

NEGOTIATING CULTURE AND CARE: CHALLENGES AND OPPORTUNITIES IN  
MENTAL HEALTH AND REPRODUCTIVE HEALTH CARE  
IN THE SULTANATE OF OMAN

by

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## THESIS ABSTRACT

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Title: Negotiating Culture and Care: Challenges and Opportunities in Mental Health and Reproductive Health Care in the Sultanate of Oman

The Sultanate of Oman's health system has developed rapidly since 1970, with the discovery of oil as well as the strong central government of Sultan Qaboos bin Said. However, despite its investment and dedication to improving the health care available to its citizens, Oman has just begun to address concerns linked to cultural beliefs and social perceptions, including mental health and reproductive health. This study examines how the government has addressed mental and reproductive health, the realities on the ground, and the ways in which cultural perceptions and recent social change influence these health challenges. This study is based on semi-structured interviews with Omani health professionals that have been used to identify hurdles as well as opportunities that exist to strengthen the quality of care in these newly emerging fields in the Omani public health system.

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## CHAPTER I

### INTRODUCTION

*“It is health that is real wealth and not pieces of gold and silver.”*

–Mahatma Gandhi

The revolutions, demonstrations and conflicts that have emerged out of what has been broadly termed the Arab Spring have drawn extensive examination of the various, political, social, economic and historical phenomena which have contributed to these popular movements. Less attention has been paid, however, to the rapid change that many Gulf states are currently experiencing as a result of various external as well as internal forces, and the significant social transformations occurring within these societies.

The Sultanate of Oman provides a particularly remarkable example of such rapid social transformation, which it has experienced due to its economic growth, social and political policies implemented since the 1970s as well as reactions and responses to globalization. Reconciling the demands of becoming a modern state and global player with concerns over perceived threats to Omani cultural and religious tradition is a constantly evolving and often experimental process that continues to be negotiated on a national as well as local and individual level. The Omani government has increasingly been forced to grapple with how to interact and at times limit the impact of global and economic influences, as these forces threaten to significantly alter the lifestyle of its citizens as well as conceptions of Omani identity. Despite the dramatic changes that have occurred in Omani society within a period of roughly fifty years, these trends have gone largely unexplored in academic research. This is especially true in regard to the development of the health care system and current perceptions and approaches to health

concerns. Advancing the health care system in order to align with international ideals of what constitutes modern standards without compromising social and cultural values is an increasingly relevant question in Oman that must be addressed as the state continues to develop its public health infrastructure.

### **Observations of Social Change, Development, and Culture in Muscat from the Field**

One reason Oman that I chose to focus my research on Oman, and Muscat as the epicenter of the change occurring there, is due to the unique circumstances within the country in conjunction with the country's seemingly balanced approach to development. Policy makers as well as Omanis themselves seem to gracefully maneuver advocating for respect of social values and traditions with their continued development as a high-income country in the Gulf. The ways in which these issues are being addressed both nationally and in the social sphere is quite extraordinary and complex.

There has been some expression of social dissatisfaction in Oman in recent years following the Arab Spring, including peaceful marches and sit-ins as well as some more contentious protests in the northern city of Sohar.<sup>1</sup> Most of these demonstrations were related to concerns over issues such as corruption, unemployment, wages, representation in government, and work opportunities. Unlike some of Oman's neighbors, however, there have not been widespread calls for a regime change in Oman, as there is still a pervasive sense of respect for Sultan Qaboos bin Said, the leader who has managed to create such significant change for his people in the time span of just one generation. With the government's investment in education, health, infrastructure and access to technology, the changes in quality of life for Omanis have been substantial. Many of the

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<sup>1</sup> As covered in the BBC News article (Nicoll 2011).

Omani participants who I interviewed expressed to me that although we were often focused on discussing shortfalls in the health system, that they were very proud of their country and the developments that have been made over the past half-century, and that they are optimistic about the progress that will occur in the years to come. Even taxi drivers, who are all Omani citizens as a result of recent Omanization policies to reserve certain jobs for Omani citizens, would often show off the city with pride, and spoke about their appreciation for the Sultan's dedication to improving the country and its infrastructure.

For most of my time in Oman, Sultan Qaboos was not in the country, as he had been receiving medical treatment in Germany for the past eight months.<sup>2</sup> His return, several days before I left Oman, was celebrated in the street, and met with an outpouring of Omani pride. People gathered around televisions in all of the outdoor cafes to watch the Sultan descending the steps from his plane. Omanis covered their cars with flags, and gathered to march in the streets in the heart of Muscat to celebrate the homecoming and wish the Sultan continued health and the ability to continue to lead the country in prosperity. The newspaper the following day was filled only with full-page ads taken out by local businesses wishing the Sultan future good health and welcoming him home. Oman has undoubtedly experienced considerable progress in terms of social development throughout the country. However, opening up to innovation and reinvigorating the economy for a future post-oil period while maintaining respect for tradition may prove a difficult challenge, as other Gulf countries have discovered. The government is currently trying to bolster tourism (its investment in the "Beauty has an Address" campaign and

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<sup>2</sup> As covered by Al Jazeera (2015) in "Oman's Sultan returns after undergoing treatment abroad."

easing visa restrictions include some of the attempts to encourage this) as well as its growing medical tourism industry, but Muscat is not yet overwhelmed with tourists. Issues that may arise with increased reliance on tourism have therefore not been fully addressed. Access to alcohol in Oman is largely limited to a number of hotels targeting Western tourists. The government has recently contemplated plans to ban alcohol as well as public smoking of shisha, but has had to consider the ramifications for tourism.<sup>3</sup> There are also standards of dress and conduct to regulate behavior in Oman—including rules about being openly rude and dressing inappropriately—in order to try to maintain certain standards of decency and respect for the customs. Including Muscat as a stop in cruise ship routes may present a challenge to these rules.

The magnitude of the changes that have occurred in Omani society in such a short period of short time are apparent in many aspects of daily life. Everyone has a smartphone, for example. Even some of the much older taxi drivers I met were utilizing Whatsapp and smart phone technology to communicate with their families as well as customers who would message or call them for rides. Unfortunately, many drivers often use Whatsapp and their phones while speeding on the freeway, which may contribute to Oman having the highest car accident death rate of all the GCC countries.<sup>4</sup> This issue has presented a new challenge for the Omani government and has sparked a campaign to try to encourage drivers not to use their phones while they drive.

Development and modernization have greatly impacted the life and landscape of Muscat. However, the government has tried to prevent uncontrolled development. All

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<sup>3</sup> For more information see Times of Oman articles by Reijimon K (2014) and Al Ghadani (2014).

<sup>4</sup> According to the WHO—see more information in the Muscat Daily article “Oman has Highest Road Accident Death Rate in GCC: WHO Report” (2013).

buildings in Oman have to stay within an acceptable range that fit the traditional landscape—either white or tan in color and no taller than eight stories in height. The capital is therefore not dominated by garish structures or skyscrapers which could detract from the beauty of the white houses and shops which sit in contrast to the unique natural landscape of the rocky mountains in the distance, pristine beaches, and the green date producing palm trees which thrive in Oman.

In their attempts to explain Omani society, several of the participants I spoke with said that they view Oman as a more open-minded society compared to their neighbor Saudi Arabia, but articulated that it is also a similarly more traditional society in a sense, as Omanis have maintained a dedication to culture, tradition and family. Even in Muscat, you rarely see Omani men or women out of traditional dress. For women this means ornately decorated black abiyas and colorful hijab, and for men long, white (or occasionally gray or blue) dishdasha and decorative Omani caps (kumma). Omani hospitality and dedication to family and community was also very evident in all of my conversations, which were often over Omani cardamom-seasoned coffee (or sometimes Nescafe) and Omani dates.

Over the approximately three and a half months I spent in Oman (one trip in 2013 and my second in 2015), I witnessed many attempts by the state to emphasize and celebrate Omani history and culture. I was fortunate to be able to attend an Omani cultural festival in February of 2015, which is held annually in Muscat in several of Oman's large, beautiful public gardens. The festival was an interesting mix of an amusement park atmosphere for children (including huge, moving model dinosaurs, games, and amusement park rides) but also included events which celebrated Omani

culture—including performances by Omani dancers and singers, artwork depicting Omani cultural heritage, handcrafted gifts, and a traditional market. A Ministry of Health tent, where those attending the festival could learn more about health concerns in Oman, was also included in the festival. There are also a number of museums throughout Muscat dedicated to its history—including its political history and an extensive collection of artifacts, including a display of how dress in Oman has evolved throughout the years, beautiful historical coffee pots, as well as elaborate jewelry and khanjars (decorative daggers) from the region.

In health, as in many aspects of life in Oman, merging development goals with social and cultural values is obviously an evolving process. The role of family and community, faith, and tradition all continue to play an important role in people's lives, but in some ways previously dominant structures are changing due to social shifts within the country. Increased access to higher education, job opportunities in the capital, and international influences, have inevitably had an impact on Omani society. A shift towards more nuclear family structures, access to more information and influences online, advancements in health care and other social changes resulting from Oman's development are effecting how health is approached and perceived in Oman. However, it was very evident from the beginning of my time in the field that both physicians and patients continue to find that Omani traditions and values shape how Omani's utilize and perceive care. I also found that as in other aspects of its development plan, the government is not embracing dramatic development in the health system without taking these factors into consideration. Therefore, I was very interested to explore how culture as well as social change are impacting health care challenges, and how the government is



addressing, or perhaps failing to take into account, factors which critically shape the health care needs of the population.

### **Questions Addressed in This Study**

In this study, I examine several main components in order to analyze the state of mental and reproductive health in Oman. The first involves how the government is currently tackling issues related to mental health and reproductive health—including how this looks on the primary care level when a patient initially comes in with a mental health or reproductive health issue, how patients are referred, and what resources are available to them. I also aimed to examine the government’s future goals in developing the fields of mental and reproductive health, and how these goals aligned with my interviewees’ perceptions of issues on the ground. To understand these challenges on the ground, I wanted to discover what health specialists perceive as the primary hurdles to addressing issues in both fields, and what they believe prevents patients from receiving adequate and quality care; in terms of resource and infrastructural limitations as well as any other social hurdles.

My second aim was to understand how culture and social factors shape care in these areas, including how mental and reproductive health are perceived and addressed in Omani society as well as in terms of determining how patients receive care and their ability to access and receive quality care. I wanted explore how physicians and health professionals take culture into account, how they see this come up in their practices, and how they perceive the role that culture and social perception play in health.

### **Research Questions**

- How is the current system addressing mental health and reproductive health

concerns?

- What are the primary hurdles to addressing health in these areas in Oman?
- How does culture and social change effect health approaches and patient perceptions in mental and reproductive health?
- Where are the gaps in the government's approach and goals for the future and the realities on the ground to addressing care in these areas?

### **Significance of the Study**

While Omani society is significantly understudied compared to other nations in the region, there has been a moderate amount of research related to the social change that Oman has experienced over the last 50 years and what this means in terms of the future structure of government in the country. The history of the Imamate tradition, democratic elements of the current government, as well as the state's future democratic potential are some of the most widely explored topics. The work of Nikolaus Siegfried and that of Jeremy Jones and Nicholas Ridout present contrasting arguments concerning the significance of recent democratic advancements made in Oman (Siegfried, 2000, p. 375; Jones & Ridout 2002, 2012). Scholars such as Hussein Ghubash have also analyzed the unique Ibadi Imamate tradition in Oman, covering the period from the beginning of the Imamate and the Kharijite movement, to the disintegration of the Imamate (Ghubash, 2006). Noted scholar in the study of Oman's history John Craven Wilkinson in his 1987 work *The Imamate Tradition of Oman* similarly examines the development and influence of the Imamate on Omani society until it was overpowered by the Sultanate and ultimately driven out in the 1950s (Wilkinson, 1987). Some attention has also been given on the impact of social change on women's roles and empowerment (Eickelman, 1993;

Al-Riyami, Afifi & Mabry, 2004; Al-Barwani & Albeely, 2007). Limited research has been conducted, however, in regard to the transformation of Oman's health system or challenges that still exist in terms of expanding health care in Oman. Now that communicable disease has largely been addressed throughout the country, the government is attempting to better incorporate health issues that are more closely linked to culture and lifestyle into its health development plan. As changes in the health system have occurred so rapidly, there isn't much information about current practices or realities on the ground. Especially in regard to how culture and social perspectives are shaping or influencing health, studies are considerably lacking in the case of Oman.

By interviewing healthcare professionals and scholars who address these concerns on a daily basis, as well analyzing Oman's *Health Vision 2050* report, I explore how the Ministry of Health has expanded in these areas, what factors may provide obstacles to improving quality of care, and the part that culture and social change has played in terms of shaping care in these areas. The study focuses on mental health and reproductive health specifically. These are two areas in which the Ministry of Health has expressed dedication to expanding care, and they are both closely tied to culture and social perception. There are also important intersections between these two fields, including maternal mental health concerns. Therefore, I explore these issues separately but also examine how they are interconnected in regard to maternal mental health.

This study analyzes the current state of mental health and reproductive health in Oman as well as conceptions related to health concerns in these areas. By approaching this from neither a strictly clinical nor ethnographic approach but incorporating both

cultural and clinical perspectives and concerns in this study, I attempt to achieve a more comprehensive look at these issues.

This study emphasizes the significant role that culture and local beliefs play in shaping how health is conceived and treated, as emphasized in anthropological approaches in health. However, it also aims to examine the challenges and opportunities involved in translating these elements into a health system in the context of Oman's rapid development and focus of balancing global and local influences. The Sultanate of Oman's balanced approach to development and the challenges and opportunities that exist within the current context, could provide a model for other countries within the region. Despite the hurdles that still exist in terms of the country's overall development, the significant strides that have occurred should be highlighted.

### **Thesis Overview**

The purpose of the first chapter is to provide an overview of the focus and intent of this study. Chapter I concludes with a brief overview of relevant background on the social, economic and political contexts in Oman. Chapter II explores relevant academic literature in order to frame current discourse surrounding these health issues and their implications for this study. Chapter III examines the development of the health system in Oman, including Oman's health development goals as articulated in the *Health Vision 2050* report. It also provides an overview of relevant research related to mental and reproductive health conducted in Oman. Chapter IV analyzes reoccurring themes from the 15 interviews I conducted with health professionals as well participant observations in the field. Chapter V concludes with recommendations for future action that emerged out of the exploration of these themes.

## **Methodology**

In this study, I conducted 15 semi-structured interviews with health professionals in Oman. The majority of my participants were medical practitioners in addition holding a position at Sultan Qaboos University, and therefore were able to provide unique perspectives as scholars and health professionals. Having trained and educated students, conducted studies of their own in their relevant fields, in addition to regularly treating and interacting with patients, I found that they had great insight and valuable perspectives as a result of holding these various positions. I also analyzed reports from Oman's Ministry of Health to better understand the future health goals and approaches of the government. My participant observations in Oman, including my visit to Al Masarra hospital, also provided a useful source of information. I then analyzed the content of the interviews and my observations in order to find common themes that emerged regarding the current state and trends in mental and reproductive health in Oman.

I recruited my participants primarily by searching through reports and articles to identify current medical practitioners as well as other health professionals conducting research in reproductive health or mental health in Oman. Looking at recent research, conferences, as well as clinic, hospital, and University staff information online, I sent preliminary emails explaining my study and inviting all of those who qualified as health professionals in both fields to participate. After potential participants expressed interest in becoming involved in the study, I then contacted them over the phone to explain the interview process and set up an interview appointment. Several participants also recommended other professionals that I could contact and offered advice on how best to reach them.

The length of the interviews ranged from forty-five minutes to over two hours, depending on the availability of the participants. However, the average time was approximately an hour. I also spent time outside of the interviews with several of the participants, where we had more informal discussions about health issues and Omani society in general. The format of the interviews was semi-structured. I had a set of twelve to fifteen interview questions prepared to ask each participant (see the Appendix A: Interview Questions for the set of questions the participants were typically asked), but then adapted my questions depending on their answers, what they wished to discuss, and their time constraints. I also let participants know that as these were somewhat sensitive topics, they could choose not to answer any questions they felt uncomfortable speaking about or offering a professional opinion on. All participants in the study chose to remain anonymous, and were given a pseudonym.

### **Participants in the Study**

My participants provided a more diverse sample than I initially expected. I was concerned at the beginning of my research about the number of reproductive health participants who would elect to take part in the study, as in the beginning more mental health professionals contacted me to participate and fewer specialists in reproductive health seemed willing to participate. This may partially have been effected by the fact that the vast majority of reproductive health professionals in Oman are women, while the majority of mental health professionals in Oman are men. However, this soon balanced out reasonably well, as I ended up interviewing six reproductive health specialists and nine mental health specialists. “Appendix B: Study Participants” outlines some basic background information about the participants of this study. Details about their positions

are withheld for the sake of maintaining their anonymity. I also found that originally Omani physicians expressed more interest in participating, but this also shifted as time went on, and expatriates from various countries in the Middle East as well as South Asia contacted me to take part. All participants had worked in Oman for at least two or more years. The majority had lived in Oman for more than five, and nine had spent the majority of their lives in Oman.

The nine participants whom I categorized as Omani citizens were all of Arab descent and identified as Muslim. All of these participants had received their medical training in English speaking countries (typically in the United States, Canada, the UK, or Australia). The five participants whom I categorized as “expatriates from region” were from various Muslim majority Middle Eastern states, including Jordan and Iraq. Most of these participants had plans to remain in Oman for at least the next several years. Many expressed in various ways in their interviews that they shared or understood many of the values and perspectives of Omanis since they had been raised in a country with similar cultural and religious beliefs. While they sometimes contrasted their experiences in their country of origin with the situation in Oman, they often still identified with many aspects of Omani society. The three expatriates not from the region of the Middle East were of Indian origin and had received their professional training in India. None of these participants identified as Muslim, with Omani culture, or as Omani. However, one of my expatriate participants had worked in Omani for over 20 years on various Ministry of Health campaigns, and another had spent most of her childhood and adult life in Oman (although she received her degree outside of Oman). However, none of these participants

identified as Omanis, and they often alluded to the fact that their background and views differed from that of most Omani citizens.

I was also able to visit Al Masarra Psychiatric Hospital (located about an hour outside of Muscat) while I was in Oman. While I was not permitted to conduct any official interviews at the hospital, I was able to tour all of the facilities and speak with the unit supervisors in every section of the hospital (including the men and women's acute wards, the drug and alcohol rehabilitation ward and the forensic ward).

### **Study Limitations**

There were several factors that provided limitations for this study. First, all of my interviews were conducted in Muscat with physicians and health professionals who work in the capital. While this was convenient and useful, as many of the larger health facilities and the University are located there, I did not get to experience or speak to professionals about issues which may be unique to the periphery of Oman. However, I did discuss some of the issues that exist outside of the capital with my interviewees who often had some awareness of the situation there and could still speak to the issues. Several also had experience working in the periphery of Oman. Because this study was limited to professionals in the capital, however, it should not be considered representative of the status of health care throughout all of Oman.

While I have studied Arabic for four years, I chose to conduct the interviews in English. All of the participants received their degrees in English speaking countries and use English on a regular basis in their professional settings. Therefore, I decided that communicating in English would be more realistic than attempting to conduct the interviews in Arabic. I was prepared to conduct interviews in Arabic if participants



preferred this, but they were all comfortable communicating in English. I recognize that conducting interviews in participants' second language affects their ability to communicate their ideas as they would in their first language. However, my knowledge of Arabic and previous exposure to Omani culture helped me to understand the Arabic phrases and cultural nuances incorporated into the interviews.

### **The Social, Political and Economic Landscape in Oman**

The Sultanate of Oman, resting at the southeastern corner of the Arabian Peninsula, borders the United Arab Emirates, Saudi Arabia and Yemen. Oman has a small population, at 3.6 million, but it is scattered over great distances. The terrain in Oman can be difficult to maneuver, with mountainous areas as well as barren valleys. Most of Oman's population is concentrated in the North of the country, in and around Muscat, the country's capital city. Approximately 32 percent of Oman's population lives in the Muscat governance around the capital city, while 25 percent lives in the neighboring Al Batinah district. Oman has a very large expatriate population living in the country; about 42.2 percent of the current population is expatriates or non-nationals (Sultanate of Oman, 2014, p. 20).

Oman is a majority Ibadi Muslim country (officially 75 percent of the population, but the actual number may be closer to 45-60 percent) and also has Sunni and Shia minorities (Central Intelligence Agency, 2013). Oman is one of the few areas of the world in which Ibadi Islam has a significant following, and this continues to be perpetuated as an important distinguishing aspect of the state's identity and historical narratives.

### ***Political Situation***

Oman is officially an Islamic Sultanate. It has been ruled by the same family, various descendants of the Busaidi dynasty, since 1754 (Hoffman, 2004, p. 202). After staging a coup against his father in 1970, Sultan Qaboos bin Said became the 14<sup>th</sup> Sultan from the Al Busaid dynasty. Criticizing his father's severe and isolationist rule, Sultan Qaboos came to power with a vow to create a modern government, open Oman to cooperation with foreign governments, and improve the overall quality of life for the country's citizens. The period under his governance is referred to in Oman as "the Great Renaissance," as it has transformed Omani society considerably (Peterson, 2004, p. 124).

Oman is an absolute monarchy; Sultan Qaboos has ruled the country for over forty years. While the government has recently attempted to incorporate some democratic aspects into its political system, the significance of these shifts has been debated in terms of how much of an impact they have actually had on governance in Oman.

Nikolaus Siegfried (2000) has argued that the 1996 Basic Law, which was enacted with the introduction of Oman's first constitution, is largely symbolic, as it is primarily concerned with meeting International standards in terms of commercial, banking and corporate interests. In terms of Sharia law, he notes that its role has been largely minimized to the domain of personal status law, as a separate court has been created to deal with commercial disputes and penal cases. He also analyzes the role of Oman's Shura council—concluding that although it is minimally elected, and enjoys freedom of speech within its meetings, its role is more that of a monitor of public opinion than an actual representative governmental body. The limited scope of the Omani council—while it provides a venue for citizens to exchange views with the government, does not have the power to draft laws. Siegfried also notes the emergence of a "sacralized legitimacy" of

the Sultan in the constitution—as he is the only legitimate interpreter of Sharia law (Siegfried, 2000, p. 375). Siegfried ultimately concludes that the constitution is largely a move to appear internationalized—civil rights, and the public sphere are still restricted and the changes have not helped to develop the public sphere in Oman (p. 379).

Other scholars have argued, however, that Oman is currently in a state of transition, and has successfully incorporated aspects of representative governance into its political system. However, it has attempted to develop a model which will work best for the specific circumstances in Omani society. Jeremy Jones and Nicholas Ridout (2007, 2012) argue that these democratic aspects of Omani governance should not be compared to that of the West. While scholars in the study of the Middle East acknowledge that there is no “one-size fits all” approach to democracy in the region, aspects of the Omani system are still often compared to a Western system rather than being examined in its own right and in relation to its own specific societal and historical context. They argue that Oman is in an experimental phase—as it has continued to develop and define the roles of institutions such as the majlis al-dawla and majlis al-shura and other governmental bodies in order to determine what will best meet the needs of Omani society (Jones & Ridout 2007:376). Omani society will continue to evolve based on the specific political ecologies of the country, and should not be analyzed in terms of Western conceptions of democratic governance.

As previously mentioned, while Oman has experienced some peaceful protests and sit-ins calling for various governmental reforms, there were not calls for the Sultan to step down as in some other Arab states. Oman ultimately appears to fit into the rentier-state model of seeking “political quiescence in return for public services, subsidies,

public-sector jobs and light or no taxation” (Jupp, 2014). By providing significant welfare services to its citizens, the Omani government has been able to avoid any serious political instability or significant challenges to its authority.

### ***Economic and Social Development***

Oman experienced profound development in terms of infrastructure and social welfare in the 1970s largely due to the discovery of oil and the increased revenue that poured into the country as a result. Oman currently has 5.5 billion barrels of reserved oil, which makes it the 21st largest provider of oil worldwide, and the 7th largest provider in the Middle East. 95 percent of Oman’s oil exports go to Asia, and half of this is exported to China (US Energy Information, 2013).

Oman has experienced an unexpected increase in crude oil over the last few years due to advancements in oil recovery techniques. However, the Omani government has attempted to invest in alternative venues in order to diversify the economy, as it is not clear how much longer Oman’s oil reserves will last (US Energy Information, 2013). The government has also attempted to develop its natural gas, mining, tourism, and fisheries sectors (Al-Barwani & Albeely, 2007, p.125). However, Oman’s economy remains considerably oil-dependent. While Oman has identified tourism as a potential area of growth as it remains a “safe” place to visit in the Middle East, addressing some of the issues associated with an increase in the tourism industry (as Dubai has had to do) may pose significant new challenges to the Sultanate.

In terms of social welfare, despite starting with very little in terms of wealth and infrastructure compared to its Gulf counterparts who possess greater oil reserves (Oman and Bahrain are the poorer nations in the Gulf Cooperation Council), it has made as much

progress in forty years as many of the wealthier Gulf countries (Peterson, 2004, p.128). Before the 1970s Oman lacked most basic infrastructure including roads, primary schools, healthcare and electricity. However, the government has implemented social programs to address literacy, access to education, healthcare, childhood diseases, infant mortality and gender inequality (Al-Barwani & Albeely, 2007, p.124). Before 1970 there were only three schools for boys to serve all of Oman. Now primary education is nearly universal, half of all students are girls, and the literacy rate for men and women is 98 percent (World Health Organization, 2011). Women also currently make up 55 percent of the University population (Al-Barwani & Albeely, 2007, p. 127).

These advancements in the social programs available to Omanis have had a considerable impact on the daily lives of its citizens, and have in some ways challenged traditional discourses of power as well as common social practices. However it has also been widely recognized that the Omani government has attempted to balance cultural, religious, and traditional values with the demands of modernity.

## CHAPTER II

### LITERATURE REVIEW

#### **Perspectives on Culture and Health**

The notion that that culture and social context play an important role in shaping meanings attributed to illness, how notions of wellbeing are conceptualized, as well as how illnesses are approached and treated within a society has been illustrated by many scholars in medical anthropology, cross-cultural psychology, cultural anthropology, community psychology in addition to other fields. The need to incorporate local belief systems and cultural ideas into health care systems in order to ensure quality care that is appropriate to that society has been emphasized by many renowned scholars in anthropology and medicine, including Kleinman and Good (1985) Helman (1984) Airhihenbuwa (1995) and Good (1977). Others have also called for more focus on how clinical research and settings can be better integrated with culturally relevant perspectives and anthropological work to improve health systems (Napier et al., 2014; Kleinman & Good, 1985; Kral et al., 2010).

This study emphasizes the significant role that culture and local beliefs play in shaping how health is conceived and treated, as emphasized in anthropological approaches in health. However, it also aims to examine the challenges and opportunities involved in translating these elements into a health system in the context of Oman's rapid development and focus of balancing global and local influences.

One of the main guiding documents I use to frame the incorporation of social, cultural, and global factors into health approaches is the *Lancet Commission on Culture*

*and Health*. Published in 2014 as a collaboration of 27 professionals from various fields at University College London, including anthropologists, social scientists, and medical professionals, the *Lancet Commission on Culture and Health* outlines why culture and context should be incorporated into health systems, how this can be done, and why it presents a grave risk if these considerations are not taken into account in clinical settings—including in terms of financial cost, efficiency and for the quality of care available to all members of society. *The Lancet Commission on Culture and Health*, published out of University College London, is the first undertaking of its kind; its in-depth and multidisciplinary analysis of the direct implications of culture on health and its recommendations for incorporating these factors into care could have a significant impact on developing health systems and making health care approaches more culturally competent.

### **Health System Approaches: Incorporating Culture into Care**

*The Lancet Commission on Culture and Health*

In *the Lancet Commission on Culture and Health*, the authors argue that factors such as migrations, societal structures, disease patterns, and non-communicable and communicable disease prevalence all significantly impact how notions of wellbeing are perceived and negotiated (p. 1607). Culture, shaped by political, economic, and moral ideas, also determines how health is understood within societies. However, despite the role that culture plays in shaping ideas surrounding health, in clinical settings there is often an attempt to “standardize human nature” ignoring diversity and the contrasting ways that notions of wellbeing are conceived or the importance of context. There is often an assumption that clinical settings can address “patient needs and caregiver obligations

in universally understandable terms” (p. 1607). Emphasizing biological wellness at the expense of considering the influence that alternative measures of wellness and values in society have on notions of health may threaten to drive out consideration of these cultural factors in health systems altogether—despite the fact that they have a significant role in shaping wellness as well as impacting health outcomes and adherence to treatment for specific populations. The authors argue that, “the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide” (p. 1611). The commission therefore aims to bring attention to the necessity of implementing measures that help to better incorporate cultural perspectives into health systems.

Napier et al. (2014) argue that “failure to recognise the intersection of culture with other structural and societal factors creates and compounds poor health outcomes, multiplying financial, intellectual and humanitarian costs” (p. 1607). In the Lancet Commission, the authors aim to show how “inseparable health is from culturally affected perceptions of wellbeing” (p. 1608). They propose twelve principles that should be incorporated into practice to improve health care worldwide:

1. Medicine should accommodate the cultural construction of wellbeing
2. Culture should be better defined
3. Culture should not be neglected in health and health-care provision
4. Culture should become central to care practices
5. Clinical cultures should be reshaped
6. People who are not healthy should be re-capacitated within the culture of biomedicine
7. Agency should be better understood with respect to culture
8. Training cultures should be better understood
9. Competence should be reconsidered across all cultures and systems of care
10. Exported and imported practices and services should be aligned with local cultural meaning
11. Building of trust in health care should be prioritised as a cultural value



12. New models of wellbeing and care should be identified and nourished across cultures (p. 1608).

The cultures that exist within health care agencies themselves provide one hurdle to culturally competent care. The ways in which universities, hospitals, laboratories, and government agencies function are all greatly influenced by cultural assumptions, and these organizations also have unique cultures within themselves (p. 1611). However, they often don't realize how their moral frameworks and values shape their behaviors, and assume that their outlook is universal.

