Beyond 2003

Situation Analysis of Children and Women in Oman

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1. National Context

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Illness
BFHI	Baby Friendly Hospital Initiative
CBR	Community Based Rehabilitation
CDD	Child Diarrhoeal Diseases
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSG	Community Support Group
DGWCA	Directorate-General of Women's and Children's Affairs
ESCWA	Economic and Social Commission for Western Asia
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
GNI	Gross National Income
GNVQ	General National Vocational Qualification
GOYSCA	General Organization for Youth Sports and Cultural Activities
GTO	General Telecommunication Organization
HIV	Human Immuno Virus
IBFAN	International Breastfeeding Action Network
IDD	Iodine Deficiency Disorder
ILO	International Labour Organization
IMAM	Integrated Management Approach to Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
JMP	Joint Monitoring Program
KAP	Knowledge, Attitude, and Practice
MoE	Ministry of Education
MoH	Ministry of Health
MoJ	Ministry of Justice
MoLA	Ministry of Legal Affairs
MoNE	Ministry of National Economy
MoSA	Ministry of Sport Affairs
MoSD	Ministry of Social Development
MSALVT	Ministry of Social Affairs, Labour and Vocational Training
MSBP	Munchausen's Syndrome by Proxy
NCDP	National Community Development Programme
NGO	Non-Governmental Organization
NHS	National Health Survey
NOSG	National Organization for Scouts and Guides
NVQ	National Vocational Qualification
OFHS	Oman Family Health Survey
OR	Omani Riyal
ORS	Oral Re-hydration Therapy
OVQ	Omani Vocational Qualification
OWA	Omani Women's Associations
PASI	Public Authority for Social Insurance
PBUH	Peace Be Upon Him
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
ROP	Royal Oman Police
PNC	Postnatal Care
RTA	Road Traffic Accidents

SGRF	State General Reserve Fund
SHD	School Health Department
SQU	Sultan Qaboos University
STD	Sexually Transmitted Diseases
U5MR	Under 5 Mortality Rate
UAE	United Arab Emirates
UN	United Nations
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRPP	Women's Reproductive Patterns Profile
WTO	World Trade Organization

PREFACE

A Rights-based Approach

At the start of the twenty first century, research, policy-making and programming concerning children has expanded through the guiding framework of the 1989 United Nations Convention on the Rights of the Child (CRC). The CRC acknowledged, for the first time, that children are full subjects of human rights but also recognized that children have additional, special rights as they are undergoing a critical stage of physical, mental, and social development. These are rights to survival and development, protection from all forms of abuse and exploitation, and meaningful participation in society, in line with their age and maturity.

All nations, bar two, have ratified the CRC. Those who endorse it accept the obligation to report regularly to the Committee set up under Article 43 of the CRC to monitor its implementation. The provisions of the CRC have yielded two main results:

- They have stimulated a new approach to children and childhood, in which children are seen as subjects of rights rather than objects of concern
- It has generated a demand for more and better information on all aspects of children's lives, covering a broader range of concerns than traditional focus on family, health, and education

A child rights approach requires one to move beyond the realms of survival and development strategies that concentrate on education, health care, and other basic needs such as nutrition and shelter. A holistic approach to children's rights means that rights are indivisible, interrelated and that each right is of equal importance. The starting point for developing a rights framework is the setting of basic rights identified by the Committee on the Rights of the Child – rights that affect the implementation of all other rights in this tool; these are:

- Non-discrimination (Article 2 CRC)
- Best interests of the child (Article 3 CRC)
- Survival and development (Article 6 CRC)
- Participation (Article 12 CRC)

Non-discrimination implies that all rights must be available to all children without prejudice. This requires identifying discriminatory practices and patterns with disaggregated data by sex, age, gender, class and geographic location, promoting gender equity, and assigning preference to particularly disadvantaged groups including those who are excluded, marginalised and difficult to reach such as children with disabilities, girls, or children from poor families.

The **best interests of the child** must come first, thus governing all decisions affecting children. Children's own views are vital in determining their best interests and considered in accordance to the child's age/maturity. The best solution should be sought for each child individually and should be the basic concern, given primary consideration in the allocation of resources.

Right to Life, Survival and Development is a holistic concept, which demands looking at the child as whole and taking approaches that are multi-disciplinary. Every child is unique. Full support should be afforded to all children in order for them to grow and reach their full potential. Basic services and protection from neglect, violence, abuse, and exploitation must be ensured.

Participation is key, so that all children have the right to express their views, which should be considered on matters affecting them directly. They must also have the right to relevant information in a form they can understand. Involvement of child-centred interactive learning enhances the learning process and promotes child participation. Furthermore, children should be permitted to form their own groups.

Viewing children's rights as the basis for policy and programme structure has two further consequences. Though it is still important to pursue agreed programme goals, such as further reducing infant mortality rates (IMR), a child's rights perspective focuses on the percentage of children whose rights are not achieved. Thus, rights-based programming shifts the focus from service provision and children's needs, to asking questions related to the fulfilment of rights. It is necessary to know what services are available for health, education, or recreation, for example. It is also important to identify the extent to which these services meet the needs of children, by comparing the number of children who benefit from the services, with the total child population of the relevant age group in particular areas. Furthermore, an overall understanding of children whose rights are not being met, due to insufficient access to services, such as the ill, working, or disabled, or simply that live too far away, is imperative.

One of the most important tools in collaborative planning between UNICEF and any partner nation is a situation analysis. Although it appears in print, a situation analysis is more than a publication; it is a continuous process. This procedure is a national responsibility, aided by technical support from UNICEF. It is also part of the country programme of cooperation, in which the CRC mandates UNICEF to assist in the process of monitoring children's rights and regular reporting to the Committee on the Rights of the Child.

A broad range of information is required from government and intergovernmental organizations, academic disciplines and the research records of non-governmental organizations (NGOs). A situation analysis combines quantitative and qualitative information, paying close attention to the actual lives of children and their families. Numerical data is analysed as social products within their cultural contexts so that human considerations are not 'subordinated to statistical and technical aspects'. Moreover, the analysis acknowledges the complexity of people's lives by tracing the links between international, national, community and family life.

The Preliminary National Report on the Convention on the Rights of the Child, prepared by the national committee for (CRC) activation headed by MoSD's Under secretary and composite of representatives from the concerned bodies (MoJ, MoE, ROP and MoLA), reflects the long-term commitment of Oman to child welfare. The report also sets in motion the process of moving away from a more traditional child development approach focusing on education, health, and special protection, towards a comprehensive framework that reflects, in unison, the CRC provisions, and the legacy of Omani traditions and values.

Vision 2020, the strategic plan prepared by the Ministry of National Economy (MoNE), bares direct implications for Oman's children, as it makes explicit provisions for the continued health of the welfare state, which underpins the well-being of Omani children, including:

- Sustainability of the development gains of the past three decades
- Training and qualifications of welfare state professionals, particularly among Omanis
- Training and certification of women who are currently responsible for delivering child care services as community volunteers
- Promoting the development of specialists and experts working with children

In countries such as Oman, that have achieved the majority of their health and education goals, new challenges emerge, previously obscured by the need to reduce mortality and morbidity and to improve and extend education. Thus, upon elimination of the major childhood killer diseases, survival, and development are assured for most children, and other child needs are revealed. Some children, who may not have survived in the past, do survive, but with a disability, which bring into play further rights issues. On the other hand, paediatricians began to notice that some children show signs of non-accidental injuries potentially indicating violation of their right to protection from abuse. Ensuring the full range of rights – civil, political, economic, social, and cultural – requires the collection of new data on topics that have not always been associated with information regarding children, including justice, citizenship, and exploitation**.**

The current database on health and education in Oman provides a good basis for monitoring survival and development rights. However, the Sultanate requires more information on protection and civil rights issues. To establish the basis for future periodic monitoring and reporting on child rights and conditions in Oman, it is vital to build a nationwide child rights database. Under Article 45 of the Convention, UNICEF is given a special mandate to provide technical assistance in matters relating to reporting. Thus, the development of technical capacity in collecting data pertaining to children's rights and developing a routine monitoring system is a natural component of cooperation between the Sultanate of Oman and UNICEF.

The commitment of the government of the Sultanate of Oman to promote children's rights is based on a strong indigenous values system and a modern history of child welfare services in health and education. The databases developed for these sectors can serve as a model for data collection and management for monitoring the entire range of child rights beyond survival and development rights. UNICEF, for its part, is committed to using the framework of the UN Convention on the Rights of the Child as the basis of its work and technical assistance, going beyond the former basic focus on child welfare. The development of a rights-sensitive database on children is thus a key element in current and future plans for co-operation between the Sultanate and UNICEF.

The Sultanate of Oman has embarked on a future path of economic modernisation on a foundation of traditional values. Education is clearly the key to Oman’s ability to meet this objective, which perpetuates the values of the modern Omani state and corresponds to a child rights perspective. Since children are the citizens of the future, the implication is that future planning must take into account the entire range of human rights encompassed by the CRC and Omani laws and values, beyond achieving survival.

EXECUTIVE SUMMARY

The Ministry of National Economy has put together this revised Situation Analysis of Children and Women in Oman, updated in December 2006. The last publication of Oman's situation analysis was in 1995.

Objectives

To ascertain the most up to date country statistics regarding children and women in the areas of, health, education, development, rights, protection, and gender disparities.

Methodology

For the realisation of this report, a multitude of studies and investigations performed by relevant ministries in the Sultanate and various UN sources were utilised. Essentially, it has amalgamated the studies pertaining to the topic of children and women, over the past ten years or so, and incorporated all new data, using the Census 2003 as a core reference.

Oman Vital Statistics

GEOGRAPHY/DEMOGRAPHIC	STATISTICS
Total area of Oman	**309,500 km^2** (3165 km of coastline)
Total Population (2004)	**2,415,576** ▪ Male – 1,360,891 (56.3%) ▪ Female – 1,054,685 (43.7%)
Total Omani population (2004) (Accounting for 74.6% of overall total)	**1,802,931** ▪ Male – 911,135 (50.5%) ▪ Female – 891,796 (49.5%)
Total Expatriate population (2004) (Accounting for 25.4%)	**612,645** ▪ Male – 449,756 (73.4%) ▪ Female – 162,889 (26.6%)
ECONOMY	**STATISTICS**
Gross Domestic Product at Market prices (2004) **GDP Per Capita (2004)** [(1)] Gross National Income (GNI) per capita (2004) [(1)]	OMR 9527.1 Million **OMR** 3944 (OMR 3731)
Employment average annual growth rate (2003)	5.3%
Overall participation rate (economically active)	**41.8%** ▪ Male – 64.7% ▪ Female – 18.7%

HEALTH	STATISTICS
Life Expectancy (at birth) (2004)	**74.3 years** ▪ Male – 73.2 years ▪ Female – 75.4 years
Total Fertility Rate [births per women 15-49 years] (2004)	3.19

(1) Provisional

HEALTH (Continued)	STATISTICS
Crude birth rate [per 1000 population] (2004)	24.0
Crude death rate [per 1000 population] (2004)	2.6
Infant Mortality Rate (2004)	10.3 (per 1000 live births)
Under Five–Mortality Rate (2004)	11.1 (per 1000 live births)
Protein Energy Child Malnutrition (Under 5) [per 1000 children below 5 years]	19.0%
Maternal Mortality (2004)	18.5 (per 100,000 live births)
Maternal Malnutrition (Anaemia) (2004)	32% (At child bearing age)
Leading causes of child mortality (2004)	**Under 1 year of age** ▪ congenital anomalies and perinatal conditions **Over 1 year of age** ▪ poisoning mainly due to RTA, followed by diseases of circulatory system
HIV Prevalence (2005)	53/100000 (majority of cases are seen between 20–44 years of age)
Improved drinking water supply (2003)	▪ Rural – 65% ▪ Urban – 76.5% ▪ Oman – 73%
Population with access to permanent health services (1999/2000) Population with distance of less than 5 KM from health facility	▪ 95% ▪ Rural – 27% ▪ Urban – 57%

EDUCATION	STATISTICS
Net Enrolment Ratios (NER) (2004/2005)	**G (1-6):** 89.8% **G (7-9):** 72.9% **G (10–12):** 57.7%
Females by educational level (2004/2005)	**Basic education:** 48.9% **G (1-6):** 49.1% **G (7-9):** 46.5% **G (10–12):** 49.1%
Kindergarten Growth	Approximately 6.7% annually
Higher Education Enrolment (2004/2005)	60,568 (rate = 18.1%)
Illiteracy Rates , Omani, 2003, (15+)	**22%** ▪ Male – 14.6% ▪ Female – 29.4%

Sources: Census 2003; MoH Annual Health Report, 2004; MoE Educational Statistical Year Book 2004 and MoNE Statistical Year Book 2004

Findings (more detailed)

- Overall hospital-based mortality rates for children up to 14 years old has decreased by approximately 7.1% from 1997 to 2004
- Postnatal care coverage is lower than antenatal care
- Maternal nutrition is still a major concern; 40.9% of 12–19 year olds, 42.7% of pregnant women aged (15–49 years), and 30% of all non-pregnant women (20–49 years) were anaemic
- In 2004, nearly 7.2% of child deaths (under 15 years), reported by health institutions, were due to injuries (largely road traffic accidents) and poisonings
- Acute respiratory illness and diarrhoeal disease rates in children under 5 years have dropped significantly from 1997 to 2004, by roughly 24% and 29% respectively
- Women are more aware of birth spacing and as such use of contraceptives increased by 8% in a 5 year period
- A case study, conducted in 2000 by the MoH, to assess feeding practices of children 2 years and younger, revealed only 31% were exclusively breastfed for the 1st 4 months, and that 66.9% continued to breastfeed after the age of 1 year
- The rate of protein energy malnutrition cases has marginally increased from 18 per 1000 children under 5 years in 1998 to 19 in 2004
- 40% of infants, under 1 year of age were recorded as bottle-fed, with Dhofar having the highest level at 72%
- 3.7% of females and 0.2% of males aged 15–19 years were married, according to census 2003 data
- Of the married girls aged 15–19, 10.69% were illiterate, 15.86% could read and write but did not attend school, and 34.07%, 21.40%, and 17.98% attended grades 1-6 (primary), grades 7-9 (preparatory) and grades 10-12 (secondary) + schooling according to 2003 Census data.
- According to the same source, 41.67% of all married Omani women are illiterate
- Academic year 2004/05 saw 8,433 pupils enrolled in the 143 kindergartens nationwide, and 429 teachers, giving a student:teacher ratio of approximately 20:1. However, this is still insufficient, as this number only represents 10% of the population aged (4 -5) years.
- Total civil ministries expenditure devoted to education rose by 5% from 1995 to 2004
- The total number of students enrolled in general education increased by 21.9% during the period 1994/95–2004/05. Females represented 48.4% in 2004/05 compared to 48.2% in 1994/95.
- Net enrolment rates (NER) at the three educational levels in Oman from academic year 1995/96 to 2004/05 have shown remarkable improvement since the Situation Analysis Report of 1995. At cycle 1, the NER increased by 5.7% to 89.8%, cycle 2 was up by 19.6% to 72.9%, and grades 10–12 enrolment was up by 21.6% to 57.7%.
- Average class sizes have reduced only slightly in the past 5 years from 33 to 30
- Average student:teacher ratios have declined only slightly, from 21 to 17 in the past 5 years
- Dropout rates showed significant reduction over a 5–year period. For girls, these reduction rates were, 1%, 2.7%, and 2.9% at cycle 1, 2 and G10-12 respectively. For boys these reductions were 0.8%, 4.7% and 3.3% for the same levels
- Repetition rates also showed significant decline over the same 5–year period. For girls, these were reductions of 6.6%, 4.3%, and 2% for cycle 1, 2, and G10-12 respectively. For boys, 10.2%, 11.2% and 4.3% for the same levels
- On average, girls fared better than boys in all school subjects
- 102 literacy centres were operating as of 2004/05
- Illiteracy rates fell from 41.2% in 1993 to 22% in 2003 (for the Omani population) aged(15+)
- Female illiteracy is more prevalent than male. In 2003 the figures were 29.4% and 14.6% for females and males respectively
- Among the 15–19 age group, illiteracy rates are far less prominent, with only 5.9% down from 8.4% in 1993, to 2.5% in 2003.
- Illiteracy showed significant variations by region, with Al Wusta having the highest rates, at roughly 52%
- 27.63% of the Omani population, in 2004, were between the ages of 15–24
- 57.3% of the Omani population, in 2004, were of ‘working’ age, 15–64

- Student enrolment numbers increased by 21.9% from 1994/95 to 2004/05
- Females represented 48.4% of total enrolment in 2004/05
- Higher education enrolment for 2004/05 was 60,568, representing 18.1% of the total 18–24 population. This is more than triple the rate of 1995
- There are 6% more female enrolled in higher education than males
- The most popular bachelors degree subject is Education, followed by Arts and Social Sciences
- Females account for approximately 50% of all Sultan Qaboos University graduates in 2004/05, the largest number of which are from the Faculty of Arts and Social Sciences (66%)
- As of 2004/05, 14,265 Omani students were studying abroad, 58.9% of them were female, the majority of which were studying for a bachelors in Education
- In 2004/05 the total number of students training to be teachers were 7,979, of which 58% were female
- The proportion of Omanis employed by the Ministry of Education rose from 54.5% to 84% from 1995 to 2004
- As of academic year 2004/05, five technical colleges were in operation in Oman, staffed by 561 teachers, responsible for 9,615 students, of which 42% were females
- As of academic year 2003/04, four vocational training centres were offering basic courses for semi-skilled and longer courses for skilled workers according to the National Vocational Training system, to 1,951 male students, having a teaching staff of 310
- There are 38 sports clubs spread across the country
- Scouts and guides numbers have increased. In 2002 it was estimated that there was roughly a 20,000 strong membership, with 647 scout leaders and 571 guide leaders and assistants
- Census 2003 data showed only 13.54% of Omani in the age group 15-19 were economically active
- 49% of the total Omani 'employed' population, according to the census 2003, are of intermediate or below average educational standards. Approximately 19% attained secondary education grades, 8% post secondary (non-tertiary) levels, and 11% university degrees and above
- The preferred employment sector for Omanis is the public sector
- Most private sector employment benefits non-Omanis
- There is still concern as to the numbers of Omani job seekers, 14% of males and 37% of females , were job seekers particularly in the 15–24 age bracket
- Omani children are subject to the juvenile justice system and have the right to be subjected to judicial procedures consistent with their age and special position in society
- Childhood disability assessment of 1999 roughly estimated that between 23,250 and 52,000 children under 15 are disabled with an annual increase of 1500 to 3700
- From the National Health Survey of 2000, it was reported that around 52.6% of ever-married women had 'consanguine' marriages, defined as having close 'blood' relations to ones husband/wife (38.6% were first cousins)
- There are 6 non-governmental organisations that offer services to the disabled
- There is limited data on the number of orphans in Oman
- 5,434 orphans claim social security benefits awarded specifically for them
- Factual information on abusive practices and non-accidental injuries in Oman are not yet available
- Injuries that required inpatient management in below 15 years of age were due to falls 41%, RTA 14%. While in age group 15-44, it was mainly because of RTA (38%) and falls 29%.
- The minimum age of employment was raised in 2003, by royal decree, from 13 to 15, conforming to ILO Convention No 138
- In the academic year 2004/05, 422 female Omani students were studying at the Faculty of Agriculture at Sultan Qaboos University; 38 had already graduated
- More than 10% of women stated that they were not allowed to move around (alone) freely
- Only 30% stated they had total freedom of movement. Freedom increased with age
- Women's economic participation rates are increasing rapidly. From 1993 to 2003, there was an increase of 13.6% (from 8.6% to 22.2% in the same period).
- More than two thirds of all Omani women employed in 2003, in the private sector were between (20-29) years of age
- In 2003, women accounted for a 22.2% share of the Omani labour force

- By 2004, 35.8% of governmental positions were occupied by women, concentrated mostly in the education and health sectors
- There are currently 4 females at the minister level in Oman, one at the undersecretary level, and two at the ambassador level (from the Netherlands and the USA, 2005)
- Royal Decree No. 35/2003 issued the new Omani Labour Law stipulating that there be equality between the genders in job opportunities, rights and obligations resultant from the job, provided that the working conditions are the same. This law also prohibits dismissal of a female worker if she is absent from work due to pregnancy as proven through a medical certificate
- Women may not be employed in 'night work', i.e. from 7pm to 7am, or in a position that is 'objectionable on health or moral grounds'
- Women-headed households constitute 7% of total Omani households, with an average size of 4.31, less than half that of a male-headed household
- Women nowadays are getting married later, as opposed to just 10 years ago, particularly in urban settings. According to census 1993, 29% of girls were married before the age of 15 and 52% between ages 15 and 20. From the Oman Family Health Survey of 1995, among 20–24 year old women, 26.8% were married before age 15, 47.3% before age 18 and 55.5% before age 20. In the year 2000, the National Health Survey found that amongst women 20–24 years old, around 38% were married overall. As of census 2003, 3.7% and 30.2% of women aged 15–19 and 20–24 were married.

Conclusions and Recommendations

It is clear that Oman is committed to continually finding ways to improve the health and education of its citizens, particularly its children. Health care services reach virtually all communities and basic education is almost universal, yet emerging needs define the challenge to ensure children's rights 'beyond survival and development'. This includes protection and participation issues, along with some remaining survival and development issues. Thus, the U.N.'s technical support role may still be required in the Sultanate, in particular with respect to certain areas of children's rights that have not yet been adequately explored in the data record.

The major issues identified in this *Situation Analysis* include improving the database on children in order to allow a full range of monitoring of child rights, decreasing regional and gender disparities, institution building and community participation, and sustainability and Omanization of service provision while maintaining quality. These new challenges often hidden by the impressive gains of recent years emphasize the continued need for UNICEF involvement in Oman and the need for new modes of UNICEF intervention and support in the future. Meeting these new needs will be more complex and demanding than the largely 'build-and-train' activities of recent years.

Specific child rights issues that need further attention in Oman include:

- Data collection on the complete range of child survival, development and rights, as comprehensively identified by Omani laws and values and the CRC
- Development of social mobilization and community responsibility
- Sustaining gains made in child rights and welfare in the light of new economic realities
- Identifying and addressing regional disparities
- Further promoting the role of women in development
- Ensuring full participation by children and young people in national life and development
- Protecting people living in difficult circumstances and routinely monitoring such protection
- Making voluntary services more professional in nature
- Development of understanding of changing social contexts, particularly with respect to family dynamics, eating habits and lifestyles
- Further capacity-building within the Omani population, in order to promote the Omanization of the work force while maintaining quality and efficiency

- Special attention to adolescents, in particular to out-of-school children and to ensuring integrated policies to provide recreational services
- Expanding access to pre-schools, enhancing vocational training and improving the relevance and quality of education
- Improving and expanding the services available to the disabled and integrating them into existing social and community services

Children's rights are a main consideration and guiding framework for future collaboration between UNICEF and the Government of Oman, given Oman's impressive child health and education gains in recent decades and its ratification of the CRC. Although the Sultanate has submitted a preliminary report to the Committee on the Rights of the Child, the government still needs to establish a routine monitoring system for the progress towards full implementation of child rights. The data used to monitor children's rights have four main characteristics:

- Desegregation, so that groups of children whose rights are not being met can be targeted in efficient programming
- Focus on children, rather than services designed to meet their needs
- Focus on children, rather than adults or institutions
- Not purely quantitative, but contextualized in qualitative understanding of the social and cultural dynamics in which children live

The Sultanate of Oman's success in its commitment to ensuring comprehensive child rights, in line with the wider global context of the CRC, will require new efforts in three main priorities:

1) The development of new childhood databases that will extend child rights monitoring beyond survival and development issues
2) The further development of civil society, including community mobilization, to reduce dependence on centralized, state-provided services and expatriate expertise
3) More attention on the rights of children over the age of five years, particularly adolescents.

For Oman, the youngest generation is a source of immense hope and expectation. Now enjoying the full benefits of rapid health and education development, Oman's youth will ultimately determine the success of Oman's Vision 2020 by building a diverse, technologically advanced economy.

1. National context

1.1 Geography

The Sultanate of Oman is located in the extreme South Eastern corner of the Arabian Peninsula and has a total area of approximately 309,500 square kilometres. To the north of its main land mass is the Musandam peninsula, separated from the main bulk of the country by a part of the United Arab Emirates. The Musandam peninsula is positioned at the entrance to the Arabian Gulf overlooking the Strait of Hormuz. The entirety of Oman's 3165 kilometres of coastline lies outside the Arabian Gulf on the Gulf of Oman to the north and the Arabian Sea to the south. Oman is also sovereign over a number of small islands in the Arabian Sea, most notably the island of Masirah see Figure 1.1. Muscat Governorate, situated on Oman's northern coast, has a population of approximately 664,826 (2004). Oman's oil and gas reserve is largely found in the north and south of the country.

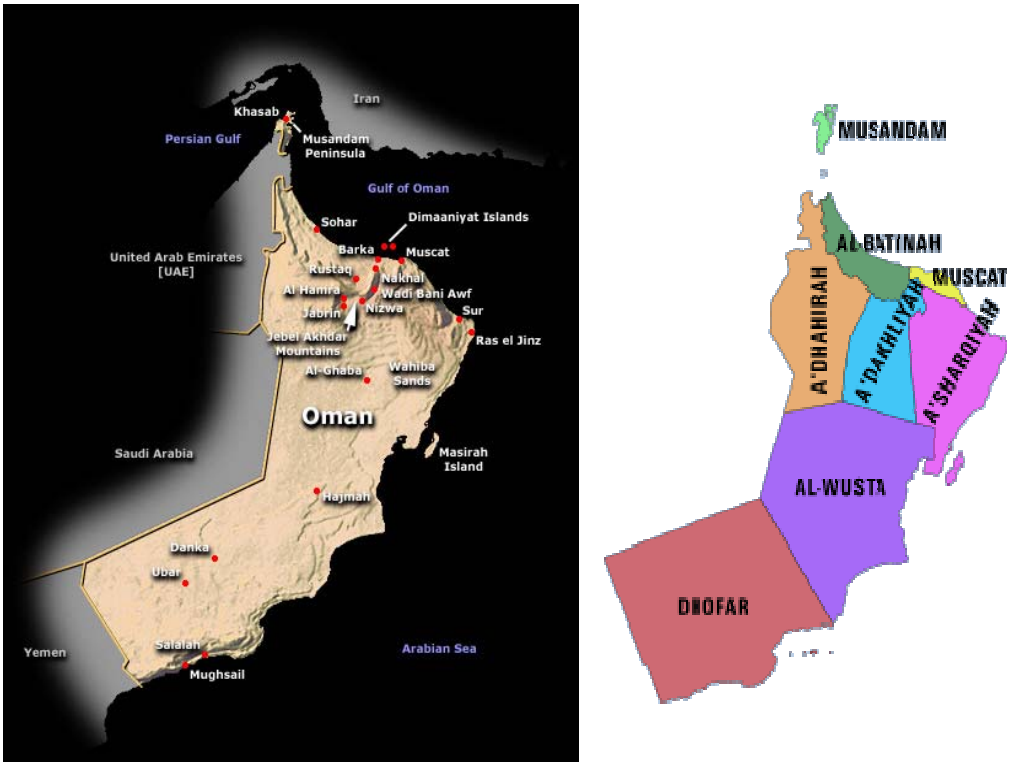

Figure 1.1: General and Regional Maps of Oman

1.2 Demographic

Based on the Census 2003 data, the Ministry of National Economy estimation for the total population in 2004 is 2,415,576 persons, with Omanis making up 74.6% of the resident population (1.80 Million) and 0.62 million non-Omanis making up 25.4%, see Table 1.1.

Table 1.1: Total Population of Oman, by Age Group and Sex (Mid-Year Estimate) 2004

Age Group (years)	Omani				Total Population			
	Male	Female	Total	%	Male	Female	Total	%
0-4	110,830	108,001	218,831	12.1	125,918	122,906	248,824	10.3
5-9	120,654	116,043	236,697	13.1	133,896	128,623	262,519	10.9
10-14	138,961	134,414	273,375	15.2	149,468	143,696	293,164	12.1
15-19	136,654	130,973	267,627	14.8	143,312	137,067	280,379	11.6
20-24	115,917	114,640	230,557	12.8	141,547	131,351	272,898	11.3
25-29	82,520	83,228	165,748	9.2	152,538	108,817	261,355	10.8
30-34	52,782	50,770	103,552	5.7	136,885	77,452	214,337	8.9
35-39	38,728	39,669	78,397	4.3	113,337	60,770	174,107	7.2
40-44	26,132	29,366	55,498	3.1	90,628	43,284	133,912	5.5
45-49	21,423	23,898	45,321	2.5	65,630	31,267	96,897	4.0
50-54	16,705	16,556	33,261	1.8	42,239	20,489	62,728	2.6
55-59	17,722	15,559	33,281	1.8	27,221	17,485	44,706	1.9
60-64	11,679	9,182	20,861	1.2	15,481	10,368	25,849	1.1
65-69	9,387	8,226	17,613	1.0	10,557	8,912	19,469	0.8
70-74	4,606	4,233	8,839	0.5	5,247	4,692	9,939	0.4
75-79	3,095	3,340	6,435	0.4	3,354	3,585	6,939	0.3
80 +	3,340	3,698	7,038	0.4	3,633	3,921	7,554	0.3
Total	**911,135**	**891,796**	**1,802,931**	**100.0**	**1,360,891**	**1,054,685**	**2,415,576**	**100.0**
%	**50.5**	**49.5**	**100**	**-**	**56.3**	**43.7**	**100**	**-**

Source: Statistical year Book, Ministry of National Economy, 2005

The Omani population is characterised by its youth. The 2004 population distribution showed an estimated 40.4% of Omanis are aged less than 15 years, a number that has declined over time, estimated at 51% in 1996. From this distribution, Omanis under 20 years of age constitute more than half the population (55.2%). In contrast, non-Omanis are mostly men of working age, with those less than 20 years making up only 14.4%. Taking both the Omani and expatriate populations into consideration, the proportion of the population under 20 years of age remains high at 44.9%. Children, defined by the CRC as those 18 years and under, represented roughly 53.0% of the total Omani population in mid 2004. The corresponding percentage for non-Omanis is 15.1%

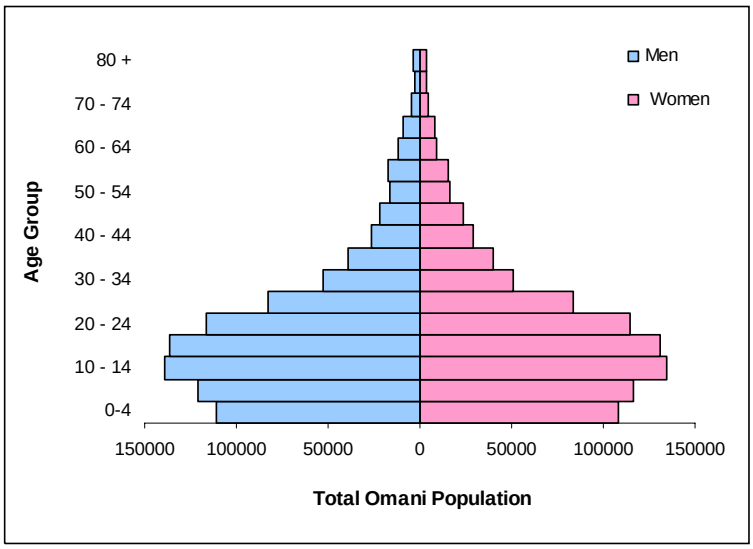

Figure 1.2: Age Pyramid for Omani Population (2004)
Source: Statistical year Book, Ministry of National Economy, 2005

Over the last two decades, **urbanization** has been rapid. The two principal urban regions are Muscat and Salalah. According to the 2003 census, 71.5% of the total population lived in urban settlements with a population of more than 1,673,480, compared to 33% in 1985 and 25% in 1980. The total urban population has grown at an average annual rate of 8% over the past 25 years. Currently, roughly 33.1% of Omanis live in rural areas (mostly in villages of 500–1,000 inhabitants) and only 0.52% of Omanis are fully nomadic, following annual migration routes with their families and livestock herds. See Figure 1.3 for detailed breakdown of population according to region based on mid-year estimates for 2004.

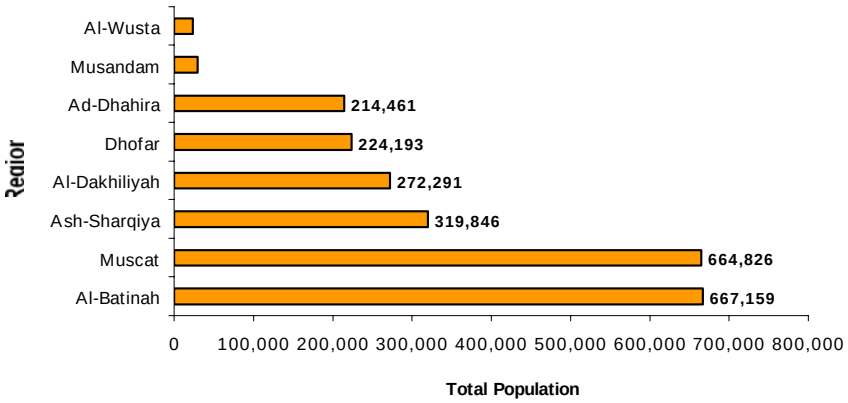

Figure 1.3: The Total Population of Oman by Region, 2004

The majority of those moving to the cities are believed to be young or middle-aged men in search of employment, as well as some young people wishing to pursue higher education. Omani officials are concerned with the implications of extensive internal migration. One of the aims of the two-day weekend (Thursday/Friday), instigated in Oman in 1988, was to allow people working in urban areas to return to their villages on weekends. The key determinant of migration patterns in the future is likely to be the ability of rural communities to offer attractive employment opportunities to the educated young. Agriculture is small-scale and provides an income largely for older men and expatriate labour. This sector must be further developed in order to attract the direct involvement of new generations of educated and ambitious young people.

1.3 Economy

1.3.1 Gross Domestic Product and Growth

Box 1: Vision 2020

- Diversify the economy
- Boost living standards
- Develop Omani human resources
- Encourage the private sector
- Reduce regional differences
- Improve productivity

Oil revenues became the basis of the economy around 1967 and have since comprised the major part of the Gross Domestic Product (GDP) in Oman. Oil revenues have been invested in an extensive programme of modernization of social and physical infrastructure.

According to official figures, the GDP (at market prices) has grown from OR 7,639.2 Million in 2000 to OR 9,527.1 Million in 2004, registering a 13.7% growth in 2004, see Figure 1.4. Total petroleum activities constituted 42.2% of GDP in 2004 compared to 48.7% in 2000 see Figure 1.5. Oil revenues in 2004 were OR 3,155.8 Million, equivalent to 78% of total revenues of OR 4,040.2 Million that year.

