# Oman Report NCPI

## NCPI Header

COUNTRY

**Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any:**
Ms Nashia Nasib
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**Describe the process used for NCPI data gathering and validation:**
NCPI data was gathered by an external consultant in collaboration with NAP staff. Data collection included document review, site visits, observations and interviews with key informants from government, civil society and UN agencies were conducted, and key findings and main conclusions were presented and discussed during a stakeholder validation meeting, to which all sectors and persons interviewed had been invited. Discussions during the meeting were used to reach further consensus and adjust final NCPI report where needed. The NCPI was subsequently completed by the consultant and the NAP and MOH reviewed and provided comments and additions to the final version.
**Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**
Inputs from document review, site visits, key informant interviews and a national validation meeting with key stakeholders from government, civil society and UN were used to triangulate data and reach overall consensus. Where different opinions existed, these were accommodated in the “Comments” sections in the NCPI, while average ratings were given if different respondents gave different ratings; however, large differences in ratings did not occur. In addition, the fact that separate Parts (A and B) were available for government vs. civil society and UN already allowed accommodating any potential differences in opinion.
**Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):**
Data quality: information given may not always be independent, as most respondents work for Government directly or indirectly. Data cannot always be verified from independent sources. Limited input available from civil society due to the fact that civil society is weakly organised and very few NGOs play an active role in the HIV field.

NCPI - PART A [to be administered to government officials]

| Organization | Names/Positions | A.I | A.II | A.III | A.IV | A.V | A.VI |
|---|---|---|---|---|---|---|---|
| MOH-NAP | Ms. Nashia Nasib, NAP Manager | Yes | Yes | Yes | Yes | Yes | Yes |
| MOH-NAP | Dr. Samir Shah | Yes | Yes | Yes | Yes | Yes | Yes |
| MOH-Central Public Health Lab | Dr. Suleiman Moh’d Al-Busaidy | No | Yes | No | No | Yes | No |
| MOH-Nat’l TB / Leprosy Control Programme | Dr. Mohd Redha Moosa Al Lawati | No | Yes | No | No | Yes | No |
| MOH-Dept. of Blood Services | Dr. Shahnaz Nidham Shah Al-Balushi | No | No | No | Yes | No | Yes |
| Ibn Sina Hospital, Drug Treatment Facility | Dr. Mahmood Al-Abri | No | No | Yes | Yes | No | No |
| Royal Hospital-ART and PMTCT | Dr. Firyal Al-Lawati | No | No | No | Yes | Yes | Yes |
| Medical Stores | Mr Saeed Rashdi | No | No | No | No | Yes | No |
| - | - | No | No | No | No | No | No |

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

| Organization | Names/Positions | B.I | B.II | B.III | B.IV | B.V |
|---|---|---|---|---|---|---|
| UNICEF | Dr. Laila Gad, Country Director | Yes | Yes | Yes | Yes | Yes |
| UNFPA | Ms. Sara Abdulla Al-Lamki, Prog, Communication Assistant | Yes | Yes | Yes | Yes | Yes |

| | | | | | | |
|---|---|---|---|---|---|---|
| al-Hayat | Mohammed bin Ibrahim Al Zadjali, Founder, GM | Yes | No | Yes | Yes | No |
| Ex-IDU | Anonymous | Yes | Yes | Yes | Yes | Yes |
| UNFPA | Salah Al-Saleh, Programme Associate | No | No | No | No | No |
| Al Hayat Association | IDU group - Focus group | Yes | No | Yes | Yes | No |
| UNICEF | Hanadi J. Al Rajab, Govt. Project Officer Health | No | No | No | No | No |

# A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
**(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):**
Yes
**IF YES, what was the period covered:**
2008-2011
**IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.:**
N/A: No modifications, since the 2008-2011 National Strategy was Oman's first. It is currently undergoing revision and being updated

1.1 Which government ministries or agencies

**Name of government ministries or agencies [write in]:**
National AIDS Programme, Ministry of Health

1.2. Which sectors are included in the multisectoral strategy with a specifc HIV budget for their activities?

SECTORS

| Included in Strategy | Earmarked Budget |
|---|---|
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| No | No |
| Yes | No |
| Yes | No |

**Other [write in]:**
Religious Affairs, Social Development, Sports Affairs, Higher education, Information, Tourism (both no earmarked budget)
**IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specifc activities?:**
The budget of the MOH and other ministries does not show specific budget allocations for HIV-related programmes and services. Budget allocations for recurrent costs in the context of ARV and other treatment and care, laboratory costs, staffing etc. are included, but allocations for special programmes, e.g. in the field of prevention and other areas are mostly made on an ad-hoc, "as needed" basis. Therefore it is impossible to provide an overview of earmarked budgets for HIV.

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

**Men who have sex with men:**
Yes
**Migrants/mobile populations:**
Yes
**Orphans and other vulnerable children:**
No
**People with disabilities:**
No
**People who inject drugs:**
Yes
**Sex workers:**
Yes
**Transgendered people:**
Yes

**Women and girls:**
No
**Young women/young men:**
Yes
**Other specific vulnerable subpopulations:**
Yes
**Prisons:**
Yes
**Schools:**
Yes
**Workplace:**
Yes
**Addressing stigma and discrimination:**
Yes
**Gender empowerment and/or gender equality:**
No
**HIV and poverty:**
No
**Human rights protection:**
Yes
**Involvement of people living with HIV:**
Yes

**IF NO, explain how key populations were identifed?:**
N/A
**1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:**
Men who have sex with men (MSM) Injecting drug users (IDUs) Sex workers PLHIV Prison population Migrant workers
**1.5. Does the multisectoral strategy include an operational plan?:** Yes

1.6. Does the multisectoral strategy or operational plan include

**a) Formal programme goals?:**
Yes
**b) Clear targets or milestones?:**
No
**c) Detailed costs for each programmatic area?:**
No
**d) An indication of funding sources to support programme implementation?:**
No
**e) A monitoring and evaluation framework?:**
No

1.7

**1.7. Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?:**
No involvement
**IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case:**
Overall, civil society is weakly developed in Oman: there are few NGOs, and at the time of the development of the national HIV strategy in 2006, there were no NGOs specifically working in the HIV field. At present, there are some NGOs working with injecting drug users, women etc. and these NGOs will be involved in the development of the new NSP, which is planned for 2012.

