

Healthcare in Oman Between Past and Present Achievements, Human Security and the COVID – 19 Pandemic

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ABSTRACT

This article results from research on the most recent effects of the COVID-19 pandemic in the Sultanate of Oman. Interdependence is investigated along with the inherent fragility of a health system made more vulnerable by the high reliance on migrants. As part of the history of modern Oman the health sector development was pursued with huge reforms during Sultan Qaboos' reign (1970-2020): the achievements of those years are valued and studied, against the backdrop of Omani cultural roots and peculiar social environment. The regional dimension emerges with the interregional networks of this country. The issue of human security comes to the fore and it is even more evident in relation with the challenges posed by the health emergency in 2020. At the beginning of Sultan Haitham's reign, new efforts are requested to address an unprecedented crisis, as underlined in the article, stressing also the importance of initiatives related with investments and re-qualification, within a regional and interregional dimension.

Keywords: Oman, healthcare, immigrants, human resources, COVID-19.

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INTRODUCTION

The outburst of the COVID-19 pandemic in 2020 was soon perceived in the Sultanate of Oman, as it happened elsewhere, not only as a dangerous and concrete threat to the population's health and the healthcare system, as it was developed in the last 50 years, but also as a domestic crisis affecting internal balances related to the broader issue of human security. Rising interdependence with other countries, their expertise and human resources, aroused concerns and highlighted the fact that health security and human security are “inextricably linked concepts”, which was particularly evident in front of such a global emergency in this country. This article results from some research on the most recent effects of the COVID-19 pandemic in this part of Arabia, in the awareness that “the nature of global health problems has the potential to transcend the traditional Westphalian state boundary system, whilst overwhelming many states' capacities for contending with these problems”.²

The case-study of the Sultanate allows to shed some light on specific features of the healthcare system development in this area and on a series of cultural, political and social interlinkages affecting the same health sector until our century. The methodological criteria directing this research-work imply that the historical approach is complemented with the study of the environment and its social dynamics. Positive contribution offered by other disciplines is used to integrate the textual evidence, data and relevant information collected both online during the last year of

² Robert L. Ostergard Jr. and Jeffrey A. Griffin, “Global Health and Human Security”, in Colin McInnes, Kelley Lee, and Jeremy Youde (Eds.), *The Oxford Handbook of Global Health Politics*, p. 7.

global health emergency, and in fieldwork carried out in the Gulf region in previous years.

Interdependence of Oman at the regional, interregional and global levels was re-confirmed stronger than ever in this crisis that highlighted the inherent fragility of a system made even more vulnerable by the high reliance on migrants. Nonetheless, such a crisis was also confronted with strength, thanks to some important achievements and a development process of healthcare started in the 1970s. The historical approach allows to re-construct such a process and to define it in the light of the peculiar Omani social environment, where the social networks of the tribes matter, an Islamic-tribal paradigm keeps affecting the State's institutions, and cultural and religious beliefs have been affecting some approaches to health.

Looking back at history...

Healthcare was both shaped and shaped social, political and institutional realities in the history of modern Oman: social growth and human development largely depended on the modernisation of healthcare, and yet the latter was also affected by a set of values and a cultural identity founded on a rich Past, connecting Oman with the ancient tradition of medicine in Islam. Al-Mubasshir ibn Fatik, writing on the preservation and well-being of the people as a duty of the ruler in Islam in the 11th century reminds us that heritage here is rooted in the classical heritage of Islam.³ Omani culture always held in high esteem physicians and rulers able to contribute to the preservation of health among their people. The 16th

³ F. Rosenthal, *The Classical Heritage of Islam*, London, 1975, p. 35.

century physician Bin Omairah of Rustaq was a prominent personality in the field of medicine and pharmacy, who had travelled to Bahrain, Baghdad and Al Qatif to learn more and to write useful works, in which he recorded various diseases, he described the human organs and their functions along with their treatment. His scientific approach inspired his preparation of herbal medicines for his patients in his laboratory. The Omani National Commission for Education, Culture and Science in 2013 not by chance supported a nomination by UNESCO of this important Omani figure to include him among the world's most influential personalities in the global programme "Important historical and influential figures" at its 37th session of the General Conference in 2013.⁴

⁴ Oman Daily Observer, *Rashid bin Omaira — 16th Century Omani Physician*, 9.02.2019, accessed online <https://www.omanobserver.om/rashid-bin-omaira-16th-century-omani-physician/> 21.01.2021.



Manuscript by bin Omairah containing a poem on eye anatomy, copied by Mohammed bin Hamad bin Salam Al Harasi in 1305H (Source: Sultanate of Oman, Ministry of Heritage and Culture, Historical Manuscripts).