Furthermore, Napier et al. (2014) argue that in global health approaches, inequalities across societies are given priority over many other considerations. However, the authors argue that focusing on global inequality alone is a mistake, as it is necessary to understand cultural systems in order to address negative impacts as well as the positive potential that exists within a society to address health issues in a particular context. Focusing on worldwide equality at the expense of culture ignores the role that culture could play in bettering health outcomes, and ignores context-specific hurdles which significantly impact health. To deny local prejudices as well as local goals, and instead prioritizing the promotion of universalism in reality shows a cultural bias on the part of international organizations in thinking that these ideals can be promoted over local ones. They argue "It is important then, to understand how wellbeing is socioculturally generated and understood, and how cultural systems of value relate or not to notions of health and to systems of care and delivery" (p. 1611). Because wellbeing is not just biological but also hinges on social factors, considering sociocultural influences that impact people's health and happiness is important.

Recognizing the culture and values of patients as well as the culture of care that shapes how care is given, and identifying any gaps that can cause divides between them should be a primary aim in delivering care. In the *Lancet Commission on Culture and Health*, the authors look at cultural competence, health inequality, and communities of care. They argue that it is necessary to explore how to communicate across cultural divides, how culture impacts health inequality, how actions to address health in communities succeed or fail, and social aspects which can either negatively impact or positively affect wellbeing. To overlook these factors is to overlook the benefits of diversity, and the value of local knowledge and resources as well as different models of cooperation (p. 1610). They argue that “clinical competence should include cultural competence” (p. 1612).

The US health system has been increasingly marked by a reliance on laboratory tests over spending time going over personal medical history with patients, despite the fact that spending more times going over medical history has been shown to be more beneficial in terms of patient outcomes. Yet this emphasis on laboratory tests over reviewing medical history is being replicated in other settings around the world (p. 1613). Over-reliance on testing, even though it is not cost effective and doesn't have the best long-term outcomes for patients is a bias of the system in the United States is perhaps due to the influence of capitalism and the emphasis on technology that has come to dominate the American system.

Cultural competence is often vaguely understood as a need for cultural sensitivity training. However, Napier et al. (2014) argue that this can contribute to developing assumptions that certain ethnic groups are less successful in responding to clinical

treatment or tend to perpetuate certain ideas about how certain groups perceive and react to medicine. Cultural stereotypes or pre-conceived associations can sometimes be perpetuated in cultural sensitivity training. The significant role that language plays—both in terms of translation as well as beliefs, attitudes and ideas surrounding aspects of health care as well as agency—is also often neglected (p. 1614). Improving cultural competence should involve improving the understanding of both patient and caregivers’ ideas surrounding wellbeing and illness. Making sure there is mutual understanding—and that there are not assumptions being made about mutual understanding—is necessary. This helps to bridge the gap in differing perspectives on illness between the patient and care giver. Allowing time to create mutual understanding and discovering meaning helps to cut expenses as well as improve care by identifying barriers to care for patients. Using social capital and working to understand the realities of patients’ lives to set shared goals is much more effective. Improving cultural competence includes developing mutual respect, acknowledging differences in patient needs, and also recognizing prejudices and assumptions of the medical perspective. This should not be a secondary concern, but an essential part of training and education.

The authors also argue that taking into account the role that oppression, disenfranchisement, structural violence and social determinants of disease into consideration is also important. Education about agency, the structures within society that either advance or limit wellbeing, and examining the ways in which those who are disenfranchised in society are disempowered, should be introduced (p. 1624). Cultural systems and values that impact inequality can cause care givers to unknowingly partake in practices that are discriminatory. Without awareness of these issues, they may also

contribute to ignoring the voices' of the disenfranchised and not recognizing how they are often left out and underrepresented.

Napier et al. (2014) also advocate for increasing community care resources. In the 20<sup>th</sup> century, with the increasing spread of medicalization, there was a resulting decrease in community involvement and empathy in health care. But we often fail to recognize that what we consider “medical knowledge” is not absent of cultural beliefs, history, tradition as well as the influence of economic forces. These factors shape categorization of illness and methods for approaching illness (p. 1627). By allowing communities to create new systems of care when resources are lacking or the system is overburdened, new models of care can emerge that are more community based and which advocate for the health of those who most need it. Shifting more responsibility to local communities to improve the health of the public can lead to more creative ways to express culture, which can improve overall health. Wellbeing hinges on more than just the biomedical. Behavioral changes and social ability to engage in change are both closely tied to culture. Non-adherence and reoccurring problem are often a result of failing to take cultural needs and perspectives into consideration.

Napier et al. propose that the following questions may help to establish shared understanding between patients and care givers:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect this problem to take? How serious is it?
- What do you think this problem does inside your body?
- How does this problem affect your body and your mind?
- What do you most fear about this problem?
- What do you most fear about the treatment? (p. 1614).

The *Lancet Commission on Culture and Health* is a well articulated collaborative effort to demonstrate the necessity and possibilities that exist to better integrate cultural and socially specific meanings into health care. Applying these principles in an effort to improve systems and approaches to care may help to bridge the gap that can often exist between increasing medicalization and Western influenced systems and the needs and perspectives of communities within societies.

### **Culture, Context and Social Variation in Health Perspectives**

Levesque and Li (2014) similarly articulate principles put forth in the *Lancet Commission on Culture and Health*, including that cultural variation in perceptions of health exist between and within societies, and must be understood and incorporated into health systems as well as the policies and programs implemented in a given society. This is necessary to ensure that health care coincides with local understandings and priorities in health, thereby better meeting the needs of the population.

Examining various cross-cultural studies, they point to evidence that many groups emphasize different aspects and relationships in their conceptions of health. In some cultures this means harmony with others, with God, the supernatural world, or nature. In others a more independent understanding, which emphasizes lack of illness as central to health, is prioritized. Additionally, depending on their outlook on health, groups utilize different resources to promote health and wellbeing than others. Levesque and Li point to studies which have shown that participation in cultural traditions, such as with First Nations in Canada, Native Hawaiian communities, Arab communities in Sweden, Chinese living in Britain, and Pakistani migrants in the US, is a useful way to promote health.

In Levesque and Li's own study of Francophones, Anglophones, and First Nations living in Canada, they found that First Nations participants were more likely to include family, community and environment in their definitions of health, and therefore had a more interdependent outlook. They were also more likely to participate in interdependent health practices, including health activities to promote health in their families and communities. Anglophone and Francophone citizens were more likely to be involved in health activities aimed at improving individual health. First Nations participants also expressed the importance of maintaining and practicing culture as an aspect of health, and emphasized spiritual health over physical health. Comparatively, Francophones and Anglophones placed more emphasis on physical health and biomedical perspectives due to the history of biomedical influence. Lastly, they also found that while Anglophones saw health as an achievable goal, First Nations individuals tended to see health as a process rather than an end state. Levesque and Li conclude that culture does impact how health is conceptualized by various populations, and that to address health in a multicultural society, there should be more awareness of these variations in health perspectives among health care providers as well as in programs and policies. If these differences are taken into account, patients will be more willing to trust doctors, will be more satisfied with the quality of care, and will be more likely to follow the directions of their doctors. Policy makers and program planners will also be better able to target and satisfy specific needs within a society.

Cecil G. Helman (1990) similarly stresses the need to take note of how culture influences health care, including how medicalization and Western cultural ideas about health have influenced how health systems function, and how these may be incompatible

with health conceptions in non-Western societies. Helman argues that there is a need for further advancement of medical anthropology, which he defines as the examination of how different cultures and social groups understand the causes of illness, the treatments they apply, those in the community who they go to in order to address ill health and how these beliefs about health relate to the biological and psychological factors related to health (Helman, 1990, p. 4).

He argues that culture can be defined as “a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment” (Helman, 1990, p. 3). As emphasized in the *Lancet Commission on Culture and Health*, he also points to the importance of examining subcultures that exist within societies which may include professional subcultures, such as groups of medical, nursing, legal or military professionals who may develop their own group rules and features distinct from the rest of society (p. 4). This can lead to prejudices towards the rest of a population or in the case of medical personnel, lead to communication issues with patients in medical settings. Helman also stresses that it is important to recognize how increasing medicalization worldwide— ascribing modern medicine to phenomena which were not previously designated as medical issues—has altered how health issues are approached in society, and how this may influence relationships such as that of communication and discord between doctors and patients aims, and patients’ satisfaction with the care they are receiving (p. 137).

*As the Lancet Commission on Culture and Health* and other medical and cultural

anthropologists have emphasized, Helman argues that the role of culture must also be understood in terms of the context which influences it—which includes historical, economic, political, social and geographic factors. In this sense, it is important to not portray culture as something static, and to recognize that culture and society is constantly being shaped by various external and internal factors. Therefore one should avoid the danger of trying to claim something is a distinct and inherent cultural belief unaffected by the influences of context (p. 5). As a result of these influences, Helman also argues that especially in terms of health, it is important to look at how economic divides, discrimination, unemployment, and the distribution of wealth impact health in order to truly understand underlying issues related to poor health within a society.

Using case studies throughout his guide for professionals on culture, health and illness, Helman demonstrates why it is necessary to properly understand culture beliefs for health care initiatives to work. In one example, he discusses Oral Rehydration Therapy (ORT) in Pakistan, which has been promoted by the government since the 1980s, and is available to citizens for free. However, it was often not utilized because some mothers viewed diarrhea as a natural part of teething and children's growth. Some mothers also feared that stopping diarrhea may trap the fever and allow it to spread to the brain. Others thought diarrhea to be caused by spirits, and therefore didn't believe ORT would be effective. Some mothers viewed diarrhea as a "hot" illness which should be treated with a cooling remedy, and as ORT was viewed as a hot remedy, it was unsuitable for treating diarrhea. Helman argues that many similar cases have demonstrated the necessity of taking local beliefs and ideas about health into account. This includes what people believe about ill-health and how it should be treated, as well as factors related to



context which shape their experiences of health (p. 10).

In their examination of the various ways that culture is incorporated into studies related to psychology, Kral, Garcia, Aber, Masood, Dutta and Todd (2010) differentiate how community psychology has differentiated itself from other cultural psychology approaches. Community psychology has a history of incorporating culture into its studies with an emphasis on community context, ecological frameworks, and human diversity. It has increasingly emphasized human ecology to uncover relationships in society that influence group dynamics and institutions within society. It also takes into account diversities in society, rather than attempting to draw universal similarities, as some cross-cultural approaches attempt to do. Instead, community psychology generally examines how gender, class and ethnicity impact experiences in society. While asking what a community's culture is remains a complex question, looking at Kleinman and Kleinman's (1991) notion of what is most at stake and what matters most to people within the community, is a good place to start. Kral et al. (2010) argue that while there have been attempts to incorporate culture in a meaningful way into the practice of psychology, often this involves including limited elements of cultural belief into analysis; it often lacks contextualization. While approaches in cultural psychology are often more anthropological, attempting to understand the experiences of a specific group, learning their history and values, there is still a considerable amount of diversity in how culture is studied in psychology. Community psychology has become increasingly interdisciplinary, but has also taken an interpretivist stance that goes beyond positivism. As Geertz articulates, it emphasizes using qualitative methods to understand meaning through context—attempting to understand subjective experience, intentions and

expressions. Community psychology has also been marked by an emphasis on participatory research—looking at issues such as power, agency, social justice and marginalization (p. 50). However, it emphasizes local knowledge and choice over externally imposed programs or rapid push for change. Instead, it aims to incorporate local communities into programs and promote community ownership. While there is still the risk that community psychology could become dominant artificially in this way, maintaining an emphasis collective agency and working towards elective empowerment is necessary. Furthermore, focusing on self-determination, empowerment and allowing individuals to identify how forces in society impact their choices and how they view themselves they can confront systems of power in their life, while also staying true to their cultural identity. There has been an increased emphasis in community psychology on understanding psycho-political power within the community. There is also more of an emphasis on action over theory or research for its own sake, unlike some social science approaches. However, rather than trying to create drastic change, it emphasizes allowing the community to recognize possibilities for change. While there has been increased emphasis on understanding “subjective shared meanings” through qualitative and ethnographic research in community psychology, they argue that there should be a more definitive emphasis on culture—not just as a factor studied as a result of understanding community dynamics. Kral et al. (2010) also argue that qualitative and quantitative approaches in cultural psychology in general need to communicate with each other, as these various approaches have much to offer each other.

## **Mental Health and Sociocultural Perspectives**

While many scholars have demonstrated the various ways that culture and social perspectives greatly influence individuals' relationship and ideas about health and wellness more broadly, this may be even more crucial in terms of shaping ideas surrounding mental health. Arthur Kleinman and Byron Good (1985) address the tendency in mental health for clinical and anthropological perspectives to view each other as oppositional. However, As Kral et al. (2010) suggest, Kleinman and Good argue that bridging the gap between clinical and anthropological approaches in mental health would be tremendously beneficial. Supporting a cross-disciplinary approach to studies involving culture and depression, they argue that ethnocentric bias in psychological categorization necessitates increased incorporation of anthropological perspectives in psychology, as the emotional lives of individuals are not identical cross-culturally (p. 15). The causes and presentation of depression symptoms, as well as cultural meanings surrounding depression, greatly depend on the relevant social structures and circumstances within a given society. Kleinman and Good challenge the commonly held notion that western criteria for psychological disorders can be applied to other cultural contexts (p. 17). In their work *Culture and Depression*, they include studies from various disciplines, based in both clinical and anthropological approaches, but that all deal with questions of how culture impacts the presentation, depiction, and conceptions of depression in various cultural contexts. By increasingly adopting multi-disciplinary methods that take into account cross-cultural perspectives, a greater understanding of relevant factors that impact mental health in various contexts can be developed.

Cross-cultural psychiatry examines mental illness across cultures. It focuses more

on the behavioral and sociocultural aspects associated with psychological disorders rather than on the organic causes. Comparatively, anthropologists tend to look at cultural factors that impact ideas about behavior, delusions, and attitudes towards mental illness. Helman (1990) argues that culture determines what is considered normal versus abnormal, influences the presentation of mental illness and shapes how mental illness is explained and labeled by society. Helman questions if psychiatry is applicable across cultures, if we can understand behavior as normal or abnormal across all humans and if psychoses of Western psychiatry are transcultural or shaped by cultural experiences.

Helman argues that:

Each culture provides its members with ways of becoming ill, of shaping their suffering into a recognizable illness entity, or explaining its cause, and of getting some treatment for it...Mental illness can therefore be explained by, for example, spirit possession, witchcraft, the breaking of religious taboos, divine retribution, and the capture of one's soul by a malevolent spirit (Helman, 1990, p. 230).

What is normal versus abnormal in society is shaped by norms concerning what are acceptable ways for people to conduct themselves and relate to one another. This can also include how individuals present themselves—including appearance, language, facial expressions—to the world. Certain forms of expression may be acceptable in some cultures but to others may seem to be evidence of mental illness (p. 216). Some cultures also have different relationship to supernatural forces, spirits, and hallucinations, which are considered an accepted part of life, and are in no way considered a sign of mental illness. In some societies cultural possession or the influence of spirits or witchcraft is also an acceptable explanation for certain phenomena. But norms in such societies often dictate who can be possessed, in what way and in which circumstances and how this

presents itself (p. 217).

As culture shapes what is considered abnormal behavior, Helman argues that labeling something as abnormal should not just be based on what is considered delusional thinking from a Western perspective—it is only abnormal if the behavior and thinking is considered to be such in that community. Criticizing the tendency to portray diseases as “universal entities,” Helman also critiques this in the application of Western mental illness categorization to various cultures. Helman points to Kleinman’s criticism of the WHO approach to studying schizophrenia across different cultures, but applying the same symptomology without taking into account cultural differences, and attempting to apply a category created from a specific society to others where it may not be valid (Helman, 1990, p. 222).

Helman also points to Foster and Anderson’s (1978) argument that rather than comparing categories across cultures, symptom patterns should be compared. This way other cultures’ perceptions of mental illness are not just fit into Western categories (Helman, 1990, p. 224). Other conditions may have neurotic or somatic symptoms that only make sense within particular society, and have specific components and changes in behavior associated with them unique to that culture. Not only in the presentation, but the meaning of the condition for the individual and their family are unique to context.

Even among European countries, there can be a considerable variety in criteria for psychiatric diagnoses, such as with schizophrenia. Diagnoses in mental health are not straightforward and often depend on how a psychiatrist was trained, the approach of the diagnostic interview, as well as the personality and background of the psychiatrist. Categories also tend to overlap, and change over time. In a study by Katz, Cole and

Lowery (1969), when American and British psychiatrists were asked to diagnose several patients from the same videos, there was considerable variation in the symptoms they noted—Americans saw more paranoid projection and perceptual distortion while British psychiatrists noted more anxious intropunitiveness. British psychiatrists were less likely to diagnose schizophrenia, while American psychiatrists were more likely to diagnose it (Helman, 1990, p. 229).

Culture also shapes the language that is used related to experiencing psychological distress and how it is expressed to others (p. 230). Symbols associated with mental illness relate to personal psychological and emotional concerns, but also reflect the values of wider society. Helman (1990) also notes that cultural minorities in society may have to adopt symbols of the dominant culture in order to be able to seek help and express distress.

Somatization of psychological distress is also common in many societies. Distress is linked to physical symptoms as a way to express psychological pain. A study by Lau, Kung and Chung (1983), found that patients in Hong Kong experiencing depression tended to express it as epigastric discomfort, dizziness, headache, insomnia, malaise, feverishness, cough, menstrual disturbances or lower back pain. Initially 96 percent complained of somatic symptoms, and none of them expressed emotional distress as a primary complaint. Therefore, it is important to recognize the somatic symptoms in society that tend to be communicated to express emotional pain (referenced in Helman, 1990, p. 234).

Culture-bound disorders are a group of illnesses unique to culture with a set group of symptoms or behaviors that are recognized by a social group and usually addressed in a

standard way (p. 234). They usually have their own network of meanings—moral, social and psychological for patient and others.

In the West, Helman argues that the treatment of psychological issues is pursued by the individual, in a professional settings like an office, away from friends and family. If the patient and physician are from the same background, they often share similar assumptions about the basis of illness. Although with psychoanalysis patients may go through a process of acculturation to learn new way to express their distress in the framework of psychoanalysis, patients and physicians eventually develop a shared worldview.

Outside of the Western world, treatment for psychological issues, including somatic symptoms, may be more of a community event. Health problems are often seen as a reflection of conflict or disturbance in the social fabric (p. 239). Therefore, there may be a need to address social problems in order to get to the heart of the distress. It often brings people together to help pay for and provide healing for the individual. This helps reintegrate the person back into society and restore ties between groups. Family plays an important role in helping the patient get well. In the West, mental illness can be alienating and does not serve this social function.

In terms of cultural healers, Finkler (1981) found that folk healing could be useful in terms of psychotherapy for “neurotic disorders,” “psychological and somatized problems.” Kleinman also found in his study of cultural healing in Taiwan that it helped address neurosis and somatization (referenced in Helman, 1990, p. 241). Cultural healing tends to put illness in wider social context, and helps to mobilize social support for individuals—reinforcing group cohesion and reducing anxiety in individuals and those

around them. Helman notes that there has been an increased interest among medical anthropologists, psychiatrists and family therapists in “widening the definition of ‘patient’ beyond the individual to include their family—and where relevant, their community as well” (Helman, 1990, p. 241). For some healers the family is the main focus of diagnosis and treatment. They may view family as a small-scale society. Families often have their own cultures with their own views, values and relationships which impact health. Family scripts—ways of behaving and reacting emotionally to avoid conflict, can contribute to the development of certain health issues due to these relationship dynamics. Helman argues that there is great reason for optimism in the cooperative advancements that psychologists, psychiatrists and medical anthropologists have made in family therapy.

Airhihenbuwa (1995), like Helman, overviews the social function of healers. He examines recent attempts to incorporate healers into health systems, and why this would be beneficial. He argues that in many cultures, health issues are viewed as being caused by some form of imbalance—either with the environment, nature, conflict with others, or perhaps elements of the body (p. 51). Many healers in society have valuable practices that have been developed over many years to address specific problems. The function of traditional medicine is thereby unique to that society, that culture, and its history. Recently there has been increased interest in integrating traditional health systems and better utilizing the beliefs of traditional medicine. The WHO, UNICEF and several noted scholars have supported this idea of integrating allopathic and traditional health systems. However, past attempts have met several main difficulties. Often healers are put under one umbrella, even though they specialize in different things. Physicians also often treat



them with suspicion and as if their practices are unscientific and unprofessional, and therefore a relationship of mutual trust and cooperation does not develop. There is also often an assumption that healers need to be modernized and don't have much to offer clinical settings. They are not recognized as having their own beneficial knowledge. There have also been some projects and programs that have attempted to incorporate healers. But healers are often not given important tasks. In order for the incorporation of healers into health systems to be beneficial, the relationship should be treated as a mutual opportunity to learn from each other. Measures to protect the ownership of healers' knowledge also need to be taken. While the integration of healers into allopathic health systems has not always worked in the past, Airhihenbuwa argues that doing so would be beneficial in that it would allow people to enjoy the best of both worlds.

Demonstrating how Western categorization of mental illness are not always applicable across cultures, Good (1977) examines a specific case in his study "The Heart of What's the Matter the Semantics of Illness in Iran." Good argues that despite evidence that culture plays an important part in how diseases are framed and understood, there still exists a strong assumption that diseases are based primarily in the natural and physiological. These assumptions are especially evident in terms of the perceived relationship between disease and language. In order to incorporate cultural considerations, studies typically look to how disease is classified in a specific culture. However, this does not take into account the significance of ideas surrounding the classification of disease and how these conceptions are tied to the cultural and societal context from which they are emerging. Rather than assuming that diagnoses are made based on a set presentation of certain symptoms across cultures, one must look to the

networks of meaning and the social interactions which surround these understandings of illness and classification of disease within a specific context.

In his study examining experiences of “heart distress” in Iran, Good demonstrates the significance of cultural relevance in understanding the context and significance related to disease. While one might assume that the use of the term heart distress in the Iranian context is simply a physical manifestation of depression or anxiety, Good argues that it is not this simple. He found that many different anxieties were linked to the same description of heart distress as a physical symptom. One woman in his study experienced heart distress due to her fear and anxiety over becoming pregnant, her children, living in tight living quarter, and getting along with her mother-in-law. In another case, a woman who worried about her husband smoking opium, her work, and recent deaths in her family lead her to experience heart distress. Good therefore found that heart distress was often expressed due to tensions related to female sexuality and fertility concerns, sadness and grief over conflict in relationships or the death of a loved one, and worry or anxiety over living conditions or money. Specific stressors were commonly understood to cause heart distress. Therefore, there was a network of symptoms that gave heart distress a specific meaning in Iranian society. He argues that that there is specific language and discourse of the illness and what social stressors they represent. However, the meaning of the illness may also change over time, depending on societal changes. These structures of meaning linked to heart distress cannot be simplified as equivalent to a nature based disease which is identical to that in Western society. Good also found that those who experienced heart distress could use their condition to negotiate change which could ease their anxiety and discontent. They may be able to create change in their relationships in

order to address the issues that were causing them unhappiness. Understanding these culturally specific meaning linked to disease, therefore, can also help develop approaches in which to address them.

Yang, Kleinman, Link, Phelan, Lee and Good (2007) also discuss the importance of cultural contextualization in terms of stigma surrounding mental illness in society, and how this impacts the ways in which people with mental illness are treated in their communities and as a result, their health outcomes. Expanding on stigma theory, they argue it is not only the stigma faced by individuals that needs to be considered, but also the experiences and circumstances of the “stigmatized” as a group, as well as the perspectives of the “stigmatizers” (p. 1528). These social dynamics and discourses of power which dictate social institutions and which may institutionalize discrimination against disenfranchised groups should be examined—as various political, historical and economic factors greatly impact policy and stances that in turn influence discriminatory behavior against certain groups in society. The “moral experience” or what is most important to those in society is often viewed as being somehow threatened by the stigmatized groups—and stigmatizing them may therefore be viewed as a natural reaction and necessary for self-preservation. Therefore, looking at what matters most in the daily lives of local people and examining this moral element to stigma may bring about a greater understanding of why and how disempowerment is perpetuated. Understanding these interpersonal aspects of stigmatization in society can help contribute to the creation of more effective programs to address discrimination and attitudes about those in society dealing with mental illness.

Becker and Kleinman (2013) argue that although in 2005 the WHO and European Ministerial Conference on Mental Health put forth the statement that there is “no health without mental health,” in terms of the allocation of resources and access to these services, it is obvious that mental health is often critically neglected (Becker & Kleinman 2013, p. 66). They argue that beginning in the 1990s, more awareness of the magnitude of the disease burden associated with mental disorders was recognized with the development of DALYs (Disability Adjusted Life Years). In 2010, a Global Burden of Disease study found that anxiety, drug-use and alcohol disorders, schizophrenia, bipolar disorder, and dysthymia are among the 20 health conditions which cause the largest YLDs (Years Lived with Disability) (Becker & Kleinman, 2013, p. 67). Globally, mental illness has the highest burden of YLDs then any other disease category. However, resource allocations continue not to reflect this.

Becker and Kleinman note that developing enough mental health human resources within a country takes commitment from governments to this cause. Mental health has to be actively made a priority in order to coordinate efforts in education and resources and between NGOs, governments, multilateral agencies, and researchers. Training more mental health specialists, and improving training opportunities to improve quality of specialists is also needed. For low and middle-income countries that don't have these resources, a collaborative model—having community health workers and primary care professionals receive training to be better able to address mental health is one possibility. They would continue to then receive training and would be supervised by specialists. Task shifting is another possibility, which involves incorporating community health workers into more clinical settings

The World Health Organization's mhGAP is an effort to help improve training and the ability of primary care medical personnel to address mental illness. There is an mhGAP intervention guide and training package to help improve primary clinic's capacity to treat mental health. However, Becker and Kleinman argue that there is a lack of data showing how effective it is to approach mental health this way, especially in various cultural settings. There is a significant lack of literature on mental health outside of high-income countries. More studies are needed which focus on how best to deliver care in countries with a shortage of resources. More research should also be conducted on diagnostic tools that can be used at the primary care level, and their effectiveness in various contexts. They also point out that unfortunately, stigma that often goes hand in hand with mental illness in society, including for mental health workers and policy advocates, can make people shy away from work in this area. Therefore prioritizing mental health and committing resources to this important issue often continues to be neglected.

### **Mental Health and Wellbeing: The Impact of Religiosity and Spirituality**

In Andrea Blanch's (2002) work, she makes a case for incorporating spirituality and spiritual beliefs into mental health approaches. She argues that mental health systems have been shaped by Western science to a great extent, and that there is a lack of consideration of sacred concepts which are prevalent elsewhere in the world. While spirituality is an important part of individuals' everyday lives and how they conceive of the world around them, there has been a reluctance to merge concepts of religion and spiritual experiences in fields that are considered scientific—as these areas are often depicted as being in opposition to one another. However, she argues that studies have

increasingly shown that there can be tremendous benefits to incorporating this important aspect of human experience into clinical mental health approaches (p. 252). She argues that failing to understand the ways in which religious belief shapes normative beliefs and behavior could lead to misdiagnosis or limit viable treatment options. She suggests that incorporating the religious views of patients' may help them see their mental health journey as a more meaningful spiritual journey and that this can give them something to work towards while also providing them with comfort and possibly the support of a religious community. While negotiating how much of the spiritual life of patients should be incorporated into treatment is still needed, working from clients' own perspectives in terms of how they view the world may help to build trust as well as improve the success of treatment (Blanch, 2002, p. 257). Strengthening beliefs may help clients to better control their emotions, and increasing the knowledge of care givers about possible spiritual resources may help provide more local support networks for those seeking treatment.

Tiliouine, Habib and Cummins (2009) similarly make a case for the importance of taking religiosity and spirituality into consideration when looking at health, including its impact on subjective wellbeing and overall perceptions of happiness and satisfaction. They point out that while there has been a significant amount of studies focused on the relationship between quality of life, wellbeing and religious belief, these are most often focused on Europe or the United States in terms of Christian belief. While their study in Algeria, focused on the relationship between religiosity and demographic differences, as well as subjective wellbeing and religiosity did not result in clear correlations between these factors, it did uncover some interesting relationships. For instance, their

research found that subjective wellbeing fell with less religious practice and with those less involved in religious altruism, which they suggest demonstrates the important aspect in religious practice that social capital and social interaction plays. They also conclude that there was not a strong correlation between subjective wellbeing and religiosity in their study due to the heavy impact that the context in Algeria in a post-conflict situation has had. The increased stress, economic and political toll, as well as increases in conflict related anxiety and post-traumatic stress has significantly affected Algerians sense of subjective wellbeing. Therefore, the contexts in which such relationships are measured are significant when trying to understand religiosity and wellbeing.

In their study of health, subjective wellbeing, and religiosity among young adult Qatari students, Abdel-Khalek (2013) found a positive association between religiosity and both subjective wellbeing and health. He argues that this may be because religion provides adherents with a sense of hope and meaning in their lives. It also often gives them a community of support, is a source of strength on which they can rely, and religious activities may allow adherents to feel closeness to God as a mechanism for dealing with stress. Religion also shapes a person's values and norms, which can also play a role in individuals' health. For instance, those with increased religiosity may emphasize "hope, love forgiveness, and gratitude" in their lives (p. 314). He also points to Muslim belief of accepting whatever happens as God's will, and being satisfied with whatever is destined to be. While Muslims should attempt to work and thrive under any circumstances, there is a sense of accepting what they are given in life (p. 314). The study found that with both male and female participants in the study, the only predictor of religiosity was satisfaction with life. Abdel-Khalek argues that the association with high

scores on religiosity correlating with individuals seeing themselves as having a higher subjective wellbeing and health, shows that religiosity can play a role in improving subjective wellbeing and overall health (p. 315).