**1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:**
Yes

1.9

**1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:**
Yes, all partners

**2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?:**
Yes

2.1. IF YES, is support for HIV integrated in the following specifc development plans?

**Common Country Assessment/UN Development Assistance Framework:**

N/A
**National Development Plan:**
Yes
**Poverty Reduction Strategy:**
N/A
**Sector-wide approach:**
Yes
**Other [write in]:**
N/A

2.2. IF YES, are the following specifc HIV-related areas included in one or more of the development plans?

**HIV impact alleviation:**
Yes
**Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:**
Yes
**Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:**
Yes
**Reduction of stigma and discrimination:**
Yes
**Treatment, care, and support (including social security or other schemes):**
Yes
**Women's economic empowerment (e.g. access to credit, access to land, training):**
Yes
**Other[write in below]:**
N/A

**3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:**
No
**4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:**
No
**5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:**
Yes
**5.1. Have the national strategy and national HIV budget been revised accordingly?:**
No
**5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:**
Estimates of Current and Future Needs
**5.3. Is HIV programme coverage being monitored?:**
Yes

5.3

**(a) IF YES, is coverage monitored by sex (male, female)?:**
Yes
**(b) IF YES, is coverage monitored by population groups?:**
Yes
**IF YES, for which population groups?:**
ANC women ART and pre-ART patients MSM IDUs Sex workers Blood donors (HIV screening) Prison inmates (HIV screening) Migrant workers (HIV screening)
**Briefly explain how this information is used:**
Information on service uptake and coverage of the different population groups mentioned is used for a number of purposes: 1) Advocacy for continuation of these services (e.g. ART, PMTCT); 2) Programme planning (decisions regarding the number of expected clients and the focus of services); 3) Research prioritisation (e.g. for research on MSM, IDUs, sex workers).
**(c) Is coverage monitored by geographical area:**
Yes
**IF YES, at which geographical levels (provincial, district, other)?:**
Governorates (regions) Wilayats (districts)
**Briefly explain how this information is used:**
Information on geographical coverage and service utilisation is used for decisions regarding planning and programming of services and activities; Procurement; Staffing; Training needs and other logistical issues.

**5.4. Has the country developed a plan to strengthen health systems?:**
Yes
**Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:**

Health-systems-strengthening efforts have allowed strengthening HIV-related services and programmes in the following areas: * Adequate HIV testing of clients and handling of samples (trained staff); * Strengthened laboratory infrastructure allows adequate follow-up of ART patients; * CD4 testing decentralised to Governorate level (equipment purchased in 2011; to be rolled out in 2012); * Strengthened ANC services (infrastructure, female counsellors and other staff) facilitates effective HIV testing of all ANC women and high coverage of PMTCT for all women in need; * Treatment centres available in geographically remote areas; * Improved coordination with private health-care providers through special Directorate-general of Private Services; this facilitates HIV testing, counselling and PMTCT services.

**6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?:**

6

**Since 2009, what have been key achievements in this area:**

* 99% coverage of ANC screening for HIV and access to comprehensive PMTCT package, incl. ART for eligible mothers and children; * Overall access to, and acceptance of ART has improved (e.g. early 2010: 412 ART patients; end 2011: 628 ART patients); * More education and related efforts to address reducing HIV-related stigma and discrimination; * More attention for HIV prevention among MARPs: qualitative studies conducted among MSM, sex workers and IDUs with a view to developing and implementing targeted programmes in the near future (2012); * Quality of ART and other treatment and care for PLHIV has improved; * Improved patient monitoring of ART patients: decision to start resistance testing has been taken in 2011; Lab staff has been trained in Germany: Implementation to start in 2012; * Strengthened notification system (2010) in line with revised WHO guidelines; * Initiation of electronic surveillance system: this allows feedback to all Governorates/regions'; * Multisectoral meeting was held in early 2011, which aimed to discuss achievements and the way forward with regard to planning of strategies in health and non-health sectors. The meeting also focused on advocacy for more specific attention for HIV prevention among MARPs.

**What challenges remain in this area:**

1. In general, there is a lack of systematic follow-up of the strategies and activities planned in the NSP 2007-2011. The NSP identifies strategies and activities to be implemented by various sectors, but there is a gap between strategies and plans of action on the one hand, and actual operationalisation and implementation of these planned strategies on the other. This particularly affects the response by non-health sectors, which typically have difficulty identifying their specific role and added value in the national response to HIV/AIDS. There is a great need for engagement of non-health sectors and assessment of their roles and responsibilities towards HIV; 2. In this context, the lack of a clear budget for HIV-related interventions hampers the adequate allocation of resources and implementation of the NSP by all sectors; 3. The NSP 2007-2011 recently expired, but to date, no concrete action has been taken to develop a new national strategy; 4. Strategic planning for HIV prevention through sustainable outreach programmes among MARP groups needs to be consolidated – this also includes harm reduction programmes for IDUs (incl. needle-and-syringe-exchange programmes and opioid substitution therapy); 5. Acceptable ways of condom promotion and distribution need to be discussed for all sectors (health, tourism; young people; higher education; transport, labour etc.); 6. The impact of legislation and policies that hamper effective HIV prevention, care and treatment services needs to be systematically identified and addressed: these have a particularly negative effect on HIV prevention among MARPs, and other vulnerable groups, including migrant workers.

# A - II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high offcials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

**A. Government ministers:**

No

**B. Other high offcials at sub-national level:**

Yes

1.1

**(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):**

No

**Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:**

N/A

**2. Does the country have an offcially recognized national multisectoral HIV coordination body (i.e., a National HIV Council or equivalent)?:**

No

**IF NO, briefly explain why not and how HIV programmes are being managed:**

NO/YES, but: While Oman does have an officially recognised multisectoral coordinating body – the National AIDS Committee – it does not regularly meet and does not effectively fulfil all its tasks.

