

COUNTRY PROGRESS REPORT

SULTANATE OF OMAN

Reporting period: January 2010-December 2011

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I. STATUS AT A GLANCE

(a) Inclusiveness of the stakeholders in the report writing process

The consultative process was undertaken under the auspices of His Excellency Dr. Ahmed Al Saidi, Minister of Health. Initial consultation meetings took place from the outset with high level officials within the Ministry of Health to endorse and provide support to the entire data collection, validation and review processes.

The process to develop the Sultanate of Oman Global AIDS Response Progress Report 2012 was led by the National AIDS Programme (NAP) Team within the Department of Communicable Disease Surveillance and Control. The process took place through broad consultations, over the course of three months, with key stakeholders involved in the strategy setting and implementation of Oman's National Response Strategy to HIV and AIDS. UNAIDS MENA provided an international consultant to assist in the overall process of data collection and consolidation of the final report.

Data collection for the indicators and the NCPI took place through review of policy documents, programme reports, health statistics, health facility reports, research reports and studies, as well as site visits to key facilities and interviews with national stakeholders and key informants from government, civil society and UN agencies. Interviews and site visits included policy makers at MOH and other ministries, several hospitals and health facilities involved in ART service delivery, PMTCT, drug-treatment facilities, Medical stores, NGO offices and UN agencies. In addition, a focus group discussion with injecting drug users was held to get first-hand inputs from this population. Furthermore, discussions with young people added to insights regarding the risks and vulnerabilities of this group.

A roundtable discussion meeting was held to present and discuss the preliminary findings of the data-collection process, whereby all key national stakeholders were invited and were given an opportunity to provide inputs, raise concerns and ask for further clarifications. This roundtable not only served to validate all data with key stakeholders, but also engendered a discussion with stakeholders from all sectors and constituencies with regard to priority issues to be addressed in the next period. These discussions will also serve as inputs for the revision and development of the new National Strategic Plan.

After incorporation of all inputs that were received through the data-collection process described above, final data entry was done by the NAP and UNAIDS consultant. All data entered was cross-checked and discussed before final submission.

The Sultanate of Oman's Global AIDS Response Progress report 2012 is the result of this inclusive process over the course of three months.

(b) Status of the epidemic

The HIV situation in Oman can be characterised as low-prevalence. Between 1984, when the first Omani HIV case was reported, and the end of 2011, a cumulative total of 2,164 Omani HIV cases has been reported. More than one-third of these people has died of AIDS, while 1,371 (63.4%) were still alive at the end of 2011. More than two-thirds (72.2%) of all reported Omani cases were males, and 28.8 percent females. The main routes of transmission are heterosexual (50.2%), homosexual or bisexual (14.1%), mother to child (5.5%), injecting drug users (4.2%) and blood transfusion (3.3%). Apart from Omani cases, all expatriates seeking residency in Oman are mandatorily screened for HIV and other infectious diseases before

they are granted a residence permit. HIV screening results among expatriates show a reasonably stable number, from 106 cases in 2005; 130 (2006); 114 (2007); 140 (2008); 137 (2009); 110 (2010) to 125 in 2011.

Since July 2009, Oman has started to offer HIV testing and counselling services to all pregnant women, with the aim to prevent mother-to child transmission (PMTCT) by providing treatment and follow-up services. HIV positive patients are treated at 15 different sites spread over in Oman; there were around 661 persons on Anti-retroviral treatment at the end of 2011.

While limited research has been done among the most-at-risk populations, including sex workers, men who have sex with men (MSM) and injecting drug users (IDUs), available data and information from focus group discussions and key informants show that these MARP groups are all present in Oman and face considerable HIV risks. High-risk sexual and/or drug-injection behaviour may contribute to the further spread of HIV, not only among MARP groups themselves, but also to the general population. In this regard, clients of sex workers may play a role as a bridge population to the general population.

In addition to MARP groups, specific groups of the general population may be particularly vulnerable to HIV. Changing sexual norms and practices and drug use, as well as international travel and increased exposure to other cultures may place young people at special risk of HIV infection. Other vulnerable groups include expatriate workers who make up a considerable proportion of the Omani population, and who may face special vulnerabilities.

(c) Policy and programmatic response

The national response distinguishes the two levels of: 1) national *commitment* and 2) actual programme *implementation*. While implementation is key, it is dependent on adequate support from high level policy- and decision-makers.

1) In terms of ***national commitment***, in the 2010-2011 period, Oman has taken initial steps towards the development of a revised NSP, and a more comprehensive national response to HIV. In addition to the long-existing commitment for free access to comprehensive treatment, care and support for Omani PLHIV, the last two years have seen an increasing acknowledgment of the importance of HIV prevention, including targeted interventions for most-at-risk populations (MARPs). Political support and leadership are reflected at the institutional and organisational level; in policy and programme development; and in terms of allocation of human and financial resources:

- Institutional strengthening is needed for the effective functioning of the *National M&E Committee* as the key multisectoral coordination body. In addition, the National AIDs Programme faces understaffing and constraints in resource allocation. Furthermore, the role of civil society in the national response needs to be strengthened.
- Key priorities regarding *policy and programme development* include the development of an updated national strategic plan (NSP), and the systematic review of general legislation and policies that hamper effective HIV prevention, care and treatment.
- The lack of earmarked budgets and *resource allocation* has been one of the major stumbling blocks for the effective implementation of the multisectoral national strategy. Another challenge is the lack of clearly defined and understood roles and responsibilities regarding of other sectors.

2) Implementation of the 2007-2011 NSP in the 2010-2011 period has remained selective, and skewed towards massive screening and repatriation (of HIV-positive) of expatriates –

and controlling HIV cases among Omani nationals through ART. Nevertheless, some important steps were made towards strengthening prevention efforts. One of the most successful efforts in this regard has been the nearly 100% implementation of the PMTCT policy. In addition, studies among sex workers, IDUs and MSM were conducted; initial community programmes for MSM and IDUs started; and there have been increasing collaboration efforts between NAP and civil society organisations. Importantly, the NAP leadership fully acknowledges the pending priorities and has a clear intention to strengthen NSP components that have so far received less attention. Key priority areas remain quality and coverage of treatment, care and support programmes, with special attention for the rights of PLHIV; as well as HIV programmes for MARP groups, expatriates, and the initiation of VCT services.

(d) Indicator data in an overview table

NO.	INDICATOR	REPORTED DATA AND COMMENTS
		SEXUAL TRANSMISSION
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Study among 3,473 university students (19-22 years) Convenience sampling at annual Muscat festival Correct answers on 5 HIV-knowledge questions: All:3.92%; Male: 3.92%; Female: 3.91%
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	This question is considered culturally inappropriate, hence not enquired. However, there is anecdotal evidence from peer informants that first sexual experience before 15 years is not uncommon, especially for young men.
1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Anecdotal evidence from peer informants reveals that high-risk sexual practices are increasingly common among young Omani people, in particular young men. Sexual behavioural patterns in Oman are rapidly changing, with young men having premarital sex, including with sex workers, other young men (MSM), or domestic workers. Sexual contacts take place in Oman, or on international trips. Young women are much less likely to engage in premarital sex.
1.4	Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	Condom use in general is very low among high-risk sex; however a study is planned to determine that among injecting drug users during 2012. Small study (60 participants) conducted among MSM found that condom usage is less than 10% in Quriyat wilayat (district) of Muscat governorate. Study among sex workers is not conducted.
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Non-representative survey conducted during 2011 therefore cannot report the indicator. However testing and counselling is widely done across the country through health facilities, which is reported in universal access reporting, indicator 1.16, using programme records.
1.6	Percentage of young people aged 15–24 who are living with HIV	NO COMMENT
1.7	Percentage of sex workers reached with HIV prevention programmes	No representative study is conducted among sex workers so far. Outreach activity among sex workers does not exist by either government or civil society organisations; therefore condom is also not provided. Small study among 87