Eloul, Ambusaidi and Al-Adawi (2009) examine whether women in the Middle East and North Africa experience a higher rate of depression, and the role that Islam may play in this. Some recent studies have suggested higher rates of depression in women than men in the MENA (Middle East and North Africa) region and the role of Islam in this has been debated in terms of if religious practice causes more distress in women in the region.

Looking specifically at Oman, Eloul et al. note that since the 1970s, there has been a dramatic increase in education, literacy, and women entering the workforce. Now there are more women than men in higher education. The role that rapid socio-economic shifts and how this has affected women's status should be examined. Some have argued that this may cause strain, as cultural values continue to emphasize family while women have to balance new roles and priorities outside of family, which can cause anxiety.

Some studies conducted in the Middle East and North African countries have also seemed to suggest that higher rates of postpartum depression occur compared to Western countries. Eloul et al. argue that bearing more children is still greatly valued by community and families in the region, as they often see children as a gift from God. Women's identity is closely tied to her role as a mother. While Oman launched a birth spacing campaign and has seen a fall in fertility rates, the birth rate has still been high compared to many developed countries. They argue that higher birth rates may increase the risk of postpartum depression. As women in the region are more likely to have



children earlier, and have more children, their chance of developing depression may be higher.

Eloul et al. also emphasize that there are limitations to being able to accurately measure such subjective experiences such as depression and other symptoms associated with psychological disorders. As Kleinman has proposed, they argue there may be a “category of fallacy” in attempting to apply categories developed for one cultural group to that of another social and cultural context (p. 10). Because of depression’s subjectivity, measuring levels of depression in MENA may be inaccurate.

Other factors that may effect measurements of depression in the region include that many may not seek help because of stigma, and many people seek help from healers until they reach advanced stages of illness. In some cases, women suffering from depression is more accepted by family members than if men suffer from depression, so men may attempt to hide emotional problems more than women. Conversely, however, men can use instances of women suffering from mental illness to justify divorce or taking on a second wife. In some cases, then, there may be more men seeking mental health services than women over fear of this happening.

Mental health professionals may also have difficulty adapting to local associations and expressions of mental illness which are common—such as the link to spirits and the tendency to equate mental distress with physical symptoms. Physical symptoms can be a more acceptable way to demonstrate distress, however this may cause mental health issues to go unrecognized.

Eloul et al. conclude that there are not necessarily more cases of depression in women in the Middle East and North Africa. Any increased rates are likely due to

shifting circumstances and roles which women in many developing countries are experiencing—not just the Middle East and North Africa. They also specify that it is important to separate religious from social and cultural influences; rates of depression should not be correlated with religion baselessly. Men in Oman are actually more likely than women to seek mental health services, therefore women are underrepresented in mental health services. However, they do not necessarily experience higher rates of depression. More studies using measures specific to the region would need to be conducted to better understand relationships between gender and depression in the region.

### **Reproductive Health, Society and the State**

Development and health perspectives suggest that as a country reach certain standards of development, it should experience a demographic transition. As the death rate in a country decreases due to better access to health care, food, and improved sanitation, fertility will temporarily increase, level out and then eventually begin to decrease (Jacobsen, 2014, p. 6). Therefore, there is an assumption that populations in increasingly prosperous countries will begin to make more ‘rational’ decisions about family size as access to education, employment and contraception increase for women. However, by focusing on merely the expected demographic transition and fertility rates within a country, other aspects which greatly influence such trends and social influences which impact reproductive decisions are not taken into account. Such perspectives also risk narrowing the definition and focus of reproductive health to fertility and contraceptive use alone and not examining other important aspects of care and cultural factors that shape reproductive health.

Browner and Sargent (2011) emphasize that reproduction is greatly impacted by larger “sociopolitical, economic and ideological processes” (Browner & Sargent, 2011, p. 2). They argue that by examining global, regional, state and local forces, and studying how they impact reproductive trends, we can better understand both women and men’s ability to exercise “initiative and intent”(p. 2). They argue that to understand reproduction, one must take into account global and state politics, as well as the influence of various human rights, public health, and feminist organizations, in addition to that of religious movements and local power dynamics and relationships within communities. They also argue that there has been a lack of focus on the impact both the state and globalization have had on reproduction, and how these various forces impact local decisions about reproduction which are made on a daily basis. By looking at how these various influences and pressures impact reproductive health of local people, as well as how they exercise agency in making decisions about reproduction, we can better understand the experiences and trends that we see within these communities. Kligman (1998) similarly points out that reproduction is easily politicized because it is so intrinsically linked to matters of identity and nationality, and the continuation of a specific group of people. However, individuals, families, and the state may have very different perspectives and interests in how they approach reproduction (referenced in Browner & Sargent, 2001, p. 12).

Obermeyer (1994) examines specifically how state interpretation of religious doctrine impacts the reproductive choices of women in Muslim majority countries. In her study of the relationship between Islamic interpretation and reproductive choice, she argues that that political factors greatly influence how relevant Islamic principles are

interpreted, and that the state has the ability to influence women's options as a result of its stance on religious interpretation.

Obermeyer applies feminist theory's framework of reproductive choice, which suggests that women have autonomy and can make decisions in regard to reproduction. This includes having access to both information and care that allow the decisions they make to be realized (1994, p. 58). In her study, Obermeyer looks at status indicators across Muslim countries to measure the ability of women to make informed decisions about reproduction and reproductive health.

In many countries, Obermeyer notes there is still a lower level of education and employment for women, and this suggests that they have less autonomy. There is also low contraceptive use, early marriage and a gap between preferred fertility and actual fertility levels. This, along with assumptions that in Muslim countries women are often subordinate to men and therefore women's health and reproductive health are not prioritized, seem to suggest a lack of reproductive choice for women. This is linked to factors such as male dominated societies, the segregation of the sexes, arranged marriage and men having multiple wives. In some countries access to health care and professional birth attendants is also a factor that affects reproductive choice. However, Obermeyer argues that different interpretations related to reproductive choices are possible, and that it varies by the country, circumstances, and climate within the country.

There is considerable variation in Muslim majority countries in how women are viewed—some stress religious passages which highlight the differences between men and women and those that seem to suggest women are not equal to men, while others stress passages that suggest a more egalitarian view. Obermeyer also notes that within the last

four decades or so there have been significant changes for women throughout the region—girls are increasingly present in schools, there are more women employed, there has been a decline in fertility in many countries, and life expectancy has increased for women. However, Obermeyer argues that to really understand how Islam is shaping reproductive options in various contexts, you have to look at the political situation, and how this determines the interpretation of religious doctrine. Looking at the case of Iran, Obermeyer notes how before Iran’s 1979 revolution, Reza Khan as well as Mohammad Reza Pahlavi attempted to modernize Iran and address women’s roles—prioritizing education, increasing the age of marriage, as well as attempting to change how women dressed. The Shah also tried to improve the ability of women to divorce, gain custody of their children, and limit polygyny.

However, with the 1979 Revolution, the state’s policies towards women drastically shifted. There was an increase in pronatalist policies and the government encouraged women to remain in the domestic sphere. The age of marriage was again lowered, and the family planning program from the previous regime was halted. Abortion and sterilization were also outlawed. Population growth was viewed as a sign of Iran’s success, and the return of women to certain roles was viewed as a return to the true values of Islam (p. 68).

However, Obermeyer argues that as the political and economic environment in Iran changed, the perspectives and policies that the government supported in terms of reproduction and women’s roles also shifted. After Iran’s war with Iraq, the government reissued its birth control policy, and used Islam to justify this as acceptable practice. Religious leaders supported family planning, and the government began to provide a

greater range of contraception choices. They used radio, TV, newspapers, and Friday prayer sermons to support family planning, and breastfeeding—quoting the Qur'an and health professionals to promote this cause. Obermeyer argues that this shift towards family planning occurred because population growth came to be viewed as the source of many of Iran's woes following the Iran-Iraq war. There has also been an increase in girls' education, and the age of marriage and life expectancy has also increased. So ironically, she points out that some of the Shah's policies have been embraced again under the Islamic state (p. 70).

Obermeyer argues that this case demonstrates the complexities involved in the relationship between the status of women and the state—including the important role that political, economic and legal shifts play in determining women's reproductive choices as well as their status in society. Obermeyer argues that policies towards women and reproduction are often where larger social issues play out. Therefore, it is important to recognize the role state politics play in determining religious interpretation in these matters—rather than simply boiling it down to Islam being incompatible with human rights. She argues that more research in reproductive health that examines if issues related to reproductive health are more determined by socio-economic conditions or gender inequality needs to be conducted. She also points out that there is a tendency to only focus on contraceptive use, and attitudes about contraceptive use in the Middle East. There is a lack of more comprehensive studies that look at women's status in relation to reproductive health. Understanding what most shapes current ideology around relations between men and women and women's roles is important for understanding reproduction choices within Muslim majority countries (p. 72).

Looking specifically at the role that religion and the state play in determining the options and approaches to reproduction available to couples, Inhorn (2011) examines the role that Islamic interpretation in the Sunni and Shia majority countries have played in shaping the reproductive technologies available to infertile couples. She notes that there has been an increase in the assisted reproductive technology (ART) and even a marked success of private IVF clinics emerging throughout the Middle East. However, despite this increased access in Muslim majority countries, not all forms of ART are considered acceptable. In the Sunni world, there is strong religious regulation on assisted conception. Sunni majority countries have banned third party gamete donation, while Iran and Lebanon (Shia majority countries) have permitted it to more of an extent. IVF is permitted in Sunni majority countries as long as it is the husband's sperm and the wife's egg. But it is not acceptable to have a third party provide sperm, egg, embryos or surrogacy (p. 129). Religious rulings have therefore determined what clinics offer as well as what many patients accept as their options for conceiving. Even though many of the IVF clinics are private, and doctors operate with little government interference, one study of clinics' practices found that they do in fact follow these religious rulings, and do not provide sperm donation or other third party donation. There has been an acceptance of religious law as if it were state law even though it is not enforced legally. The fatwa on third party donation has therefore been "morally internalized" (p. 131). Inhorn found that those who inquire about third party donation are usually discouraged from it or referred to European countries. For many Sunni couples, many of whom maintain that third party donation is wrong, it is not considered an option because introducing a third party is equal to adultery, it interferes with kinship and inheritance important in patrilineal

societies, thereby destroying a child's lineage. Infertile couples then have to decide whether or not to pursue human gamete if they do not have other ways of conceiving.

In contrast to Sunni majority countries, in the 1990s Iran's Ayatollah Khamenei permitted donor technology, including egg and sperm donation. However, sperm donation has recently been outlawed, and gamete donation has been limited to married couples. Egg donation is acceptable if the husband temporarily marries the donor. Embryo donation with sperm and egg from another couple is also allowed. Surrogacy also occurs in Iran, even though there is not a clear ruling on this. There is currently a push in Iran to allow more forms of donation as well. In Lebanon there has been a lack of regulation on ART due to disagreement on these issues and inability of the state to implement or regulate it. Lebanon and Iran are therefore the only Muslim majority countries where third party donation is practiced. Some infertile couples from Sunni majority countries are choosing to go to these clinics to receive treatment in secret in order to conceive a baby that looks Middle Eastern. Inhorn argues that this has led to an increase in reproductive tourism across Sunni and Shia divides, and that the Shia stance on gametes has weakened Sunni stances on these issues.

Emma Varley (2012) in her study of family size and organizations' family planning campaigns in the Gilgit-Baltistan region in Northern Pakistan found that decision-making regarding family size and contraceptive use was not as simple as family planning organizations attempted to frame it. Varney found that organizations such as that of the prominent non-governmental organization FPAP—Family Planning Association of Pakistan, while really pushing secular and health driven objectives, attempted to use moderate Islamic discourse to initiate change at the local level. Using



local values and norms to support a change towards greater empowerment in women's decision making to use contraception, seek reproductive health resources, and control family size, such organizations often framed their campaigns in terms of making the 'rational' choice of having smaller families versus the irrationality of having larger families. Varney argues that FPAP and other organizations have used "Islamic biopolitics" to attempt to decrease family size and promote smaller families as the most moral, responsible and rational decision (p. 191). However, Varley found that considering the realities of men and women living in the area, making decisions regarding contraceptive use and family size were not as simple as what was "rational vs. irrational." Rather, men and women experience various values and pressures in society which influenced their decisions about family size (p. 195). For instance, the objections that many mother-in-laws had to contraceptive use, conservative Sunni pronatalist ideas, the agency that women gain after bearing several children, as well as the material and social-status that some families who are tied to villages receive after having children, sometimes made having larger families outweigh the costs and inconveniences. Furthermore, many women had a different definition of what a 'small' family should look like—unlike FPAP's two children household model, many women said that 3, 4, or 5 children were more desirable—and that they would be more likely to use contraceptives, despite the stigma associated with them after having several children (p. 201). Therefore, Varney argues that having larger families was not an 'irrational choice' given the circumstances. Rather, decisions made regarding family size and contraceptive use were influenced by many social factors.

Varley's examination of the various influences locally and internationally which impact the decisions that women can make regarding contraception, and the disconnect that can occur between globally focused contraceptive and birth spacing campaigns and the realities on the ground are an important consideration when trying to understand their effectiveness.

Just as Varley argues that trying to create immediate change in terms of family size cannot be brought about by organizations with a secular agenda without taking into consideration the various factors that drive reproductive decisions, Gruenbaum (2011) makes a similar observation in her study of the practice of Female Genital Cutting in Sudan. Political Islam and the various influences of feminist, human rights and public health movements that have all been shaped by Western influences and globalization, have all had an impact on FGC practices and ideas about the practice in Sudan.

While many western influenced organizations have tried to adamantly argue against FGC and called for total irradiation of the practice—Gruenbaum argues that this is ethnocentric, not to mention an ineffective way go about creating lasting change. It may in fact damage women's sense of agency and their ability to make decisions about their bodies by artificially making FGC the most important issue for women, and emphasizing eradication of the practice over other issues which women may find more important. Just as family size in Pakistan is greatly shaped by many different social factors, FGC in Sudan has various roots and circumstances surrounding the practice which influence these decisions—including western influenced organizations pushing for eradication, the stances of Islamist groups, geopolitical forces, as well as the legacies of colonialism, which all continue to impact shift in attitudes about FGC. Some local groups, including

some Islamist groups, have argued that anti-FGC campaigns are pro-Western, against Islam, and have colonialist ties. However, while some Islamist groups do continue to support FGC, many have rejected more severe forms—such as infibulation and clitoridectomies—as un-Islamic, and instead support more moderate forms. Some groups claim that these less severe forms are sharia practice. Greunbaum found that overall the more severe forms of FGC have become less common. And while she found that young people were increasingly willing to discuss and question the necessity FGC practices, in some areas more moderate practices of FGC have actually increased in popularity. She argues that this has been influenced by displacement and migration patterns, and concerns over daughters’ marriageability due to these population shifts. Therefore, FGC continues to be a complicated issue which is influenced by many different local as well as global influences. Therefore, trying to force change will not be effective. By allowing local people to set the agenda and their own priorities for creating change on this issue, it will be possible for communities to work out issues related to FGC on their own terms.

Just as Varley (2012) and Gruenbaum (2011) draw attention to the many factors which influence reproductive choices in Pakistan and Sudan, Dudgeon and Inhorn (2004) similarly argue that in their attempts to empower women in reproductive health programs, the influence and involvement of men is often dismissed or overlooked by organizations. As Varney argues, decisions about reproductive health are not just made by individuals alone—rather they are influenced by many other factors. Men are often simply viewed in the context of how they present obstacles to women’s decision-making ability, and are excluded from relevant programs. However, Dudgeon and Inhorn argue that men greatly impact reproductive health, and should be incorporated into health

interventions. Men are often portrayed in stereotypical ways that are not always accurate. Men impact many important reproductive health decisions—such as whether or not contraceptives are used, perceptions of STIs, decisions regarding family size, and whether or not abortion is deemed an acceptable choice (p. 1385). Either directly, through their enforcement of certain laws, or indirectly through their support or rejection of certain ideas involving reproductive health, men play a considerable role in women's ability make certain choices. Therefore, Dudgeon and Inhorn argue that the relationship between men and women, and how men influence reproductive health are incredibly important factors to consider. How men and women relate to each other will vary depending on the society, and interventions need to take these variations into account. Men and women need to be able to define and articulate their experiences with these issues for themselves, and should both be able to access resources and information regarding reproductive health issues.

### **Medicalization of Reproduction**

Another area of concern in terms of the influence of globalization in reproductive health on developing countries is the influence of Western models and the lack of consideration of the impact such influences will have on society. It is possible that in attempting to modernize medical system in a way that emulates models in the West, there can have unforeseen consequences on societies. For instance, Hibba Abugideiri (2004) argues that colonial influence in the modernization of Egypt's medical institutions greatly impacted the image and role of women in society. Colonial ideas of what a modern, Egyptian doctor looks like—specifically male, upper class, urban, and English speaking, impacted the role that women had previously held in health care (p. 88). Midwives used

to not only take care of births and gynecological emergencies, but also helped locally with other minor medical issues such as broken bones and administering vaccines. However, as colonization changed the system of medical education and along with it defined a new legitimacy as well as a professional class of Egyptian men who graduated from the medical school, women's roles in medicine were redefined. Midwives were now subjugated under medical doctors, and were depicted as fulfilling a "motherly" role (p. 95). Women were also increasingly portrayed in terms of their roles as mothers who stay at home as caregivers to their children. Colonial influence also increased depictions of women as being naturally more fragile and weak, while also increasing their nurturing, and maternal roles. Abugideiri argues that medical modernization under colonial influence contributed to a subordination of women in Egypt.

Morsy (2009) also argues that medicalization in Egypt has caused increased concern and focus on maternal mortality. The state has promoted more health strategies specifically targeting maternal health because of the agendas and influence of international organizations such as USAID, the World Bank and feminist groups. However, Morsy argues that there is a risk with such policies related to maternal and child health on emphasizing population control and it becoming "a medicalized form of fertility regulation" (p. 163). Egypt's priorities in women's health are similar to that of USAID in that it is disproportionately focused on family planning as a way to promote overall health for women. It has emphasized that lowering the number of births can decrease maternal mortality. Morsy also argues that mothers are often depicted as incompetent, which helps to rationalize the need for the medicalization of reproduction. There is also a tendency to blame women's reproduction for halting Egypt's

development. The use of “deadly reproduction” language is similar to that of the colonial era (p. 171). Therefore, Morsy argues that there is a need to examine the political and economic influences of these approaches.

The failure of the campaign in Egypt to change fertility should not be a surprise, Morsy argues. Current economic circumstances make it necessary for many rural couples to have large families. In her study, conducted in 1974, Morsy found there tended to be a divide in urban women versus rural women in their opinions and use of contraception. Women in rural areas often preferred indigenous fertility regulation over free contraception available from the state. Women in rural areas were more likely to have more children to meet their labor needs as well as expectations that they have more children. In villages, there was often a lack of utilization of free fertility, as there was concern over side effects. Many women in rural areas also choose to deliver local midwives at home rather than delivering in hospitals.

By placing so much emphasis on maternal health and lowering birth rates, Morsy argues that there has been a neglect of other aspects of reproductive health and women’s health. Focusing only on the reproductive capacity of women is occurring at the expense of other health concerns (Mosry, 2009, p. 171). For instance, there is not as much focus on improving the lives of pregnant women, which would also decrease maternal mortality. Morsy concludes that it is necessary to look at the political and economic context of maternal mortality rather than merely reducing the phenomena to women’s subservience to men. National policies are often not critiqued in this way. However, the focus on maternal mortality may hide motives for population control with its rhetoric of health concerns and feminist critique of reproductive choice.

Helman (1990) also makes the argument that in some ways there has been a medicalization of women's lives more than men's. For instance, pharmaceutical companies have often portrayed psychotropic drugs as a solution to address emotional issues specific to women. He argues that advertisements have increasingly depicted that some emotional tribulations experienced by women require a drug (p. 139).

In terms of reproductive health, he argues that menopause has increasingly been framed around the world as a disease as it has become medicalized. By framing menopause this way, as an endocrine disorder, it becomes a medical problem that should only be managed through the medical system. However, this has caused disagreement about whether certain vague symptoms that have come to be associated with menopause are really a part of the process itself or are simply due to other sociocultural life changes which women also undergo at the time, and are not necessarily a result of physical causes (p. 142).

While the increased rate of births that occur in hospital settings has greatly helped reduce maternal and neonatal mortality and morbidity and aided in premature infants survival, Helman argues that it has also lead to more emphasis on physiological over the psychosocial aspects of pregnancy and the experience itself.

In the hospital setting, there is more emphasis on the technical medical experience of birth rather than on the meaning of pregnancy and childbirth for women. There is also an emphasis in hospitals of producing a perfect baby, while the mother is just secondary consideration. Surrounded by technology, those who control the technology in medical setting are those who have control over the whole experience (p. 148). This approach reinforces the emphasis on science and technology and medicine's control over natural

occurrences as well as the importance of institutions over the beliefs of individuals (p. 149).

Helman argues that there are often contrasting perspectives and priorities in childbirth for women compared to that of their doctors. Doctors may treat the childbirth as an isolated medical event, whereas for the mother it is closely linked to other aspects of her life; having a child changes her social situation, relationships, effects her financial situation, and many other aspects of her life. The quality of the childbirth experience, outcome, and control of the birth itself may be also present points of contention for doctors and pregnant women. Women may experience dissatisfaction with the medicalization of the birth process.

Helman also notes that until the 17<sup>th</sup> century in the UK, midwifery was an exclusively female profession valued in society. In the 19<sup>th</sup> Century, however, the UK incorporated midwives into the medical system but as a subordinate position to obstetricians. Before 1880, births were primarily assisted by female relatives or birth attendants at home. By the 1930s, however, more births were taking place in hospital than in homes for the first time. Today 99 percent of births in the UK take place in the hospital, and 98 percent of births in the United States do (Helman, 1990, p. 146). As a result of this emphasis, there has been an increase in hospital midwives, but a decrease in community midwives.

Helman demonstrates in his overview of the medicalization of the birth process and other aspects of women's health the importance of recognizing how these shifts have transformed how people relate and frame life events, and how this is impacting the quality of care that individuals are receiving.



## **Implications of These Works for This Study**

Examining how current medical approaches are incorporating cultural and social perspectives into the health system, as well as the potential of missed opportunities and continued hurdles are primary concerns of this study. Therefore, *the Lancet Commission on Culture and Health* is tremendously useful in terms of examining how these factors may be better addressed and adopted into clinical settings. Examining these elements specifically in terms of the health system in Oman provides a framework to analyze opportunities to better integrate these considerations on the ground. The *Lancet Commission on Culture and Health* also emphasizes opportunities that can arise out of involving communities in developing care approaches and the benefits of community centered care. Working towards more community inclusive care is one concept that became a central theme in the interviews in this study. The emphasis in the *Lancet Commission on Culture and Health* that cultures can exist within medical communities is also pertinent for this study. As the majority of physicians in Oman were trained in the West, this may influence how professionals interact and relate to their patients.

Levesque and Li's (2014) point that groups within society utilize different resources for health and have varying ideas concerning wellbeing is also an essential concept. Omanis for example, may find that their wellness is defined less as individuals and relate more to their extended family, as this is an important aspect of life in Oman. Overall, incorporating notions of wellbeing into care as it relates to reproductive and mental health is necessary if patients are going to trust and adhere to the recommendations of their doctors.

This study is also sensitive to the impacts of medicalization, and how Western influences are balanced with local perspectives and definitions of quality care. Oman's *Health Vision 2050* report articulates improving the quality of care as its primary focus. Increased medicalization of certain phenomena may occur in Oman due to Western training and the influence of international organizations. Therefore, in examining the quality of care available to Omanis, it is important to consider the impact that increased medicalization could have on approaches to health issues. As Helman (1990) also discusses, it is necessary to consider the social context, which greatly influences culture, such as historical, economic, political and social factors. Culture should not be approached as if it is a set, unchanging entity. This study considers these various factors that shape cultural perspectives in Omani society rather than treating them as an inherent cultural beliefs isolated from these influences.

This study also takes into account the emphasis on community psychology that Kral et al. (2010) discuss. Aiming to help create change, but including local perspectives rather than imposing an external path to change, provides a useful framework. Involving communities and community perspectives into programs and allowing communities to identify opportunities for change may provide more sustainable improvements in mental health. Encouraging cooperation between multidisciplinary qualitative and quantitative approaches to better address these issues is also important to understand how these changes can best be implemented in various contexts.

As Kleinman and Good (1985) encourage a cooperation between the clinical and anthropological to better understand mental health challenges related to culture, this study will similarly consider both clinical realities on the ground as well as how cultural factors

shape ideas about mental health and illness. Identifying gaps between clinical approaches and cultural perspectives to better meet the mental health needs of Omanis is also of primary concern, as these considerations of the cultural determinants of health should ultimately have implications which help to shape future developments in health care systems.

While this study does not examine the networks of meaning associated with specific mental health issues expressed by patients themselves, Good's (1977) work is an important reminder of how cultural context and culturally specific meaning and associations shape understanding of anxiety and notions of mental wellness and illness. Therefore, my approach does consider of how social perspectives and ideas about mental illness as well as social circumstances and the relationships and positions of individuals within society shape their realities and ability to receive treatment. Understanding how these specific networks of meaning associated with mental health needs as well as individuals' position in society impact care is necessary to address these concerns effectively.

Helman's (1990) overview of cross-cultural psychiatry clearly demonstrates the variation that can occur in terms of how mental illness presents, is expressed and communicated, as well as the contrasting ways mental distress can be approached depending on social context. These considerable differences need to be recognized when attempting to address the mental health needs of a specific population. Therefore, these principles are reflected in this study. Helman's discussion of definitions of the abnormal being culturally defined is also important when considering the spiritual and religious associations to experiences of mental illness in Oman. The belief that symptoms of

mental illness can be caused by *jinn* (supernatural beings), for example, and that proper treatment can be sought with the help of a spiritual healer, is an accepted norm in Omani society. This is important so as to understand what is considered abnormal or acceptable in Omani society and their links to religious beliefs. This study does not explore specific language and acceptable expressions of mental illness in Omani society in depth as Helman explores in his discussion of culture bound disorders. However, the need to consider this in the treatment approaches for mental illness is a concept that emerged from the interviews in this study.

Similarly, Helman (1990) and Airhihenbuwa's (1995) discussions of the role of spiritual healers is very relevant to mental health in Oman and are useful in framing the status of healers in society. The value and benefit of receiving care from these community leaders, as well as ways in which they could be better incorporated into care, is another important discussion that relates to mental health approaches in Oman. Airhihenbuwa's (1995) evaluation of past challenges in incorporating healers into allopathic systems and emphasis on the need to protect healer knowledge and build mutually beneficial relationships, is also relevant in framing the discussions I had with professionals regarding how healers could be incorporated into care. Helman's emphasis that mental health approaches, which can include healers, are often framed as a community and family event, is also relevant to Omani society, as there is frequently a need to address familial conflict to assist in the individual getting well.

Yang et al.'s (2007) examination of the stigmatization of people with mental illness in society is also useful in this study so as to understand the underlying factors that contribute to stigma. As stigma surrounding mental illness is a major issue in Oman,

unpacking this stigma may be key to improving the utilization of psychiatric services. Becker and Kleinman's (2013) exploration of models for training more mental health workers, and emphasizing the investment in human resources as an important step for countries developing their mental health systems, is very relevant to the case of Oman, which is severely lacking in human resources specific to mental health. They also point out the need to conduct studies on how to develop more mental health resources in countries that currently have a shortage. The applicability of diagnostic tools in various cultural settings is also very relevant to the Omani context.

As Blanch (2002) Tiliouine et al. (2009) and Abdel Khalek (2013) suggest, this study will also consider how religion and spirituality impact how individuals cope and address illness and health issues in general. Religious beliefs play a central role in the lives of Omanis and in shaping how they view the world. Therefore, it is necessary to consider how these beliefs impact notions of wellbeing, health, as well as their acceptance of the health care they are receiving. Blanch (2002) specifically emphasizes the importance of spiritual beliefs in mental health approaches. She emphasizes that spiritual beliefs are an important aspect of human experience that can be better incorporated into mental health treatment. Framing patients' wellness as a spiritual journey can help give the process more significance and meaning, which may help patients in their recovery process. As religious beliefs and their identity as Muslims are important factors that shape the day-to-day lives of Omanis and how they think about mental health, better incorporation of religious beliefs into care approaches could provide a significant opportunity to improve the quality of mental health care in Oman. Abdel-Khalek (2013), in demonstrating the positive association between religiosity, subjective

wellbeing and health, also illustrates the importance and benefits of considering faith in health approaches. Providing individuals with a sense of meaning as well as a community of support provides a possible tool and opportunity for improving health.

Eloul et al.'s (2009) discussion of the dangers of correlating religious factors with rates of depression provides an important warning about making baseless speculative evaluations of societal beliefs. Their work also brings attention, however, to the current transitions occurring within Omani society that could contribute to increased pressures on women, as well as the potential of high fertility rates to increase the presentation of postpartum depression.

Browner and Sargent's (2011) argument regarding how reproductive health trends are greatly affected by social, political, economic and ideological factors is also critical for understanding reproductive health in Oman. Men and women in Oman are directly and indirectly affected by various global, regional, state and local forces that shape the dynamics related to their reproductive choices. The influence of international organizations and the state's attempts to align with international standards and collaborate with the WHO, Western trained expatriate as well as Omani physicians, in addition to local power dynamics and changing socio-economic conditions which impact local priorities, greatly influence the daily decisions made by men and women regarding reproduction.