2.1. IF YES, does the national multisectoral HIV coordination body

**Have terms of reference?:**

Yes

**Have active government leadership and participation?:**

No
**Have an official chair person?:**
Yes
**IF YES, what is his/her name and position title?:**
His Excellency Dr. Ali Jaffer, Adviser to MOH
**Have a defined membership?:**
Yes
**IF YES, how many members?:**
15
**Include civil society representatives?:**
No
**Include people living with HIV?:**
No
**Include the private sector?:**
No
**Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:**
No

**3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?:**
No
**What challenges remain in this area:**
The main challenges for improved coordination and collaboration between the government, civil society and private sectors include: 1) A weakly developed civil society sector, which makes it difficult to implement services particularly for MARP groups; 2) While there is some collaboration between government and private sectors to finance specific HIV-related programmes, overall these efforts are ad-hoc and lack a systematic, long-term focus. 3) The roles, responsibilities and comparative advantages of government, civil society and private sectors in the national response to HIV/AIDS are not clearly defined and need to be identified. 4) HIV viewed as a health issue to non- health sectors.
**4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?:**
0%

5.

**Capacity-building:**
Yes
**Coordination with other implementing partners:**
Yes
**Information on priority needs:**
Yes
**Procurement and distribution of medications or other supplies:**
No
**Technical guidance:**
Yes
**Other [write in below]:**
N/A

**6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?:**
No
**6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:**
-
**7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?:**
6
**Since 2009, what have been key achievements in this area:**
A key achievement has been the increased political support for addressing the HIV-prevention needs of MARP groups (sex workers, MSM, IDUs)
**What challenges remain in this area:**
Key challenges that remain include: 1) The need for sustained support for MARP interventions; 2) More attention for HIV prevention, both among MARPs, vulnerable groups such as young people, as well as the general population. To date, the response has been skewed towards health-sector-based interventions – particularly ARV treatment, PMTCT and large-scale screening. However, Effective HIV prevention requires high-level political support to address sensitive issues.

# A - III. HUMAN RIGHTS

1.1

**People living with HIV:**
No
**Men who have sex with men:**
No
**Migrants/mobile populations:**
No
**Orphans and other vulnerable children:**
Yes
**People with disabilities:**
Yes
**People who inject drugs:**
No
**Prison inmates:**
Yes
**Sex workers:**
No
**Transgendered people:**
No
**Women and girls:**
Yes
**Young women/young men:**
Yes
**Other specific vulnerable subpopulations [write in]:**
N/A

**1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:**
No
**IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:**
N/A
**Briefly explain what mechanisms are in place to ensure these laws are implemented:**
N/A
**Briefly comment on the degree to which they are currently implemented:**
N/A
**2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:**
Yes

IF YES, for which subpopulations?

**People living with HIV:**
Yes
**Men who have sex with men:**
Yes
**Migrants/mobile populations:**
Yes
**Orphans and other vulnerable children:**
No
**People with disabilities:**
No
**People who inject drugs :**
Yes
**Prison inmates:**
Yes
**Sex workers:**
Yes
**Transgendered people:**
Yes
**Women and girls:**
No
**Young women/young men:**
No
**Other specific vulnerable subpopulations [write in below]:**
N/A

**Briefly describe the content of these laws, regulations or policies:**
Existing laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key

populations and vulnerable groups include: 1) Laws and policies regarding the employment rights of PLHIV; 2) Laws criminalising sex work; 3) Laws criminalising MSM practices; 4) Laws regarding (injecting) drug use, including drug-treatment services; 5) Laws and policies on mandatory screening of foreign migrant labourers and repatriation of HIV-infected foreigners; 6) Laws and policies restricting access to prison inmates for HIV prevention programmes.

**Briefly comment on how they pose barriers:**

1) Employment rights of PLHIV have a major impact on the quality of life of PLHIV and their families: PLHIV avoid applying for jobs in the private sector as HIV is a mandatory test for application in private sector. They could lose their jobs and face a major income loss; in addition to financial problems, unemployment and associated stigma has a large impact on their psychological health and social well-being. 2-4) Criminalisation of the behaviours of MARP groups makes it hard to reach them with HIV-prevention, care and treatment services, as they will typically avoid being identified by outsiders, especially government staff. In addition, lack of clarity with regard to legal protection makes it difficult for outreach workers and staff to provide services to MARPs, as they may face legal action. 4) The absence of a legal framework for harm-reduction services hampers the implementation of needle-and-syringe-exchange programmes, as well as opioid substitution therapy (e.g. methadone maintenance treatment); 5) Mandatory testing of foreign migrant workers and the associated repatriation of HIV-infected individuals affect their access to HIV prevention and treatment; some will avoid testing and stay in the country as illegals, further compromising their access to health and other services. This way, they also present a risk for HIV infection of others. 6) HIV-prevention services for prisoners depend on collaboration of the Ministry of Interior and the prison authorities; this is typically associated with restrictions regarding the scope of services and interventions.

# A - IV. PREVENTION

**1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?:**

Yes

IF YES, what key messages are explicitly promoted?

**Abstain from injecting drugs:**
Yes
**Avoid commercial sex:**
No
**Avoid inter-generational sex:**
No
**Be faithful:**
Yes
**Be sexually abstinent:**
No
**Delay sexual debut:**
No
**Engage in safe(r) sex:**
Yes
**Fight against violence against women:**
No
**Greater acceptance and involvement of people living with HIV:**
Yes
**Greater involvement of men in reproductive health programmes:**
No
**Know your HIV status:**
No
**Males to get circumcised under medical supervision:**
No
**Prevent mother-to-child transmission of HIV:**
Yes
**Promote greater equality between men and women:**
No
**Reduce the number of sexual partners:**
No
**Use clean needles and syringes:**
No
**Use condoms consistently:**
No
**Other [write in below]:**
Information on modes of HIV transmission