GDP per capita, in 2004, stands at OR 3,944; see Figure 1.6 for full details.

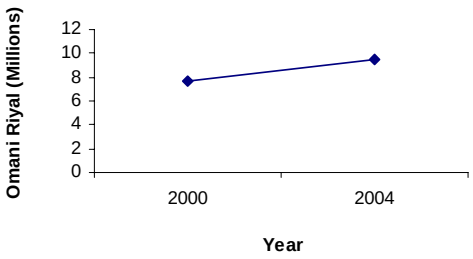

Figure 1.4: GDP Changes from 2000 to 2004

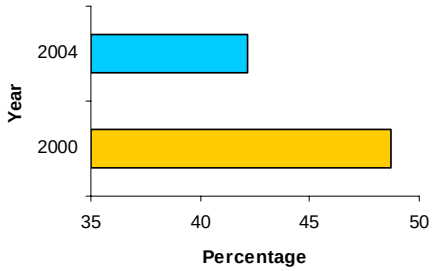

Figure 1.5: GDP Petroleum Activities

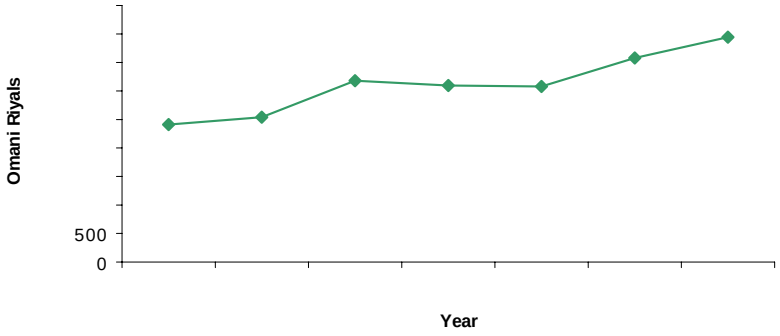

Figure 1.6: Trend in Omani GDP per capita

The **Omani economy** is mainly oil-based, with oil exports representing 81.4% of total exports, however, the Sultanate also produces and exports *fish*, *live animals*, *processed copper*, *cement*, *and textiles*. Oman's major trading partners are Japan, UAE, South Korea, United Kingdom, USA, and Singapore.

Box 2: GNI per capita information

GNI = final good and services produced by Omani owned business organizations in Oman + good and services produced by Omani owned businesses abroad.

The economy is heavily oil dependent, but oil price fluctuations have not reduced commitments to welfare and development

GNI per capita which dropped for a few years is now on the rise, see Figure 1.7

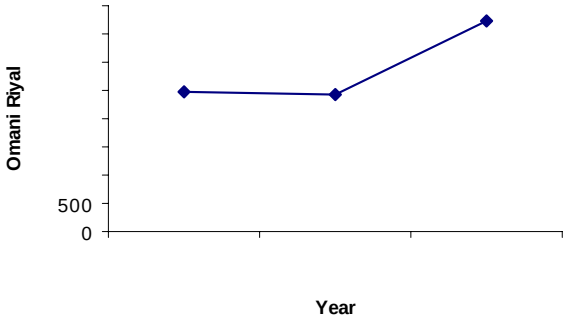

Figure 1.7: Changes in GNI per capita from 1985-2004

Clearly, as the Omani economy is heavily reliant on oil revenues, it is vulnerable to the frequent fluctuations in its price, which reached a record low of $12 in 1998. Learning from this event, the Sultanate began establishing its' annual budget on a depreciated price per barrel to that of market value, hence possessing additional unaccounted annual revenue, which is subsequently directed to the State General Reserve Fund (SGRF).

Due to the drop in oil monies, revenue-raising measures were implemented in 2003, including an increase in fuel prices by approximately 1.7% and an introduction of a road tax on vehicles travelling to the UAE. In addition to this, the Government used the SGRF resources to finance the increasing expenditure and the Government deficit.

Recent events related to oil have strengthened government resolve to pursue more vigorously, its strategy of **economic diversification**, including industrialisation and trade liberalisation, promotion of foreign investment and privatisation, which are cornerstones of its long-term strategy. In its annual country report, the IMF commended the Sultanate's pragmatic economic policies, in particular its recent progress in diversifying the economy and promoting social welfare in a climate of financial stability.

The targeted growth rate in the industrial sector in the Sixth Five Year Development Plan (2001-2005) is 10.3% with an aim to boost its share of GDP to 13.4% by 2005. Major industrial projects include construction of an aluminium smelter and petrochemicals complex in Sohar, development of the third train Liquefied Natural Gas complex and Indo-Oman fertilizer project in Sur.

Privatization in Oman is among the most advanced in the Gulf region, starting with the establishment of the Manah power project in 1996, and Salalah container port in 1998. In a significant development in 1999, the General Telecommunications Organization (GTO) was transformed by Royal Decree 46/99 into an Omani closed stock holding company (Oman Telecommunications Co., SAOC), marking another step along the path towards privatisation of services. Plans for privatisation of electricity and water supply, Omantel, and Muscat and Salalah airports are also under way.

Tourism is another growing sector of the economy. In its endeavour to integrate its economy in the world markets and attract private foreign investment, Oman joined the World Trade Organization (WTO) in 2000.

1.3.2 Expenditure on Social Sectors

Government spending (as a percentage of total Gov. spending and not necessarily in absolute amounts, due to the sharp increase during this period in Oil revenues and consequent increase in Gov. spending) has declined in most major areas including education, health and defence from 2003 to 2004, see Figure 1.8.

- Education, down 0.8% from 9.6% to 8.8%
- Higher Education, down 0.3% from 3.7% to 3.4%
- Health, down 0.6% from 5.4% to 4.8%
- Defence, down 1.7% from 31.7% to 30%
- 'Other' expenditures went up by 3.5% from 49.5% to 53%

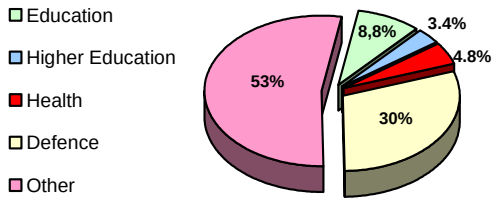

Figure 1.8: Percentage of Major Government Expenditure in 2004

Oman's human development improvements can be monitored over time in relation to a steady increase in budgetary provision (see Table 1.2 and Figures 1.9-1.11), which has increased despite fluctuations in oil revenues. In other words, the best interests of children have been served despite national economic pressures; financial stringencies have not been passed on to the most vulnerable group in society that has no voice to advocate for its own rights. This also meets with the rights provided in Article 4 of the CRC, stated below.

Article 4
States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, parties shall undertake such measures to the maximum extent of their available resources and where needed, within the framework of international cooperation.

Table 1.2: Budgetary Provision for the Health and Education Sectors in Oman, with related Outcome Indicators, 1981– 2004

Year	% of national budget expenditure on health	IMR	% of national budget expenditure on education (academic year)	Number of Public schools	Number of children enrolled in schools
1981	2.6	59.0	4.4	408	120,718
1985	3.8	45.0	5.1	588	218,914
1990	3.9	29.0	7.2	779	355,986
1995	5.3	20.0	8.1	953	488,797
2000	5.5	16.7	8.7	993	554,845
2003	5.4	10.3	9.6	1022	576,472
2004	4.8	10.3	8.8	1038	572,864

Source: Statistical Year Book, Ministry of National Economy, 2005; Progress of Educational Statistics 1970-2001, 2002; Ministry of Health, 2005

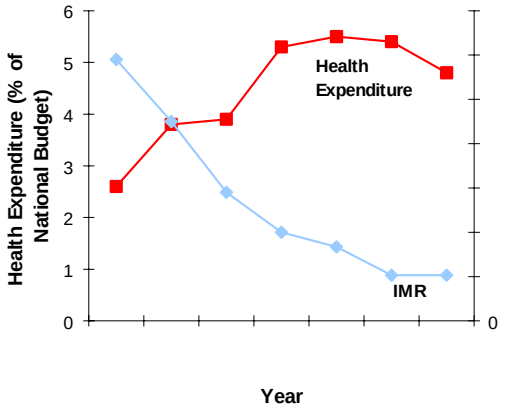

Figure 1.9: Health Expenditure versus Infant Mortality Rates,1981-2004

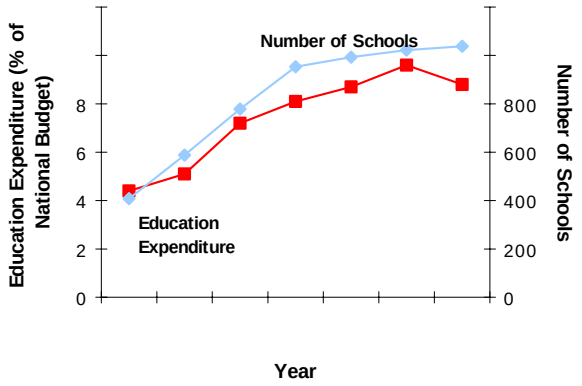

Figure 1.10: Education Expenditure versus Number of Public Schools in the Sultanate 1981-2004

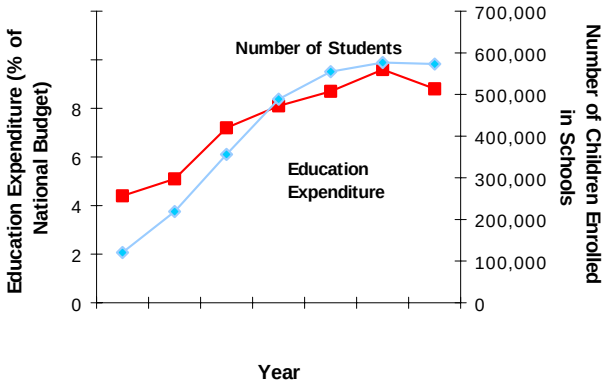

Figure 1.11: Education Expenditure versus Number of Children Enrolled in Schools, 1981-2004

1.3.3 Employment

Omani labour force (economically active population) has been increasing rapidly over the years, growing from 304,733 to 442,517 between 1996 and 2003, an annual growth rate of 5.3%, see Figure 1.12. This indicates a participation rate of 41.8% for the Omani man power population, 64.7% for males, and 18.7% for females in 2003. Though female participation rate is lower, it represents an increase of 8.9% over the seven-year period. Consequently, females' share in the labour force increased from 13.3% in 1996 to 22.2% in 2003.[1]

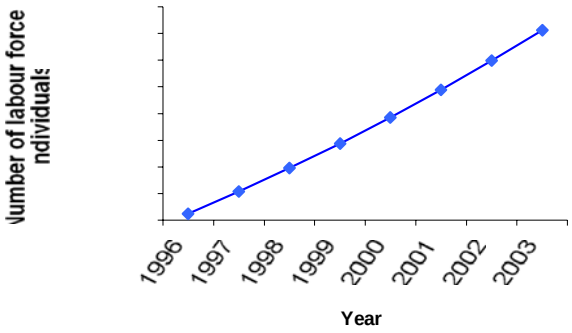

Figure 1.12: Omani Labour Force Employment Rates

From 1995–2000, total employment grew at an average annual rate of 2.3%. The annual growth rate of Omani employment during this period is estimated at 3.4% while non-Omani employment has grown at an average annual rate of 1.9%.[2]

According to the 2003 Census, the majority of Omanis are wage and salaried employees (90.2%), with 7.6% as self-employed/managing their own business/employing no one, and non-paid family workers and with around 1.9% as employers. The predominance of wage employment reflects the large share of public sector employment; 46.3% of Omanis are employed in the government sector, in administrative and defence positions. The health and education services, which are largely provided by government, attract around 16.7% of employed Omanis. Omanis constituted approximately 81% of total Civil Government employees in 2003.

1.3.3.1 Omanization of the labour force

A policy of gradual 'Omanization' of the labour force is under way. In this endeavour, the government stresses the importance of education and technical and vocational training. It also emphasizes the importance of encouraging private initiatives and self-employment in small-scale enterprises so that Omanis can assume jobs now staffed by expatriates in trade and services. This policy aims to ensure that increasingly educated and qualified young Omanis find jobs when they seek to enter the labour force. If they are to take over the jobs currently occupied by foreign workers, Omanis need to develop the practical skills required by the labour market, along with pride in non-academic qualifications and employment.

According to census 2003 statistics, 430,949 expatriates are working in Oman, representing the majority of the private sector. Of those, approximately 26% are engaged in construction and 15.4% in the wholesale and retail trades. Omanis held only 27.4% of private sector employment in that year.

[1] Ministry of National Economy, Population Housing and Establishment Census 2003
[2] Sixth Five year Development Plan, human Resource Development, VOL. 2, Ministry of National Economy, 2002

The government acknowledges the vital contribution of expatriates in building and sustaining the national infrastructure, but is also concerned about the rising numbers of Omani job seekers and the outflow of capital in the form of expatriate remittances from the Sultanate.

1.3.4 Income and Consumption

The results of the 1999/2000 Household Expenditure and Income Survey revealed that 56.6% of Omani households live on monthly incomes of less than OR 500 (equivalent to US $1300). The survey indicated that the average monthly consumption of commodities and services for Omani households with an average size of 8.5 persons is **OR 497**. Food items constitute 32.4% (OR 161.4) of the monthly consumption.

The survey results have shown high disparity in terms of consumption between the highest and lowest quintiles; the highest 20% of Omani households account for 47.7% of total consumption, the share of the lowest 20% is only 5.1%. This corresponds well with the fact that 20.5% of the Omani population lives on a monthly income of less than OR 200 while 23.8% of the population enjoys a monthly income of OR 800 and above. Disparities in living standards are apparent between regions and governorates. The highest recorded average monthly household consumption is Muscat at OR 630, followed by Dhofar at OR 551 and the lowest, Al-Wusta, at OR 362 (Al-Wusta constitutes less than 1% of Oman's population in 2004). Consumption disparities are higher in rural rather than urban areas, whereas the Gini coefficient for the former is 36% compared to 35% for the latter. However, average consumption is higher in urban settings; see Table 1.3 and Figure 1.13.[3]

Table 1.3: Average Monthly Consumption in Urban and Rural Areas and by Regions/Governorate in Oman, 1999/2000

Urban/Rural areas	Consumption (OR)	Gini coefficient %
The Sultanate	497	35.7
Urban	541	34.8
Rural	396	35.9
Regions/Governorates		
Muscat	630	32.8
Al-Batinah	408	35.2
Musandam	456	37.8
Al-Dhairah	527	35.2
Al-Dakhliyah	423	34.8
Al-Sharqiyah	409	36.7
Al-Wusta	362	35.8
Dhofar	551	35.4

Source: Household Expenditure and Income Survey, Ministry of National Economy, 1999/2000

[3] The Gini coefficient measures the disparities in the distribution of income (expenditure). Its value lies between zero and one. A value closer to zero indicates lower inequality in the distribution while a value closer to one indicates higher inequality in the distribution.

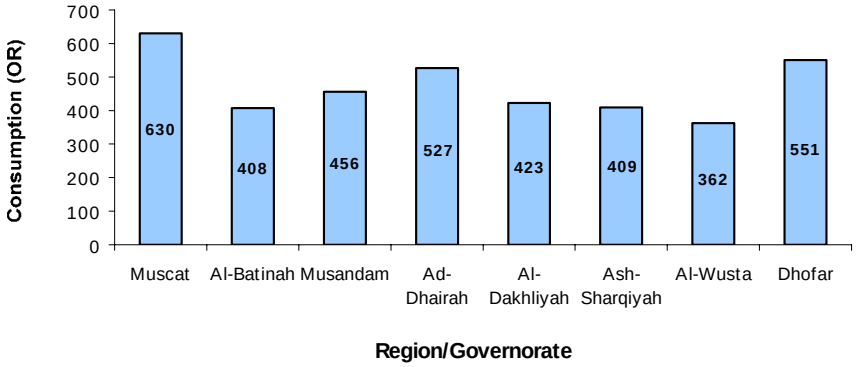

Figure 1.13: Average Monthly Consumption in Regions/Governorates of Oman, 1999/2000

Access to health care and clean water, along with other key health indicators, in some rural areas are well below national averages. According to the results of Expenditure and Income Survey, a smaller percentage of rural households live within a distance of 5 kilometres or less from public service facilities, such as primary schools, health centres, and hospitals, compared to those living in urban areas, as shown in Figure 1.14

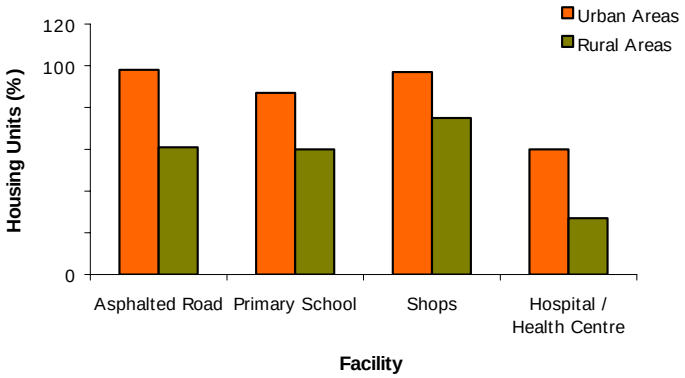

Figure 1.14: Population with a less than 5 KM distance from Public Service Facilities, 1999/2000
Source: Household Expenditure and Income Survey 1999/2000, Ministry of National Economy

According to the results of the second housing and establishment census 2003, only 25.9% of rural dwellings have access to piped drinking water, and 48.7% in urban areas. The total household percentages using piped (public and private), public water points, private well and public well, and mineral water for drinking can be seen in Figure 1.15.

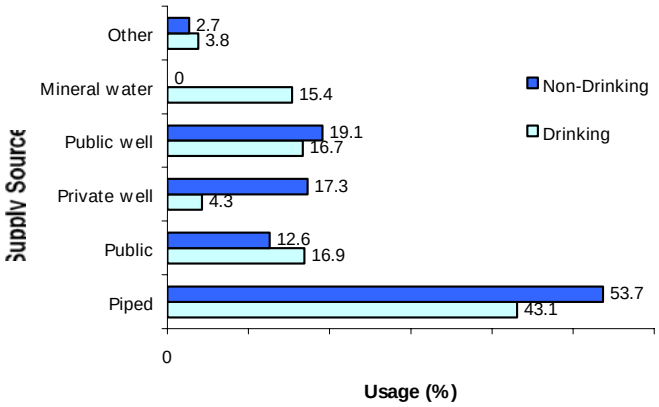

Figure 1.15: Distribution of Water Usage in Oman, 2003

If piped and bottled water, in addition to public water points are considered"improved" drinking water supplies, then around 75.31%, 79.01% and 63.96% of the total, the urban and the rural populations in Oman have access to "improved" drinking water supplies.
However, an additional, yet unknown percentage could be added of the population that have access to safe drinking water from wells. .

Table 1.4: Distribution of Population living in Traditional Housing Units (Villa/Apartment/Arabic House/Rural House) by Main Source of Water Supply for Drinking & Household Uses (2003)

Main source of water supply	Total	Rural	Urban
For drinking	**%**	**%**	**%**
Public piped	29.73	5.79	37.52
Private piped	13.36	20.07	11.17
Public water point	16.85	35.2	10.88
Private well	4.26	5.99	3.7
Well outside the living quarter	16.66	22.19	14.85
Mineral water	15.37	2.9	19.44
Other sources	3.76	7.85	2.43
Not stated	0.00	0.01	0.00
Total	**100.00**	**100.00**	**100.00**
For household uses	**%**	**%**	**%**
Public piped	39.1	6.73	49.64
Private piped	14.67	18.57	13.18
Public water point	12.64	22.40	8.92
Private well	17.27	18.46	16.81
Well outside the living quarter	19.14	26.47	16.35
Other sources	2.64	7.40	0.83
Not stated	0.00	0.00	0.00
Total	**100.00**	**100.00**	**100.00**

Source: Ministry of National Economy, Population Housing and Establishment Census 2003

An important activity in the water/sanitation sector is the establishment of a national database for water sources and water/sanitation facilities. This forms the heart of a national water quality monitoring system that can detect water–related diseases and other health problems, plus seasonal, annual, and geographical variations. Since 1994, all public drinking wells must undergo inspection and licensing, according to new specifications, by mid 1995. Water tankers and wells have been colour coded according to quality and use.

Box 3: Clean Water Availability in Oman

Clean water availability, quality, reliability, and access are problems in many villages. Most private wells and *aflaj* in rural areas are open to air, and are susceptible to pollution and over-exploitation. The core problem is the pollution of wells and *aflaj* by human and animal faeces that are washed into the water sources. Ground water reservoirs are also susceptible to contamination through infiltration from inadequately constructed septic tanks.

Regarding sanitation coverage, the 2003 Population Census showed that 92.2% of the population lived in houses equipped with toilets. This figure disguises the fact that many septic tanks are health hazards, as they are improperly built and/or maintained. The Household Expenditure and Income Survey did not cover this topic. The WHO/UNICEF Joint Monitoring Program for Water Supply and Sanitation (JMP) 2000 assessment figures for sanitation coverage are 98%, 61%, and 92% for urban, rural, and total populations respectively. Oman, together with a few other countries, including Turkey and the Syrian Arab Republic, appears to be an exception in that sanitation coverage is higher than water supply coverage.

More research is required to determine how family income levels and other quality of life disparities by region, education level, employment and other pertinent criteria affect children/ women, and their rights. Such research is currently in the planning stage.

1.3.5 Social Security and Poverty

The CRC assumes that families deliver rights to children and that it is the duty of states to support parents and other caregivers in this responsibility, through legal, social and economic mechanisms. Studies of the impact of world recession and structural adjustment have shown that children are more vulnerable than adults to the effects of poverty.[4] There is a need to conduct studies in Oman to determine the extent of poverty and it's impact on children living in poor families.

[4] See for example, Cornia, 1987, Davies, & Sanders, 1988.

Article 26

1. States Parties shall recognise for every child the right to benefit from social security, including social insurance and shall take the necessary measures to achieve the full realisation of this right in accordance with their national law.
2. The benefits should, where appropriate, be granted, taking into account the resources and circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to and application for benefits made by or on behalf of the child.

Article 27

1. States Parties recognise the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.
2. The parent(s) or others responsible for the child have primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.
3. States Parties, in accordance with national conditions and within their means, shall respond appropriately to assist parents and others responsible for the child to implement this right and shall in case of need, provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.
4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.

Those entitled to social security:

- Under Royal Decree 61/77, four groups of Omani citizens became entitled to social security; *orphans, widows/widowers, divorced women, and people with low income*.
- In 1980, Royal Decree 21/80 came into effect, raising the sum of the state 'pension'.
- Royal Decree 87/84 added *abandoned groups*, meaning women abandoned by their husbands, *unmarried girls*, meaning women who have never married and who have no resources or family members able to support them, *families of convicts* and *men and women over 70 years of age, who have no breadwinner to provide for them and insufficient resources*.
- Care is also available to other eligible citizens, including, *foster families, families of soldiers killed in action, civilians affected by military action, and the families of disabled persons*.
- In 2005, Royal Decree 74/2005 raised the sum of the state 'Pension'.

Social security fixed monthly transfers are –

- A beneficiary family of one individual will receive OR33
- A family of three persons is entitled to OR 64
- A family of six persons is entitled to OR85
- A family of eight persons is entitled to OR 97
- A maximum of OR 107 is given to a beneficiary with a family of 10 dependents

An average annual increase of 5.1% in numbers of cases receiving social security payments between 1980 and 2004 is explained in part by the increased number of eligibility categories, (see Table 1.5). The average payment doubled in the period 1980–2004, but without having a study on poverty and cost of living in Oman, it is difficult to decide whether this increase has a real effect if the impact of price inflation is taken into account.

Table 1.5: Social Security Cases and Allocations, Sultanate of Oman, 1980-2004

Year	Total cases	Total funds (OR)	Average Annual payment (OR)
1980	14,456	3,618,673	250
1985	34,944	9,659,000	276
1990	37,746	14,693,000	389
1995	42,155	21,209,583	503
2000	46,032	23,255,677	505
2003	47,765	24,530,700	514
2004	48,486	25,057,300	517

Source: Ministry of National Economy, Statistical Year Book, 2005

Those benefiting from social security, according to the Ministry of Social Development in 1999, were 105,200 individuals, representing 6.1% of the total Omani population. The Household Expenditure and Income Survey indicates that roughly 9.5% of Omani households have an average consumption expenditure of less than OR 150 (average consumption expenditure on food by an Omani household amounted to OR 161). These households comprised an estimated 163,700 individuals, representing approximately 9% of the Omani population in 2000.
It should be noticed that the national average reflects the consumption expenditure of all society's groups and it does not necessarily represent the poverty line or the cost of the basket of basic items. The best comparison must be made with the poverty line.

The distribution of the beneficiaries by type of receiver is indicative in terms of its implication for child rights. In 2004, for example, orphanage, widowhood, and divorce represented approximately 36% of cases. This indicates that special attention needs to be given to these groups, as they contain children who would require much needed help in care, attendance, health, nutrition, and education. This becomes more urgent given the meagre resources made available through the social security fund.

Furthermore, the social security transfer payments do not seem to be adequate, at least on the family level, when compared to the minimum wage, set at OR 100 a month, plus an allowance of OR 20 for accommodation and transportation, if not provided by the employer. The average monthly 'pension' payment per case was OR 42 in 2001, which is only 35% of the minimum wage.

In its effort to encourage income–generating activities among the social security receivers and raise their living standards, the government established income–generating projects for the families who have the experience, desire, and capacity to operate such projects. The number of implemented projects increased from 141 in 1995 to about 173 by 2000. However, only a few of such projects were successful and by the end of 2000, only 44 were outstanding. Many factors attributed to the failure of these projects, chiefly, inexperience, illiteracy, and old age of those responsible.

In addition to the social security assistance, families with limited incomes (between 130–250 OR) were eligible for an interest free loan of up to OR 15000 to build or buy a home. Between 1991 and 2000, 2366 families benefited from these loans. The number of applicants for these loans by far exceeded the funds available for finance. In 2003, the total applicants exceeded 19,000, 4,000 of whom were living in Muscat. On the other hand, the program faced a problem regarding the difficulties encountered by some of the loan-receivers in repayment, which the program attempted to solve through requirements of a guarantee for the loan.[5] This might of course, result in some of the most needy being unable to obtain the loan as they could fail to meet this condition.

[5] Alwatan Newspaper, June 2003, No. 7261, Vol. 33

1.4 Political and Administrative System

1.4.1 Political Structure[6]

Today, Oman has a modern government with modern institutions and systems, with the administrative apparatus of state development evolving in four distinct phases. The second phase of development, up to mid 1975, established modern state functions, under a Royal Decree that created a Council of Ministers from just a handful of ministries, led by the ministries of health and education.

In the early 1970s, there were no laws or regulatory systems to define how institutions functioned, their principles and goals, or the rights and duties of employees. The codification of the government began in the mid 1970s. In July 1975, Royal Decree 26/75 introduced laws to regulate the administration. It set out the Council of Ministers and other government bodies with powers and responsibilities, in tandem with the first Civil Service Law of Royal Decree 27/75, which outlined civil servants' rights and duties.

Oman's government is a bicameral system. The Basic Statute of the State provided for the establishment of the Council of Oman, created by Royal Decree in 1997. It comprises the Majlis a'Shura (Consultative Council), whose members are elected by public elections every three years and the Majlis Al Dawla (State Council), whose members are appointed by the Sultan.

According to His Majesty Sultan Qaboos, the State Council is "another powerful building block in the Omani social edifice, which reinforces its achievements and reaffirms the principles we have laid out." These principles established a Shura (consultation) process, inspired by Oman's national heritage and values and the Islamic Sharia that incorporates features of the modern age.

Acting as an upper chamber, the State Council is fundamental to Oman's development goals. Appointed for their expertise at senior levels in various fields, State Council members represent a wide range of views and experiences. The Council examines the issues presented to it, preparing studies on development and solving problems, and promotes cohesion and unity.

The State Council's president and members are prominent members of the Omani community chosen for their expertise and seniority and appointed by Royal Decree. State Council members must be Omani nationals, aged 40 years and above, of high status and reputation and with appropriate practical experience. Membership is for three years and is renewable. The membership size of the Council does not exceed that of the Majlis a'Shura.
The Council submits proposals and recommendations to H.M. the Sultan or the Council of Ministers. The council president submits an annual report to the Sultan on its activities and deliberations. The current State Council's 53 members include five women, reflecting Sultan Qaboos' commitment to promoting Omani women to senior institutions and his belief that women can and will contribute to the welfare of the nation.

In 1990, H. M. Sultan Qaboos announced that the Consultative Council would replace the state consultative council (Majlis Al Istishari Lil Dawla), a body of nominated members created in 1981. December 1991 saw the creation of the first elected Majlis a'Shura, with its 59 members representing every wilayat in Oman. The Majlis a'Shura plays a purely advisory role, reviewing proposed legislation, and submitting suggestions and proposals to ministers.

Omani citizens elect members of the Majlis a'Shura by popular vote, the council members elect two vice-presidents through a secret ballot, and the council president's appointment is by Royal decree. Each term lasts three years, and members may stand for re-election when the term ends. Candidates must be Omani citizens aged over 30, well educated and of good reputation. Successful candidates

[6] Sources for this and the subsequent section are Oman 2002/2003, Ministry of Information, 2005.

must resign from existing official posts. Membership of the Majlis a'Shura was extended to women in 1994, when two women were elected.
The last Majlis a'Shura elections took place in October 2003, when 196,711 voters flocked to polling stations across the country. There are no political parties in Oman and the 506 candidates, including 15 women, stood for election as individual candidates. Two women were among the 83 candidates elected to the fifth term (2004/2007) of the Majlis a'Shura, which went into session in 2004.

H. M. Sultan Qaboos inaugurated the second term of the Council of Oman in November 2004, outlining the Sultanate's domestic and foreign policy in the period ahead. His speech stressed the need for partnership between the government and Omani people, highlighting the need to diversify the economy and to prepare the Omani workforce to meet the needs of the modern age.

In September 2001, in a joint session of the Council of Oman, which comprises the Majlis Al Dawla and the Majlis a'Shura, Sultan Qaboos addressed the need to develop human resources, creating new jobs for nationals and educating citizens about the importance of hard work.

1.4.2 The Civil Service

From 1980, the Civil Service entered a new period of development, under the second Civil Service Law of Royal Decree 8/80 and later the new royal Decree 120/2004. This upgraded the administration, improving government institutions and expanding state services. This period saw growth in the number of people employed by the state. Since 1970, the Sultanate's administrative system has developed two characteristics:

- Regulating traditional state activities such as security, defence, justice, and foreign affairs; managing public funds and the state economy and setting up ministries to administer them
- Changing the concept of the state, to promote productivity and provide services. Ministries exploit and manage natural resources including oil, gas, agriculture, fisheries, commerce, industry, and manpower

Oman is administratively split into eight regions and governorates, which are further sub-divided into 59 *wilayats* (districts), each headed by an appointed *wali* or district governor. The *walis* fall under the jurisdiction of the Ministry of Interior. The *wilayat* system provides an efficient mechanism through which national-level administrative, legal, and executive decisions can be implemented throughout the country.

Regionalisation and decentralisation are now established strategic policies in almost every government ministry. Thus, the role of *walis* and the administrative efficiency of regional and *wilayat*-level systems are crucial in ensuring the well-being of Oman's people, especially women and children.

Other than Muscat, Salalah, and Sohar, which have their own municipal authorities, town and village affairs, fall under the jurisdiction of the Ministry of Regional Municipalities, Environment, and Water Resources. There are a total of 5,051 cities, towns, villages, hamlets and other settlements throughout the country.

Regionalisation and decentralisation have been the basis of government strategies to prevent major disparities between urban and rural regions, or between population groups that may enjoy different levels of education, income, awareness, or basic services. Between 1970 and 1990, developmental expenditures were unavoidably concentrated in the Muscat region, since the priority was to establish basic national government agencies and infrastructural services, and due to the concentration of population in the capital area. The task of assuring basic human services for all Omanis faces the reality that most of rural Oman comprises small, thinly populated and widely scattered villages and population clusters, amidst often rugged and inaccessible mountain or desert terrain.

Very few **foreign influences** sway the internal affairs of the Sultanate. Amongst United Nations organizations only the WHO and UNICEF have a regular in-country presence, with the expected arrival of the UNFPA by years end. Although, there is periodic cooperation on projects with the Regional Offices of UNESCO, ESCWA, and ILO, no bilateral governmental or international non-governmental organizations exist in Oman. However, economic cooperation activities are underway through resident embassies of several countries. Only a few local non-governmental organizations (NGOs), which are not subsidized and coordinated by the government, operate in Oman; they tend to be charity-oriented. NGOs dealing with women or people with disabilities operate under the aegis of the Ministry of Social Affairs, Labour and Vocational Training (now divided into two ministries: Ministry of Social Development dealing with social affairs and Ministry of Manpower dealing with labour and training issues). There are no registered community–based organizations as such. However, community–level work does take place and community support groups are an offshoot of health programmes. Women's voluntary organisations have allowed many women to become involved in community–based volunteer activities and to have a positive impact beyond their traditional responsibilities in the home.

Evidence of Oman's policy of peaceful international coexistence is clear in historic border pacts, signed with neighbouring Yemen and the United Arab Emirates. Oman continues to participate actively in regional organizations, such as hosting the 46th meeting of the Gulf Cooperation Council (GCC) health ministers in February 2000. Its presence in international bodies has also been strengthened. Oman has been a member of the UNICEF Executive Board (1997–1999), and in 1999, the Director General of Health Affairs was elected, Chairman of the Executive Council of the World Health Organization (WHO). Furthermore, in1999, Oman was elected to UNESCO's Executive Board and in 1998, was awarded the first prize shield of the Arab League Education, Science and Culture Organization in recognition of its outstanding efforts to combat illiteracy.

1.4.3 Islamic Values

The Omani people take pride in their strong, deep social and cultural traditions. Islam is the state religion and is central to the social and cultural life of the country at all levels of society. The majority of the population are members of the Ibadhi sect, and approximately 15–20% are Sunnis and Shi'ites, including expatriate workers. Ibadhi Islam has nourished Oman's tradition of religious tolerance, exemplified in the allocation of land by H. M. Sultan Qaboos for the construction of Christian churches and Hindu temples.

The values of Islam are an important resource that guides people in all areas of daily life. The joy of parents at the birth of a new son or daughter is seen as a reflection of the Prophet Muhammad's (pbuh) utterance that 'Children are the butterflies of Paradise' (Hadith Sharif) and of the plea in the Quran 'Our Lord! Grant unto us wives and offspring who will be the comfort of our eyes.' (Surat al-Furqaan, Verse 74)

Sharia law provides the basis for Oman's judicial system. In recent years, separate bodies have been established with specific responsibility for adjudicating civil and commercial disputes to which it is hard to apply Sharia law. Sharia law provides the guiding principles in matters of family law, such as divorce and inheritance. A network of 45 Sharia courts function under the direction of the Ministry of Justice and a Court of Appeals in Muscat considers appeals of judgements issued by these courts.