Obermeyer's (1994) discussion of the tendency to make assumptions about reproductive choice in Muslim majority countries and how variations in views related to women vary depending on political and economic factors, is also pertinent to the case of Oman. These complexities in Omani society, where women are greatly represented in

higher education and employment, yet their role as mothers and gender segregation is still strongly emphasized, needs to be understood in terms of the context of these various influences. Varley's (2012) study is also important in considering how national policies are impacted by international, economic and social shifts occurring within society. Her emphasis on the fact that top-down family planning and birth spacing campaigns fail to take into account the many factors which influence choices made about family size is also relevant to the case of Oman. While the Omani government has seen some success with its birth spacing campaign, the pressures and benefits that may lead some couples to decide to have larger families may prove the most 'rational' choice for them given their situation. It is important to consider the gap that can exist between internationally influenced campaigns and the social and economic realities that are influencing decisions about fertility and contraceptive use. Similarly, Gruenbaum (2011) illustrates how issues such as FGC are influenced by many forces in society, and are therefore not effectively addressed with top-down health campaigns. The necessity of taking these various local, state and international influences into account in implementing programs related to reproductive health is emphasized in this study.

Dudgeon and Inhorn's (2004) emphasis on the need to involve men in health interventions related to reproductive health is also relevant to this study. The direct and indirect influence that men, extended family and the community have on reproductive choices is substantial in Oman. Therefore, there is a need to better incorporate these groups into health interventions.

Inhorn's (2011) study is also relevant in considering the role that religious doctrine and the interpretation of religious rulings have on shaping the reproductive

options available to couples in Muslim majority countries. As infertility is high in Oman, and religious rulings do determine the options available to infertile couples, this is an important discussion. The need to be conscious of the influence of Western medicalization and how this could change system approaches as well as influence social factors in Oman, as Morsy (2009) and Helman (1990s) discuss, is also considered in this study. Looking critically at international organizations' influence and emphasis on contraceptive campaigns over other aspects of women's health, prioritizing lowering fertility and family size as a way to improve maternal health over other aspects of at the expense of other needs is also crucial for this study. The political and economic context that impacts these motives should not go unnoticed. Helman's (1990) reflection on the increasingly medicalized setting for pregnancy and giving birth, and the gaps that may exist between patient needs and clinical approaches and priorities in the medical setting is also important in the Omani context. There is a need to consider how these shifts influence the satisfaction and relationship Omanis have to the health care system. Examining the impact that medicalization and reproductive health policy can have in terms of limiting the comprehensiveness and quality of approaches in women's health is also relevant to consider for the purposes of this study.



## CHAPTER III

### THE DEVELOPMENT OF OMAN'S HEALTH SYSTEM AND FUTURE GOALS

*As it is well known that a healthy mind is in a healthy body, health should be a right of every citizen. Since July 1970, we have decided to attach high priority to the development of health of the Omani people.*

–His Majesty Qaboos bin Said, Sultan of Oman

Oman has seen remarkable advancements in terms of health care infrastructure and the quality of care available to Omani citizens. In the early 1970s Oman had only two hospitals and ten clinics to meet all of the health needs in Oman. But by the 1990s most essential social services were reaching the most remote areas in the interior of the state, and through the establishment of municipalities, responsibility of these services were turned over to local towns and villages (Peterson, 2004, p. 133). By 2006, the government had established 49 hospitals, 150 health centers, as well as 19 extended health centers administered by the Ministry of Health (World Health Organization, 2008, p. 8). This does not include the private health centers in the country. The 1997 Human Development Report praised Oman for being a pace setter for human development in health and education. The 2000 World Health Organization report also rated Oman first out of 191 states for its efficiency in improving health and 8th for the overall efficiency of its health system (Sultanate of Oman, 2014, p. 28). Life expectancy at birth in Oman increased thirteen years from the early 1980s to 2010 (ESCWA-UN, 2011, p. 2). Life expectancy is now 74 for men and 78 for women (World Health Organization, 2014, p. 1). All health services and medications (including psychotropic drugs) are completely free for all Omanis (World Health Organization, 2008, p. 5). With these improvements in

Oman's health care infrastructure and the ability of the government to meet basic health needs, the country is now experiencing a shift away from a primary focus on communicable diseases and is increasingly addressing issues related to lifestyle and quality of life. The government is now working to develop and improve the secondary and tertiary care available to its citizens in order to meet the newly emerging health concerns that come with changing social conditions, as well as health issues which have not yet been adequately addressed. The government is now approaching health challenges that are more closely associated with lifestyle, culture, and social perceptions for the first time. This includes improving specialized care in mental health and reproductive health—two realms closely tied to social perspectives.

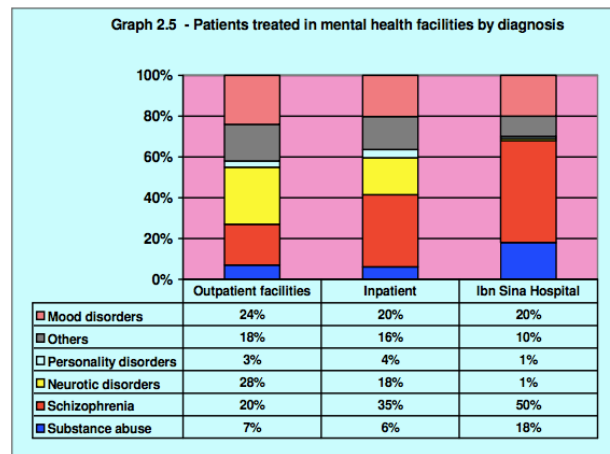
The healthcare system is one of the developments in which the Omani government has taken the most pride. The government has been very ambitious in terms of targeting these emerging health concerns and developing health plans which incorporate these new aims. But many factors related to these non-communicable health concerns have been greatly influenced by the socio-economic changes that have occurred within the country in the last few decades. Therefore, just as it will be required to consider the impacts of globalization and fears over threats to Omani culture in terms of its overall development trajectory, the government will also be required to address these factors as well as social attitudes as it works improve the health of its citizens.

### **Mental Health in Oman**

Neuropsychiatric disorders are thought to account for 16.8 percent of the burden of disease in Oman (World Health Organization, 2011). Sultan Qaboos University Hospital reported that 2,200 new cases of depression were diagnosed in the year 2011—an

increase of 20 percent. The Ministry of Health also reported in its 2011 yearly report that there were 1,612 new cases of mood disorders and 3,687 stress-related mental disorders diagnosed in that year (Country Cooperation Strategy, 2010, p. 25). A shocking statistic in the first part of 2012 also found that every 6 days an Indian expatriate in Oman committed suicide (Ginn, 2013). Furthermore, a recent study of Omani adolescents found that 14 percent suffer from an anxiety disorder, mood disorder, or depressive disorder (Country Cooperation Strategy, 2010, p. 25). Despite these figures, mental illness is considerably underreported and undiagnosed in Oman, and data estimating the number of individuals suffering from mental illness is lacking. However, worldwide mental illness and substance abuse are the leading cause of disability, and 350 millions people are believed to suffer from depression alone (World Health Organization, 2012). Furthermore, mental disorders' co-morbidity rates with other non-communicable diseases is as high as 30 percent in many countries (Country Cooperation Strategy, 2010, p. 25). A 2008 WHO AIMS report focused on Oman found that in outpatient facilities, neurotic disorders and affective disorders were most prevalent, while in the inpatient units and hospital schizophrenia and affective disorder were the most common diagnoses (p. 14). In the two community-based psychiatric inpatient units 35 percent had a diagnosis of schizophrenia and 20 percent were diagnosed with affective/mood disorders (p. 11). Figure 1 (below) shows the distribution of diagnoses by mental health facilities.

Figure 1: Patient Diagnosis Distribution (WHO, 2008, p. 14).



The only hospital which exclusively addresses psychiatric disorders as well as addiction in Oman—Al Masarra Hospital—was established by the Ministry of Health in 2013. With 245 beds, it is located in a fairly isolated location outside of the capital of Muscat. The new hospital replaced the first and significantly smaller mental hospital (Ibn Sina), which was more centrally located in the capital (“From Now,” 2013). Additionally, as of 2008, there were 26 outpatient mental health facilities throughout the country. However, the WHO’s 2008 AIMS report found there were no outpatient facilities focused on follow up in communities, mental health mobile teams, or any day treatment facilities (p. 10). There were two community based psychiatric outpatient units, and all inpatient units were found to have psychotropic medicines in each therapeutic class. However, it also found that the majority of mental health resources were concentrated in the capital (p. 25).

The number of health workers working in mental health is 14.18 per 100,000 of the population (WHO, 2008, p. 25). As of 2010, there were only 67 registered psychiatrists and 12 psychologists working in mental health facilities in Oman (Country Cooperation

Strategy, 2010, p. 25). The majority of psychiatrists are expatriates and recruited from abroad, as only five Omani doctors had completed Oman's psychiatric residency program (which was introduced in 1999) as of 2006. With this dependence on expatriate doctors to meet the mental health needs of Omani citizens, there is some concern that they may not adequately understand all of the social factors that may impact mental health for Omanis. However, medical students appear not to be interested in pursuing psychiatric specialization (Al-Sinawi & Al-Adawi, 2006).

Since 2005, the Omani government has attempted to reform its mental health approaches in order to provide more adequate care. The government has stated that it aims to focus on improving access to services for all groups, increase mental health advocacy and protections, increase mental health components incorporated in primary care, and improving mechanisms for monitoring and measuring the quality of care in the mental health sphere (WHO, 2008, p. 9). Oman's first national meeting on mental health was held in 2007, and it was recommended that Oman develop a Mental Health Act which would focus on improving information and referrals in the primary health care systems in terms of mental health services, introduce a school based program, and promote advocacy to decrease stigma (Country Cooperation Strategy, 2010, p. 26). Despite attempts to incorporate components related to mental health in its overall health plan, there are still many hurdles that make addressing mental health difficult in Oman. As in many societies, mental illness can be extremely marginalizing and can bring stigma to sufferers and their families. So far, the government's success in strengthening mental health services and reaching its mental health aims has been an arduous process.

## **Discussions of Cultural Beliefs and Mental Health in Oman**

Al-Sharbati, Al-Sharbati and Gupta (2014) examine some of the social factors which impact the ability of people in the Middle East to seek mental health services. They argue that social stigma plays a large part. Stigma, as well as lack of awareness, in conjunction with accessibility of services and economic factors, limits the utilization of mental health services. Therefore, they contend that there is an under-diagnosis of psychological disorders in the Middle East. Arab people may be hesitant to seek psychotherapy to address mental health concerns because of associative stigma—social shame can bring on a whole family rather than just the individual (p. 5). The interdependence and collective nature in many of these societies also means that people tend to rely on family networks for support rather than seeking professional help. Sharbati et al. argue that the influence and importance of these family networks should not be ignored when addressing mental illness. For female patients, it may also be difficult to seek help because it may be seen as inappropriate to share personal information with a stranger. For men, expressing emotional pain may be viewed as a threat to their masculinity and identity, as control over one's emotions is valued.

In Oman specifically, as of 2009, there were only 39 registered mental health professionals to address all of the needs of Oman's population of over 3 million (p. 6). Sharbati et al. argue that in addition to the overall insufficient number of mental health professionals in the country, there is also a lack of Arabic speaking psychotherapists, as well as specialists with proficient communication and counseling skills.

Sharbati et al. also point out that in Oman, there is also a strong link between mental illness and the supernatural. Many Omanis with mental health concerns seek the

help of a spiritual healer (*muttawa*). A *muttawa* might read specific verses of the Qur'an (called *ruqya*) and also have the individual recite certain verses as homework. Drinking blessed water, as well as *zar* (a practice to address spirit possession) are also used.

Sharbati et al. argue that because of the prevalence of these beliefs, it is important to be sensitive to patients' spiritual and cultural needs. Patients often expect to be given a quick solution that can immediately address their suffering. However, Sharbati et al. argue that in their experience, patients can become very invested and involved in doing homework as part of their therapy, and family members can also be a source of support and help patients work on their therapy homework. Therefore, engaging with patients' religious beliefs may help in their overall recovery.

Sharbati et al. also argue that many patients expect professionals to be able to understand their inner world, including their belief system. They argue that it is important for professionals to be familiar with patients' beliefs so that they can help patients address issues using the same framework and worldview. Therefore, if professionals are well versed in religious beliefs they can use these ideas to help patients understand their experiences in a new way and to help frame their wellness journey.

In their study, Sharbati et al. examined the use of psychotherapy in Oman, and those who participated in psychotherapy. They found that women were more likely to seek services than men, and single people were more likely than married people to utilize psychotherapy. Almost one third of participants suffered from anxiety disorders (p. 11).

Sharbati et al. also found that psychotherapy had a culturally sensitive approach. The cultural meaning of illness, as well as patients' spiritual and religious beliefs were explored. Metaphors from the Qur'an were also used to present certain concepts and new

outlooks to patients. Patients' beliefs were also incorporated into their homework. Certain prayer recitation may be used if patients found that it contributed to their wellbeing and was a useful coping strategy.

The authors conclude that while many people still seek the help of traditional healers, because it addresses cultural beliefs that mental health issues are caused by external supernatural forces, recognition of the merits of psychotherapy have been increasing. Patients and physicians both agree, however, that faith is an important aspect of coping with mental anguish. Sharbati et al. also suggest that an emphasis should be placed on awareness campaigns to bring attention to the benefits of mental health services. Additionally, awareness for professionals on the benefits of a multi-disciplinary approach to improve the quality of services and care is also important.

In their 2002 study concerning perceptions of mental illness in Oman, Al-Adawi et al. (2002) found that there were many shared conceptions about the causes of mental illness and set notions about individuals with mental illness. In their study (conducted in the capital of Muscat) they found that 42 percent of medical students, 45 percent of the public, and 23 percent of relatives of individuals with mental illness believed mental illness to be caused by spirits (or *jinn*). They also found that the majority of those interviewed believed that they could recognize those with mental illness from their strange appearance, and many expressed a desire to keep those with mental illness away from their communities. Al-Adawi et al. argue that attitudes towards mental illness can significantly impact how well mental health can be addressed within a community, as well as how possible disenfranchisement and disempowerment can influence those seeking treatment to improve their health (Al-Adawi, 2002). They argue that Oman's



history and isolation before the 1970s, has led to unique attitudes and perceptions of mental illness, which remain prevalent even in medical students in Oman. In order to adequately approach mental health concerns in the country, these perceptions must be taken into account. As a result of relating mental illness to spirit-forces, Omanis often seek alternative treatments—such as visiting a spiritual healer—rather than seeking medical care for the symptoms they are experiencing. Individuals often do not pursue medical treatment until their symptoms have escalated and after exhausting all alternative options. This prevents individuals from receiving help at an earlier stage in the illness (Al-Sinawi & Al-Adawi, 2006).

In Al-Riyami, Al-Adawi, Al-Kharusi, Morse and Jaju's (2009) study on mental health service utilization among adolescents, they concluded that improving access to primary health care, making psychotropic medications available in these settings, and having a clear referral system for allopathic services does not guarantee that mental health services will be utilized. Al Riyami et al. aimed to investigate if given the changes that have occurred in Oman, including free education and access to healthcare, utilization of mental health services among young people has improved. While the Ministry of Health has tried to introduce programs to improve the ability to recognize psychiatric disorders at the primary care level, they found that utilization remains poor for adolescents with psychiatric disorders.

Al-Riyami et al. therefore conclude that there is still a need to better address religious, social, and cultural barriers that exist in order to improve use of mental health services. They emphasize that because psychiatric distress is often viewed as occurring due to *jinn*, envy (*hassad*), the evil eye (*ain*) or sorcery (*sihr*) psychiatric care may be

viewed as being incompatible with Omani society and beliefs about the causes of mental illness (Al-Riyami et al., 2009, p. 8).

The authors found that while females were more likely to make initial contact for treatment, men often outnumber women in clinical settings. Men who are suffering from mental illness may be seen as weak and having weak character. Public health education on mental health to address these issues would therefore need to be emphasized if psychiatric approaches are to be successful.

Exploring some of the reasons why mental health services may be underutilized include the limited number of registered mental health professionals for all of Oman's population, which is spread over 300,000 square kilometers. Most services are in tertiary hospitals, plus two mental health centers in the capital. Primary health care is usually the first point of contact, but there is often a lack of awareness about mental health issues and also a lack of consistent relationship with primary health care providers. Psychotropic drugs are also available and free at the primary care level, but there is a lack of awareness of these and other treatment options.

Psychiatric services are modeled after Anglo-American models, stressing neurogenic aspects and a clinical outlook. Traditional healers also have special value in society, and are thought to better align with social and cultural ideas of the community. Al-Riyami et al. therefore conclude that there is a need to better integrate allopathic and non-allopathic systems in Oman. Like Al-Sinawi and Al-Adawi (2009), Riyami et al. found that many people seek help from traditional healers before seeking psychiatric help, and many end up going healer shopping. After exploring all of these options, they may then eventually seek help in an allopathic system. Those suffering from mental

illness may also go between both allopathic and non-allopathic systems while receiving treatment—more studies should be conducted to examine patterns of use of these services (Al-Riyami et al., 2009, p. 9). Helping to bring together allopathic and non-allopathic services may be useful, as coping with mental illness an important aspect of treatment, and allopathic services can help do this for patients.

What also complicates the utilization of psychiatric services in Oman is the question of whether Western psychology can be applicable in a society where interconnectedness is so emphasized and concepts of “self” and developing the self vary significantly from western thought. More studies about using Western criteria in Oman need to be examined. There should also be more focus on creating a culturally sensitive interventions for youth in Oman. Existing institutions could also be better utilized to train new psychologists, psychiatric social workers and mental health workers in a culturally sensitive ways at a quicker rate then it takes to train or recruit psychiatrists (Al-Riyami et al., 2009).

In their study of the use of HADS—Hospital Anxiety and Depressive Scale in detecting emotional problems in patients with traumatic brain injuries, Al-Adawi, Dorvlo, Al-Naamani, Karamouz, Chae and Burke (2007) argue that certain diagnostic and detection tools may be ineffective in certain cultural settings. In the treatment of traumatic brain injuries, they emphasize that it is important to identify and treat emotional issues that may accompany them. Anxiety disorders, including post-traumatic stress disorder, and depression are common, and tend have much higher rates in those suffering from traumatic brain injuries (TBI). HADS is a common tool used to detect these problems in patients with TBI.

In their study, Al-Adawi et al. aimed to detect rates of emotional issues in TBI patients using their own interview methods, and analyze the effectiveness of the Arabic version of HADS in screening for these issues. They concluded that the Arabic version of HADS was not effective in measuring mood disorders in culturally diverse samples with TBI.

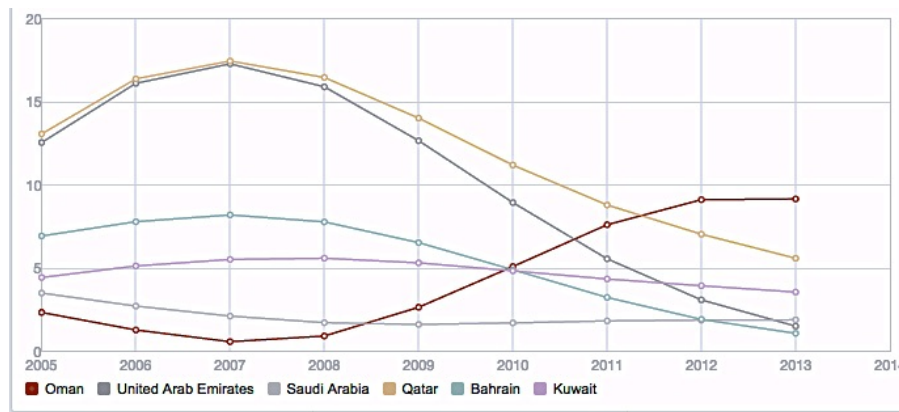
Indications of anxiety and depression using HADS resulted in lower numbers than what they believe should have found given their alternative methods. Semi-structured interviews found that 57.4 percent of TBI patients had depressive illness, and 50 percent had anxiety disorders (p. 391). Therefore, they conclude that HADS is not an appropriate tool for screening for mood disorders in TBI patients in Oman. These and other screening tests should be reevaluated in terms of their cultural relevance and effectiveness.

### **Reproductive Health in Oman**

Reproductive health has presented another significant challenge for the Omani government in terms of responding to modern needs while respecting perceptions of Omani cultural values. Since 1994, the government has provided free contraceptives to all married couples through its primary care centers. However, recent studies related to family size and population growth in Oman suggest that shifting economic and social factors may be impacting Oman's population growth in an atypical ways. While most Gulf countries have experienced a recent decrease in their population growth rate, the expected "demographic transition," has not occurred in Oman. Countries usually see a demographic transition occur as death rates decrease and access to education and health care increase. While the population continues to grow for a brief period, birth rates eventually begin to decrease steadily (Jacobsen, 2014, p. 6). However, Oman has

continued to experience a rise in population growth, which as of 2012 was 9.3 percent. Comparatively, Qatar’s growth rate is 7.05% and Bahrain’s is 1.92 percent (World Bank-Oman, 2014). Recent studies have suggested that shifting conceptions of what it means to be “Omani” and an Omani family due to changing socio-economic conditions may be impacting these trends (Eickelman, 1993; Al-Barwani & Albeely, 2007). Figure 2 (below) depicts the annual percentage of population growth in Oman from 2005 to 2013 compared to neighboring Gulf states.

Figure 2: Population Growth, Annual Percentage (World Bank, 2013).



### Discussions of Reproductive Health, Gender and Development in Oman

In a 1993 study conducted by Christine Eickelman, she found that there has been an increase in the desire for larger families in Oman. She argues that having a large family—with 10 or more children—had become a newly emphasized aspect of possessing a distinctly “Omani” family identity. Despite socially being encouraged to enter more vocations and to continue in higher education, she found that an increasing number of educated women were prioritizing having more children. She also noted an increase in social stigma surrounding the idea of controlling births following the 1980s (Eickelman, 1993, p. 655). She attributes these local responses to changing socio-

economic circumstances and increased status tied to postpartum visits and a families' ability to increase their social status through networks and displays of hospitality after having a child. These shifting perceptions of what it means to be a successful Omani family may impact the government's interventions related to reproductive health and family planning.

In a brief study conducted by Al-Riyami, Afifi and Mabry (2004) concerning the relationship between education, empowerment, and contraceptive use in Oman, the authors were surprised by their findings (Al-Riyami et al., 2004). While the strongest correlation between "met need" in terms of use of contraception was education, the results varied considerably from a similar Egyptian study conducted by Kishor et al., which found that Egyptian women's autonomy was a better indicator of contraceptive use. Riyami et al. therefore conclude that while there were fewer unmet contraception needs among college educated and employed women, education has not necessarily improved women's decision-making or freedom of movement. They conclude that this may be due to the fact that while Egypt has been in the process of modernizing the country for quite some time, Oman has only seen significant changes in a time span of one generation of adults. Cultural attitudes and practices take time to change significantly, therefore Oman is simply experiencing a "cultural lag" (p. 152). While the government has made contraception widely available and free for married couples, half of the 1,830 women in the study said that their husbands would still decide whether or not they would use contraception. There was also still an expectation for women to have a child within the first year of marriage (p. 145).

In Al-Barwani and Albeely's (2007) examination of the Omani family, they

consider the ways in which social programs such as education have impacted traditional family structures, and note certain trends that have emerged from these changes; including women marrying later (especially women in urban areas), educated women being less likely to enter polygamous unions, having smaller families, contributing to lower fertility rates, and an increase in contraceptive use (Al-Barwani & Albeely 2007, p. 126). They found that the percentage of women in the workforce increased from 6.7 percent in 1993 to 34.4 percent in 2003 (p. 125). While many women work in health and education—as these are seen as jobs appropriate for women, they are beginning to enter new fields—including engineering, marketing, law, and academics. In response to these changes, they found that there has been increased pressure to balance and maintain the tradition Islamic family structure. They note that while the Islamic family is considered necessarily in order to encourage moral development that can stand up to Western influence, patriarchal structures have been threatened due to globalization. For instance, men are no longer always the primary economic providers, and women do not necessarily have as many children as in the past—threatening the traditional large family network. However, Al-Barwani and Albeely predict that a balance between traditional family structures and modernity will be negotiated.

Women's empowerment, family size, threats and responses to challenging patriarchal societies have all been complicated by Oman's rapid development and experiences of globalization. Many of these studies seem to suggest differing trends in Omani society, as these issues are being contested and negotiated in Oman. Therefore, there is not a simple correlation between education, female empowerment and family size in Oman.

In Jaffer and Afifi's (2005) study of reproductive health education and understanding among primary school students, they discovered that there are considerable gaps in general knowledge related to reproductive health. While 90 percent of the sample they questioned were over 16 years of age, only about half recognized the major changes associated with puberty among their own sex, and the percentage was even less in terms of recognizing changes in the opposite sex. Furthermore, only 19 percent of females responded that these changes were normal (p. 58). Additionally, 71 percent of the girls said that they would use modern contraceptive methods in the future while 66.6% of boys responded that they would (p. 54). However, understanding of where they could receive contraception was poor. While boys and girls both had high levels of understanding about AIDS, their understanding of the transmission of other STIs was poor. Therefore, Jaffer et al. conclude that there is considerable room for improvement in terms of education related to puberty (especially the perceptions of girls who view these changes as abnormal), family planning, and sexually transmitted diseases. Deciding how to best approach these sensitive topics may prove difficult.

#### **National Perspectives: Development Plans from Oman's *Health Vision 2050***

Oman's *Health Vision 2050* was created in May of 2014. In light of the outstanding progress Oman's health system has made in past forty years, the Ministry of Health report looks ahead to the development needs and targets for the next forty years. The goal of *Health Vision 2050* is to ensure that Omanis are able to live "healthy and productive lives through establishing a well-organized, equitable, efficient and responsive health system, grounded by societal values of equity and social justice." Therefore, the report is themed "Quality Care and Sustained Health" (Sultanate of Oman, 2014, p. 4).



The document notes that due to the epidemiological shift that has occurred in Oman, non-communicable disease, health concerns related to behavior, and inherited conditions will be of more concern in the coming years. The document was developed as the result of a three-day conference in which both local and international specialists participated.

### ***Structure of the Report***

The report, which uses the World Health Organization's *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*, uses the organization's six building blocks as structure: leadership/governance, financing, human resources for health, service delivery, information, medical products, vaccines, and technology.

*Health Vision 2050* lists the following concerns as targets of its coming health development:

- Prevention over simply seeking a cure through the promotion of health and healthy choices
- Incentive for quality of care such as outcome based budgeting, and knowledge support for professionals in clinics
- Increasing specialist services throughout the country
- Community support for chronic diseases
- Integrating preventative and curative services
- Transparency for health worker performance—including knowledge, experience, motivation, collaboration among workers for a more efficient system.
- Keeping up with newest medical technologies to manage health

- Developing biomedical engineering (p. 9).

### ***The Health System in Oman***

In the *Vision 2050* report, the health care system prides itself on providing universal coverage for both citizens and expatriates. The Government covers about 81.1% of Total Health Expenditure in Oman, providing 83.1% of hospitals, 92.5% of hospital beds, 62.2% of outpatient services and 94.5% of inpatient services (Sultanate of Oman, 2014, p. 50). The health system in Oman has a decentralized approach, with the health regions in Oman aligning with 11 districts (wilayats) which make up the country (p. 79).

### ***Population Growth and the Expatriate Population***

Oman has a small population, at 3.6 million, but it is scattered over great distances. The terrain in Oman can be difficult to maneuver, with mountainous terrain as well as barren valleys. Approximately 32 percent of Oman's population lives in the Muscat governance around the capital city, while 25 percent lives in the neighboring Al Batinah district. Oman has a very large expatriate population living in the country; about 42.2 percent of the current population are expatriates or non-nationals (p. 2).

It is predicted that Oman's population will double by 2050, reaching 7 million people. According to Oman's 2010 census, the population growth has been 2.4 percent annually since 2003—1.3 for the Omani population and 5.5 percent for non-nationals. Therefore, if the fertility of the Omani population stays stationary—the total Omani population will be 4.7 million by 2050, if it declines slightly—4.3 million, and if fertility decreases it will be approximately 3.95 million. In the future, the government has plans to decrease the expat population to 1/3 or less of the total population. Therefore, Oman's

population could reach 7 million (from 3.6 million in 2012) over the next 38 years (Sultanate of Oman, 2014, p. 20). An increased aging population due to increased life expectancy in Oman is also of concern in terms of improving the country's capacity to address new health care needs that come along with a growing elderly population.

### ***Omanization of the Health System***

*Health Vision 2050* emphasizes the need to invest in training for more Omanis so that they can join more specialized jobs in the workforce. In the health sector, Omanis make up just 29 percent of physicians, 54 percent of nurses, 27 percent of pharmacists and 20 percent of dentists (Sultanate of Oman, 2014, p. 126). The report argues that having so many non-nationals can make a health system less effective—as health care workers have different backgrounds and levels of training and may require further training to ensure homogenous health care. Furthermore, it can be difficult to maintain an adequate human resource-to-population ratio when the system relies so heavily on expats, as they can be harder to retain for a significant amount of time. The report asserts that Omanization of the health care sector and human development for health professionals will be “vigorously pursued” (p. 187).

The Ministry of Higher Education and the Ministry of Health often pay for Omanis to receive higher education and medical school training abroad. To be more self-reliant, there will be an attempt to increase the intake of students in medical school, as well as increase teaching staff at medical schools. Upgrading and increasing the number of students admitted to the Ministry of Health training institutes and providing more postgraduate specialties will also be prioritized.

### ***Maternal Health and Reproductive Health***

In terms of maternal and reproductive health, the report notes that Oman has been successful in encouraging women to take part in antenatal care; as of 2012 less than one percent of women do not register for antenatal care (p. 59). The report also argues that encouraging birth spacing has had some success, as 34 percent of women who delivered in 2012 spaced children by three or more years and 42 percent by two to three years. Oman introduced its birth spacing program in 1994 (Sultanate of Oman, 2014, p. 59).

The report does note that the rate of sexually transmitted diseases is on the rise, and yet only 3.9 percent of students in higher education could correctly identify ways of preventing the transmission of HIV. There is also currently only one specialty clinic for AIDS patients (p. 65).

