Volume 18, Issue 4

Sultanate of Oman Ministry of Health

April-June 2009

Community Health & Disease Surveillance Newsletter

Inside this issue:

Oman: The Role Model for the 'National Health Research System'

(Excerpts from the published paper)

"Health research systems in the Eastern Mediterranean Region are not well developed to generate and use knowledge to improve health, reduce inequity and contribute to economic development. The above study aimed to provide core data on National Health Research Systems (NHRS) in 10 Eastern Mediterranean countries in order to inform actions to strengthen health research system governance and management. Whilst there were examples of good practice, few countries had a formal NHRS and many basic building blocks needed for an effective system had not been put in place. Although limited in focus, the study provides useful information for countries to initiate action to strengthen their NHRS".

The aim of the study was to collect key information needed for NHRS strengthening, which would allow each country to initiate action at the policy and governance level at relatively short notice.

Method

The collaboration started with a planning meeting in Riyadh, Saudi Arabia, in November 2005 which included 10 Eastern Mediterranean Region or GCC countries that had expressed a strong interest in strengthening their national systems of health research. These representatives of Bahrain, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Tunisia, United Arab Emirates and Yemen attended. The Council on Health Research for Development (COHRED) employed a "process" model for NHRS strengthening. It was designed not as a "one-off, data collection event", but rather as an action-oriented, ongoing process of system development. In this approach, compiling and analyzing the evidence are complementary "process" activities and need to be iterative with actual interventions made in support of NHRS development. The COHRED model could therefore be phased, depending on resources available, on the level of sophistication of the existing systems, and on actions taken following analysis. NHRS analysis was conducted at four levels:

- Mapping: of the people, structures, institutions and policies that make up the NHRS;
- Profiling: of the human, institutional, financial, production and utilization capacities of the system;
- Performance assessment: of the NHRS and its impact on health sector decision-making, health and health equity;
- Evaluation of interventions: This is a long-term commitment to a cycle of evidence-based management of the NHRS based on routine and ad hoc monitoring and evaluation.

During the Oman workshop in 2006, the national project leaders decided on a phased approach, i.e. a NHRS mapping study as the first phase to decide on priorities for strengthening the health research system. A shortened version of the COHRED NHRS mapping form was prepared and is available on following URL:
www.cohred.org/NHRSsupport/em2006

"Oman is the only country to have all the components of the 'National Health Research System' governance and management among the GCC states."

The form elicits mostly qualitative information, and consists of a series of questions to guide a standardized description of a NHRS in four key areas:

- Governance and management of the NHRS
- Institutions engaged in research for health
- Key stakeholders involved in research for health
- Available literature and data review

The form was to be completed by the project leader from each country, based on information gained from document review and interviews with senior staff engaged in health research in the countries. Due to the considerable variation in NHRS set-ups, information was collected in an open question format and the responses were then coded for analysis. Data collection took place during July and August 2006.

In coding the responses, 2 principles were observed. First, the main focus of the study was on structures, policies or statements dealing with the overall national research and health research system rather than on specific parts of the system, e.g. sections of the Ministry of Health or research in specific institutions. Second, the questions were intended to gauge the formal system and not to deal comprehensively with ad hoc or occasional examples of good practice.

The following definitions and distinctions were used to guide coding:

"NHRS governance" is concerned with the relationships, systems, processes and rules for making decisions within the system. It also provides the structure through which the objectives of the system are set, and performance and achievement of these objectives are monitored. "Research management" was defined for the purposes of this study as being concerned with the planning and execution of the activities required achieving the objectives of the system in an effective and efficient manner.

As there is a wide range of ways in which countries create policies to deal with research, any formal plan or strategy providing direction for the health research system of the country was accepted. Such plans could be part of broader policy documents, for example focused on health, research, science and technology or national development. In such cases, these documents were classified as "health research policies" if they had significant health research content, as opposed to the simple identification of health research as a strategy with no further elaboration.

"Values" were defined as guiding principles for the system. Stipulations to adhere to ethical or other principles, but without an explicit statement of underlying values, were not considered as a valid value statement.

"Aims" were identified from statements of aims, goals or objectives, or from a vision or mission statement for the system.

The responses for all countries were coded by COHRED to provide consistency.