Under the leadership of H. M. Sultan Qaboos, Oman is striving to preserve the strengths of its traditional culture and to safeguard its Islamic values, while embracing the latest advances in science and technology. In an interview in 1997, His Majesty commented, "While we believe that certain traditions should be observed, Islam provides for *ijtihad* for everything being reviewed and interpreted in the time and context of the moment[7]." Tradition and modernity combined in the late

[7] Miller, J., 1997, Creating modern Oman, *Foreign Affairs*, May/June 1997, 13-18.

1980s, for example, when religious leaders and institutions were active in the drive for immunisation and oral re-hydration therapy. Muslim religious leaders and institutions enjoy a respected position in the community and can influence community–based efforts to improve health care practices for women and children. Their central role in the community continues to have potential for supporting the ongoing shift from state health provision to community responsibility.

Prior to 1970, education of the young was principally conducted in Quran schools, which still play an important role in parallel with the national education system. In the academic year 2004/05, 519 such schools with an enrolment of 21,108 boys and girls operated under the auspices of the Ministry of Awqaf and Religious Affairs.[8]

2. The Right to Survival and Good Health

Article 6 of the CRC clearly states that every child has the right to life, survival and to unhindered development. It is a holistic concept for child development recognising individual variations between children and demanding that they be supported in order to grow and fulfil their potential. There must be a guarantee with respect to basic services, such as health and education. The combination of 'survival and development' in these provisions such as Article 6 http://www.unicef.org/crc/fulltext.htm - art6 (paragraph 2), Article 18 (paragraph 3) and Article 24 is intended to emphasize the essential value of action. The emphasis is on the need to enhance children's health through preventive health care measures; yet it is in no way limited to a physical perspective. Rather, these articles emphasize the need to ensure the child's development to his/her potential, including his/her spiritual, moral, and social development and the key role of education in ensuring and enriching such development.

Article 6

. States Parties recognize that every child has the inherent right to life.
. States Parties shall ensure, to the maximum extent possible, the survival and development of the child.

Article 18

. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from childcare services and facilities for which they are eligible.

Article 24

. States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
. to diminish infant and child mortality
. to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care
. to combat disease and malnutrition including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution
. to ensure appropriate pre- and post-natal health care for expectant mothers
. to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of, basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene, environmental sanitation and the prevention of accidents
. to develop preventive health care, guidance for parents and family planning education and services
. States parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in this article, In this regard, particular account shall be taken of the needs of developing countries.

[8] Statistics of Ministry of Endowments & Religious Affairs, 2005

2.1 Indicators of the Right to Survival and Good Health: Infants and children

Article 24 recognises the child's right to the 'highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.' It emphasises the need for governments to enhance children's health through preventive health care measures. Children's right to curative and rehabilitative health care and the right to health care for mothers, particularly at the antenatal, delivery and postnatal care are some of the key points highlighted.

2.1.1 Provision of Health Services

In Oman, the Ministry of Health is the main provider of preventive and curative health care, complemented by health services provided by the Ministry of Defence, the Royal Oman Police, Petroleum Development Oman and Sultan Qaboos University Hospital; see Box 4. The numbers highlighted below are representative of MoH figures only.

TOTAL BUDGET in 2004 ⟶ roughly OR 176.5 Million or 4.8% of government expenditure

Box 4: Total Health Institutes throughout the Sultanate

MoH	Hospitals = 49 Health centres = 136
Other government	Hospitals = 5 Health centres = 44
Private sector	Hospitals = 4 Clinics = 686

The private sector plays a relatively small role in the provision of health services, mostly comprising private clinics, almost entirely staffed by Asian expatriates, together with two private hospitals in Muscat, and two private hospitals in Dhofar governorate.

According to the WHO World Health Report 2000, Oman's health system ranked first globally for its health financing efficiency. It was also ranked 8th using a composite index measuring performance of the health system, attainment of health goals, responsiveness to users and the fairness of its financing.[9]

Box 5: Preventive care, antenatal care, and infant immunisation services

All preventive care is provided free of charge to Omanis and government–sponsored expatriates.

Other services are provided with a nominal fee (OR 1 for initial registration and 200 baisas for initial visits with free medications, follow-up visits, and in-patient care).

The Ministry of Health estimated access to health services, defined as health facilities with trained personnel within one-hour drive of the patient's home, to be 100% in urban areas in 1993 and 94% in rural areas. Despite a generally good situation on a national level, some pockets of hardship have been identified in remote areas. However, if the definition of access is, less than 5 km from a hospital or health centre, it drops to 27% in rural areas and 60% in urban areas according to the Household Expenditure and Income Survey.[10] Although approximately 69% of Omani households have access to a car,[11] this information does not reveal if there are difficulties in accessing health services due to distance/lack of transportation.

A comparison of regional data shows some disparities in provision of health services due, partly, to remoteness and population spread. Although the ratio of population per hospital bed was 527 for the nation as a whole in 2004, it was significantly higher in North Batinah (899) and South Batinah (821)

[9] World Health Organization 2000, World Health Report 2000
[10] Ministry of National Economy, 2001, Household Expenditure and income Survey results
[11] Ibid.

regions. Likewise, these same regions have a higher hospital death rate (1.4 and 1.6% respectively as a percentage of total number discharged) compared to the national average (1.3% as a percentage of total discharge)[12], possibly because the cases are managed by these hospitals, being in the mostly populated areas of Oman. Studying these regional disparities would be useful for future planning and development of health care services.

2.1.2 Maternal Mortality

In Oman, maternal mortality rates currently stand at 18.5/100,000, a reduction of 31.5% from its 27/100,000 in 1994.[13] Although hospital–based maternal deaths are systematically reported and reviewed, due to the lack of death certification, the extent of maternal deaths remains unclear. It appears, however, that it is not amongst the leading causes of death for women of reproductive age, those are - *infections, pulmonary embolism, hypertension disorders and eclampsia*. The underlying causes could be the negative impact of high fertility and close intervals between births and diseases that are sometimes associated with a modern lifestyle, such as heart diseases, hypertension, diabetes, and obesity.

The National Health Survey 2000 showed that 99.6% of women, who gave birth in the three years prior, had made at least one ANC visit, hence near universal levels, regardless of age, residence or educational level. The Annual Health Report (2004) showed that more than half of women (64.2%) had their first ANC visit during their first trimester and 84.7% visited the clinic 6 or more times.

Box 6: Antenatal Care (ANC)

A key goal of Oman's antenatal care policy is to ensure that examination of all pregnant women occurs at least six times during their pregnancy, with their first ANC check immediately upon confirmation of their pregnancy.

Greater concern is placed on adolescent women (15–19 years), where according to NHS (2000) as many as 10.3% managed only one or two antenatal visits throughout their pregnancies. An additional concern is that in the past 5 years roughly 12% of deliveries in the Dakhliyah region have been home births.[14] Greater efforts should be made to promote the importance of ANC to these particular groups.

Postnatal care (PNC) coverage levels are lower than ANC but the NHS (2000) indicated that approximately 80% of women made use of PNC services. Muscat (65.6%) and Dhofar (68.7%) saw the lowest attendance rates, for the oldest age group, women aged 45–49 years (65.0%). Perinatal and postnatal risks remain relatively high since at least one–fifth of women do not make PNC visits, few health staff conduct home visits, and most mothers leave the hospital within 24 hours of delivery.

Maternal nutrition, however, continues to be a major concern since the most common and serious problem in pregnancy is anaemia. The NHS found that 40.9% of young women aged 12–19 years, 42.7% of pregnant women aged (15–49 years) and as much as 30.0% of all women aged (20–49 years) had anaemia. Regionally, the prevalence of anaemia in pregnant women was 56.3% and 51.7% in the Dhahira and Muscat regions respectively. According to the Annual Health Report (2004), around 32% of pregnant women had anaemia in 2004. The negative affect of maternal anaemia on both the mother's and baby's health is universally recognised. It is not clear if iron supplements provided during routine ANC visits have not alleviated this problem and unless the underlying causes are identified and addressed, the prevalence of anaemia may remain high.

[12] Ministry of Health, Annual Health Report 2004
[13] Ibid
[14] Ministry of Health, National Health Survey 2000

2.1.3 Child Morbidity and Mortality

Child health is both an indicator and an outcome of national health performance. Yet, precise information on child morbidity and mortality is not easy to come by, particularly since it is hospital–based and not divided at the sub–national level. In addition, data in Oman defines children as those under the age of 15 years; thus, information on a large number of adolescents is not readily available. In recent years, diseases of the Respiratory System, Infection and Paras Diseases, Injuries& Poisoning and Conditions in the perinatal period were found to be main causes of inpatient morbidity of children under the age of 15 years. In 2004, death registration showed that perinatal conditions lead the way for infant mortality (i.e. under 1 year, at 27%), replaced by road traffic accidents in children aged 1–15 years, accounting for 16% of deaths. Roughly, 7.2% of health institution reported deaths for children in this age group were of injuries and poisonings, of which large percentages were due to road traffic accidents.[15] This is gravely concerning, not simply because they are highly preventable causes of morbidity, disability and death but also that they could be an indication of physical neglect or abuse.

Morbidity – Leading causes of *external* morbidity amongst children in Oman (less than 12 years old) is falls. This is followed by exposure to mechanical forces, contact with heat/hot substances, contact with hornets, bees and wasps, etc. See Figure 2.1 for full details. [16]

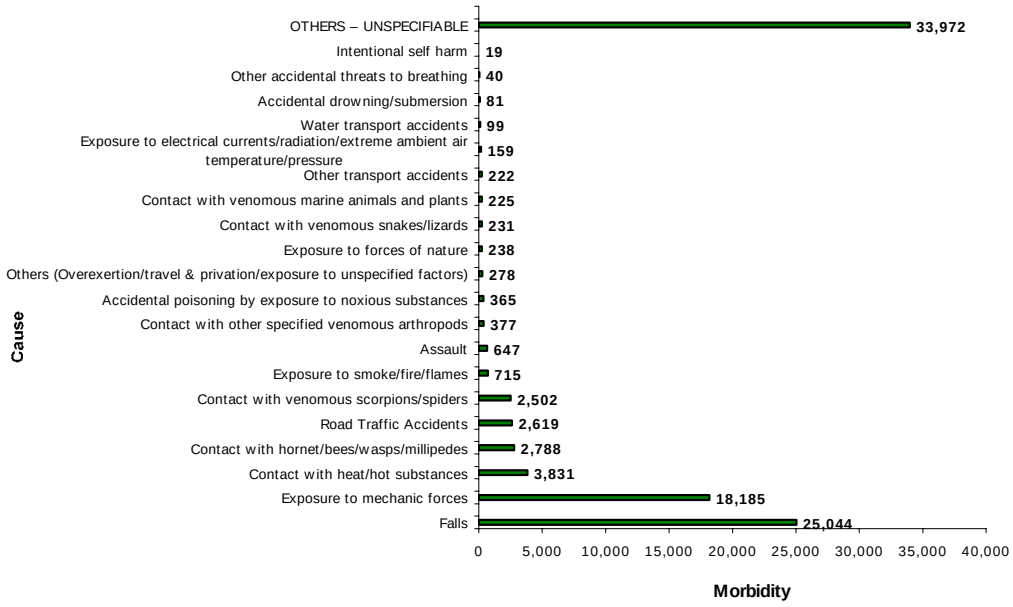

Figure 2.1: External Causes of Outpatient Child Morbidity in Oman (2004)

Regarding In-patient morbidity rates in children below 15 years of age, the leading cause of hospital admittance in 2004 was disease of the respiratory system, followed by infectious and parasitic diseases; see Figure 2.2 for full details.

[15] Ministry of Health, Annual Health Reports 1997 and 2004
[16] Ministry of Health, Annual Health Report 2004

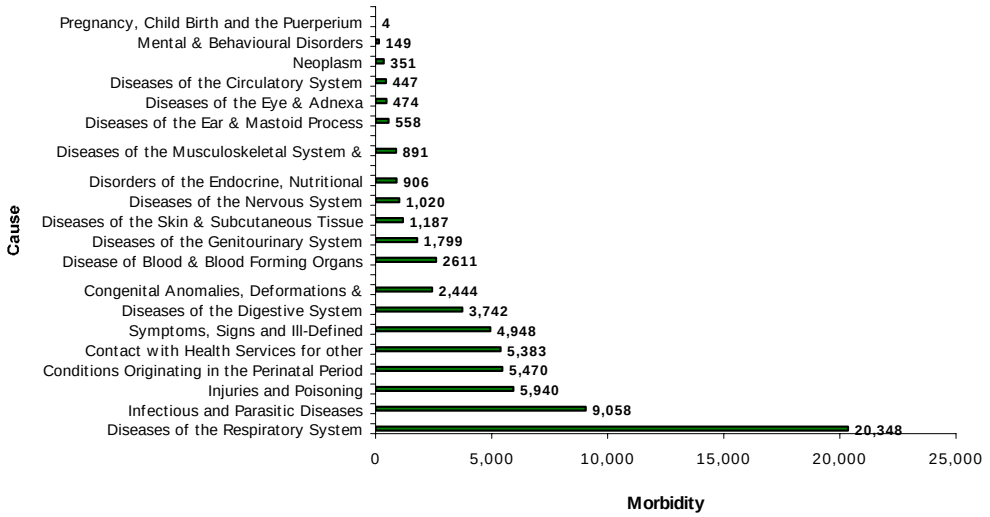

Figure 2.2: In-Patient Causes of Child Morbidity in Oman (2004)

Mortality – Newborn children are particularly vulnerable with their survival depending on the mother during pregnancy, delivery, and lactation. Neonatal and all post neonatal mortality rates have fallen significantly in the past two decades, with data consistently linked to low birth weight. A survey in 1998/99 concluded that perinatal mortalities average 21 per 1000 births with regional disparities.[17] Infant Mortality Rates (IMR) has fallen dramatically over the years, decreasing by almost 50% from 20 to 10.3 per 1000 live births, between 1995 and 2004.

The establishment of the **foetal death registry** in 1999 increased awareness of foetal deaths and may go some way in explaining the further decline in neonatal deaths. In 1997, around half the deaths of children Under 15 years occurred in the first seven days of life, this percentage decreased to 38.6% in 2004 (see Table 2.1 and Figures 2.3 and 2.4). The stillbirth rate dropped from 1.3% to 0.8% of all births during the same period.[18] Neonatal deaths are often related to social factors and are more difficult to improve through hospital–based services. These social factors include mothers' attitudes toward antenatal care, fertility rates, men's attitudes to contraception, child–spacing practices, female nutrition, attitudes to breastfeeding and age at marriage. Such factors could be reduced by establishing a more intensive network of general and reproductive health–focused education.

Table 2.1: Hospital-based Mortality for Children 0–14 years, 1997 and 2004

Age Group	1997	2004
Under 7 days	231	181
7 – 28 days	47	63
29 days – 1 year	90	92
1 year – 4 years	67	55
5 – 14 years	70	78
TOTAL	505	469

Source: Ministry of Health, Annual Health Reports 1997 and 2004.

[17] Ministry of Health and UNICEF, 1999, Report on Perinatal/Neonatal Infant Mortality
[18] Ibid

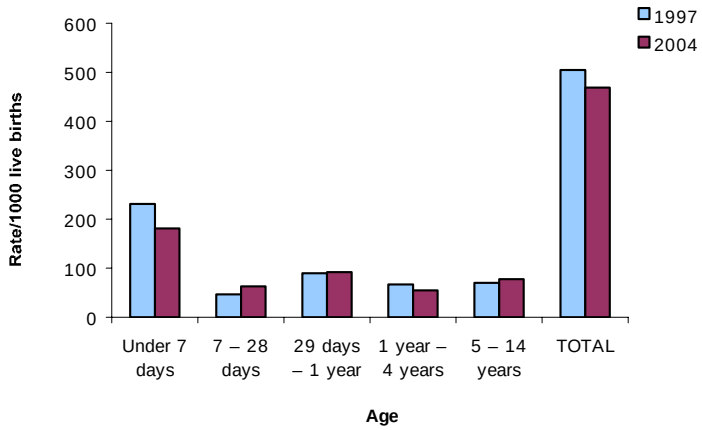

Figure 2.3: Hospital-based Child Mortality in Oman (2004)

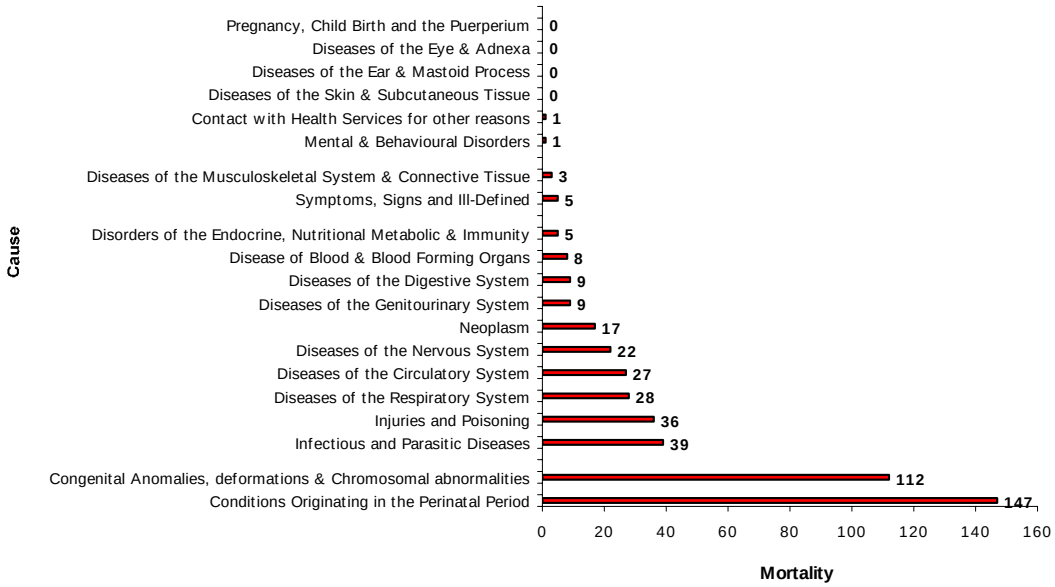

Figure 2.4: Causes of Children Deaths in Oman (2004)

Looking more specifically at acute respiratory illness (ARI) and diarrhoeal diseases (CDD), in children under five years, there is an optimistic picture, as rates for both have dropped significantly in the past 7 years (see Table 2.2). The severity and deaths caused by respiratory illnesses have also dropped, although it is useful to state that numbers were not high in the first instance.

Table 2.2: ARI and CDD Rates, 1997 and 2004

		1997	2004
ARI episodes per 1000 children under 5 years		2121	1618
Severity (%)	**Mild**	81.5	84.7
	Moderate	17.7	14.9
	Severe	0.8	0.4
Primary ARI deaths		4	2
ARI-related deaths		10	3
CDD Episodes per 1000 children under 5 years		399	285
Severity (%)	**Without dehydration**	90.4	87.3
	Mild/Moderate	9.4	12.5
	Severe	0.2	0.3
Diarrhoea-related deaths		1	0

Source: Ministry of Health, 1997 and 2004, Annual Health Reports

The slight increase in more serious cases of diarrhoea is of concern however, and if the trend continues, must be monitored carefully. These figures do not accurately depict the situation as it is occurs as an episode. Thus, there is no distinction between one child having six diarrhoea episodes in one year compared to six children having one episode each. Nevertheless, the decrease by one-third is positive. Results from the National Heath Survey in 2000, help to show what can be done to raise awareness at the community level. At the time of the survey, nearly 9% of children surveyed had diarrhoea within the last two weeks; a majority of these were under 3 years of age. Of these, around 67% were given some form of oral re-hydration therapy.[19]

Water and sanitation underlie the survival rights in Article 6 and are specifically implicated in the provisions of Article 24 regarding IMR and Primary Health Care (PHC). Additionally, water and sanitation are relevant to the right to an adequate standard of living. Interventions in this sector have focused on two parallel and related strategies, improving the quantity and quality of water/sanitation services whilst simultaneously enhancing people's awareness of the linkages between water/sanitation facilities, personal hygiene habits and incidence of disease. However, significantly more research/action is required in this area taking into consideration that 75.3% of the population have access to "improved drinking water supplies" namely piped water and public wells.

An important activity in the water/sanitation section is the establishment of a national database for water sources and water/sanitation facilities. This forms the core of a national water quality monitoring system that can detect water–related diseases and other health problems, as well as seasonal, annual and geographical variations. Since 1994, all public drinking wells had to be inspected and licensed according to new specifications and all tested by mid 1995, resulting in water tankers and wells being colour coded according to quality and use.

Although many diarrhoeal and respiratory illnesses may be due to environmental causes, breastfeeding and appropriate complementary feeding is critical for the health and wellbeing of infants and young children.

Road traffic accidents (RTA) are a significant concern for all in Oman, particularly children and young people. With 128 child deaths recorded in 2004, 93 of whom were 14 years and younger, this is a warranted concern, which requires attention. Table 2.3 highlights the causes of mortality as seen in

[19] Ministry of Health, National Health Survey 2000

2004, for children 14 years and younger, as stated in the MoH Annual Health Report[20]. See also Figure 2.5.

Table 2.3: Distribution of Child Deaths due to external causes in MoH Institutions, 2004

Cause	Total	5-14 years	1-4 years	29 days-1 year	7-28 days	< 7 days
Road Traffic Accidents	93	75	14	4	0	0
Falls	12	7	3	2	0	0
OTHERS (UNSPECIFIABLE)	6	3	3	0	0	0
Exposure to smoke, fire and flames	8	7	1	0	0	0
Intentional self harm	4	3	1	0	0	0
Exposure to mechanic forces	2	1	1	0	0	0
Exposure to forces of nature	1	1	0	0	0	0
Contact with heat/hot substances	1	0	1	0	0	0
Accidental drowning/submersion	1	0	0	1	0	0
Total	128	97	24	7	0	0

Source: Ministry of Health, Annual Health Report 2004

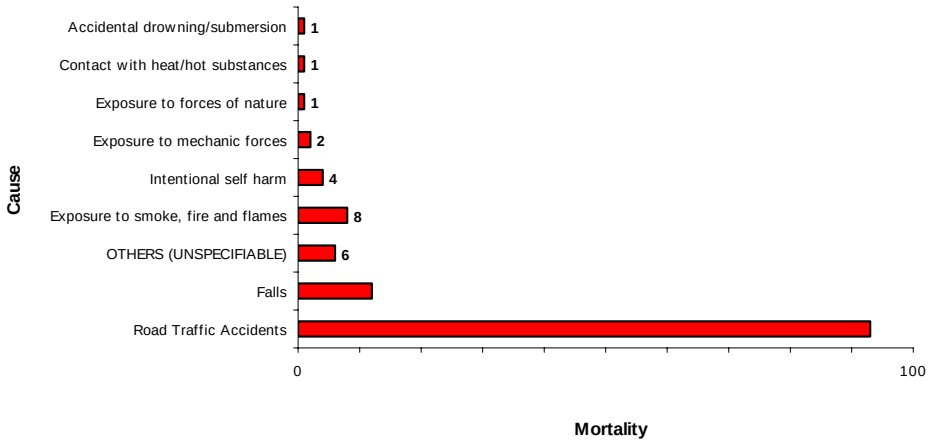

Figure 2.5: External Causes of Child Mortality in Oman (2004)

The continued rise in childhood and adolescent injuries are symptomatic of the changing nature of society and lifestyles in Oman. Public education and awareness campaigns on child safety and accident prevention, particularly RTA, are important in ensuring the health and survival rights of children. This issue is discussed further in Chapter 3.

[20] Ministry of Health, Annual Health Report, 2004

2.1.4 Children and the National Health Programmes

A national standardized child health programme was launched by the Ministry of Health in 1988 where all newborn infants were given a comprehensive child health card covering the first six years of life and with a duplicate kept at the family's health centre. This card and the accompanying child health register have played an important role in achieving and maintaining high immunization coverage.

The **Integrated Management of Childhood Illness (IMCI) strategy** was piloted in the capital region in 2001. Due to its successful approach, distribution occurred throughout the regions in 2002. Although it is still at a developmental stage, signs show that this holistic approach to managing childhood illnesses at the primary health care level will lead to improved health care practices. However, since many of the underlying causes of child morbidity and mortality correlate to various social/environmental factors, greater emphasis on inter–sectoral cooperation in addressing fundamental concerns is required. For example, the access to safe drinking water and empowering the community to bring about change in attitudes and behaviours in relation to breastfeeding and child safety.

Box 7: School health programme

There are *three* main objectives - to screen all school students, to promote healthy lifestyles and to improve the physical environment of schools.

Extensive efforts are made to conduct health examinations for all students in first primary, first preparatory and first secondary each year. Those identified with a health problem are referred to a health centre for further evaluation. Although the physical examination includes numerous checks (hearing, Rinnes test, teeth and gums, eyes and vision, behavioural and social skills), the effectiveness of identifying and managing cases, although assessed, needs to be strengthened.

Health education is not taught as a separate subject in the classrooms but is included in the regular curricula (in particular the science textbooks). The Facts for Life approach was introduced nationally to teach secondary school students key health issues. This programme needs further attention and streamlining. It has the potential to affect nearly every household in Oman, since nearly one–third of the population are students, teachers, or education administrators. Evaluation of the programme, particularly on its prime target, secondary school children, is critical for monitoring its usefulness in providing health messages.

Accessible preventive and curative health care is a key strength of the health care services in Oman. Mental health care, however, is weak; for example, each region has at least one psychiatrist in the regional hospital but most of the psychiatric beds are in Ibn Sina Hospital in the capital area, and there is no specialisation in child psychiatry outside Sultan Qaboos University Hospital. Although diagnosis, management and referral are provided within the primary health care system, the services are not exclusively for children. The identification of child mental health cases within the school health system may be the first step in addressing the mental health of children, however, this issue requires more attention.

2.1.5 Proxy Indicators

Fertility rates, birth spacing and maternal mortality rates are useful proxy indicators for the value ascribed by any society to children and women. Low rates of both fertility and maternal mortality, together with planned spacing of fewer births, are measures of a society's activist commitment to the wellbeing of its children and women.

Fertility rates have dropped significantly in the past 10 years, from an average of 6.0 in 1995, to 4.7 in 2000, to 3.19 from the latest available data, in 2004 see Figure 2.6.

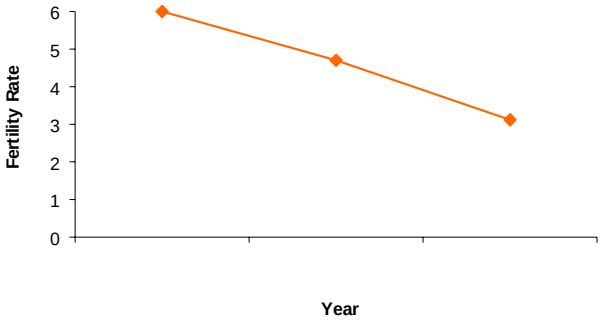

Figure 2.6: Fertility Rates Trends, 1995-2004

A consistent pattern has been observed over the last 10 years, whereby younger ages (under 35 years) and higher educational levels are directly correlated to a decline in the mean birth rates. This drop in total fertility rates is probably due to the increased age at marriage.

Equality not only varies with age and education levels but also by region. The highest percentage of women with 6 or more children was seen in Al-Sharqiyah, Al-Batinah, Al-Dakhliyah and Dhofar, with 48.7%, 44.7%, 44.5% and 39.0% respectively.[21]

Birth spacing was first assessed systematically by the 1989 Child Health Survey. The data showed an average birth interval of 26.5 months for all mothers, rising from a low of 20.8 months amongst 15–19 year olds to a high of 29.7 months amongst 45–49 year olds. The NHS 2000 showed a dramatic increase in average birth intervals, 29.8 months, rising from a low of 22.0 months for women aged 15–19 years and 35.1 months for women aged 40–44.[22]

In 2004, the Ministry of Health statistics showed that 20.9% of mothers had a birth interval of less than 2 years while 39.1% had an interval of more than 3 years.[23]

In general, it seems that Omani women are well aware of the available birth spacing methods. In 2000, 94.7% of women had heard of at least one modern method of birth spacing and 74% had heard of five or more methods. This increased awareness has also raised the current use of contraceptives from 24% in 1995[24] to 32% in 2000.[25] As may be expected, use of contraceptives is higher amongst more educated and older women. Although, the average ideal family size dropped by nearly one from 6.4 in 1995 to 5.5 in 2000, it remains high, even for university graduates (4.7 in 2000).[26]

The 1997 Knowledge, Attitude, and Practices (KAP) Survey found that 59% of women and 61% of men believe that there are harmful side effects to modern methods of birth spacing, thus it is recommended that more information should be targeted to couples.[27] The NHS showed that for nearly two–thirds of the women interviewed, it was the man's decision to have another baby. Due to the importance of the husband's involvement in birth spacing decisions, the Ministry of Health have developed campaigns specifically targeting men. However, making birth spacing clinics more male–friendly, particularly addressing the fears they may have concerning contraception, should be explored.

[21] Ibid.
[22] Ministry of Health, National Health Survey 2000
[23] Ministry of Heath, Annual Health Report 2004
[24] Ministry of Health, Oman Family Health Survey 1995
[25] Ministry of Health, National Health Survey 2000
[26] Ministry of Health, Oman Family Health Survey 1995, Ministry of Health, National Health Survey 2000
[27] Ministry of Health, National KAP Survey on Birth spacing 1997

The common birth spacing message encouraging couples not to have them "Too young, too old, too many or too frequent" can easily be applied to Oman. The current birth spacing programme focuses only on birth spacing, thus only touches upon one aspect of maternal biological risk factors. Including these risk factors in the current birth spacing campaigns will increase contraceptive use but also have an impact on the perinatal mortality and low birth weight, of which the latter has consistently remained in the region of 8% over the past few years.

2.1.6 Nutrition issues

Nutrition is an important factor in the development of the child. Article 24 of the CRC explicitly states, in two places, that State Parties shall take measures to, "Combat…malnutrition within the framework of primary health care…and through the provision of adequate nutritious foods and clean drinking water" and "Ensure that all segments of society (have)…basic knowledge of child health and nutrition…(and) the advantages of breastfeeding." Malnourished children have impeded growth and development as well as specific nutritional deficiencies such as vitamin A deficiency, iron deficiency and iodine deficiency. The health and nutrition of young girls has a serious impact not only on themselves but also on their children, since a stunted child becomes a small mother who then gives birth to a low birth weight baby and the cycle of malnutrition continues. In the same way, malnutrition makes children more vulnerable to infectious diseases, which can lead to exacerbated levels of malnutrition – again a vicious cycle. It is imperative, therefore, to break the cycle of poor nutrition by addressing issues at an early age.

2.1.6.1 Protein Energy Malnutrition (PEM)

Four different studies, the National PEM Study (1999), Aspect of Care Study (2000) , the Qualitative Study on PEM (2002) and the study on Risk Factors Associated with PEM(2004); have been carried out over the past few years to gain a clearer understanding of the extent of PEM in Oman and feeding practices.

The National PEM survey found that the prevalence of underweight children was 17.9% whilst for stunting and wasting the statistics were 10.6% and 7.0% respectively. These figures were distributed evenly between males and females. Regional variations were significant, varying from a low prevalence of 7.9% in Dhofar to 26.6% in the North Sharqiyah region[28]. Although these figures are lower than those found in the Oman Family Health Survey where approximately 24% were underweight,[29] malnutrition remains an issue of public health concern.

The Aspect of Care Study was conducted to assess the feeding practices of children two years of age and younger. It established that only 31% of children were exclusively breastfed for the first four months of their lives and only 66.9% continued breastfeeding after the age of one. In addition, a significant percentage received complementary feeds early, before the 4th month (17.6%) or late, later than six months (14.6%). And for those children above 12 months of age, more than half (53.7%) were fed complementary foods less than three times a day (compared to the UNICEF recommendations of 4–5 times daily).[30]

A qualitative study was one of the first to examine causes of malnutrition in Oman. It involved focus group discussions with mothers, caregivers, community support volunteers, health workers, and others. It highlighted three main concerns, lack of nutritional awareness among parents, caregivers, and health workers, high frequencies of pregnancies with poor birth spacing and lack of safe and sanitary water resources in many regions.

[28] Ministry of Health, National PEM Survey 2001
[29] Suleman, A.J.M., Al Riyami A, faris S, Ebrahim GJ (2001) Oman Family Health Survey 1995,Journal of Tropical paediatrics, Vol.47, Suppl.1
[30] Ministry of Health, Aspect of Care Study 2000

The Multivariate analysis of the study of the risk factors associated with PEM revealed that birth-weight (O.R. 8.4, p=0.001), height of mother (O.R. 2.7, p=0.0027), diarrhoea in the last 15 days (O.R. 3.9, p=0.0029), formula feeding (O.R. 2.2, p=0.014), having meals in a separate plate (O.R. 2.1, p=0.024), mother's employment (O.R. 0.1, p=0.023), and water quality index (O.R. 4.7, p=0.0018) were significantly associated with underweight. The family income and birth spacing were not found to be significant in this model.

According to Ministry of Health statistics, the rate of new PEM cases has marginally increased from 18 per 1000 (children below 5 years) in 1998 to 19 in 2004. As with the PEM Survey, a majority of cases are below the age of two years, see Figure 2.7.[31] There were no PEM related deaths recorded in 2004.

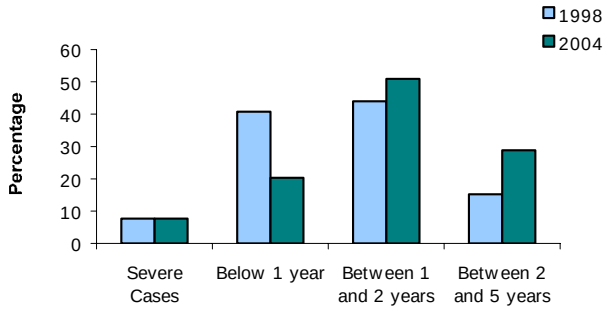

Figure 2.7: PEM among Children Under 5 Years of Age,2004

According to the Oman Family Health Survey of 1995, 78% of mothers exclusively or predominantly breast-feed their infants for four months. The Aspect of Care Study found that only 30.1% of mothers exclusively breastfed their infants aged 0–4 months. Similar figures are seen in the National Health Survey, where 56% of mothers exclusively breastfed their infants from 0–3 months.
A concern, however, is that roughly 40% of infants, less than 12 months old, were bottle-fed. Bottle feeding rates were particularly high for children in Muscat (52.6%) and Dhofar (72%), with mothers with secondary (58.3%) or university (75%) education as well as mothers who worked outside their homes (70.5%).[32] These latter figures are at least partly due to short maternity leave (45 days) with mothers choosing to initiate bottle feeding before the infant is even six weeks old rather than expressing breast milk.