	(condom distribution; HIV testing)	sex workers {66 (76%) of whom were Omani sex workers} conducted during 2011 did not inquire about where to receive a HIV test in details.
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	No representative study is conducted among male or female sex workers so far. Outreach activity among male or female sex workers or MSM does not exist by either government or civil society organisations; therefore, condom usage is not known. Small study among 87 sex workers {66 (76%) of whom were Omani sex workers} conducted during 2011 revealed that % were using condom; though condom usage with most recent client was not inquired.
1.9	Percentage of sex workers who received an HIV test in the past 12 months and know their results	No representative study is conducted among sex workers so far. Outreach activity among sex workers does not exist by either government or civil society organisations. Small study among 87 sex workers {66 (76%) of whom were Omani sex workers} conducted during 2011 revealed that % were aware about where to receive a HIV test.
1.10	Percentage of sex workers who are living with HIV	No representative study is conducted among sex workers so far. Outreach activity among sex workers does not exist by either government or civil society organisations therefore regular HIV testing among them is not done. Small study among 87 sex workers {66 (76%) of whom were Omani sex workers} conducted during 2011 did not include a HIV test.
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No representative study is conducted among MSM so far. Outreach activity among MSM is not existing by either government or civil society organisations therefore condom is also not provided..
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No representative study has been conducted among MSM so far. Outreach activity among MSM does not exist by either government or civil society organisations. Small study among MSM conducted during 2011 did not enquire about condom usage during last sex.
1.13	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results	No representative study is conducted among MSM so far. Outreach activity among MSM is not existing by either government or civil society organisations therefore HIV testing is not done routinely. Small study among MSM conducted during 2011 revealed that 58 MSM participated in it, 14 among them screened for HIV, and 12/14 knew their result.
1.14	Percentage of men who have sex with men who are living with HIV	No representative study is conducted among MSM so far. Outreach activity among MSM does not exist by either government or civil society organisations therefore HIV test is not offered as a routine. Small study among MSM conducted during 2011 did not include HIV test as a part of that.
		INJECTING DRUG USERS
2.1	Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes	No formal harm reduction programme is currently in place where needle and syringe provision or exchange can take place. No size estimate among MARP including IDU is conducted till date. Therefore this indicator cannot be reported. However, small, unsystematic distribution of syringes (not collection) is done in Muscat area
2.2	Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	No formal harm reduction programme is currently in place where counselling and condom promotion also could take place. No size estimate among MARP including IDU is conducted till date. No representative study conducted among IDU's regarding condom usage during sex, therefore this indicator cannot be reported.
2.3	Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	No formal harm reduction programme is currently in place where safe injecting practices promotion also could take place. No size estimate among MARP including IDU is conducted till date. No representative study conducted among IDUs regarding safe injecting practices, therefore this indicator cannot be reported.
2.4	Percentage of people who inject drugs who received an HIV test in the past 12 months and know their	No formal harm reduction program is currently in place where HIV testing also could take place. No size estimate among MARP including IDU is conducted till date. Therefore this indicator cannot be reported.

	results	
2.5	Percentage of people who inject drugs who are living with HIV	Percentage (%) of injecting drug users who test positive for HIV: 1.4% Numerator Number of injecting drug users who test positive for HIV: 13 Denominator Number of injecting drug users tested for HIV: 929
		PMTCT
3.1	Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission	ANC coverage in Oman is more than 99% and HIV testing among ANC is 99.4%. Therefore, denominator is taken as actual HIV cases reported among ANC women. Secondly Oman was not included as a part of estimation exercise by UNAIDS/WHO-EMRO therefore estimates using latest spectrum data is not available. Percentage (%) of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child Transmission = 95.8% (23/24)
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Percentage (%) of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth = 25/30 = 83.3%
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	Oman was not included as a part of estimation exercise by UNAIDS/WHO-EMRO therefore estimates using latest spectrum data is not available.
		ANTIRETROVIRAL TREATMENT
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	No denominator data is available in the absence of estimations regarding the actual number of adults and children with advanced HIV infection; hence, no accurate percentages can be given beyond the absolute number of people known to be on ART.
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data on 12-month retention are not available for patients who initiated ART in 2010 specifically, but available for patients that initiated ART during an earlier time period (e.g. 2009 or 2008) = 74.26% (75/101)
		TB-HIV CO-INFECTION
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Percentage (%) Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV = 7/7 = 100%
		AIDS SPENDING
6.1	Domestic and international AIDS spending by categories and financing sources	Total 2011: USD 4.7 million Prevention (PMTCT, MSM, Blood safety): USD 0.52 million Treatment, care & support: USD 1.38 million Mandatory testing: USD 2.50 million
		CRITICAL ENABLERS & SYNERGIES
7.1	National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and M&E)	Overall ratings (1-10) 1. Civil Society involvement: 6 2. Strategic Planning: 6 3. Political Support & Leadership: 6 4. Human Rights: 3 5. Prevention: 4 6. Treatment, care & support: 8 7. M&E: 5
7.2	Proportion of ever-married or partnered women aged 15-49 who	No data

	experienced physical or sexual violence from a male intimate partner in the past 12 months	
7.3	Current school attendance among orphans and non-orphans aged 10–14	Oman does not have problems with (non) school attendance of orphans or non-orphans in relation to HIV/AIDS. All children, with or without parents have access to free public education = 35/35 = 100% Denominator Number of children who have lost both parents
7.4	Proportion of the poorest households who received external economic support in the past 3 months	No data

II. OVERVIEW OF THE AIDS EPIDEMIC

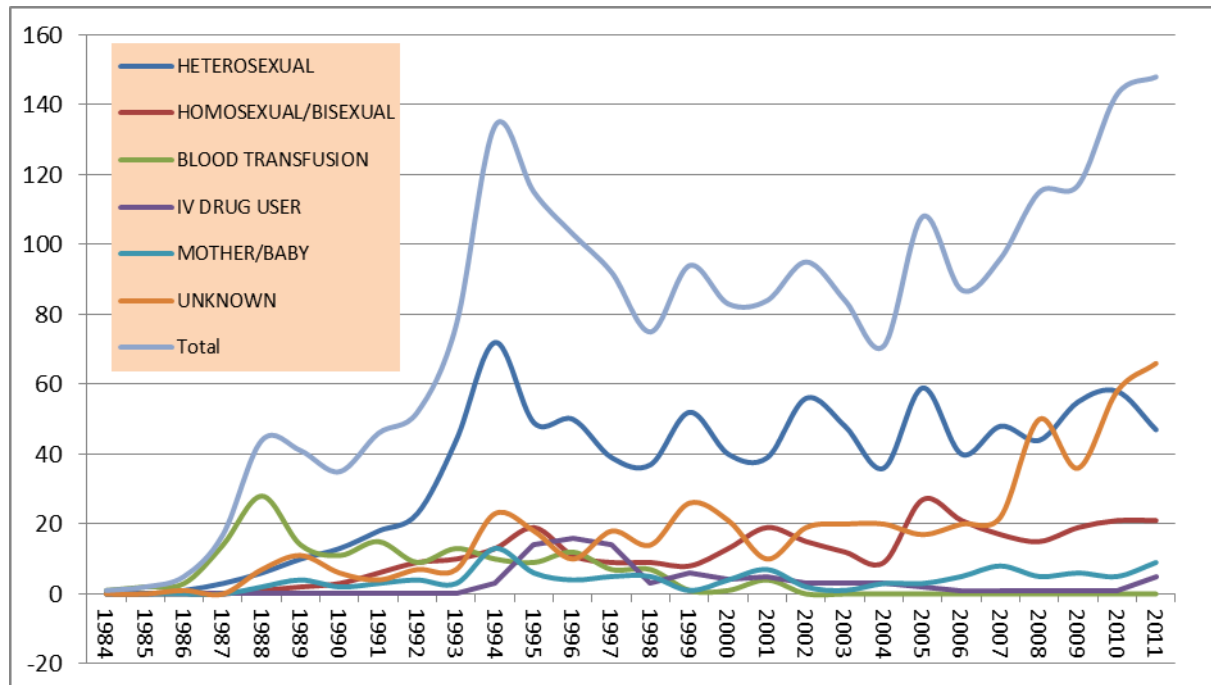
Reported HIV cases among Omani nationals and expatriates