The results were then circulated to the national project leaders for verification and clarification on areas of uncertainty. To classify participating countries in terms of socioeconomic development, the United Nations Development Programme (UNDP) Human Development Report classification was used.

Key results

Oman is the only country to have all the components of the NHRS governance and management as seen from the following table:

Component of the NHRS	EMRO countries with presence of this component (in alphabetical order)
Formal NHRS governance structure	Jordan, Lebanon, Oman, Tunisia
Formal NHRS management structure	Jordan, Lebanon, Oman, Tunisia
National health research policy/plan/strategy	Oman, Tunisia
National health priorities	Bahrain, Oman, Qatar, Saudi Arabia, Tunisia, Yemen
National health research priorities	Lebanon, Oman, Yemen
Statement of values for the NHRS	Oman, Tunisia
Statement of aims for the NHRS	Jordan, Lebanon, Oman, Tunisia, Yemen
Monitoring and evaluation system	Oman

Discussion

This mapping of governance and management mechanisms of national health research has provided information that can be used by all countries involved to improve on key aspects of their NHRS. This study has identified that few countries have a formal NHRS, and that there is considerable fragmentation and limited coordination between the parts of the system that need to collaborate if health-related research is to be produced and used. The basic building blocks required for a responsive and needs-driven health research system are missing in many places. At the same time, there is growing interest in developing and strengthening national health research. With few exceptions, the most effective means to stimulate health research and the systems to manage this is through the following actions. These represent core features of good research systems that can be applied in almost all countries in this study.

- Set national health research priorities through a credible and regularly updated process;
- Develop a national health research policy, on its own or as part of the policy frameworks for science, technology and innovation;
- Establish governance and management structures that will facilitate implementation of policies and actions.
- With these in place, further strengthening of health research can be achieved by:
- Defining the underlying values and aims of the NHRS;
- Establishing an effective monitoring and evaluation system to increase accountability, relevance to research priorities and quality of research;

Developing systems to include research knowledge in decision-making processes at all levels of the health sector.

The issue of ingraining science in society and effectively using research knowledge and capacity for development has been identified as a significant problem in the Eastern Mediterranean region. The gaps in routine data observed in this study support this claim, as does the finding that four of the countries have not yet identified their national health priorities. A functioning health research system with strong leadership at the governance and management levels can help to ensure that demand for research in the health sector and production and utilization of such research can be realized.

A number of the countries that took part in this study have recognized the limitations of their current systems and are in the process of establishing formal mechanisms to better coordinate their systems of health research. Tunisia and the Gulf States have decided to engage in national health research priority setting in 2007, while WHO-EMRO plans to start this process in other countries. The study also identified interesting examples of good practice, notably in Oman and Tunisia, which can serve as models for others.

The countries with established governance and management structures for their NHRS had built these within the general research councils. Further research on these systems will be useful to assess whether these structures fulfill the needs of the health sector, or whether such systems favor research on priority areas for science and technology and economic development at the expense of research to inform health-related decision-making.

Despite the limitations of data collection caused by the need to obtain rapid and actionable results, the methods employed in our study provide valuable evidence to allow country teams to assess the priority areas for further development of the governance and management of their health research systems. However, it is clear that once the large governance and management issues have been dealt with, further detailed mapping, profiling and performance assessment will be required to provide more specific information, including on how the NHRS can identify and address the issue of health equity.

The political and professional commitment to systematically analyze health research

"Tunisia & the Gulf States have decided to engage in national health research priority setting in 2007, while WHO-EMRO plans to start this process in other countries."

Evidence-Informed Policy Networks (EVIPnet)

The Ministerial Summit on Health Research in Mexico City in November 2004 focused on the need to improve the use of knowledge for better health policies. After the summit a World Health Assembly resolution in May 2005 called on the World Health Organization: 'to establish mechanisms to transfer knowledge in support of evidence-based public health and health-care delivery systems, and evidence-based health-related policies'. In response to this call, the World Health Organization (WHO) launched the Evidence-Informed Policy Networks (EVIPnet) in 2005.

