported by the idea that improvements to public health systems in both countries would have taken place and have been tailored to address public health emergencies in light of these prior outbreaks. In fact, the World Health Organization's 2015 health profiles for both countries support this reasoning. Following the emergence of MERS, a major gap in Qatar's lack of a national infection control program was revealed, requiring the country to begin prioritizing enhancing surveillance measures for severe acute respiratory infections (SARS), developing new and improved policies and plans based on scientific evidence, and building up their public health workforce¹⁸. This led to the development of a national infection prevention and control program which is now active through the country's Ministry of Public Health. As for the United Arab Emirates, MERS shined a light on some of the gaps in the country's public health systems by testing their capacity for routine surveillance and their ability to detect the emergence of health threats. The country then refocused its efforts on establishing a program for monitoring and mitigating such threats, creating national policies targeting emergency preparedness and response, and redirecting focus to community vulnerabilities⁷. These efforts should have given some sense of preparedness to these countries, but the number of confirmed cases and reported deaths due to COVID-19 suggests otherwise.

Failure to account for the specifics of population susceptibility may present an explanation for the elevated numbers of confirmed COVID-19 cases and associated deaths. As

previously mentioned, men have been reported to be more susceptible to COVID-19. Population graphs from 2010 demonstrate that the populations of both Qatar and the United Arab Emirates are primarily male (see Figure 4)^{7, 18}. This would suggest that a greater percentage of the population in both Qatar and the United Arab Emirates were susceptible to the virus and thus contributed to the higher numbers seen in these countries. Qatar also has the added factor of immigrant workers forming the predominant part of its population. Since these workers are disproportionately likely to travel outside the country as they leave or return for work, this increased amount of travel can serve as a big transmittance vector thus contributing to the country's overall confirmed case number. Figure 1 reports that confirmed cases in Qatar were more prevalent among non-Qatari patients than for Qatari patients.

In both countries, it appears that policies followed observed health threat, with the most policies enacted in March (see Figures 2 and 3). There may also be an economic factor that caused delayed implementation of certain restrictions such as travel bans and restrictions on commercial businesses, however, this requires further study.

4.0 Conclusion

As a new phase of this pandemic approaches due to the promise of a viable vaccine, the capacity of the political actors to offer effective public health policy response becomes of even greater importance. This makes the understanding of how governments acted at the pandemic's onset a priority. Their action or inaction can be predictive for the creation and implementation of new policies going forward.

Understanding population demographics, including which groups within the country are most vulnerable or susceptible to the disease, is vital for creating policy that can best serve the country's population as a whole. Also, as restrictive policies are rolled back with vaccine availability, it is important to understand what warning signs need to be tracked. This was a

necessity in the implementation of initial restrictive policies but is also necessary in the end-of-pandemic management.⁶ While the value of the numerical epidemiological thresholds as signals for policy measures is mostly understood, the political will and the political capacity to make those policies remain a variable in need of studying. Qatar and the United Arab Emirates are members of the Gulf Cooperation Council, and that could serve as a platform to reaffirm commitment to cross-border surveillance and enhanced regional capacity for infection prevention control¹⁸.

