

UNGASS COUNTRY PROGRESS REPORT

Sultanate of Oman

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- National AIDS technical committee members

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II. Status at a Glance

a. The Inclusiveness of the Stakeholders in the Report Writing Process

The process to develop the Sultanate of Oman 2010 UNGASS Progress Report was led by the National AIDS Program (NAP) Team within the Department of Communicable Disease Surveillance and Control. The process took place through the 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. The consultative process was undertaken under the auspices of His Excellency Dr. Ahmed Al Saidi, Minister of Health and His Excellency Dr. Ali Jaffer, Advisor, supervising Director General of Health Affairs. 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.

Over the course of a one day meeting held in January 2010, which included key stakeholders from key ministries involved in the HIV and AIDS effort, a three-month data collection and analysis plan was developed, including the nature of the data to be collected in line with UNGASS indicators, roles and responsibilities and the identification of information sources. This meeting was facilitated by the National AIDS Program (NAP) Team and included key members of the national HIV and AIDS Technical Committee, the National M&E Committee, stakeholders representing line ministries as well as representatives from the different UN agencies involved in the HIV and AIDS national response effort. The key UN agencies engaged with the NAP were part of these discussions and provided an invaluable perspective to their work as well as to progress made through the national response effort.

Due to the limited availability of civil society in the Sultanate of Oman participating in HIV/AIDS area, no representatives from NGOs were part of this consultation process. One of the shortcomings of this process was that persons living with HIV (PLHIV) in Oman did not attend the initial or data validation meetings and did not provide input into the NCPI questionnaires (part B).

Following a broad data collection effort, bi-lateral meetings were held to validate the data that was collected, and a one-day data validation meeting took place, to ensure that all information being reported on appropriately and comprehensively reflect the current national response effort in Oman. Over the course of this day-long meeting, the data collected was validated and endorsed. Important to note, is that this broad consultative process has also allowed for identification of key information gaps that currently exist and ways by which the current M&E systems within the National AIDS Program could be strengthened to provide more accurate information on HIV and AIDS programming in the future. The Sultanate of Oman's UNGASS Progress report for 2010 is the result of this inclusive process over the course of three months.

(a) The status of the epidemic

The first official case of AIDS was notified in 1984. By the end 2009 a cumulative number of 1,854 HIV/AIDS infections were notified, some cases may be duplicated as National ID number is not available for all HIV/AIDS cases. Analysis of the cumulative HIV/AIDS cases indicate that 2/3 are males, and that 71.5% are from the active and productive age group of 25-59 years, 17.4% are young adults (15-24 years), and 8.1% are less than 15 years. Out of all cumulative cases to date alive cases as of end of 2009 are 1,157 (62.4%). Before 1995 the, transmission of HIV by blood transmission was 26%, Transmission of HIV by blood transfusion is no longer a concern. Among alive cases with known mode of transmission, the main modes of transmission were heterosexual (47.6%), homosexual-bisexual (12.5%), mother to child (5.4%), injecting drug users (5.1%) and Blood transfusion (4.0%). HIV + Patients are treated at 15 different sites spread over in Oman, three of them in Muscat, which has the highest number of patients seeking treatment as well as tertiary health facilities.

Currently the Ministry of Health MOH Guidelines for the management of HIV Infection and AIDS is used in the management of patients with HIV +, which was published in 2004 and the latest edition is in the process of renewal & should be out by the end of 2010. In the current guidelines patients are started on anti retro viral treatment at the level of CD4 < 200, but the treating physicians with the National AIDS program , has agreed on starting the patients on treatment at the level of CD4 of <350 since mid 2007, which will be included as recommendations in the coming guidelines.

(b) Overview of the policy and programmatic response

The Sultanate of Oman's has taken important necessary measures to curb the spread of HIV and AIDS, especially in light of rapid social and economic changes associated with demographic and epidemiological changes in the Sultanate. The National Program for combating HIV and AIDS developed its national strategic plan (NSP) to combat HIV and AIDS in 2007 in collaboration with the Ministry of Health, Education, Social Development Defense, *Awkaf* and Religious Affairs, Higher Education, Directorate of Royal Oman Police Medical Services, the National Organization for Scouts and Guides, and the General Organization for Youth Sports and Cultural Activities. Based on MoH information sources, the NAP is integrated in the fourteen programs of the MoH and is integrated in its general development plans, namely the 7th five-year health strategic plan.

Oman's National Response Strategy to HIV and AIDS has five strategic interventions: Promotion and Development of Supporting Environment, Broadening Prevention Initiatives, Strengthening Surveillance, Expanding High Quality Care and Case management for PLHIV, and Monitoring and Evaluation. The goal of this national strategy is to control the spread of HIV and AIDS through comprehensive interventions for prevention, management and care and to expand the participation of key stakeholders in the Oman national response to HIV and AIDS.

The national multi-sectoral strategy interventions include activities related to the sectors such as those related to labor, health, young people, women, education, oil and migrant workers but no information is available on the earmarked budgets for and/or by each sector. The strategy generally focuses on the

following target groups: STI and TB patients, prisoners, and young people and some reference to high-risk groups. The strategy also generally addresses prisons and workplaces as vulnerable settings. It also tackles addressing stigma and discrimination and involvement of people living with HIV and AIDS.

Developing the national strategy is considered an important step towards scaling up and coordinating national response efforts. However, much needs to be done for its implementation, including the development of annual operational plans and the costing of activities and initiatives in order to track budget commitments and expenditures on an annual basis. The summary of the strategy does not include any reference to clear budget allocations to ensure the fulfillment of the strategy or an annual operational plan. It is also has yet to outline the roles and responsibilities of the different actors entrusted with the implementation of the NSP, a timeline in which the plan is to be implemented or a monitoring and evaluation framework to ensure delivery on national targets.

The involvement of a number of Ministries in the development of the strategy reflects strong political commitment to and engagement on the national HIV and AIDS strategy. High level officials within the Ministry of Health speak publicly and favorably of HIV and AIDS efforts. Oman also has two technical multi-sectoral management and coordination committees, namely the National AIDS Technical Committee and the national Monitoring and Evaluation Committee for the National Strategy. At the central level, HIV and AIDS prevention and control section in the department of Surveillance and Disease Control, Directorate General of Health Affairs, MoH is responsible for the coordination with other governmental, private and civil society sectors. At provincial level, focal points and counselors have also been assigned to carry out this role at the provincial level. There exists the political will and some of the policy level infrastructure in place that is required to pursue efforts in combating HIV and AIDS.