The emphasised link between this historical figure with the contemporary implementation of policies to give Omani people a modern and more efficient healthcare system can be seen as the expression of a nation-building process in need of identity symbols and points of reference since the 1970s...after an “obscure time”, in which modern healthcare did not simply exist for Omanis. And yet, the days in which bin Omairah had lived, marked by the growing importance of his town in the centre of Oman, Rustaq, tell us that pre-modern times in this region had witnessed the presence of traditional laboratories for the extraction of herbal medicines and growing interest in improving treatments of various diseases. Rustaq controlled access to the harbours and cultivated fields of

the Batinah, while being included in the political heart of interior, and emerging then as one of the capitals in the country's history.⁵ Bin Omairah's travels to other important agricultural areas in Arabia, like al-Qatif and al-Bahrayn, confirm the relevance of herbal medicines production and use in those times, which is something that continues until nowadays in the region. Folkloric medical heritage has been preserved: healthy herbal waters, like *margadush*, extracted from marjoram and origanum, recommended for abdominal pain, or *al-zamuta*, extracted from origanum and thyme, used against stomach acidity, and *al-hilwa*, extracted from aniseed, used as a vitamin, and *hilba* (fenugreek plant), thought to be good against breathing difficulties and to regulate the function of the liver and bladder, are just few examples of a long list of folk-medicines well known in the whole region.⁶ Natural chemical-free products are re-evaluated today, as attested by the growth of local production, according both to the most modern techniques and the traditional use of herbs in the ancient medicine books of the Arab-Islamic culture. At one and the same time, the high rate of morbidity and mortality in pre-1970s Oman, like in the pre-oil era Arabia as a whole, is still inscribed in the old people's minds. The widespread use of rock salt as a disinfectant by Arab folk-medicine in childbirth could not prevent the extremely high rate of mothers' death before the introduction of modern medical facilities in all

⁵ J.G Lorimer, *Gazetteer of the Persian Gulf, Oman and Central Arabia, vol.II, Geographical and Statistical*, Superintendent Government Printing, 1908, p. 1369.

⁶ Cf. Mahdi Abdallah Al-Tajir, *Language and linguistic origins in Bahrain*, Kegan Paul International, London, 1982, pp. 140-141.

the Arab Gulf countries, also because the possibility to store and handle these items hygienically was scarce.⁷

The political decision to establish the Ministry of Health in Oman in 1970 was crucial for a government determined to legitimise itself also by improving the population's health and hygienic condition through strict coordination with the World Health Organisation (WHO) and its assistance, which was a shared approach in the Gulf. The College of Medicine, established in 1986 in Sultan Qaboos University soon started attracting students from other countries of the GCC (Gulf Cooperation Council), in particular Bahrain. Regional and international healthcare networks have been emerging and consolidating since then.

The *Nahda* and the creation of a modern health system

When Sultan Qaboos assumed power in 1970, the so-called *Nahda* (Renaissance) started in the country: it led both to important achievements in terms of economic and social development, and to new efforts to adapt the local Islamic religious discourse (Ibadism) and its value-system to the modernization process. The traditional and conservative approach of the official Ibadi doctrine did not always help, but far-sighted plans were implemented, and delicate balances were pursued between the various components of the Sultanate and the powerful tribes of the interior. Continuity and innovation apparently merged, affecting welfare and health sector as well.

⁷ Cf. Frauke Heard-Bey, *From Trucial States to United Arab Emirates*, Longman, London, 1999, p. 148.

As part of the history of modern Oman the health sector development was pursued with huge reforms, financed through the oil and gas revenues: in July 1970, when life expectancy was 49 years, there were only two hospitals, run by an American Mission, and ten clinics and dispensaries in the whole country. Three years later there were already nine fully operative hospitals at Ruwi, Salalah, Tan‘am, Matrah, Muscat, Nizwa, Rustaq, Sohar and Sumail, and rising numbers of health centres and dispensaries in each region⁸. It is not to be neglected the fact that the government’s investment in this sector, following the patterns already implemented in the other Gulf Arab countries, contributed to gain people’s support and to enhance its legitimacy in their eyes, considering that health care access was rare and difficult in a country where episodes of malaria, trachoma infection, pulmonary tuberculosis and hepatitis were widespread and could hardly be treated, given the very limited numbers of physicians.⁹ The Ministry of Health developed the system in three main stages. Between 1976 and 1990 the focus was mainly on health infrastructure building, between 1991 and 2005 new strategies were adopted to establish a system of decentralised health centres, widely spread in eleven health administrative divisions throughout a country divided in seven administrative regions. In such a way, the right to free primary health services could rapidly be guaranteed to the Omani citizens almost

⁸ *Quarterly commercial and economic progress reports on Oman*, 1973 Jan 01 - 1973 Dec 31, p. 11, The National Archives, UK, accessed online at <https://agda.ae/en/catalogue/tna/fco/8/2014>

⁹ Moeness M Alshishtawy, *Four Decades of Progress. Evolution of the health system in Oman*, SQU Med J, April 2010, Vol. 10, Iss. 1, pp. 12-22, Epub. 17th Apr 10, p. 13.

everywhere, from urban areas to the most isolated rural and Bedouin's areas, from the mountains to the desert and the coasts.