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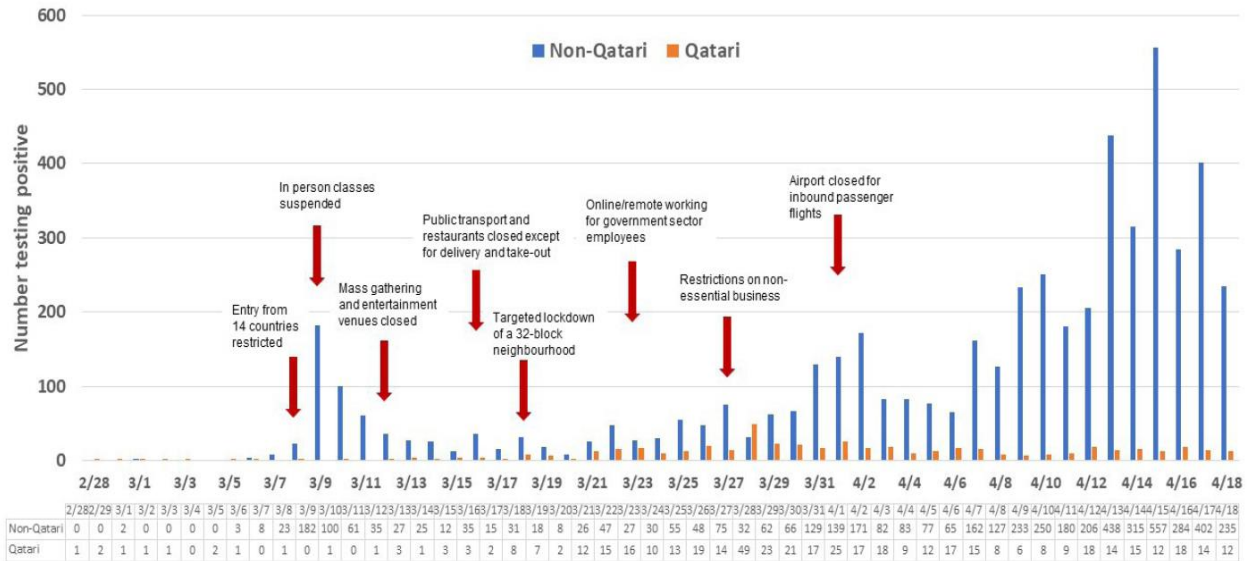


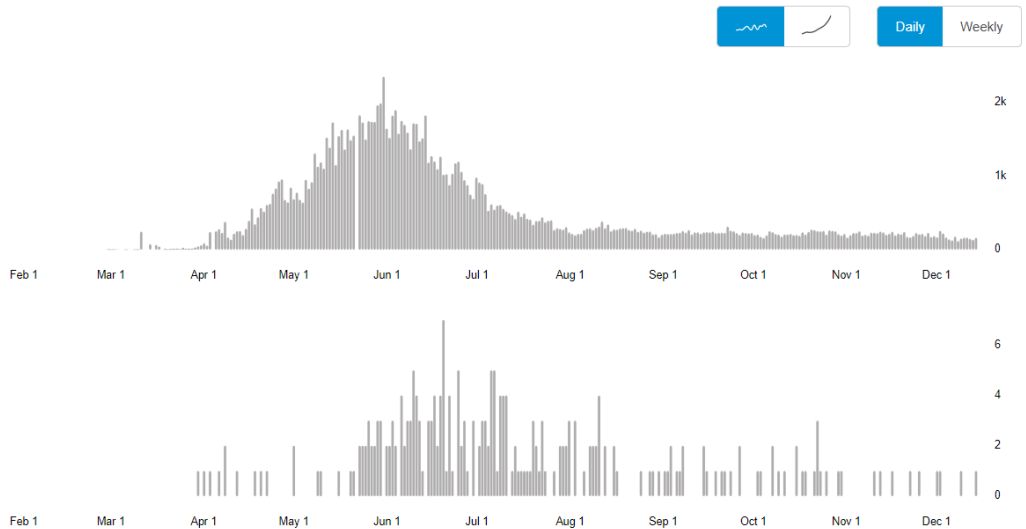
Figure 1 Epidemiological curve of patients with COVID-19 in Qatar.

Source: Al Kuwari, H.M., Rahim, H.F.A., Abu-Raddad, L.J., Abou-Samra, A.B., Al Kanaani, Z., Al Khal, A., Al Kuwari, E., Al Marri, S., Al Masalmani, M., Al Romaihi, H.E. and Al Thani, M.H., 2020. Epidemiological investigation of the first 5685 cases of SARS-CoV-2 infection in Qatar, 28 February–18 April 2020. *BMJ open*, 10(10), p.e040428.