**1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:**

Yes

**2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:**

Yes

2.1. Is HIV education part of the curriculum in

**Primary schools?:**
No
**Secondary schools?:**
Yes
**Teacher training?:**
Yes

**2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:**
Yes
**2.3. Does the country have an HIV education strategy for out-of-school young people?:**
No
**3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:**
Yes
**Briefly describe the content of this policy or strategy:**
In 2011, the NAP made initial steps towards the development of a IEC strategy that would specifically target MSM, sex workers and IDUs, with messages focusing on safer sex, condom use and awareness raising on transmission routes. The NAP aims to continue this increased focus on MARP groups in 2012, including eventually specific programmes and services for MARPs.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

| IDU | MSM | Sex workers | Customers of Sex Workers | Prison inmates | Other populations |
|---|---|---|---|---|---|
| No | No | No | No | No | - |
| No | No | No | No | No | - |
| Yes | Yes | Yes | No | No | - |
| No | No | No | No | No | - |
| No | Yes | No | No | No | - |
| Yes | Yes | Yes | No | No | - |
| No | No | No | No | No | - |
| No | No | No | No | No | - |

**3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?:**
6
**Since 2009, what have been key achievements in this area:**
Key achievements with regard to policy support for HIV prevention since 2009 include: 1) Near-100% access to PMTCT for eligible ANC women and children; 2) First time attention for MARPs and their successful involvement in studies and initial peer education activities for MSM initiated.
**What challenges remain in this area:**
Key challenges regarding policy support for HIV prevention include: 1) Re-establishing voluntary counselling and testing services that meet the need of people; 2) MARP-specific HIV-prevention programmes, including outreach work, peer education, condom promotion, harm reduction (NSEP, OST); 3) More specific and effective HIV education for young people; 4) HIV-prevention programmes for migrant workers; 5) Strengthening rights-based approaches to HIV prevention, focusing on the health and related rights of vulnerable populations.
**4. Has the country identified specifc needs for HIV prevention programmes?:**
Yes
**IF YES, how were these specific needs determined?:**
1) An assessment was done 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; 2) A number of qualitative studies was conducted among MSM, sex workers and IDUs to assess their HIV prevention needs.

4.1. To what extent has HIV prevention been implemented?

**Blood safety:**
Agree
**Condom promotion:**
Strongly Disagree
**Harm reduction for people who inject drugs:**
Strongly Disagree
**HIV prevention for out-of-school young people:**
Strongly Disagree
**HIV prevention in the workplace:**

Strongly Disagree
**HIV testing and counseling:**
Disagree
**IEC on risk reduction:**
Strongly Disagree
**IEC on stigma and discrimination reduction:**
Agree
**Prevention of mother-to-child transmission of HIV:**
Strongly Agree
**Prevention for people living with HIV:**
Disagree
**Reproductive health services including sexually transmitted infections prevention and treatment:**
Disagree
**Risk reduction for intimate partners of key populations:**
Strongly Disagree
**Risk reduction for men who have sex with men:**
Disagree
**Risk reduction for sex workers:**
Strongly Disagree
**School-based HIV education for young people:**
Agree
**Universal precautions in health care settings:**
Agree
**Other[write in]:**
N/A

**5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:**
4

# A - V. TREATMENT, CARE AND SUPPORT

**1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:**
Yes
**If YES, Briefly identify the elements and what has been prioritized:**
Priority elements of treatment, care and support include: 1) ART 2) ART for TB patients with HIV 3) Early Infant Diagnosis (EID) 4) Treatment and care for TB patients 5) TB screening for PLHIV 6) PMTCT 7) Prophylaxis and treatment of OIs
**Briefly identify how HIV treatment, care and support services are being scaled-up?:**
1) Access to PMTCT services has been scaled up to >99% through the integration into ANC services countrywide (opt-out screening); 2) Decentralisation of CD4 counts (equipment purchased in 2011) will allow easier provision of ART in the Governorates; 3) More training and supervision of health-care staff involved in treatment and care for HIV patients; 4) EID has been scaled up in the 2010-2011 period, especially in the context of PMTCT.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

**Antiretroviral therapy:**
Strongly Agree
**ART for TB patients:**
Strongly Agree
**Cotrimoxazole prophylaxis in people living with HIV:**
Agree
**Early infant diagnosis:**
Agree
**HIV care and support in the workplace (including alternative working arrangements):**
Disagree
**HIV testing and counselling for people with TB:**
Strongly Agree
**HIV treatment services in the workplace or treatment referral systems through the workplace:**
Strongly Disagree
**Nutritional care:**
Strongly Disagree
**Paediatric AIDS treatment:**
Strongly Agree
**Post-delivery ART provision to women:**
Strongly Agree
**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):**
Strongly Disagree

**Post-exposure prophylaxis for occupational exposures to HIV:**
Agree
**Psychosocial support for people living with HIV and their families:**
Disagree
**Sexually transmitted infection management:**
Agree
**TB infection control in HIV treatment and care facilities:**
Strongly Agree
**TB preventive therapy for people living with HIV:**
Strongly Disagree
**TB screening for people living with HIV:**
Agree
**Treatment of common HIV-related infections:**
Agree
**Other [write in]:**
N/A

**2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:**
Yes
**Please clarify which social and economic support is provided:**
1) PLHIV in need receive limited monthly financial support, e.g. if they are unemployed; 2) Social support is provided through Ministry of Social Development to PLHIV and their families.
**3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:**
Yes
**4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:**
Yes
**IF YES, for which commodities?:**
Oman and other Gulf Council Cooperation (GCC) countries use a regional PSM mechanism for procurement of all pharmaceutical and health products, including ARV and other HIV-related drugs, test kits, reagents, medical equipment and commodities, etc.
**5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:**
8
**Since 2009, what have been key achievements in this area:**
1) Access to ART for HIV-infected ANC women; 2) Access to ART for children 3) Increased access to ART for adults discovered through PMTCT (e.g. husbands or other family members) 4) Scaled up ART: increased number of HIV patients on ART; 5) Higher ART coverage through improved ART services in Governorates; 6) Improved screening for eligibility; 7) Better follow-up of ART patients.
**What challenges remain in this area:**
1) (Need) Assessment of each HIV patient for social and/or economic support; 2) Legal support for PLHIV (risk of dismissal from job may lead to non-adherence: avoid being seen taking ARV drugs, e.g. on oil platforms); 3) Patient adherence and retention in care; 4) Resistance testing still to be introduced (equipment is there; staff trained); currently regimen changes based on educated guess, not on test;
**6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:**
No
**7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:**
5
**Since 2009, what have been key achievements in this area:**
The issue of OVCs is not applicable to Oman, which has a very low HIV epidemic.
**What challenges remain in this area:**
None, see above