In the 1980s and early 1990s, the Ibadi official discourse, while supporting the importance of scientific and medical education with health initiatives, could not prevent some religious scholars, like the Mufti Ahmed bin Hamad Al-Khalili, from re-affirm gender roles definition according to the most conservative interpretation of Islam. Paradoxically, the Mufti, like other non-Ibadi Muslim scholars, mentioned the views of the French author Alexis Carrel when he asserted that “chromosomes of women are dramatically different from those of men”, thus making obvious biological differences between men and women the foundation of some decisions on gender roles and rights in the Omani society, which, in a way, were affected by specific demands for the respect of differences at schools, at universities, at the workplaces and in hospitals at that time.¹⁰ Such a position, which was strengthened by tribal customary codes (*'urf*) hindered in a way a more extensive inclusion of Omani women in scientific sectors, but enhancing the presence of women in health care professions became all the same an important government's objective. Records regarding medical students provided by the Ministry of Health, by Sultan Qaboos University and by the Oman Medical Speciality Board attest a rise in health workforce feminization among doctors in the new century: the proportion of specialised female doctors reached 31% in 2015 compared to 21% in 1990, and female general practitioners reached 50%

¹⁰ Khaled Al-Azri, *The Political Equilibrium: Legitimation and Modernization in Oman*, in Valeria Fiorani Piacentini and Elena Maestri, *From Tribe to State*, CRiSSMA WP, vol, 1, n. 14, I.S.U. Università Cattolica, Milano 2007, p. 43.

in 2015 compared to 30% in 1990. This trend is positive, and yet it does not seem to be able to affect the proportionately too large numbers of immigrant medical staff in a significant way in the medium term.¹¹

All of that has an impact both on foreign human resources employed in the country's healthcare and on the general efficiency of the system. No continuity of professional care is guaranteed due to a huge turnover of personnel, often moving back to their home countries or to other countries after only few years. Uncertainty is a negative aspect both for the foreign medical staff and for the host country's patients.

Between 2006 and 2010 more comprehensive plans were conceived to involve both central health institutions and local structures in the various divisions, in order to better address the new challenges¹². Health initiatives based on prevention became a top priority: while malaria and other infectious diseases had been eradicated in a few years, non-communicable diseases had started increasing with modernisation.

The relevance of a community-based approach comes to the fore: in 2000 Oman reached the World Health Organisation's top ranking for the ability to invest efficiently in health improvements, apparently without disparities.¹³ Such an approach seems to be quite consistent with the Ibadi ethos, which contributed throughout the centuries to "weld together Omani

¹¹ Nazar A. Mohamed, Nadia N. Abdulhadi, Abdullah A. Al-Maniri, *et al.*, "The trend of feminization of doctors' workforce in Oman: is it a phenomenon that could rouse the health system?", *Human Resources for Health* 16, 19 (2018).

¹² *Al-sihha fi 'ahd al-nahdha al-mubarakata t'bur kull shabr bi-l-bilad*, *Al-Shabiba*, 18 November 2019, <https://www.shabiba.com/article/235544>

¹³ Jeremy Jones, Nicholas Ridout, *A History of Modern Oman*, Cambridge University Press, New York, 2015, p 175.

society into a unity that was relatively little divided by social barriers”.¹⁴ The social principles of “justice, equality, and equal opportunities between Omanis” are also clearly expressed in article 12 of the Basic Statute of the State, declaring the state’s responsibility “for public health and the means of prevention and treatment of diseases and epidemics”, and adding that “the State endeavours to provide healthcare for every citizen and encourages the establishment of private hospitals, polyclinics and medical institutions.”¹⁵ The latest available data, related to the quality of health developed during Sultan Qaboos’ reign, place Oman in line with the other GCC member States and in the group of countries with the highest human development (see figure 1).