Given the low prevalence rate of HIV in Oman, future strategic steps in the country include reaching high-risk groups, such as injecting drug users, commercial sex workers and men who have sex with men that cannot be reached through the existing general prevention programs. The National Strategic plan includes various strategic interventions related to broadening prevention Initiatives, including a strong information, education and communication campaign concerning HIV and AIDS prevention for the general population. The 'Let's Talk AIDS' campaign, implemented in 2009, is cited as by far the most successful of program prevention efforts undertaken within the national response. Additionally, as part of its prevention efforts, the MoH conducts a yearly campaign on HIV education and produces around 500,000 leaflets and 6,000 posters a year. The inclusion of HIV-related awareness as part of the education curriculum starting from secondary schools is generally cited as an additional success in Oman's prevention efforts, where in around half a million "Facts of life" books are published which contains a chapter on HIV/AIDS.

As part of harm reduction interventions to prevent HIV transmission among injecting drug users, Oman reviewed its policy and as well as programmatic aspects that that both enable and obstruct the introduction of harm reduction measures. The outcomes of this policy review effort will require further program action. Additional prevention efforts by Oman is to screen all pregnant woman from 1st July 2009 onwards and provide comprehensive package of services which also include providing HIV positive pregnant women with antiretroviral therapy from 14 weeks of gestation, during labor, post partum to

mother and child, avoiding breast feeding, providing appropriate vaccination to prevent transmission to the unborn child.

There is strong delivery of services associated with blood safety, universal precautions in health care settings, prevention of mother to child transmission and as well as reproductive health services, and school based information. However, prevention programming requires greater efforts be exerted in access of most-at-risk and vulnerable groups on IEC on how to reduce risk, IEC on stigma and discrimination, in condom promotion, in HIV testing and counseling, in harm reduction for injecting drug users, risk reduction for MSM or sex workers and HIV prevention in the workplace.

Oman's strategy to provide quality treatment, care and support is as a comprehensive strategy with key successes in provision of free anti-retroviral therapy, in pediatric HIV/AIDS treatment, in STI management and in supportive care of common HIV related infections, and in TB screening and or treatment and care facilities. In terms of country needs for ART, there is recognition that Oman does have sound estimates for current and future needs. However in order to strengthen aspects of treatment, care and support, both more needs to be done to address barriers to prevention, treatment and care faced by most at risk and vulnerable populations. An emphasis was placed on ensuring that people are aware that treatment is free and accessible, while addressing issues of stigma and discrimination so that there can be more client-initiated and more people in need to access the necessary treatment. Current programming challenges mostly include the need for a sound system for testing and counseling and not just a reliance on post test counseling. Additionally, UN agencies highlighted the need for the National Strategy's monitoring framework to be developed to ensure that policies and guidelines are being adhered to.

(d) UNGASS indicator data in an overview table

The following Table summarizes the update on UNGASS and other national indicators. More details on each indicator value are to be found in the on-line report as well as in the body of this report.

Table 1: UNGASS and National Indicators Overview.

NATIONAL COMMITMENT AND ACTION INDICATORS	
1. National Spending	Total expenditures from Government is US\$ 621,234 for the year 2009 and US\$ 190,537 by UN Agencies. No National AIDS spending assessment (NASA) was conducted to generate this information. Information generated was provided by the different sections of Ministry of Health, other ministries and UN agencies involved in the response effort. Detailed table is uploaded on the reporting website.
2. National Composite Policy Index	A total of 16 NCPI questionnaires administered (12 to Government and 4 to UN Agencies in Oman). Detailed analysis is uploaded on the reporting website and is also included throughout this report.
INDICATORS OF NATIONAL PROGRAMS	
3. Percentage of donated blood units screened for HIV in a quality assured manner	Value for Numerator is zero and Denominator 44,485 (Final Value: 0%) Presence of Standard Operating Procedures in the Sultanate of Oman, No Quality Assurance System in place in general. Recommendations made as a result of this process to initiate quality assurance system in 2010.
4. Percentage of Adults and Children with advanced HIV Infection receiving ART	Value for Numerator 486 and Denominator 513(Spectrum) (Final Value: 94.74%) Most advanced HIV infection patients are currently under treatment. Extensive patient monitoring initiated by six monthly follow up recordings of each patient (Forms-1 & 2) in 2009 irrespective of the need for treatment.
5. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	Value for Numerator 9 and Denominator 21(Spectrum) (Final Value: 42.86%) Most HIV infected pregnant patients are under treatment (or Prophylaxis as per the need) after July 2009. Plan for Extensive follow –up of HIV infected pregnant women initiated (National HIV registry for Pregnant women in place).
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Value for Numerator 3 and Denominator 3 (Final Value: 100%) All patients of TB, tested for HIV routinely and all HIV cases get screened for TB. Three patients had TB & HIV in 2009 and treated for TB & HIV. Need to improve system of monitoring of all deaths related to HIV.
7. Percentage of women and men aged 15-49	No population based surveys undertaken.

who received an HIV test in the last 12 months and who know their results	Extensive HIV testing done for in regular health services, in CDC largely for expats, blood donors, CPHL lab, Royal/SQUH hosp lab, ANC clients. Age and gender segregation not available as per the requirements. "Who knows the result" clause difficult for all tested.
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No data is available because of lack of Behavioral surveillance or other special surveys. Only MARP accessible now in Oman is Injecting drug users. All injecting drug users (IDU) accessed health facilities are not tested for HIV (missed opportunity), HIV status results not traced. No policy for re-testing IDU's accessing health facilities regularly. No idea about IDU in community who are not accessing health facilities. "Who knows their result" clause difficult for all tested.
9. Percentage of most-at-risk populations who reached with HIV prevention programs	No data is available because of lack of Behavioral surveillance or other special surveys. Only MARP accessible now in Oman is Injecting drug users. No specific HIV prevention program for MARP. Considerations underway for IDU's harm reduction package which includes counseling, HIV testing, de-addiction and rehabilitation, needle & syringe exchange, and condom provision.
10. Percentage of orphans and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	Topic is not relevant to country epidemic status. Mainly for generalized epidemics.
11. Percentage of schools that provided life-skills based HIV education within the last academic year	Value for Numerator 815 and Denominator 815 (Final Value: 100%) All government schools provide life skills based HIV education. All private schools provide life skill based HIV education. Considerations being made for more targeted messages.
INDICATORS FOR KNOWLEDGE AND BEHAVIOURS	
12. Current school attendance among orphans and non-orphans aged 10–14	Topic is not relevant to country epidemic status. Mainly for generalized epidemics.
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No population based surveys undertaken. 2007 data available for students of university with an average age of 20 on knowledge related to HIV transmission which is 3.9% for all five questions, individual questions related data are uploaded on the reporting website.