The HIV situation in Oman can be characterised as low-prevalence. Between 1984, when the first Omani HIV case was reported, and the end of 2011, a cumulative total of 2,164 Omani HIV cases has been reported. More than one-third of these people has died of AIDS, especially those who were infected in the early stages of the epidemic when antiretroviral treatment was not yet available, while 1,371 (63.4%) were still alive at the end of 2011.

More than two-thirds (72.2%) of all reported Omani cases were males, and 28.8 percent females. Furthermore, 72 percent were from the age group of 25-59 years; 17.4 percent 15-24, while 7.8 percent were younger than 15.

Before 1995, blood transfusions were still a major route of transmission (22.6%), but since then it is no longer a cause of concern as all donated blood is tested for HIV. The main routes of transmission are heterosexual (50.2%), homosexual or bisexual (14.1%), mother to child (5.5%), injecting drug users (4.2%) and blood transfusion (3.3%), while the mode of transmission was *unknown* a quarter of all cases (26%). Figure (1) gives an overview of the trends over time for the proportion of different HIV-transmission routes.

Figure 1: Number of Omani HIV cases according to mode of transmissions for the years 1984-2011



The available data on the number of known Omani HIV cases do not allow providing an accurate estimate of the true *number* of cases, and the overall HIV *prevalence* among nationals, since the available HIV data is mainly based on mass screening among blood donors, premarital and pre-employment screening, in which most-at-risk populations are

typically under-represented. In the absence of functional VCT services, it is not easy for persons at higher risk to get a confidential HIV test.

Apart from Omani cases, all expatriates seeking residency in Oman are mandatorily screened for HIV and other infectious diseases before they are granted a residence permit. In addition, all expatriate workers are tested on renewal of their contracts every 2-3 years, while citizens from countries with higher HIV rates are tested every year. Thus, the number of HIV cases reported among expatriates reflects both those who already lived in Oman, and those who were seeking entry to the country. HIV screening results among expatriates show a reasonably stable number, from 106 cases in 2005; 130 (2006); 114 (2007); 140 (2008); 137 (2009); 110 (2010) to 125 in 2011.

Since July 2009, Oman has started to offer HIV testing and counselling services to all pregnant women, with the aim to prevent mother-to child transmission (PMTCT) by providing treatment and follow-up services. HIV positive patients are treated at 15 different sites spread over in Oman; there were around 661 persons on Anti-retroviral treatment at the end of 2011.

HIV risks and vulnerabilities among most-at-risk and other vulnerable populations

As mentioned above, the mass screening of foreigners and certain categories of Omani nationals does not provide an accurate picture of the HIV epidemic in the general population. It gives an even less reliable picture of HIV among most-at-risk populations, such as sex workers, MSM and IDUs. However, in the absence of special sero-surveillance studies, there are no reliable estimates of HIV rates among these groups.

HIV risks among female sex workers

Sex work is present in Oman, but it is extremely hidden and to date, no targeted HIV-prevention programmes are available for these women. To date, there has been very limited research on sex work in Oman, and little is known about the exact scope and nature of the phenomenon. In 2011, a first study among 87 female sex workers was done, which will provide a better understanding of the dynamics of sex work in Oman. While the full results of this study were not yet available at the time of developing this GARP report, preliminary data provide some information on sex worker communities in Oman. Seventy-six percent (76%) of the sex worker respondents were Omani, while the remaining 24% were from various countries in South-East Asia (14%) as well as the Middle East (10%). Results reveal that sex workers are networking with each other, with respondents on average knowing more than 60 other sex workers. While percentages of condom use are not given, sex workers report a variety of reasons for not using condoms with clients, the main one being that customers refuse to use condoms. Other reasons include that the sex workers themselves do not want to use condoms; financial reasons (as they are offered more money to have sex without using condoms); unavailability of condoms; and not being aware of benefits of condom use. The main ways of protecting themselves include ejaculation outside the vagina; avoiding vaginal sex and group sex; condom use; while they also reported avoiding sex with “dirty men”.

Anecdotal evidence from interviews with key informants in the context of this GARP report provides additional information on the Omani sex-work scene. They report that women from different nationalities are involved in sex work. Omani women mostly operate from (rented) apartments, while foreign women may combine sex work or transactional sex with their work in other professions, including that of housemaid. There is evidence from the wider region,

that some of these sex workers may be victims of human trafficking, although there are no accurate data with regard to the Omani situation.

Currently, there is no data at all on the HIV-prevalence rates among Omani and foreign sex workers. Those foreign sex workers who entered the country *legally* – because they have a work permit for a regular job, which they may combine with sex work for additional income – will have been screened for HIV. However, illegal foreign sex workers – e.g. those who are trafficked – as well as Omani sex workers are unlikely to be entered in the current HIV-screening programmes. Thus, many of these local and foreign sex workers may not know their HIV status, while they engage in high-risk sex with multiple partners. It is clear that this represents a serious HIV risk, which requires targeted HIV-prevention programmes for these women.

HIV risks among men who have sex with men (MSM)

While MSM and homosexuality exist in Oman as in all other countries of the world, it is extremely hidden and little is known about the exact scope and nature of the phenomenon. Data of officially reported Omani HIV cases indicate that 14 percent of all 2,164 cases (cumulative) were related to MSM sex. This is a remarkably high percentage, given the fact that MSM-related HIV cases are severely under-reported in most countries in the region, which seems to indicate that the Omani reporting system is more effective in identifying actual routes of transmission. Nevertheless, even this 14 percent is likely to be an underestimate, as many HIV-infected MSM will be reluctant to admit MSM behaviours. In this regard it should be mentioned that in 26 percent of reported HIV cases the transmission route is “unknown”: it is assumed that a substantial proportion of these are due to MSM contacts.

Apart from officially reported HIV cases among MSM, very little socio-behavioural research has been done among this group. A first study among 113 MSM was conducted in 2011, which is expected to provide a better understanding of the dynamics of sex behaviours among MSM in Oman. While the full results of this study were not yet available at the time of developing this GARP report, preliminary data provide some information on MSM communities in Oman.

The study was conducted among 113 MSM, with a mean age of 29 years; half of them were single (51%), while more than one-third (36%) was married and 13 percent divorced or widower. The high proportion of married or once-married men (49%) was also found in other research in countries in the Middle East and North Africa, which show that MSM often marry and have a family in order to meet societal expectations and avoid being identified as homosexual. The initial results of the Omani study reveal that most MSM respondents have extensive networks, with on average more than 200 MSM contacts, and regular (social) contacts in the last month. Respondents mention several reasons for having unprotected sex, including the lack of enjoyment with condoms; being under the influence of drugs; refusal by the partner to use a condom; trust because sex partners know each other; or the unavailability of condoms.