Figure 1 - Quality of health in GCC countries in the last decade

	Lost health Expectancy*	Physicians	Hospital beds
HDI RANK	(%)		(per 10,000 people)
Very high human development	2017	2010-2018^a	2010-2015^a
35 United Arab Emirates	13.9	23.9	12
36 Saudi Arabia	13.7	23.9	27
41 Qatar	14.7	0.0	12
45 Bahrain	14.7	9.3	20
47 Oman	14.7	19.7	16
57 Kuwait	14.9	25.8	20

* **Lost health expectancy:** Relative difference between life expectancy and healthy life expectancy, expressed as a percentage of life expectancy at birth.
^a Data refer to the most recent year available during the period specified.

Source: adapted by Elena Maestri from data in Dashboard 1, Human Development Report 2019.

Health and Omani environment

The Primary Healthcare System (PHS) based on the *wilayat*, or districts subdivision, is the closest to the community and it is well complemented

¹⁴ John Wilkinson, *Ibadism. Origins and Early Development in Oman*, Oxford University Press, New York, 2010, p. 320.

¹⁵ Basic Statute of the State of Oman.

by the services of mobile medical teams provided to the population living in remote mountainous and desert areas. Within PHS, a growing trend in the utilisation of health centres by the population is recorded, as they proved to be efficient in providing some preventive and curative primary health care. In addition, the extended health centres started to provide some specialty care as well, in coordination with local hospitals, also providing PHC services.¹⁶ Despite the remarkable development of the system, many Omanis still trust traditional medicine, despite growing modernisation of their lifestyle. The PHS has been contributing to spread basic hygienic and health education among the population, by supporting informative campaigns against unhealthy practices either connected with ancient traditions (for instance, consequences in terms of hereditary diseases coming from tribal consanguineous marriages, still widespread in the country) or modern lifestyle (lack of physical exercise, unhealthy food, etc.). As far as folk medicine is concerned, some Sultanate's doctors and researchers have been considering the possible integration of it in the PHS services, provided it is scientifically founded.

The practice of traditional medicine varies from region to region in Oman, but the common belief that it is without risks, in comparison with pharmaceutical drugs, has led to its growing popularity and utilisation in modern times, despite the possible toxicity of herbs and the risk posed by some mechanical practices of folk medicine. All of that led to growing scientific interest in researching these aspects to integrate, when possible, traditional medicine in prevention and treatment, in the Sultanate, but

¹⁶ Moeness M Alshishtawy, *op. cit.*, p. 18.

information campaigns in this direction are considered crucial to avoid use of herbs and dangerous practices, such as the case of mechanical healing of cauterisation (*wasam*), “a crude method of applying a counter irritant “ widely used by healers in Arabia and in Egypt since the most ancient times and often resulting in complications, such as septic shock and tetanus. A survey carried out in 2009 at the tertiary care teaching institute of the Sultanate stated that 62.3% with infectious keratitis sought traditional methods before an ophthalmologic visit; another study on 400 patients with risk factors for stroke stated that 19.5% of patients chose to be treated first with traditional methods, which included *wasam*, at home.¹⁷

The last ten years, no doubt, witnessed some interesting research and related informative campaigns in this direction as well, but this is still an issue with a cultural and social dimension to be addressed with greater determination by the authorities, along with other relevant issues, like disabilities/special abilities and hereditary diseases, diseases resulting from social and lifestyles changes in the last decades, like hypertension, hypercholesterolemia, obesity and diabetes mellitus that are on the rise, and cardiovascular diseases and neoplasm that are the leading causes of deaths. Consequences of too high rates of car accidents among Omani male youth and the rising number of Omanis aged 60 and older are also implying the need of more health services to the population.¹⁸

¹⁷ Redha Shenoy, Alexander Bialasiewicz, Rajiv Khandekar, Badar Al Barwani, Habiba Al Belushi, *Traditional Medicine in Oman: Its Role in Phtalmology, Middle East African Journal of Ophtalmology, April 2009*, pp.93-94, accessed online from <http://www.meajo.org.on> on 27,01.2021.

¹⁸ Oman’s Ministry of Health, Annual Health Report 2019, Oman, p. 52.

The habit to segregate children with special abilities in Gulf Arab societies is a thorny aspect requesting further efforts to be contrasted. It was publicly tackled for the first time in the area in 2005, during the International Rehabilitation Conference for the Arab Region in Bahrain. The rich Conference agenda focused on rights of people with special abilities highlighted the urgent need to improve their condition by rising awareness against some negative attitudes towards them in social and tribal contexts still more prone to hide them in closed family spaces rather than to allow them outside contact, education and access to health services. Such a need was shared by Oman, where the some interesting initiatives gained institutional support both in the light of Islam, that clearly stigmatises such attitudes, by urging parents to safeguard their children always, and in the light of Sultan Qaboos' pursued balance between the positive values of tradition and modernity. And yet, such a balance when it comes to children and youth with special abilities, is not so easy to achieve in this country, particularly in rural areas and for those citizens from financially and/or culturally disadvantaged backgrounds. Eradicating social stigma related with disabilities is a process already started, but still in need of more education and training programs, with specific initiatives aimed at the people of the interior in Oman, as well as an appropriate legislation that Oman and all the GCC countries have been promoting to protect some basic rights of persons with disabilities.¹⁹

¹⁹ Profanter Annemarie, Stephanie Ryan Cate, Embraced or embargoed: Special ability and needs issues in the Arabian Gulf, *Procedia - Social and Behavioral Sciences*, Volume 15, 2011, pp. 1248-1256.