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Topic is relevant, indicator appropriate but no special behavioral survey undertaken. No specific program in Oman for MARPs.
15. Percentage of young women and men who have had sexual intercourse before the age of 15	No population based surveys undertaken. Mainly for generalized epidemics
16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	No population based surveys undertaken. Mainly for generalized epidemics
17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse	No population based surveys undertaken. Mainly for generalized epidemics
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	No behavior survey conducted, no accessibility to sex workers
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	No behavior survey conducted, no accessibility to MSM
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No behavior survey conducted. Currently no program for IDU to provide harm reduction services.
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No behavior survey conducted. No program for IDU to provide harm reduction services including needles & syringes. Needles & Syringes are not provided to IDU accessing services.
IMPACT INDICATORS	
22. Percentage of young people aged 15-24 who are HIV-infected	No biological survey conducted. Spectrum estimates do not factor immigration hence NAP do not consider appropriate to report.

<p>23. Percentage of most at risk populations who are HIV-infected</p>	<p>No Bio-behavior survey conducted. No program for IDU to provide harm reduction services including HIV testing. Main issues for NAP are harm reduction program initiation and improvement of HIV testing for IDU's accessing services.</p>
<p>24. Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of ART</p>	<p>Value for Numerator 53 and Denominator 64 (Final value-82.8%). Extensive patient monitoring initiated by six monthly follow up recordings of each patient (Forms-1 & 2) in 2009 irrespective of the need for treatment.</p>
<p>25. Percentage of infants who are born to HIV-infected mothers who are infected</p>	<p>Value for Numerator 9 and Denominator 21 (Final value-42.9%) Spectrum estimates are used for both pregnant women and infants, lower range of values are considered. Most HIV infected pregnant patients are under treatment (or Prophylaxis as per the need) after July 2009. Plan for Extensive follow –up of HIV infected pregnant women initiated (National HIV registry for Pregnant women in place).</p>

III. Overview of the HIV/AIDS epidemic

The first official case of AIDS was notified in 1984. By the end 2009 a cumulative number of 1854 HIV/AIDS infections were notified. Analysis of the cumulative HIV/AIDS cases indicate that 2/3 are males, and the 71.5% are from the active and productive age group of 25-59 years, 17.4% are young adults (15-24 years), and 8.1% are less than 15 years. Out of all cumulative cases to date alive cases as of end of 2009 are 1157(62.4%). Before 1995 the, transmission of HIV by blood transmission was 26%, Transmission of HIV by blood transfusion is no longer a concern. Among alive cases with known mode of transmission, the main modes of transmission were heterosexual (47.6%), homosexual-bisexual (12.5%), mother to child (5.4%), injecting drug users (5.1%) and Blood transfusion (4.0%). HIV + Patients are treated at 15 different sites spread over in Oman, three of them in Muscat, which has the highest number of patients seeking treatment as well as tertiary health facilities.

In Oman, HIV and AIDS are mandatory reportable conditions. HIV screening is carried out for blood donors, TB patients, STI patients, and expatriate workers; moreover, expatriates are screened for HIV every other year. Prisoners are systematically screened for HIV up on entry.

The actual testing strategy is based on initial ELISA. The sera are screened initially as single specimens by ELISA test. If the test is positive, 2nd Elisa test is done on same sample. If one of the two tests results is positive, the serum is considered reactive by ELISA. This sample is again tested by Western Blot Test and if positive then gets re-confirmed by second Western blot test on a re-bleed sample. If the re-bleed is intermediate, repeat the whole procedure again in 3-6 months

In Oman there are two places where confirmation by Western Blot could be done: at Central Public Health Laboratory (CPHL) in Darseit (Muscat) & at Sultan Qaboos University Hospital. All ELISA positive samples from public, private, military and police health structures are sent to the CPHL for Western Blot confirmation.

Any confirmed HIV positive case is received by the HIV counselor of the health facility for information and counselling and information. HIV cases are asked to inform his/her family/partner about his/her sero-positive status.

HIV/AIDS surveillance is under the responsibility of the National HIV/AIDS Program (NAP). The HIV case notification form is jointly filled out by doctor and the counselor and handed to the HIV focal point in the health institution. The focal point who is usually the HIV counselor will perform the case investigation and sends by fax the notification form along with the investigation report to the NAP. Confidentiality is ascertained in all the situations.

The HIV reporting form includes a part on AIDS and death reporting. However as this form is completed at time of a first HIV and test results, AIDS and death reporting is limited at time of HIV testing and further during follow-up forms every six months.

Currently the Ministry of Health MOH Guidelines for the management of HIV Infection and AIDS is used in the management of patients with HIV +, which was published in 2004 & the latest edition is in the process of renewal & should be out by the end of 2010. In the current guidelines patients are started on anti retro viral treatment at the level of CD4< 200, but the treating physicians with the National AIDS program , has agreed on starting the patients on treatment at the level of CD4 of <350 since mid 2007, which will be included as recommendations in the coming guidelines.

IV. National response to the AIDS epidemic

1. National Commitment/National Expenditure on HIV

The Ministry of Health's Central Budget is the source of the major proportion of resources committed to HIV/AIDS in the Sultanate of Oman. Although Oman has not undertaken a National AIDS Spending Assessment, an attempt has been made to provide estimates on how much has been expended in 2009 on HIV AIDS related program implementation. Total expenditures from Government are US\$ 621,234 for the year 2009 and US\$ 190,537 by UN Agencies. No National AIDS Spending Assessment (NASA) was conducted to generate this information. Information generated was provided by the different sections of Ministry of Health, other ministries and UN agencies involved in the response effort. We may be under estimating the actual costs as expenses incurred for care and management by sister institutes and private sector do not reflect accurately in these estimates. We do not have accrual basis budget hence most costs are estimates of actual usage.

What is evident is that none of the sectors involved in the national response has a specific budget for HIV because the resources committed for HIV related programs and activities are from the general budget of the MOH and/or each of the involved Ministries. Additionally, although the National Strategy does have clear programmatic goals, it does not include clear financial spending targets, its programmatic areas are not budgeted and there is no indication of the funding sources to support each program implementation. As such, there are no explicit resource amounts committed for activities on prevention, treatment and care and therefore it is difficult to ascertain what the rationale is for rationale for resource allocations and expenditure by program category.