# A - VI. MONITORING AND EVALUATION

**1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:**
In Progress
**Briefly describe any challenges in development or implementation:**
1) Limited participation of non-health sectors in the development of a common M&E system; 2) Limited number of staff trained in M&E-related concepts; 3) Not all existing surveillance and M&E systems are automated yet, which will make it more difficult to develop a unified national system; 4) The development of the National M&E system has been delayed due to problems with hiring consultants; 5) Currently, no clear budgets are available for M&E: this is expected to be a problem for the roll-out of a

future national M&E plan.

**Briefly describe what the issues are:**

The national M&E plan is yet to be developed; therefore harmonisation of M&E requirements will be discussed as part of the development.

2. Does the national Monitoring and Evaluation plan include?

**A data collection strategy:**

-

**A data analysis strategy:**

-

**A data dissemination and use strategy:**

-

**A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):**

-

**Guidelines on tools for data collection:**

-

**3. Is there a budget for implementation of the M&E plan?:**

No

**4. Is there a functional national M&E Unit?:**

No

**Briefly describe any obstacles:**

1) Currently, there is no dedicated M&E Unit within the National AIDS Programme; Lack of qualified staff to adequately implement all M&E-related duties; 2) There are no clear, standardised procedures for M&E, such as data-collection plans.

4.1. Where is the national M&E Unit based?

**In the Ministry of Health?:**

-

**In the National HIV Commission (or equivalent)?:**

-

**Elsewhere [write in]?:**

N/A

Permanent Staff [Add as many as needed]

| POSITION [write in position titles in spaces below] | Fulltime | Part time | Since when? |
|---|---|---|---|
| N/A | - | - | - |

Temporary Staff [Add as many as needed]

| POSITION [write in position titles in spaces below] | Fulltime | Part time | Since when? |
|---|---|---|---|
| N/A | - | - | - |

**4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:**

No

**Briefly describe the data-sharing mechanisms:**

Not applicable: currently there is no M&E unit or national M&E system However, all key medical data from HIV patient records, PMTCT etc. are sent to the NAP and stored in separate databases (not unified)  see details under point (6) below.

**What are the major challenges in this area:**

1) The absence of a national M&E plan hampers the systematic collection, collation, storage and utilisation of data from surveillance, research and programme records; 2) To date, M&E data is limited to the collection of patient data; some first qualitative studies among MARPs were conducted in 2011, but proper programmatic M&E systems to monitor programmes and services are not in place; 3) As mentioned, currently there is no M&E unit at the national level; hence, collection and collation remain challenges.

**5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?:**

No

**6. Is there a central national database with HIV- related data?:**

Yes

**IF YES, briefly describe the national database and who manages it.:**

* A central database is available that contains records of all HIV patients since 1985; this includes information on diagnoses, location, pregnancy state (if applicable), treatment regimens, CD4 and viral load data etc. * The database does NOT include information on programmes and services delivered by other partners; * The database is managed at the NAP.

**6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:**

Yes, but only some of the above

**IF YES, but only some of the above, which aspects does it include?:**
* Patient records, including treatment regimens, CD4 and viral load, medical conditions of HIV patients enrolled in ART or pre-ART; * Data is disaggregated by sex, age and geographical location; * Limited research data is available at NAP, but not as part of a central database; * In 2012 and beyond, more systematic HIV prevention programmes for MARPs are to be implemented: M&E systems will be designed to monitor the performance of these programmes and data is planned to be stored in a central database.

6.2. Is there a functional Health Information System?

**At national level:**
Yes
**At subnational level:**
Yes
**IF YES, at what level(s)?:**
A unified Health Information System is in place at all levels of the national health-care system. This includes all 221 public health facilities at all levels: • Primary health-care centres; • Extended primary health centres • Local hospitals • Wilayat (District) hospitals • Governorate (Regional) hospitals • Tertiary hospitals Hospitals of sister organisations, such as the Sultan Qaboos University Hospital (SQUH) and the Armed Forces Hospital have a separate HIS.

**7. Does the country publish an M&E report on HIV , including HIV surveillance data at least once a year?:**
Yes

8. How are M&E data used?

**For programme improvement?:**
Yes
**In developing / revising the national HIV response?:**
Yes
**For resource allocation?:**
Yes
**Other [write in]:**
N/A

**Briefly provide specific examples of how M&E data are used, and the main challenges, if any:**
Examples: 1) Problems identified regarding the delay of CD4 test results were used to mobilise resources for additional CD4 machines to be placed at the Governorate level; 2) Results from a PMTCT pilot programme were used to convince policy makers to institutionalise PMTCT as integral part of ANC services countrywide; Challenges: The national response to HIV is centred around health-system driven interventions, such as ARV treatment, OI prophylaxis and treatment, PMTCT, as well as large-scale screening of specific population groups. However, HIV-prevention programmes for most-at-risk and other vulnerable groups are not systematically implemented. Furthermore, there has been very limited research in the HIV field. As a result, there is limited programme M&E data and research data to guide planning and programming to expand and scale up the national response beyond health-sector-based interventions.

9. In the last year, was training in M&E conducted

**At national level?:**
No
**At subnational level?:**
No
**At service delivery level including civil society?:**
No

**9.1. Were other M&E capacity-building activities conducted` other than training?:**
No
**10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:**
5
**Since 2009, what have been key achievements in this area:**
1) Improved patient monitoring; of CD4 and viral load testing; resistance testing equipment purchased in 2011; to be introduced soon (2012); 2) Decision has been taken to develop a national M&E system; implementation has been delayed due to problems with recruitment of consultant.
**What challenges remain in this area:**
1) Drug-resistance testing to be implemented (2012); 2) Establishment of a national M&E Unit for HIV/AIDS; 3) Development and roll-out of a national M&E Plan and System; 3) Lack of adequately trained staff for M&E; 4) Limited programmatic responses in HIV prevention field, especially among MARP groups: hence no M&E data available; 4) M&E culture yet to be strengthened: systematic collection, analysis and use of all available data (screening, surveillance, research, programme M&E etc.) for policy and programme development, resource allocation and advocacy.