Regionalization of the Omani Health System

In Gulf Arab history, health has generally been a productive field for reconciliation among tribes and peoples, proved to be more able to establish and strengthen relations against disruptive forces when facing health emergency crisis. That was true when in 1920, the Saudi-Wahhabi *Ikhwan* attacked Kuwaitis at Jahrah, contesting, among other things, the presence of an American Mission Hospital, suspected to cover espionage activities against Ibn Saud's interests;²⁰ after their defeat, they were treated at the same American Mission Hospital without any discrimination between them and Kuwaitis: the defeated Ikhwan had lost about 800 men on that occasion, and they had as many more wounded, with high incidence of infection, but the equal treatment guaranteed by doctors and nurses there was a message that Abdulaziz Ibn Saud understood very well, which contributed to overcome tensions and re-establish good relations with Kuwaitis, starting from health²¹. Although under very different circumstances and without any war, most recently in 2021, the diplomatic and political crisis between Saudi Arabia, the UAE and Bahrain on the one

²⁰ Author's interview at *Dar Al-Athar al-Islamiyya* (Amricani Cultural Centre), Kuwait, December 2016. The Centre has established an interesting museum, displaying the history and the role of the American Mission Hospital in Kuwait and relevant documentation is made available on this page of health history in the Gulf. Cf. IOR/R/15/1/522, 'File 53/57 I (D 35), *Jariyah [Jahra] Affair and Boundary Dispute between Bin Saud and Shaikh of Kuwait*, Qatar Digital Library. Cf. Ffrench G.E., Hill A.G. (1971) *Trauma, Temperance, Tuberculosis and Toxoplasmosis. In Kuwait. Medizinische Länderkunde / Geomedical Monograph Series (Beiträge zur geographischen Medizin / Regional Studies in Geographical Medicine)*, vol 4. Springer, Berlin, Heidelberg. https://doi.org/10.1007/978-3-642-65172-4_11, p.72.

²¹ Author's interview with the Director of *Dar Al-Athar al-Islamiyya* (Amricani Cultural Centre), Kuwait, December 2016. The Centre has established an interesting museum displaying the history and the role of the American Mission Hospital in the region and relevant documentation is made available on these pages of health history in the Gulf.

hand, and Qatar, on the other, was overcome during this century pandemic crisis and one of the first initiatives was Saudi decision to establish an health center at the Salwa border crossing with Qatar.²²

Oman, being part of this Islamic-tribal cultural environment, shares with its neighbours some priorities to improve healthcare regionally since old times. Being an active member of the Gulf Committee for Health Systems Development, which convened its first meeting in 2004, the Sultanate signed a document on strategic regional cooperation to improve education, training and employment of Gulf Arab human resources, health information systems, information and communication technology, management and accountability, coordination and burden of disease. The document was updated in the following years to cope with the evolving situation, with more emphasis on professional learning and training in medical professions, health and statistics, provision of infrastructure required for application of e-health, initiatives for elimination and prevention of communicable diseases, reduction of burden of disease due to non-communicable diseases and injuries, weak health research and surveys.²³

The “family practice system”, according to which each family unit is attached to a health centre and a family doctor, and the “public health laboratory system”, providing instruments and personnel for sanitary inspections (in particular food inspection) were adopted as a rule in Bahrain in 1970; Oman soon followed this system, which was a shared

²² *Gulf News*, “Saudi Arabia opens health centre at Qatar border”, January 9, 2021.

²³ Tawfik A. Khoja, Gulf Committee Health Systems Development Document, 2012.

one in the Gulf.²⁴ All of that helped the Sultanate to catch up with the rest of the Arab Gulf countries, that had already started developing modern health systems in the first half of the 20th century, and in terms of medical education and training it was even able to overcome some of them, as it started in the 1990s to be recognized and appreciated as a very good destination for medical studies by Gulf Arab students.