There is a need for clear indication on resource availability and commitments for HIV and AIDS in terms of planning, program implementation and M&E. Both government and UN agencies, stressed the impotence of allocations and expenditure monitoring on an annual basis so as to help in assessing the cost-effectiveness of program delivery in particular areas and in making appropriate policy and program decisions regarding where to focus spending.

Indicator # 2: National Policy Composite Index

A total of 12 responses from government and 4 responses from representatives of UN agencies in Oman inform this NCPI analysis.

Strategic Plan

Oman's multi-sectoral response strategy on HIV/AIDS (2008-2011) is widely seen as representing the appropriate response to issues of HIV in the country, and has been widely endorsed by governmental and specific non-governmental development partners. Government and UN agencies view this strategy

as having been based on studies and statistics that have helped to outline target populations and geographic focus areas. While the strategy articulates a wide set of target populations, there are varying views between government and UN agencies as to whether this strategy, in its actual implementation address the most-at-risk groups in Oman, namely IDUs, FSW and MSM.

Government representatives had varying views on whether or not the current national AIDS strategy is well integrated in overall national development plans of Oman. There is a common perception that HIV is not fully integrated into Oman's general development plans, so issues of prevention, treatment, care and support, reduction of gender inequalities as associated with HIV and AIDS are only dealt with through the National AIDS Strategy. However, several government representatives also cited Oman's 7th Five Year Health Plan which dedicates a chapter to HIV-related program and policy responses, and tackles issues of HIV prevention, treatment for opportunistic infections, ART, treatment, care and support, and reduction of stigma and discrimination associated with HIV.

In general, there is a favorable perception amongst government and UN of strategy planning efforts in HIV programs in 2009 with successes including that the strategy was developed and launched, the "Lets Talk Campaign", policies regarding free ART, ANC testing, and the partnership of UN agencies with the Government of Oman in the execution of programs that address HIV.

There is also wide recognition/appreciation for the current policy level support for issues of HIV and AIDS, at both central and district levels. The current national AIDS committee, chaired by H.E. Dr. Ali Jaffer, Advisor of Health Affairs, is seen to actively engage in reviewing program and policy positions. UN agencies however, point to need for greater support, in promoting collaboration and coordination amongst different stakeholders, especially in providing greater encouragement for civil society and the private sector to engage in program delivery and influence decision-making.

Government representatives perceive of the on-going review of national policies to be well-aligned with the national AIDS Program, as translating to introduction of new policies such ANC screening, free access to HIV prevention services, free access to ARTs to all those in need and quality HIV-related care and support. While there are no gender based barriers to such services. On the other hand, UN agencies place greater emphasis on the need for greater policy support on issues of human rights, enforcement of existing policies, support for programming for most-at-risk populations and ensuring that issues of stigma and discrimination are adequately addressed.

Policies and Laws

While Oman's national strategy emphasizes that people should not be discriminated against and that human rights should be respected, all UN respondents to the NCPI noted that there are no *explicit* non-discrimination laws in Oman for vulnerable and most-at-risk populations, They pointed to the policies that present obstacles for effective HIV prevention, treatment and care and support, such as 'mandatory screening and repatriation of HIV positive foreigners' and the inadequate protections for those people

who are seen not to be abiding by the Law. UN representatives noted that there are no existing laws that include explicit protections of IDUs, MSM, sex workers or prison inmates and that there is no explicit policy to ensure access of MARPs to HIV prevention treatment, care and support. Additionally, there is no mechanism currently in place to document cases of discrimination against PLHIV or MARPS.

The recent establishment of the National Human Rights Committee, though not yet widely publicized, is seen by some within the UN as a potential enforcement mechanism for issues of human rights and a means to ensure that national policies and laws are better aligned with the national AIDS program. Examples cited include the need to review policies associated with harm reduction programs for IDUs and risk reduction programs for MSM and SW. This sentiment is echoed by several government representatives. Due to the recentness of its establishment, the National Human Rights Committee is not known to a number of UN agencies themselves, there remains the perception that human rights enforcement mechanisms do not exist. UN representatives also noted that there are no legal aid services for PLHIV, although there has been some effort to educate and raise awareness amongst PLHIV regarding their rights. Enforcement of human rights is seen as a priority amongst UN agencies, citing the need for Oman to develop and enforce a human rights framework for PLHIV.

Most-at-risk Populations (MARPS)

With regards to most-at-risk populations, there was overarching agreement amongst government and UN representatives that while the current national strategy appropriately targets women, youth, and IDUs, it can do more to target at most-risk-populations such as IDUs, MSM, sex workers or other vulnerable populations. This is an expressed need for more targeted programs to reach MARPS. There is a concern that MARPS are not seeking health services within the health institutions for fear of stigma and that in the absence of programs offering needed health services, these populations remain unknown in their numbers and largely unreached by the necessary prevention and treatment options made available in Oman. As such, UN agencies stress the need for more targeted harm reduction and risk reduction programs for MARPS, in order to facilitate access to these groups, ensure that they are aware of their right to health services associated with HIV and guarantee them protections from stigma and discrimination.

Civil Society Engagement

An important area of focus for government and UN agencies responding to NCPI is that there is extremely limited civil society involvement in areas of strategy development, in policy formulation, or in budgeting processes and in program delivery of aspects of the national strategy. In reality, there are only a few NGOs in Oman, none of whom are engaged exclusively in HIV related programs. However, there is a strong sense that the current programming efforts are not encouraging civil society involvement in providing services. UN agencies stressed there are no barriers to civil society accessing financial or technical assistance or engaging in HIV-related efforts. As such, all UN agencies stressed the need to increase involvement of CS in activities such as prevention for youth, prevention for MARPS,

testing and counseling, reduction of stigma and discrimination, ART provision or programs for orphans and vulnerable children. Several recommendations were made by the UN in this regard, namely to strengthen mechanisms that promote interaction between government and civil society on the HIV strategies and programs. Another recommendation made was to encourage the formation of a network of PLHIV in order to ensure that their voices are heard in program planning and strategy development, and most importantly that services are geared to meeting their needs. In fact, it was noted that there is currently no mechanism in place to ensure that PLHIV and MARPS are involved in aspects of policy and program development. From a UN perspective, the voices of PLHIV and MARPS are currently absent in both policy and program spaces.