With near universal immunisation coverage in Oman, the key diseases, potentially related to PEM are diarrhoeal diseases, discussed earlier. Fundamentally, there is concern with respect to access to safe drinking water and sanitation. A further issue that requires exploration is the link between household incomes and PEM, particularly since more than half of all Omani households have a monthly household income of less than OR 500 and yet the average monthly consumption rate is very nearly the same amount.[33] But without having a decent study on poverty and cost of living, no conclusion could be reached based on this statistical statement as the national average could be well above the minimum level of income required to insure decent life for people.

A regional comparison of the PEM rates with possible risk factors reveals some interesting information, potentially providing insight into this issue; see Table 2.4 and Figure 2.8 and 2.9. The Sharqiyah and Dakhliyah Regions had the highest prevalence of underweight babies in 1998 according to the National PEM Survey. The Ministry of Health statistics for the PEM rate in each region, confirm the survey results. Possible explanations for the figures seen in this table include

[31] Ministry of Health, Annual Health Reports 1998 - 2004
[32] Ministry of Health, National Health Survey 2000
[33] Ministry of National Economy, Household Income and Expenditure survey 1999/2000

elements such as higher fertility and lower income. A regional comparison of access to safe water and sanitation and literacy rate of adult women would provide further insight.

Table 2.4: PEM Rates and Related Factors by Region

	% Low Weight for Age*	PEM rate/1000 children**	CDD Rate /1000 ORS children**	Mean # children ever born***	Exclusive breast feeding rate (0 – 3 months)****	% Intro. complementary foods at 0 – 2 months****	% Intro. complementary foods 6+ months****	% earning <200 OR/month****	Average monthly per capita income (Omanis)
Muscat	12.9	12	225	4.47	40.9	4.9	12.6	12.56	104.08
Dhofar	7.9	4	284	4.75	23.5	4.5	12.5	7.43	89.46
Dakhliyah	22.9	36	395	5.14	68.8	5	25.2	19.17	64.34
N. Sharqiyah	26.6	31	423	5.44	81.8	13.7	15.1	31.54	63.11
S. Sharqiyah	19.7	19	384						
N. Batinah	17.4	10	206	5.27	64.3	4.3	13.7	26.76	54.88
S. Batinah	22.2	30	417						
Dhahirah	14.9	13	281	4.59	62.5	7.7	19.2	21.83	63.30
Musandam	21.5	13	199					27.38	64.27
Al Wusta	-	61	342	-	-	-	-	23.20	65.30
National	17.9	18	301	5.0	56	5.8	15.9	20.51	74.86

** Source: Ministry of Health, National PEM Survey 1998.*
*** Source: Ministry of Health, Annual Health Report 1998.*
****Source: Ministry of Health, National Health Survey 2000.*
***** Source: Ministry of National Economy, Household Income and Expenditure Survey 1999/2000.*

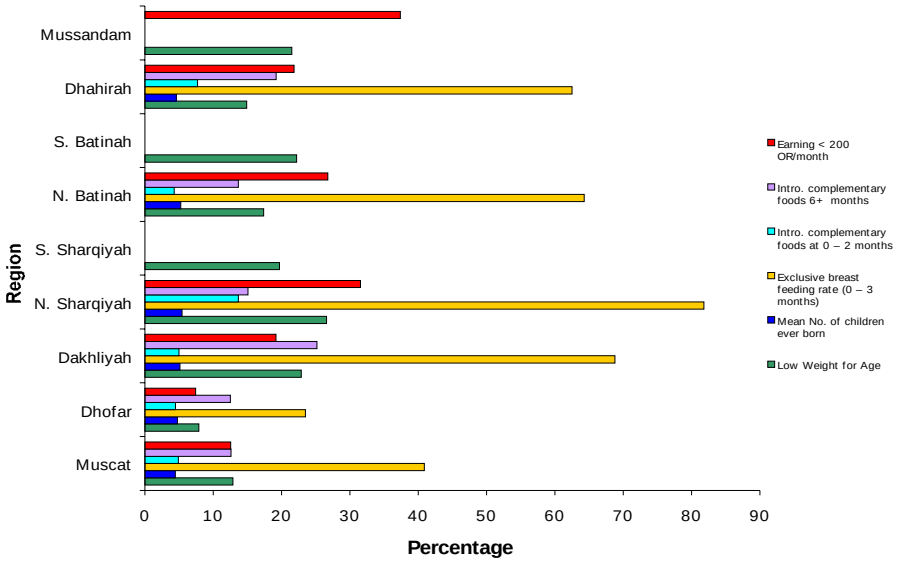

Figure 2.8: Low-Birth Weight and Complimentary Feeding By Region

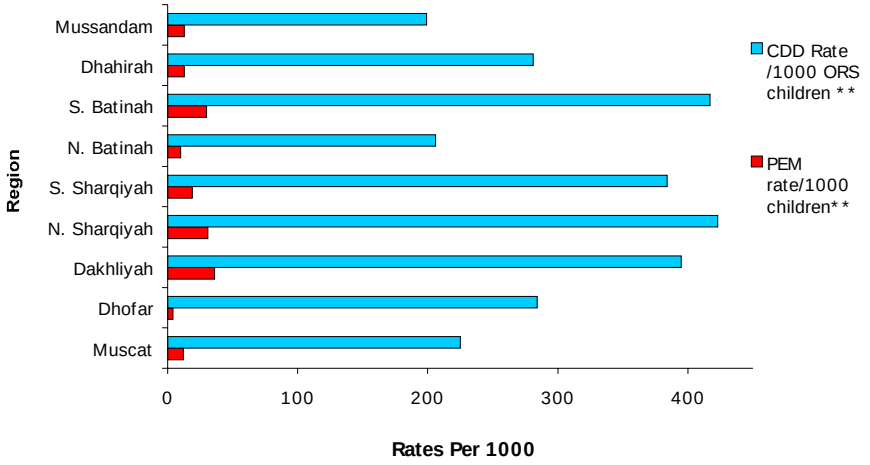

Figure 2.9: PEM and CDD Rates in Children

Having a bulk of cases in children under the age of two is seen in many countries. After this age, many children tend to grow at the same rate as well–nourished children; however, they remain smaller due to the deficiencies that occurred in earlier life. Such stunting also has long–term effects on their mental and emotional development. Since this is a critical and influential period in child development, with negative implications on the child if left unaddressed, focused efforts are needed on this age group.

Although feeding practices and repeated infections, insufficient access to food, either by unavailability in the market or insufficient resources to purchase appropriate foods, inadequate maternal and childcare, possibly due to large family size, and poor environmental factors, particularly access to safe drinking water and sanitation, are the most recognizes underlying causes globally. However the study of risk factors associated with PEM looked at all these aspects and found that the most important of which in the context of Oman are birth-weight, height of mother, diarrhoea in the last 15 days, formula feeding, care factors, mother's employment, and water quality index. Family income and birth spacing were not found to be significant in this model.
The multifactor risks to malnutrition demonstrate that this issue is not only the concern of the Ministry of Health but involves other sectors.[34] Nevertheless, numerous activities are underway to address malnutrition.

Within the Ministry of Health, two different processes are in place to identify cases of malnutrition. A national program to combat malnutrition was initiated in 2002, which is composed of early screening for all children in the community, referral to the health centers, and management of the related diseases, and counselling for adequate child growth, breastfeeding and complementary feeding. This program was put together based on the IMCI management module for PEM, and it made use of the existing structure of Community support Group members, EPI clinics and utilized the child health card and child health register to identify cases. Also, the PEM register was established were all PEM cases were tracked for improvement. In 2005 the coverage rate for this program was more than 90%.

As a participant of the Multicenter Growth Reference Study, and following the launching of the new international growth curves in May 2005, the MoH Oman revised the child health card to include the new growth charts. The card also included tools to monitor breast and complementary feeding as well as motor development milestones at each age for the child

[34] Ministry of Health and UNICEF, 2002, Child Nutrition in Oman, Perceptions and Beliefs, Muscat

In the early 1990s, the Ministry of Health placed greater efforts on increasing nutritional awareness through the assistance of UNICEF. Breastfeeding and complementary feeding booklets and posters were made and distributed. The Community Support Group (CSG) volunteers' initiative started in 1992 as a part of the Baby Friendly Hospital Initiative (see 2.1.6.2 for more details). Volunteers throughout the country were trained to advise women on breastfeeding. This ongoing programme has expanded to cover complementary feeding and other health issues of importance to women. In 2002 the Infant and Young child feeding policy was adopted and a series of training workshops for all health care workers in PHC service was carried out.

The obvious concern in the persistently low percentage of exclusive breastfeeding has led the Ministry of Health, with the assistance of the WHO, to conduct training, to establish a cadre of lactation counsellors at the local level, with initial training taking place in early 2003, followed up by a serious of training workshops. As of January 2006, more than 100 lactation counsellors were trained on the WHO 40 hours lactation course, and are practicing in PHC service, delivery suites and maternity wards all over Oman. .

Monitoring of the system is another aspect that the program is pursuing. The monthly report on malnutrition shows the number of cases of PEM in each health center, number recovered and worsened, referred etc. Also, the program has integrated a quality assurance component in which self assessment by health centres is carried out on an annual basis, in addition the regional nutrition coordinator carries out an external assessment once a year too, and an auditing takes place once every two years. The quality assurance system looks at the equipment, supplies, the process of the implementation of the program in PHC facilities..

The Ministry revised the exclusive breastfeeding policy in 2002 and now advocates exclusive breastfeeding up to six months of age. Its impact on infant feeding practices and PEM remains to be seen. However, anecdotal information shows that there is marked resistance by both mothers and health professionals. The mothers feel that it is difficult to exclusively breastfeed for so long and are not convinced of the importance of exclusive breastfeeding. Physicians, too, remain unconvinced partly since little effort was made to include a large number of paediatricians in the decision–making process and to raise awareness in the regions upon national implementation.

Clearly, then, there is the lack of knowledge amongst caregivers, health professionals and the community. In fact, one of the key outcomes of the qualitative study was the recommendation to conduct a social marketing campaign to raise nutritional awareness in all sectors. This has been identified as a priority activity in UNICEF's cooperation with the government.

A social marketing campaign and strengthening health services are useful. However, other innovative interventions need to be explored. The current approach does little more than counsel mothers on appropriate feeding practices. The Ministry of Health should be proactive in encouraging the community to address this issue by using health staff at the PHC level, the Wilayat Health Communities, and community support group volunteers. For example, a variety of interventions such as practical instructions on feeding methods, environmental sanitation, market availability of energy dense foods, micro–enterprise, and reinforcement of growth monitoring could be carried out through the primary health care system. Since some factors seem more relevant in one region compared to another, varying approaches according to local needs is a strategic method of addressing this issue. Extra efforts should be made in those Wilayats and regions that have fallen behind in the development process, such as efforts to improve water and sanitation, leading to a decrease in diarrhoeal disease or to increase literacy rates since maternal literacy is directly related to child survival.

2.1.6.2 The Baby Friendly Hospital Initiative

Breastfeeding is the best form of nutrition for young infants. It contains the complete range of nutrients required, provides extra immunity to children and is more digestible than commercial products. Advocating breastfeeding in hospitals where children are born is one way of promoting breastfeeding. The multi–sectoral Baby Friendly Hospital Initiative (BFHI) National Committee, established in 1992 with UNICEF cooperation, successfully implemented the BFHI in Oman. All 51 public sector hospitals in the country were declared baby friendly in December 1994. All BFHI hospitals now implement the ten steps to successful breastfeeding and strictly ban the promotion or free distribution of milk substitute samples. An assessment procedure has been initiated to ensure continuous monitoring of the ten steps a hospital must take to obtain the BFHI designation.[35]

Baby Friendly Hospital Initiative status has been sustained in all government hospitals and all Ministry health centres, since 1996. Moreover, two private hospitals in the country are certified as Baby Friendly. . In 2005 the Ministry of Health, in collaboration with UNICEF and WHO conducted a national assessment of the program, to identify the opportunities for improvement. One of the important aspects of the review was the need to train assessors to conduct periodic assessment of hospitals. All the hospitals in Oman were assessed and gained BFHI status once in the beginning of the program, however they were not re-assessed to ensure compliance and sustainability. Therefore the MoH is currently working on finalizing the tools, and training of assessors of hospitals as well as PHC facilities**.** Observations from a visit to randomly selected urban and rural public health facilities, by the Director of the International Code Documentation Centre of the International Breastfeeding Action Network (IBFAN),[36] confirmed the high level of BFHI training, commitment and compliance among public health workers.

Oman enjoys a leadership role in this field among its sister countries in the GCC. Since 1998, internal assessments were performed by the BFHI managers. Lately, questions have been raised regarding the overall impact of the BFHI programme. Data are showing that almost 99% of the mothers do start breastfeeding, but almost 31% continue to exclusively breastfeed for 4 months, as many introduce bottle feeding sometime in the first year. Therefore it was essential to improve the role of PHC facilities in breastfeeding.

The National Code on the Marketing of Breast milk Substitutes was signed into law in 1998. However, the mechanisms for monitoring its implementation such as monitoring at points of sale and marketing strategies, has not been established. Anecdotal evidence indicates that non–compliance of the Code by distributors of Breast milk Substitutes, in advertising, distribution and other marketing techniques, is widespread, confirming the challenges in enforcing the current legislation. A greater, more active effort in sectors other than health is needed, particularly the Ministries of Commerce and Regional Municipalities who are responsible for implementing the policy. (See also Annex 1)

2.1.6.3 Micronutrient deficiencies

Micronutrient deficiencies in Oman could be a reflection of the poor nutritional status of many women and children. Several specific vitamins and mineral play a role in the development of the child. Here we discuss in particular vitamin A, iodine and iron.

[35] *Protecting, promoting and supporting breast-feeding: the special role of maternity services*; Joint WHO/UNICEF Statement. Geneva, 1989

[36] IBFAN is a partnership of over 150 groups in 90 countries campaigning to end commercial promotion of artificial infant feeding and to protect infant health: http://www.ibfan.org

2.1.6.3.1 Vitamin A deficiency

Vitamin A deficiency is not only associated with blindness but also makes children more vulnerable to infections. According to a 1994/95 nationwide study of children aged between 6 months and 7 years, Vitamin A deficiency was a moderate public health problem in children below 3 years of age. The problem was nationwide and not related to gender or relative economic wellbeing, although the intensity varied by region, being less pronounced in Muscat. It concluded that sub–clinical Vitamin A deficiency is likely to contribute to increased severity of morbidity and mortality in Omani children under the age of 3. The likely cause of the problem is poor eating habits resulting from a lack of information on nutritionally balanced diets, especially among women of reproductive age and in young children during and immediately after the complementary feeding periods.[37] As a direct consequence of this study, the Ministry of Health have introduced Vitamin A supplements as part of the EPI schedule for all children at the ages of 9 and 15 months. Since 1997, supplements have also been provided for mothers after giving birth. Currently, 98% of children under two years of age and 95% of mothers receive vitamin A supplements.

A study was performed in 1998, to monitor the outcome on the Vitamin A status of the population based on a sample of 1,200 children aged 6 months to 3 years and using serum retinal. It concluded that vitamin A deficiency continues to be a public health concern. Although a vitamin A supplement programme is in place, unless underlying causes are addressed, this deficiency will probably continue. The likely cause is poor eating practices, particularly for women of reproductive age and young infants during the period of complementary feeding.

The latest study carried out by MoH Oman, WHO and CDC/Atlanta in 2004 showed that Less than 6% of children 6-59 months had vitamin A deficiency. However, among children <2 years old almost 18% were vitamin A deficient. This was significantly greater than the 3% of children 2-5 years old who were vitamin A deficient. Less than 0.5% vitamin A deficiency was found among non-pregnant women of reproductive age**.**

The case of Vitamin A clearly illustrates the challenges to government in the face of a health transition. Although centrally planned strategies to deliver health services, such as Vitamin A supplements, can improve a problem, the fundamental solution lies in developing a community response that will change attitudes and practices in family nutrition. More needs to be done at the community level to achieve a sustainable improvement in children's nutrition.[38] Food fortification and legislative actions should also be part of the preventive strategy.

2.1.6.3.2 Iodine deficiency disorders (IDD)

Iodine is required for normal growth and development of infants and children and for normal physical and mental activities of adults. Iodine deficiencies result in goitres reduced mental function and increased rates of stillbirths and infant mortality. In June 1995, the Minister of Commerce and Industry issued a decree for iodisation of salt for human consumption within a 6 months period. Collaborative surveys subsequently established to monitor household consumption of iodised salt show an improvement in the situation, from 35% to 65% in 1996 and 1997 respectively. Yet the 1997 survey found that only 65% of households used iodised salt, despite 72% availability, with 41 brands of iodised salt on the market.[39] This consumption pattern increased slightly to 68.5% in 2000.[40]

In the micronutrients survey 2004 (MoH/WHO/CDC) revealed that the median urinary iodine (UI) among non-pregnant women of childbearing age was 223 µg/L. The prevalence of UI <100 µg/L and

[37] Ministry of Health, UNICEF & WHO, 1995, *National study on the prevalence of Vitamin A deficiency (VAD) among children 6 months to 7 years,* Muscat.
[38] Ministry of Health & UNICEF, 1997, *Community Nutrition Action: an Omani experience*, Muscat
[39] Ministry of Health *iodised salt surveys*, 1996 and 1997. Government of Oman, Muscat
[40] Ministry of Health and UNICEF, Monitoring Oman's progress in achieving universal salt iodisation 2000

<50 µg/L among Omani non-pregnant women were 17% and 5% respectively. However, one-third of women (33%) had a UI >300µg/L. No particular subgroups of women were found based on demographic data to identify groups with IDD. The median iodine content in salt collected from households was 31 ppm. Approximately 59% of the 390 households had adequately iodised salt (≥15ppm) available at the time of the survey. Approximately 71% of households had original salt packaging available and of these, almost 96% were labelled as iodised. Among those, well over two-thirds of the samples (72%) contained at least 15 ppm of iodine.

Overall, the salt iodisation programme has stagnated, largely due to the lack of legislative enforcement at the various points of distribution, and the lack of focussed activities since 1996. Oman still needs to achieve 90% iodised salt consumption in order to meet the recommendations made by the WHO, UNICEF, and the International Council for the Control of Iodine Deficiency Disorders.[41]

Non–iodised salt enters Oman by land from neighbouring countries. This issue needs greater monitoring and control. To ensure more intensive monitoring of universal salt iodisation legislation and salt iodisation, testing kits have been provided by UNICEF to the Ministry of Regional Municipalities, Environment and Water Resources and Muscat Municipality officials. Kits were also provided to the Ministry of Health for their annual field monitoring surveys. In light of the seriousness of the situation, an intersectoral workshop was held in 2002 to highlight the importance of eliminating IDD and to develop a comprehensive plan to address this issue. Some of the key recommendations as a result were to form a national IDD committee, to revise current legislation related to universal salt iodisation and to establish a central information database and procedures at factory and packaging centres.

Salt iodisation is not just a matter of legislation; it depends on extensive and sustained advocacy, and intensive monitoring of both the market and consumption patterns, as well as on social mobilization and awareness. Once again, this underlines the need to transfer some elements of responsibility from central government to communities and families.

2.1.6.3.3 Iron deficiency

Anaemia is the most common nutritional deficiency as previously mentioned. This deficiency leads to lower energy levels, lower learning abilities, as well as weakening the immune system. A UNICEF supported study indicated that nearly 40% of pregnant women suffered from iron deficiency anaemia in 1996. Due to these results, a national legislation requiring iron and folate fortification of white wheat flour became legal and effective as of 1998. The National Health Survey 2000 indicates that the prevalence has remained roughly the same; among pregnant women, 42.7% were anaemic.

All women attending ANC clinics, approximately 99.6%, receive iron/folate supplements. A training session (workshop) on nutritional anaemia, attended by 35 dieticians and health staff in 1998, strengthened the national capacity to address the special nutritional needs of adolescents and women, and to develop a plan of action to combat anaemia.

A national 1986 study found that 54% of pregnant women in Oman had haemoglobin values less than 12 g/dl[43], and in the same year, a national iron supplementation program for all pregnant women was implemented. A WHO evaluation of this program in 1993 showed that 48.5% of pregnant women had haemoglobin levels less than 12 g/dl. The national study of anaemia in 2000 showed that 28.4% of all women were anaemic with a haemoglobin value less than 12 g/dl[44].

For children, the results of a 1992 national study found that 78.2% of school children and 60.2% of preschoolers were anaemic with haemoglobin values less than 11 g/dl [45]. A 1996 national survey found that 51.5 % of school children had haemoglobin levels less than 11.0 g/dl and 19% had serum

[41] Ministry of Health & UNICEF, *Monitoring universal salt iodisation in Oman: Collaborative project of MoH/UNICEF* 1998, Muscat

ferritin levels below 20 ng/dl, [46] suggesting that the anaemia in this target population was caused by multiple factors in addition to iron deficiency.

The most recent micronutrients survey (MOH/CDC?WHO) showed that the prevalence of anaemia among preschool children was 42%. The anaemia prevalence was significantly higher in children under 2 years (66%) compared to those 2-5 years of age (26%). The prevalence of anaemia among non-pregnant women was 39%, compared to 12% in men. The haemoglobin distribution for the three groups is presented in Figure 3-3 and the prevalence of anaemia is shown in Figure 3-4. Using the WHO classification in Oman, the public health significance of the prevalence of anaemia among preschool children is "severe", while it is "moderate" among women, and "mild" in men. This indicates that public health interventions should be prioritised towards prevention and control of anaemia in preschool children and women.

Among preschool children, the prevalence of iron deficiency was 19% and the prevalence of iron deficiency anaemia was almost 8% (Figure 3-4). A third (33%) of non-pregnant women of child bearing age was iron deficient whereas 19% had iron deficiency anaemia. Iron deficiency accounted for almost 50% of the anaemia among women of childbearing age and 32% of children 6-59 months old. Income, education of the head of the household, age-group and marital status were not significantly associated with iron deficiency or IDA among non-pregnant women (15-49 years) or children (6-59 months). Because the serum ferritin test required venous blood collection, there were many refusals by parents to have their children undergo this procedure, especially for children less than 12 months of age. In general, younger children are more likely to be iron deficient and therefore we believe the above results underestimate the true prevalence of iron deficiency in children.

As with other micronutrient deficiencies, centrally planned health service strategies do not always provide a long-term solution. In this case, providing iron and folate supplements has not brought a change in the status of anaemia. Since iron/folate supplements are routinely provided to pregnant women, reasons for non–compliance should be examined and/or why supplementation does not seem to reduce the number of women who have anaemia. Social mobilisation addressing these concerns could increase the intake of iron supplements but more importantly, could alter the feeding habits. Although bread is the most common food item in Oman, flour fortification does not seem to have had an impact on the rate of anaemia. Similar to the universal salt iodisation programme, extensive advocacy and sustained monitoring of the market and consumption patterns are required.

2.2 Indicators of the Right to Survival and Good Health: Adolescents

2.2.1 Healthy lifestyles

Little is known about the health of adolescents in Oman outside the school health-screening program. The health statistics combines children with young teenagers in one group (5–14 years), discussed further in chapter 3, and older teens with adults (15–44 years). The recent KAP survey of secondary school students provides some insight, even though only 59% of this population is enrolled in schools.[42] This survey showed that only half of adolescents interviewed knew the obvious physiological and emotional changes that take place during puberty, to themselves, but the percentage is lower with regards the opposite sex. Although many boys (59.9%) saw these changes as normal, most girls (78.3%) did not.

Information on **HIV/AIDS** is seemingly reaching many students, since the National Health Survey (data not shown), the Adolescent Health Survey, and a 2005 UNICEF funded HIV situation and response analysis found that the majority of people know about HIV/AIDS. It should be noted that Oman is a low prevalence country at 0.051%, and from 2000 to 2005, Oman has seen a reduction in

[42] Ministry of Health/UNICEF/World Health Organization,2001, Adolescent Health Survey

HIV mortality rates from 4.5% to 0.81% respectively. However, this survey also showed that secondary school students know little about other sexually transmitted diseases (STD), see Table 2.5. The high number that do not know about the changes in puberty as well as the high proportion who understand little about STDs demonstrates the importance of directing reproductive health messages to youths.

Table 2.5: Knowledge of Sexually Transmitted Diseases in Adolescents, 2001

	Males	Females
AIDS/HIV	99.0	98.3
Gonorrhoea	54.4	15.0
Chlamydia	6.9	5.0
Syphilis	27.3	18.4

Source: Ministry of Health, Adolescent Health Survey 2001

The current peer education program in the Muscat region directed towards increasing awareness of HIV/AIDS is one endeavour aiming to enhance young people's knowledge of healthy behaviours and reproductive health. Expansion of the health education curriculum is required to include such critical issues as adolescent physical development, explaining the changes that will take place to their bodies due to puberty. Such curriculum changes could also bring about opportunities to address sexual education.

As with youth in other parts of the world, those in Oman do take unnecessary risks. From the Adolescent Health Survey more than 25% of boys and 10% of girls smoked or tried **smoking**. About 6.6% of boys and 2% of girls said they had tried **alcohol**, and 30% of boys and 9.7% of girls said they believed their peers consume alcohol. These figures suggest that the level of smoking and alcohol consumption are under-estimated in the country. Similar discrepancies in use and perceptions are observed with drugs. The majority believe it is easy to obtain both alcohol and drugs in the country. Information regarding unsafe driving also reflects a high percentage of young people both driving at high speeds and driving without a license (see Table 2.6)

Table 2.6: Risky Behaviours in Secondary School Students (16–18 years), 2001

	Males	Females
Smoking Cigarettes	**(%)**	**(%)**
Currently smoke	8.0	7.3
Tried smoking	20.1	2.7
Think smoking is common with peers	79.3	9.0
Alcohol		
Have consumed alcohol	6.6	2.0
Think many of their peers consume alcohol	30.0	9.7
Think it is easy to obtain alcohol	95.2	97.6
Drug Abuse		
Have been pressured into taking drugs	7.2	2.2
Think drug abuse is common with peers	18.1	12.3
Think it is easy to obtain drugs	90.2	90.5
Unsafe Driving		
Drove at high speeds	42	62.3
Think their peers drive at high speed	92.2	52.0
Drive with out a license	57.6	12.2
Think their peers drive without a license	91.4	41.7

Source: Ministry of Health, Adolescent Health Survey 2001

The only other available data concerning risky behaviour is from the National Health Survey regarding smoking (see Table 2.7). A direct comparison cannot be made between this and the Adolescent Health Survey due to differences in survey methodologies.

It is disturbing to see that the prevalence of smoking increases with age for young males so that the proportion that smoke aged 25–29 is higher than for all men in general. In the adolescent survey, questionnaires were self-administered assuring students anonymity, whilst for the National Health Survey head of households were interviewed, who may not know the full extent of the behaviour of the adolescents in the household.

Table 2.7: Distribution of Smoking amongst Omani Youth, 2000

	Ever smoked Cigarettes	Stopped Smoking Cigarettes	Currently Smoking cigarettes	Currently smoking any tobacco Products
Males				
15-19	2.7	0.1	2.6	2.9
20-24	8.1	0.6	7.5	8.8
25-29	15.2	2.1	13.1	15.8
All males	11.4	2.7	8.7	10.7
Females				
15-19	0.0	0.0	0.0	0.0
20-24	0.0	0.0	0.0	0.0
25-29	0.0	0.0	0.0	0.4
All females	0.2	0.1	0.1	0.4

Source: Ministry of health, National Health Survey 2000

The majority of smokers, globally, start before the age of 18. A survey of several developing and transitional countries found that around 20% of school children are regular smokers. Although the figures in Oman are lower, the easy availability of tobacco along with the sophisticated advertising by cigarette companies makes it likely that this rate will increase unless stronger efforts are made to address this issue.[43] Further studies would provide a clearer picture of the social issues faced by young adults.

Adolescence is a time when children verge on the brink of adulthood. They are gaining their independence in decision-making and self-reliance. A strong supportive **family environment** can ease this transition. Only 43.2% of the students in the adolescent survey describe their familial relationships as strong and supportive. Nearly 25% stated that support was merely confined to studies or were actually negative. This may explain, in part, the relatively poor mental health observed, recording that 41.7% of boys and 49.4% of girls felt they suffered from melancholy, anxiety, and depression. Planning interventions and prevention programs, such as a life skills program, should be made a priority. Such a program should focus on mental and physical well being.

Young people may have risky behaviours for a variety of reasons, curiosity, peer pressure, rebellion, or low self-esteem. However, those alienated from families and easily influenced by their peers are more likely to have an unhealthy lifestyle. Those that have supportive parents tend to take more initiatives socially, are less depressed and more self-confident.[44] The importance of providing the information and skills to young people to help them adopt positive attitudes towards a healthy lifestyle must be considered in all programs targeting this group. Their point of view needs to be considered.

[43] UNICEF, Adolescence A Time that Matters 2002
[44] WHO, Promotion Adolescent Health and Development Using information, Education Communication 2002, Report of an Inter-country Workshop with Partners, Amman Jordan. 6-9 May 2002)

Section two looked into nutritional concerns in children and women. The adolescent survey also raises nutritional concerns. Nearly a quarter of the subjects did not eat vegetables or salad or dairy products regularly. This was especially true for girls. Compared to boys, girls ate more chips and chocolate. The high rate of anaemia in adolescent girls (40.9%) is of great concern since they are the mothers of the future and could perpetuate a cycle of ill health to the next generation. Great efforts need to be made to promote healthy eating in this age group, not only by including educational material in the school curriculum but also by having healthy choices in school canteens.

Another example of poor nutrition is the high prevalence of **anorexia** in Omani teenagers (33.0%) compared to non-Omani teens living in Oman (9.2%). What is interesting too is that these eating disorders were rare in the Omani adult population (2%). This study was performed in the capital area; it is not clear how widespread this problem is. Nevertheless, it is speculated that the psychological stress faced by these young individuals due to the rapid economic and socio-cultural transition leads some to use eating as a coping mechanism. Males, perhaps, are worse off since Oman is a paternalistic society and may face more adjustment difficulties.[45]

Although a majority (77%) of students surveyed in the Adolescent health Survey were aware of concerns of **teenage marriage** for girls, 39% of the boys and 17.5% of the girls supported teenage marriage in this survey. In general, boys gave a younger age as appropriate for marriage for both men and women (22.9 years and 19.97 years respectively) compared to girls (23.7 years and 21.4 years respectively). In a similar manner, girls appeared more progressive in the mean ideal family size of 4.3 compared to boys of 5.49. A majority support the use of contraceptives (70.8% of girls and 66.6% of boys) but as many as 15% of boys thought birth intervals of less than two years were healthy and 15.7% of girls and 11.5% of boys did not know this information.

The Census 2003 found that 3.69% of Omani females aged 15 to 19 years and 0.2% of Omani males aged 15–19 years were married (see Table 2.11). The proportion married increased by age so that for those aged 25–29 a majority were married (69.29% of women and 48.09% of men).[46]

Table 2.8: Marital Status of Youth Aged 15 to 29, 2003

	Single	Married	Other (divorced, widowed)
Men			
15-19	99.75	0.20	0.05
20-24	92.22	7.45	0.33
25-29	50.51	48.09	1.40
Women			
15-19	96.09	3.69	0.22
20-24	68.64	30.17	1.19
25-29	27.25	69.29	3.46

Source: Ministry of National Economy, Population Housing & Establishments Census 2003

For the youngest women, more than a quarter had not completed grades 1-6 (primary school) but about 18% had completed secondary school. The proportion with secondary school education or more, increased to approximately one-third for those over 20 years of age. Compared to all married women, these younger groups were more highly educated, showing the dramatic improvements that have been made in education in Oman, see Table 2.9.

[45] Al. Adawi, S et al. "presence and Severity of Anorexia and Bulimia Among Male and female Omani and None. Omani Adolescents," Journal of the American Academy of child and Adolescent Psychiatry 2002 41(9):1124-1130).
[46] Ministry of National Economy, Population Housing and Establishments Census 2003.

Table 2.9: Educational Status of Young Married Women, 2003

	15-19	20-24	25-29	All Women
Illiterate	10.69	6.85	8.85	41.67
Can read and write	15.86	9.21	11.98	14.67
Grades 1-6 (Primary)	34.07	26.06	24.26	14.09
Grades 7-9 (Preparatory)	21.04	10.10	7.40	6.06
Grades 10-12 + (Secondary +)	17.98	47.78	47.51	23.51

Source: Ministry of National Economy, Population Housing and Establishments Census 2003

The adolescent survey showed some concerns regarding **birth spacing**. The National Health Survey reinforced this concern since the youngest group of women had the lowest mean birth interval (22.0 months) compared to the group as a whole (29.8 months). Clearly, however, the median age at first birth is higher in this younger legion than for all married women, probably due to the increase in the median age of marriage. The significant role of education on fertility is most plainly seen in the linear relationship between education and mean number of children, so that those with secondary education or more have the fewest number of children in all age groups (see Table 2.10).

The survey had a section on the **empowerment of women**, which asked married women if they were involved in selected household decision-making issues and if they were allowed to go to specific places alone (or with their children). Compared to older groups, married women in their teens were the least involved in household decisions and less likely to have freedom of movement. Although these empowerment indicators increased with education, these youngest groups are likely to remain comparatively less empowered even as they age, since they remain less educated as a whole (see Table 2.11). Thus, it appears that the greatest challenges they face are important decision-making, which affect their lives and those of their children.