### ***Mental Health in Health Vision 2050***

The only significant mention of mental health concerns in the *Health Vision 2050* report notes that major depressive disorder moved from seventh position to third position from 1990-2010 in a measurement of diseases which contribute to loss of life, measured by DALYs (Disability Adjusted Life Year) (p. 75).

### ***Tertiary Care and Specialization***

Tertiary care can get very congested, and the *Health Vision 2050* report states that there is a need to expand these specialty services as well as increase the amount of specialties offered. To address these needs, there is a plan to construct a medical city with more tertiary services by 2020 in the capital (p. 114). The medical city will also include more training and education for health care professionals, so that they will not have to go abroad for training. After the medical city is completed in the capital, they will also be

established in north Al Batinah and then the Al Wusta governorate. Redefining and reconstructing current medical buildings will also occur, as primary health care clinics will be expanded to provide more extensive primary care, hospitals will be reconstructed to provide secondary care and some tertiary care services, and more secondary care hospital will be build in areas which are currently underserved. The report argues that medical cities will provide more state of the art tertiary care as well as training opportunities for medical personnel—both of which are greatly needed.

### ***Improving Training Opportunities and Health Research Coordination***

The health report also articulates that there is a need to provide more postgraduate training for more specialties—including for dieticians, occupational therapy and other specialties that are not currently available. In 2001, a specialized nursing institute, which includes training for midwifery and mental health, was established (p. 132). To further improve specialty-training opportunities, the government plans to construct the University of Oman. Within this institution, there will be a faculty of medical sciences and public health. This will increase the infrastructure for public health education for professionals. However, the report notes there is a need to enhance the ability of hospitals to adequately train undergraduates and postgraduates in clinical training.

Another issue for advancing health in Oman is the lack of coordinated health research (p. 158). The report calls for a better system to coordinate research efforts between the Ministry of Health, Sultan Qaboos University and other institutions, as well as improve the coordination of research with international organizations. It also plans to develop the implementation of a burden of disease study, as well as an electronic record

keeping system that can be accessed by both public and private institutions. It articulates the need to increase the budget for health research generally.

### ***Connecting to the Public to Address Behavior and Health***

The report notes that there is a need to address certain behavioral choices in Oman that can pose a risk to citizens' health. It argues that using religious leaders—such as those from the Ministry of religious affairs, to bring health messages about risky behavior and health education—such as eating habits, physical activity and smoking—may be a useful tool for improving the health choices of Omanis (p. 168).

### ***Overview of Health Developments and Goals in Oman***

It is evident, considering the strides that have occurred in the country, that Oman has invested heavily in improving access to primary care, meeting the essential healthcare needs of its population, and in maternal and antenatal care. The *Health Vision 2050* report identifies several key needs to improve the quality of care in Oman, including enhancing specialized care, the quality of professionals, and training opportunities. It is noteworthy, however, that community-centered care and the influence of culture on care and cultural competence are not mentioned significantly. The report does mention that decentralization could lead to more locally driven care, but plans to shift care to community approaches (as several of my interviewees discussed) is not explored.

CHAPTER IV  
THE EXPERIENCES OF HEALTH PROFESSIONALS WORKING  
ON THE GROUND IN MUSCAT

In my interviews with health professionals who work in various settings throughout Muscat, there were many reoccurring themes which participants identified as pressing issues or major challenges and hurdles to providing Omanis with quality care. The majority of mental health professionals identified public awareness and education, stigma, language barriers, and cultural beliefs as major factors that impact care in Oman. Reproductive health specialists identified issues related to gender, fertility, family and community influence, and cultural conceptions about reproduction as major influences that shape reproductive health in Oman.

Participants in both areas of focus agreed that culture and social perceptions in Oman present both challenges as well as opportunities to improving care. Most also agreed that while care in the primary health care centers has improved greatly, and can now adequately address many basic health concerns, there are still considerable improvements that could be made to address specialized care in mental health and reproductive health more comprehensively and consistently. Similarly, many participants pointed to the lack of well trained, Arabic speaking, and culturally aware professionals as a major hurdle to quality care in both areas.

## **Perspectives and Emerging Themes from Mental Health Professionals**

### ***Awareness of Mental Health Issues***

The majority of my participants identified awareness of mental health issues as a primary hurdle in treating mental health in Oman. Ms. Sinha said that she believed mental health is one of the least touched upon subjects, as is often the case around the world. Education and awareness campaigns are considerably lacking. She mentioned Whispers of Serenity Clinic's (a private clinic in Muscat) current video campaign entitled "You Are Not Alone" or "We Are With You" in Arabic as an example of some work being done in this area. Whispers of Serenity created a video in Arabic, with English subtitles, attempting to reach the Arabic speaking population in Oman. The video campaign attempts to address stigma surrounding mental health by showing various Omanis in different positions in society who have suffered from mental illness or a mental health issue. It helps give a human face specific to Oman related to mental illness. She argues that more awareness campaigns like this are needed in Oman.

Mr. Nabhani said that there is considerable focus on community services in Oman, and especially on education for the public. The College of Nursing, for instance, has done an educational service on mental health, and another on women's mental health. However, this is not necessarily done as regularly as it could be.

Mr. Al-Omari noted that Oman has done an amazing job investing in health education—in schools and in health centers, for example. However, he said that he is not sure how effective the mental health campaigns have been. For mental health day, they conducted activities in public spaces, including at Muscat City Center and the University. Mr. Al-Omari said that in his experience, people are very receptive to hearing about



health campaigns, “so, when you take it to the people, they are very interested in it as well. And very polite, and very willing, and know what to ask about. So they are receptive as well.” Therefore, he was hopeful that continued health campaigns may be effective in the future to address stigma and awareness.

Dr. Abiha argued that there needs to be more emphasis on awareness about resources available for mental health, as well as why you should seek out these services. She was adamant that just letting people know that it is okay to receive help for various hardships is important to emphasize in awareness campaigns.

In the community, I would say maintaining awareness about mental health [is a pressing issue]. Even if you don't have like, a counselor, a TV show, or a radio show, or having exhibitions at the city centers about mental health, where do you go if you have a problem with yourself, your husband, or whatever? Just letting them know, there are problems out there, and you can do something about that. You can't just let it go on and on and on and the pressure is building and a break happens.

Ms. Sinha, Ms. Deora and Dr. Abiha each stressed several times in their interviews that more awareness is needed in Oman about the various reasons people may choose to seek help, and that it is okay to receive outside help for any kind of stress people may experience in their lives. Ms. Sinha emphasized that she wants people to know that getting help does not mean that they are mad or crazy. Rather, it is just that life can be difficult and it's okay to need help to get through these challenges.

Ms. Deora similarly agreed that awareness surrounding mental health concerns should be increased in Oman. She suggested that awareness could be increased by adding content about mental health and ways to take care of yourself into school curriculum. She argued that although there is a Women's Association that will sometimes include mental health as a part of their campaigns, they cover it as “psychiatric problems.” Because of

this, people avoid engaging with this part of the displays because they worry that if they do, someone will think they are suffering from a psychiatric disorder. She explained that she does not like this approach, because in her experience, labeling mental health awareness “psychiatric problems” rather than framing it simply as mental health, people find it insulting and stigmatizing, saying “I’m not *majnoon!*” (crazy) and avoid exploring these issues. Several of my participants echoed this frustration, saying that there is often a focus only on mental illness, and narrowing conceptions of mental health to only psychiatric disorders, rather than approaching it more comprehensively as improving mental health wellness.

Ms. Deora also said that she makes a point when she goes to schools for three weeks for health awareness, she always assigns a student to cover a mental health issue. Although this is small scale, it may at least make one student more knowledgeable about a mental health topic.

Mr. Ballal said that in his experience, when nurses go through the nursing program, their outlook changes significantly on mental health. Nursing students fill out a questionnaire before their course on mental health and clinical experience in mental health settings. After their 16-week program, he said that it is amazing to see how their thinking about mental illness changes significantly. Therefore, he expressed that he has hope that negative attitudes about mental health can be changed in Oman. He suggested that better coordination of institutions like University alumni groups, the medical colleges and nursing colleges, could help to better plan and organize awareness programs throughout Oman which may have a greater impact.

## *Stigma and Mental Illness*

Dr. Rashid identified stigma as one of the primary hurdles to addressing mental health in Oman. He said that:

Like many other countries, mental health is usually associated with negative feelings, negative perspectives, negative outcomes, so the person with mental health [issues] gets to be stigmatized against when they are applying for a job, when they want to continue their studies, when they are socializing. And this is against people who present to mental health services believe it will be shameful to be seen in a psychiatric office. So, that's another component. Okay, and people [...] they stigmatize not just towards the patients but also the psychiatrists because people think that they are abnormal themselves because they are associated with working with people with mental health problems, even though mental health is not contagious. I think that stems from the idea that public knowledge about what does a psychiatrist do? We still come across people who think that psychiatrists can read your mind, or analyze your personality by talking to you, which basically there's no evidence for that at all, we are not interested, basically! [laughs].

Dr. Rashid stressed the point, therefore, that not only do individuals and families with individuals experiencing mental illness suffer the consequences of disenfranchisement and judgment in society, but professionals working in mental health experience similar marginalization. Dr. Al-Hazizi also found that it was common for patients to shop around for a physical diagnosis to explain their suffering because of the stigma surrounding mental health.

So most of our patients they will be, sort of, shopping from doctor to doctor, looking for the physical cause of their suffering. One of the things is of course due to stigma. So for them, it is much better to be told you have this problem because you have, for example, a brain stroke than to be told you have this problem because you have depression. So they prefer to have a brain stroke rather than depression because, of course, stigma. So they'll be moving to one doctor to another to find a cure until they, you know, they are fed up, and they decide or agree to go see a mental health physician. In addition to that, we have also another problem of using, you know, sort of, spiritual or religious healers—traditional healers for managing their problems. So most of the patients we see actually, almost all of them, probably more than 80 percent—they have tried some of those things before coming to us. So probably they have tried a traditional healer,

maybe shopping to different doctors to see if there's any physical cause, and in the end then they will come to psychiatry.

Dr. Al-Hazizi therefore found that patients usually ended up seeing him as a last resort. A number of my other interviewees agreed that somatic complaints and searching for a physical cause was common in Oman and related this to stigma. Dr. Abiha, for instance, said that she found somatic complaints to be common, and that she believes this occurs because it is not acceptable to express psychological distress, as this can be stigmatizing. Therefore, people find other ways to express their emotional pain.

Dr. Abiha identified stigma as the main challenge to addressing mental health in Oman. She has found that her students are often very hesitant to talk about family members who they suspect suffer from mental illness. Even when they cover mental health material in their courses, they are embarrassed and reluctant to do so. However, she said that overtime students become more open as they learn about mental health, and will even come and speak to her after the course about how to help family member struggling with mental illness.

Mr. Al-Omari similarly found that in Oman you still see relatives desperate to hide mental health problems. Therefore, they tend to seek traditional healers which can be less stigmatizing. However, he also notes that the Sultan Qaboos University Hospital ward and Al Masarra are generally full of patients of all ages. Therefore, people may not be averse to utilizing these facilities. Dr. Yusuf agreed that there is a hesitancy to attend clinics because they are worried about being labeled and stigmatized as a result.

The stigmatization of people with mental health issues can also negatively impact them in the workplace as well as have consequences for the entire families. Dr. Al-Hazizi

found that in the workplace, even when they work for the government, people are afraid to request sick leave because they would have to show they have been referred to a psychiatrist. They would rather not take leave rather than risk people in the government or other employees finding out.

Ms. Deora found in her work in communities throughout Oman, that if a family finds out another family has someone suffering from a mental illness, they will not want to marry from the family. When she spoke to people in the villages, they would point out houses with a “*majnoon* person.” She found that mental illness isolated and stigmatized the whole family, as they would no longer be invited to functions and would be labeled as a family who has someone suffering from mental illness.

### ***Receiving Treatment in Later Stages of Illness***

Many of my interviewees also pointed out that coming in for treatment at later stages, after the problem has progressed, is also a major issue. Dr. Rashid emphasized that as earlier intervention is linked to a better outcome—as there is a better chance of recovery if patients seek treatment earlier on—this is a major issue.

Similarly, Ms. Sinha explained that patients wait until they are in a more severe situation before they seek help, perhaps because they are unaware of the resource available, or they are hesitant to seek them to due stigma. Saying that:

You don't need to wait until you are desperate until you seek help. You can start from the beginning, it doesn't mean that you are crazy, or psycho, and that is why you are going to a psychologist. It's just that certain things are difficult, and you are just trying to get through it with the support of someone else. Or, I think that idea still needs to be made clear to a lot of people. That it's not only mad people that go to mental health professionals.

She expressed her desire for more awareness campaigns in Oman to encourage more people to seek help at earlier stages, before it turn into such a desperate situation. If people sought help earlier, they would be able to work through their issues before it escalates into a more critical case.

Mr. Ballal also agreed that early detection is one of the main hurdles in providing care in Oman. He said that he has found that as many people seek help from religious healers, they are reluctant to come forward for treatment, which delays their getting help.

Dr. Abiha similarly found that while there are resources in the hospital and clinics for mental health, these need to be better focused towards addressing mental illness at the earlier stages:

We need to activate these kind of resources to service people who are suffering from mental illness. And the earlier we approach them, the better. Rather than approaching them once they are an acute case or chronic, or when they come to us when they are very chronic.

Ms. Deora agreed that family member do not generally bring people in to utilize mental health services until they are in the later stages of a problem, after they have become a public nuisance and after visiting a religious healer. Then they will see a general practitioner. However, she stressed that receiving proper care at this point depends on the GP being able to identify the issue as a mental health issue and knowing how to address it.

#### *Beliefs Regarding the Causes of Mental Illness and the Role of Spiritual Healers*

All of the mental health professionals agreed that seeing a traditional or spiritual healer is extremely prevalent in Omani society; especially in the case of addressing a mental health problem. Dr. Al-Hazizi estimated that over 80 percent of his clients had

sought help from a traditional healer. While my participants had varying perspectives on how useful or trustworthy spiritual healers are, they all agreed that they are an often utilized resource in Omani society and that they are highly valued and respected by Omanis. Some agreed adamantly that spiritual healers could be better incorporated into current mental health approaches, while others were more skeptical of this idea. However, they all agreed that it is important to respect and not vilify patients or their families for receiving help from spiritual healers, as they are viewed as having religious authority and are often trusted leaders in their communities.

Dr. Rashid noted that as mental health is often believed to be caused by *jinn*, the evil eye, sorcery, or black magic, seeing a religious healer for these issues is often viewed as a more legitimate and culturally accepted (and therefore less stigmatizing) method of receiving help for these concerns. He said that in some cases, a traditional healers will tell families that their son has a mental illness, and that they should take him to the hospital.

And this is helpful as patients:

still have more faith in the faith healers—that is why they are called faith healers. And because they are based in the community, there is no stigma attached to that. And because they speak the same language, and they are believed to have special skills and powers. They have all the scoring points, basically that make a particular person a good doctor. They have good communication skills.

Because of their value in society, Dr. Rashid said that he has found it helpful to collaborate with the faith healers. He found that simply saying no, we don't mix with them, or disapproving of them doesn't work. As he put it, people have faith in the faith healers—that is why they call them faith healers! Therefore, establishing certain boundaries, for example, asking the healers to agree that they will not give patients

anything to eat or drink that may harm them, or any additional medication, they can work together to help the patient.

Dr. Rashid also points out that often there are religious treatments like reciting certain verses of the Qur'an, which are not harmful and can even have a positive effect, which can be incorporated into the patient's therapy. Incorporating these long-held beliefs, which are very important to families, into care, the patient may feel they are receiving more comprehensive and community accepted care.

Dr. Abiha similarly agreed that traditional healers are valued and respected by Omanis. She said that in her experience, the trend is always that first patients will go to the traditional healer, and when that fails you go to the hospital. Sometimes they pay a lot of money, even though the hospitals are free for Omani society. Although this may seem surprising, she stressed that healers are greatly respected in society. They are not just healers, but they are seen as having religious authority as well.

When I asked Dr. Abiha about what I had heard from others about incorporating spiritual healers into the treatment of mental illness, she agreed excitedly, saying that she had suggested this in some of her previous work on mental health in Oman. She said that it is necessary to work with them, "otherwise we are losing the community. Because they know how to grasp them very quickly. It's in Arabic, it's in a religious way that people appreciate, and so on." She emphasized that if these kind of local considerations are not taken into account patients—and their families—will not be willing to come in to receive treatment.

Several of my participants also pointed out however, that while there were more legitimate healers, or at least healers that do not do any harm, some charge a lot of money



for their services. Dr. Al-Qadi warned that some are far from the faith and are not legitimate healers, and may just be in it for the money. However, he did say that there were some he knew to be respected leaders in the community that do not do any harm.

All of my participants agreed that faith healers hold a respected position in Omani society and that they are consistently still sought for issues related to mental health. While some professionals were more open to working with them than others, and some viewed them as potentially having more of a positive impact than others, they all agreed that healers play an important role in understanding mental health in Oman; as a majority of patients visit healers first before seeking out other types of services.

### ***Mental Health at the Primary Care Level***

The majority of the mental health professionals I interviewed said that they did not believe addressing mental health concerns was adequate at the primary care level. Dr. Rashid pointed out that general practitioners in primary health care centers are often the first point of contact for people seeking help for mental health issues, but their ability to address these concerns varies greatly. If a patient happens to see a doctor who is adequately trained in mental health, knows the right questions to ask, and can recognize the symptoms, patients are much more likely to get help. In order for individuals to have more reliable care for mental health at the primary care level, there needs to be an emphasis on improving training and empowering general practitioners and family medicine physicians to treat mild cases and refer more complicated ones.

Dr. Al-Hazizi said that although improvements could be made, he thought the capacity to address mental health at the primary care level is improving. In his experience, he said that it is better than it was just three, four, or five years ago. The

ability of some family health care physicians to address certain mental health issues has been increasing and practitioners have been trained better in mental health recently.

Dr. Abiha, however, said that in her experience this was still a major issue. She conducted a study on general practitioner's knowledge of how to advise patients with mental health issues—asking them where they would tell patients to seek help. The majority responded that they were lacking in training and knowledge in this area, and that they weren't sure how to treat patients or refer these cases. As many general practitioners only received one section on mental health in medical school, they often don't know what to do in those situations. She said that not knowing how best to refer patients can lead to a delay in patients receiving help, and that this seriously contributes to the case becoming more chronic.

Mr. Nabhani emphasized that while primary health care centers have advanced greatly in their infrastructure, equipment professionals, staff development, and professionals, for mental health, they are still not providing adequate care. The only adequate level of care begins at the secondary and tertiary level. There are still too many obstacles and shortages at the primary care level. At primary care centers now, certain issues like those related to maternal and child health services, the elderly, and chronic illnesses are well developed areas. They have focused teams to address these issues and specialize in care in those areas. However, for mental health you do not find this in primary care. While there are plans to improve this, currently it is not adequate.

Ms. Sinha said that while there are some social workers and psychologists at clinics, they are not always available and there are not enough in proportion to the need. Her private clinic does some training with doctors at the primary health care centers in

basic counseling skills, but she emphasized that there could be much more done in this area. She stressed that as a psychologist, she realizes that mental health cannot come without physical health, just as physical health cannot come without mental health. However, she expressed her frustration that doctors in primary health care centers may not see mental health as important, and may devalue the role that it plays in physical health. Therefore, it may not be regularly addressed and treated as an important factor to overall health. Dr. Al-Qadi also said that care and attitudes towards mental health are lacking at the primary care level. There needs to be more training of the staff in primary care to be able to identify mental health problems. There can also be a lack of medication available at the primary care level. He said that this unfortunately can lead to relapses as a result of this lack of follow up at the primary care level. Ms. Deora also said that there needs to be more courses to prepare nurses, counselors, social workers, and doctors to handle mental health, as it is possible to treat some cases at the primary care level, as long as they have the appropriate training to handle them. However, currently the system does not have the capacity to do this.

### ***Respecting and Adapting Cultural Beliefs into Care***

All of my participants specializing in mental health in Oman emphasized that culture plays a critical role in terms of how mental health and wellbeing are conceptualized in Omani society. They also all agreed that it is important to take the social and cultural perspectives into account in how they provide care to their patients. Two of my interview questions involved whether or not the professionals believed culture plays an important role in how mental health and wellbeing are thought about in Oman, and if this should be taken into account in how mental health is approached. However,

before I got to these two questions (which I asked later in the interview) all of my participants had already discussed in various ways how culture and social perception shaped ideas surrounding mental health as well as how they approach treating mental health issues. By the time I reached this portion of the interview, we had often already covered a lot of the relevant points, so they simply reiterated the importance of taking these perspectives into account and provided further personal examples. This demonstrated, to me, that in regard to mental health, it is vital to address these considerations when attempting to work in the mental health field in Omani society.

Dr. Rashid emphasized that respecting the desires of Omanis when it comes to what is appropriate with male and female relations is important. A woman may not be comfortable seeing a male psychiatrist one-on-one, for example, and this must be respected.

In a similar vein, Dr. Al-Hazizi said that in his practice he utilizes a lot of homeopathic, alternative and natural medicine, because he has found that this can be much more acceptable to patients than drugs.

As an expatriate not from the culture working as a psychologist in Oman, Ms. Sinha found that it is extremely important to be careful not to say anything that could offend anyone's beliefs, and that it was important to be mindful of what you say and how you say it. She also stressed to me that dressing respectfully and professionally—including wearing full sleeves and full pants—is vital as an expatriate working in this context, so that people are comfortable and also to show respect for the customs in Oman.

Mr. Ballal, also an expatriate not from the region, expressed frustrations that traditions can create limitations for those attempting to provide care. For example, in

Oman female staff often prefer to work with female patients, and male staff with male patients. However, Mr. Ballal also concluded that for anything to change in Oman, it would have to come from within, saying:

Culture is a sensitive thing, and there can't be changes to culture unless they choose it for themselves—if it's coming from them. That will come through education, and observation and their experience from life, mixing with different people. So maybe in the future. But I do think people are very cooperative here. I know people working in different parts of the Middle East, and they always say Oman is the best country and the people are the very best. The people will treat you like them, there is no differentiation. Patients are very cooperative. Even though our patients are psychiatric patients, we never receive any incivility from them. It shows they have a respect for culture.

Dr. Al-Qadi also insisted that in his interactions with patients, it is important to be careful in how he advises them and to not to appear to antagonize their beliefs. Being respectful while they discuss faith healers, for instance, is important because they believe in them strongly. If you undermine them, they will not come to see the specialist again. Therefore, it is necessary to be careful in how you address issues with patients individually, their families, and society as well.

Dr. Abiha also stressed that mental health approaches will not be successful unless culture is taken into account. Especially considering the role that social pressures play in contributing to mental illness. She said:

It's all about pressure, you have to study, you have to do this, you have to marry. So always a lot of pressures that will sometimes cause a breakdown. Because there's no independence in any way. It's straight to culture. So if you want to address this, you have to address it from a cultural point of view. Otherwise, they will never ever come to you and listen. Because you are talking something against their beliefs, against their religion, against their values. So you have to be very sensitive when you are approaching such problems because culture is definitely affecting the way they perceive mental health.

Mr. Al-Omari, who teaches a course on mental health, also highlighted that incorporating culture in the curriculum is important for Omani students to connect to the material. On his own, he would find relevant references which he believes students better relate to. When he teaches the theory course on mental health, which relies on an American textbook, he emphasized that he always makes sure to include an Islamic perspective from the Qur'an and hadith for every topic. He said that there are plenty of examples available if you look for them. He also includes in every section the Arabic and Omani perspectives:

So I always ensure that they get the cultural perspective—Islamic, Arabic and Omani on every issue. Whether it is substance misuse or schizophrenia, I would bring that into the teaching and learning situation. So, it's important really to include. This textbook which is the basis of the theory course does have course chapters on culture and spiritual aspects, to be fair, it's a very good chapter, on theory including Arabic and American beliefs and so on, but it's not enough, you know. So it depends on the lecture, day to day.

Mr. Al-Omari found that bringing culture into the material helps to enrich and enhance students' understanding, as they are better able to connect and relate to it.

Several of my participants similarly said that in conducting research or interventions, it is important to take language and cultural perspectives into account. Dr. Abiha used the example of a study focusing on increasing the awareness of carers of schizophrenic patients. For a family intervention to work, the study found that it had to be culturally defined. They had to change the name of the intervention, as Family Intervention for Schizophrenia was not accepted, and the term schizophrenia itself was not accepted. With this label, families would find it stigmatizing, and would not approach the clinic. The study also found that it was important to be selective about what to address and what not to broach with families, and to make the families comfortable talking about these

issues. Dr. Abiha stressed that including the extended families was very important, as the intervention cannot be just about the individual—rather, the family has to be convinced it is the right decision in order to get the individual involved in the intervention.

Ms. Deora, who primarily works in mental health, but has also worked on a contraceptive community health campaign, found that people in Oman have very strong faith. She said that you have to take a cultural and religious approach if you want it to reach the people. Working on a contraceptive campaign, she found that at first their awareness group was met with anger, as they viewed the campaign as going against the culture and religion. However, after finding a few lines in the Qur'an which reference breastfeeding for two years after a baby is born and started the campaign again from this perspective, the community was much more accepting of the program. Therefore, Ms. Deora suggested that working through the local mosques for health campaigns like improving the awareness of mental health issues might be more effective. Although Ms. Deora did not identify as Muslim, after living and working throughout Oman for over 20 years, she emphasized that she had come to the realization that working through mosques and with peoples' faith was necessary for campaigns to be effective.

Dr. Yusuf similarly said that health concerns as well as symptoms need to be framed in a socially relevant way and in a language that can be understood by Omanis.

So some concepts I think related to, for example, depression, like feeling loneliness or feeling worthlessness, or not feeling happiness or issues related to hot flashes, for example for menopause. We need to present appropriately addressing these issues using the language that people can understand. If I ask a lady, let's say my wife, she might think I am asking her if she has a fever. Like that, but a hot flash is not a fever. So these issues related to language are very much needed.

A specific example he gave involved needing to make sure examples and the language from screenings make sense in that society, as translating concepts from one culture to another can be very difficult. For example, the concept of eye contact in screening for autism was a very difficult concept to communicate. Participants thought they were being asked if their children stared at them. To bypass this issue, they made videos to illustrate normal eye contact versus avoiding eye contact.

Another example he gave in terms of making sure translations of questionnaires are culturally specific was that of a questionnaire which was directly translated from a study conducted in Denmark. The first question asked if the women answering the questionnaire had any children. The second question asked if she was married. Laughing at this predicament, Dr. Yusuf explained that women in Oman got very offended by this, as a woman in Oman would not have any children unless she were married. He joked that, unlike in Denmark where perhaps women would feel lucky to have children without having to put up with a husband, (as many women in Denmark are unmarried), this is not acceptable in the Omani context. As the questionnaire came from a very different social setting, something as simple as the order of the questions being asked needs to be considered.

### ***The Influence of Family in Mental Health Care***

Many of my participants brought up the strong influence family, including extended family, have on individuals in Omani society. This can include acting as an incredible support system as well as a source of stress and pressure. Many of my participants emphasized how lucky Omanis are to have such a network of support around them, and expressed that family and respecting one's family is an important value in



Omani society. However, others also emphasized that extended family, and a spouse's family, can also be a considerable source of pressure, stress and can sometimes be overly protective. However, they all emphasized that taking extended family into account is important in order to help strengthen networks of support as well as to address discord.

Dr. Rashid argued that family support can be very important in shaping a patient's wellness journey. He found that if family member don't understand their family member's struggle with mental illness they may:

Judge the person because they are physically well—they can talk, they can walk, it's not that you have a fever or you have a chest infection, you have to by lying down, they usually look well, so the family finds it very difficult to cope with such a person who sometimes might appear as difficult, aggressive, annoying, stubborn, so all those very negative characters associated with that.

Expressed emotion, how the family reacts to the person with mental health issues, can have a great impact. Negative expressed emotion—such as being too critical, calling them lazy, telling them they are doing nothing with their life—can slow their recovery and increase their risk of relapse. While some studies suggest that there is less negative expressed emotion in the Middle East, it is still a problem. Similarly, the opposite can sometimes present a problem in Oman, as there is so much family support. Dr. Rashid explained that because families are so close, patients with mental illness may not ever have to face the challenges of living on their own, having to build a life, or holding down a job because they always have their extended family around to support them. Therefore, Dr. Rashid suggested that helping families to set goals and push the person beyond their comfort zone can be helpful.

He also explained that when someone in a family is suddenly affected by mental illness it can be hard for them to process, stating:

Especially when a young person, here a patient with schizophrenia at the early ages, before college, appears to be doing very well, and then suddenly they deteriorate. And they go from being the future doctor or engineer of the family to being hopeless and jobless and no family. So the family finds it difficult to explain this, and they try to attach it to their cultural beliefs.

It is important, Dr. Rashid emphasized, to involve the family, so that they can better understand and support their family member in a productive manner.

### ***Family Oriented Therapy***

Many of my participants agreed that families can play an important role in their patient's therapy, as addressing such issues on an individual basis may not be as common of an approach in Oman. Ms. Sinha, for example, said that it was common to see someone in their mid-twenties to late thirties still having their parents come to therapy because they want to be supportive (or possibly because they are overprotective). She stressed that parents stay very involved in their children's lives forever, and this is an important aspect of the structure of Omani society.

Dr. Rashid has found that it is more effective to work with the family's beliefs and wishes, as:

I think the idea is to become more collaborative with the family. Because if they are not well, they are bound to look after them. So it makes life easier if you agree to the point about shared responsibility, and phrase it in a less threatening way so I will say, this is my opinion, and I think it will be helpful if you follow this 1, 2 and 3, rather than saying "I am the doctor, and I know better." Because the faith healer doesn't do that.

Therefore, Dr. Rashid has concluded that it is important to work with and find common ground with families so that they can all work towards improving the health of the individual with mental illness together. Similarly, Dr. Abiha argues that in order for anything to change for the individual, you have to take into account the family dynamics

which may contribute to the mental health issues. As family plays a huge role in shaping the lives of individuals, as there is not a strong concept of individualism apart from the family, families can be a great source of pressure in addition to a source of support. As she previously mentioned, the pressure to do well in school, to marry, and other family expectations can contribute to mental health and wellness—it is therefore important to address the source of this stress.