# B - I. CIVIL SOCIETY INVOLVEMENT

**1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to**

**strengthening the political commitment of top leaders and national strategy/policy formulations?:**
2
**Comments and examples:**
Civil society is still weakly developed in Oman as in most countries in the region. There are few NGOs, especially those with an interest in working in HIV. Recently, an NGO was officially established that aims to provide services to injecting drug users; in addition, there are a few community-based initiatives for working with IDUs, but these are not systematised. UNFPA has been supporting the Y-Peer initiative, in which young people conduct awareness raising and peer education on sexual & reproductive health, including HIV/AIDS. As a result, to date, civil society has not been in a position to strengthen political commitment of top leaders on national strategy/policy formulations, although the NAP is actively trying to engage with the existing NGOs and community groups, and will definitely actively involve them in the development of a new NSP in 2012.
**2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:**
0
**Comments and examples:**
* As explained above, civil society organisations (CSOs) with an interest in HIV/AIDS work have started to emerge only recently. Hence, CSOs have not been involved in the development of previous NSPs, but will be in the development of the next one. * As for budgeting, the lack of clear budgets and the subsequent allocation of funds is one of the main weaknesses of the national response to date. For the past NSP there was high-level commitment from various ministers, but this did not translate into firm budget allocations for implementing the NSP components. Government funds have primarily been spent on mandatory screening programmes and ART, but activities in the field of HIV prevention have largely depended on support from UN agencies and the private sector. Civil society has had no direct influence in the allocation of these funds, although they have to some extent benefitted from them.

3.

**a. The national HIV strategy?:**
4
**b. The national HIV budget?:**
0
**c. The national HIV reports?:**
4
**Comments and examples:**
Although the role of civil society has been clearly highlighted in the National HIV Strategy (a), as mentioned, this national strategy has not been adequately operationalised, and has not been allocated the funds needed to implement its key components (b). Therefore, civil society has played a minimal role in the actual implementation of the national strategy so far.

4.

**a. Developing the national M&E plan?:**
0
**b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?:**
0
**c. Participate in using data for decision-making?:**
0
**Comments and examples:**
There is no National M&E Plan. In addition, there is no M&E unit or working group, and no dedicated person for M&E in the NAP. Given the overall weak M&E system and the weakness of the civil society sector itself, its involvement in monitoring and evaluation of the national HIV response has been almost non-existent.

**5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:**
2
**Comments and examples:**
As mentioned above, the role of civil society has been very limited to date, and a number of NGOs and CBOs have only recently started to express an interest in working in the field of HIV. This includes an NGO working with IDUs, some small-scale community activities with MSM, and faith-based organisations involved in reproductive health issues. PLHIV are also involved to some extent. It is expected that the role and involvement of civil society in the national HIV response will increase considerably in the next few years, as NAP acknowledges their added value, especially for HIV prevention among MARPs and other vulnerable groups.

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access

**a. Adequate financial support to implement its HIV activities?:**
2
**b. Adequate technical support to implement its HIV activities?:**
3

**Comments and examples:**
While there are very few NGOs in general, and particularly few working in the HIV field, representatives of NGOs indicate that financial support can be mobilised through the local private sector. Similarly, technical support from local organisations (e.g. Ministries, universities) can be accessed. UN agencies such as UNICEF and UNFPA have been involved in financial and technical support for CSOs in the field of HIV, but overall there is limited awareness among CSOs about the mandates and possibilities for UN agencies to support them financially or technically.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

**People living with HIV:**
<25%
**Men who have sex with men:**
<25%
**People who inject drugs:**
25-50%
**Sex workers:**
-
**Transgendered people:**
-
**Testing and Counselling:**
<25%
**Reduction of Stigma and Discrimination:**
25-50%
**Clinical services (ART/OI)*:**
<25%
**Home-based care:**
-
**Programmes for OVC**:**
-

**8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?:**
6
**Since 2009, what have been key achievements in this area:**
The number of civil society organisations (CSOs) is on the rise, and there is an increasing call for more involvement of CSOs in the national HIV response. While on the one hand the National AIDS Programme is increasingly engaging civil society in the national response, on the other hand there are still many obstacles for an active role of civil society, due to the difficulty to establish NGOs, as well as the fact that most HIV-related issues are still very sensitive in Omani society, which makes it hard for CSOs to address them. In this context, the UN has an important role to play to further strengthen the role of civil society in Oman in general, and in the field of HIV/AIDS in particular. This requires high-quality technical support as well as political lobbying with high-level decision-making bodies.
**What challenges remain in this area:**
Despite positive signs of an increasingly active civil society in Oman, overall its role remains relatively limited, and sustained political, financial and technical support is needed to further strengthen civil society involvement. To date, few CSOs have been active in the HIV field, and they still lack technical expertise and experience in delivering programmes and services, especially in the field of HIV prevention. Government (MOH-NAP and other ministries) and UN agencies have a key role to play to further strengthen the capacity and commitment of CSOs to work in the HIV field.

# B - II. POLITICAL SUPPORT AND LEADERSHIP

**1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:**
Yes
**IF YES, describe some examples of when and how this has happened:**
Government, especially through the National AIDs Programme (NAP), has shown increasing political commitment to involving PLHIV in the national response. E.g., in the context of World AIDS Day, a week-long event was held with support from UNICEF and USAID to address PLHIV issues, with speakers from the Ministries of Health and Education, as well as a PLHIV. Similarly, NAP has increasingly been involving NGOs and representatives of IDUs and MSM in small-scale HIV-educational initiatives. As mentioned above, it is expected that PLHIV and (CSOs working with) MARP groups will also be actively involved in the development of a revised National HIV Strategy in 2012/13.