Table 2.10: Fertility Characteristics of Young Married Women

	15-19	20-24	25-29	All women
Mean number of children ever born	0.60	1.68	3.46	5.00
Educational level				
Illiterate	0.40	2.19	4.84	7.70
Some primary	0.53	2.32	4.27	5.47
Grades 1-6 (Primary)	0.85	2.30	3.98	4.10
Grades 7-9 (Preparatory)	0.47	1.69	3.47	2.45
Grades 10-12 + (Secondary +)	0.38	0.88	2.04	2.11
Region				
Muscat	0.71	1.80	3.00	4.47
Al Batinah	0.79	1.74	3.64	5.27
Dhofar	0.35	1.81	3.63	4.75
Al Sharqiyah	0.75	1.69	3.21	5.44
Al Dakhliyah	0.55	1.42	4.17	5.14
Al Dhahira	0.33	1.42	2.78	4.59
Median number of months between last birth	**22.0**	**25.0**	**27.7**	**29.8**
Median age at first birth *	-----	**18.6**	**18.6**	**17.9**

**Not calculated since more than 50% of the women in the age group have not yet had a birth*
Source: Ministry of Health, National Health Survey 2000

Table 2.11: Ever-Married Women and the Proportion Involved in Household Decision-Making and Having Freedom-of-Movement

Decision-making	15-19	20-29	All
Food cooked	36.8	59.5	65.9
Expenditures	1.1	5.9	9.0
Children's clothes	76.8	81.3	72.2
Children's medicine	94.6	96.5	94.0
Problem solving	63.5	70.9	68.7
Birth spacing	35.1	42.5	43.7
Another baby	25.5	30.7	33.1
Visit relatives	31.6	41.5	43.7
Freedom-of-Movement			
Go shopping	42.1	47.1	56.5
Go the health centre/hospital	60.0	71.8	76
Go to children's school	38.9	49.6	56.3
Visit relatives	70.5	79.3	83.1
Visit friends	63.2	72.1	77.5

Source: Ministry of Health, National Health Survey 2000

Therefore, concerns remain high for women marrying young. Even though the minimum age of marriage is 18, risks remain, particularly in a culture where women feel the need to establish their fertility soon after marriage. A child of an adolescent mother is more likely to suffer poor nutrition and late physical and cognitive development. The risks of childbirth are twice as high for teenage girls over 15 years of age than mothers in their 20s. Of particular concern is the high rate of anaemia, which increases the risk of miscarriage, stillbirth, premature birth, and low birth weight, perinatal and maternal mortality.[47] With nearly 10% of the births taking place to women of this age group,[48] raising awareness as to these risks and providing health services in a supportive environment will assist these young adults in making informed decisions.

3. The Right to Education and Development

Development rights are inscribed in Articles 28 and 29 of the CRC, Article 31, which deals with recreation and Article 17, which addresses the media. Of paramount importance is the principle of non-discrimination, cited in Article 2 of the CRC.

The concept of development is holistic, which is underlined by the complementary nature of Articles 28 and 29. The former, which is supported by the 1990 Jomtien Declaration on basic education and is often referred to as 'Education for All',[49] emphasises the need to provide schools and to make them free and accessible to all children without discrimination. It lays down a number of provisions for different types of educational services, plus for topics such as school discipline. However, of the implementation of children's rights to education cannot be gauged, only in terms of numbers of schools, teachers and pupils, for the meaning of education is broader than 'schooling'; it refers to the lifelong development of the potential of every human being. In Article 29, therefore, the content and objectives of education are established within the context of the overall human rights agenda, based on respect for dignity and freedom.

Article 28: Free and compulsory education services
States Parties recognise the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

[47] UNICEF, Adolescence, A time that Matters 2002
[48] Ministry of Health, National Health Survey 2000
[49] *World Declaration on Education for All*, World Conference on Education for All, 5-9 March 1990, Jomtien, Thailand

a) Make primary education compulsory and available free to all
b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take appropriate measures such as the introduction of free education and offering financial assistance in case of need
c) Make higher education accessible to all on the basis of capacity by every appropriate means
d) Make educational and vocational information and guidance available and accessible to all children
e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates

From Article 29: The aim of education
States Parties agree that the education of the child shall be directed to:

a) The development of the child's personality, talents and mental and physical abilities to their fullest potential
b) The development of respect for human rights and fundamental freedoms and for the principles enshrined in the Charter of the United Nations
c) The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate and for civilizations different from his or her own
d) The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin
e) The development of respect for the natural environment

3.1 Indicators of Children Abilities

3.1.1 Early Childhood Development and Pre-School Provision

The provision of pre-school facilities needs to be expanded. There is no government provision of free pre-school education, which remains the responsibility of the private, profit making and voluntary sectors. Nevertheless, the Ministry of Education has maintained a keen interest in the expansion and quality improvement of pre-school education. The government has encouraged the private sector to establish nurseries and kindergartens. The Ministry of Education, with UNICEF support, has designed and introduced a curriculum for pre-school education, and undertaken teacher training.

Kindergartens continue the education from the post-nursery level until primary level at the age of six years. During the period 1995/96–2003/04, this was the fastest growing sector of the education system achieving an average annual rate of growth of 6.7% as Table 3.1 suggests. However, these facilities are insufficient encompassing less than 10% of the population in this age group (4-5 years).

Table 3.1: Growth of Kindergarten Education, 1995/96–2004/05

Year	Kindergartens	Total pupils	Teachers	Pupil/teacher ratio
1995/96	81	5,265	268	19.7
2001/02	131	7214	219	33
2003/04	129	7402	345	21.4
2004/05	143	8433	429	19.7

Source: Education for All, 2003-2015, 5th Draft, Ministry of Education
Educational Statistical Year Book 2003-2004, 2004-2005, Ministry of Education

Nurseries accept children from 3 months to 3.5 years. The overwhelming majority of these facilities are located in the Muscat area, with 28 out of the national 33 in 2003/04.[50] The total number of children enrolled in these nurseries in 2003/04 was 1400. The supervision of these nurseries is the responsibility of the Ministry of Social Development.

There are a number of private entities that provide these services for profit and government units that provide these services for their employees. Among these are 22 childhood Care Homes, which fall under the responsibility of the Rural Development Centres of the Ministry of Social Development. The total number of children enrolled in these Homes reached 2256 in 2004 with girls representing approximately 48% of the total. Child Corners is another form of these facilities where their number in 2001 totalled 55, of which 45 are run by Oman Woman's Associations and 10 affiliated to Women Rehabilitation Centres. The total number of children enrolled in these Child Corners in 2004 reached 45474, with girls representing almost 50%.

Government units that provide preschool facilities for the children of their employees include the Royal Oman Police and the Royal Navy of Oman.

The last forms of pre-school facilities are the Oman Recital Schools, which are supervised by the Ministry of Awqaf and the Islamic Affairs and spread in all governorates and regions of the sultanate. The total number of children enrolled in these schools in 2001 reached close to 14000, with girls representing 54.4% of the total.

However, all pre-school facilities suffer from a number of shortages. The most prominent of these are the poor qualification of teachers working in them and the lack of basic requirements, which are prerequisite for their proper and efficient operation. Moreover, research is required to ascertain whether this imbalance is the consequence of demand or other factors.

3.1.2 Schooling in Oman

The Basic Statute of the state, issued in November 1996, by Royal Decree No101/96, stipulates the same spirit as the relevant CRC articles. The statute places great importance on education in its broadest sense. It specifically embodies the following paragraphs in article 13:[51]

- Education is a cornerstone for the progress of society, which the state fosters and endeavours to spread and make accessible to all.

- Education aims to raise and develop the general cultural standard, promote scientific thought, kindle the spirit of research, respond to the requirements of economic and social plans and build a generation that is physically and morally strong, that takes pride in its nation and heritage and preserves its achievements.

School education in Oman consists of 12 years of full-time study. Primary education begins at age 6 and lasts for 6 years, followed by 3 years of preparatory schooling. Those who pass the intermediate examinations may continue for a further 3 years of secondary schooling. At this level there is a choice offered between the humanities (*adabi*) and science (*'ilmi*) streams.

The education system in Oman has undergone a number of changes in recent years. What was initially a curriculum run as a 'General Education' (GE) system, has now been replaced with the new 'Basic Education' (BE) system. Although, the GE system can still be found in many schools throughout the Sultanate, the new curriculum and system, BE, is more commonly utilised. The BE system is constructed as follows: Cycle 1 (including grades 1–4), Cycle 2 (including grades 5–10), and grades 11–12 (G11–12) as their own entity. Other reforms include the introduction of co-education in Grades

[50] Education For All, 2003-2005, 5th Draft, Ministry of Education, Sultanate of Oman
[51] Basic Statue of the State, issued in 1996

1–4 of the basic education, extension of the school day, introduction of English Language from Grade 1, instead of Grade 4, increased hours for mathematics and science, and the introduction of information technology as part of the basic education curriculum from Grade 1. Further reforms include, equipping schools with learning resource centres, enhanced laboratory work, revision of the examination system and upgrading of teacher training to a graduate profession at university level, along with enhancement in service training.

NOTE: Although all these changes are being introduced into the educational system of Oman, it has not been entirely implemented and so results are still presented in their grades 1–6, grades 7–9, and grades 10–12 formats.

Great strides have been made in the provision of educational facilities, with the aim of enabling all Omani children to enjoy free grades 1-6 (primary), grades 7-9 (preparatory) and grades 10-12 (secondary education). To achieve this, the government has gradually increased its investment in the educational sector. The percentage of total civil ministries expenditure devoted to education has risen from 21.6% to 26.6% from 1995 to 2004[52]. Table 3.2 shows the development of the education system in terms of numbers of pupils by gender and total pupil numbers since the 1995 Situation Analysis.

Table 3.2: Enrolment by Gender at General Education Level, 1994/95-2004/05

Level	1994/95			2004/05		
	Female	Male	Total	Female	Male	Total
Basic Education	-	-	-	85,618	89,302	174,920
Grades 1-6	141,669	151,973	293,642	62,878	65,206	128,084
Grades 7-9	53,393	63,100	116,493	65,349	75,040	140,389
Grades 10-12	31,201	28,513	59,714	63,555	65,916	129,471
Total	**226,263**	**243,586**	**469,849**	**277,400**	**295,464**	**572,864**

Source: Ministry of Education, Educational Statistical Yearbook 2004l05
Ministry of Education, Educational Statistics in the Sultanate 1970 - 2001

Table 3.2 shows that the total number of students enrolled in general education increased by 21.9% during the period 1994/95–2004/05 with the percentage of females representing 48.4% in 2004/05 compared to 48.2% in 1994/95. The percentage of females by level of education in 2004/05 was 48.9% at basic education, 49.1% in grades 1-6, 46.5% in grades 7-9 and 49.1% at G10-12 levels.

One issue of continuing concern is the lack of sufficient school buildings, which has necessitated a double shift system. The Ministry of Education has made the elimination of the afternoon shift a priority; thus during the period 1994/95–2003/04 it has added an additional 1900 classrooms to existing buildings and constructed 201 new school buildings. In 2004/05, 157 schools still using a double-shift system, representing 15% of all schools, compared to 37% of schools that had double shifts in the mid 1990s.[53]

In addition to government schooling, 143 private schools operate in Oman under the supervision of the Ministry of Education. These schools, which include kindergartens, are responsible for the education of 25,472 pupils under the supervision of 2,040 teachers. The pupil teacher ratio in government schools is 17:1, whereas in the private sector the average is 12:1[54].

[52] Statistical Year Book, different issues, Ministry of National Economy
[53] The Ministry of Education and UNICEF, *EFA Assessment Report, Year 2000, Muscat, p.* 122; Ministry of Education statistics for 1999,
[54] Ministry of National Economy, *Statistical Yearbook, 2005,* Ministry of National Economy, Sultanate of Oman

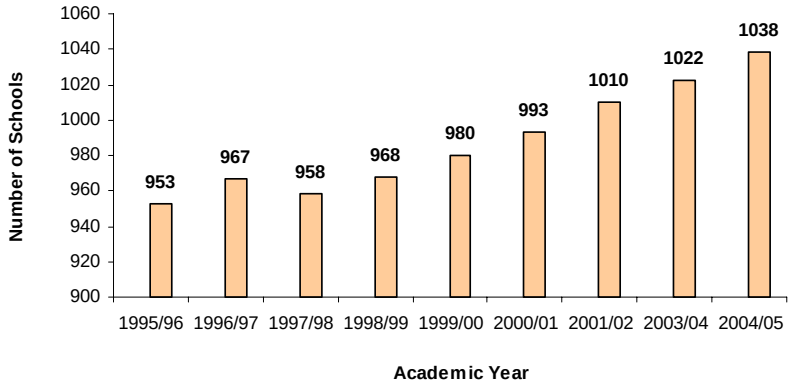

Figure 3.1: Total Number of Schools, 1995/96–2004/05

3.1.3 Net Enrolment Ratios

The net enrolment ratio (NER) is widely used as an indicator of the status of accessibility to education. The NERs at the 3 educational levels in Oman for the school years 1995/96 and 2003/04 showed remarkable improvement since the Situation Analysis Report of 1995. From 1995/96 to 2003/04, the NER increased from 84.6% to 89.1% at the grades 1-6 level, from 50.4% to 69.9% at grades 7-9, and from 36.1% to 58% for G10–12 levels respectively. Therefore, findings suggest that 10.9%, 30.4%, and 42% of children at grades 1-6, 7-9 and 10-12 levels, were not enrolled, as of the 2003/04 academic year. However, these rates do not take into account pupils enrolled in schools other than those of the Ministry of Education, the Royal Court, and Omani National Guards. Despite these improvements over the past few years, efforts are still needed to enrol more children at all levels of education, particularly at the grades 7-9 and 10-12 levels.

Table 3.3 shows that the NER of girls is higher than that of boys at both grades 7-9 and 10-12 levels, during this 8–year period, with the exception of the year 1995/96, where boys had a slightly higher ratio than girls at the grades 7-9 level.

Table 3.3: Net Enrolment Rates by Educational Level, 1995/96-1998/99

Level	1995/96			1996/97			1997/98			1998/99		
	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total
Primary* (grades 1-6)	83	85	84.1	83	85	84.4	87.1	89.1	88.1	87.5	89.4	88.5
Preparatory (grades 7-9)	53.1	53.6	53.3	57.8	56	56.9	66.2	62.5	64.3	69.5	66.4	68.3
Secondary (grades 10-12)	39.7	32.5	36.1	40.0	34	37	44.1	37.3	40.6	48.0	39.4	43.6

**includes basic education as from 1998/99. Source: MoE Statistical Year Books 1995-1999*

Table 3.3: Net Enrolment Rates by Educational Level, 2000/01-2004/05

Level	2000/01			2001/2002			2002/2003			2003/2004			2004/2005		
	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total
Cycle 1 (grades 1-6)	89.2	90.2	89.7	91.2	91.6	91.4	90.1	91.1	90.6	89.2	89.0	89.1	89.8	89.7	89.8
Cycle 2 (grades 7-9)	71.0	69.1	70.0	70.9	69.4	70.1	72.4	71.1	71.8	70.1	69.2	69.6	73.5	72.4	72.9
G10-12	57.7	46.5	52.0	61.8	51.8	56.8	65.2	54.9	60.0	62.5	53.7	58.0	62	53.5	57.7

Source: MoE Statistical Year Books 2000-2004

This development in enrolment is a clear reflection of the governments' commitment to providing general education in all regions of the country, coupled with the growing awareness of the importance of education by Omani families. However, this positive development will not negate the importance of enacting legislation that makes basic education compulsory.

3.1.4 Education Quality

3.1.4.1 Class Size and Pupil/Teacher Ratios

The average class size at the general education level dropped slightly in 2004/05 to reach 30 pupils as compared to 33 pupils in 1997/98. As can be seen from Table 3.4, class size dropped from 34 pupils in 1997/98 to 30 in 2004/05 at the grades (1-6) level, decreased from 32 to 31 at the grades (7-9) level, and decreased by 1 to 29 at the grades (10-12) level (see Table 3.4).

Table 3.4: Average Class Size, 1997/98–2004/05

Level	1997/98	1998/99	1999/00	2000/01	2001/02	2003/04	2004/05
Grades (1-6)	34	34	34	34	33	31	30
Grades (7-9)	32	32	32	33	33	32	31
Grades (10-12)	30	31	31	31	31	29	29
Average of the three levels	33	33	33	32	32	30	30

**includes basic education as from 1998/99*
Source: Statistical Year Book, 35th Issue, Academic Year2004/05, Ministry of Education

There were marked differences in class sizes among governorates and regions in 2004/05. Class size at the grades 1-6 level exceeded the national average in Muscat Governorate (34), Al Batinah North (34), Al Batinah South (32), Al Dakhliyah (32) and Al-Sharqiya North (31), while it remained below the national average for the rest of the regions with the lowest class size in Al Wusta region (24) and Dhofar Governorate (16). The class size at the grades 7-9 level was above the national average in Muscat Governorate (35), Al Batinah North (35), Al Batinah South (33,) Al Dakhliyah and.Al-Dhahirah North (32). These same regions had a class size above the national average at the grades 10-12 school level with Al Wusta again having the lowest class size.

The Pupil/Teacher ratio for the three education levels combined declined during the 1997/98–2004/05 period, from 22 to 17 respectively. The biggest drop in this ratio occurred at the grades 1-6 level as it came down from 27 to 24. The ratio at the grades 7-9 and 10-12 levels was reasonable at 25 and 19 respectively in 2004/05 though slightly higher than their levels in 1997/98 as shown in Table 3.5.

Table 3.5: Average Pupils/ Teacher Ratio throughout the Period 1997/98–2004/05

Level	1997/98	2000/01	2001/02	2002/03	2003/04	2004/05
Basic Education*	-	28	28	29	28	28
Grades (1-6)	27	27	29	27	26	24
Grades (7-9)	19	18	21	25	25	25
Grades (10-12)	16	17	19	20	20	19
Average of the three levels	22	21	20	19	18	17

**includes basic education as from 1998/99*
Source: Statistical Year Book, 35th Issue, Academic Year 2004/05, Ministry of Education

Regionally the pupil/teacher ratios vary considerably for all educational levels in 2004/05 except for the basic education level where it ranged between 4 in Al-Wusta and 12 in Muscat and Al Sharqiyah North. The regional variation was more evident at the grades (1-6), (7-9) and (10–12) levels of the general education. Musandam, for example, had the highest ratio of 32:1, 87:1 and 57:1,

pupil/teacher, at all three levels while Dhofar had the lowest ratios at 15:1 for the Grades (1-6) and (10-12). Al Wusta had the lowest ratio of 14:1 at the grades (7-9) level.

3.1.4.2 Dropouts, Failure and Repetition

School dropouts and repetition rates are utilised to determine the quality and internal efficiency of the education system. The most recent figure for dropout rates are from academic year 2003/04, which showed rates at approximately 0.4% for girls and 0.3% for boys, down from 1.4% and 1.1% in 1996/97 respectively. Cycle 2 rates also declined for both girls and boys in 2003/04, to less than half their 1996/97 figures. Generally, drop out rates were found to be lower for girls than boys, with the only exception noted at the grades 1-6 school level. Rates for grades 7-9 school level boys and girls, in the academic year 2003/04, also decreased considerably, compared to 1996/97, and were lower for girls (see Table 3.6).

Table 3.6: Drop outs by Gender, 1996/97–2003/04

Level	1996/97		2003/04	
	Girls	Boys	Girls	Boys
Grades (1-6)	1.4	1.1	0.4	0.3
Grades (7-9)	4.4	8.0	1.7	3.3
Grades (10-12)	7.1	11.1	4.2	7.8

Source: Education for all (2003-2015), Ministry of Education, 2003

A major obstacle faced by the government is the lack of accurate, in-depth analyses of these issues, hence making it very challenging to introduce efficient remedial measures. However, reasons cited by some professionals, working in the field of education, for the high dropout and failure rates include, poor scholastic performance and lack of economic means.

Table 3.7: Repetition rates by Gender, 1997/96–2003/04

Level	1996/97		2003/04	
	Girls	Boys	Girls	Boys
Grades (1-6)	7.2	10.9	0.6	0.7
Grades (7-9)	8.3	19.0	4.0	7.8
Grades (10-12)	6.8	14.5	4.8	10.2

Source: Education for All (2003-2015), Ministry of Education, 2003
Annual Education Statistics, Ministry of Education, 2004

Repetition, as with dropouts, result in an inevitable drain on resources. Table 3.7 shows the repetition rates at the three levels of general education for the period 1996/97–2003/04. Although the rates had come down considerably for both, girls and boys, from 7.2% and 10.9% to 0.6% and 0.7% in 1996/97 and 2003/04 respectively in grades 1-6. At the grades 7-9 level, these figures were recorded as 8.3% for girls and 19.0% for boys in 1996/97 to 4% for girls and 7.8% for boys in 2003/04. They are still very high and warrant the concern and attention of the government. The percentage of male repetition was significantly higher than female at all levels. In the absence of detailed research, it is hard to know why some pupils, especially boys, perform poorly and must repeat a year or more at each level.

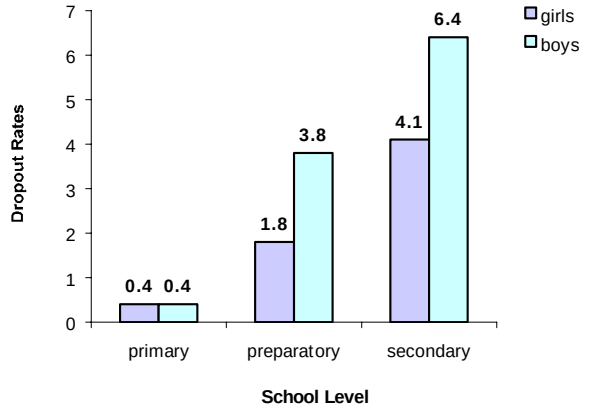

Figure 3.2: Dropouts by Gender and Level of Education 2003/2004
Source: Education for All (2003-2015), Fifth Draft, Ministry of Education 2003, February

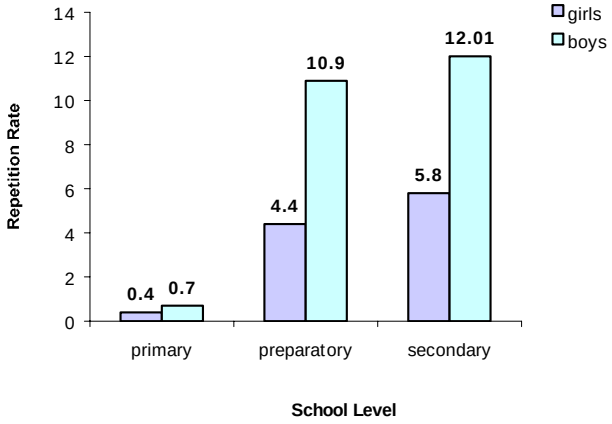

Figure 3.3: Repetition rate by gender and level of education 2003/2004
Source: Education for All (2003-2015), Fifth Draft, Ministry of Education

Perhaps the most important goal remaining for education in Oman is the achievement of universal educational opportunities, which entails reaching those boys and girls who are not enrolled, who drop out, or whose progress thorough the school system is slowed by having to repeat grades. In addition to the above tasks, Oman now faces the more difficult and expensive challenge of providing for hard to reach and possibly resistant groups of children, such as those living in remote areas and the disabled. While no country in the world fully achieves, 100% enrolment, Oman is committed to the twin goals of raising further the enrolment rates whilst working to enhance the quality and relevance of education.

3.1.4.3 Learning Achievements

A study on learning achievements in mathematics and science for grade 8 students, conducted on a sample of 32 schools and 910 students[55], found that the average student answered 29.3% of mathematics test questions correctly; whilst for science this number was 51.2%. The investigation determined that there were no significant differences in achievements between genders. However, clear variations were seen in mathematics, according to area, with urban students fairing better than their rural peers.

These findings were supported by a joint project conducted by the Ministry of Education (MoE) and UNICEF in 1999. The study covered four topics for grades 4, 6 and 9, finding that the average percentage of accurate answers for grade 4 girls were 60.3%, 59.9%, 49.4% and 50.4% in Arabic Language, Mathematics, Science and Life Skills respectively. Boys scored lower in the four subjects and both girls and boys in urban areas scored higher than their rural counterparts. The overall performance was low for both girls and boys as shown in Table 3.8.

Table 3.8: Average Percentage of Correct Answers for Grade 4 Pupils by Subject, Gender and Place of Residence (1997)

	Arabic language	Mathematics	Science	Life skills
Gender				
Girls	60.3	59.9	49.9	50.4
Boys	54.3	53.7	47.6	46.3
Place of residence				
Urban	59.6	55.4	50.9	49.2
Rural	55.8	53.6	47.0	47.8
Total	57.7	54.5	48.9	48.5

Source: Education for All (2003-2015), Fifth Draft, Ministry of Education, 2003

The performance of grade 6 pupils, both girls and boys, was poor, particularly in mathematics, regardless of region. However, girls did score higher than boys, in the remaining subjects, see Table 3.9 for full details.

Table 3.9: Average Percentage of Correct Answers for Grade 6 Pupils by Subject, Gender and Place of Residence (1999)

	Arabic language	Mathematics	Science	Life skills
Gender				
Girls	59.8	28.6	49.3	58.5
Boys	53.8	28.4	48.6	56.6
Place of residence				
Urban	57.4	28.4	49.4	58.4
Rural	55.6	28.9	46.7	56.1

Source: Education for All (2003-2015), Fifth Draft, Ministry of Education, 2003

Results for grade 9 pupils revealed a similar, poor trend, with girls, once again, out performing boys in all subjects, except life skills. Urban boys and girls scored higher in all four subjects, see Table 3.10.

[55] Ahlawat, K and Victor Billeh, "Achievement of second preparatory students in the Sultanate of Oman on International Tests of Science and Mathematics, July 1994.

Table 3.10: Percentage of Correct Answers for Grade 9 Pupils by Subject, Gender and Place of Residence (1999)

	Arabic language	Mathematics	Science	Life skills
Gender				
Girls	63.7	46.7	60.4	47.3
Boys	55.8	45.1	54.6	48.7
Place of residence				
Urban	59.4	47.1	58.0	48.5
Rural	58.8	43.5	56.1	47.2

Source: Education for All (2003-2015), Fifth Draft, Ministry of Education, 2003

Efforts are underway to improve the curriculum and teaching materials, and to alter the nature of classroom instruction itself. The goal is to adopt a more child-centred approach to learning. Rote learning is to be replaced by an emphasis on problem solving and the encouragement of intellectual skills. Under the current Government/UNICEF Programme of Cooperation (2004-2006), a national workshop on *The Omani Developed Curricula and Educational Innovations Related to Teaching and Learning of Mathematics, Science and Life Skills* was conducted in 1997 for Omani policy-makers, facilitated by five international education experts. The recommendations were widely disseminated among government staff, providing a guide for further policy consideration in national curriculum development.

An inter-sectoral committee on life skills is now in place, created by the MoE, to develop an appropriate curriculum. Several MoE officials were trained in Educational Theory and the Practice of Educational Planning at the National Centre for Human Resource Development in Jordan. Following this, a number of in-country workshops were performed by the MoE in 1998 and 1999 to equip trainers, senior teachers, headmistresses, and deputy headmistresses with the necessary skills to implement educational reform. Additionally, teachers are being trained in school administration and educational guidance at the diploma level at Sultan Qaboos University. Another important activity was decentralising training on Basic Education Reform, particularly for female teachers to the regional level.

3.1.5 Illiteracy

Efforts to eradicate adult illiteracy were initiated in 1973/4, with the help of UNESCO and the World Bank. A National Plan, prepared by the MoE, to eradicate the illiteracy of more than one hundred thousand Omanis during the 6th (2001-2005) and 7th (2006-2010) development plans has been implemented. According to MoE statistics, in 2004/05, 102 literacy centres were operating with an enrolment totalling 7641. The overwhelming majority of students were women (96%). Upon successful completion of the two-year course, adult learners may continue their studies in an adult education programme.

Illiteracy among the Omani population aged 15 years and above dropped from 41.2% in 1993 to 22% in 2003. Illiteracy amongst women was notably higher than in men, 53.9% and 29.4% in 1993 and 2003 respectively, against 28.9% and 14.6% for males over the same period. Despite the marked drop in illiteracy rates from 1993 to 2003, in comparison to the other countries of the Middle Eastern region and those at similar stages of development as the Sultanate, it is still very high. Thus, it is crucial to intensify the efforts directed towards the eradication of illiteracy, particularly among women.

Illiteracy among the young generation was considerably lower than the national average, and registered rapid decline between 1993 and 2003. Rates were at 2.5% for the 15-19 age group in 2003, down from 8.4% in 1993, and 5.6% for the 20-29 age group in 2003 compared with 32.5% in 1993, rising steadily with age. Women suffer more from illiteracy than men, attributing reasons being social

factors, whereby education of girls was less popular in the past than now, see Figure 3.4 for full details[56].

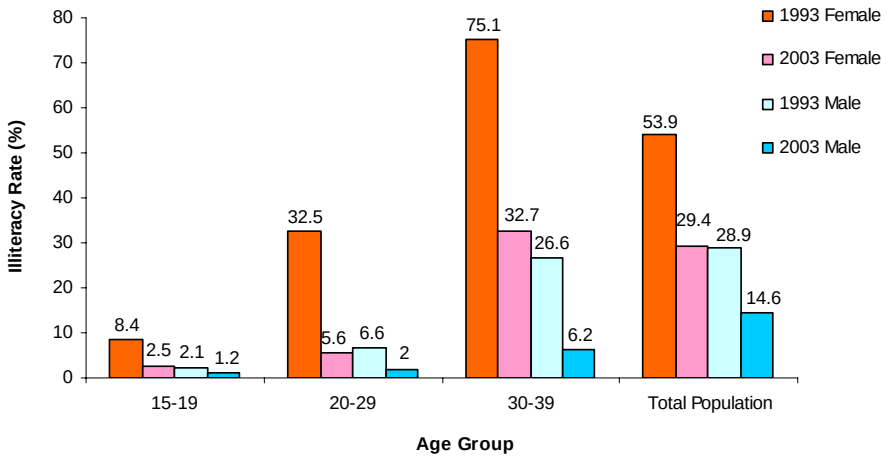

Figure 3.4: Illiteracy Rates amongst the Youthful Population by Gender

Wide discrepancies in illiteracy rates exist (in 2003), at the regional level, with only three regions enjoying lower illiteracy rates than the national average, namely, Muscat, Ad-Dhairah and Dhofar. Al Wusta region has the highest illiteracy rates of roughly 52% amongst the total population with the highest rates among its female and male population, standing at 66.2% and 40% respectively. One possible explanation for the prevalence of such high illiteracy rates is the nomadic life style of the population of this region. Women are worse off than men in all regions of the Sultanate, with Al Wusta, Musandam, Al Sharqiyah, Al Dakhliyah and Al Batinah regions having the highest illiteracy rates above national average, see Figure 3.5 and Table 3.11 for full details.

Table 3.11: Illiterate Omani Population (15 years and above) by Governorate/ Region, 2003

Governorate/Region	Female	Male	Total
Muscat	19.7	8.2	13.6
Al Batinah	31.6	16.7	24.2
Musandam	37.9	26.4	31.7
Ad Dhairah	27.5	13.3	20.4
Al-Dakhliyah	33.8	14.9	24.7
Ash Sharqiyah	36.9	20.8	29.0
Al Wusta	66.2	40.0	51.7
Dhofar	24.9	11.7	18.1
Total Population	29.4	14.6	22.0

Source: Ministry of National Economy, Population Housing & Establishments Census 2003

[56] Ministry of National Economy, Population Housing & Establishments Census 1993; Population Housing & Establishments Census 2003

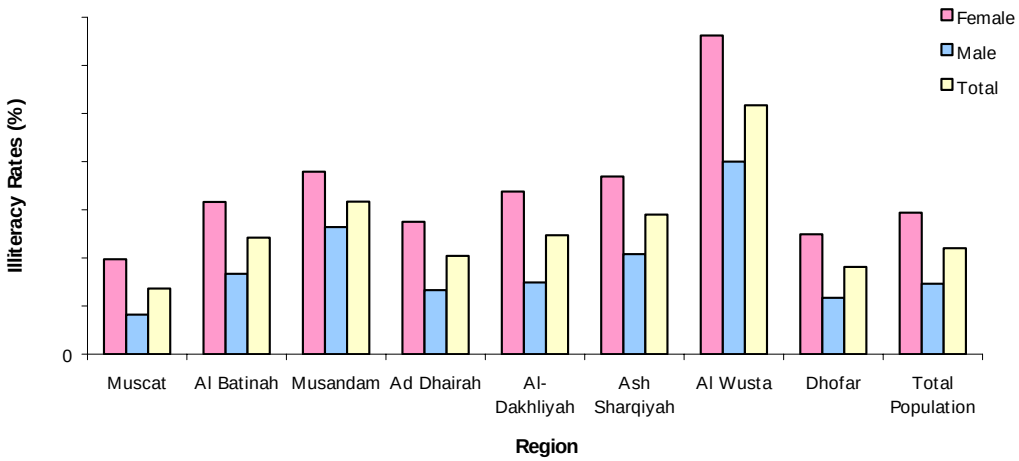

Figure 3.5: Illiteracy Rates by Region,2003

3.1.6 The Right to Participation

The Sultanate has introduced important innovations with respect to children's participation in schools. Measures have been taken to enable children at different stages of education to express their views within the school environment. The Preliminary National Report to the CRC highlights the approved education curriculum that enables students to express their views and to contribute through cultural and educational clubs in schools, according to, and with a view to enhancing, their competence.[57] They are expected to demonstrate positive behaviour, present practical projects and participate in competitions and debates. Children are expected to practice their right to expression in and outside educational institutions within the limits of religious conviction and/or socially accepted norms. Children's views are also respected in school management, at least beyond primary levels. After successfully completing the first year of secondary school, pupils are permitted freedom to choose their subject specialisation area in arts or sciences. The school gives appropriate counselling according to a student's academic abilities and achievements over the past years. Students retain the right to decide the specialisation area they wish to study, although parental influences are likely to affect this choice.

Children are given the opportunity to contribute to decision-making at the school through a number of means, including:

Class Boards: Article 35 of the Organisational Statutes of General Education Schools stipulates that students in each class, starting at grade four, shall elect four individuals to represent them in social, cultural, sports and art activities. The students elected form the 'class board'. The mandate and accountabilities conferred to the Board within the context of affecting decision-making include:

i) Supervising students morning assembly, classroom control and cleanliness
ii) Endeavouring to involve every student in at least one school co-curricular group
iii) Organising cultural and social functions for students, parents and teachers

[57] also Ministry of Social Development, 1998, *Preliminary National Report on the Convention on the Rights of the Child*, Muscat, Sultanate of Oman7.2.2

iv) Organising class trips and visits to the local community, local institutions and the officials in charge
v) Building up class libraries, organising projects to be studied and implemented by their classmates and assigning tasks to students as a group

School Activity Groups: All general education schools are obliged to form school activity groups to provide students with opportunities to acquire practical and mental skills, express their views, make appropriate decisions and shoulder the responsibilities of organizing and implementing such activities. Articles 30 to 33 of the Organisational Statutes of the General Education Schools specify the objectives, functions and limitations of these school activity groups.

With respect to expressing an opinion outside schools and accessing information pertaining to rights, Omani children have the opportunity to acquire various kinds of information and ideas through school, printed media, television and radio. Satellite channels have become an important source of information. There is no censorship of information received by children in international or local television programmes. Omani media are committed to promoting the cultural heritage and traditions of the country, but are also open to a variety of international cultures.

Further information is required regarding the implementation of children's right to have their opinion taken into account in the various decisions taken on their behalf in family life, court decisions and other arenas, as requested by the Committee on the Rights of the Child.

3.1.7 Recreation, Play and Culture

General implementation measures of Article 31 suggest the need to identify and coordinate between the responsible departments and agencies within government, such as the departments of culture and sport, education, labour, health welfare and planning, as well as to analyse strategies and budgets for ensuring that children's rights to recreation, play and culture are met. More specifically, information is required on the subject of training for, 'play workers, town and environment planners, employment inspectors, administrators of art and culture, artists, and social workers,'[58] to become more sensitive and responsive to a child's right to play.