### ***The Quality of Mental Health Professionals in Oman***

The training, experience and communication skills of mental health specialists in Oman is another issue that arose in many of the interviews. Ms. Sinha said that in her experience, psychologists and counselors are not always well trained. They may have basic training but could often use more opportunities to develop their skills. As professionals in this field, she argued that opportunities to stay updated and improve their skills should always be a part of their development, and that increasing these training opportunities is important.

Even more so than the expertise and experience of psychiatrists and psychologists in Oman, many brought up as a major issue the limitations of relying on a non-Omani nursing workforce. The majority of my participants brought up the fact that language can provide a significant barrier to providing adequate care. Mr. Al-Omari, for instance said that he has found that although some psychiatrists, psychologists and social workers are Omani, or at least speak Arabic, that the nurses working at Sultan Qaboos University Hospital and Al Masarra are not able to communicate to “any acceptable degree” with patients. This limits therapeutic interactions and does not allow a therapeutic relationship to be established between nurses and patients. He even found that some patients were so

desperate to communicate that they learned the language of the nurses. Laughing about this idea, Mr. Al-Omari said that this is something typical of Omanis—that they are so nice and inclusive that they are willing to learn someone else’s language rather than expecting them to learn the language of their country.

Dr. Abiha, who emphasizes the therapeutic role of nursing in her work, says that it is frustrating to observe that what she teaches is not being practiced in the wards. Due to limitations in the ability to communicate, the therapeutic role in nursing is lost.

Because I teach them about communications skills, how to build a therapeutic relationship, trust, and the intervention, the treatment would come. But most of the nurses they don’t speak the language. They don’t speak Arabic. So it’s giving them the medication and delivering the patients without any communication or help. And I think maintaining communication with the patient is very important. Letting him express his feelings, setting limits sometimes to some of the behaviors to change those behaviors is very important, because it’s part of the treatment. All of this is not there. Because there is no communication. What the nurses do is just deliver medication, and that’s it. So this is one of the major observations that I have seen.

Because patients largely interact with nurses on a daily basis more often than they do with the psychiatrist or social worker, this is a critical missed opportunity for providing care to patients. Most of my mental health participants identified and emphasized this as a major problem—especially in terms of nursing care in Al Masarra’s inpatient wards.

Dr. Abiha also identified a lack of professionals who understand the cultural factors that shape perceptions of mental health as a major issue, saying that:

the shortage of local mental health personnel who are involved in the culture and know how people react to mental health and mental illness and what sort of perception they have culturally, it’s very important. Because the way they perceive mental health and mental illness is so much modeled from the culture. So you need someone who is also well trained but would provide culturally sensitive kinds of treatment.

Several of my participants noted that they believed that having nurses from various cultural backgrounds and with different levels of training could also be a very enriching opportunity, as it allows Omanis to learn from their sometimes greater experience in psychiatric care. For instance, Mr. Nabhani, an expatriate who is from the region of the Middle East, emphasized that working in Oman is a unique experience, in that it has such a mix of so many cultures, in an environment where they can learn from each others' professional skills and backgrounds. He insisted that in his experience, Omanis are very welcoming and accepting of others, and that Omanis as well as expats benefit from this interaction. Dr. Al-Zahabi also said that as long as they are in a strong hospital system, having so many expatriates can be a positive and enriching experience. While language can sometimes be a problem, body language manages to communicate many things. Ms. Deora also noted that expatriates help to provide training to Omanis. There are many Indians with psychiatric specialties working in the wards, for example. However she did note that when locals provide care there is more communication, and that this is needed, as there is a tendency to just to focus on giving patients medication over incorporating talking-oriented approaches into patient therapy.

### ***Relying on Medication for Care***

Dr. Al-Hazizi highlighted in his interview that mental health services are mainly oriented towards psychopharmacology. More talking therapy and other approaches, which do not just rely on medication, are needed.

Ms. Sinha also said, however, that in some cases patients also tend to want medication as a quick fix, as they may be hesitant to talk about their problems and often don't understand the process of therapy. She said that they will sometimes question

therapy by arguing “I talk all the time, why do I need to come and pay money to talk about my problem?!” Therefore, they may want medication to address the problem immediately.

Mr. Al-Omari and others also noted that medication is often the primary form of treatment because of the language barriers for nurses. Nurses rely on dispensing medication for treatment, as they can’t focus on developing a therapeutic relationship by speaking with the patients.

### ***Drugs and Alcohol***

The majority of the participants also said that substance abuse is an increasing problem in Oman. Dr. Rashid said this may be because it has become a transit country, so more drugs are coming into the country from its many borders. However, there is a lack of resources and awareness in families, schools as well as a lack of rehabilitation programs to deal with this increasing problem. However, almost all of my participants noted that Oman has recently developed a halfway house (in addition to its detoxification and rehabilitation units in Al Masarra), which they all agreed was an important step in the right direction.

Mr. Ballal suggested that drug use may be an increasing problem due to the recent social shift to more nuclear families. Children are feeling more isolated, and parents often work long days. He said that there needs to be more emphasis on drug and alcohol abuse in schools in order to better detect it. While there are currently two wards for substance abuse for males and they are starting one for females in Al Masarra, the facilities are always full, and they have to take patients on an appointment basis as spots become available. Therefore, there is a need to increase these services. Ms. Deora also noted that

drug use is increasing among high school students who now have access to these substances in school. She agreed that there are not enough facilities to address substance abuse in Oman.

Dr. Abiha said that she initially did not believe alcohol and drug misuse was a major issue, but once she was actually in the field, she realized it was significant problem. She didn't immediately believe it to be a major issue because nobody expresses it or talks about it. She thought that this was because it stigmatizes people from a religious standpoint; because alcohol and substance are forbidden, it is often difficult to address. People only receive help after it becomes a serious problem and it is necessary to go the hospital. Dr. Al-Qadi who also agreed that this is an increasing problem, said that although he runs a general clinic which doesn't advertise that it offers drug and alcohol treatment, he sees quite a few patients coming in for this purpose.

### ***The Lack of Omanis in the Mental Health Field***

Dr. Rashid, when I asked about the lack of Omanis going into the psychiatric specialty, said that the number has been slowly improving. They accepted five doctors to the specialty last year, and have accepted six more this year. Psychiatrists train for five years in Oman, and then have the opportunity to go abroad for a fellowship program to focus in a specific area. Dr. Rashid emphasized that it is important to train Omanis so that they have professionals who understand the language, the specific cultural barriers to care, and can relate to their patients. They need specialists who do not just treat Omani beliefs as superstitious or abnormal, but understand their influence on how mental health presents. Dr. Al-Hazizi said that although it is true that it has been difficult to get Omani medical students to go into the psychiatric specialty, medical students receive more

comprehensive training in mental health in their general medical school training than many medical students get elsewhere.

Mr. Ballal also noted that even though he commonly sees positive changes in the attitude of the nurses who finish the mental health theory and clinical course in the college of nursing, none go on to specialize in psychiatric nursing. Therefore, most psychiatric nurses are expatriates. Therefore, even though Omani nurses are preferred, as they relate better to patients, there is a shortage of Omani psychiatric nurses. Mr. Al-Omari and others also said that while there is a diploma option at the Omani Specialized Nursing Institute for psychiatric nursing, to get a Master's degree students would have to go abroad (or be accepted into a recent program which partners with a UK university for a Master's degree).

Mr. Nabhani and several of my other participants said that nurses trained in Oman get a fairly comprehensive overview of mental health issues, as they take both a theory course as well gain significant clinical experience. Over a semester they learn the symptoms of different illnesses, therapeutic communication, specific nursing skills related to mental health, as well as social and legal aspects related to psychiatric care. They even learn some family therapy and group therapy techniques and how to talk to family members of patients with chronic conditions. He also noted that Oman is very generous when it comes to sending people abroad for specialty training—as the Ministry of Health has scholarships for Master's degrees and PhD programs. He stressed that Oman has done a good job developing their professionals. However, he named Omanis' reluctance to go into the mental health specialty a major issue.



### ***Community Based Care in Oman***

In discussing the future of mental health care, and what resources they think should be developed, many suggested a shift to more community-based care. Dr. Rashid said that patients shouldn't have to travel to a hospital or polyclinic for specialized care, and that more community based care is needed. Mr. Zahabi also discussed that because the country is large and the population is very spread out, some patients are not well taken care of. They may not be able to always make it to their clinic visits. He suggested that there is a need for more community psychiatric services where teams could travel to patients to provide them with care as well as medicine; rather than just waiting for patients to come to them.

Dr. Abiha also stressed that more of a community approach is needed to help spread awareness so that patients can access services for various problems they may face. Mr. Al-Omari reiterated several times in his interview that the lack of community care is one of the primary issues that needs to be addressed more comprehensively, as it contributes to the revolving door syndrome:

There's no community mental health nurses, there's no multidisciplinary mental health teams that would go and look after patients at home, there's no facilities like this. So one of the major challenges is what we call the revolving door syndrome. Where patients with psychiatric disorders, even after they are referred to the hospital after they are admitted, for two or three weeks or a month, then they are discharged. There is no preparation for care whatsoever. So really when they go out, like they know, they are not taking their medications because they don't like them, because they think they are better. Because of their delusional ideas or their bad experience with side effects, so really after two or three months, there are symptoms again and they go back to the psychiatric facility

Mr. Nahbani also identified incorporating mental health into community care as a primary need to improve mental health in Oman. He explained in his interview, that

while they had planned to place nursing students in community mental health settings to help them gain experience in these settings as part of their training, it is not yet advanced enough to do this. Orienting mental health care towards a community approach was a common issue that the participants prioritized as vital for improving the quality and accessibility of care in Oman.

### *Accessibility of Services*

Many of the participants also noted that all of the specialty services for mental health are concentrated in the capital, as Al Masarra and Sultan Qaboos University are the only tertiary centers for care. Therefore, as Ms. Sinha pointed out, services in the city are not always accessible to those in the interior of Oman. As a psychologist working in a private clinic in Muscat, she cannot easily interact with people from the interior. While the government has provided healthcare facilities around all of the cities, towns and villages, there is no way of knowing how mental health care is addressed at all of these health centers. Mr. Al-Omari points out that in addition to Al Masarra, there are some units attached to general hospitals, polyclinics with mental health clinics, and outpatient care at the Sultan Qaboos University Hospital behavioral medicine unit. Additionally, there are some private clinics.

Dr. Yusuf also said that services for mental health care are still primarily centralized within tertiary hospitals. While there are more mental health clinics in polyclinics, he said that they are still often lacking in qualified people and in the range of services they offer. Ms. Deora, who has worked in Oman for over twenty years, said that when she started working in Oman there were only two hospitals that provided any mental health care—Ibn Sina and one facility in Salalah. But steadily there has been an

increase in clinics and professionals. However, this is not in proportion to the population and need. Dr. Al-Qadi similarly notes that psychologists are really only available in tertiary care, as there is a shortage of specialists in Oman.

While all of the participants noted that Al Masarra has state of the art facilities, the hospital is a distance from central Muscat and isn't accessible to everyone. Mr. Al Omari claimed that Al Masarra was purposefully built far from the heart of the city. He told me that while the original plan was to build it in the Al Khoudh area of Muscat (the area around Sultan Qaboos University), the location changed because:

the people protested and then decided to take it away. So, you could say due to democratic response from the people! But nevertheless, it is old-fashioned thinking. But in the UK and US, people go to work, so eventually villages build up around the hospitals and this is what is happening. There has to be a couple of hundred people working there who want to be reasonably near there, so therefore sooner or later it will be within its own population center.

Therefore, although Al Masarra was built about an hour outside of Muscat, he predicted that residences will eventually build up around that area. Mr. Al-Omari also highlighted in his interview that Al Masarra has great recreational therapy, physiotherapy, occupational therapy, workshops for mental and wood, and occupational therapy. However, as several of my other participants also noted, these services are significantly underutilized.

### ***The Need for Adolescent and Elderly Specialization***

Mr. Ballal indicated in his interview that better detection of mental health issues in children is an issue that needs further focus and improvement. He said there is currently a lack of diagnoses of Autism and ADHD cases, and he suggested that psychologists in schools would greatly help to address these concerns.

Mr. Al-Omari also noted that while there is a plan for a children and adolescent unit in Al Masarra, and it has been open since 2013, they see patients only in an outpatient capacity. It hasn't expanded to admit inpatient cases yet. This is a need that should be addressed.

Dr. Yusuf also suggested that certain age groups provide specific challenges that need to be addressed. For instance, a recent study showed that children and adolescents made up only 1 percent of those who go to psychiatric clinics. This indicates that there is a need for more services to cover children and adolescents. There may be a lack of children and adolescents in care because parents don't expect 13-year-old boys or girls to be suffering from depression or anxiety disorders, or even suicidal thoughts. While they may expect it from adults who have gone through more challenges and traumas in life, they don't always consider this possibility in younger people. But, he argued, this doesn't mean that they are not suffering, only that they aren't utilizing clinic services.

Just as children and adolescents need more attention, several of my participants also noted that the elderly also require more care. Dr. Rashid pointed out that as the population is living longer, more services are needed for older people. Families need more information on dementia and cognitive disorders. It is common for family members caring for elders to have trouble distinguishing between normal aging and dementia. The notion of nursing homes is not accepted in Oman. However, taking care of people with multiple physical as well as mental issues can be very difficult. The government has introduced more services, including sending carers to homes. However, there is a need for more awareness about dementia and other issues related to aging.

### ***Mental Health Care for Expatriates***

While care for mental health is available to expatriates, their utilization and the actual accessibility of these services may vary depending on their situation. Ms. Sinha explained to me that many expatriates are not aware of resources available, and tend not to find them until they are in a serious situation. Ms. Deora said that while expatriates working for the ministries or bigger companies are covered by medical insurance, most psychiatrists are from Arabic countries, so it may be difficult for expatriates to communicate. She said that she has observed that while resources are technically available to expatriates, they don't utilize them. She suggested that there should be services specifically for expatriates with lower wage jobs that provide more reasonable treatment. An expatriate may not be able to afford 10 rials per visit.

Dr. Al-Qadi concurred that there is a high rate of suicide among the expatriate population, especially among workers, and that some insurance companies don't cover mental health. However, he disputed the price, claiming that it is only approximately 15-17 dollars for them to receive care, which should be affordable.

### ***Issues of Privacy and Consent***

In his interview, Mr. Al-Omari expressed concern over the fact that there is not official law on mental health in Oman. There are resulting issues related to consent as a result of this. When admitted to Al Masarra, a family member, whoever admits them, signs a consent form; the patient doesn't usually have any say. After this, doctors can then decide to administer ECT—Electro Convulsive Therapy or give the patient any medication. Mr. Al-Omari insisted that doctors do not tend to abuse this, and patients are able to leave against medical advice. This practice is shaped by the emphasis on the

family's role in Oman, and is not seen as a major problem. However, he suggested that sooner or later legislation to address this will be required.

Dr. Rashid, in terms of respecting patients' privacy, also said that while it is important to include the family in care, it is also necessary to balance this with respecting patients' desire for keeping certain information private from their family members.

***The Intersection of Mental Health and Reproductive Health: Maternal Mental Health***

Dr. Rashid told me that at his hospital, psychiatrists sometimes give talks to obstetricians so that they are better equipped to detect and pick up on cases of postpartum depression. Dr. Rashid also pointed out that there is a great network of family support for women in Oman. Women often live with her mother for the first year after having their first child, which can be tremendously helpful:

Because I imagine that most women might be panicking, all of a sudden you have this little creature who is always hungry, who always sleeps when you are awake, and he wakes up and screams. So, it's likely nerve racking. So the presence of a mature person, a mom, is very supportive. Because then the new mom gets a break to have a lay down, and just relax and recover from the process of childbirth.

Dr. Rashid said however, that it would be useful to help families be more vigilant in detecting any problems. However, he also reflected on what kind of support for this would be accepted in society, and said this would be an interesting question that would have to be negotiated—as something like a support group for mothers may not be accepted.

Dr. Al-Hazizi also said that there is almost 24 hour service for women in Oman in terms of support after childbirth. Women are very well taken care of after giving birth.

Dr. Al-Qadi similarly said that unlike in the United States, where a woman might be left

alone from 8 am to 8 pm and really struggle and feel overwhelmed after giving birth, in Oman there is a strong tradition of family support—as mothers, sisters, and aunts all pitch in. Several of my participants contrasted having children in Oman, versus their own experience having children while they were studying in Western countries, and found these to be extremely different experiences—several said that they had a much more isolating experience without family support in the West.

While she was unsure about the amount of focus given to maternal mental health, Dr. Abiha said that it should be emphasized, as the change in hormones in addition to the shifting roles women experience as they go from being married to having children, puts a lot of pressure on women. Dr. Abiha said that in general, these major transitions in life can be stressful and challenging. She emphasizes to her students that sometimes these major life changes may require some help to adjust and get through them. Dr. Abiha again pointed out that family can be a great source of care and support in this area, after a woman gives birth, however, it can also provide more pressure. For example, if the woman lives with her in-laws instead of her family, they may not understand and be critical of her if she says she is not feeling well after giving birth.

Dr. Abiha also emphasized that, as a woman in a focus group explained to her, the pressure to have large families can be a source of distress. The woman, when asked about mental health said “how can you ask me about mental health when I am just cooking, being pregnant, after pregnancy I have to wake up and cook again, take care of children, no one is taking care of me. Every year to have a baby, and it’s a disaster if I don’t have a boy, so I keep on trying and trying and trying.” Dr. Abiha stressed that it is

important to take adapting to these roles and the reality of women's lives into account to understand mental health challenges in Oman.

Dr. Al-Qadi also noted that there is often the belief that if a woman is suffering from postpartum depression and recently had a boy, it is the evil eye affecting her. This common belief also has to be taken into account when addressing maternal mental health.

Mr. Al-Omari also pointed out that unlike in some developed countries, babies are not admitted with mothers in Al Masarra for puerperal psychosis or postnatal depression so that mothers can bond with the baby. While family members may often bring the baby to see the mother, the importance of having the baby with the mother to bond is not emphasized.

### ***Visiting Al Masarra Hospital***

It is obvious when approaching and entering Al Masarra Hospital that the Omani government invested heavily in the hospital in order to ensure that it provides well-equipped and humane services for those requiring inpatient care. It is located a significant distance from the heart of Muscat, but the grounds and facilities are beautiful.

During my visit, I was able observe Omani nurses-in-training interacting with patients in one of the acute wards. The communication and therapeutic skills that Dr. Abiha emphasized as essential for patient recovery was evident in the nurses' approach with patients. The nurses did take the time to establish trust with the patients and learn their stories, and the patients did obviously appreciate these conversations. The nurses provided a calm, assuring presence, allowing the patients to feel comfortable enough to open up about their concerns and anything they wished to talk about.

In the other wards, this was not being done. Patients were being herded around,



but there wasn't this kind of communicating and interaction. Therefore, I witnessed first-hand the concerns over language barriers which many of my participants discussed. In the occupational therapy area, I saw the kitchen being used by two patients who were led by a nurse, but otherwise the outside recreation and occupational therapy rooms were not in use. While the potential to create woodwork, art, cook, and exercise was very impressive, I didn't witness these outlets (which could provide a great opportunity to improve care for the patients) being utilized.

While in Al Masarra, I was also able to tour the forensic ward of the hospital. Patients can be sent to Al Masarra either by choice or court order to receive treatment after committing a crime (patients who committed minor crimes related to drug addiction will be sent to rehabilitation, while other patients who commit crimes and are mentally ill will be sent to the forensic ward). They will eventually be sent back to the courts and then possibly back to prison. Half of the forensic ward is like a police station. Speaking to a policeman and a mental health worker, they told me that it was initially difficult having to negotiate the balance of addressing security concerns and treating the patients like prisoners, and trying to meet their mental health care needs. These contrasting priorities and perspective caused some tension and disagreements between the police force and mental health specialists that had to be worked out.

The potential to improve the utilization of the Al Masarra facilities—such as the occupational and recreational therapy—is there. Creating more opportunities for patients to utilize these services simply needs to be better incorporated into treatment approaches. Improving the daily interactions and ability for patients to communicate with nurses could also be addressed, but this would likely require more training and emphasis on

acquiring staff that can communicate in Arabic and relate to the patients.

### **Perspectives and Emerging Themes from Reproductive Health Professionals**

In my interviews with reproductive health specialists, many said that they believed ideas related to gender, fertility, family and community influence, and cultural conceptions related to reproductive health shape care in Oman. Furthermore, the need to increase the capacity to deal with both the delivery needs of Omani women as well as improve services for other women's health concerns were also central issues which we discussed.

### **Culture's Role in Shaping Reproductive Health**

#### ***Gender and the Obstetric Gynecology Specialty***

One of the main issues that came up in my discussion of reproductive health in Oman, is the fact that it is not acceptable for female patients to be examined by male doctors for reproductive health concerns. Therefore, there are hardly any practicing obstetric gynecologists in Oman. Many of my participants stressed that this is not by law, it is simply a case of patient demands shaping the system. Almost all of my participants said that they believed that this should change, as it is based in tradition rather than actual religious belief. However, how tangible they viewed a transition to include male doctors varied. Some emphasized this as a necessity, whereas others, while they said it would be a positive change, said that this would require a complete social transformation which they had difficulty envisioning as a possibility in the near future.

Dr. Tarhouni stressed the exclusion of male doctors from working in the obstetrics specialty as one of her primary concerns. She argued that the rationale for excluding males, though thought to be based in religious belief is merely tradition:

It's not only religion, because we always confuse between religion and culture. Culture is different because in Saudi Arabia where they have the same religion and they're supposed to be more strict than us there are a lot of male obstetricians. Actually the male obstetricians are almost preferred to female obstetricians in Saudi Arabia.

Several of my interviewees pointed this out as a contradiction in Omani society; claiming that Omani society is less conservative, so it does not make sense that male obstetricians are not accepted in Oman but are in Saudi Arabia. Dr. Yusuf mirrored Dr. Tarhouni's views, saying that it is ironic that male obstetricians and gynecologists are not accepted in Omani society, yet they are in Saudi Arabia. He also said that this was not due to religious restrictions, but social customs. He suggested that religious authorities address this in order to encourage people that it is okay to be seen by male doctors. However, he said that while he hoped this would change, it would not be possible without considerable changes in attitudes.

Dr. Tarhouni also emphasized that excluding male doctors was discriminatory and unfair to both the male doctors who want to specialize in this area, as well as the obstetricians and gynecologists who are overburdened due to this limitation. She told me the story of one resident, who had been trained abroad and then returned to Oman and tried to join the specialty. He was met with such criticism and skepticism that he eventually felt pressured to change specialties. Dr. Tarhouni argued passionately that the practice of excluding male doctors from obstetrics needs to change in Oman:

Unless we open that door, it will never be there, and it will stay, like a woman only place. And the other thing is even educating our own doctors and our own students that this is a very good specialty that you can specialize, and that you will not be discriminated, if you get specialized in this. Because I think that what that resident had was really discrimination, even his own family, and his own colleagues. He was not treated the same once he came to this specialty.

Dr. Al-Shahrani similarly said that men who try to go into the obstetric gynecology specialty get harassed by people in their communities. She said, for instance, that they might claim he doesn't have the job of a proper man because he is witnessing births and doing physical exams. They also put pressure on his family and shame his family to such an extent that the resident will often choose to work abroad or change specialties.

Dr. Al-Shahrani also argued that this inability of men to examine women is specific to anything concerning or related to reproductive health. For instance, as most surgeons in Oman are male, it is considered acceptable for a male surgeon to examine women's breasts. It is also acceptable for women to have an abdominal examination by a male doctor when she is experiencing pain but is not pregnant. However, if she is pregnant, it is not considered appropriate for a male doctor to palpate her stomach. Because it is related to reproduction, and reproduction is often taboo in society, she speculated that this makes an abdominal examination similar to a vaginal examination—only because it is related to reproduction.

Dr. Al-Shahrani agreed that this exclusion of male doctors from obstetrics gynecology needs to be addressed. She told me that, in trying to explain why this should be acceptable, she often reminds people that the greatest historical physicians—Ibn Sina and al Razi—treated both men and women. She argued that male doctors not being able to go into the specialty is simply an example of a religiously-based notion (that men and women should not interact unnecessarily) being extended too far and to a ridiculous extent. This has been reinforced at many levels, so it has simply become the norm. However, it is unnecessary and should be addressed by Omani society.

Dr. Al-Hamdani said in her interview that gender is a major issue; in terms of not allowing male doctors to practice in the field as well as for reproductive health generally, as it is often culturally and religiously sensitive. She said especially with her work with infertile couples, this can be difficult to address.

Dr. Tarhouni argued that while she believes it is important to respect culture and customs, it should not be done to such an extent that it sacrifices care—which she believes is occurring in the case of not permitting male doctors into the obstetrics specialty. She said that it is important to challenge misconceptions in society and issues that the society itself believes needs to be changed. She also gave the example to certain screenings and vaccines, such as those for Sexually Transmitted Diseases and vaccines for HPV. They claimed that these are not emphasized in Oman’s health campaigns because of assumptions about Omani values and the assumptions that Omanis don’t have multiple sexual partners. However, she argued that we have to examine if this is really the reality. Furthermore, she said that there is a reluctance to address culturally sensitive issues, both by the Ministry of Health and the population, when it comes to issues like female circumcision. However, she emphasized again that if something is important to a society, it must be addressed. These issues should not be avoided simply because they are culturally sensitive—they need to be discussed if anything is going to change.

### ***The Value Placed on Pregnancy in Omani Society***

Dr. Al-Shahrani explained to me that in Omani culture, pregnancy is very desirable for women of any age—as long as they are married. Men and women tend to think of it as a natural occurrence. Because of this, it can be very difficult to convince a couple it is not safe to go through a pregnancy if this is the case. Women also tend to

have children for as long as they can—into their forties—without considering the risks.

She also argued that because the ways pregnancy is conceptualized in Oman, there is not a notion of a “planned pregnancy”:

We don't have what is called pre-conceptual counseling. Women they don't seek it. Even if it is available in the health care structure, women they don't go to find it. They don't ask themselves what should I be doing to have a healthy pregnancy? They think it is the normal thing. It is going to happen. It's God's will. So whatever He wants that is what will happen to me, and I accept it. That notion of I have a role taking care of myself and having a healthy pregnancy and healthy baby, this is for them—I find this is the least accepted idea. They spend lots of time preparing for their wedding. Which is the hallmark of starting a sexual relationship. Which is expected to result in a pregnancy. There is nothing like... I read that if a lady wants to get pregnant she should be on folic acid and a couple months before she gets pregnant, for example. There is nothing like that. Nothing on planning. With the wedding I should plan also my pregnancy. There is no concept of such.

Dr. Al-Shahrani said that she thought the reason for this is that reproductive health, and anything related to it, is often taboo. Therefore, women don't learn how to prepare for pregnancy or even about the details of pregnancy. They also don't prepare themselves for the role of motherhood. Dr. Al-Shahrani said that “people rely on that they will know it when it happens. I find really that education in reproductive health is something that really needs to be addressed at the professional level as well as the community level. Mainly at the community level. People need to know.”

Mr. Al-Omari brought up a similar idea when discussing maternal mental health, saying that unlike in the UK, where they have antenatal classes, for example, to teach women about exercise and diet, how to prepare for birth, the various choices for giving birth, there is none of this in Oman. He noted that they also don't tend to care about the male perspective, as “the baby's in the woman, we just worry about the woman.”

### ***Incorporating Culture into the Medical and Nursing School Curriculum***

Dr. Al Zahabi argued that aspects related to culture need to be taken into account into nursing and medical school curriculum for students. For example, the nursing curriculum comes from the US. Because students sometimes do not connect with the material, they don't always find it relatable. She argued that there is a need for more of a global, international approach that takes into account all of the different backgrounds and factors which influence health care in areas like maternal and reproductive health. As an educator, she argued that it is necessary to prioritize strategies to enhance intercultural appreciation and explore the various factors which impact health care.

### ***Community and Family Influence on Reproductive Health***

Dr. Al-Shahrani emphasized in her interview the strong influence that community has as a source of information for women in Omani society. She explained that it is still common practice for Omani ladies to meet up with their neighbors everyday, usually in the late morning, for about an hour or an hour and a half. These discussions become a trusted source of information for women. However, it can also exacerbate the spread of misinformation. For instance, if one woman says she had a bad experience with a specific kind of birth control or had a surgery that didn't go well, another may assume that it is not worth trying and is entirely negative. Dr. Al-Shahrani explained that she has found that the opinions of patients' family members, neighbors and friends are generally much more valued than her professional opinion. Information coming from a professional in a clinical setting, is in no way taken over the advice and information she receives from those she trusts. Therefore, Dr. Al-Shahrani said that she has to take these influences into account in her practice.

I have some ladies that I want to advise for example, they have an issue with fertility or they have an issue with a tumor, or a thyroid or ovarian cyst that needs to be removed. No doctor, my neighbor had that surgery and she had a problem or it didn't work for her. So I want to take my mother's opinion in that. So the community and the family have that strong influence and the pushing force. It is hidden to doctors. And sometimes you try to rationalize with women. You know, I am a doctor. I spent a minimum of seven years studying medicine And then I did at least six years of sub-specialization, so by this criteria, my opinion should be more trusted. This logic, this argument, doesn't work for women. It completely doesn't work. You know, my sister told me, my neighbor told me, my auntie, or whatever. It means more to them than me.

Dr. Al-Shahrani said that men will similarly get information from the women close to them (though they do not usually discuss it with their wives). Furthermore, to make any decision related to fertility, the husband's consent is necessary. Dr. Al-Shahrani also observed that there is a lot of pressure on men to not be too involved in matters related to reproduction or childbirth. They may be criticized for participating too much in the pregnancy, as it is not seen as a man's role. Attending the birth is especially met with criticism. Dr. Al-Shahrani found that only couples from the periphery who don't have family in Muscat will generally have the husband in the delivery room. Because they don't know anyone in Muscat, they don't have to fear the disapproval they would receive for this.