Research among MSM in the Middle East reveals frequent high-risk sex, with unprotected anal sex with many casual, unstable partners. Many Omani MSM are likely to have the financial means to travel in and outside the region, and may go for MSM sex in other countries, where the social climate around homosexuality is more liberal. This may also involve sexual contacts with local male sex workers. These high-risk behaviours imply HIV-infection risks not only for these MSM themselves, but also for their (potential) spouses and children.

While there is no conclusive evidence of HIV rates among MSM in Oman, the reported risk behaviours indicate the potential for a rapid spread of HIV within the MSM community. In this context, it is a priority to conduct studies among MSM to better understand the HIV risks in this community, and guide future policies and programmes for HIV prevention among MSM. This includes mapping, size-estimation studies and socio-anthropological research. In this context it is important to mention that an initial, small-scale MSM outreach programme started in Muscat at the end of 2011; this opens up possibilities to get a better understanding of the HIV-related risks and service needs of MSM in Oman.

HIV risks among injecting drug users

To date, 4.2 percent of all 2,164 reported Omani HIV cases (i.e. 91 cases) were the result of injecting drug use. Most likely, however, this number does not represent the accurate figure, since IDUs are a largely hidden population, and many HIV cases are likely to be missed by the official statistics. In the absence of recent sero-surveillance studies, the HIV prevalence rate among IDUs is unknown.

Apart from HIV rates, more information is also needed about *behavioural* risks among IDUs, as well as the total size of the IDU population and in what settings injecting drug use takes place. Interpersonal interviews and a focus-group discussion with IDUs and ex-IDUs conducted in the context of this GARP report revealed some of the dynamics in the Omani IDU community. Respondents indicated that while most IDUs are young men, young women are increasingly engaging in drug use as well, especially in the last five years. Typically, young people get introduced to drugs at a young age by their friends, brothers or other family members. They may be susceptible because of family problems, unemployment or just having the “wrong friends”. Drugs are readily available, also due to the proximity of the Iranian coast, with Oman being on the drug-trafficking route to other GCC countries and Europe. Most start using hashish and gradually move to heavier drugs, including tablets, morphine and heroin. Initially, they start smoking or sniffing, but then soon move to injection. Most commonly injected are heroin, morphine, or a combination: respondents reported using 2-3 doses per day, at a daily expense of approximately OR 25.- (USD 60.-). Initially, most drug use takes place in groups, with needle sharing commonly reported. Overdoses are frequent, and many IDUs end up in prison, where they continue using drugs. However, with limited access to clean needles, sharing is common, which is evidenced by the high Hepatitis C rate of 48 percent in 2011 among IDUs, as reported through screening data from hospital-based drug-treatment facilities.

These findings confirm the results from a rapid assessment on drug use and HIV in Oman that was conducted in 2006-07. The study showed high HIV and HCV levels among IDUs, of approximately 20 and 50 percent respectively. Despite high HIV knowledge, many IDUs reported engaging in unsafe behaviours, such as the use of non-sterile injecting equipment and unprotected sex with multiple partners, including sex workers and same-sex (male) partners. More than 90 percent of respondents admitted sharing of injection equipment, with an average of 2-4 times in the last month. None of the respondents used bleach when sharing syringes. Furthermore, drug overdose was very high: more than two-thirds ever overdosed, with a range of 1-30 overdoses per respondent. This study also mentioned high levels of imprisonment and associated sharing of injecting equipment. The drug use history revealed similar patterns as described during focus group discussions, starting with hashish and heroin being the most commonly drug first injected. More than half of the respondents reported injecting drugs outside Oman.

As mentioned, study findings also revealed high-risk sexual behaviours, with two-thirds never using condoms, while sex with sex workers was frequently reported: more than two-thirds ever, and more than 30 percent had had sex with a sex worker in the last month.

Furthermore, results showed high prevalence of same-sex contacts between men (MSM): one-third admitted having ever had MSM sex, with the majority (60%) of those who had had MSM sex not using condoms with MSM in the last year.

These consistent findings from studies, focus groups and interpersonal interviews confirm that IDUs are a particularly at-risk group, with frequent needle-sharing and unsafe sex with different partners, including sex workers and MSM. Experiences from other countries in the Middle East with high HIV rates among IDUs – such as Iran, Egypt and Libya – have shown that there is no room for complacency in the face of a looming HIV epidemic among IDUs. Therefore, the recently emerging community initiatives for IDUs by civil society organisations and former drug users, and supported by the NAP, are an important component of the national response to HIV, which need to be further expanded and systematised. More collaboration is needed with the government drug-treatment facility of the Ibn Sina Hospital.

More research on (injecting) drug use is needed to better understand the HIV risks among this population. This includes mapping and size-estimation studies, as well as biological and behavioural surveillance studies.

Behavioural risks among young people

HIV risks are commonly associated with the most-at-risk populations described above: sex workers, MSM and IDUs. However, merely one-fifth of all reported HIV cases among many citizens is attributed to MSM or IDU behaviours, while the majority is associated with heterosexual contacts. Although this category includes different types of heterosexual contacts, most have unprotected sex with a non-regular partner in common: even if women are infected by their husbands, this is associated with extramarital sex by the husband.

Hence, the HIV epidemic is not limited to MARPs groups, but HIV risks also exist among specific vulnerable groups of the general population. As mentioned, the common denominator is unprotected sex with a non-regular partner: this may include sex workers as well as girlfriends (and boyfriends) in- and outside Oman. However, while little is known about the specific HIV risks of sex workers, even less is known about HIV risk behaviours among the *general population*: research on sexuality in general, and among young people in particular, is highly sensitive and difficult to discuss openly.

In this regard, interviews that were held with peer informants in the context of this GARP report, reveal that high-risk sexual practices are increasingly common among young Omani people, in particular young men. These key informants report that sexual behavioural patterns in Oman are rapidly changing, with a large proportion of young men having premarital sex, including with sex workers, other young men (MSM), or domestic workers. Sexual contacts take place in Oman, but a considerable proportion of young men have the financial means to travel to other countries in the region and beyond, such as South-East Asia, with the specific aim to engage in sex with sex workers. While young women are much less likely to engage in premarital ‘regular’ sex – in order to preserve their virginity – informants report that a certain proportion of girls will have oral or anal sex with their boyfriends.

While much of this remains anecdotal evidence, it is confirmed by studies and reports from neighbouring countries, which reflect the rapid changes in sexual behaviour patterns among young generations, especially among young men, and which highlight the importance of conducting further research to identify the scale and scope of risk behaviours among Omani youth, and develop appropriate HIV-prevention programmes.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

1. National Commitment

In terms of national commitment, in the 2010-2011 period, Oman has taken further steps towards the development of a revised NSP, and a more comprehensive national response to HIV. In addition to the long-existing commitment for free access to comprehensive treatment, care and support for Omani PLHIV, the last two years have seen an increasing acknowledgment of the importance of HIV prevention, including targeted interventions for most-at-risk populations (MARPs). Or as one non-governmental informant put it: *“HIV is now on the agenda: before, HIV/AIDS was seen as an MOH issue, but other, non-health sectors increasingly understand they have an important role to play in the national response to HIV/AIDS”*.

This increased commitment now needs to be operationalised through the revision and effective implementation of the NSP, which expired last year. Achievements as well as challenges with regard to political support and leadership in the field of HIV in Oman is reflected at the *institutional and organisational level*; in *policy and programme development*; and in terms of *allocation of human and financial resources*.