Prevention

The Sultanate of Oman has a well-recognized strategy that promotes information, education and communication to the general population. Government representatives concur that the strategy includes all the messages required to raise awareness about HIV related prevention. This view is not shared by UN agencies who note that there are key messages regarding sexual abstinence, being faithful, reducing number of sexual partners, abstaining from injecting drugs, avoiding commercial sex or engaging in safe sex, fighting violence against women and involving men in RH programs that are not explicit and widely communicated. However, there is broad recognition amongst government and the UN that the 'Let's Talk AIDS' campaign, with its focus on focus on Oman's young population, has been a significant success in terms of prevention efforts. This is primarily because 50% of those newly infected in Oman are in that age bracket of 20—35 years, and almost 17% are under the age of 20 years. Both concurred that this success needs to be complemented by greater efforts to fight stigma and discrimination within the general population. UN Agencies place greater emphasis on the need for an IEC strategy specifically geared to behavioral change amongst most at risk and vulnerable populations (harm reduction for injecting drug users, risk reduction for MSM/SW). As such, a recommendation made was for greater involvement of PLHIV and individuals from at-risk groups in the planning for and implementing of HIV prevention related activities.

The inclusion of HIV-related awareness as part of the education curriculum starting from secondary schools is generally cited as an additional success in Oman's prevention efforts. However, while school based access to this information is available for both men and women, there is no strategy in Oman for the out of school population. Additionally, UN agencies made note of the fact that results of the KAP adolescence study for 2007, reveal that a significant number of youth have basic knowledge of HIV and AIDS, but hold huge misconceptions regarding transmission. The recommendation made was to ensure that school based IEC efforts are assessed for the effectiveness of the messages amongst this critical population group.

Government and UN representatives agree that in terms of prevention, there is strong delivery of services associated with blood safety, universal precautions in health care settings, prevention of mother to child transmission and as well as RH services, and school based information. However, UN

agencies primarily highlighted that much more could be done for people to access IEC on how to reduce risk, IEC on stigma and discrimination, in condom promotion, in HIV testing and counseling, in harm reduction for injecting drug users, risk reduction for MSM or sex workers, HIV prevention for those populations that are out-of-school, and HIV prevention in the workplace.

Treatment, Care and Support

Oman's strategy to provide quality treatment, care and support is largely seen as a comprehensive strategy, determined largely through statistics and studies. While there is an overall positive perception of this strategy, several issues were raised both by government representatives and the UN, namely in that the strategy has yet to address barriers to prevention, treatment and care faced by most at risk and vulnerable populations. Emphasis was placed on the need for this strategy to be more geared to providing the appropriate treatment and support options, namely first by ensuring that programs are able to build trust, reach and target most-at-risk groups in a non-discriminatory environment. UN representatives therefore stressed that more people need to be made aware that treatment is free and accessible, while addressing issues of stigma and discrimination so that there can be more client-initiated and more people in need to access the necessary treatment.

Overall implementation of current care, treatment and support services are perceived very favorably by government representatives, with key successes in provision of anti-retroviral therapy, in pediatric AIDS treatment, in STI management and in palliative care of common HIV related infections, and in TB infection control in HIV treatment and care facilities. In terms of country needs for ART, government representatives affirmed that Oman does have sound estimates for current and future needs. However in order to strengthen aspects of treatment, care and support, both government representatives and UN, stated that more needs to be done through the national response effort on psychosocial support for PLHIV and their families, home based care, improving counseling practices, as well as improving HIV care and support in the work place etc.

From the perspective of policy support, there is agreement that such a positive policy environment on treatment and care has led to successes such as the review and update of the policy for allowing access to ART, the review of WHO guidelines in 2009, as well as the policy associated with HIV screening in ANC. Challenges mostly outlined by UN agencies include the need for a sound system for testing and counseling and not just a reliance on post test counseling. Additionally, UN agencies highlighted the need for the National Strategy's monitoring framework to be developed to ensure that policies and guidelines are being adhered to.

Monitoring and Evaluation

Monitoring and evaluation is broadly cited by both government and UN agencies as one of the core areas requiring more substantial attention in the short to medium term, with a key constraint being the absence of an overarching M&E Framework for the National AIDS Program (See Section on M&E

Environment). Without such a framework M&E in place, there is broad recognition amongst government and UN representatives that this is hindering the NAP's ability to comprehensively obtain, analyze and appropriately use the data to the benefit of programs or at the policy level. Some of the challenges cited were existing capacities, in that there is no dedicated point person/ unit, training on M&E remains inadequate and that the current national M&E committee has not been fully functional. Additional M&E System limitations include the lack of standardized indicators, guidelines on tools for data collection, data analysis strategy and data dissemination plans. As such, there is no mechanism in place for NAP and implementing partners to submit routine reports and to share data, so as to ascertain the collective contribution to the national response on HIV/AIDS. As such, there is a sense within UN responses to the NCPI that what information that is currently being collected is not used for appropriately for strategy review, for resource allocation, or for program improvement.

Indicator 3 Blood safety: Oman has 15 blood banks in total and all of them operate by using standard operating procedures (SOP) however Quality assurance system is not in place hence indicator shows much poor showing than reality. A Process has been initiated to establish Quality assurance system and it will be in place very soon.

Indicator 4 HIV Treatment – Antiretroviral Therapy: Oman offers free treatment to all its citizens and 15 designated treatment sites are geographically well represented in the country. There is availability of hospitals and human resources to carry out the task. Communication and Logistics of medicine supply is very good and no stock out is witnessed for the entire reporting period. The only bottle neck is in the immunological monitoring of patient by CD4 evaluation and this will be addressed in 2010 to ensure every HIV patient gets monitored at least once in six months hence we expect treatment coverage to go up. Within this report, higher range of values of spectrum estimates are included as denominator and actual number of patients on treatment as numerator for calculating coverage, which is about 95%.

Indicator 5 Prevention of mother to child transmission: Large-scale efforts are made in this area as Oman has launched a massive initiative to offer all women (estimated to be 64,000 per year) in antenatal period for HIV starting from 1st July 2009. All Health institutes in Oman have now trained female MCH counselor who is working in ANC area to ensure smooth implementation. Training and capacity building is carried out at sub-national level in order to continue the services uninterrupted. Logistics of testing, reporting, referral, counselling and support, treatment or prophylaxis, delivery plan, post partum prophylaxis and monitoring for child, avoidance of breast feeding and appropriate vaccination is in place. Plan for extensive follow –up of HIV infected pregnant women and their child is initiated in terms of National HIV registry for pregnant women in place. Out of the estimated HIV positive pregnant women, 43% received antiretroviral to reduce mother to child transmission.