Dr. Al-Shahrani also argued that because reproductive health is not always openly discussed, it doesn't tend to be included in health campaigns—even for health issues which clearly have reproductive health implications. For example, when examining the risks associated with being overweight, health campaigns will talk about the effects on the heart, the lungs, the knees, blood pressure and blood sugar. However, the impact that it has on the ability to get pregnant, the higher risk of miscarriage, and the complications that can occur in pregnancy as a result are never included. Even though pregnancy is



something highly valued and prioritize in Omani society, these issues are not always openly discussed.

Dr. Al-Shahrani said that overall in terms of culture shaping reproductive health care, “we have deep rooted cultural beliefs that have a direct healthcare implication on women’s health [...] I can’t think of any other field where this has been effected at this magnitude. In all aspects.” While Dr. Al-Shahrani said that in some ways culture can determine the focus and choices in reproductive health care too much in Omani, she also highlighted that there is a positive aspect to cultural views related to reproduction. In Omani society, there is a great emphasis on pregnant women needing care, family support, and women being taken care of well. She explained that the idea that women should have access to health care, and deserve to be well taken care of is a value deeply embedded in Omani society. Therefore, while there are certain aspects that should be changed in the health care system, this is an intrinsic value that positively impacts women’s health.

### ***Family and Social Pressures to Conceive***

Almost all of the reproductive health professionals in this study mentioned that there is significant pressure on young married couples to have a child within their first year of marriage. Although couples are getting married later (Dr. Yusuf said he believes the average age of marriage has increased recently from 18 to 24 over the last 15 years), and family size is decreasing, the pressure to conceive immediately after marriage is still significant. Therefore, the majority of my participants identified infertility as a great cause of stress for many young couples. Some women may fear that her husband may divorce her or marry a second wife. Most of my participants said there is great pressure

and questioning from the mother-in-law and other relatives asking them why they haven't gotten pregnant yet if they do not conceive within the first year of marriage.

This pressure from family and the community makes discussing contraception difficult, as choosing to wait to have children isn't common. Dr. Al-Hamdani related her own experience with this. After getting married she and her husband decided to wait to have children, as they were both planning to go abroad for their medical degrees. But she experienced constant pestering about why they were not having a child yet. She was uncomfortable trying to explain her choice to wait and decision to use contraception. She joked that she couldn't just say, "I'm on contraception, okay? It is none of your business!"

### ***Women's Health in Primary Health Care Centers***

All of the reproductive health professionals explained to me that when a woman is first pregnant, she visits a primary health care clinic. As long as she doesn't have a high-risk pregnancy or any complication, she will continue to receive care at the primary care level. She receives a green antenatal card which is a record of her pregnancies, and it stays with her throughout her pregnancy. She is also assigned an antenatal care number. If she does have a complicated pregnancy, she will be referred to secondary or tertiary care hospitals—which in Muscat would be either Royal Hospital, Sultan Qaboos University Hospital or Khoula Hospital, for tertiary care.

However, while most follow up care is given through the primary care health centers, all deliveries occur at the hospital. Dr. Tarhouni said that Oman has prioritized attempting to reach a 100 percent delivery rate in hospitals, and it is currently around 98 or 99 percent. However, because all women deliver in the maternity units in the hospitals,

the hospitals are often overwhelmed. As the physical capacity of the wards has not increased in these hospitals over the last 20 years, they are not sufficient to handle so many births.

When I asked about the quality of care for reproductive health at the primary care level, many of my participants said it really depends on which doctor the patient sees that day. Dr. Tarhouni said that ideally all doctors working in primary care should have enough family medicine background to cover any women's health issue. However, because of the shortages of physicians in Oman, some doctors are accepted even though they do not have adequate training in obstetrics and gynecology. Because the patients sometimes shop for care, and don't trust the system, they may go from one clinic to another. Or to avoid seeing a doctor without proper experience, they may chose to go to a private facility, as they also tend to offer more ultrasounds, and may feel that they receive more thorough care.

Dr. Tarhouni also suggested that there could be more focus on obstetrics and gynecology in the medical school in Oman. Right now they spend only three or four months in the obstetric gynecology specialty as part of their family medicine training. She argues that this is not enough training for them to then be running antenatal and gynecology clinics in primary health centers.

Dr. Al-Shahrani also pointed out that when women have a gynecological issue, they can't see a gynecologist directly. Since there is a referral system, they have to be seen multiple times and rely on the referral being sent. Because of this inconvenience, many women end up going to private clinics even though the care isn't better quality in the private sector. However, it can be difficult for working women or women who rely on

rides from their husbands to have to go through the multiple appointments. Because clinics are usually only open until afternoon and don't have evening hours like the private clinics often do, convenience can sometimes outweigh the added financial cost. While it would be better not to have to go through this referral system, realistically, there are not enough resources for women to see a specialist whenever she wants, so the primary health care system was established to expedite care.

### ***Shortages in Human Resources***

Dr. Tarhouni also articulated that the level of physicians' training is a major issue, as the number of well-trained doctors in reproductive health is not adequate. Some doctors may just be assigned to a clinic or health center without considering this. She explained that sometimes, if they are placed somewhere where they can work with others and learn from them, it may be okay, but if they are assigned to a more remote area, they may be expected to jump in. This is risky for both the doctors and patients. She also pointed out that many senior doctors do not want to be assigned to the periphery health centers, as they would prefer to be in Muscat.

Dr. Yusuf also noted that in his experience with a medical school internship program, it is often difficult to convince medical school graduates to go into obstetrics gynecology. It is a stressful and demanding specialty due to the on-call, surgical expertise, and so on. Residents often worry about sacrificing their social life for this specialty.

Dr. Al Zahabi also mentioned that in Oman the emphasis on pregnancy in primary care often overshadows women's health in other aspects. There isn't a concept of anything like women's health centers. Dr. Al-Shahrani also noted that while there are

health centers in every village or town in Oman, the capability and level of training in reproductive health can be questionable. While they can provide infertility investigations and antenatal care, they may be limited in doing anything else that requires a higher level of expertise or more than basic training. She also argued that there is a need for more specialized nurses in reproductive health.

Dr. Yusuf echoed Dr. Al-Zahabi's comment that antenatal care dominates women's health care. He said that Oman has a:

Very good system in terms of antenatal care. It was rated very highly by the WHO. It is quite an achievement for the country. But I have reservations. For us, reproductive health means pregnancy. Only pregnancy. But it is not. It is before becoming pregnant, after becoming pregnant, during pregnancy. So the focus is very much oriented towards the pregnancy period. But what happens before, what happens after we don't pay enough attention as it should be. In my humble view, we can shift what we do with the same resources.

Dr. Yusuf then went on to suggest that in the current system women have 7 or 8 visits throughout a pregnancy. He argued that this number is unnecessarily high, as pregnancy is not an illness. The WHO even questioned the need for so many visits. If the number of visits was reduced to four, the number the WHO does suggest, Dr. Yusuf contested that the resources that were previously applied towards those visits could be redistributed to provide better care for women in other areas.

Dr. Al-Kandari agreed that there is a need for more emphasis on human capital, and building this capacity. She pointed out that there are currently only three subspecialists who focus on infertility, even though it is a major issue that is of great concern in Oman.

Many of my reproductive health specialists also emphasized that the physical capacity of the delivery wards were severely inadequate. This is one of the main

problems that Dr. Tarhouni identified. Dr. Al-Shahrani also said that while human resources have improved in the last twenty years, as the number of services provided has improved as well the labs and capacity to do more, they are functioning with the same resources in terms of the number of beds and the amount of space as they were 20 years ago. The planning is too slow for the immediate needs. While the *Health Vision 2050* plan is very good, she noted it does not demonstrate what will be done in the short term. What will be happened to meet immediate needs and address daily suffering and shortages? She gave the example that while she was meeting with me (and on call in the delivery ward) she currently had two women laboring in the Emergency Room because they didn't have beds to accommodate them. To her this was completely unacceptable. When I asked Dr. Al-Shahrani about the *Health Vision 2050* plan, she said that while she likes it, and it had a lot of important aspects included in its long-term plans, she didn't know if she was going to be here in forty years! Therefore, there needs to be a clearer articulation of how the government will meet more immediate needs, such as the lack of capacity of the hospitals to meet all of the current needs.

Dr. Tarhouni suggested that creating low-risk birthing centers, where women would give birth if they do not have a complicated pregnancy, might help to ease some of this burden. When I asked several of my other participants about this, they agreed that this might provide an interesting solution to address some of the issues currently experienced by the hospitals and hospital staff.

Several of my participants also noted that another consequence of the hospital delivery wards being so overwhelmed with patients because women always come to the hospital to deliver, is that it does not always allow specialists to actually focus on their

areas of expertise. Because they have to deal with so many deliveries and face whatever comes through the door, whether it requires specialized care or is a low risk case, their skills are not fully utilized. Dr. Al-Shahrani said that:

It would be a good idea to allow the people who have the subspecialties do the higher level of care. But now based on the current system they are not allowed to do that. The system does not give them the opportunity to do so. For example, Dr. K\* is a maternal fetal specialist. A lot of her patients, because there is no one else to take care of the women, a lot of her clinic they might not be high risk who need her expertise. I am a gynecologist; I'd like to do more of what I'm good at. So if there were other obstetricians to take care of women that would be good, but there are not. That is why it is my obligation and my duty to take care of women the way it should be done, regardless of whether she is obstetric or gynecology.

Because their facilities are always so overwhelmed with patients due to the structure of the current system, specialists may be unable to practice primarily in their area of focus.

### *Midwifery*

My participants explained to me that Oman offers a three-year midwifery program through the Ministry of Health. All of the participants I asked about Omani midwives said that in their experience they were very well trained, provided a phenomenal contribution to care, and were an asset to the current system. However, they all emphasized that retaining midwives can be very difficult. Dr. Tarhouni noted that because of the salary structure in Oman, midwives are paid like any other nurse. Despite the fact the midwifery is a much more demanding job. Reacting to this fact, she exclaimed:

They are midwives. They are different then regular nurses. They're practicing a high risk job. They work nights, the nature of their work is very hard, right? With the obstetric. But they're paid like any other nurse who is sitting in the clinic from morning until whatever, two o'clock or until three pm. So there tends to be now a lot of our young, good midwives, they want to go out of midwifery.

Because there are no significant benefits for doing the more difficult work, she has found that many do not stay in midwifery very long. They will transfer to a general nursing position instead. Exasperated by this, she argued that this needs to change.

Dr. Al Zahabi similarly notes that even though there is a great need for midwifery, there is not a recognized ladder that allows them to work as a specialist. Therefore, nurses get frustrated and burned out. She explained that they understandably want more recognition of their advanced role and level of training. Dr. Al-Zahabi also explained that while there is a great need for midwifery, a Master's program was not selected to be developed in Oman because there is a lack of resources to train them.

Dr. Tarhouni was the first adamantly to suggest the need to increase incentives for midwives to stay in midwifery, and many of my participants agreed that this was needed and had the potential to improve the current health care system significantly. Dr. Yusuf agreed that this was needed, and also suggested that investing in more home care, and building the capacity to visit women in their homes, would also be beneficial.

Dr. Al-Shahrani explained to me, and many of my participants echoed this, that nursing—and shift work especially—is not desirable in Oman. There is often pressure on women to have a more stable job after they get married. Especially once they have children, if the husband has a stable daytime job, it might not be seen as acceptable for her to work night shifts. The husband or his family may put indirect pressure on her to leave her job. Many nurses decide to go into nursing before they are married, but then there may be pressure to get out of shift work once they are married, from both the husband as well as his family and the community.



Dr. Al-Shahrani also emphasized that midwifery is a very physical job. Positioning women in labor, handling babies, suturing tears; it is difficult work. Not distinguishing midwifery as a different category of nursing is therefore problematic. Having midwives better incorporated into the system would be extremely helpful. Like Dr. Yusuf, she agreed that it would be ideal to have midwives as more of a community service, birthing from homes. But this might be difficult to establish, as there are a lack of emergency vehicle service throughout all of the country. She also agreed that low-risk birth centers could be useful, and that midwives could be better incorporated into these centers. She explained passionately that:

I would love to see a day where midwifery is incorporated, especially in reproductive health doing more than they are. And I wish to Omani midwives who love the job to be helped to stay on the job. Because we are putting on a lot of boundaries for them to continue [...] Midwives need to be taken care of on all levels. Many of them are young, and have unlimited love for the job. They come to it because they love it, they like it. So I wish to give them, to be able as a system, to provide them with all of the incentives and the support and the opportunities to continue on in the job and improve on it.

Dr. Al-Shahrani also said that midwifery should be better publicized and encouraged. More awareness about the job in the community and the importance of the work would be helpful.

### ***Awareness and Education***

When I asked the participants if there was enough awareness about reproductive health among the youth, Dr. Tarhouni replied that she was invited to do a lecture at a school, but that she doesn't know if this is regularly incorporated into the curriculum or if it was just teachers taking the initiative to do this.

Dr. Al-Shahrani said that reproductive health is only covered in one chapter of a schoolbook. It covers basic anatomy and signs of puberty; however, she said that it is not clear how this information gets incorporated into students' minds. As she runs a teen clinic, she said that she often sees that there is a lack of awareness about these issues among male and female adolescents. While they can google information these days, it is not always reliable. She told me that she has heard that the Ministry of Health has put together teen health guidelines for primary health centers, and that this is a positive step. She also emphasized that sexual health education about sexual relationships, STDs, and vaccinations are not well incorporated into the mainstream education system. Even doctors are not necessarily well trained or any more informed in these areas. While some medical school courses will have a debate about some of these issues, it does not always occur consistently.

Dr. Yusuf, when I asked about general awareness of issues related to reproductive health in society, said that he believed both the earlier stages and later stages of the reproductive cycle are not covered well. For girls, experiencing changes in their bodies, and for women going through menopause, there is not a lot of information available. Furthermore, he said there is not enough information about common problems in reproductive health such as Polycystic Ovarian Syndrome (PCOS). Women who suffer from PCOS may be overweight, have excess growth of hair, acne, irregularity in their menses, and can experience infertility. These women might have difficulty getting pregnant after they get married. Although the condition is easily treatable, many women do not realize they have the condition in Oman. A recent study found that only .3 percent of women are diagnosed with the condition in Oman. However, in most countries the

percentage ranges from 5-20 percent. Therefore, he said that they must be missing a lot of cases in Oman, as it is not uncommon. Women may be addressing the individual symptoms they are experiencing, but may not know they have the underlying condition.

Dr. Yusuf also said that he thought menopause was generally neglected. In a study of Omani women's experiences of menopause, many were not oriented about it, such as the risk of osteoporosis and body changes. He said that more information about menopause is needed.

Dr. Al-Hamdani said that there is a need for more information for patients at every level of care. In her experience, there are many misconceptions that can actually be dangerous. For instance, some women will refuse cesarean sections even in an emergency because they worry it will impact their ability to have children in the future. Additionally, because the family is so involved, doctors also often have to speak to and convince husbands, mothers, and mother-in-laws that this is needed. Women will also sometimes wait until the last minute to come in to give birth because they are worried about having to have a cesarean section, which can put them in danger. Dr. Al-Hamdani said that dealing with all of this at once—the misinformation and education while they are doing the other aspects of their job, can be very challenging.

Dr. Al-Shahrani also suggested that another challenge is that women are often reluctant to complain or come in for a problem related to women's health. Many women suffer for a long time, and come in at a later stage of a problem. There is also a lot of misinformation which can lead women not making the best or most informed choices. She agreed with Dr. Yusuf that with menopause, women often don't know where to go if they do have a problem, and often suffer in silence. She said:

Something, if it is not a chest infection or a heart condition or something like that, she has a problem relating to the vagina to the sexual relationship, anything like that, there is a great reluctance for women to actually approach a healthcare provider and ask for help. For me that is one big thing. Sometimes that is resulting from cultural norms. Everybody thinks that women should not complain, they should not have a problem. Their job is to get pregnant and go on with life. Nothing is easy. So this cultural belief I think it's been rooted in our country that the strength of those fruits vary from one area to another. And the more the lady is educated, the more those roots become weaker.

Dr. Al-Shahrani also emphasized that when we talk about education and awareness this also needs to include the whole community, not just the individual women. There is a tendency in Omani society to consider anything related to reproductive health to be a woman's issue. But Dr. Al-Shahrani argued that it is important to include the husbands, as they play a huge role in shaping the decisions couples make. Dr. Al-Shahrani said that she found it is important to include men in the infertility investigations, for example, or they may distance themselves from it, assume it is the woman's issue and try to avoid becoming involved.

### ***STIs and Other Health Campaigns***

Many of my participants said that sexually transmitted infections are often not discussed in Omani society, and dismissed based on the assumption that the rates are not high in Oman. Dr. Tarhouni, Dr. Al Zahabi and Dr. Al-Shahrani all said that this was an issue often avoided because it is stigmatizing and because it is a sensitive issue. Dr. Al Zahabi said that there is a lack of information provided for students on this issue. She suggested that more research on strategies to provide such information in an acceptable way might be useful. While birth spacing, contraception and other topics are more acceptable to talk about now, she said that she has found that there is still stigma and an inability to discuss STIs in Omani society.

Dr. Tarhouni pointed out that assumptions that HPV and other STIs are not prevalent in Oman because of Omani values are dangerous. She said that it is important to look at the reality rather than avoiding it just because it is a sensitive issue. These assumptions then impact health approaches such as the current lack of emphasis on the HPV vaccine and the prevalence of screening for sexually transmitted infections.

### ***Community Health Approach***

As many of the mental health specialists suggested, many of the reproductive health specialists also recommended shifting towards a more community oriented approach to reproductive health issues. Dr. Tarhouni said that the Society for Obstetrics and Gynecology organized a women's health event on Omani Women's Day in October. They made displays in the main malls in Oman on issues related to women's health, like the HPV vaccine and breastfeeding. However, she noted that there are not many community groups focused on such issues. Dr. Al-Zahabi also said that in the College of Nursing there is a community health course where students go out into the community and educate families and hold community activities. But she said that this is not as structured as it should be, especially considering the demand.

As Dr. Al-Shahrani noted previously, Dr. Al-Zahabi also said that the relationships that most influence women are important to take into account. Therefore, a community outreach approach is needed rather than one which simply targets women. She said:

You know the image of women, power issues, power dynamics between men and women. Decision-making, all of these things. These are very important when targeting, for example an intervention for women. It's very important to think about the husband, and even the family. Because family plays a very significant role. A very significant role. So chatting with women alone I don't think will achieve that much as a family intervention. When you talk to a family. So the community would be the best place for productive interventions and educating

them. I think it's the best place, because families are highly valued. I came from an Arabic country, and I can tell it's even more valued and connected. So this is very important [...] so if you talk to a woman about condoms and she knows it is important, that it can help, and you don't educate the husband and the family it might be useless. Actually we are hurting, and putting pressure on the women because she is becoming worried and she can't make a decision.

Dr. Shahrani also emphasized that community groups are limited, and for those that do exist, reproductive health is not a priority, except when it comes to contraception. Other topics are not covered. She also emphasized that a community approach is important because in order for people to trust information, you cannot assume that just presenting it to them once will be enough, and that they will accept that information from someone they don't know. To really have an effect it takes a lot of time and effort. And she said that this is not being prioritized enough.

Two of my participants (Dr. Yusuf and Dr. Al-Zahabi) suggested that better utilizing technology to provide more reliable information in the form of a mobile phone application would be beneficial. Both emphasized that as everyone in Oman has smartphones, developing a means of utilizing it to access health information would be very helpful in terms of improving awareness about certain issues. As Dr. Yusuf explained, because the population in Oman is scattered and broken up by mountains, wadis (valleys) and deserts, it is difficult to provide homogenous services everywhere. He suggested that the government invest in mobile technology to improve awareness and access to information. An application in Arabic that covers the primary topics patients may need to know about would help to bridge gaps in their access to health information. Dr. Al-Zahabi similarly suggested that for sensitive topics such as those related to puberty and STIs, the ability to access reliable information through mobile technology

would help to improve the quality of information young people are receiving. She explained that Arab countries might have to be more inventive in coming up with ways to address topics that are stigmatizing. She suggested strongly that technology could provide one method for approaching such issues.

### *Promoting Birth Spacing and Breast Feeding*

Dr. Tarhouni said then when women come in for their babies' vaccinations, they receive counseling about contraception at this time. However, Dr. Al-Hamdani related that many women fear the side effects of contraception, and are therefore not very open to it. Dr. Yusuf also said that while the idea of using contraception has become more accepted as a general idea, and is not necessarily seen as going against God, there is much debate over what kind of contraception is right or acceptable. He said:

There are several ways of achieving birth control, it ranges from oral contraceptive pills, injections, barriers, etcetera. I remember initially when the government started birth spacing there was some resistance from people. Because they thought this is not natural. This may be against the will of God. Because we shouldn't do this. Maybe this is not appropriate, like that. But after education they realized the benefits of birth spacing. Then came the issue of which one to select. And at some point in time discussing some men resisting something like barriers. They would put pressure on the women to go in for injections or oral contraceptive pills. Though there might be sometimes side effects. So these issues need to be tackled with more transparency. And with more cooperation from both sides.

He suggested that both men and women need to be involved in the discussions and negotiations regarding family planning. Dr. Yusuf also emphasized that in Oman it is necessary to consider religious teachings in reproductive health. He used the example of tubal ligation:

Some people might perceive it as manipulation of the body. It is quite highly prohibited that somebody play with the body. It is totally unaccepted that somebody would hurt his or her body because it was created by God—there is a

holiness in it. So people might think if you do tubal ligation it is as if they have manipulated what God has created. And here the culture and religious teachings need to lead them about the needs. Because also in the religious teachings there is a good discussion about balancing the benefits and the harms. And if there is anything harmful than you should prevent it. Like the principles of bioethics—beneficence and non-maleficence.

Therefore, it is important not only to consider and encourage men and women to discuss and negotiate these issues, but in Omani society religious perspectives must also be engaged.

Dr. Shahrani also said that women often grapple with issues related to contraception—regarding what is appropriate and what is acceptable from a religious and cultural perspective. She also maintained that while the Ministry of Health has had health campaigns targeting birth spacing, and there have been community support groups and volunteers focused on contraception, women are still hesitant to take medical contraception. Natural contraception is preferred. Dr. Shahrani said that while for some people this may be acceptable, it does have a failure rate of around 20 percent. If it is dangerous for a woman to get pregnant, as a gynecologist it might be difficult to accept this choice, as they may think the failure rate is too high. However, she explained that if a woman comes into a clinic for advice, it is important to see them multiple times to understand the barriers that exist for her to use contraception, establish what she considers safe and effective, and reach some kind of agreement about what choice to make.

### ***Family Size***

All of my participants agreed that family size is decreasing in Oman. While many of the professionals mentioned that the fertility rate is still quite high compared to other



countries in the region, they did all note that due to the social changes that have occurred recently, it is declining. Dr. Tarhouni said that she typically sees women having 3-6 children on average, whereas they used to have as many as 12 or 13. Dr. Al-Hamdani said that as women are getting married later, taking their time in education, and as children are more expensive to invest in in terms of education and health, Omanis are having fewer children (typically 4 or 5). Dr. Al-Zahabi said that although family size is going down, the fertility rate is still very high, as family planning is not always accepted. However, Oman has seen a drop in family size, as in her experience many women in their forties had 10 children, while women now may have six, and the younger population may have four. She said that this is bound to change given Oman's modernization, but that family will still always be emphasized as long as Oman is influenced so strongly by Islam.

Dr. Al Kandari also said that in the 1970s Omanis had fewer children because of poor healthcare, this increased in the 1980s and 1990s to an average of ten, but that it is now reducing to around five.

Despite these shifts, Dr. Yusuf articulated that high parity, or grand multiparity—which occurs when women have more than five children, is still 27.1 percent in Oman. This is one of the highest worldwide (Oman is only second to the United Arab Emirates according to Dr. Yusuf). He suggested that birth spacing is still an issue that needs to be addressed in Oman. He also pointed to a research study recently conducted by the Research Council regarding the change in generational beliefs about family size. Some expected desired family size, due to the changes that have occurred in Oman, to be all the

way down to two children. However, girls in the study said that they wanted four children, while boys typically said they wanted more than four.

Dr. Yusuf also gave his own personal story as an example of how there can also still be pressure to have larger families. He had fourteen brothers and sisters. He planned to only have two children with his wife, but his father said:

There is something wrong with you my son. Go for a check up for hormones. It is just a shame, yanee [I mean]. How could my son produce only two?' And so my father forced me to increase my reproductivity (laughs). So I reached six now. But my children, they think, no way. They would like to have only two. So you can see the trend. So I think it is the education. Higher education has become quite popular among boys and girls. And by itself it has increased the average age of marriage. I remember like fifteen years ago the average age of marriage was around 18 or 19 for girls The last time I saw it, it was around 24, and I think it is increasing. After a few years it will be 28. By itself it will reduce the fertility rate.

He explained that while for some there might not be as much pressure to have larger families, this pressure does still exist. He explained, "some people have full autonomy. For me it is not. I grew up in a small village. And after I finished in America I came back to the same village, I built my house there. I am still the son of a farmer. And that's why I can't say no to him."

As Dr. Yusuf pointed out, Dr. Al-Shahrani similarly said that because there are more girls in higher education, they might not be approached for marriage until after they have finished their degree. As they are getting married later, there is a shorter time span in which to have children. Children are also often spaced more for the convenience of the wife's career.

### ***Infertility and Reproductive Technologies***

The majority of my participants also said that a public infertility center, which has the capacity to do in vitro fertilization, is a considerable need in Oman. Dr. Tarhouni told

me that currently, couples can receive basic infertility treatment through tertiary hospitals or secondary care clinics. However, for IVF couples have to go to private clinics or hospitals, or may travel abroad. She had heard that there are plans for a fertility center, but didn't know when this would occur. Dr. Al-Hamdani said that for infertility in general there are limited options. The public clinics are limited in the treatments they can provide, and private clinics can be very expensive. Dr. Al-Kandari also emphasized infertility as a major issue, saying that it has increased due to a rise in STDs as well as other factors in Oman. There has especially been a rise in male cases of infertility. While Dr. Al-Kandari told me that the government will sometimes sponsor couples for two rounds of IVF, others said that while this is possible, couples have to meet certain criteria and aren't always selected. She also said that couples struggling with infertility will often get nervous after six months of trying to conceive, and will go to a private clinic at that time. She explained that couples get constantly nagged about having children right away, as they are expected to be pregnant in under one year's time.

Dr. Yusuf concurred that he had heard there were plans to establish a public infertility center that would be better equipped for IVF and hopefully for PGD (preimplantation genetic diagnosis) screening. He also said there were plans to provide IVF in government hospitals. He emphasized that given Oman's higher rate of congenital and hereditary disorders, while IVF is expensive, considering the expenses necessary to care for individuals with such disorders, it is worth the government's investment. He pointed to examples like Italy, Greece and Iran who have been successful in preventing congenital hematology disorders. As Saudi Arabia has begun doing this, he said that he believes Oman will follow.

### ***Maternal Mental Health***

Like many of the mental health specialist participants, when I asked Dr. Tarhouni about maternal mental health she said that in general there are not enough psychiatrists, social workers and psychologists and that they are not always easy to access. Especially since patients have to be referred from the primary care level to secondary care, and then to the tertiary care level.

Dr. Al-Hamdani also pointed out that there are no counselors in the infertility clinics, and that they don't usually refer patients unless they are obviously depressed. She noted that dealing with infertility, especially considering the pressures to conceive in Omani society, is extremely difficult, and that improving referrals or having an infertility counselor may be helpful. At the same time, Dr. Al-Hamdani also suggested that there is an attitude that whatever God wills they will accept. There is more of an inner peace due to their faith. When I asked her if families were a source of support for maternal mental health she agreed, but also emphasized that they can be a source of great pressure (as she demonstrated earlier with her own example of being pressured to have children right after she got married despite her plans to go to Canada to study medicine).

Dr. Al-Kandari said that there was not an emphasis on mental health with pregnant ladies. While there is a lot of family support, they don't have specialists for maternal mental health or which focus on mental health during the pregnancy period.

Like several of the mental health specialists pointed out, Dr. Yusuf said there is a tendency to assume women might be experiencing depression because of sorcery or the evil eye. It occurs because she is experiencing good fortune. This is especially thought to be the case if she has had a boy.

Dr. Al-Shahrani told me that mental health is included as a risk factor on the antenatal card women bring to their appointments. However, women are more likely to get help if there is a red flag on the card, for instance if they have had depression or psychosis with a previous pregnancy. But it can be difficult to catch it if there isn't a red flag. Overall, she said that while screening for depression is supposed to be part of the antenatal visits, she doesn't know how diligently it is being done.

### ***Incorporating More Screenings and Vaccines***

Dr. Tarhouni stressed in her interview that regular screenings and vaccines need to be emphasized as a part of women's health overall. Regular pap smears, for instance, are not part of the Ministry of Health's screening program. The HPV vaccine is also not promoted. She said that HPV should have a health campaign just like the Ministry does for any other vaccine. She also suggests the Hepatitis B screening should also be promoted for pregnant women, just as they have done with HIV since 2009.

Dr. Al-Shahrani said that when women come into the clinic for a pregnancy, she sees it as an opportunity to address other issues. This is the primary time when women will most be seen by a doctor, as there is not a concept of regular women's health exams. Dr. Al-Shahrani explained therefore, that when they come in for pregnancy, it is an opportunity to do other screenings. This includes mental health screenings.