1) At the ***institutional level***, challenges remain with regard to the effective functioning of the *National M&E Committee*, which was established as a multi-sectoral body to provide overall high-level leadership and supervision to the national response to HIV. To date, however, the Committee has been functioning sub-optimally, and little progress was made towards revitalising the fulfilment of its mandate. Furthermore, the *National AIDS Programme* has continued to face challenges in terms of understaffing, and lack of adequate resource allocations to effectively fulfil its tasks. Apart from the national manager and one technical expert, the NAP has no dedicated staff for M&E, while limited expertise exists in the field of HIV prevention.

While the role of different Government sectors is crucial in demonstrating national commitment, *civil society* has an equally important responsibility. In this regard, the overall weak presence of CSOs in the national response to HIV has hampered the effective implementation of strategies, especially for HIV prevention among MARP groups. In this regard, coordination and collaboration mechanisms between Government and civil society need to be improved.

2) At the level of ***policy and programme development***, the major priority is updating the previous national strategic plan (NSP), which expired in 2011. In the period 2010-2011, selective attention was given to the priorities as outlined in the NSP. One of the main shortcomings has been the lack of systematic follow-up of the planned activities of the NSP 2007-2011. The NSP consisted of a comprehensive approach, which focused on four pillars: surveillance, community prevention, treatment and care, and blood safety. Specific attention was given to addressing the needs of MARPs and other vulnerable groups. While the Plan identified priority interventions to be implemented by various sectors, there has been a gap between these strategies and plans of action on the one hand, and *actual* operationalisation and implementation of these planned strategies on the other. With the exception of Ministry of Education and Ministry of Awqaf and Religious Affairs, implementation of the NSP has been particularly weak in the non-health sectors, due to inadequate prioritisation and allocation of financial and human resources. On paper, all key sectors were involved, but in practice their active commitment and involvement needs considerable strengthening. This includes sectors such as Education, Labour, Youth, Social Development, Defence and Interior, Religious Affairs and others. A key obstacle for the implementation of targeted HIV

prevention for MARPs has been the overall weak development of civil society in Oman, and NGO involvement is particularly weak in the HIV field. This is linked to the sensitivity of the topic, and inadequate support from high-level decision makers.

In the past two years, no concrete steps were taken to review and refocus the previous NSP; the first steps towards a revised NSP have only been made in 2011. Apart from updating the NSP as an overall policy document, special attention is needed for a costed operational Plan, that clearly highlights the priority interventions, especially in the HIV-prevention field, which has not received due attention to date.

In addition to HIV-specific policy and programme development, general legislation and policies that hamper effective HIV prevention, care and treatment services need to be systematically identified and addressed: these have a particularly negative effect on HIV prevention among MARPs, and other vulnerable groups, including migrant workers. In the absence of an overall supportive legal and policy context, effective implementation of the new NSP – especially HIV prevention – will continue to face major challenges.

3) Allocation of financial and human resources – While there has been sustained political commitment for HIV/AIDS, and while a National HIV Strategy existed, the lack of earmarked budgets and resource allocation has been one of the major stumbling blocks for the effective implementation of the multisectoral national strategy. Most HIV-related resources in Oman are spent on mass screening and ARV treatment. However, these resources are not specifically earmarked for HIV, but are part of existing mass health-screening programmes for expatriate workers and Omani population groups such as premarital and pre-employment screening, which is not specifically aimed to control HIV. Similarly, ART provision takes place in the overall context of clinical treatment and care. While these key programme components have benefitted from existing resources, novel programmes – especially in the field of HIV prevention – could often not be implemented due to a lack of a systematic budget-allocation process.

2. Programme Implementation

As mentioned in the previous section, an important obstacle for effective implementation of the NSP in the 2010-2011 period has been the lack of systematic and reliable resource allocation, especially with regard to HIV prevention for MARPs and vulnerable groups, such as youth. Although there has been a relatively favourable climate for strengthening the HIV response, HIV/AIDS remains a low-priority problem in the health sector and especially in non-health sectors. In addition, many of the high-impact interventions for MARPs remain sensitive in the Omani context, and it is difficult to gain sufficient political and financial support for such targeted programmes.

As a result, implementation of the 2007-2011 NSP in the 2010-2011 period has remained selective, and skewed towards “trusted” interventions that focus on “keeping HIV out” – such as massive screening and repatriation (if HIV-positive) of expatriates – and controlling HIV cases among Omani nationals through ART. Nevertheless, some important steps were made towards strengthening prevention efforts. One of the most successful efforts in this regard has been the nearly 100% implementation of the PMTCT policy through provider-initiated testing and counselling (PITC) in the context of antenatal care (ANC) services, and the subsequent provision of PMTCT services for infected mothers and their infants. In addition, studies among sex workers and MSM were conducted; initial community programmes for MSM and IDUs started; and there have been increasing collaboration efforts between NAP and civil society organisations. Importantly, the NAP leadership fully acknowledges the

pending priorities and has a clear intention to strengthen NSP components that have so far received less attention.

HIV prevention

In the last 2 years (2010-2011), HIV prevention has received increasing attention. While full implementation of planned NSP (2007-2011) strategies was not feasible, the traditional narrow focus on massive screening and ART is broadening, with an acknowledgement of the need to address sensitive issues that are associated with HIV prevention among MARPs and youth.

HIV screening and testing – As mentioned above, large numbers of people are screened for HIV each year, predominantly expatriate workers and other foreigners (72% of all HIV tests), while the remaining 28% are Omanis who are mainly screened in the context of ANC services, blood transfusions, STI and TB patients, prisoners, IDUs seeking health care, and pre-employment HIV testing. A major development in this field has been the successful roll-out and implementation of the universal ANC-screening policy that was introduced in 2009. The PMTCT programme has highlighted the importance of counselling as part of HIV testing, which is expected to contribute to the re-establishment of voluntary counselling and testing (VCT) services, which will allow access to (voluntary) testing for those groups who are currently not picked up by screening programmes.

PMTCT – As mentioned, the PMTCT programme, which was started a few years ago, has been further rolled out successfully, reaching 99% rates. More than in other massive screening programmes, there is special attention for counselling and the right to know one's HIV status.

HIV education – In terms of general awareness-raising, the regular educational activities have taken place around World AIDS Day. However, the impact of these one-off interventions is very limited. Another good opportunity to raise HIV awareness are the massive screening campaigns, which reach large groups of people, but which are not accompanied by HIV education messages.

Furthermore, there have been ongoing efforts in the field of HIV education and peer outreach for young people, especially through the UNFPA-supported *Y-Peer* initiative, and youth outreach activities in the context of the Muscat and Salalah festivals, which draw large groups of young people. While these efforts have so far taken place on a modest and ad-hoc basis, reaching relatively small numbers of youth, the experiences and lessons learned can be used to develop more effective HIV-education approaches for young people, including out-of-school youth.

While HIV education has been part of the curriculum for school children for a long time, teachers were not properly trained and prepared to discuss sensitive issues surrounding sexuality and relationships, and school-based education mainly focused on medical facts. Still, many challenges remain, given the taboos and sensitivities surrounding sex education for children and young people, especially in a conservative society like Oman.

Targeted interventions for MARPs and other vulnerable groups – Stigma, discrimination and criminalisation of sex workers, IDUs and MSM continue to hamper targeted HIV-prevention programmes for these MARP groups. Nevertheless, in the 2010-2011 period, small but meaningful progress was made towards addressing HIV risks among these groups. Studies among sex workers and MSM, and a planned study among IDU will help better understand HIV-service needs among these groups, and develop interventions that are targeted to these needs. The NAP aims to continue this increased focus on MARP groups in 2012, including eventually specific programmes and services for MARPs.