Indicator 6 Co-management of Tuberculosis and HIV treatment: For many years now in Oman every patient who is diagnosed for TB is getting tested for HIV as well as every diagnosed patient of HIV gets screened for TB including Moutoux test. Those HIV patients who are clinically not having TB but are

showing more than 5 mm of induration in Mountoux test are also treated for 9 months for Latent TB. All three patients diagnosed with HIV and TB during 2009 received treatment for both HIV and TB.

Indicator 7 HIV testing in general population: No population based survey is undertaken to accurately assess HIV testing in general population however HIV testing is widely done (605,755 in 2009) in all health institutes of Oman. These include HIV testing done in regular health services, in CDC largely for expats, blood donors, Central Public health lab, Royal/SQUH hosp lab, ANC clients. Age and gender segregation for all persons tested for HIV is not available as per the requirements. "Who knows the result" clause is difficult to ascertain for all those tested.

Indicator 8 HIV testing in most at risk population: No data is available because of lack of Behavioral surveillance or other special surveys. Only MARP accessible now in Oman is injecting drug users. All injecting drug users (IDU) accessed health facilities are not tested for HIV (missed opportunity), and HIV status results not traced. There is no in place policy for re-testing IDU's accessing health facilities regularly. No information is available about IDU in community who are not accessing health facilities. "Who knows their result" clause is difficult to ascertain for all those tested.

Indicator 9 Most at risk population prevention program: No data is available because of lack of Behavioral surveillance or other special surveys. Only MARP accessible now in Oman is injecting drug users. No specific HIV prevention program for MARP. Considerations are underway for IDU's harm reduction package which includes counseling, HIV testing, de-addiction and rehabilitation, needle & syringe exchange, and condom provision.

Indicator 10 Support for children affected by HIV and AIDS: Indicator is not relevant to country epidemic status. Mainly for generalized epidemics.

Indicator 11 Life-skills based HIV education in schools: All government schools (678) provide life skills based HIV education. All private schools (137) provide life skill based HIV education. Peer education related to HIV is ongoing in 404 schools from grade 9-12. Considerations are underway for delivering more targeted messages.

Indicator 12 Orphans: School Attendance: Indicator is not relevant to country epidemic status. Mainly for generalized epidemics. However all orphans irrespective of the reason are supported by the government for all physical needs and school/college education. Many orphans also do get adopted in other families from orphanages but generally into their extended family.

Indicator 13 Young people: Knowledge about HIV prevention: Behavior survey is conducted during 2007 in Universities; students are selected by proportional probability sampling method from all universities in Oman. Sample is nationally representative and average age of respondents is 20 years (range 19-22 years). Data were gathered by self administered questionnaires.

Indicator 14 Most-at-risk populations: Knowledge about HIV transmission prevention: No data is available because of lack of Behavioral surveillance or other special behavioral surveys. Among the MARP's the only survey was done for IDU's in 2006 which did not address the specifically the requisite five areas.

Indicator 15: Sex before the Age of 15: No population based surveys undertaken. Even in the behavioral survey which was conducted among University students in Oman, the exact question was not asked. The question is considered culturally offending.

Indicator 16: Higher-risk Sex: No population based surveys undertaken. Even in the behavioral survey which was conducted among University students in Oman during 2007, the exact question was not asked.

Indicator 17: Condom Use During Higher-risk Sex: No population based surveys undertaken. Even in the behavioral survey which was conducted among University students in Oman during 2007, the exact question was not asked.

Indicator 18: Sex Workers: Condom Use: No special behavioral survey conducted. No special services for sex workers. Condoms are mainly distributed to females through birth spacing clinics & they are easily available at pharmacies, hyper markets & even small super markets. Recently they are made available at the STI clinics and in general government health services clinics

Indicator 19: Men who have sex with Men: Condom Use: No special behavioral survey conducted. No special services for MSM. Though it is one of the reported methods of HIV transmission in Oman.

Management of Anal Infections has been introduced under the Syndromic case management at the primary health care along with counselling & condom provision. Condoms are also being distributed at the STI clinics, in general government health services clinics and they are easily available at pharmacies, hyper markets & even small super markets.

Indicator 20: Injecting Drug Users: Condom Use: No special behavioral survey conducted. The IDU survey which was conducted in 2006, did not address the exact question. The questions related to condom use from the survey were ever used condom, always use condoms in the past year & never used condom in the past year. Currently considerations are made to provide harm reduction services to IDU. This question will be added among the new IDU case notification form in the near future.

Indicator 21: Injecting Drug Users: Safe Injecting Practices: No special behavioral survey conducted. The IDU survey which was conducted in 2006, did not address the exact question. The questions related to injecting practices from the survey were; do not share needle currently, ever Shared and average number of times shared in the last month. Currently considerations are made to provide harm reduction services to IDU including needles & syringes. This question will be added among the new IDU case notification form in the near future.

Indicator 22: Reduction in HIV Prevalence: Spectrum estimates are available but they do not factor in immigration factor. These estimates are not acceptable to HIV program and policy makers as they do not represent the reality.

Indicator 23: Reduction in HIV Prevalence: Men Who have Sex with Men: MSM as a MARP are not accessible to HIV program for any intervention or services. Though we get HIV cases in MSM so prevalence among them is not measured ever so reduction cannot be commented upon.

Indicator 24: HIV Treatment: Survival After 12 Months on Antiretroviral Therapy: Our goal of providing antiretroviral therapy is to increase survival among infected individuals. This indicator is very useful in monitoring our efforts, 83% patients initiated ART in 2008 were continuing ART 12 months after in 2009 where 95% of estimated patients in need of treatment are on treatment is an encouraging sign.

Indicator 25: Reduction in Mother-to-child Transmission: Large scale efforts are made in this area as Oman has launched massive initiative to offer all women (estimated to be 64,000 per year) in antenatal period for HIV starting from 1st July 2009. Plan for Extensive follow –up of HIV infected pregnant women and their child is initiated in terms of National HIV registry for pregnant women in place. Spectrum estimates 43% of infants born to infected mothers as positive for the year 2009 but we are determined to reduce this substantially in years to come.

V. Best practices

1. Scale-up of HIV testing in pregnancy: Large-scale efforts are made in this area as Oman has launched massive initiative to offer all women (estimated to be 64,000 per year) in antenatal period for HIV starting from 1st July 2009. All Health institutes in Oman have now trained female MCH counselor who is working in ANC area to ensure smooth implementation. Training and capacity building is done at sub-national level in order to continue the services un-interrupted. Logistics of testing, reporting, referral, counselling and support, treatment or prophylaxis, delivery plan, post partum prophylaxis and monitoring for child, avoidance of breast feeding and appropriate vaccination is in place and documented in Standard operating procedure manual which is widely circulated. Plan for Extensive follow –up of HIV infected pregnant women and their child is initiated in terms of National HIV registry for pregnant women in place.
2. HIV/TB management: For many years now in Oman every patient who is diagnosed for TB is getting tested for HIV as well as every diagnosed patient of HIV gets screened for TB including Moutoux test. Those HIV patients who are clinically not having TB but are showing more than 5 mm of induration in Moutoux test are also treated for 9 months for Latent TB.