### ***Traditional Medicine***

When I asked if traditional medicine is still commonly used, Dr. Tarhouni said that she sees a lot of women using herbal remedies—including to induce labor as well as for illegal abortions. Dr. Al Hamdani also noted that massage and herbal remedies are

often used. Dr. Al-Zahabi said that it is still very common, and that these traditions should be respected:

We should not ignore the effectiveness. Because traditional medicine, I say, is evidence-based practice for the society. Because they observe a lived experience of someone who would say, I used this and I got better. So it is very powerful in the lives of people. So when, I think it is practiced, and we should always take it into considerable attention when we deal with patients. We should know about it, and have valuable input about it. And respect it. So I will learn and talk about certain herbs, they help, for example ginger. In some cultures they do believe that ginger can cause abortion. While in others, they don't. If you go and tell them, no it doesn't cause abortion, and it's very safe. You might lose the entire trust relationship. Because she will consider that you are trying to harm her. It is deeply immersed in her values. Because she knows! She has seen people. They don't know that there are other variables, and so on. It is there, it does exist, and for health care providers they have to know how to deal with these issues, in order to maintain the trust relationship. Once the trust relationship is built, then women might start accepting the interventions about this.

In contrast, Dr. Al-Kandari said that she did not see many women utilizing traditional medicine or seeing traditional healers for reproductive health issues.

### ***Religious Doctrine and Reproductive Health***

Within our discussion of the ways in which culture shapes reproductive health care, several of my participants brought up the role religious interpretation plays in terms of determining what is permitted. For example, Dr. Al-Hamdani pointed out that third party donation as well as surrogacy is not allowed in Oman. Pregnancies are also not generally terminated unless they present a health risk to the mother. Dr. Al-Kandari also noted that egg and sperm donation are not permitted. She also told me that fetal reduction, if a women gets pregnant with five or six embryos, is also controversial and not allowed. She also suggested that in Oman there is an emphasis on the child being of the couple's genetic material.

### ***Screening for Inherited Disorders***

In her interview, Dr. Al-Hamdani brought up the fact that premarital screening for certain inherited conditions—due to the high rate of sickle cell and other issues—has increased. However, she said that it is important to be sensitive about it and maintain patients' privacy, as this can cause people to be labeled and impact their marriageability. Mr. Al-Omari similarly pointed out that screening for inherited issues is needed, as Omani law does not make it easy to marry non-Omanis. As a result, there is a lot of intermarriage.

Dr. Yusuf also said that the high rate of congenital disorders due to consanguineous marriages is an issue in Oman. Currently, hereditary disorders like thalassemia and sickle cell disease are only addressed after birth, when it is decided how best to manage it. Keeping up with advancements, such as Preimplantation Genetic Diagnosis (PGD) is important. PGD helps to diagnose genetic diseases in an embryo before it is implanted via IVF. That way, parents can get advice on whether or not to continue with a pregnancy.

### ***Privacy and Patient Confidentiality***

Dr. Al-Hamdani emphasized in her interview that respecting the privacy of her patients was very important, but could be a challenge. For example, she has had cases where a mother or mother-in-law inquires about the details of an infertile couple, or a husband may ask for a wife's report to justify marrying another woman. It's important, therefore, to keep patient's information confidential.

Dr. Al-Shahrani agreed that keeping patient information private was important, and said that it is a major issue that needs more attention. She told me that there is not a

concept of confidentiality or keeping patients' information quiet in health care settings in Oman. Patients at the reception desk are asked about the purpose of their visit, then they talk to a nurse, and then to a doctor. Because they often have a relative, friend or neighbor who works at the clinic, someone is likely to know her from the community. As there is not any control over the flow of information, private patient information gets around. She told me a personal example of her sister's experience with confidentiality issues. Her sister visited a primary health care center for a pregnancy test. Her husband was away so she didn't tell him and she didn't talk to anyone. In two days, her cousin's family was telling her family that she was pregnant.

Dr. Al-Shahrani stressed to me that confidentiality has not been prioritized as an aspect of healthcare or a responsibility of workers in health institutions. However, this needs to change, as patients' privacy needs to be protected.

### ***Maternity Leave***

Several of my participants also brought up the issue of maternity leave. It is currently 50 days. However, after a woman has her fifth child, she is not granted any maternity leave. One of my participants said that like Indonesia, Malaysia, and the Philippines, maternity leave should be closer to three or four months. Not having adequate leave makes it difficult to breastfeed and have adequate time to bond with the baby. Dr. Al-Hamdani said that it puts unnecessarily stress on working women and can cause them mental anguish (causing us to have a serious mental health issue, she joked). Dr. Al-Kandari also mentioned this as an issue, saying that although women have a lot of family support to help take care of the child, this is still an important issue for working women.



### ***The Need for More Research***

Several of my participants emphasized that there is a need for more coordinated and focused research in matters related to reproductive health. Dr. Al-Zahabi said that research on issues such as abuse and what violence means within culture is important, as it dramatically impacts the lives of women and has implications for women's health overall. Mr. Ballal also said that there is a need for researchers to take more initiative in conducting research in Oman.

Dr. Al-Shahrani said that while research in Oman has been increasing, research related to women's health is still limited. She pointed out that those who do research in this area are obstetric gynecologists. However, they already have so much work and other commitments that research does not come as a priority. They have teaching, clinic and administrative obligations, and there is always something more urgent that requires their attention.

She also noted that not being able to gather information from various institutions can make research difficult. Clinics and hospitals are not always obliged to share their information, as they have not established a sense of mutual benefit from doing this. That is why there are no numbers for infertility in Oman, for instance. She acknowledged that there is a plan to create one accessible database for all of this information. However, she said that this may not be for some time, and expressed hope that it be implemented sooner rather than later, as access to this information is needed in order to be able to conduct more vital research.

However, Dr. Al-Shahrani did mention in her interview that there has been more national cooperation between professionals, such as more workshops and conferences over

the past several years, and that this has allowed a professional community revolving around women's health to develop. This is a hopeful sign for future collaboration and strengthening the community of caregivers in women's health in Oman.

## CHAPTER V

### CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to examine how the current health system in Oman addresses reproductive health and mental health, to identify some of the main hurdles on the ground to providing quality care, and to understand how culture and social change shape these health issues. While it was often the case that the interviews explored the ways in which the system is lacking, remarkable examples of improvements and trends that are occurring on an individual basis, as well as significant insights and suggestions, also arose. Many of the professionals in this study were already finding innovative ways to utilize opportunities within the culture itself to improve the quality of care for patients. It became evident throughout the interview process that these professionals were incorporating principles articulated in the *Lancet Commission on Culture and Health* on a daily basis in their interactions with patients as well as their students. These practices are often occurring on a small scale, as professionals take it upon themselves to address these issues. Therefore, some of these practices may simply require more coordination and to be prioritized on a larger scale in order to have a more significant impact. The following conclusions and recommendations simply outline these hurdles as well as opportunities that our conversations explored.

It is also important to acknowledge that there are a number of forces at work that influence health care decisions in Oman. The majority of professionals have been trained in the West. The positions of the state are shaped both by citizen demands as well as international organizations and development aims which attempt to align with

international standards. Therefore, it is important to consider these influences in addition to the important role that families and communities play. Both local, state and international positions can also be influenced by socio-economic trends. At times, pressures and influences may continue to exist despite change in circumstances—for instance, pressures to have larger families may continue despite not having the means or desire to do this in light of recent social changes. Therefore, it is not as simple as embracing western influenced medical system or integrating “local” knowledge into these systems. There are many complex factors that influence these trends.

### **The Influence of Family and Community and Respecting Patient Perspectives**

It became apparent in my interviews with both mental health and reproductive health specialists that Omanis often value the opinions of family, friends, and neighbors over that of medical specialists. They don’t necessarily view doctors as having superior knowledge even though they are specialists in these areas. The knowledge and opinions of the people in their lives is often more important and influences their decisions more than that of the physicians that they visit in the clinics. Therefore, building relationships with patients to establish mutual respect and understanding, rather than insisting that the physician has superior medical expertise, is important.

Several of my interviewees stressed this point, and said that it was important to work with patients’ ideas and concerns as well as with family members in order for care to be effective. As Dr. Al-Shahrani said in her interview, in order for people to accept information and advice, trust needs to be established, which has to be developed over multiple interactions and involves identifying barriers to care and establishing a mutual understanding regarding the path for treatment that is right for them.

This notion, articulated in various ways throughout many of my interviews, demonstrates many of the principles of the *Lancet Commission on Culture and Health*. While incorporating patients concerns, perspectives on medical issues, barriers to care, and their ideas about the best treatment options for them, is often occurring on an individual basis—as physicians chose to incorporate this into their care strategies to build more effective relationships with their patients—encouraging this and providing trainings on how this could be better introduced into care settings could be useful. For instance, going back to the questions the *Lancet Commission on Culture and Health* outlines in terms of guiding physicians discussions with patients may be helpful:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect this problem to take? How serious is it?
- What do you think this problem does inside your body?
- How does this problem affect your body and your mind?
- What do you most fear about this problem?
- What do you most fear about the treatment? (p. 1614).

Encouraging physicians, especially in their approaches with mental health and reproductive health care, could help to better take these perspectives into account to increase the quality of care as well strengthen their relationships with patients.

### **Community Focused Care**

The necessity of increasing community-oriented programs in terms of outreach and services was discussed by the majority of my participants. Relatedly, including families and community members in education campaigns in order to spark discussion within these groups about important health issues was also emphasized. Just as Dudgeon and Inhorn (2004) discuss the importance of including men in these discourses, many of my participants echoed a similar need to better incorporate men and other influential

community members into reproductive health discussions. Many of the participants said that simply providing individuals with health information is not, in itself, enough. As Varley (2012) and Gruenbaum (2011) similarly suggest, top-down campaigns that ignore the various social factors that influence these issues, will not be effective. Therefore, Providing health awareness but encouraging citizens to discuss and work these issues out for themselves may be more impactful than top-down campaigns. For example, this may involve community campaigns that cover various reproductive health options and encourage people to have discussions in communities about these options, rather having the information presented to them at doctor's office or through a Ministry campaign.

In some ways this is already being done. Again, it is just on a smaller scale in both mental health and reproductive health. Many of my participants said that they had taken part in community awareness campaigns—discussing these issues with people in communities who were very often very open and engaged. However, more coordinated and consistent efforts, as Mr. Ballal suggested, might have a greater effect. Planning more consistent community programs and increasing collaboration among different groups which focus on women's health, mental health as well as other related health concerns, may help increase the discussion surrounding these often culturally sensitive issues.

The need to strengthen the capacity of community services outside of the capital was also emphasized in the interviews. For mental health, this may include increasing the number of psychiatrists, psychologist, counselors and social workers in local primary healthcare centers, or improving the number of psychiatric clinics. Several of my participants also mentioned that having mental health teams that can go into communities

without quality mental health coverage to provide medication and care would also be a very beneficial development. This might help prevent patient relapse due to living in areas where care is not as accessible. A shift towards more community oriented service is not something clearly articulated in the *Health Vision 2050* report, but something that should be considered—as the majority of health professionals identified this as a significant need in order to improve the quality care available to Omanis.

Establishing and offering training for volunteer groups within communities throughout Oman may also help to spark more discourse around these health issues and provide opportunities for education and discussion.

### **Maternal Mental Health**

While some of my participants said that there were some trainings and screening for maternal mental health issues, many agreed that there was not enough to detect or treat these issues consistently. Additionally, increasing family awareness of these issues so that they can encourage women to receive help if needed, could also be useful. Encouraging obstetric gynecologists to do regular screenings for postpartum depression and other mental health screenings during and after pregnancy would also help detect such cases. As Eloul, Ambusaidi and Al-Adawi (2009) suggest, while these issues may not be more prevalent in the region of the Middle East and North Africa, the fact that women on average have more children in Oman may make them more vulnerable to developing mental health related concerns. As the pressure to have a child immediately after marriage remains high in Oman, referring or providing couples struggling with infertility with counseling services could present an opportunity to improve care in this area.

## **Family Therapy**

As previously discussed, Helman (1990) notes the increasing trend of “widening the definition of ‘patient’ beyond the individual to include their family-and where relevant, their community as well” (Helman, 1990, p. 241). As families often have their own cultures within themselves, and as the strong influence of these relationships can greatly impact patients’ health, it is important to consider these dynamics when treating patients. Especially given that family members play such an important role as both a support system as well as sources of pressure and influence in Oman, including them as part of this process would be beneficial to their recovery long-term.

## **Smartphone Application for Health Information**

Another useful suggestion was the potential to utilize technology to improve access to information by developing an application in Arabic for smartphones. This could help address gaps in homogenous health care and to provide more accurate information about sensitive topics related to mental health and reproductive health. Including screenings as well as a forum for discussing these issues could increase and promote health awareness.

## **Language and Culturally Specific Screenings**

Several of my participants, especially in Dr. Yusuf’s case, emphasized that screenings and questionnaires need to be applicable to the setting and language used in the region. More research should be conducted to evaluate how effective specific screenings are in Omani society, and how they could be improved in terms of the translation and relevance to circumstances in Oman. The importance of language in shaping the specificities of illness and the treatment of patients is another essential



principal put forth in the *Lancet Commission on Culture and Health* and is a concept that Dr. Yusuf and others recognized as an important aspect for improving care.

### **Increasing Research Coordination and a Shared Research Database**

Encouraging more collaborative research, especially in areas related to women's health as this is considerably lacking, was also another need expressed in the interviews. Giving obstetric gynecologists more opportunities to focus on research as well as encouraging both private and public clinics to contribute to a shared database in the near future, as planned in *Health Vision 2050*, would help these efforts.

### **Respecting Local Knowledge**

Another primary theme emerging out of my interviews in both fields was the need to respect local knowledge. Many of the health professionals emphasized that they do not get anywhere with patients if they doubt something that has been a belief in their families and communities for years. They will simply lose their respect, trust, and the ability to connect with them. Many of my participants demonstrated how they work with patients' beliefs on a regular basis. This is another prominent principle in the *Lancet Commission on Culture and Health*, which professionals are applying in their practices.

Several of my participants also mentioned that making nursing and medical school curriculum more culturally specific, as well as more conscious of other cultures, is also needed. While some instructors are already adapting curriculum on their own to enhance student learning, encouraging this on a larger scale may be beneficial.

While many of the Omani participants and specialists from the region emphasized the importance of working with local beliefs, some of the South Asian expatriates, while they agreed taking culture into account was important, sometimes expressed attitudes that

implied that Omani beliefs were wrong and that they did not necessarily see the need to try to understand these beliefs or religious perspectives in treatment. Some of their responses seemed to imply that they were coming from the correct, educated perspective and did not always recognize their own cultural bias. Therefore, training expatriate professionals to better incorporate local beliefs and perspectives into care without judgment might be helpful.

### **Incorporating Faith Healers/Traditional Healers into Care**

As many of the specialists I interviewed pointed out, traditional healers have value and status in the community due to their religious role. They also have strong communication skills and know how to connect with people in a meaningful way that psychiatrists and psychologists sometimes fail to achieve. Seeking help from a traditional healer is also less stigmatizing than seeking psychiatric care. Therefore, collaborating with healers to some extent may help to encourage families to utilize mental health services. This could potentially reduce the stigma associated with receiving care for mental health issues.

In their study of how Muslim faith healers address mental health and substance addiction issues in the UK, Rashid, Copello and Birchwood (2010) conclude that collaboration between faith healers and mental health professionals would help to bring about more culturally appropriate care and improve the overall quality of care for Muslim patients (Rashid, Copello and Birchwood 2010). While their study was primarily focused on the ways in which faith healers explain the causes as well as how they approach psychosis and substance abuse, they argue that forming a relationship between physicians

and traditional faith healers would help to address issues more comprehensively, and improve the quality of care for Muslims seeking help for either of these issues.

Abdel-Khalek (2011) also argues that certain Islamic practices can help ease stress. Prayer, recitation of the Qur'an, fasting, remembering Allah, can all aid in addressing issues like depression. Many Muslims would say their faith is central to their lives as well as their sense wellbeing.

Airhihenbuwa (1995) and Helman's (199) discussions of incorporating healers into health systems are also relevant here. For truly collaborative and mutually beneficial relationships to develop, there would need to be protections to be ensure healers are not marginalized or taken advantage of. However, working with faith healers could benefit patients by providing less stigmatizing care integrated with spiritual beliefs.

### **The Role of Faith in Shaping the Causes and Treatment of Mental Illness**

Most of my participants were Muslim, and many had been raised in Oman. Therefore, some of the professionals I interviewed may have had shared beliefs about the role of *jinn*, or had personal experiences with religious belief playing a part in mental health and the recovery process.

However, these mental health professionals did not discuss their personal views or beliefs about *jinn* or their associations with mental health with me. As I was raised and educated in the West, they may have assumed I would not relate to these beliefs. However, most of my participants agreed that it was important to engage with patients' faith and beliefs, as this is an important aspect of their lives.

As previously mentioned, several of the expatriates from India who I interviewed did not emphasize that religious beliefs were important in treatment. This perspective

varied from the positions of my participants who were from Oman or the region of the Middle East, and were Muslims themselves. One of the participants who worked in a private clinic and was not Muslim, for instance, said that she had to convince her patients that the fact that she was not Muslim would not negatively influence their treatment, as many patients were initially hesitant to see a psychologist who was not Muslim. Another of the participants not from the region had the attitude that Omanis needed to realize that their beliefs are not correct in terms of the causes of mental illness. However, this contrasted with the opinions of participants from the area who were Muslim, most of whom agreed that there was value and a need to incorporate beliefs into treatment, as they are important in shaping both patients' outlook on life, as well as their beliefs about mental illness. Therefore, as several of my participants suggested, more training for expatriates so that they can better understand the important role that beliefs play in shaping care, as well as its potential to aid in a patient's recovery, may be needed. Otherwise, incorporating beliefs into treatment may be a missed opportunity for care when Omanis receive treatment from an expatriate caregiver.

Several of my participants suggested that engaging with religious communities to better promote health awareness campaigns or improve care was a potential opportunity to reach communities. However, local mosques, spiritual healers, and the Ministry of Religious Affairs all represent different forces in society, which are shaped by different factors, and therefore have differing motives and perspectives. It is necessary to examine the motives and perspectives of these various groups in society, as they influence their approaches to these issues.

### **Broadening Mental Health Awareness Campaigns**

Developing awareness campaigns with a less stigmatizing approach was another useful suggestion that arose out of the interviews. Rather than narrowing the scope of mental health awareness to psychiatric disorders or problems and by emphasizing that mental health is not just limited to mental illness, these issues may be more easily embraced by the public. For example, discussing how individuals can take precautions to take care of themselves and how they can seek help in various ways if they need to work through certain problems in their lives, may be easier to discuss than mental illness. Not having a more comprehensive take on mental health, as several of my interviewees pointed out, limits the idea of mental health to associations with more severe psychiatric disorders and detracts from understanding it as a wider notion of wellbeing. As several of my participants emphasized, mental health is not just mental illness.

### **Improving Mental Health Training for Primary Care Staff**

Many of my participants said that better training opportunities for primary care staff would help the system overall. This is a goal articulated in *Health Vision 2050* which could greatly improve the quality of care in mental and reproductive health in Oman. As several participants pointed out, some mental health issues can be managed at the primary care level, depending on the capacity of the health center. However, this would require physicians to be able to adequately identify the problem, and have knowledge about how to treat it.

Furthermore, the ability of physicians to recognize an underlying mental health issue and to know how to properly advise and refer patients is also very important in order to prevent patients from going from one clinic to another to find answers, allowing

the condition to become more chronic. Understanding and recognizing somatic complaints specific to Omani culture that are linked to mental health issues would also be helpful. As Good (1977) and others have illustrated, expressions of distress vary from culture to culture, and it is important to understand these nuances and what they represent for people in society in order to address the root of the distress. Training primary care staff's capacity to identify, refer, and possibly treat mental health concerns would help patients receive care before their case escalates to more critical needs.

### **Improving the Therapeutic Capacity of Nurses**

Most of my mental health participants said that culture and language barriers negatively impact psychiatric nursing care in Oman. The lack of shared language and the inability of nurses to communicate with patients doesn't allow them to take on a therapeutic role with patients. As Dr. Abiha said "I think maintaining communication with the patient is very important. Letting him express his feelings, setting limits sometimes to some of the behaviors to change those behaviors is very important, because it's part of the treatment. All of this is not there. Because there is no communication." Nurses failing to engage in this kind of therapeutic role is a tremendous lost opportunity for care. Especially in Al Masarra, where the majority of patients' interactions are with the nurses, not being able to communicate with them at all is very problematic.

While shortages in psychiatric nursing and nursing in general may explain why Oman has not been stringent about requiring nurses to speak Arabic, this should be reexamined. Requiring nurses to learn the language as well as receive training about Omani culture may help. Encouraging and incentivizing more Omani nurses to go into the psychiatric specialty would also strengthen care. Training nurses to better incorporate

a therapeutic approach in their day-to-day interactions with the patients, for those who do speak Arabic or even English, would also be useful. The College of Nursing at Sultan Qaboos University Hospital is already encouraging students to do this with their curriculum. Further training on this, and making sure this is adapted in the nursing curriculum throughout the country could also improve this therapeutic approach.

### **Training and Incentives for Omani Nurses in Psychiatric Nursing and Midwifery**

One of the primary, and potentially most impactful suggestions that several of my interviewees suggested, is the need to increase incentives for nursing specializations—both in mental health and midwifery. Improving pay, creating positions with more status and benefits which take into account the more demanding hours, stress, and difficulty of work, could have a significant impact.

Especially in midwifery, this shift could have a significant effect, as many women go into the job because they love it, but because there are not enough incentives or benefits to stay in the position, end up leaving. Increasing midwifery may greatly help to address the shortages in obstetrics and gynecology, and allow obstetric and gynecology specialists to focus on their specialties rather than the majority of their efforts going towards low-risk deliveries, which could be handled by midwives. Recruiting medical students to the obstetric gynecology specialization is also difficult. Similarly, recognition of the demands of job could incentivize more people to go into specialization. Increasing midwives may also help to ease some of the burden currently felt by obstetric gynecologists due to the shortage of specialists.

### **Encouraging the Psychiatric Nursing Specialty Among Omani Students**

When I visited Al-Masarra psychiatric hospital, I was able to see some Omani nursing students interacting with the patients in one of the acute wards. Mr. Al-Omari told me that the patients look forward to the nursing students coming, because they actually get to do activities and enjoy being able to sit and talk with them. Discussing the patients' stories, why they were there, how they were doing, was obviously appreciated by the patients. Encouraging and providing more incentives for Omani nursing students to pursue a psychiatric nursing specialty would therefore be incredibly beneficial for Omani patients.

### **Low Risk Birthing Center**

When I raised Dr. Tarhouni's suggestion of introducing low-risk birthing centers as a way to ease the overcrowding and resource shortages in the hospitals with some of the participants, they agreed that this could be very useful. This would likely also require an increase in midwives or obstetric gynecologists to run these facilities—therefore it would need to be developed in conjunction with increased training of midwives. Low-risk birth centers may also provide specialists with the opportunity to focus their expertise where it is most needed, allowing them to better utilize their skillset.

### **Community Midwifery Services**

Increasing the number of midwives in Oman and improving emergency transportation services could pave the way for developing community midwife services, which would allow midwives to assist in deliveries at home. Several of my participants mentioned that this would be very useful.



### **Training More Local Counselors and Psychologists**

Increasing training opportunities to boost the number of local counselors and psychologists, in addition to encouraging more doctors to go into the specialty, would also be incredibly beneficial. These counselors and psychologists could then work at primary health care centers, schools, and hospitals. Having more local counselors and health workers that are better equipped to recognize and address mental health rather than depending on recruiting professionals from abroad would increase the capacity to detect and treat these issues. As Al-Riyami et al. (2009) and Kleinman and Becker (2013) suggest, existing institutions could be expanded to train new psychologists, social workers and mental health workers in a culturally sensitive way faster than it would take to train or recruit the needed number of psychiatrists.

### **Better Utilization of Al Masarra Occupational and Recreational Therapy**

I visited Al Masarra in March of 2015. Several of the participants told me before I visited that while Al Masarra has state of the art facilities, including occupational therapy, art therapy, wood-working, kitchens, and outdoor recreation facilities, they are often underutilized. During my visit, I did not see any patients using these services (other than a few patients who were cooking something in the kitchen). Patients were brought into a central garden area to enjoy the fresh air, but otherwise it was not clear to me how much these beautiful facilities were actually used. Therefore, encouraging and providing patients with more opportunities to use these services as part of their therapy experience could be improved.

### **Addressing Privacy, Confidentiality and Consent**

Increasing the protections for patient information and confidentiality is important to ensure that patients feel comfortable and secure visiting their local health centers. As Mr. Al-Omari also pointed out, issues related to patient consent, especially in Al Masarra, should also be addressed to strengthen protections for patients.

### **Awareness and Preparation for Birth and Motherhood**

While shifting ideas about birth as a natural process in Oman in favor of a more clinically focused outlook should not necessarily be emphasized in Oman, several of my participants said that more preparation for birth, being more informed about having a healthy pregnancy, as well the dramatic shift in roles that come with motherhood may help women to be more prepared for these experiences.

Dr. Yusuf also suggested that reducing the number of antenatal visits and shifting these resources to other aspects of women's health may be beneficial.

### **Including Men in Obstetrics and Gynecology**

While this may continue to be controversial and will have to be negotiated in Omani society, due to the shortage of specialists in obstetrics and gynecology, permitting men to practice would help address the shortage of human capital and services.

### **Conclusion**

Almost all of my interviewees expressed to me that they are proud of the improvements that have been made in Oman, and have great hope for the future of the health system. Therefore, I will end with two of their statements about the progress and potential of the Omani health system in mental health and women's health.

Mr. Al-Omari:

But actually the health centers, wherever you are they tend to do a good job there. And the level of education at all levels is amazing, what they've achieved in forty, forty-four years. It's enlightened government, honestly. Again, we have to be careful what we say about politics, but definitely wiser than most Arabic countries, I would say. And more genuine, and more compassionate to its people, I would say. For resources they are spoiled; education and health, just take it. A doctorate, apply to it and we'll take care of you.

When I asked Dr. Al-Shahrani if she had any final comments, she said:

I love my country. And I am very optimistic. And I think that good things are happening. Although we spoke only about the problems. But actually there are lots of good things happening and it give us hope that women's health in Oman is improving and in each aspect of it [...] so I know we have a lot of positive things, and I know good is coming, we just need to expedite things a little bit and look at women holistically and enforce the introduction of incorporating healthcare, reproductive health in other related women's health issues.

While there are many ways in which the Omani system could continue to refine care to better serve the reproductive health and mental health needs in the country, the trajectory overall is positive. Many of the *Health Vision 2050* development plans coincide with the identified needs on the ground in mental and reproductive health. Therefore, as long as mental health and reproductive health are included in the future development aims in public health, tertiary and specialization training, and primary care goals, the quality of care in these areas will likely continue to improve. The professionals in this study also demonstrated their commitment to many of the concepts and recommendations put forth in *the Lancet Commission on Culture and Health* concerning the importance of taking social and cultural contexts into account and providing culturally relevant care. While this could perhaps be incorporated more effectively and systematically on a larger scale, these trends occurring on the ground provide considerable opportunities for the further development of mental and reproductive health care in Oman.

## APPENDIX A

### INTERVIEW QUESTIONS

1. What would you say are some of the main hurdles/challenges to addressing mental health/reproductive health in Oman? What factors most impact care for the general population?
2. Are there any reoccurring or pressing issues that you see with patients that you think needs to be addressed more comprehensively?
3. How well would you say mental health/reproductive health concerns are addressed at the primary care level when a patient initially comes in with a concern? How do patients usually end up coming to see you?
4. Do you think that there are enough mental health/reproductive health specialist throughout the country?
5. Do you think education/awareness for the general population and in schools needs to be improved?
6. Would you say culture plays a significant role in terms of how mental health/reproductive health and wellbeing are thought about? How do you see this come up?
7. Do you think culture should be taken into account in terms of how mental health/reproductive health is treated? How so?
8. Do you still commonly see traditional medicine or alternative medicine being applied to address mental health/reproductive health concerns?
9. Are there any services or focus on the intersection between mental health and reproductive health in terms of mental health resources for new mothers/families?
10. (For mental health specialists) Are drugs and alcohol an increasing problem in Oman? How is this being dealt with?
11. (For reproductive health specialists) Is there midwifery training in Oman?
12. (For reproductive health specialists) I understand that family size in Oman has been declining, have you experienced this trend in your practice?
13. Is there anything else that we haven't discussed that you find important for understanding the current state of mental health/reproductive health in Oman?

APPENDIX B

RESEARCH PARTICIPANTS

Pseudonym	Sex	Status in Oman	Specialty/Work Setting
Dr. Rashid	Male	Omani Citizen	Psychiatrist, Public Health System
Dr. Hazazi	Male	Omani Citizen	Psychiatrist, Private Clinic
Ms. Sinha	Female	Expatriate	Psychologist, Private Clinic
Dr. Tarhouni	Female	Omani Citizen	Obstetrics/Gynecology, Public Health System
Dr. Al-Hamdani	Female	Omani Citizen	Obstetrics/Gynecology, Public Health System
Dr. Al Zahabi	Female	Expatriate, from the region	PhD, Women's Health, Public Health System
Mr. Ballal	Male	Expatriate	Mental Health Professional, Public Health System
Mr. Nabhani	Male	Expatriate, from the region	Mental Health Professional, Public Hospital
Mr. Al-Omari	Male	Expatriate, from the region	Mental Health Professional, Public Hospital
Dr. Abiha	Female	Expatriate, from the region	PhD, Mental Health, Public Hospital
Dr. Al-Kandari	Female	Omani citizen	OBGYN, Fertility Specialist, Public Hospital
Dr. Yusuf	Male	Omani citizen	Public Health/Family Medicine, Public Hospital
Dr. Al-Shahrani	Female	Omani Citizen	Gynecology Specialist, Public Hospital
Ms. Deora	Female	Expatriate	Mental Health Specialty, Public Hospital
Dr. Al-Qadi	Male	Expatriate from the region	Psychiatrist, Private Clinic

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