Qatar Situation

141,121
confirmed cases

241
deaths



Source: World Health Organization

Figure 2: Confirmed cases in Qatar from February 1st to December 15th. Source: World Health Organization

Comparing COVID-19 Policy Response in Qatar and the United Arab Emirates

United Arab Emirates Situation

186,041
confirmed cases

618
deaths

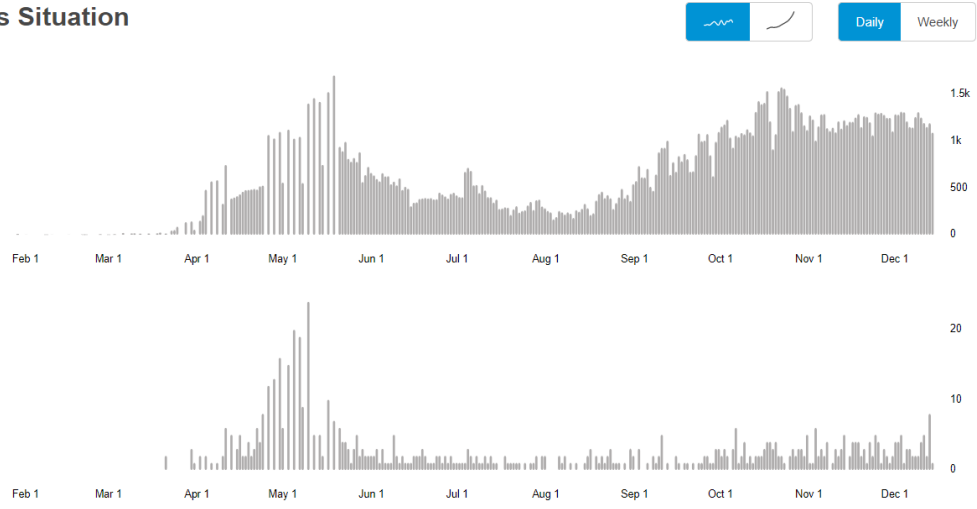
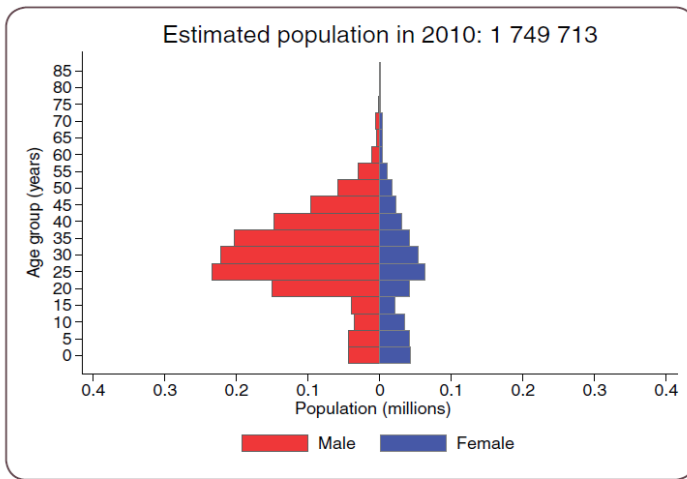


Figure 3: Confirmed cases and reported deaths in the United Arab Emirates from February 1st to December 15th. Source: World Health Organization

A

Population pyramid 2010



B

Population pyramid 2010

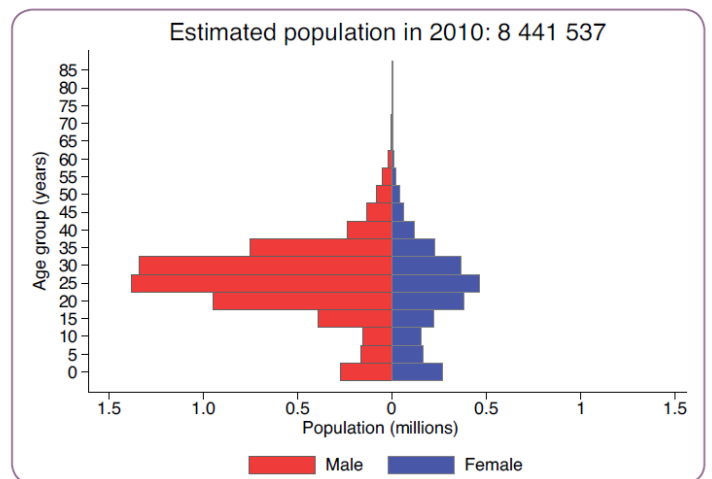


Figure 4: (A) Population distribution of men versus women in Qatar in 2010. (B) Population distribution of men versus women in the United Arab Emirates in 2010. Source: World Health Organization^{7, 18}