EVIPnet promotes the systematic use of health research evidence in policy-making. Focusing on low and middle-income countries, EVIPnet promotes partnerships at the country level between policy-makers, researchers and civil society in order to facilitate both policy development and policy implementation through the use of the best scientific evidence available. EVIPnet comprises networks that bring together country-level teams, which are coordinated at both regional and global levels. Low and middle income countries have scarce resources to address their health system challenges and need high-quality evidence to use those resources efficiently. Scientific evidence is a fundamental building block to improve the public health situation. If health sector managers and policy-makers ignore evidence on the root causes of problems or what works best to address these problems, they risk wasting precious resources on inadequately designed programmes and policies. The direct consequence of ignoring this evidence is poor health for the population.

Unfortunately, health policies are not always informed by the best available evidence. Poorly managed policy-making is one of the reasons why services may not reach those most in need and why health indicators are off-track. It also means that many low-income countries may fail to meet the health related Millennium development Goals (MDGs) and priority national goals.

"EVIPnet promotes partnerships at the country level between policy-makers, researchers & civil society through the use of the best scientific evidence available."

How does EVIPnet work?

EVIPnet's pragmatic efforts to directly support evidence-informed health systems have focused primarily on regional and national capacity-building activities to produce and plan the evaluation of policy briefs and secondarily on organizing and planning for the evaluation of national policy dialogues at which the policy briefs are discussed.

In keeping with a 'learning by doing' approach and learning together to better work together in a sustainable, empowered way, both a senior policymaker or programme officer and a researcher from each country team produce a draft policy brief about how to address one of many current policy challenges. For instance, representatives of six EVIPnet Africa countries (Burkina Faso, Cameroon, Central African Republic, Ethiopia, Mozambique, and Zambia) and from the East African Community participated in a workshop in February 2008, in Addis Ababa to produce a draft policy brief about how to address one of many current policy challenges: how to support the widespread use of artemisinin-based combination therapies (ACT) to treat uncomplicated falciparum malaria in their respective countries. They are currently in the process of reviewing and finalizing the policy brief.

EVIPnet country teams and expert members of its Resource Group provide opportunities for:

(Continued from page 3)

systems is a core requirement of NHRS building. Countries in the Region that have not yet examined their NHRS are encouraged to do so. The study shows that a phased action-oriented approach can enable decision-makers to quickly move to system improvement initiatives".

Reference

Kennedy A, Khoja T.A.M., Abou-Zeid A.H., Ghannem H, and IJsselmuiden C, on behalf of the WHO-EMRO/COHRED/GCC NHRS Collaborative Group .*National health research system mapping in 10 Eastern Mediterranean countries*. Eastern Mediterranean Health Journal; Volume 14 No. 3 May - June, 2008.
http://www.emro.who.int/publications/emhj/1403/article1.htm Accessed on 30 May, 2009.

Identifying priority policy issues and questions.

Checking the quality of available systematic reviews, guidelines, and other relevant research results to help identify and/or formulate policy options that better address health systems issues. In this process, country teams then move on to consider whether to confirm or change delivery, financial, and governance arrangements that must be put in place to address a priority issue. Finally, country teams may consider how best to support the necessary changes to the behavior of those involved in the implementation of the policy at all levels (policy makers, public health managers, care-givers, community health workers, and communities of users of the health system). The country teams draw on several overviews of systematic reviews, including ones examining the effects of alternative delivery, financial and governance arrangements, supporting behavior change, and many single studies that had been conducted in their own country or region.

Each country team prepares a policy brief presenting at least three viable policy options for addressing the selected priority issue, each comprising different "bundles" of the aforementioned delivery, financial and governance arrangements within their respective health systems, and potential strategies for supporting the implementation of the policy options. Also helpful is the identification of 'policy paths,' that facilitate the understanding of who are the main stakeholders in the implementation of these specific policies (including in other sectors outside the health sector). Each policy option is accompanied by an assessment about what can reasonably be expected (in terms of both costs and consequences) in the country's health system by pursuing each of the policy options, as well as a description of any gaps in our understanding about what can be expected. The assessments are based on the best available research evidence that had been examined for its quality and local applicability and for equity and scaling up considerations.