Interregionalization and challenges ahead

The quality of healthcare in Oman, despite some important achievements, cannot always meet modern standards. That is a fact both in regional and sub-regional (*muhafazat*) hospitals, and in the main national hospitals. According to some surveys, the rates of Omanis who would prefer to get treatment abroad is still high (around 43%). This trend is particularly evident when it comes to the treatment of non-communicable diseases, which needs to be founded on the high quality of research. At the same time a recent study notes that Oman together with the other GCC states, is “currently experiencing an increased demand for health care services due to an immense population growth, increasing life expectancy and higher incidence of non-communicable diseases”.²⁵

²⁴ Government of Bahrain, *Annual Report*, 1970, pp. 31-32. See also A.M. Rendel, “Rewarding and Hopeful Prospects after a Year of Historic Decision”, *The Times*, December 16, 1971.

²⁵ Cf. Francis Owtram, Annemarie Profanter, Elena Maestri, “In Oman, no security for the migrant health workers fighting the pandemic”, <https://www.opendemocracy.net/en/north-africa-west-asia/in-oman-no-security-for-the-migrant-health-workers/>, 23 July 2020.

The spread of COVID-19 showed that the efficiency of the PHS and its closeness to the population contributed to limit the effects of the pandemic, but the role of human resources in the local and national hospitals was re-confirmed as a critical issue by the pandemic and the services required when hospitalization was necessary, in particular because most infections regarded immigrants and mainly low skilled laborers. The role of immigrant workers in the health sector to meet the expanding needs was re-confirmed as more critical than ever in the health sector, as occurred in all the GCC states, including the ones more committed to workforce nationalization programs, like Oman, Saudi Arabia and Bahrain. In 2020, the government of Oman tried and used the pandemic to accelerate its Omanization programme and the number of immigrant workers in the Sultanate, where some decline was announced in June 2020: 1.9 million expatriates were registered in comparison with 2.1 million of three years before, but the numbers vary in the different governorates (*muhafazat*) (see Figure 2). The health crisis spurred authorities to push for further decline, but at the same time the need for medical staff was a fact, which shed new light both on immigrant workers safety and relations with their origin country. Despite a surge in COVID -19 cases in summer, with 70,000 cases and over 330 deaths in the month of July, the curve of the infection rate soon declined in the following months.

Figure 2 – Health governorates and national/immigrant population distribution rates

Governorate	Total Population	% Immigrants
Muscat	1,421,409	61%
Dhofar	452,194	51%
Musandam	45,401	34%
Al-Buraymi	115,658	50%
Al-Dakhliyah	485,323	25%
Al-Batinah North	782,507	34%
Al-Batinah South	437,818	28%
Al-Sharqiyah South	320,788	33%
Al-Sharqiyah North	284,064	35%
Al-Dhahirah	223,388	28%
Al-Wusta	49,379	49%
Total	4,617,927	43%

Source: elaborated by the Author on 2018 estimates of Oman's National Centre for Statistics and Information.

The extension of free testing and treatment both to nationals and to regular immigrants was a decision taken in line with the rest of the GCC States, and that is another factor contributing to the encouraging results in limiting the effects of the pandemic in the whole area, but all of that did not prevent a deep sense of insecurity from spreading among the immigrant population, above all the Indian community, and its health sectors professionals in Oman, which probably contributed to place the country last in the region (see Figure 3).

Figure 3 - Ranked comparison of the average performance over time of GCC countries in managing the COVID-19 pandemic in the 36 weeks following their hundredth confirmed case of the virus on a total of 98 countries

Rank	Country	Average
35	UAE	57.5
44	Bahrain	50.2
50	Qatar	47.1
64	Saudi Arabia	38.5
80	Kuwait	28.9
91	Oman	20.3

Source: elaborated by the Author on estimates of Lowy Institute, www.lowyinstitute.org.

The politics of citizen versus migrant labour is founded on the *kafala* (sponsorship) system in Oman, and that is a feature shared with all the GCC States, where migration flows are mainly governed by the requirement that either institutions or citizens sponsor migrants. The Omani administrative complex regulating migration issues is an integral part of the regional political landscape,²⁶ and it shaped the political decisions related to the pandemic containment as well, through the application of the “deportation mechanism”. A number of migrant workers, mainly Bangladeshi, Indian, Pakistani and Philippine citizens, convicted of violating the rules against the spread of the coronavirus, like mass gatherings, failing to wear a mask and bans on movement, were deported from Oman, after their names and photos were showed in the local press. That was only the peak of the iceberg of greater insecurity suffered by the tens of thousands of low skilled labourers in the region,

²⁶ See Omar Hesham AlShehabi (2019): Policing labour in empire: the modern origins of the Kafala sponsorship system in the Gulf Arab States, *British Journal of Middle Eastern Studies*, p. 19.