In Oman, the Ministry of Education, its Department of Information, and the Ministry of Sport Affairs (erstwhile the General Organisation for Youth, Sports and Cultural Activities) and the Public Authority for Scouts and Guides are engaged in an ambitious, extensive range of activities at local, inter-Arab and international levels. Arts, cultural resources and sports programmes are widely available, but perhaps not under the umbrella of an integrated strategy and their access and use may be strategically monitored.

The Sultanate has involved children and youth in environmental issues. This has afforded them the opportunity to participate directly in activities that influence society. The Sultanate is one of the top ten countries worldwide in the league of national environmental conservation. This may be a solid foundation for the development of child participation in environmental planning, which has been so successfully demonstrated elsewhere over the past three decades.

Omani Media and Children

Similar considerations apply to children's involvement in the media, as active participants rather than passive recipients. Social mobilisation of children as a group entails more than single large-scale events at which children are visible. Children the world over have been involved in writing, filmmaking and publishing, introducing development of both cultural and citizenship skills.[59] Given

[58] Hodgkin, R., & Newell, P., 1998, (compilers), implementation Handbook for the convention on the Rights of the Child, Geneva, UNICEFP425
[59] Ibid, Chapter 14

the relative lack of locally produced books and magazines for children, the involvement of children themselves in producing such materials might be a logical point of call for implementation of Article 17; this could also protect children from external cultural influences and ideas, which might be harmful (Article 17e).

The Preliminary National report to the Committee on the Rights of the child draws attention to the opportunities enjoyed by Omani children for accessing various media from which they can acquire information and ideas, although the focus is often on educational rather than recreational materials.[60] In general, specially designed, locally produced media for children and adolescents is rare. This leaves the young open to influences from media produced elsewhere.

Table 3.12: Number of Hours of Radio and Television Transmission, 2004

Type of programme	Total		Type of transmission			
			Television		Radio	
	Percent	Hours	Percent	Hours	Percent	Hours
News	17.6	3,087	15.9	1,400	19.2	1,687
Development	18.8	3,303	14.7	1,288	22.9	2,015
Religious & Cultural	32.2	5,665	28.3	2,484	36.2	3,181
Children	5.6	985	9.7	854	1.5	131
Youth & Sports	3.4	593	5.3	467	1.4	126
Recreational & Art Program	20.2	3,551	23.1	2,032	17.3	1,519
Advertisements	0.2	41	0.5	41	-	-
Program & Announcement	2.0	343	2.5	218	1.4	125
Total	100.0	17,568	100.0	8,784	100.0	8,784

Source: Ministry of National Economy, Statistical Year Book 2005

Children's radio and television programmes represent a small percentage of total broadcasting. In 2004, children's programmes accounted for 5.6% of total broadcasting (9.7% on television and 1.5% radio), increased from 1995, which saw 3.8% of total broadcasting catering for children, 9.7% on television and 1.2% radio. The 1993 Census showed that 96% of households owned televisions, with 38% also owning video players. Only in Al Wusta(with 1% of population and nomadic life style) was the percentage low (3.7% of households with television).

Television ownership has increased in the past decade, whilst radio broadcasting has decreased in importance. The proportion of hours of radio broadcast of material for children decreased, from 1.19% in 1996 to 0.8% in 1998. At the same time, the proportion of television coverage directed particularly at children increased, from 9.7% in 1996 to 10.2% in 1998. Of course, children also tend to watch and listen to programmes intended for adults. No data exists revealing the quantity of time spent by children, listening to the radio and watching television, nor is there information regarding preferred programmes.

3.2 Developing Youth Potential

The distinction between children, adolescent and youth is often difficult to make because these three segments overlap. The United Nations, for instance defines children as the population in the age below 18 years whereas youth are taken as the population in the age group 15–24. Different countries also use different age groups depending on where the emphasis is placed and on the purpose of the report or study. In this chapter, however, youth population are taken as the segment in the age group 15-24 who represented 22.9% of the total Omani population in 2004. In addition, 64.9% of the population were in the working age group 15-64 years in 2004 and their number will continue to grow in the coming years. The legitimate question here is whether the education, training, job opportunities

[60] Ministry of Social Development (The erstwhile ministry of social affairs, labour and vocational training), 1998, Preliminary National Report on the Convention on the Rights of the Child, Muscat, Sultanate of Oman. Part 4.4

and needs of this segment are provided for and whether they are assuming their full role in the economic, social, cultural and recreational life of their communities.

3.2.1 Access to Education and Training

3.2.1.1 Secondary Education

The provision of secondary education for the total segment in the relevant age group has become an endeavour for all countries. It is one of the basic human rights and is a prerequisite for economic and social development. Clarification was made in the Dakar Framework and other forums, where the former stated that, "No country can be expected to develop into a modern and open economy without having a large portion of its population completing secondary school."[61]

The government of Oman has been engaged in the provision of education since its renaissance in 1970. During the first two decades of the education system in Oman, quality was abandoned in favour of quantitative development, with the number of students continuing to increase dramatically. The total number of students enrolled at secondary school level increased from 68,852 in 1995 to 129,471 in 2004. Girls represented 51% and 49% of the totals in 1995 and 2004 respectively. The gross enrolment rate at this level was 79.5% for females and males combined. It is interesting to note that at this level the gross enrolment rate for girls (79.4%) is higher than for boys (79.6%). The net enrolment rate was 57.7% for both male and female together with females having a higher net enrolment rate than males.

One of the roles of secondary education is the preparation of students for admission to higher education institutions. The absorptive capacity of these institutions is still limited with less than half who successfully completed secondary school certificates admitted to higher institutions; see Table 3.13. The problem is aggravated further by the expansion of secondary education over the past decade and the age composition of the population, which is continuously increasing as more children, under 15 years of age, pass into the next age bracket. The positive aspect here is that no gender disparity is observed.

Table 3.13: Venues Open to Secondary School Graduates

Category	2000			2001			2004		
	Girls	Boys	Total	Girls	Boys	Total	Girls	Boys	Total
Total passing secondary certificate	19298	13661	32959	20412	14632	35044	25822	23152	48974
Total admitted to higher and vocational education and as percentage	6330 (37.5%)	5851 (46.3%)	12181 (41.2%)	7611 (39.41%)	5685 (41.6%)	13296 (40.3%)	10438 (41.9%)	8387 (43.4%)	18825 (42.6%)
Total expected to enter the labour market	10555	6790	17345	11687	7976	19663	14474	10634	25408

Source: Ministry of National Economy, Statistical Year Book, different issues

The table above reveals that the total number of secondary school graduates who are not in higher education institutes has been increasing with time. This situation would pose problems for those youth

[61] UNESCO 2001

and for the country at large, in view of the limited job opportunities at present. (Oman is, currently, hosting more than 500 thousand expatriate workers and the mismatching between the skills required by labour market and the skills of job seekers prevents Omanis from benefiting these opportunities)

3.2.1.2 Higher Education

The total number of students enrolled in higher education in the academic year 2004/05 reached 60,568; see Table 3.14. This figure was more than triple the 1995 rate of 6.4% with the number of girls exceeding that of boys by 6%.

Table 3.14: Enrolment in Higher Education, 2004/05

Institutions	Girls	Boys	Total	Girls as % of the total
Sultan Qaboos University*	6,439	6,416	12,855	50.1
Colleges of education	4,588	3,391	7,979	57.5
College of Sharia & Law	162	552	714	22.7
Technical Colleges	4,051	5,564	9,615	42.1
Other government collages	2,203	684	2,887	76.3
Private Colleges	7,262	6,437	13,699	53.0
University & Colleges Abroad	8,097	4,722	12,819	63.2
Grants at domestic institutions				
Total	32,802	27,766	60,568	**54.2**

** includes undergraduates, masters, diploma and GCC students.*
Source: Ministry of National Economy, Statistical Year Book, 2005

The quality of higher education is of great concern to the government. Government institutions such as Sultan Qaboos University, teacher training colleges and technical colleges pose no greater problem if targeted by reform. The distribution of students of Sultan Qaboos University (Table 3.15) by specialisation as well as students studying abroad (Table 3.16) shows a clear tendency for social sciences. Reversal of the situation is required in lieu of problems that may arise in the future, particularly concerning employability of these graduates. However, private colleges and institutes are the ones that need more attention and supervision.

Table 3.15: Omani Students Studying for Bachelor Degrees in Sultan Qaboos University, by Specialization in 2004/05

Specialization	Girls	Boys	Total	Total as a percentage	Girls as % of the total
Arts & Social Science	1449	762	2211	18.8	66
Education	1694	1091	2785	23.6	61
Agriculture & Marine Science	422	550	972	8.2	43
Medicine & Health Science	433	440	873	7.4	50
Science	847	713	1560	13.2	54
Engineering	330	1364	1694	14.4	19
Commerce & Economics	722	971	1693	14.4	43
Total	5897	5891	11788	100	50

Source: Ministry of National Economy, Statistical Year Book, 2005

- Approximately 56.8% of all students enrolled in Sultan Qaboos University (SQU) are in three core specialisations, Education (23.6%), Commerce and Economics (14.4%) and Arts and Social Sciences (18.8%)

- From graduate statistics, 2004/05, it is clear that girls accounted for over half (55%) of all SQU graduates. The largest numbers of female graduates were from the Faculty of Arts & Social Sciences (66%), and are noticeably under-represented in the Faculty of Engineering (19%)

- Graduates of Education, and Commerce and Economics may not face difficulties in finding jobs in the near future. Graduates of Arts and Social Sciences, and to a lesser extent those from the college of Agriculture, may well find they come up against many obstacles, see Table 3.16.

Table 3.16: Omani Students Studying Abroad by Specialization in 2004/05

Specialization	Girls	Boys	Total	Total as a percentage	Girls as % of the total
Medicine & Health Sciences	476	327	803	5.63	59.28
Pharmacology	123	52	175	1.23	70.29
Engineering	91	476	567	3.97	16.05
Science	216	203	419	2.94	51.55
Agriculture	21	59	80	0.56	26.25
Education	4,789	975	5,764	40.41	83.08
Computer	113	426	539	3.78	20.96
Arts	1,456	771	2,227	15.61	65.38
Law	47	512	559	3.92	8.41
Commerce & Administrative Sciences	283	1,035	1,318	9.24	21.47
Economics & Political Science & Secretarial	13	93	106	0.74	12.26
Information & Journalism	34	192	226	1.58	15.04
Languages	9	35	44	0.31	20.45
Islamic Law	606	705	1,311	9.19	46.22
Other Subjects	98	29	127	0.89	77.17
Total	8,401	5,864	14,265	100	58.9

Source: Ministry of National Economy, Statistical Year Book, 2005

- Nearly one third of Omani students studying abroad in 2004/05 were enrolled in Education (40.4%)

- The percentage of girls in total students enrolled in universities abroad exceeded 58% with their percentage in Education 83.0%, 70.3% in Pharmacology and 65.4% in Arts (see Table 3.17 for full details)

Royal Decree created a Higher Education Council in September 1998. One of the first issues to come before the council was the establishment of private universities. The government has responded positively to this initiative since private institutions are seen as a way to meet the rising demand for higher education. Three new private universities have been approved, with one already in operation.

3.2.1.3 Teacher Training

Oman has six colleges of education for training new teachers, offering university level diplomas through a four-year programme under the auspices of the Ministry of Higher Education. In 2004/05, the total number of students enrolled was 7,979 with women constituting 58% overall. Omanization of the teaching workforce is occurring at an accelerated pace, particularly at the basic and primary

levels. The proportion of Omanis employed in the Ministry of Education rose from 57.1% to 85.3% from 1995–2004 and is set to rise further as more nationals qualify from teacher training colleges. Omanization of the teaching staff at different levels of the public education system reached 84.7% at basic levels, 87.8% at primary levels, 76.3% at the preparatory level and 73.5% at the secondary level.

3.2.1.4 Technical Training

Technical and vocational training has been available in Oman for several years. The General National Vocational Qualification (GNVQ) and National Vocational Qualifications (NVQ) systems were first implemented on a trial basis in 1994/95. Five technical colleges offer courses at intermediate and advanced levels. Full courses take three years to complete. One such college, Higher Technical College in Muscat, was upgraded in 2002/03 to offer BSc after four years of study. The subjects on offer range from computing and accounting to mechanical and civil engineering. In 2004/05, the five colleges were staffed by 561 teachers responsible for 9,615 students, of whom 42% were girls.

Additionally, four vocational training centres offer basic courses of nine months duration to produce semi-skilled workers, and 9-12 month long courses for skilled workers, according to the National Vocational Training system introduced in 1996. Courses cover subjects from mechanics and construction work to carpentry and auto-repairs. In 2003/04, these four centres had a combined teaching staff of 310 and a student body of 1,951, all of who were male.[62]

3.2.2 Sports and Culture

In its efforts to develop and upgrade the potential of Omani Youth, the government established The ministry of sport affairs (The erstwhile General Organization for Youth Sports and Cultural Activities "GOYSCA"). Since its establishment, (MoSA) has undertaken the task of developing sports facilities and cultural activities through a network of sports clubs and youth complexes.

There are now 38 sports clubs spread in all regions and wilayats of the Sultanate together with six youth complexes. The total number of beneficiaries from complexes and clubs in 1997 reached 110,000 and 38,000 youth respectively. Table 3.17 shows the regional distribution of those who benefited from these facilities in 1997.

Table 3.17: Beneficiaries from Youth Complexes and Sports Clubs 1997

Governorate/ Region	Youth Complex	Sport Clubs	Total
Muscat	75,129	5,978	81,107
Al Batinah	11,500	8,500	20,000
Al-Sharqiyah	5,200	6,333	11,533
Al Dakhliyah	4,550	9,363	13,913
Al Dhairah	-	1,575	1,575
Dhofar	1,120	3,126	4,246
Musandam	13,500	2,756	16,256
Total	**110,999**	**37,631**	**148,630**

It is evident that full utilisation of these facilities has still not been realised and that more emphasis is placed on sports as opposed to cultural activities. Due to cultural norms, most of the beneficiaries are young men. Physical and cultural activities need to be promoted for this age group, particularly encouraging more women to become involved. However, barriers and constraints to youth participation need to be explored further and addressed.

Sports wise, however, the Sultanate had impressive records in both international and regional competitions. During 2001, Omani teams won 91 medals and its national under 17 football team

[62] Ibid

represented the Arab world and Asian continent as Asian champions at the under 17 World Cup finals in Trinidad and Tobago. Oman has also achieved impressive results in swimming, tennis and shooting. Internationally, its swimming team has won 21 medals, tennis 7 and shooting 19.

3.2.3 Scouts and Guides

The first organised scout pack was founded at the Saidiya School in Muscat in 1948. Scouting for girls was introduced in 1972, and the Oman girl guides celebrated their silver jubilee in 1997. The National Organisation for Scouts and Guides (NOSG) was launched in 1975. In 1983, Sultan Qaboos was named Chief Scout, in recognition of his keen interest in the scouting movement.

The movement: (in 2002)

- 647 scout leaders
- 571 guide leaders (and assistants)
- Total membership of 19,124, of those
  - 11,181 scouts
  - 7,943 guides

The year spanning 2001/02 saw the launch of a 47–strong scout band. Five scout and guide camps took place at the Sultan Qaboos scout camps near Muscat, with two summer camps held in Dhofar, attracting scouts from the United Arab Emirates.

3.2.4 The Youth and Economic Participation

An increasing number of Omani youth join the labour market annually. According to the sixth five-year development plan between 20-26,000 Omanis are expected to join the labour market per annum during the plan's period. According to the 2003 census, economic participation rates in the age group, 15-24, was 32.5%; higher for males (44%) than females (21%). Those aged 25 and above saw a higher rate of participation at around 49.3%. The expansion of education, the large number of Omanis aged 15 to 24 years enrolled in the schools, and the low female rate explains the lower economic activity of this group. It is notable, however, that although female labour market participation is lower than male, a greater percentage of females in this age group are economically active compared with those above 25 years. The latest achievement of women in the attainment of education and the large numbers graduating from secondary schools together with increasing opportunities explains this development.

Table 3.18: Omani Economic participation, 2003

	Males	Females	Total
Participation Rates:			
All population (15+)	64.7	18.7	41.8
Age group (15-24)	43.6	21.0	32.6
Age group (25+)	81.7	16.9	49.3

Source: Ministry of National Economy, Population Housing & Establishments Census 2003

Although the educational attainment of the Omani labour force is low (an average of 5.33 years estimated from 1993)[80], an obvious improvement is noted in more recent years with an increasing percentage of employed youth with secondary and college education. As Table 3.19 shows, approximately 33.8% of employed Omanis, in the 15–29 age group, have secondary education compared to 18.9% and 4.2% in the age groups 30–44 years and 45+ respectively. The rates of employed citizens with post secondary non-tertiary education were 16.6%, 12.6% and around 4% for 15–29, 30–44 and the 45+ age groups respectively.

Table 3.19: Employed Omanis by Education Level and Age, 2003

Education	Percentage in Age Group		
	15 – 29	30 – 44	45+
Intermediate and below	40.0	57.0	90.3
Secondary	33.8	18.9	4.2
Post secondary non-tertiary	9.6	11.5	1.6
University and higher	16.6	12.6	3.9
Total	100.0	100.0	100.0

Source: Ministry of National Economy, Population Housing & Establishments Census 2003

The preferred sector of employment for the majority of Omanis is the public sector. In 1996, over 80% of the employed Omanis with college or university education were working in the public sector. Higher wages and generous benefits, together with job security and social status associated with government employment are among the reasons for this preference. An abundance of expatriate workers, willing to work for lower wages than the reservation wages of Omanis at comparable levels of skills, have been important factors in the private sector decisions to hire expatriates. In addition, lack of appropriate education and skill mismatch supplied by the nationals and demanded by the private sector have been an important deterrent to hiring nationals.

With most of the private sector employment growth benefiting non-Omanis and the slowing growth in government recruitment, a growing number of young Omanis are not finding jobs. As the Minister of Manpower indicated in his speech to the Shura Council in May 2003 these rates amounted to 14% among males and 37% among females, based on 1996 Labour Survey results. The majority of job seekers were in the 15-24 age group. School leavers and dropouts of primary and intermediate levels represented a large percentage of the job seekers (60.3%), while those with secondary level education represented only 35%.

The government has expressed its concern over the rising rates of job seekers among Omani youth and is undertaking a number of measures that may contribute to their employment.

In October 2001 a symposium on "The employment of national labour," was organised that focused on several issues relating to employment of Omanis including Omanization, support of individual initiatives and self-employment, education and training professional guidance and media awareness. A major outcome of the symposium was the creation of the Sanad Fund established under the Royal directives, which aimed at augmenting the role of national labour in development activities and provision of additional opportunities for the recruitment of Omanis. Its objectives include the encouragement and support of individual initiatives and projects of self-employment, by developing plans of small-scale projects and the establishment of incubators to assist individuals willing to pursue these projects.

Sanad Program:

The program has a number of components that aim to contribute to encouragement and enhancement of individual initiatives that expand their employment opportunities:

- A Sanad Fund to finance small projects by providing support to professionals and technicians to establish their own projects through loans via the Omani Development Bank to a maximum of OR 5000, at a cost of 2% annually and to be repaid in seven years.

- A fund for financing sources and means of livelihood to social security families seeking work to provide for their dependents, under the direction and administration of Ministry of Man power.

- Sanad Incubators, established by the government, local societies and the private sector, intended to provide guidance, consultation, technical and administrative support for small projects to attain maturity.

The Youth Project Development Fund, also established by Royal directives, was formed to combat unemployment among the youth and open new avenues of opportunities for them to participate in the labour market. It supports private initiatives and small-scale establishments by contributing an amount equivalent to a maximum of 50% of a projects capital. Since this programme is still in its early developmental stages, its success has not yet been determined. However, it would be useful to review the current projects supported, to identify areas of improvement in the overall operation of the fund, the types of initiatives supported and to identify constraints to the success of these projects.

Vocational and technical training has been central in the efforts undertaken by the government to increase Omanis share of private sector jobs. Vocational training of new entrants to the labour market with secondary and intermediate levels of education is offered in government training centres and private institutes. These institutions adopt National Vocational Qualification (NVQ), where the government bears the training cost in these institutes within the approved financial resources for the Additional Programme of the Human Resources Development. In (1999/2000), the government adopted an Omani Vocational Qualification (OVQs) in the government vocational training centres to provide skilled and semi-skilled labour. It has been more than five years since the NVQs were initiated. With more than 6,000 people trained, it would be useful to evaluate the system of training and the success of individuals who completed the program. Such an evaluation would be the basis for further development and improvement of the NVQ systems in supporting youth in their transition into the labour market.

Omani Vocational Qualifications (OVQs): Aim at achieving compliance of the vocational training programs outputs with the requirement of the private sector for skilled and semi-skilled labour. They are prepared in coordination with specialists and technicians in private sector establishments. Presently, there are 28 vocational qualifications, of which 19 are at the skilled level and 9 the semi-skilled level.

National Vocational Qualification (NVQs): Provided by 38 approved private institutes, mostly located in Muscat. During the period 1996-1999, these institutes trained 6388 individuals at a cost of OR 9.4 Million.

The second symposium on "The employment of national labour", held in February 2003 in collaboration with the private sector, stressed the importance of training and the provision of financial support for the establishment of small-scale enterprises by Omanis through the Sanad Fund as a means of creating new job opportunities. Another benefit cited was, a way in which to replace expatriates, largely engaged in own-account work in commercial and service activities. Thus, during 2002 the fund financed 171 small projects in handcraft, commercial and service activities. It also provided finance and support for 426 individuals to establish grocers and work in the sale and distribution of foodstuff.

4. Civil and Protection Rights

Worldwide awareness of child neglect, exploitation, and abuse has grown, as have the associated problems. A child rights approach recognizes that some children are more vulnerable than others are to abuse, exploitation, and violation of their rights. Accordingly, the global perception of vulnerable children, used by UNICEF, has undergone revision. This chapter examines some of the issues related to child civil rights and the protection measures for the small vulnerable sub-groups, through legal, legislative, and community-based action. The CRC provides the framework for the discussion and

focuses in particular on the rights to nationality and identity (Articles 7 and 8). Further attention is focused on articles 19, 20, 23, 32 and 40, which refer to the child's right to rehabilitative care and assistance if mentally or physically disabled, protection and assistance when without families or when their families fail in their responsibilities, to be protected from economic exploitation and hazardous labour, and the upholding and respect of their civil rights by the judicial system.

4.1 Nationality and Identity

Nationality and identity, which are the focus of Articles 7 and 8 of the CRC, are fundamental to modern ideas of human rights. An Omani national, as defined by Omani Nationality Law is a person born:

i) In Oman or outside Oman to a father with Omani nationality
ii) In or out of Oman to an Omani mother, if the father is unknown, no legal proof of paternity exists, or the father has lost his Omani nationality
iii) In Oman, with parental identity unknown
iv) In Oman to a father born in Oman who has lost his Omani nationality[63]

Article 7:

1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.
2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless.

Article 8:

1. States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference. Where a child is deprived of some or all of the elements of his or her identity, States parties shall provide appropriate assistance and protection, with a view to speedily re-establishing his or her identity.

Thus in the Sultanate even abandoned and orphaned children are assured of their right to nationality. UNICEF, as a necessity in securing child rights, has recognized birth registration, 'A birth certificate is a ticket to citizenship. Without one, an individual does not exist and therefore lacks access to the privileges and protections of a nation'.[64] A Royal Decree in 1999 brought about a system of registration for births and deaths. Through Royal Decree 66/99, births must be reported within two weeks and a civil card registration and number are provided seven days after birth. After the age of 15, Omanis receive an identity card and children under this age can be provided with a card with parental consent. The arrangements for abandoned children also require that the Ministry of Social Development provides them with a name. The Sultanate's first report to the Committee on the Rights of the Child also highlights the awareness of the importance of birth (and death) registration for developing, 'A proper demographic base on which effective strategies can be built'.[65]

[63] Ministry of Social Development, *Preliminary National Report on the Convention on the Rights of the Child*, Muscat, Sultanate of Oman, Part 4, paragraphs 4.1 to 4.2
[64] UNICEF Executive Director, Carol Bellamy, in *The progress of nations*, 1998, p. 1
[65] Quotation from Hodgkin, R., & Newell, P., 1998, *Implementation handbook for the Convention on the Rights of the Child*, Geneva, UNICEFP99; see also Ministry of Social Affairs, Labour and Vocational Training, 1998, *Preliminary National Report on the Convention on the Rights of the Child*, Muscat, Sultanate of Oman

4.2 Juvenile Justice

Article 12 is one of the general principles identified by the CRC, which has requested data concerning a number of environments in which children's opinions may be ascertained, such as child protection, health services and institutions, community decision-making and the juvenile justice system.[66] High priority is given to juvenile justice by the Committee on the Rights of the Child as can be seen in Article 40. Other international instruments operate in the field of juvenile justice.[67] Arab League concerns for juvenile justice were an important consideration in drawing up the Charter on the Rights of the Arab Child in 1983 in addition to subsequent conventions and guidelines on youth and children. These include proposals for social monitoring services attached to juvenile courts and the requirement that a parent or guardian should be present when a juvenile is interrogated.

In conformity with the provisions of Article 40 of the CRC, Omani children are subject to a Juvenile Justice System and have the right to be subjected to judicial procedures consistent with their age and special position in society. Under the provisions of Oman Penal Law issued by Royal Decree No. 71/74, persons less than 18 years of age must be treated in a manner appropriate to their age, which preserves their dignity and encourages their sense of belonging to society. The Omani philosophy of juvenile justice is one of rehabilitation rather than retribution. Priority is given to reforming juveniles and equipping them with the necessary tools to play a constructive role in society.

The system provides for minimum ages for civil and criminal accountability and for testifying in Civil and Criminal Courts. The age of criminal responsibility is currently 9 years; however, no sentence of imprisonment may be imposed before the age of 13 years. Specific ages define the type of penalty a judge may impose. Between 13 and 15 years of age, when found guilty of a crime that would be punished by death or life imprisonment if committed by an adult, a juvenile will receive a sentence of between 3 and 5 years. For lesser offences, imprisonment of between 1 and 3 years are imposed. For minor misdemeanours, the period of imprisonment will last from 10 days to 6 months. Juveniles between 15 and 18 years who are found guilty of a crime for which an adult would receive a death or life sentence are liable to a period in prison of between 5 and 10 years, for less serious crimes from 3 to 7 years and between 10 days and 12 months for a misdemeanour.

[66] Hodgkin, R., & Newell, P., 1998, *Implementation handbook for the Convention on the Rights of the Child*, Geneva, UNICEF, pp. 166-7

[67] These include the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules) 1985, The United Nations Rules for the Protection of Juveniles Deprived of Their Liberty, 1990, and The United Nations Guidelines for the Prevention of Juvenile Delinquency (The Riyadh Guidelines) 1990

Article 40:

1. States Parties recognize the right of every child alleged as, accused of, or recognized as having infringed the penal law, to be treated in a manner consistent with the promotion of the child's sense of dignity and worth, which reinforces the child's respect for the human rights and fundamental freedoms of others. There must also be consideration of the child's age and the desirability of promoting the child's re-integration and the child is assuming a constructive role in society.
2. To this end, and having regard to the relevant provisions of international instruments, States Parties shall, in particular, ensure that:
   a. No child shall be alleged as, be accused of, or recognized as having infringed the penal law by reason of acts or omissions, which were not prohibited by national or international law at the time they were committed;
   b. Every child alleged as or accused of having infringed the penal law has at least the following guarantees:
      i. To be presumed innocent until proven guilty according to law
      ii. To be informed promptly and directly of the charges against him or her, and if appropriate through his or her parents or legal guardian, and to have legal or other appropriate assistance in the preparation and presentation of his or her defence
      iii. To have the matter determined without delay by a competent, independent and impartial authority of judicial body in a fair hearing according to law, in the presence of legal or other appropriate assistance, and unless it is considered not to be in the best interest of the child, in particular, taking into account his or her age or situation, his or her parents or legal guardians
      iv. Not to be compelled to give testimony or to confess guilt; to examine or have examination of witnesses on his or her behalf under conditions of equality
      v. If considered to have infringed the penal law, to have this decision and any measures imposed in consequence thereof reviewed by a higher competent, independent and impartial authority or judicial body according to law
      vi. To have the free assistance of an interpreter if the child cannot understand or speak the language used
      vii. To have his or her privacy fully respected at all stages of the proceedings
3. States Parties shall seek to promote the establishment of laws, procedures, authorities and institutions specifically applicable to children alleged as, accused of, or recognized as having infringed the penal law, and in particular:
   a. the establishment of a minimum age, below which children shall be presumed not to have the capacity to infringe the penal law
   b. whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected

A variety of dispositions, such as care, guidance and supervision orders, counselling, probation, foster care, education and vocational training programs and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate, to both their circumstances and the offence.

When minors are taken into custody, an inquiry into their character, social environment and any previous criminal activities is conducted prior to trial. This inquiry is compulsory when the offence committed is a felony. The court then assigns a judge who is competent in juvenile affairs to investigate the alleged offence and its immediate background. At this point, the judge determines whether the minor will receive a custodial sentence. A judge may reprimand minors appearing before him and then place them in the custody of their guardian. The guardian is required to sign an undertaking ensuring responsibility for proper care of the child and to prevent further offences taking place within the period specified in the judgement. If guardians do not comply with these undertakings, they are subject to the same penalties as those guilty of child neglect.

The Prisons Regulation System No 28/94 provides in S.21/7 that 'prisoners under 18 years shall be isolated from other prisoners in their living quarters, bathrooms and during leisure time exercises'. In addition, prisoners may, under appropriate conditions, meet their families and friends 'of sound repute' twice a month, provided the visitors do not exceed six in number in each visit and that the

duration of the visit is no longer than half an hour, during working hours. In sections on children's educational and medical services the Prisons Regulation System states cultural, educational and sports activities during imprisonment shall be determined in the light of health care needs. A division of female police has responsibilities that include women and juveniles in prisons.

Juvenile offenders are currently dealt with by the Sultanate's criminal court. To implement the principles of the Basic Statute of the State, officials are currently studying a juvenile law bill, which would establish special courts for juveniles. In addition, the draft Judiciary Organization Law provides for establishing a juvenile court system with judges who have specialized knowledge of juvenile law. The Royal Omani Police supports the enactment of this legislation as well as the establishment of a prison exclusively for juveniles. In addition, it supports a special administration for juveniles established within the General Administration of Criminal Inquiries and Investigation that would:

i) Coordinate government agencies responsible for rehabilitation and reform, including the Ministry of Social Development, Ministry of Education, Ministry of Endowments and Religious Affairs and other Governmental and non-governmental organizations
ii) Participate in preliminary investigation of major criminal cases and attend hearings and trials
iii) Conduct research and studies with reference to offenders in criminal cases

While the legislative reforms conform in many respects to the requirements of Article 40 of the CRC, there is very little information regarding the implementation of current law and penal practice. The guidelines for reports to the Committee on the Rights of the Child set out the basic information required as to the numbers and characteristics of children who have committed offences. Insight also, into the process indicators, as to the manner young offenders experience juvenile justice, including the extent to which their opinion is taken into consideration and the conditions under which they give evidence. The conditions by which those under 18 years of age serve custodial sentences, in addition to the types of rehabilitation programmes utilized are also topics of concern. Furthermore, the Committee takes particular interest in the specialist training in juvenile justice and treatment of offenders received by police, social workers, judges and other legal experts, prison staff and all other persons working with children accused of criminal offences. Although some studies of topics within the general area of juvenile justice have taken place in Oman[68], there seems to be a need for a comprehensive database for monitoring the Articles of the CRC relating to juvenile justice.

4.3 Children with Disabilities

Children with disabilities form a sub-group of the child population, with all the needs and rights of able-bodied children. They should not be set apart or separated from social life, education, recreation, protection, the right to express themselves and to have their opinions taken into account, as with their contemporaries. Thus, an entire range of CRC articles apply to children with disabilities, particularly Article 2, which implies the need to address issues of discrimination and stigmatization and Article 23, which focuses specifically on the additional rights of children with disability: identification, prevention, cure or amelioration where possible, rehabilitation and integration.

[68] See for example, in a pre-1993 compilation of research by the Directory of Research and Studies of the Ministry of Social affairs, labour and vocational training , reference to a 1992 study of juvenile delinquents in Omani prisons

Article 23:

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.
2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.
3. Recognizing the special needs of a disabled child; assistance extended in accordance with paragraph 2 shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.
4. States Parties shall promote in the spirit of international cooperation the exchange of appropriate information in the field of preventive health care and of medical psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of

4.3.1 Identification

Identification and recording of children with disabilities is the first vital step towards good planning. Although it is by no means an easy task, census 2003 attempted to capture as comprehensive an outlook on the Sultanate's disability situation as possible. Statistics suggest that there are 41,303 registered disabled citizens nationwide, 8,768 of whom are under the age of 15 years (rising to 13,141 for those 19 years and younger). The data obtained provides a glimpse into this sub-group and reveals that approximately 2.32% of the Omani population has a disability, see Table 4.1. Of all those registered as disabled, 8,497 are recipients of social welfare.