VI. Major challenges and remedial actions

An Accurate Description of the Epidemic

There is an expressed need, to develop a more accurate description of the extent and nature of the epidemic in Oman as well as to validate available data from national HIV/AIDS database in order to support evidence-informed program and policy responses. Due to limited availability of civil society engagement or programs that specifically reach and target most at risk groups, access to such populations, obtaining size estimations, understanding risk factors and risk behaviors, and getting an accurate description of the drivers of the epidemic in Oman remains a challenge. Cultural and social sensitivities maintain silence and denial over the presence of high-risk groups such as sex workers and men who have sex with men. An additional challenge remains with regards to undertaking special studies and surveys in a contextually appropriate manner and using the information generated by such studies to develop programs that specifically target high-risk groups.

M&E

M&E is the area largely unknown to many stakeholders who informed the NCPI, the extent of the information that is gathered is not clear and the way in which HIV-related information is used is the area of least clarity. As such, it was cited as one of the areas requiring more substantial attention in the short to medium term, with one of the challenges being the existing capacity and resources to develop and implement an M&E Plan. Without a proper M&E plan, this is hindering ability to obtain, and appropriately use, the data to the benefit of programs or at the policy level. As such, there is a strong sense that what information that is currently being collected is not used for strategy review, for resource allocation, or for program improvement.

Civil Society Involvement

Due to limited availability of civil society engagement in programming and policy 'spaces' on HIV is an obvious limitation in terms of providing an alternative perspective or a voice for PLHIV on government commitment and policy and program performance on issues of HIV. This limited involvement also extends to engagement in research and special survey, in program implementation and in monitoring and evaluation. A particular case in point is that the difficulty in accessing information related to high risk populations (intravenous drug users (IDU), men having sex with men (MSM) and sex workers (FSW) is attributed to the non existence of civil society organizations dealing with these groups that can adequately engage, and carry out surveillance and research or monitor activities being undertaken in Oman. NCPI respondents highlighted the significance role that NGOs can play in this regard as well as in implementing and monitoring programs for high-risk groups.

Stigma and Discrimination

Policies are in place to ensure equal access to HIV-related services and up-hold principles of non-discrimination. However, reference is made within the NCPI responses to concerns over stigma and discrimination being a key factor in individuals fearing and refusing HIV related services. Fear of exposure to stigma and discrimination within the health system, their workplaces and communities is hindering the ability to reach a those populations who are at risk as well as the proportion of people living with HIV who know their HIV status and who require treatment and care from health service providers. Issues of stigma and discrimination were seen (especially by UN agencies working in Oman) to require further attention in program and policy responses.

Human Rights

Amongst the strategic interventions included in Oman's National strategy is a focus on ensuring the policy and societal frameworks aim to encourage a non discriminatory environment for People Living with HIV (PLHIV), including the participation of PLHIV in all aspects of life and their legal protection. While this is the case, Oman does not have any mechanism to record, document or address cases of discrimination experienced by people living with HIV, most at risk and vulnerable populations. This represents a challenge to ensuring that the voices of PLHIV are heard and their rights protected. The recently established national committee for Human Rights is seen as the entity that will help to address issues of human rights violations, if and when they arise. Oman also continues to uphold mandatory testing of expatriates wishing to reside and work in Oman, of prisoners and other groups, and to repatriate those who test positive for HIV. Such a practice was raised in UN responses to the NCPI as a concern from a policy perspective.

Assessing Effectiveness of Current HIV Programs

A core challenge related to monitoring, evaluation and learning stems from the need to assess the effectiveness of current programs in order to ensure that they are reaching intended target groups and to focus on knowledge and behavioral change. As an example, current efforts led by the department of school health within the Ministry of Health offer extensive HIV related information within the school setting. In Oman all 10-12 grade Government schools(678) and all private schools (137) provides life skill based HIV education additionally 404 schools from grade 9-12 provides peer education related to HIV. While this is hailed by government and UN agencies an important and critical program to continue supporting, the challenge is to ensure that the programs are yielding the intended societal and behavioral changes. A recent (2008) KAP Survey conducted for students in 32 colleges across Oman revealed that only 3.9% students with an average age of 20 know all five questions related to HIV/AIDS transmission correctly.

Prevention

Lot more work is required for creating awareness related to spread and transmission of HIV in schools, colleges, work places using interactive modes of health education. Promotion and provision of condoms has to be done in culturally and socially accepted manner especially in educational institutes catering to

vulnerable age group of population. Involvement of media both print and electronic has to continue and better targeting of messages can be looked at.

Treatment, Care and Support

All HIV patients in the country have to be assessed regularly for immunological parameters like CD4 and viral load at least once in six months. Though it is a policy to monitor each patient regularly currently NAP is struggling to ensure compliance from patients as well as limitations at laboratory level to implement it effectively. Training and re-training of HIV treatment focal point and new country guideline in tune with latest scientific developments will help the process. All pregnant women are screened for HIV starting from July 2009 and comprehensive package of services are provided to all positive women. Those PLHIV who needs social/financial support is provided by Ministry of Social development.

Remedial actions for these challenges:

Following are the remedial actions in various stages of consultation/approval/implementation;

1. Extensive follow up of all cases with specially designed format is integrated into the regular system of surveillance to ensure better reporting and follow up. New HIV notification form (PR-83) is designed and implemented to ensure more comprehensive information. This notification is also to be implemented for expatriates to better map out the epidemic. The process of reconciliation of data between national and sub-national level is initiated to ensure better co-ordination and completeness of the data. This process will ensure validation of all available data from national HIV/AIDS database is also required.
2. More awareness and education related to stigma, discrimination, access to treatment and counseling services is required to improve knowledge about HIV prevention.
3. There is a bottle neck is in the immunological monitoring of patient by CD4 evaluation and it will be fixed soon to ensure every HIV patient gets monitored at least once in six months hence we can increase treatment coverage.
4. Plan for Extensive follow –up of HIV infected pregnant women and their child is initiated in terms of National HIV registry for pregnant women hence accurate monitoring of prevention of mother to child transmission can be done.
5. All persons tested for HIV/AIDS require having age and gendering segregation hence necessary modifications will be made in recording and reporting.
6. Harm reduction package needs to be implemented which will include counseling, HIV testing, de-addiction and rehabilitation, needle & syringe exchange, and condom provision.