where they live in overcrowded buildings and camps.²⁷ The promotion of preventive measures in such contexts simply did not exist and the most followed practice shared by Oman in the region was either to repatriate them or deport them in case of violation of the rules established by Oman's Supreme Committee, which was instituted by Sultan Haitham in 2020 with the specific aim to fight the pandemic. If, on the one hand, origin countries could plan some return flights, it was not easy for their citizens regularly working in the Gulf to take the decision to lose their job. Most of them did not accept to leave, if their employer had not sacked them, as a consequence of the negative economic effects of the pandemic on the local economy; some of them continued to reside in the host country in an irregular status, which enhanced the number of irregular migrants, who were obviously much more vulnerable to the COVID-19 health threat, and started even being feared by the population as "the ones who spread the virus". At the same time, those infected people among nationals, who were hospitalised, realised that they owed a lot for their treatment to the immigrant qualified foreign nurses and doctors, who, in Oman, are mainly from India.²⁸

A few words are worth as far as India's involvement in the Omani health sector is concerned. "Indian migration to Oman...points to a confluence of various economic, political, social and cultural interactions, resulting in a process of 'virtual' inter-regionalisation".²⁹ Such "inter-regionalisation"

²⁷ Ramadan Al Sherbini, "Oman expats face deportation over COVID-19 violations", *Gulf News*, 4 December 2020.

²⁸ This fact emerged in the author's conversation with some GCC nationals in November 2020.

²⁹ Samir Pradhan, *Oman-India Relations: Exploring the Long-Term Migration Dynamics*, in Steffen Wippel (Ed.), *Regionalising Oman*, Springer, New York, 2013, p. 126.

has been shaping the Omani health sector in a relevant way in a double direction. Indians in medical and paramedical professions are present in great numbers and above all nurses, which created tension between these workers and Omani authorities in 2020, when the Indian press emphasised that “frontline workers Indians face the highest risk from the [Corona]virus”³⁰, but the involvement of India in this inter-regionalisation of the Omani healthcare sector is also relevant as one of the main destinations of Omani patients abroad. Therapeutic journeys are a habit that Omani citizens largely share with other GCC citizens affected either by hereditary (often related with the endogamy tribal practice and with non-communicable diseases). This health care habit strengthened relations with the Indian hospitals and private clinics, and it created new relations with hospitals in other Asian countries as well, like Pakistan, Thailand and China, as well as with East Africa and, last but not least, Europe. This is a practice attesting that, despite the rapid development of a modern healthcare system, Omani citizens still look abroad for treatments that are either unavailable in their country or of lesser quality. Seeking treatment abroad can be either a personal decision or an initiative recommended and sponsored by the Ministry of Health. All of that points out that there are still many challenges ahead as regards national human resources training as doctors and medical staff, although expanding “health connections” are useful to train Omanis in some excellent hospitals and laboratories in countries like the UK and France.³¹

³⁰ The Hindu, *Indian health workers on edge in Oman*, 18.06.20.

³¹ Claire Beaudevin, *Of Red Cells, Translocality and Origins: Inherited Blood Disorders in Oman*, in Steffen Wippel (Ed.), *Regionalising Oman*, op.cit., pp. 99-100.

Omanization programs and specific initiatives to involve more nationals in post-graduate medical training and care specialisation programs are still too limited. The excessive reliance on immigrants in the health sector will not change soon in the whole Arab Gulf region, where migration and citizenship policies neither favour naturalisation of immigrants nor their integration on a social and cultural level. If the numbers of immigrant workers range from 30-80 percent of the total resident population within each GCC state, the effective number of nurses and doctors is composed of immigrants in rates which do not seem to be less than 50 percent, even in those countries that reached comparatively high rates in workforce nationalisation, like Oman, Bahrain and Saudi Arabia. As far as Oman is concerned, some estimates seem to attest interesting progress, but human resources nationalisation in the health sector highly depend on policies aimed at enhancing the quality of medical education and graduate and postgraduate training, at establishing and upgrading hospitals as teaching hospitals, and at providing of course qualified teachers and trainers (see figure 4).

Figure 4 – Some percentages of national healthcare staff in 2019

	2019
Physicians	29%
Dentists	20%
Laboratory technicians	50%
Radiographers and physiotherapists	53%
Pharmacists	27%
Nurses	54%

Source: elaborated by the Author on estimates of the Oman's Ministry of Health, Annual Health Report 2019, p. 63.