Table 4.1: Type of Handicap, by Age and Sex, Reported by Household Heads in 2003 Census (Omanis only)

Age	Gender	Disabilitiy											Total
		Blind	Deaf	Dumb	Deaf/Dumb	Learning Disability	Behavioural Disorders	Hindered Movement	Hindered Body Movement	Ability to grasp and catch	Self Care	Other Difficulties	
Under 1 year	Male	8	3	5				2	11		1	28	58
	Female	3	2	1	1			3	3	1		27	41
	Total	11	5	6	1			5	14	1	1	55	99
1 - 4	Male	72	32	141	45	7	40	77	104	15	9	228	770
	Female	64	25	96	32	7	24	60	85	12	7	136	548
	Total	136	57	237	77	14	64	137	189	27	16	364	1,318
5 - 9	Male	160	111	472	120	75	157	120	121	29	35	341	1,741
	Female	139	95	298	101	70	112	94	88	17	31	245	1,290
	Total	299	206	770	221	145	269	214	209	46	66	586	3,031
10 - 14	Male	262	190	491	217	219	189	149	83	12	31	632	2,475
	Female	219	157	362	153	154	129	114	58	11	25	463	1,845
	Total	481	347	853	370	373	318	263	141	23	56	1,095	4,320
15 - 19	Male	336	168	395	178	221	235	152	96	24	43	625	2,473
	Female	285	168	290	187	140	195	103	80	24	30	398	1,900
	Total	621	336	685	365	361	430	255	176	48	73	1,023	4,373
20 - 24	Male	227	98	295	163	126	204	166	122	29	36	601	2,067
	Female	191	117	206	121	79	150	115	72	61	23	360	1,495
	Total	418	215	501	284	205	354	281	194	90	59	961	3,562
25 - 29	Male	151	71	145	95	48	184	152	113	13	24	487	1,483
	Female	106	46	115	77	27	81	104	57	15	16	288	932
	Total	257	117	260	172	75	265	256	170	28	40	775	2,415
30 - 34	Male	107	67	73	47	24	116	104	44	13	12	303	910
	Female	65	29	55	57	11	50	41	22	3	4	159	496
	Total	172	96	128	104	35	166	145	66	16	16	462	1,406
35 - 39	Male	88	53	45	29	9	78	62	38	10	10	252	674
	Female	86	42	30	29	7	45	46	21	4	3	181	494
	Total	174	95	75	58	16	123	108	59	14	13	433	1,168
40 - 44	Male	139	47	45	21	8	77	70	38	6	10	221	682
	Female	117	50	20	28	2	22	52	21	2	6	185	505
	Total	256	97	65	49	10	99	122	59	8	16	406	1,187
45 - 49	Male	220	61	28	11	6	57	92	55	14	6	239	789
	Female	188	71	29	19	1	18	66	22	4	6	175	599
	Total	408	132	57	30	7	75	158	77	18	12	414	1,388
50 - 54	Male	302	85	20	17	4	37	109	59	6	6	228	873
	Female	353	88	21	21	1	46	117	56	4	13	218	938
	Total	655	173	41	38	5	83	226	115	10	19	446	1,811
55 - 59	Male	395	96	14	12	3	41	126	62	13	6	191	959
	Female	391	85	15	11	1	18	119	39	5	5	181	870
	Total	786	181	29	23	4	59	245	101	18	11	372	1,829
60 - 64	Male	640	145	37	30	2	41	233	145	13	15	288	1,589
	Female	595	135	23	15	5	42	191	87	10	24	230	1,357
	Total	1,235	280	60	45	7	83	424	232	23	39	518	2,946
65 +	Male	2,522	687	68	57	10	128	835	428	46	102	639	5,522
	Female	2,489	513	37	48	2	143	731	343	19	104	459	4,888
	Total	5,011	1,200	105	105	12	271	1,566	771	65	206	1,098	10,410
Unknown	Male	7	7		1		1					5	21
	Female	9			1		3	3	2			1	19
	Total	16	7		2		4	3	2			6	40
Total	Male	5,636	1,921	2,274	1,043	762	1,585	2,449	1,519	243	346	5,308	23,086
	Female	5,300	1,623	1,598	901	507	1,078	1,959	1,056	192	297	3,706	18,217
	Total	10,936	3,544	3,872	1,944	1,269	2,663	4,408	2,575	435	643	9,014	41,303

Source: Census 2003, Ministry of National Economy

In general:

- Since the MoHs national survey in 1996/1997, standardized procedures for both eye and ear care have been created, to ensure appropriate patient management
- Mental disability tends to be treated alongside mental illness and as is the case with disability in general, children are not distinguished from adults in service provision, treatment, or statistics. Thus, data is not available concerning the extent of the various mental disabilities affecting children so that prevention and management services can be planned

- One child in every 500 births in Oman has Down Syndrome; thus, roughly 100 cases are born each year. Concern has been raised regarding the elevated incidence of Down Syndrome compared to figures in the West (i.e., approximately 1 in 800–1000 live births has Down Syndrome in the US)
- Spina Bifida and oral and facial clefts occur one in every 600 births. The prospects of survival for these children are much higher now than a few years ago[69] (1 in every 1000 live births in the US has Spina Bifida.)

Many of the aforementioned figures are significantly lower than the typical figure of 3–8% used internationally to estimate the extent of disability. The assessment of childhood disability conducted in 1999 roughly estimated that between 23,250 and 52,000 children under the age of 15 are disabled with an annual increase of 1,500 to 3,700 according to the international estimates. The under-estimations in the Omani data are likely to result from the definition of disabled/handicapped used, which refers to the inability to perform normal activities. By asking the head of the household whether there were people with disabilities in their household, researchers do not catalogue medically diagnosed disabilities, but rather the household's perception of whether or not a person is handicapped, together with its perception of both the type of handicap and the cause. Due to the shame and stigma still attached to people with disabilities, it is also likely that there may be people affected who went unreported.

An additional obstacle to identification of disability among children and adults is the tendency to see this as a 'health problem' rather than a 'social phenomenon'. Estimating the number of children with severe, lifelong disability is of particular importance, because of the costs to the physical and emotional health of the family, particularly the female caregivers. However, almost no national data exist on these issues. Internationally it is estimated that for every 1% of children with disabilities the handicap can be defined as 'severe', for example those with cerebral palsy who are not able to walk and those who are both blind and deaf. Applying this figure to Oman, between 230-620 children would be expected to have severe disabilities. If this is the case, then there is an urgent need to support these children and their families in a variety of issues such as toileting, personal care attendants, feeding equipment and transportation to hospitals.[70]

The rate of disability reported in the 1993 Census is greater for males than females, at all ages. This phenomenon has been noted elsewhere in the Middle East and is sometimes referred to as the 'missing females' phenomenon. One explanation for this is that disability is likely to be reported differently according to gender – 'normal life' is different according to gender role, and men's ability to be employed is more likely to be affected by certain handicaps than women's ability to perform adequately in the household.

As tends to be the case, children with disabilities disappear in the total population, even though their needs are different from those of adults with disabilities. The scarcity of accurate data on the wide range of disabilities in Oman and their possible causes makes it difficult to plan and prioritize prevention and rehabilitation services. Systematic tracing of varying types of disabilities throughout age groups and genders, is important for designing strategies for prevention of disability.

4.3.2 Prevention

Despite the continued improvement in the health care services and primary prevention programmes, the numbers of children with disabilities in Oman continues to rise. Although there have been no reports of polio in Oman for nearly a decade, better care for premature and low birth-weight children and children born with multiple disabilities means that more children survive with disabilities. This

[69] Oman Observer, 2 September 2002; p. 3

[70] Krefting, L, Assessment of children disability services in Sultanate of Oman: Update of 1993 Situational Analysis of childhood disability and recommendations, Unpublished report, UNICEF, Muscat

will present new problems for long-term care and create a greater demand for services for children with disabilities.

There are *three areas* related to preventable disability:

1) The improvement of maternal and child health services

Much has been done to improve antenatal care, particularly for high-risk pregnancies, neonatal and infant care, and nutrition. Registry of congenital anomalies, the birth spacing programme, development screening, which is part of the IMCI initiative and other health services can have an impact in reducing the numbers of children born with disabilities and in identifying affected children early.

2) The often repeated phrase that 'consanguinity is common' in Oman

There is no proof that this is on the increase, or that it causes disability in all but a narrow range of cases specifically related to blood disorders. The National Health Survey 2000 reported that around 52% of women were in 'consanguine' marriages, defined by having a relatively close blood relation with their husband, of whom 39% were first cousins, and that 'the popularity of such marital unions has been more or less stable over the past thirty years or so, regardless of residence or educational level'. Certainly there seems to be little change.[71]

One factor that obscures the understanding of this issue is that there appears to be confusion in much of the literature between the terms 'congenital' (existing since birth) and 'genetic' (inherited) in the way these issues are reported. Some disabilities exist at birth (such as Spina Bifida, Down Syndrome, hydrocephalus and microcephaly) and other conditions (congenital heart disease, diabetes, immunodeficiency syndrome, asthma and neurological problems such as epilepsy) after birth. However, the statements that such conditions are 'often a result of consanguine marriages' and the argument that first cousins are more likely to both carry the same gene than third or fourth cousins, are not supported by any documented evidence to this effect. The evidence of the inheritance of blood disorders is not unequivocal, but not necessarily tied to cousin marriages; nor does it necessarily have particularly elevated incidence. Thus, the most appropriate strategy when inherited conditions are suspected would not be to stigmatize a traditional form of marriage, but rather to encourage couples intending to have children to go for genetic counselling, including screening for specific genetic blood disorders, so that they can make informed reproductive decisions. The Ministry of Health is using this strategy and is currently strengthening services in this area. Close monitoring of this service is needed, both to assess the quality of the service provided and its impact on people who have used the service.

3) Road traffic accidents

As mentioned in Chapter 2, road traffic accidents are becoming an increasing concern. Disability related to traffic accidents has increased and may continue to increase, as those under 15 years reach 18 and are legally able to drive, and Oman sees greater absolute numbers of vehicles and drivers. While the Royal Omani Police have introduced many strategies to increase road safety, medical experts have noted that the injuries received in accidents are more severe and disabling than previously. This will increase the need for rehabilitation services in the future. Moreover, as seen earlier, the rate of general accidental injury among children is increasing.

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[71] Ministry of Health, 2000, National Health Survey, Sulaiman, A.J.M., Al-Riyami, A., and Farid, S., (eds.), 1996, *Oman Family Health Survey, 1995: Preliminary Report*, Muscat, Ministry of Health, Riyadh, and Council of Health Ministers of GCC States. The 1989 CHS documented a national consanguinity rate of 54 %(59 %rural/43 %urban), while the 1991 Musaiger study put the rate at 58 %

4.3.3 Cure and Rehabilitation Services

The Sultanate does not have a national policy on disability nor a standard system for service delivery and monitoring, though efforts are well underway to develop one. Yet there are some existing advantages in this area, including the incorporation of measures into the national health care infrastructure to prevent disability. Some examples are immunization, trachoma screening, eye, ear and oral screening (school health) and the adoption of new strategies that will further reduce childhood disability (nutrition education, improved maternal care). There is also an impressive commitment and dedication by individuals and groups serving disabled children and several heartening attempts to respond to the needs of disabled children through community-based integration rather than institution-based dependency and isolation. Attempts to elicit private sector and community support for facilities to serve the disabled have been successful.

Although some children have been integrated into the regular government schools, special education facilities appear to be the main option for children with disabilities. This, however, is an expensive strategy that can violate the rights of children with disabilities, by separating them from their families and communities and increasing the potential for stigma and discrimination. It also tends to create separate services for 'The Deaf', 'The Blind' and 'The Physically Handicapped'. Creating special centres has been the traditional, charity-based welfare approach. An integrated policy approach, as well as a policy of integration into social life, is the rights-based alternative.

- A handful of specialized centres in the country, treat people with disabilities, catering mainly to the needs of the physically disabled.

Existing education, rehabilitation and care facilities are far below the country's needs. Whilst a further two schools, the Hope Institute for the Deaf and Mute, and the School for the Mentally Retarded, cater for a further 477 students. The Ministry of Social Development estimated that at least 700 additional students are in need of such facilities.

These schools only cater up to grade 11. Therefore, graduates do not complete secondary level education thus limiting their full integration into society as adults, particularly as it relates to job possibilities and further education. Existing expertise and programmes to meet the needs of disabled children (rehabilitation experts, community play groups/nurseries, special education schools and Ministry of Social Development) cover approximately 1,000 children, or less than 2% of the children with disabilities who need these services.

Four organisations offer services to the disabled, they are:

1) The Association for the Care of Disabled Children, established in Muscat in 1991

This was the first NGO to address the needs of the disabled in the Sultanate and now operates six centres for disabled children in Muscat and other smaller towns. It has trained a number of volunteers who have started to make regular visits to areas outside the capital city, but within the Muscat region. The Association aims to open a boarding centre in Muscat that could have a positive impact on disability care facilities in other parts of the country. It has already secured significant contributions from the private sector, including free medical examinations by doctors and scholarships from private schools and continues to advocate for the needs of the disabled, such as parking places and playground facilities. In the year 2004, the number of enrolled children in this association was 329

2) The Oman Association for the Disabled, established in 1995.In 2004, the enrolled children were 191.

3) Al Noor Association for the Blind, established in 1997 with a number of 122 enrolled children in 2004.

4) The Association of Early Intervention for Children with Special Needs, established in 2000 .In 2004, 87 children were enrolled in it.

The Early Intervention Centre is the only facility that provides services for children from birth to age six, with the explicit goal of rehabilitation and developmental encouragement with the hopes of integration of some children back into schools. They all operate under the supervision of the MoSD.

The services for disabled children remain limited even with the addition of some rehabilitation departments in regional hospitals and a few new community centres. It is claimed that less than 5% of disabled children, who need services, receive assistance. The institutions/organizations targeting this group, educational institutes, NGOs and the tertiary care hospitals, are predominantly located in larger urban areas, particularly Muscat. There are a limited number of disability specialists and community workers, which has not increased significantly in the past decade. There are no services for children with multiple handicaps. Some severe cases of both physical and mental handicap are abandoned to the health services by desperate parents who cannot provide the protective environment necessary for their children - especially as they grow older - and the parents have little support or care options. A thorough assessment of the current situation by the Ministry of Social Development needs to be done so that a clear strategy and plan may be developed for the next five to ten years. Such a strategy would also clearly define the responsibilities of the various sectors, such as the Ministries of Social Development, Health, and Education and the private and voluntary sectors. Reinforcement of co-ordination and cooperation between the different partners would be a way forward to alleviate the situation.

4.3.4 Integration

The challenge of addressing the rights of the disabled in Oman may provide an opportunity for Oman to become pioneers in this human development and rights issue as it has in other areas in recent decades. Where disability does not impair mental development and the child is intellectually, if not physically, able to participate fully in community life, the rights approach stresses full integration, in education and all other aspects of life. Recreation is also an important issue for children with disability. However, a more appropriate approach would be to ensure that children and adults with disabilities can, wherever possible, access sports and other recreational facilities, such as museums and libraries, shops and public entertainment, which are used by the able-bodied.

Community-based services represent a halfway house to complete integration. The Sultanate of Oman has adopted the strategy of **Community Based Rehabilitation** (CBR) through the Al Wafa Social and Voluntary Centres. The MoSD (The erstwhile MSALVT) operates 19 volunteer-managed CBR centres for disabled children. Private corporations have started to provide financial and material support for these centres, reflecting the opportunities for greater civil society participation in development issues in Oman. These centres aim to teach families how to care for their children at home. CBR implementation began in 1990 under the guidance of the Ministry of Social Development, with volunteer centres in some *wilayats*. Volunteers had obtained secondary school certificates and attended special training courses in the field of childhood disability.

CBR Centres are small and based in the children's own communities, so that children continue to live at home. Children attend two or three times a week, sometimes with their parents. Volunteers often visit the homes of families with disabled children. CBR activities may include daily life skills, learning skills, physical exercises or therapy, group sports or active games, art therapy, music therapy, social and community skills, gardening therapy, entertainment (TV/radio), morning assembly and prayer time, special skills (relevant to a particular disability) and special events. CBR Manuals stress the need to plan for individual children as well as grouping children for particular activities. They also suggest ways of motivating the unpaid volunteers, through awards, uniforms, training, programme exchanges, publicity, promotions and certificates, as well as means of further involving the community. In some cases children who have attended CBR centres, 'graduate' and attend local schools alongside their peers. Yet it is clear that this initiative does not fully meet the demand, even in

the areas where it operates; often CBR centres will have long lists of children waiting to join a programme.[72] Moreover, questions arise, such as whether the training of volunteers is sufficient, or the ratio of three children, with different disabilities, to one semi-trained, non-specialist volunteer is adequate to meet the rights to standards of care provided in Article 3 of the CRC.

Oman has the opportunity to adopt a community-based philosophy to solving the needs of children with disabilities. There are already examples of community support services in Oman and by investing in them and expanding the approach, Oman can be among the leaders in providing equal opportunity for children with disabilities. However, prior to expanding this approach, an assessment, which is part of the UNICEF plan of action for 2003, must take place in order to identify barriers and constraints and to determine how this approach could be expanded to new communities.

4.4 Lack of Family Care

Abandoned and orphaned children are provided protection in Oman through institutional and family-based care. A child born in Oman with unknown parental identity is assured the right to nationality; she/he is defined as an Omani national by Omani Nationality law. Indeed, any one who finds an abandoned newly born child is obliged by law to hand the baby over to the nearest medical facility, police station, or the district Wali. A report is then made, including a medical check-up and measures must be taken to ensure health and protection of the child. The arrangements for abandoned children also require the Ministry of Social Development to provide them with a name.
In addition, the MoSD provides orphans with alternative care either directly through childhood care house, or indirectly through the "alternative family approach".

Article 20:

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States Parties shall ensure, in accordance with their national laws, alternative care for such a child.
3. Such care could include, inter alia, foster placement, *Kafala* of Islamic law, adoption, or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Article 21:

States Parties, which recognize and/ or permit the system of adoption, shall ensure that the best interests of the child shall be the paramount consideration and they shall:

a. Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary
b. Recognize that inter-country adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner be cared for in the child's country of origin
c. Ensure that the child concerned by inter-country adoption enjoys safeguards and standards equivalent to those existing in the case of national adoption
d. Take all appropriate measures to ensure that in inter-country adoption, the placement does not result in improper financial gain for those involved
e. Promote, where appropriate, the objectives of this article by concluding bilateral or multilateral arrangements or agreements. And endeavour, within this framework, to ensure that the placement of the child in another country is carried out by competent authorities

[72] Manual B, p 27

There is limited data on the number of orphans in Oman. A system of extended family, strong tribal ties and social cohesion ensures that orphans are provided with special protection and assistance. The social security system provides assistance for families with orphans, where in 2004 the orphanage cases numbered 5434 and represented approximately 11% of the social security recipients.

In the absence of an alternative family or other guardian, the state assumes responsibility for the child and takes care of the child's affairs. The **Children Care Home** was set up under the Ministry of Social Development to provide a place for children in need of such care. Institutional care for orphaned children is often required, even in a culture with strong family and community ties. However, foster care and/or adoption where children can be raised within a home environment, is the preferred option for the health and well-being of the child. This issue requires further investigation.

4.5 Child Abuse

The globally accepted definition of child abuse is, 'harm to children resulting from human action that is proscribed, proximate, and preventable'. In all countries, once solutions to the immediate problems of child survival are achieved, data on child abuse begin to emerge from health statistics where they were previously obscured by the overwhelming statistics on child morbidity and mortality related to common childhood killers such as measles and acute respiratory illnesses. Paediatricians now find that they have to develop new diagnostic skills and join forces with other experts, for example in social work, family counselling and rehabilitation. Paediatricians in Oman are already working with the Ministry of Health to collect and consolidate information regarding child abuse and neglect, as well as to establish mandatory reporting. Protection for children against violence is provided in the CRC in the context of families, schools and society as a whole.

Violence in the family is a concern for both women and children. In a paper to the Fourth World Conference on Women, Beijing 1995, the Sultanate commented on the issue of violence against women, saying that:

"The UN international statement on violence against women specifies the types of violence from which women have protection. By comparison, we see no such picture in our society, where our social conventions and the guarantees given by our Islamic religion ensure women's rights and enable them to live in peace and security."

The following offers proof of this statement, 'Special procedures are adhered to in order to reinforce the elimination of all types of violence against women and various laws have been issued to protect them.

- The principles and judgements of Islamic law
- The labour law
- Social insurance[73]

This statement also has implications for the protection of children against domestic violence according to Article 19.

Article 19:

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should include, as appropriate, effective procedures for the establishment of social programs to provide necessary support for the child and for those who have the care of the child and for other forms of prevention. In addition, for identification, reporting, referral, investigation, treatment, and follow-up of instances of child maltreatment described heretofore and, as appropriate, for judicial involvement.

[73] Sultanate of Oman Country Paper to the Fourth World Conference on Women, Beijing, China 4th-15th September, 1995 p.35

Within Islam, believers are duty-bound to provide a safe, protected and secure environment for children. In the words of the Prophet Muhammad (pbuh), "Love your children and be merciful to them. If you promise them, fulfil your promise, for they expect you to cater for them." In Islam, discipline is an important and explicit aspect of parenting, an expression of a parent's love and concern for the child. The Prophet Muhammad (pbuh) spoke about this: "If any of you disciplines this child, it is better for him than to give alms every day." In addition, a well-known Islamic proverb states "Play with your son up to seven years of age, then discipline him for the coming seven years, then befriend him for the following seven years. Then allow him to be independent afterwards."
The topic of **family discipline** is one on which very little information is available. It is to be expected that practices are undergoing many changes as Omani society undergoes fundamental social and economic transitions. Nevertheless, beliefs as to how best to raise children and family practices inevitably change relatively slowly, as one generation passes authority to another.

While parental responsibility for discipline must be respected, it is still important to clarify the appropriate means. Detailed, qualitative research is necessary, conducted with both parents and children, using sensitive and ethical methods, to discover the means used to discipline children and their effectiveness. This could be the starting point for advocacy campaigns to ensure that those entrusted with the care and upbringing of the young are aware of best practices and appropriate methods of discipline.

Direct information regarding abusive practices and non-accidental injuries are not yet available in Oman, except that which is inferred from existing health statistics. According to the National Health Survey (2000), the highest proportion of injuries occurs within the 16-25 age groups and is twice as common in males as females. Almost two-thirds (60.8%) are due to road traffic accidents, particularly for males (68.1%). Injuries due to falls are also common (22.3%), particularly for women (36.2%). For males, a majority of injuries (73.1%) occur away from home; for females, however, it is almost evenly distributed between injuries occurring at home (44.7%) and away (38.3%). Unfortunately, the figures are not categorised by age, thus, obtaining a clear understanding of the incidence of injuries among children is difficult.

There are some obvious analytical points to be made with respect to these figures, clearly more accidents will happen outside the home as children become more mobile and spend more time away from home. However, in this case, a gender breakdown would be very useful, since females spend more of their time at home at any age. It is necessary to remember that this is a household survey with self-reported recall by the head of household, who might choose to forget non-accidental injuries caused to children, or to report them as resulting from a 'fall'.

Chapter 2 highlighted the significance of road traffic accidents. A link may exist with the failure to use seat belts, failure to use correct seat belts or child seats for the size and weight of a child, or from children riding in front seats of cars without seat belts or child car seats. Awareness campaigns and strict implementation of road safety regulations could do much to lower these figures. Some cases of falls and poisonings may be due to failures among adults to supervise the young, or to maintain a risk-free environment, especially for the youngest children. Poisonous substances, such as medication and household cleaners must be stored out of reach of children. As already observed, some 'falls' may be the result of non-accidental injuries perpetrated by adults.

Many domestic accidents can be avoided. Adult supervision of children's activities in the home may be inadequate as parents leave children supervised by older siblings or housekeepers who are employed for general household tasks, in which child minding is a minor function. When domestic servants from other countries are employed, their language skills are likely to be inadequate. Families may also be unable to afford to employ a domestic servant despite the fact that both parents are working. In non-Omani families, in which both parents may be professionals and it is more usual for women to be employed, children are more likely to be left without parental care.[74]

[74] See for example Times of Oman supplement, 'Home Alone'. February 10-16, pp. 8-17

Direct evidence of child abuse is sparse, but does exist. An academic paper presented at the 12th International Child Health Conference at SQU described four Omani cases of Munchausen's Syndrome by Proxy (MSBP). Typically MSBP cases involve a parent simulating or producing an illness in a child in order to engage in a supportive relationship with a health care provider. This is a type of abuse more common in developed countries with sophisticated medical services and provides yet another sign of the health transition in the Sultanate. In the cases reported in Oman, children were placed on anti-epilepsy drugs as the result of their presentation to doctors at SQU Hospital. Once these cases of MSBP were diagnosed, treatment consisted of support to, and counselling for, the family.

Some likely cases of other forms of child abuse reaching hospitals in Oman, including physical and/or sexual abuse. Doctors working in accident and emergency departments in Oman's hospitals have begun to recognize the telltale signs of less obvious cases and to refer them to paediatricians. However, a system of handling children who have been abused needs to be developed based on an analysis of the current situation.

4.6 Exploitation of Child Labour

Article 34 of the CRC provides for the protection of children against economic exploitation. Other international instruments drawn up by the International Labour Office (ILO) stipulate minimum ages, conditions for employment and new legislations have been adopted by the ILO but have not yet been enforced. Oman was represented by the then Minister of Social Affairs, Labour and Vocational Training, now the Ministry of Manpower, at the June 1999 International Labour Conference, which adopted Convention 182 against the 'Worst Forms' of Child Labour. The then Minister said that, "the issue of child labour requires an in-depth analysis and measures to frame programmes and procedures to eradicate child labour by all the participating countries." Without indicating the scale of the problem in Oman he cited the steps initiated by the Sultanate in providing free education to all the children, the vocational training programme and measures to generate employment opportunities and efforts to increase female labour force participation.[75]

Article 34:
States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

a. The inducement or coercion of a child to engage in any unlawful sexual activity
b. The exploitive use of children in prostitution or other unlawful sexual practices
c. The exploitative use of children in pornographic performances and materials

Globally, perhaps the only economic sector where it may be argued that some children exercise rights is that of child work, particularly the right to fair pay for workers under the age of 18 years. The more usual approach throughout the world is to concentrate on protecting children from harmful work, rather than supporting their rights as workers by protecting them from economic exploitation.

As is the case with women working in the rural or domestic economies, it is difficult to determine the extent of children's involvement in agricultural, domestic and pastoral work in Oman. Certainly, these activities are often part of their traditional role within the family, akin to the contributions to domestic work commonly engaged by girls.

The Preliminary Report of the Government of Oman to the Committee on the Rights of the Child provides information about the legislation applicable to the employment of persons less than 18 years

[75] Times of Oman: 12.6.99

of age. It states that 'the employment of underage children in the Sultanate is virtually non-existent. All children enjoy education at institutions located across the Sultanate'.[76]

The new Labour Law issued by Royal Decree No. 35/2003, increased the minimum age of employment from 13 to 15 years, which agrees with ILO Convention No 138 on the minimum age for admission to employment (15 years of age). The Law also prohibits the employment of juveniles who are less than eighteen years old between the hours of 6.00p.m. and 6.00a.m. or for a period exceeding six hours a day or to be kept in the workplace for more than seven continuous hours, with one or two periods for rest and meals. It is also forbidden to give them overtime work and they must not be employed on the weekly rest days and official holidays.

No estimates exist in Oman to determine the extent of child labour per the definition of the Omani Labour Law, although information is available through the Government household and labour force surveys, which request information about the employment of household members over the age of 10 years and over. Available data on child labour from these surveys relate to those in the age group 15-19 since results of these surveys are published for 15 year olds and above; see Table 4.2.

These figures largely relate to activities in the formal, wage–earning sphere, whereas the economic activities of children tend to be informal, unpaid and domestic work. Some children are not enrolled in schools, drop out early in their educational career, or are in school for only half the day on a two-shift system. Information regarding what children do when not in school is required to understand better their recreational activities, but also to ascertain whether they are involved in formal and informal employment.

Table 4.2: Omani Population Aged (15-19) by Type of Activity and Gender, 2003

Economic activity		Male	Female	Total 15-19	Total all ages
Not economically active	Student	105370	96436	201806	256102
	Home worker	37	14591	14628	267627
	Income recipient	930	1058	1988	38447
	Unable to work	1195	978	2173	51598
	Total	107574	113088	220662	613774
Economically active	Labour Force	22897	11669	34566	442517

Source: Ministry of National Economy, Population Housing & Establishments Census 2003

According to the 2003 census, the labour force participation rate for Omanis in the 15-19 age group was 13.54%. The rate for males was higher than for females at 17.6% compared to 9.4%. The size of the labour force in this age group was estimated to be 34,566, the majority of whom were working as waged employees (83%). Those working in the private sector represented 56.6% of the total.

[76] Ministry of Social Development, 1998, *Preliminary National Report on the Convention on the Rights of the Child*, Muscat, Sultanate of Oman. pp. 6-7

5. Women

The CRC does not specifically address women since it is a document focusing on the rights of children. It is clear, however, that the health and well-being of women directly influences the health and well-being of their children. Discussions regarding the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the development of a country level women's strategy in recent years, has played a key role at the national level, on raising awareness regarding women and gender issues in Oman. Ratification of the CEDAW was realised in Oman, in 2005. This chapter attempts to provide a brief overview of the status of women in Oman.

5.1 Gender and Generation

Gender and age are crucial factors in assigning responsibilities and entitlements. In the absolute sense, older, married women, past the period of fertility, exercise a good deal of authority; and in terms of relative age, older siblings are empowered to direct their younger brothers and sisters. Generally, and particularly among pastoral-nomadic women, as a woman ages so too does her status and position in the community. By late middle age or towards the end of her child-bearing years, she becomes a powerful force in society. The mature woman with a grown family is respected and sought after for advice by younger females and males alike.

The role of Omani women in society continues to evolve rapidly, in view of increased education and job opportunities, reforms in the education system and greater female participation in the labour force, which has increased in the past decade from approximately 8.6% in 1993 to 22.2% in 2003.

5.2 The Traditional Role of Women

Responsibility for the early care of children has generally been entrusted to females. In particular, teaching values and customs to boys and girls is seen as a maternal function, until children reach at least the age of seven. After this time, boys come more and more under the authority of their fathers, while the training of daughters in the skills of domestic economy continues under the supervision of their mothers.

A woman commonly works outside the home in the pastoralist nomadic sector by tending herds of goats or sheep, which are likely to be her own property. In this way, she may contribute to the financial support of her family, which in formal terms is considered the responsibility of her husband. In other settings, however, the engagement of women in employment beyond the household has increased only gradually. Labour force participation rates probably do not accurately reflect the contribution that a woman may make to household income, which may be through the sale of goats and sheep, the harvesting of agricultural produce (such as dates), or other activities undertaken in the domestic setting (such as dress-making).

A special unit created within the Ministry of Agriculture and Fisheries in 1996 was designed to gain insight into the scale of women's contributions to agricultural and pastoral work. It sought to gather data on rural women and develop appropriate support activities for them. The necessary continuous outreach work has been affected by the limited number of female 'extension agents' working in the Agricultural Development Centres in the Sultanate.

In 2003, female employees in the Ministry of Agriculture and Fisheries represented just 4.5% of all staff. During the academic year 2004/05 there were 422 female Omani students studying at the Faculty of Agriculture & Marine Science at Sultan Qaboos University (43% of all students). A further 47 women had already graduated from this faculty (40% of all graduates).[77] The creation of an

[77] Ministry of National Economy, 1999, *Women's Economic Activity and Employment in the Sultanate of Oman* Internal Draft Report

effective, professional support network for women in the rural economy seems to be a current challenge.

The last few decades have brought about many changes in women's lives. The next will bring faster progress with the rapid increase in women's educational levels and a larger proportion who work outside the home, which in turn will bring changes to their traditional roles as wife and mother. The educational and employment status of women are a crucial development factor affecting the health and well-being of their families and country as a whole.
The terms women's empowerment and autonomy have been used interchangeably to denote women's independence. Education has often been a key measure of women's status or autonomy. A common assumption is that education leads to autonomy and provides a forum for women to learn about fertility control, make effective use of the health system and more generally obtain information and use it to make decisions about one's life. The National Health Survey (2000) used two indicators of empowerment, women's involvement in household decision-making and her freedom of movement. The mean decision-making index was 4.3 (on a scale of 0 to 8). Involvement with household decisions increased with a woman's age, particularly those decisions relating to what foods to cook, household expenditures, having another child and visiting relatives. In general, most women were involved with decisions relating to children but few took responsibility for household expenditures.

The average number of places a woman could go alone was 3.88 (on a scale of 0 to 6). Slightly more than 10% of woman questioned could not visit any place alone whilst nearly 30% could move freely. Freedom of movement increased significantly with age. For example, the freedom to walk alone doubles from 25% in her late teens to 50% when she is over 40. Education level also had a linear relationship with this index. As the literacy rate of women increases over time, we will be able to see that women in Oman will become more empowered to make household-related decisions that affect them and their families and have more freedom to move outside the home to gain further access to information and services they require. The inverse relationship between women's empowerment (usually measured by women's educational status) and fertility is universally acknowledged. However, it is not clear what other changes, in addition to greater number of women entering the workforce, will take place as more women are educated and empowered. Nevertheless, this is a dramatic social transformation that the society will and is facing in the future; thus, this issue calls for further study and exploration into the changing face of women's traditional role(s).

5.3 Women and Formal Sector Employment

Women's economic participation rate has been increasing rapidly over the last decade see Figure 5.1

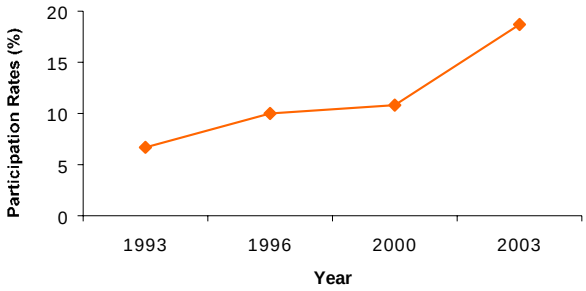

Figure 5.1: Female Participation Rates from 1993–2003

The female share in the total Omani labour force rose from 8.6% to 22.2%, in 1993 and 2003 respectively. This boost is credited to the increase in number of educated women, particularly of secondary and post-secondary graduates, changing attitudes of society towards women's work, the changing consumption patterns and the need to improve family income. In addition, the concerted

efforts of the government to provide the health and education service and nationalization of employment in these two sectors, have all contributed to the increase in job opportunities for women.

His Majesty Sultan Qaboos has signalled his firm commitment to the development of women's education and training and to the creation of opportunities for women to utilize their talents in the public domain. In a 1997 interview, His Majesty remarked that, "There should be no discrimination against working women. They should have the same job titles, salaries, and benefits."[78] A reflection of the commitment to equality between men and women in the domain of work is seen in the civil service and labour laws.

The particularly striking progress in girls' education is an important stimulus for change. Since 1970, a rapid programme of educational expansion for girls in Oman has included the opening of Oman's first university in 1986, the co-educational Sultan Qaboos University. As one researcher has commented, "The availability of education (from primary to tertiary) for women has undoubtedly played a crucial role towards the emancipation of Omani women."[79]

The 2003 census results show that a positive relationship exists between economic activity rates and educational status. The highest rates of economic activity among Omani women are found among those with Ph.D.s (94%) and first degrees (93.6%); following that are post secondary school non-tertiary and masters levels (89% each), dropping off for those with secondary certificates (36%), preparatory certificates (5.3%) and illiterates (3.5%). It should be noted that these are primarily measures of formal sector activity rates and that illiterate women are more likely to participate in informal economic activities or agricultural production.

The involvement of women in the formal economy of the public and private sectors has been a gradual and recent development. Women are slowly moving into new careers in fields such as languages, business, computer science, information technology, lab technicians, and some vocational professions.

In 2003, more than two-thirds of all Omani women employed in the private sector were between (20-29) years of age. While only 3% were in the age group (15-19) years. From 1997-2004, the number of women on the job registered with the Public Authority for Social Insurance (PASI) increased from 5329 to 14,695 at an average annual growth rate of 14.5% and represented 15.6% and 17% of the total number of employees on the job registered with PASI respectively.[80]

Women in private sector activities are concentrated in financial intermediaries and real estate services (27.8%) according to the 1996 Labour Survey, followed by the trade sector (20.9%) and then manufacturing and agriculture and fishing, having an equal share of approximately 14%. Most of those in the latter two sectors are in family and own account work. It is most likely that lately the percentage working in manufacturing has increased due to the increased number of women trained in sewing and dressmaking.