Injecting drug users are the (relatively) easiest-to-reach MARP group, as injecting drug use is not commonly associated with extramarital or MSM sex, and therefore less surrounded by stigma and discrimination. Furthermore, there are existing *drug-treatment services*, but their capacity and coverage is low and the current *detoxification and rehabilitation* programmes lack effectiveness, as evidenced by high drop-out and relapse rates. Access to IDUs is limited by the fact that many parents send their addicted children to other countries, such as Saudi Arabia, for drug treatment. Thus, a large proportion of IDUs remains invisible to the Omani authorities.

Despite the relative good access to IDUs, the Drug-treatment facility does not offer specific HIV-prevention programmes, such as HIV education or *opioid-substitution therapy (OST)* programmes. To date, OST remains seen to promote injecting drug use, and therefore remains relatively unacceptable in Oman, although recently permission was given to start an OST pilot project.

Similarly, *needle-and-syringe-exchange programmes (NSEP)* remain unavailable. Although there is clear evidence that sharing of injection equipment is common, this may not be mainly due to difficult access to syringes, but rather the fact that drugs are shared in a social context, in which needle-sharing also occurs. Therefore, there is no clear proof yet that NSEP would be an effective HIV-prevention intervention. More research is needed to better understand the scale of unsafe injection practices, the main reasons, and most appropriate interventions.

A considerable number of IDUs may be tested for HIV through *mandatory testing* on admission to the drug-treatment facility, on arrest by the police, or when sentenced to prison: while this gives an idea about HIV prevalence among IDUs, many IDUs are never tested through any of these mechanisms, and it is limited understanding of the total scenario among IDUs. It should be mentioned that in principle, HIV testing is available at all primary health-care centres. However, many people – especially MAP groups such as IDUs – do not utilise these services as they may not be aware of their existence; or due to stigma associated with getting tested, or the fact that clients have to be registered with their name, which presents an additional barrier to some.

Female sex workers – Despite the fact that female sex workers have been clearly identified as a priority group in the NSP 2007-2011, there have been no HIV-prevention activities for sex workers in the 2010-2011 period, such as HIV education, peer outreach, condom distribution or special STI services and VCT services for sex workers. To date, there has been very little information available on sex work in Oman, given the limited research, and absence of mapping or size estimations. In this regard, the recent study that was conducted among sex workers in late 2011 is an important milestone, which is expected to provide a better foundation for implementation of HIV-prevention programmes that are based on sex workers' identified needs. Furthermore, the first community-outreach initiative with MSM in Oman may provide lessons learned that can help implement similar programmes for sex workers in the 2012-13 period.

Men who have sex with men – MSM and homosexuality are still rejected by Omani society, criminalised by law, and surrounded by severe stigma and discrimination. Therefore, the MSM community is largely hidden from the public eye and it is very difficult to reach them with HIV-prevention, or any other type of programme. In this regard the recent study that was conducted among MSM in 2011 – in parallel with the sex worker study mentioned – is expected to provide key information for the delivery of targeted HIV-prevention services to MARPs in the coming period.

Initial community-outreach activities for MSM already started in Muscat in 2011, albeit on a small and experimental scale. So far, these activities are mainly focused on HIV education, while other components still need to be added. E.g., a particularly important group for HIV-prevention may be male sex workers who cater to the needs of the MSM community, and who are at the highest risk of contracting and spreading HIV. The experiences with this

programme will yield important lessons for the development and roll-out of similar programmes for other MARPs and vulnerable groups, including sex workers and IDUs. In this regard this is one of the major achievements of the 2010-2011 period regarding prevention. Many challenges remain, however, in particular with regard to continued political support, collaboration with civil society organisations, and adequate resource allocations.

Clients of sex workers – Clients of sex workers are another important at-risk group, but very hard to identify; hence, no policy or programmatic attention has been given to this group in 2010-2011. However, as described earlier, anecdotal evidence from key informants in the context of this GARP report have shown that patterns of sexual behaviour are rapidly changing among the predominantly young population of Oman, and that a considerable percentage may be regular or occasional clients of sex workers, both in Oman and in other countries.

However, targeted HIV-prevention programmes for sex-worker clients are difficult to implement, as this remains a politically and socially sensitive area. Nevertheless, more social research is highly needed to better understand the dynamics of extramarital sexual behaviours in Omani society – both among nationals and expatriates – and develop effective programmes accordingly. Peer education and outreach programmes, possibly with condom promotion, are likely to be the most feasible and effective interventions.

Condom promotion & distribution – Condom promotion and distribution remain sensitive topics. While condoms are widely available for contraception among married couples, condom promotion for HIV-prevention purposes is considered promotion of illegal extramarital sex. Thus, public condom promotion among MARPs, young people, or other segments of the general population is likely to remain socially unacceptable. However, condom education as part of wider HIV-prevention and peer-education programmes for MARPs in more confidential settings may be a feasible approach.

HIV treatment, care and support

HIV treatment, care and support have been, and remain the strongest component of the national response to HIV in 2010-2011. However, no further improvements in terms of coverage or quality of services have been attained in this period, as quality of care was already high in the previous reporting period.

Antiretroviral treatment (ART) is available to all eligible Omani citizens. Treatment is confidential, and special attention has been given to ensure there is no discrimination toward HIV patients at the treatment facility, and that their human rights are fully respected. In addition, HIV patients have access to HIV-related care and psychological and social support. Compared to HIV prevention, implementing effective HIV treatment is much easier, as Oman has high-quality health-care facilities throughout the country with free treatment for all Omani nationals.

Most HIV patients are regularly followed up, with half-yearly CD4 and viral load tests, although genotyping for drug-resistance testing is not done now, which hampers effective patient follow-up. There are some follow-up problems with patients not getting regular CD4 and viral-load tests. Non-adherence problems are reported, with patients dropping out for various reasons, including lack of resources to travel to the ART facility on a regular basis. 12-month retention rate was 74.3 percent.

In addition to loss to follow-up of some ART patients, other treatment problems are related to late diagnosis of HIV cases: some patients are not identified through any of the HIV-screening programmes (which only screen approx. 7% of the Omani population per year), and present with advanced clinical symptoms.

The major challenge with regard to access to treatment, however, is the fact that non-nationals who are found to be HIV-infected are mandatorily repatriated to their home countries. Only a small proportion of them have temporary access to treatment if this is medically required to stabilise their condition before repatriation.

Social, psychological and legal position of PLHIV – Although the main health, employment and other legal rights of PLHIV are formally protected by policies, PLHIV in Oman still face major challenges with regard to social stigma and discrimination, as well as their employment rights. Although the NAP has been trying to facilitate the establishment of support groups or an association of PLHIV, to date, most PLHIV do not want to organise themselves with other PLHIV due to social and self-stigma, and fear of public disclosure of their HIV status. Most PLHIV keep their status to themselves, or disclose it only to their spouse or closest family members and friends.

An assessment was done in 2011 among PLHIV to identify their main information channels and sources regarding HIV, with a view to better targeting HIV information for PLHIV as well as for the general population. The assessment revealed service needs with regard to emotional, spiritual, and psychological support; financial support; medical and physical care; and legal support.

While PLHIV are entitled to employment, and cannot be dismissed from their job because of their HIV status, in some sectors, PLHIV are not allowed to work, such as in clinical health care, the military and some private businesses. Thus, the employment rights of (Omani) PLHIV are not fully protected.

IV. BEST PRACTICES

While the national response to HIV in Oman continues to face many challenges, there have been important achievements and successes. Best practices that existed prior to 2010 include free access to high-quality antiretroviral treatment, with good laboratory support and well-trained staff, although time from collection of sample to knowing one's status is long. Blood transfusion services provide safe and effective services, and HIV transmission through blood or blood products can virtually be ruled out. Omanis are protected in general legally through policies for employment and human rights but HIV-infected expatriates' still face problems in terms of employment and health rights. Since 2009, the near-universal access to antenatal screening minimises HIV transmission from mother to child.