# B - III. HUMAN RIGHTS

1.1.

**People living with HIV:**
No

**Men who have sex with men:**
No
**Migrants/mobile populations:**
No
**Orphans and other vulnerable children:**
Yes
**People with disabilities:**
Yes
**People who inject drugs:**
Yes
**Prison inmates:**
No
**Sex workers:**
No
**Transgendered people:**
No
**Women and girls:**
Yes
**Young women/young men:**
No
**Other specific vulnerable subpopulations [write in]:**
N/A

**1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:**
Yes
**If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:**
The Omani Constitution does not allow discrimination based on sex, age, ethnicity etc. and endorses the human rights of all persons. Oman does not have a specific national law on non-discrimination as such, but the concept of non-discrimination is included as an article in various laws, e.g. on the rights of children, regardless whether they have Omani or non-Omani parents.
**Briefly explain what mechanisms are in place to ensure that these laws are implemented:**
Mechanisms to ensure implementation of the principle of non-discrimination include 1) the National Human Rights Commission; 2) various national or inter-ministerial committees for following up a number of conventions and laws, such as Oman's endorsement of the Convention on the Elimination of Discrimination Against Women (CEDAW) and the Convention on Rights of the Child, Persons with Disabilities etc.
**Briefly comment on the degree to which they are currently implemented:**
As mentioned, there is active follow-up on the implementation of the main laws and conventions that Oman has endorsed through existing commissions or special committees.
**2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:**
Yes

2.1. IF YES, for which sub-populations?

**People living with HIV:**
Yes
**Men who have sex with men:**
Yes
**Migrants/mobile populations:**
Yes
**Orphans and other vulnerable children:**
No
**People with disabilities:**
No
**People who inject drugs:**
Yes
**Prison inmates:**
Yes
**Sex workers:**
Yes
**Transgendered people:**
Yes
**Women and girls:**
No
**Young women/young men:**
No
**Other specific vulnerable subpopulations [write in]:**
N/A

**Briefly describe the content of these laws, regulations or policies:**
* There are several laws that may have a negative impact on HIV prevention, treatment, care and support for different populations. These include laws that outlaw key most-at-risk populations (MARPs) such as sex workers, MSM and injecting drug users, making it difficult to reach them and provide them with prevention services. * Secondly, laws and policies regarding mandatory screening of migrant labourers, who constitute a large proportion of the Omani population, have a detrimental effect on their rights to treatment, as HIV-infected foreigners are deported to their home countries, and do not have access to HIV treatment. * Thirdly, pre-employment screening also affects Omani citizens who are HIV-infected, as it affects their employment rights and compromises their position in society.

**Briefly comment on how they pose barriers:**
* As already mentioned above, criminalisation of MARP groups makes it difficult to effectively reach them with HIV-prevention programmes and services. In addition, there is no legal framework for certain HIV-prevention measures for MARPs, such as needle-and-syringe exchange programmes and substitution treatment for IDUs. * Mandatory pre-employment testing affects both foreign and Omani workesr who are HIV-infected: while foreigners will not get a work permit or will be deported and lose their jobs, local citizens also face the negative consequences of their HIV status, including loss of employment and social stigma.

**3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:**
Yes

**Briefly describe the content of the policy, law or regulation and the populations included:**
Oman has laws that protect women and children against physical and sexual violence and abuse. In addition, Oman ratified the Convention on the Elimination of Discrimination Against Women (CEDAW), although its enforcement is still a big challenge: e.g. domestic violence is a big problem, but most cases of sexual violence that occur within the marriage are not prosecuted. The problem is that most of the existing laws do not clearly specify what constitutes abuse or violence against women.

**4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:**
No

**5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:**
No

6. Does the country have a policy or strategy of free services for the following?

| Provided free-of-charge to all people in the country | Provided free-of-charge to some people in the country | Provided, but only at a cost |
|---|---|---|
| No | Yes | No |
| No | Yes | No |
| No | Yes | No |

**If applicable, which populations have been identified as priority, and for which services?:**
* Omani citizens are prioritised in HIV services, as mandatory HIV screening for foreigners leads to deportation of HIV-infected individuals. As a result, non-Omanis do not have access to the existing HIV treatment, care and support services. * In terms of prioritisation of specific population groups in Oman, there is no clear prioritisation, mainly because the current interventions focus on treatment and care of PLHIV, while HIV prevention fails to be implemented in a systematic manner: there are no targeted HIV-prevention programmes for MARP groups or other vulnerable groups, such as young people.

**7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?:**
Yes

**7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?:**
Yes

**8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:**
Yes

**IF YES, Briefly describe the content of this policy/strategy and the populations included:**
The NSP makes specific reference to the importance of targeted interventions for MARP groups. The main problem is 1) the absence of a specific operational workplan; 2) the lack of resource allocation to implement these strategies, and 3) subsequently, the non-implementation of key components of the national HIV Strategy.

8.1

**8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:**
No

**9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?:**
No

10. Does the country have the following human rights monitoring and enforcement mechanisms?

**a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work:**
Yes
**b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts:**
No
**IF YES on any of the above questions, describe some examples:**
Human Rights Commission and national committees to monitor implementation of international conventions ratified by the Omani government (e.g. CEDAW).

11. In the last 2 years, have there been the following training and/or capacity-building activities

**a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:**
No
**b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:**
No

12. Are the following legal support services available in the country?

**a. Legal aid systems for HIV casework:**
No
**b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV:**
No

**13. Are there programmes in place to reduce HIV-related stigma and discrimination?:**
Yes

IF YES, what types of programmes?

**Programmes for health care workers:**
No
**Programmes for the media:**
No
**Programmes in the work place:**
No
**Other [write in]:**
To date, there have only been general programmes to reduce stigma and discrimination. More specific sectoral programmes still need to be developed.