In 2018/2019, the total number of students enrolled in Oman College of Health Sciences reached 656 (175 Male and 481 Female, out of these 482 were nursing students³², but the most recent statistics on healthcare staff in the country seem to suggest that the rates of foreigners employed in the sector are

still very high and estimates are not so accurate if we consider their distribution both in the public and the private sector. Nursing in the public sector is emerging as an “appropriate field” for Omanis as well, but the process is much slower than in other fields, since this profession is mainly perceived as feminized one, involving work with both female and male patients: all of that certainly represents a challenge to the local mentality and to the gender norms of a conservative society. Wider recognition of skills and expertise of immigrant nurses has been helping this category to be more “protected” than others in a way. Constant transnational interaction of a series of state and non-state actors of sending and receiving states as far as nursing is concerned is a well-established fact. It has been helping to limit among migrant nurses that “sense of insecurity” which, nonetheless, seemed to be stronger in the private sector rather than in the public one in the past.³³

Healthcare improvement in Oman will continue to depend highly from regionalisation and interregionalisation in this century, in particular for tertiary healthcare. The need to work for a “strong, responsive and sustainable primary health care (PHC) system” in the country is re-

³² Oman’s Ministry of Health Report, 2018.

³³ Chrystal A. Ennis - Margaret Walton-Roberts, “Labour market regulation as global social policy: The case of nursing labour markets in Oman”, *Global Social Policy*, 2018, Vol. 18(2) 169–188.

confirmed, being considered the backbone of healthcare. That is even more important as it seems to have contributed effectively to contain the COVID-19 pandemic, under the umbrella of the governorates' health authorities empowered to detect, investigate and react to the public health emergencies, according to the national policy, with a system decentralised since 2005.³⁴

Ensuring sufficient investments in PHS is a priority for the future. Healthcare, Islamic humanism and Islamic investments have been developing new interesting links in the Omani environment: the setting up of a Health Endowment Fund (HEF) by Sheikh Abdullah bin Mohammed al-Salmi, Minister of Awqaf and Religious Affairs of the Sultanate is an interesting initiative in this direction. This Endowment Fund for Enhancing Health Services adheres to Sharia code provisions, laws and systems on regulating endowment funds. Its funds constitute revenues to be invested in enhancing activities and programmes of health services in the Sultanate and the whole process is established under direct supervision and monitoring of the Ministry of Awqaf and Religious Affairs, which will audit the fund's tasks. The goals of the HEF include solidarity and social collaboration, reactivation of the developmental role of the Islamic institution of *Waqf* (pl. *Awqaf*, endowments) in healthcare and services, attraction of donations (grants and wills dedicated to health services), regulation and investment of them to finance medical treatment, set up health establishments, procure medicines and provide medical equipment. The same *Waqf* is also aimed to support medical research,

³⁴ Oman's Ministry of Health, Annual Health Report 2019, pp. 36-37.

within a sustainability approach and according to the Sharia rules on *awqaf*. The Minister of Health, Dr. Ahmed bin Mohammed al-Sa'eedi was appointed as Chairman of the HEF, which is allowed to seek the assistance of anyone who might contribute to its tasks with his/her expertise.³⁵ Social Solidarity and an Islamic economic approach to healthcare improvement go hand in hand in this interesting initiative, which seems to open new perspectives.

CONCLUSION

Against this backdrop, one can argue that a more coherent and constructive development of the healthcare in Oman is to be founded on a renewed and more inclusive approach, in which both nationals and immigrants will continue to play a role in the medium term.

Further improvement of the educational system, according to the country's Islamic and cultural values, and in the light of the positive historical achievements of Sultan Qaboos' era in this domain is crucial. Promoting a wider synergic approach with the other Arab Gulf States and selected foreign partners having achieved high quality healthcare is another step forward to be taken, in order to develop truly integrated health systems, more able to tackle health emergency crisis at the global level within a framework inspired both to cooperation and transparency. New scientific educational opportunities related with healthcare for national students,

³⁵ Oman News, "Awqaf Minister's Decision Sets Up Health Endowment Fund", 24.03.2020, <https://omannews.gov.om/NewsDescription/ArtMID/392/ArticleID/10675/Awqaf-Ministers-Decision-Sets-Up-Health-Endowment-Fund>, accessed online on 20 June 2020.

including in rural areas and across genders, and above all the quality of educational institutions focused on scientific and medical fields demand further institutional support. Enhanced scientific education quality can effectively contribute to in-house research and training in the health field, which was largely neglected in the last fifty years in Oman and the GCC. Strengthening regional and international networks within the healthcare domain also means for Oman, its neighbours and international partners, creating a new framework able to review the philosophy of the 1990 UN Migrant Worker Convention. Ensuring protection of any type of migrant cannot set aside the need to address the issue of migrants' healthcare in times of health emergency with a renewed coordinated humanitarian approach.³⁶

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³⁶ Ahmet İşduygu, "Stranded irregular migrant workers during the COVID-19 crisis: The question of repatriation", IOM UN Migration, August 2020.

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