In addition to the main achievements that have predominantly been seen in the clinical and treatment field, Oman has been making important steps towards a more comprehensive national HIV response, with special attention for HIV prevention and most-at risk groups. While 2010 and 2011 have mainly seen *initial* steps in the right direction, these steps reflect the country's increasing acknowledgement of HIV as a national priority.

Small but significant achievements is mapping of sex workers, IDUs and MSM, and a planned study on IDUs, which will strengthen the basis for more evidence-informed strategies for these key populations.

Furthermore, small-scale but innovative outreach programmes have been implemented for MSM, while peer outreach activities among youth focus on life skills rather than mere HIV knowledge.

Another key area is the increasing collaboration between NAP and civil society organisations. While these contacts are still in early stages, they reflect the acknowledgement that partnerships that build on the comparative advantages of governmental, civil society and private sectors can create win-win situations. These partnerships are crucial for effective interventions, especially among MARPs and vulnerable groups.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

As described in previous chapters, there are still many challenges facing the national response to HIV in Oman. Most of these challenges were already reported in the previous UNGASS report in 2010, and some of them were adequately addressed in the 2010-2011 period. However, many challenges remain, especially with regard to supportive political, institutional and social environments, as well as regarding more sustained and systematic and financial resources. Stigma and discrimination, and taboos and sensitivities surrounding HIV-risk behaviours and most-at-risk populations continue to have a negative impact on programme implementation.

One important challenge is related to the fact that the numbers of HIV cases have remained relatively low in the past 25 years, and due to this HIV has never been identified as a priority public health problem. As a result, sustained political support remains a challenge, and depends more on individual support by decision-makers than on agreed national policy priorities. In this context it is difficult to ensure a systematic and sustained HIV response.

Specific challenges, specific remedies

Despite positive signs towards a more comprehensive HIV response beyond screening and treatment, specific challenges remain in a number of areas. The main areas are discussed below, and remedial action is suggested.

1. Political support to be strengthened – Despite an overall positive policy climate for the NAP, the status of HIV/AIDS still requires further prioritisation on the political agenda. The continuously low HIV-prevalence rates and sensitivities surrounding HIV make it convenient to downplay its potential to become a serious public health problem, let alone a problem for non-health sectors. Therefore, even when political support exists, it often remains symbolic, but concrete support in terms of financial and human resources remains unpredictable.

Remedial action: A combination of strong evidence (see next) and effective advocacy is needed to convince high-level decision-makers of the need to further strengthen HIV prevention. In addition, leadership from the highest levels is needed to garner support at lower administrative levels in key sectors, especially in non-health sectors. International experience and technical assistance may help highlight the priority issues.

2. Lack of evidence and strategic information regarding the potential drivers of a future HIV epidemic, the existence and scale of high-risk behaviours, and effective interventions makes it difficult to convince leaders to provide political and financial support, and to establish effective HIV-prevention programmes. The absence of adequate biological and behavioural surveillance systems, research and M&E systems hampers an evidence-informed approach, which comprises effective national policies and strategic frameworks, as well as adequate budgets.

Remedial action: 1) Research into the social and behavioural dynamics of MARP groups, as well as youth and other vulnerable groups, that increase HIV risks. 2) Strengthening of existing surveillance systems, and establishment of new ones, especially bio-behavioural surveillance studies among MARPs; as well as improved national M&E systems, that support effective information flows from data collection down to the use of data for evidence-informed decision-making; 3) Effective operational research and M&E systems that allow assessing and identifying effective HIV interventions, that are based on the specific service needs of PLHIV and at-risk groups.

3. Inadequate institutional support systems and budgets – The inadequate performance of the *National M&E Committee* (NMEC), hampers effective multisectoral guidance and action. The NMEC falls under the National AIDS Committee, which also needs to be revitalised, as current membership does not allow decision making. In addition, the MOH-based *National AIDS Programme* (NAP) remains understaffed and under-resourced to adequately fulfil its roles and responsibilities. A well-resourced NAP with adequate institutional and operational budgets is instrumental to oversee and support the implementation of the national response and to support the NMEC.

Remedial action: 1) Strengthening/revitalisation of the NMEC, with effective membership from key sectors, clear mandates and TORs, and adequate administrative support; 2) Strengthening of NAP through: a) Increased technical staffing, especially in areas such as M&E, advocacy and community initiatives.

4. Outdated National Strategic Plan and costed Operational Plan – Without an NSP and specifically described priority strategies (OP) and allocated budgets, the national response remains scattered, ad-hoc and ineffective.

Remedial action: Immediate development (2012) of an NSP and costed Operational Plan, with active involvement and participation of all key stakeholders – governmental, civil society including PLHIV, private sector and UN agencies.

5. The lack of systematic, comprehensive implementation of NSP fails to address priority issues and meet the service needs of the most-at-risk and vulnerable populations. Gaps and weaknesses exist especially in the field of HIV prevention, stigma and discrimination, and human rights of vulnerable groups, such as PLHIV and expatriates. To date, the national response has been skewed towards HIV screening and ART, but needs to be complemented by interventions based on sound evidence, proven cost-effectiveness, and which meet the needs of key populations.

Remedial action: Innovative HIV programmes and services need to be developed and implemented – in line with the NSP – especially in the field of targeted HIV prevention for key populations. Decisions regarding priority interventions need to be based on proven (cost) effectiveness, social and cultural acceptability; and expressed needs of beneficiaries. Examples include VCT services, with special attention for MARP groups; programmes to reduce stigma and discrimination; peer education and outreach for MARPs and young people; workplace programmes for Omanis and expatriates; condom promotion for MARP groups; MARP-friendly STI treatment; strengthening of PLHIV support groups; Legal support for expatriate PLHIV; harm reduction (pilot) programmes for IDUs; advocacy for and involvement of social, political and religious leaders in HIV prevention; regional collaboration with a special focus in strengthening HIV-related human rights.

6. Lack of experience and capacity in HIV prevention and weak civil society – as discussed, to date there has been very limited experience with comprehensive HIV programmes, particularly in the field of HIV prevention. Targeted HIV-prevention programmes require specific experience and skills to work with often hard-to-reach groups in sensitive areas, which can often not be offered through government institutions. The relatively limited experience in Oman is further compounded by a weak civil society, with very few CSOs capable or interested in working in HIV prevention with MARP groups.

Remedial action: Training and capacity building in the field of a) Technical expertise and skills; and b) Institutional and organisational capacity, especially for the weak civil society. This may include establishing a PLHIV association with international support from PLHIV groups. Additional activities may include site visits to successful programmes in the region, attending international conferences and organising national or regional ones in Oman; training and on-the-job technical support. c) To date, small-scale community-based organisations have initiated outreach work with IDUs and MSM. However, these initiatives need to be systematically evaluated to identify and scale up the most successful components

7. Remaining challenges regarding supportive legal, social and policy environments, including stigma and discrimination – Laws criminalising certain groups or behaviours, as seen in most countries in the Middle east and North Africa, may hamper effective outreach or may not allow certain interventions, such as opioid substitution therapy, safe injection programmes, condom promotion or explicit HIV education for young people. Similarly, social and religious norms and values may stigmatise HIV-related sexual behaviours and hamper programmes for sex workers and their clients or MSM. In the absence of these supportive environments, none of the above challenges can be effectively addressed.