**14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:**
3
**Since 2009, what have been key achievements in this area:**
The establishment of the national Human Rights Commission in 2010 was a major landmark.
**What challenges remain in this area:**
Effective implementation of the policies and laws that protect HIV-related human rights is still a big challenge, especially with regard to employment and health rights of foreign workers, and the recognition of PLHIV's rights as vulnerable groups, beyond the mere focus on reduction of stigma and discrimination.
**15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:**
6
**Since 2009, what have been key achievements in this area:**
* An important step was the withdrawal of previous reservations with regard to the Convention on the Rights of the Child. * The Child Law has been drafted, which is an important human rights instrument to protect children's rights. In June 2011, Oman engaged in the inter-country legal cooperation system on child rights in the Gulf Cooperation Council (GCC); * Oman is considering to increase the age of criminal responsibility, which currently is as young as 9; this has serious consequences for the legal rights of children in criminal courts. * Oman ratified the ILO Decent Work agenda, which has a positive impact on the rights of HIV-infected workers, including foreign labourers, although many challenges remain in practice. * Similarly, Oman participates in the Abu Dhabi Dialogue on the Rights of Migrant Workers, together with other GCC countries and countries in South-East Asia that send many migrant labourers.
**What challenges remain in this area:**
* Implementation of all the conventions and initiatives mentioned above remains a big challenge and will take years. As mentioned, there are several national committees to monitor the various conventions and agreements, but not all play an active role.

# B - IV. PREVENTION

**1. Has the country identified the specific needs for HIV prevention programmes?:**
Yes
**IF YES, how were these specific needs determined?:**
Studies were done in 2011 among MSM and sex workers, while another study among IDUs was conducted in late 2011. Both studies also tried to identify service needs. The results of these studies are an important basis for designing more effective HIV-prevention strategies for these MARP groups.

1.1 To what extent has HIV prevention been implemented?

**Blood safety:**
Strongly Agree
**Condom promotion:**
Disagree
**Harm reduction for people who inject drugs:**
Disagree
**HIV prevention for out-of-school young people:**
Strongly Disagree
**HIV prevention in the workplace:**
Strongly Disagree
**HIV testing and counseling:**
Agree
**IEC on risk reduction:**
Disagree
**IEC on stigma and discrimination reduction:**
Disagree
**Prevention of mother-to-child transmission of HIV:**
Strongly Agree
**Prevention for people living with HIV:**
Agree
**Reproductive health services including sexually transmitted infections prevention and treatment:**
Strongly Agree
**Risk reduction for intimate partners of key populations:**
Strongly Disagree
**Risk reduction for men who have sex with men:**
Disagree
**Risk reduction for sex workers:**
Strongly Disagree
**School-based HIV education for young people:**
Strongly Agree
**Universal precautions in health care settings:**
Strongly Agree
**Other [write in]:**
N/A

**2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:**
4
**Since 2009, what have been key achievements in this area:**
* 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. * There is increasing outreach to young people, such as the UNFPA-supported Y-Peer initiative, although sexuality still is a taboo topic for discussion with young people. * Since the end of 2011, there has been a small-scale MSM outreach programme in Muscat.
**What challenges remain in this area:**
* While HIV-related programmes exist, their impact is still an issue: for example, school-based HIV education tends to focus on medical facts, while avoiding issues related to sexuality and how to protect oneself against HIV infection; * HIV/AIDS and related issues such as sexuality remain surrounded by strong taboos, which makes it difficult to effectively address HIV/AIDS among the general population, young people and MARP groups; * Due to social taboos and conservative norms and values, there is a resistance against using clear messages or frank talk about sensitive issues related to HIV transmission. * Voluntary counselling and testing is a major gap in the services: mandatory HIV screening programmes lie at the heart of the national response, but there are no confidential, voluntary services where people can find out their HIV status.

# B - V. TREATMENT, CARE AND SUPPORT

**1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:**

Yes

**IF YES, Briefly identify the elements and what has been prioritized:**

* Antiretroviral and related HIV treatment * Early identification of HIV cases through massive mandatory screening, e.g. premarital, antenatal and pre-employment testing

**Briefly identify how HIV treatment, care and support services are being scaled-up?:**

A major success in the health-care sector has been the 100% antenatal testing policy, which allows good coverage of PMTCT services

1.1. To what extent have the following HIV treatment, care and support services been implemented?

**Antiretroviral therapy:**
Disagree
**ART for TB patients:**
Strongly Agree
**Cotrimoxazole prophylaxis in people living with HIV:**
Agree
**Early infant diagnosis:**
Agree
**HIV care and support in the workplace (including alternative working arrangements):**
Strongly Disagree
**HIV testing and counselling for people with TB:**
Strongly Agree
**HIV treatment services in the workplace or treatment referral systems through the workplace:**
Strongly Disagree
**Nutritional care:**
Disagree
**Paediatric AIDS treatment:**
Agree
**Post-delivery ART provision to women:**
Strongly Agree
**Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):**
Strongly Disagree
**Post-exposure prophylaxis for occupational exposures to HIV:**
Disagree
**Psychosocial support for people living with HIV and their families:**
Disagree
**Sexually transmitted infection management:**
Agree
**TB infection control in HIV treatment and care facilities:**
Agree
**TB preventive therapy for people living with HIV:**
Agree
**TB screening for people living with HIV:**
Strongly Agree
**Treatment of common HIV-related infections:**
Disagree
**Other [write in]:**
N/A

**1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:**

8

**Since 2009, what have been key achievements in this area:**

Access to free ART for Omani nationals

**What challenges remain in this area:**

* Confidential and voluntary counselling and testing is not available; * There is no smooth linkage between screening programmes and access to treatment, partly as a result of inadequate guidelines; * More comprehensive treatment guidelines are needed, including for patient counselling, nutritional support etc. * Psychological and social support needs to be professionalised * More attention is needed for care and support for family members of PLHIV * More awareness-raising is needed regarding the availability of treatment, care and support services, since many people are not aware of the existing services; this should also be done through workplace programmes.

**2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:**

No

**3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?":**

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**Since 2009, what have been key achievements in this area:**

OVCs in relation to HIV is not an issue in Oman.
**What challenges remain in this area:**
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**Source URL:** http://aidsreportingtool.unaids.org/150/oman-report-ncpi