VII. Support from the country's development partners

We gratefully acknowledge generous contribution given by Government in terms of financial and human resources to conduct various activities related to HIV/AIDS program which is definitely making an impact on performance indicators established by UNGASS.

We would also like to thank various UN agencies for their commitment and dedication of providing technical and financial support for several activities related to HIV/AIDS.

We would like to continue to receive support in the future. Immediate priorities are;

1. Bio-behavior survey among injecting drug users
2. Improvement of registry related to injecting drug users
3. Awareness and education activities for youth
4. Launch of an Arabic website for HIV/AIDS related information/interaction

VIII. Monitoring and evaluation environment

Policy support: There is high-level policy commitment for strengthening the Monitoring and Evaluation Systems in the Sultanate of Oman for the National Strategic Plan on HIV and AIDS. The Ministry of Health and the National AIDS Program recognize the critical importance of a 'One Country-Level Monitoring and Evaluation System' in providing the required information upon which to develop HIV-related policies and programs. As such, while a monitoring and evaluation framework has not yet been developed for the current National Strategy, it has been determined by the National AIDS Program through a quick needs assessment, to be a priority action for 2010. The National AIDS Program has determined that monitoring and evaluation issues require more investment, planning, and capacity strengthening over the course of 2010. A plan of action has been developed for 2010 that prioritizes key actions required to strengthen current M&E systems. The plan of action has yet to be endorsed and resources from within the Department of Communicable Diseases within the Ministry of Health).

National M&E Committee: In order to support M&E strengthening processes, a national Monitoring and Evaluation committee has been established in Oman to provide the oversight and coordination required to ensure that an M&E framework/guide and the required capacities for Oman's NSP are in place. In accordance with the Ministerial Decree 23/2008, the national M&E committee is made up of diverse representatives from the Royal Oman Police, Sultan Qaboos University, Ministries of Higher Education, Tourism, Education, and Social Affairs. Its mandate centers on monitoring all activities related to the national response. This includes developing an M&E Framework in collaboration with the relevant stakeholders, building capacity of the national staff involved in the response effort, and supporting surveys and qualitative and quantitative research. The M&E committee is a critical stakeholder in M&E and their membership and capacity will require review, especially to support the M&E priorities that have been determined.

M&E Capacity in NAP: There is recognition of the need to institutionalize the M&E capacity within the NAP in Oman. There is broad recognition that capacity constraints including dedicated staff persons as well as M&E capacity are hindering the NAP's ability to comprehensively obtain, analyze and appropriately use the data to the benefit of programs or at the policy level. Additional M&E System limitations include the lack of standardized indicators for all stakeholders involved in the national response, guidelines on tools for data collection, data analysis strategy and data dissemination plans. As such, there is no mechanism in place for the NAP and implementing partners to submit routine reports and to share data, so as to ascertain the collective contribution to the national response on HIV/AIDS. The information regarding HIV/Oman in Oman has yet to be used strategically for program/policy review, for resource allocation, or for program improvement.

M&E Framework: As such, the priority actions for 2010 as determined by the NAP include a thorough M&E systems assessment and the launch of a process to develop an overarching M&E Framework to guide all stakeholders involved in the Oman National Response. The M&E framework with help to:

1. To align the priorities set out within Oman's National Strategy with an appropriate national level Monitoring framework to guide all stakeholders involved in this effort;
2. To guide more strategic level analysis from current programs to support evidence-informed program and policy responses;
3. To demonstrate accountability in achieving results set out within the National Strategy through a system that reflects progress towards achieving targets and informs future programs and policies based on results-oriented information.

Technical assistance will be required to develop this M&E Framework in mid- 2010.

Available information/Information Gaps on HIV: A review of the literature available on Oman as well as responses obtained from NCPs (Parts A and B) reveals that there remain information gaps, especially with regards to size and behavioral profile of most-at-risk populations (MARPS). Most of the information available regarding MARP's, is on IDUs, with little to no information on female sex workers and men who have sex with men. Today, Oman does have a valuable set of studies and key pieces of research that can help inform the development of prevention programming. These include the 2006 Injecting Drug Users Survey, 2007 KAP study amongst college students, and the 2008 Female Sex Workers study. These studies provide good indications (IDU study, SW report) of knowledge levels and risky behaviors, especially for MARPS and point to a possible concentrated epidemic amongst IDUs. As such, information and figures of this nature is required support the need to target more programmatic prevention and treatment interventions for most at risk populations.

Despite availability of such information, there is an expressed need, to develop a more accurate description of the extent and nature of the epidemic in Oman in order to support evidence-informed program and policy responses. Cultural and social sensitivities require that what special surveys are undertaken, be contextually appropriate. Within this environment, and in the limited availability of civil society engagement or programs that specifically target most at risk groups, access to such populations, obtaining size estimations, understanding risk behaviors, and getting an accurate description of the drivers of the epidemic in Oman remains an important M&E priority.

Oman's Surveillance System: The 2007 Report on Oman's Surveillance System makes recommendations regarding the need for a clearer figure about the HIV epidemiologic situation in the general population of Oman. It highlights the need to carry out a biological and behavioral surveillance survey (BBSS) among IDUs, to introduce sentinel surveillance in prisons, and to develop a stronger knowledge base regarding the levels of idea about the knowledge, attitudes and behaviors of young people and IDUs. The Surveillance report also recommends conducting sociological studies to understand the perception of HIV/AIDS and STIs in different subpopulations. The report emphasizes that while Oman continues to be classified as a low prevalence country, HIV surveillance should primarily target sero-prevalence among high-risk groups. According to the report, HIV surveillance of high risk groups - as recommended by WHO for countries with low and concentrated HIV epidemics - has not been established in Oman and that "as long as information on the size of these populations and HIV prevalence among them is not available, estimates of the number of PLWH in Oman will remain in accurate". Because Oman's National

Strategy includes as its second objective, the need to strengthen Oman's surveillance system, following up on the recommendations of the surveillance report has been determined as an M&E priority for 2010.

Oman has a robust Health Information system (HIS), which includes most health visits are getting entered into computer based records. These records are getting increasing getting networked and accessed for health planning, monitoring and evaluation. This robust Health Information system (HIS) is providing crucial missing links to HIV/AIDS related surveillance with ease.