Remedial action: the creation of supportive environments is complex and typically meets a lot of resistance from different groups. Therefore, HIV programmes need to be culturally and religiously sensitive, and mobilise the active involvement and support of political, community and religious leaders for key interventions. This requires involving them in HIV programmes from the start, in research, programme development and implementation. In addition, lobbying and advocacy strategies need to focus on gaining support from political leaders. Overall, emphasis needs to be placed on norms and values that support effective HIV prevention, care and treatment.

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

While Oman is a high-income country with adequate financial and human resources, as well as excellent medical and other infrastructure, external partners – especially UN agencies – can still play an important role in strengthening the national response to HIV/AIDS through technical assistance. UN agencies such as UNAIDS, WHO, UNFPA and UNICEF represent a vast amount of expertise and experience worldwide, including specific knowledge of Oman and the wider region. Thus, UN agencies can play an important role in further strengthening technical, institutional and organisational capacity of government, civil society and private sector partners.

To date, UN agencies have been supporting various HIV-related initiatives, such as the UNFPA-supported Y-Peer programme; WHO and UNICEF support in the field of PMTCT, as well as WHO's technical assistance in the field of clinical treatment and care. Furthermore, UNAIDS has been supporting the establishment of MSM outreach programmes; while UNICEF and The World Bank have supported activities for PLHIV, and a study on MARPs.

However, UN presence in Oman is limited to UNFPA, UNICEF and WHO. Nevertheless, other UN agencies can be involved through their regional offices, including for the development of the new National Strategic Plan (ASAP, World Bank/ UNAIDS); National M&E Plans (UNAIDS); HIV prevention among MARPs (UNAIDS, UNODC); HIV treatment and care, including ART and PMTCT (WHO, UNICEF); HIV education for young people, children, in and out-of-schools (UNFPA, UNICEF, UNESCO); and HIV workplace programmes and employment rights (ILO).

VII. MONITORING AND EVALUATION ENVIRONMENT

(a) Overview of the current monitoring and evaluation (M&E) system

To date, Oman has not had a proper **system** for monitoring and evaluation of HIV/AIDS, nor has it developed a joint national M&E **plan** to systematise the collection, reporting, storage and utilisation of all HIV-related data for planning and programming purposes.

Available HIV-related data is mainly based on massive HIV screening among selected population groups and specific settings (see details below), as well as data from clinical monitoring of HIV patients. However, there is no HIV-surveillance system that accurately assesses HIV prevalence among the general population, nor among most-at-risk groups, such as sex workers, MSM and IDUs, although IDUs are tested to some extent through police, prisons and drug-treatment facilities (but this does not represent systematic data).

Similarly, only a small number of behavioural surveillance studies have been conducted, mostly very recently, and the results still need to be translated into policy and programme development. However, there is no national research agenda to prioritise research in the HIV field.

Furthermore, given the limited experience with HIV-prevention programmes among the general population or MARP groups, programmatic M&E data is mainly restricted to clinical monitoring of HIV patients. All those enrolled in pre-ART care and ART are regularly tested for CD4 and viral load.

Financial monitoring is poor: the budgeting process in the field of HIV/AIDS lacks a systematic approach, and most HIV-related expenditures are not earmarked as such. Therefore it is difficult to get an accurate overview of expenses made in the context of HIV/AIDS. Most of these costs are for HIV screening, ARV treatment and ART monitoring (laboratory), while much smaller amounts are spent on other interventions, especially in the field of HIV prevention.

Mass HIV-screening programmes

Oman has an extensive HIV-screening system, which applies to the following groups:

- Expatriates seeking employment of residency in Oman; this mainly includes foreign labour migrants;
- Blood donors;
- ANC clients;
- TB and STI patients;
- Pre-employment screening (nationals and expatriates)
- Pre-marital screening
- Food handlers (mainly expatriates)
- Patients admitted to hospitals for invasive procedures and organ transplants
- Prisons and those arrested by the police
- Others, including army recruits and staff, scholarships etc.

In the context of these screening programmes, in 2011, a total of 883,696 people were tested; around 28% were Omani nationals, while rest 72% were expatriates. Most Omani nationals are tested for ANC clients, STI/TB patients, blood donors, food handlers, pre-employment screening etc.

Clinical monitoring of HIV patients

Clinical monitoring of HIV patients is done in accordance with international standards, i.e. WHO. Patients are regularly followed up through CD4 and viral load testing, as well as clinical check-ups; there are however some problems with genotyping for resistance testing, which is only done by the *Sultan Qaboos University Hospital (SQUH)*, not in other ART facilities. There are some problems with loss to follow-up as shown by the 12-month retention rate for 2010 of 74.25 percent (75 out of 102 enrolled). This is due to some patients leaving the country, as well as social and economic problems (e.g. lack of funds for transport).

(b) Challenges faced in the implementation of a comprehensive M&E system and remedial actions to be taken

Specific challenges with regard to current M&E systems include the following issues:

1. Absence of overall national HIV strategy and framework
2. Inaccuracies and gaps in data collection
3. Availability, accessibility and utilisation of HIV-related data
4. Adequate human resources and infrastructure for HIV-related data management

1) Oman does not have a *comprehensive national M&E plan for HIV/AIDS*; there are very few interventions to be monitored outside ARV treatment. Therefore, a priority remedial action is the development of a national M&E plan and system in conjunction with the development of the new National Strategic Plan and costed Operational Plan, which is foreseen for 2012. These will specify the national priority interventions in the field of HIV/AIDS, M&E and surveillance will be a priority component for this new NSP.

2) *Inaccuracies and gaps in data collection*: as mentioned, the current mass HIV screening system is skewed towards testing of *non-Omanis*, while Omani nationals account for only 18 percent of those tested. Official HIV data rely mainly on reporting of HIV cases found through health services and screening activities. However, this existing system does not give an accurate picture of the overall Omani population, as explained earlier; while there is no systematic data collection among MARP groups. People with high-HIV-risk behaviours typically tend to screen themselves out for blood donations, or may get tested in private health service clinics/hospitals (even abroad) to avoid being identified through government set up. Similar self-selection mechanisms may occur for pre-employment testing. Hence, the number of Omani nationals found to be HIV-infected through the current screening mechanisms is likely to reflect an *underestimation* of the true number of HIV-infected Omanis.

In addition to inaccuracies with regard to HIV surveillance among the general population, there are *significant gaps* with regard to data on MARP groups and other vulnerable populations. Due to the currently extremely low HIV rates, HIV/AIDS continues to be seen as a low priority: although several studies have been conducted in the past few years on MARPs, there is no overall research agenda. In addition, and as a result of the lack of interventions in the prevention field, there is no specific experience or systems for monitoring of interventions in this field.

Hence, remedial actions in this area involve the establishment of a system of integrated biological and behavioural surveillance studies, specifically focusing on MARP groups. Furthermore, the improved roll-out of confidential VCT services will promote people to get

tested, who would otherwise not easily be found through screening. A research agenda is needed to ensure that priority research topics are identified and systematically addressed.

3) Apart from the gaps in data collection, there are some problems regarding the *availability and accessibility of data*. While most HIV data is collated and available at the NAP, there is no true central database that contains all HIV-related data. E.g., financial data collection is hampered due to a lack of clear financial monitoring systems. A priority remedial action to be undertaken in this context is the establishment of a central data base on HIV.

4) The lack of a unified national HIV/AIDS surveillance and M&E system is further compounded by the *absence of a special M&E unit or dedicated, trained data-management staff in the NAP*. More capacity building is needed in this field to ensure adequate operation of M&E systems; while a special unit should be considered for management of HIV data.

ANNEXES

ANNEX 1: National Commitments and Policy Instrument (NCPI)

See Annex in separate file