Regarding women's involvement in the public sector, by 2004, women occupied 35.8% of positions in government employment; making their share in government employment more than triple its level in the mid-eighties, see Table 5.1 and Figure 5.2. In civil service employment, the concentration of female employment has recently seen a dramatic shift, whereby fewer women are concentrated in the education sector and more joining the health sector. In 2004, these figures were 52.1% and 55.6% respectively as apposed to 68% and 20% in 1997 respectively.

[78] In Miller, J. 1997, Creating modern Oman, *Foreign Affairs*, May/June 197, p.18
[79] Al-Lamki, S., 1999, *Paradigm Shift: A Perspective on Omani Women in Management in the Sultanate of Oman* from Website *Advancing Women in Leadership* www.advancingwomen.com/awl/spring99/Al-Lamki/allamk.html
[80] Ministry of National Economy, Statistical Year Book, 2005

Table 5.1: Omani Women's Participation in Government Employment, 1985-2004

Employment in the government sector		1985	1990	2000	2004
Number of employees	Male	30,941	38,099	45,293	53,886
	Female	2,831	5925	18,641	29,997
	Total	33,772	44,024	63,934	83,883
Percentage	Male	91.6	86.5	70.8	64.2
	Female	8.4	13.5	29.2	35.8

Source: Ministry of National Economy, Statistical Year Book 2004

Omani women currently hold very high governmental positions including three at the ministerial level in the ministries of Social Development, Higher Education and Tourism, one at the undersecretary level in the Ministry of Education, two at the ambassador level and one at the ministerial level, as the head of the public "authority for Handicrafts". The Sultanate's first woman Ambassador was appointed by Royal Decree number 47/99 on September 15, 1999, to the Embassy of the Sultanate in the Kingdom of the Netherlands. The second such appointment took place in 2005; by Royal Decree number 79/2005, to the Embassy of the Sultanate in the United States of America.

The greater participation and visibility of women in the labour force, especially at higher-level government positions, is a positive influence on young girls, who aspire to such positions.

Since 1994, women were permitted to run for election, and in the same year, two were elected as members representing the governorate of Muscat. Women are also permitted to run for election of A'Shura Council. Ten years on and there are 2 women within the A'Shura Council and 8 in A'Dawla, or State Council.

The civil service and labour laws also play a positive role on women's participation and continuity in employment through provisions made for maternal and childcare. The civil service law provides for maternal leave, before and after birth, for 50 fully paid days and not exceeding 5 maternal leaves during her whole period of her service in the government. Whereas, the labour law allows for a period not in excess of six weeks, affording the woman the right, if she has had one year of continuous service, to consider this leave as leave without pay or as sick leave, hence still being entitled to receive payment by provision of the law (see also section 4.4). The civil service law also grants the Omani female employee, upon her request, a leave without pay for one year to look after her child after or within 60 days of the completion of the maternity leave. The law also entitles her to a special leave to accompany her husband, if sent abroad for a period not less than six month.

There are no studies to assess the consequences of marriage of the Omani females on their career and continuation of employment or on how far the labour and civil service laws have helped in this respect. This is an important question since the medical and teaching profession is becoming increasingly dependent on newly graduated females in these fields who are young and unmarried. Similarly, the reduction of the period of maternity leave from 60 days to 50 days raised concerns as to its adequacy and the impact it may have on childcare and its welfare. The limited availability of day care facilities and nursery schools, particularly in regions outside the capital area, is a barrier women face as they consider returning to work after they have a child. The split working hours in the private sector, which in practical terms extends the working day into the evening hours, is also difficult when women are expected to adhere to the double load of paid labour and household work, especially for families with limited income. Further studies on women in the labour market would be useful; particularly on the barriers they face, in order for amendment of policies and/or the development of strategies to address particular concerns.

5.4 Women, Laws and Legislations

The Basic Statute of the State issued by Royal Decree No. 101/96; unequivocally stresses equality and parity of opportunities between Omani males and females. It also advocates impartiality before the law, according to gender and equality in general rights and duties. This sets the stage for the issuance of the election law in 1997, which decreed women's rights to election all over the country. All present laws and regulations have propagated equal chances for Omani women in different areas such as trade, labour, civil service, social insurance, penal code and administrative regulations.

The new Omani Labour Law issued by Royal Decree No.35/2003, as with its predecessor, provides for equality between the two sexes in job opportunities, rights and obligations resultant from the job, provided that the working conditions are the same. Special provisions apply relating to the protection of women necessitated by their nature and family responsibilities. Women may not be employed for night work, between 7pm and 7am, or in work that is 'objectionable on health or moral grounds'. The new labour law prohibits dismissal of a woman worker if she is absent from work due to pregnancy as proved through a medical certificate. This is unlike the old law, which specified that the effective date of giving termination notice of contract to a woman, who is absent from work for reasons of pregnancy and child birth, shall be from the day after such absence has ended, which apparently contains a tacit allowance of dismissal in such occasions. In addition, while the previous labour law exempted agricultural workers from the application of the provisions made for the employment of women, the new labour law left it to the minister to determine the conditions and nature of jobs and occupations and industries in which women are employed.

A number of provisions specific to women can be found in legislation covering social security and social insurance. As explained, the Social Security Law entitled special groups of women to pension and special assistance including the widow, the divorced, the abandoned, and the unmarried. In addition, social security transfers are made to both men and women who are disabled, elderly, orphans and for occupational rehabilitation and families of prisoners.

The Social Insurance Law issued by Royal Decree No. (91/72) and its amendments gave special attention to the woman and entitled her, as well as the man, to insurance benefits against the risks of aging, disability, death and occupational diseases. This covers those working at the private sector companies and establishments according to permanent employment contracts, provided they are not less than 15 and not more than 59 years of age. To stress equality between man and woman, the law decreed that boys and girls enjoy pensions of their parents without gender discrimination. In addition, a widow may enjoy pension of her deceased husband and her own pension as a beneficiary of this law or she may enjoy the pension of her deceased husband and her own income from her work. The Pension and After Service Benefit Laws issued by Royal Decree No. (26/86) make similar provisions to government employees.

The Personal Status Law issued by Royal Decree in 1997, based on Islamic Sharia, covered family conditions, such as marriage, divorce, and child custody in 127 of its articles. It ensured women many rights, such as the right to a dowry and the right to renounce betrothal and file for divorce. It also confirms the woman's right to maintain her family name after marriage and to manage her personal assets.

In spite of these favourable developments in the civil and labour laws regarding the rights of women, concern arises as to the practice and proper implementation of these laws. In these areas evidence is scanty. Discussions regarding the CEDAW are a preliminary step in determining appropriate monitoring indicators for the implementation of the law so that assessments can be made to determine areas of improvement. Anecdotal information indicates that often women do not exercise their social/family rights due to family pressures and even when they do, they are faced with many barriers, such as unsympathetic government officials, prejudicial judges and the disapproval by family and

society. Thus, even though there are laws and legislation supportive to women, greater effort needs to be made to create a supportive gender-sensitive environment that addresses the legal rights of women in the implementation of such laws.

5.5 Women–Headed Households and Poverty

Widowhood, abandonment, divorce, spinsterhood, and conviction of spouse are common causes of poverty for women. In Oman, prior to 1970 there were no provisions for females whose lives were adversely affected by such situations. Advances in education and work opportunities mean that women are potentially better equipped to cope with these challenges. The creation of an extensive social care system has also been a necessary and valuable measure.

As shown in previous sections, the first social security law made provisions for a monthly allowance to women in these situations, enabling them to support themselves and their dependants. Clearly, however, these allowances as indicated in Section 1.3.5, are often minimal when compared to the minimum wage. Women also receive support as elderly, disabled and orphans. Other measures are being taken or have been suggested to assist females in these situations, including cottage industry training and marketing support, expanded centres for women's development, family counselling offices, training in tailoring and other vocations, easier access to loans and better agricultural extension services for women.

According to the Household Expenditure and Income survey, women-headed households represented roughly 7% of all Omani households, with an average household size of 4.31 compared to 8.85 for males; see Table 5.2. The estimated female-headed households' average monthly per capita consumption of goods and services is OR 58.0 and is not different from that of male-headed households whose average is OR 58.3. Cash expenditure of female-headed households is; however, lower than their male counterparts estimated at OR 51.7 compared to OR 56.9 for males as female-headed households produce more goods and services at home.

It is notable that per capita food cash expenditure for female-headed households is higher than for male with the reverse being true for non-food expenditure. Male-headed households spend more, per capita, on transport, education, recreation and entertainment. These differences may be due to the age-sex structure of the households. Though some of the groups that receive the social transfers fall under the female-headed households, the assessment of impact of state protection via aid transfers and pensions on poverty of these groups would require data on the distribution of expenditure and the impact of the different sources of income on the various socio-economic groups. Judging by the per capita consumption of female-headed households in comparison to the average consumption, these transfers have probably contributed to improving the standards of living of the needy groups.

Nonetheless, less is known about the impact on female-headed households of performing the dual role of being the main breadwinner for the family and simultaneously taking care of the children, especially since these women might be incapable of hiring the help of domestic servants. This indicates the need for further investigation, to assess truly the impact on female-headed households of shouldering such responsibility.

Table 5.2: Average Monthly Omani per capita Expenditure and Consumption by Sex of Head of Household (in Omani Rials)

Expenditure/Consumption	Females	Males	Total
Food (cash)	19.249	17.278	17.345
Own produced food	1.038	1.631	1.610
Non-food	27.481	32.158	31.998
Own produced non food	10.268	7.251	7.354
Total consumption	**58.036**	**58.317**	**58.308**
Cash transfer	1.016	0.687	0.698
Non consumption expenditure	3.955	6.750	6.654
Total cash expend.	**51.700**	**56.872**	**56.696**
No. of HH in Sample	195	2,363	2,558
Estimated No. of HH	14,358	189,061	203,419
Average HH size	4.13	8.85	8.52

Source: Ministry of National Economy, Household Expenditure and Income Survey, 1999/2000

5.6 Prospects for Female Participation

Further acceleration of women involvement in formal employment will require addressing such issues as discrimination, low self-esteem "Traditional Attitudes" and lack of suitable or attractive employment opportunities.

Early Marriage and Motherhood

In contrast with the 1993 Census findings that 81% of ever-married women had married for the first time before age 20, the 1995 *Oman Family Health Survey(OFHS),* the *National Health Survey 2000 (NHS) and census 2003 data* revealed a clear trend towards later marriage among Omani women, particularly in urban settings. Figure 5.1 shows the percentages of women who were married by the time they were 20 years of age in 1995, 2000 and 2003[81].

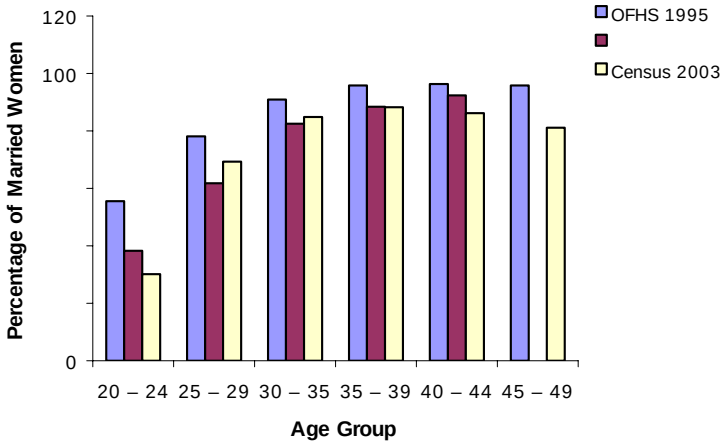

Figure 5.2: Percentage of Ever Married Women at Age 20 or Below, 1995, 2000 and 2003

[81] Oman Family Health Survey, 1995, National Health Survey, 2000 and Census 2003

In the past, the educational level of women, particularly if this reached the secondary level, had a clear bearing upon the age of first marriage, with illiterate women far more likely to contract a first marriage at a young age. However, with the spread of universal education for girls and a reduced but continuing incidence of early marriage, it is important to address the extent to which early marriage adversely affects the long-term education and employment prospects of females. Early marriage tends to be associated with early motherhood. Thus, it is important to provide options for women who marry young and have children to resume their education at secondary or higher levels and/or enter the workforce later in life.

In addressing this issue, it is important to appreciate the pressures on young women to marry, as well as the meanings attached to marriage and motherhood by young women themselves. On the other hand, less attention has been given to the perceptions of those young women themselves who marry young and have children at an early age, and to the underlying reasons. Historically, for rural women, 'the birth of a child is a rite of passage that transforms a woman into a social adult' and 'the role of mother is one that a woman can display in public'.[82] Thus, the ability to participate fully in visiting and networking within the community, which are important for social advancement, is largely dependent on whether or not a woman has produced children. Such beliefs may be less pronounced in the capital and in larger towns. However, these perceptions are significant in understanding the ramifications of encouraging later marriage in some regions of Oman.

There is a clear trend towards later marriage

- In 1993, 52% of girls between the ages 15 and 20 were married. In 2003, this number was just 3.69% (Census 1993 and 2003)
- Amongst women 20 – 24 years old, only 30.17% were married overall (Census 2003)
- 5.1% of teenagers had been married before they were 15 years old. (Oman Family Health Survey, 1995)
- Among 20-24 year old women, 26.8% were married before age 15, while 47.3% before age 18 and 55.5% before age 20. (Oman Family Health Survey, 1995)

Appropriate work

Women with different levels of education say that the shortage of suitable work is one of the major factors affecting their decisions regarding acceptance of job offers, see Table 5.3.

[82] Fertility and Social Change in Oman: Women's Perspectives, *Middle East Journal,* Vol.47, No.4, p.658

Table 5.3: Comparison of Reasons Given by Men and Women for Not Engaging in Available Private Sector Employment, 1996

Reasons	1996	
	Male (%)	Female (%)
Lack of suitable qualifications	15.4	10.3
Low wages	45.0	23.9
English language impediment	8.9	5.5
Working hours	5.1	7.8
Timing of work	0.7	0.6
Working days	-	-
Distance from residence	4.4	9.7
Future insecure	4.4	-
Socially unsuitable	-	29.1
Other	2.2	2.4
No reason given	13.8	10.7
Total	**100**	**100**

Source: Ministry of National Economy, Results of 1996 Labour Force Survey

Labour surveys suggested that women had very clear ideas as to what constituted 'suitable' work. Overall, secretarial work was considered the most appropriate, according to 38.8% of female respondents, followed by teaching (11.3%), child care (11%), accounting (9.9%), nursing (9.4%) and computing (6.8%). In contrast, service industries (represented by retail and hotel work) were not considered suitable, scoring only 3.1%.[83] A draft report by the Ministry of National Economy recommended the introduction of 'sensitization' campaigns to widen perceptions of the range of acceptable activities for women.[84]

Underlying Attitudes

A study of women in management in Oman reports that 'traditional attitudes' among men were most commonly cited by female respondents as the biggest single obstacle to their advancement in the workplace. These attitudes ranged from disapproval of women holding senior positions of responsibility, to the idea that women should not work outside the home at all. This indicates a need to influence male traditional attitudes towards women through social awareness programmes that promote women's legal right to study, work and participate in all levels and aspects of development.[85]

Many women, including those with educational qualifications, are also held back by poor self-image and lack of self-confidence. This affects their motivation to pursue work opportunities and may have an adverse impact on their performance of domestic roles. The research recommends that the General Directorate for Women's and Children's Affairs(MoSD) and the Omani Women's Associations might address this problem through workshops, the provision of clear role models and the encouragement of more networking amongst women. Thus, further acceleration of female involvement in formal employment will require addressing issues such as discrimination, low self-esteem, 'traditional attitudes', and lack of suitable or attractive employment opportunities.

[83] Ministry of National Economy, Res*ults of 1996 Labour Force Survey*
[84] Ministry of National Economy, 1999, Women's *Economic Activity and Employment in the Sultanate of Oman* Internal Draft Report, p. 29
[85] Al-Lamki, S., 1999, Paradigm Shift: A Perspective on Omani Women in Management in the Sultanate of Oman from Website Advancing Women in Leadership www.advancing women.com/awl/spring99/Al-Lamki/allamk.html

5.7 Women in Civil Society

One area in which women have been encouraged to take a leading role is the emergent voluntary sector. In 1992, the Ministry of Health created Community Support Groups (CSGs), as part of the UNICEF sponsored Baby Friendly Hospital Initiative. Initially volunteers were trained to assist other women with advice on breastfeeding practices. Since then, the women involved have received further training and have gradually expanded the range of issues on which they are able to advise others. According to a report on the CSGs published in 1999, this movement has grown into a countrywide network which, in 1997, included more than 2,500 female volunteers, with support provided by the Ministry of Health and UNICEF. Volunteers feel empowered by their acquisition of new skills and knowledge, greater engagement in the community and enhanced opportunities to meet with women from around the country. As one volunteer from Al-Dakhliyah put it, "This is the foundation for constructing the future of our country."[86] The community support group experience in Oman has confirmed the validity of community-based participation as an effective strategy to sustain Oman's impressive progress in improving the health and wellbeing of its people.

Other opportunities exist for women to create networks and acquire new skills and knowledge through the Omani Women's Associations (OWA), which in 2004 had 45 local branches and 3405 members nationwide, besides the Directorate-General of Women's and Children's Affairs (DGWCA) at the Ministry of Social Development operates ten women's training centres. The National Community Development Programme (NCDP) of the same ministry has been working for 25 years to develop the leadership and other skills of women in villages and smaller population centres throughout the country. An evaluation of its impact on individual women, as well as the community in which they are based, will provide a clearer understanding of its success and identify areas of improvement.

Despite the outstanding advances made since 1970 in educating girls and young women, females outside the larger cities play a limited role in the public life of Oman. There seems to be a lack of awareness as to the importance of volunteer work and its working system and a lack of coordination among the popular societies. Given the high female enrolment rates at secondary and tertiary levels, it is to the benefit of the whole nation that skilled and able women should make a full contribution to society. His Majesty Sultan Qaboos, stated his, "Great faith in the educated young Omani women to work devotedly to assist their sisters in their local communities, to develop their skills and abilities, both practically and intellectually, in order to contribute to our Omani renaissance, which demands the utilization of our entire national genius, for the realization of our country's glory and prosperity".[87]

[86] Ministry of Health & UNICEF, 1999, *The Circle Has Widened: community support group volunteers in the Sultanate of Oman,* Ministry of Health, Sultanate of Oman and UNICEF, Muscat.
[87] Ministry of Information, 1996, *Collection of Royal Speeches 1970-1995*, Ministry of Information, Sultanate of Oman

6. Conclusion and Recommendations

6.1 Monitoring Children's Rights – Beyond Numbers

This *Situation Analysis*, like its predecessor in 1995, affirms the paradox of Oman's successful commitment to improving the health and education of its children. Health care services reach virtually all communities and basic education is almost universal, yet emerging needs define the challenge to ensure children's rights 'beyond survival and development'. This includes protection and participation issues, along with some remaining survival and development issues. Thus, the U.N.'s technical support role may still be required in the Sultanate, in particular with respect to certain areas of children's rights that have not yet been adequately explored in the data record.

The major issues identified in this *Situation Analysis* include improving the database on children in order to allow a full range of monitoring of child rights, decreasing regional and gender disparities, institution building and community participation, and sustainability and Omanization of service provision while maintaining quality. These new challenges often hidden by the impressive gains of recent years emphasize the continued need for UNICEF involvement in Oman and the need for new modes of UNICEF intervention and support in the future. Meeting these new needs will be more complex and demanding than the largely 'build-and-train' activities of recent years.

Specific child rights issues that need further attention in Oman include:

- Data collection on the complete range of child survival, development and rights, as comprehensively identified by Omani laws and values and the CRC
- Development of social mobilization and community responsibility
- Sustaining gains made in child rights and welfare in the light of new economic realities
- Identifying and addressing regional disparities
- Further promoting the role of women in development
- Ensuring full participation by children and young people in national life and development
- Protecting people living in difficult circumstances and routinely monitoring such protection
- Making voluntary services more professional in nature
- Development of understanding of changing social contexts, particularly with respect to family dynamics, eating habits and lifestyles
- Further capacity-building within the Omani population, in order to promote the Omanization of the work force while maintaining quality and efficiency
- Special attention to adolescents, in particular to out-of-school children and to ensuring integrated policies to provide recreational services
- Expanding access to pre-schools, enhancing vocational training and improving the relevance and quality of education
- Improving and expanding the services available to the disabled and integrating them into existing social and community services

UNICEF's role should continue to be that of a supportive catalyst, promoting efforts for child rights and wellbeing through an increasing variety of interested groups and helping to expand the constituency for children that can take on responsibility for issues and concerns in a structured, organized and sustainable manner. In this process, communication will play an important role, both in raising awareness of child rights issues and mobilizing appropriate groups into action.

Children's rights are a main consideration and guiding framework for future collaboration between UNICEF and the Government of Oman, given Oman's impressive child health and education gains in recent decades and its ratification of the CRC. Although the Sultanate has submitted a preliminary report to the Committee on the Rights of the Child, the government still needs to establish a routine system for monitoring the progress towards full implementation of child rights. The data used to monitor children's rights have four main characteristics:

- Desegregation, so that groups of children whose rights are not being met can be targeted in efficient programming
- Focus on children, rather than services designed to meet their needs
- Focus on children, rather than adults or institutions
- Not purely quantitative, but contextualized in qualitative understanding of the social and cultural dynamics in which children live

Globally, when information pertaining to children is collected, the data is not commonly children–centred. Children are not considered as individuals or as a social group, neither in scientific literature (psychology, pedagogy, and sociology) nor in social research and official statistics.

In most childhood data, the unit of analysis is the family and developmental problems are at the forefront. Children are studied with respect to childhood institutions, such as the school or the family, but not with respect to the system of production or the labour market. This suggests a need for qualitative changes at the level of surveys and the need for secondary analysis of existing material. This would allow for better monitoring of the actual, total quality of life of children, along with the performance of relevant sectors such as health and education.

The data record on health and education is rich in Oman, particularly in numerical terms. It has considerable potential for child rights monitoring through the district-based information model of the health service. However, the data is limited to children under the age of 15, is scarce beyond survival and development and gives little information on other child rights issues that are of concern to Oman and the CRC.

The **CRC** does not establish quantitative standards for all the rights it contains. The Geneva-based Committee on the Rights of the Child has called for valid national monitoring systems giving information on the status and living conditions of children, as well as the progress made towards fulfilling children's rights. As the CRC covers all human rights in one document - civil, political, economic social and cultural - monitoring requires information that goes beyond health and education. Also required is data on protection, civil rights and participation.

The Committee on the Rights of the Child can act as the 'monitor of monitors' due to its global role.[88] Thus, the Committee makes a standard recommendation in its comments on all State party reports that a comprehensive and continuous national child rights monitoring mechanism should be established. The system of indicators needs to integrate national concerns and realities with the CRC framework, 'To deal with issues of equity, disparity and discrimination, and to deal with protection and participatory rights, what is needed is less a set of universal indicators than a universal technical framework – or set of frameworks – to be adapted (*in situ)*'[89]

Ideas regarding children's place in society, including their rights, have different meanings in different legal, political and cultural systems. Thus, the specific traditions of a country play a leading role in national-level implementation of the CRC, all the while not losing sight of its main universal principles.[90] These accords with the Government of Oman's proven emphasis on pursuing appropriate strategies for regional development and with UNICEF's mandate and desire to support awareness creation and behaviour change at the community level. This also requires up-to-date qualitative and quantitative information that will develop a greater awareness of community dynamics in different

[88] Hammarberg, T., 1993, The work of the Expert Committee on the Rights of the Child, Address at the Consultation on *The role of the United Nations and NGOs in the implementation of the Convention on the Rights of the Child*, UNICEF House, New York, 24 March, 1993.
[89] Gautam, K., 1 Deputy Executive Director UNICEF Programme Division, quoted in Black, M., 1994, *Monitoring the Rights of Children: Innocenti Global Seminar, Summary Report*, Florence, UNICEF-ICDC.
[90] See for example, Alston, P., 1994, (ed.), *The best interests of the child: Reconciling culture and human rights*, Oxford, Clarendon Press.

regions, together with the characteristic regional social structures and processes. In particular, more information is needed concerning the lives of women and children in different population groups.

6.2 Children and Nation Building

For Oman, the youngest generation is a source of immense hope and expectation. Now enjoying the full benefits of rapid health and education development, Oman's youth will ultimately determine the success of Oman's Vision 2020 by building a diverse, technologically advanced economy.

The roles of children in family and community life are just beginning to be investigated and documented. Children in Omani society often play a vital role in family agricultural and pastoralist activities and within the home. It is frequently through the young that good relations between neighbours are created and a strong sense of community built or reinforced. The extent and value of children's roles in these contexts should be better understood as part of an effort to develop effective support programs and services for families and communities.

Available data on the health and wellbeing of women and children needs to be supplemented by more knowledge about the contexts in which this data can be understood. For example, the Government's emphasis on pursuing appropriate strategies for decentralization, together with the emerging accent on work at the community level, make it important to develop a better understanding of socio-cultural structures and processes that characterize community and family dynamics in different regions. A key to this is better information regarding the roles of children and women in the family and community.

In addition, the impact of Oman's health transition on the lives, welfare and rights of families, including women and children, are not well known. Further research is required to identify how maternal and child conditions are influenced by several important factors, such as, rapid changes in infant and child mortality, changes in fertility and age at marriage, increased educational opportunities, rapid urbanization and modernization and new health challenges in the form of the 'diseases of development'.

6.3 Recommendations

The Sultanate of Oman's success in its commitment to ensuring comprehensive child rights, in line with the wider global context of the CRC, will require new efforts in three main priorities:

1) The development of new childhood databases that will extend child rights monitoring beyond survival and development issues
2) The further development of civil society, including community mobilization, to reduce dependence on centralized, state-provided services and expatriate expertise
3) More attention on the rights of children over the age of five years, particularly adolescents.

6.3.1 New Databases

A priority challenge for the Government of Oman and UNICEF in the period 2004-2006 is capacity-strengthening and technical support in child statistics, in parallel with ongoing regional efforts in the development of gender statistics.[91] This links with the need for closer connections among social statistics, policy, and planning, the key to which is more and better information about children. A database on children and childhood in Oman has been on the agenda for some time. It should:

[91] UNRISED, 1999, Gender, poverty and well-being: Indicators and Strategies Report of the UNRISED, UNDP and CDS International Workshop, Kerala, 24-27 November 1997, Geneva, UNRISED, UN, 1997, Report of the Regional Workshop on the Development of National Gender Statistics Programmes in the Arab Countries, Tunis, 9-14 June 1997, New York, United Nations, E/ESCWA/STAT/1997/7

- Be a routine part of government data collection
- Provide all the information required to monitor the full range of rights in the CRC
- Contain children-focused, disaggregated data
- Be based on an integrated set of age groups agreed inter-sectorally
- Be based on the successful 'district-up', computerized model developed by the Ministry of Health

A central site is required, such as a website, from which continuous, updated information and links can be collected by government agencies, thus ensuring that the development of situation analyses would be a continuous process.

Integration could occur, of further information on survival and development issues with existing data, for example:

- National-level morbidity and accident data for children disaggregated by age, gender, rural/urban and district. For this information to be most meaningful, capacity in disease classification and reporting would have to be strengthened at all levels of the system
- More detailed information concerning eating habits and lifestyle patterns in different communities and for different age groups, within the context of Omani social traditions
- Improved classification and reporting of disability, with statistical data disaggregated according to age, gender and proven causes
- Reporting of the physical and sexual abuse of children and child neglect
- Regional and district-level disparities in access to services
- Analysis of drop out and repetition rates, including information about children's out-of-school activities, whether these are in work or recreation
- Studies of the contexts of childhood, reflecting perceptions of children as well as adults, are urgently required in order to analyze statistical information and assess the impacts of recent cultural and social transformations

To monitor the full range of rights outlined by Omani law and the CRC, construction of new databases are required, in particular:

- Detailed information on children in the justice system, with respect to offences, arrest, investigation, judicial process, sentencing and rehabilitation
- Budget allocation to children
- Children's economic contribution
- Rehabilitation programmes of all kinds
- Children's participation in school, cultural and media activities

Studies of the contexts of childhood, reflecting perceptions of children as well as adults, are required in order to analyze statistical information and assess the impacts of recent cultural and social transformations. These should include:

- Regional and rural/urban comparisons
- Studies of family dynamics, including decision-making
- Research into knowledge, attitudes and practices with respect to health, education, socialization, discipline, nutrition, child care, disability, gender, consumption patterns, leisure and recreation and employment

6.3.2 Further Development of Civil Society

Social mobilization at the community level in Oman needs further development, particularly with reference to awareness of child needs and implementation of child rights. Much can be done to build alliances for the wellbeing and rights of children in Oman. Advocacy is needed to create an environment that will enhance the recognition of children's rights, and promote changes in attitudes

and practices at all levels by keeping the interests of children and women at the centre of the social policy dialogue. Partnerships for children should bring together all those involved in strengthening and preserving their rights:

- Partnerships with children and youth to promote child participation at all levels of society; building on the existing models within the school system.
- Partnerships with Government, through decentralization
- Partnerships within civil society, with NGOs, religious leaders, voluntary organizations and activities, the media, and the commercial sector
- Partnerships with young people and existing organizations in order to address issues related to youth and adolescents

With respect to civil society, the following specific recommendations are made:

- Audit and evaluate the work of volunteers at community level, with a view to providing further professional support (including payment and qualifications), and integrating activities
- Promote the development of media expertise in child rights for better communication of child rights messages to children, their families and communities
- Promote the development of children-focused print and broadcast media, including child participation in planning and dissemination
- "Partnerships for children should bring together all those involved in strengthening and preserving their rights."

6.3.3 Attention to Adolescents

Little is known about the lives of Omani children outside school data, once they have reached the age of six. Even less is known of children over the age of 10. The adolescent survey provides some basic information for this age group; however, more research is required so that formulation of plans may occur for this pivotal generation of Omani citizens. The topics on which information is urgently needed include:

- Improved morbidity and accident data
- Secondary and higher education, with particular attention paid to gender differences
- The activities of the large numbers of adolescents and young people who are neither in school nor in the formal labour market
- Recreational, educational and vocational needs, especially with respect to the perceptions of adolescents themselves
- Health and lifestyle patterns, including nutrition and eating patterns, substance use, attitudes to marriage and parenthood, intergenerational dynamics and life skills

Once again, Oman faces the opportunity to be a global leader and pioneer in implementing programs that ensure the wellbeing and comprehensive rights of women and children, this time moving beyond survival and development, and addressing wider issues of people's rights. The CRC has outlined a global commitment to this goal, while parallel Omani initiatives have already begun to address most of the key issues within the CRC. The launching of the new programme of cooperation between Oman and UNICEF provides a useful opportunity to clarify the new challenges and needs in Oman and to develop the national capacity to meet them.

ANNEX 1

The Baby Friendly Hospital Initiative (BFHI)

The Baby Friendly Hospital Initiative is a joint project by UNICEF and the WHO, which encourages hospitals to promote exclusive breastfeeding by making 'rooming in' of mothers and their newborns possible, and by prohibiting the supply of free and low-cost breast milk substitutes. To become baby friendly a hospital has to convince an assessment team that its practices conform to the UNICEF–WHO Ten Steps to Successful Breastfeeding:

- Have a written breastfeeding policy that is routinely communicated to all health care staff
- Train all health care staff in skills necessary to implement this policy
- Inform all pregnant women about the benefits and management of breastfeeding
- Help mothers initiate breastfeeding within a half hour of birth
- Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants
- Give newborn infants no food and drink other than breast milk, unless *medically* indicated
- Practise 'rooming-in', allowing mothers and infants to remain together, 24 hours a day
- Encourage breastfeeding on demand
- Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic[92]

[92] *Protecting, promoting and supporting breast-feeding: the special role of maternity services,* Joint WHO/UNICEF Statement Geneva, 1989

ANNEX 2

Glossary of Terms Used in Text

Adult literacy rate: Percentage of persons aged 15 and over who can read and write

Baby friendly hospital: A hospital is designated "baby friendly" if it adheres to the "ten steps to successful breastfeeding" promoted by WHO and UNICEF (see Appendix 1)

Complementary breastfeeding: The proportion of children aged 6-9 months receiving breast milk and complementary foods

Continued breastfeeding (20-23 months): The proportion of children aged 20-23 months still receiving breast milk

DPT3: Three doses of vaccine against diphtheria, pertussis (whooping cough) and tetanus

Exclusive breastfeeding: The proportion of children aged less than 4 months who are receiving only breast milk, bar medicines and vitamins

Gross National Product: Gross national product, expressed in current United States dollars

Infant mortality rate: Probability of dying between birth and exactly one year of age expressed per 1,000 live births

Maternal mortality rate: Annual number of deaths of women from pregnancy-related causes per 100,000 live births

Munchausen's Syndrome by Proxy: A form of abuse in which a parent, usually a mother, causes a child to undergo unnecessary medical procedures through exhibiting faked or exaggerated symptoms to medical staff. In adults, the syndrome is known as Munchausen's Syndrome, and refers to adults who fake the symptoms of disease to obtain unnecessary medical attention and treatment. In the case of children, the young patient is presented to doctors by a parent as 'proxy' for the adult's need for attention. Although relatively rare, Munchausen's Syndrome by Proxy is recognized as a form of child abuse and is clearly a category that coexists with modern medical services. The disease is named after the fictional Baron Munchausen, who perpetually lied about his fantastic adventures.

Primary enrolment ratios: The primary enrolment ratio is the total number of children enrolled in primary school, whether or not they belong in the relevant age group for that level, expressed as a percentage of the total number of children in the primary school age group. The net enrolment ratio is the total number of children enrolled in a primary school who belong in the primary school age group, expressed as a percentage of the total number in that age group.

Stunting, moderate and severe: Below minus two standard deviations from median height for age of reference population

Total fertility rate: The number of children that would be born per woman if she were to live to the end of her childbearing years and bear children at each age in accordance with prevailing age specific fertility rates

TT2+: Two or more doses of vaccine against tetanus given to a woman before or during pregnancy to prevent a child contracting neonatal tetanus

Under-five mortality rate: Probability of dying between birth and exactly five years of age expressed per 1,000 live births

Underweight: *Moderate and severe* -- below minus two standard deviations from median weight for age of reference population. *Severe* -- below minus three standard deviations from median weight for age of reference population

Vertical transmission: Transmission of the HIV virus from mother to child

Wasting, moderate and severe: Below minus two standard deviations from median weight for height of reference population