Another key step in the EVIPnet knowledge translation process is that each country team convenes a national policy dialogue, and invites senior government officials and key stakeholders (including civil society groups) to participate in a discussion about how both the public and private sector can best support addressing the selected priority issue. The policy brief will be a key input to this discussion, but so too will be local information about on-the-ground realities and constraints, values, interest group dynamics, tacit knowledge, best practices, and institutional constraints. The whole process is monitored and evaluated to make sure we learn and disseminate best practices in evidence-informed policy-making.

EVIPnet activities

EVIPnet activities at the country level are jointly led by local policy-makers and researchers and are designed to meet the specific needs of each country. Country activities currently supported under the EVIPnet umbrella include:

- Production of policy briefs and other user-friendly formats for research synthesis and discussions of policy options
- Establishment of priority-setting mechanisms for policy-relevant research syntheses and primary research;
- Production of research syntheses;
- Production of policy briefs and other user-friendly formats for research syntheses and discussions of policy options;
- Organization of 'safe haven' deliberative forums involving policymakers, and researchers and citizens groups to stimulate context-specific, evidence-informed local action;

Investigation of the potential of clearinghouses, observatories and rapid response mechanisms that might provide timely, high-quality research syntheses and research relevant to policy.

In addition, at the regional and global levels EVIPnet supports:

- Capacity strengthening and empowerment of policy-makers, researchers, representatives of civil society to enable them to make better use of evidence in policy-making and advocacy;
- Interactive learning processes building

"The EVIPnet activities at the country level are jointly led by local policy-makers and researchers and are designed to meet the specific needs of each country."

"Capacity strengthening & empowerment of policy-makers, researchers, representatives of civil society to enable them to make better use of evidence in policy-making & advocacy."

National Workshop on Adolescent Mental Health

New Evidence for Policy Implications in Oman (EVIPnet approach)

This workshop was conducted on 22nd April 2009 under the patronage of H.E. Mr Saif bin Ahmed Al-Rawahi, Undersecretary, Administrative and Financial Affairs, Ministry of Health, Sultanate of Oman. Dr Rachel Jenkins, Director WHO Collaborating Centre -Head of Section Mental Health Policy & Visiting Professor London School of Hygiene and Tropical Medicine was the chairperson. Dr Jenkins was on special visit to Oman as the WHO Consultant for the Oman Mental Health National Strategic Action Plan.

Aim

To disseminate findings to stakeholders for policy planning.

Objectives

- To transfer knowledge gained from the survey in support of Evidence Based Public (Mental) Health.
- To use present survey evidence to improve present health policy and planning
- To bridge the gap between policy makers, researchers and end users
- To identify research gaps related to mental health policy issues

A total of 60 participants consisting of Decision makers from the Ministry of health, Religious leaders, WHO expert in Mental Health, representatives from Ministry of Education, Ministry of Youth Affairs and Royal Oman Police, Local experts in mental health from MoH and SQU, School health authorities and Program managers. The following two reports along with the policy briefs were distributed on the occasion:

Prevalence of mental disorders among ado-

(Continued from page 5)

on experiences to improve evidence-to-policy methods;

- Monitoring and evaluation processes that document the lessons learned from the use of an array of evidence-to-policy processes in different contexts.

Information exchange - disseminating successful methods and tools, experience and best practices among partners and other countries, mostly through the EVIPnet Portal –an internet-based platform, and WHO country offices.

Opportunities for Eastern Mediterranean Region:

- Strengthen existing regional and national initiatives (not re-inventing the wheel)
- Benefit from existing methodologies (Tool Kit; workshops; sharing best practices) that can be adapted, adjusted.
- Scale: Regional and global

Contribute to global network: "cross pollinate"

Basic suggestions to start EVIPnet-Eastern Mediterranean Region:

- Keep as simple as possible (reality is already complex)
- Don't delay, begin today
- Solicit high level support (Ministers of Health, WHO/EMRO Regional Director)
- Start individual and institutional network
- Identify and commit funds
- Identify priorities and agree on a common regional priority

Organize a regional policy brief workshop with policy makers and researchers to produce 1st policy briefs

References:

- Available at http://www.evipnet.org/php/index.php [Accessed on 1O June 2009]
- Personal communication by Ulysses Panisset of WHO Information Evidence & Research/Research Policy & Cooperation at the EMR EVIPnet workshop, Beirut, Lebanon, 28-29 January 2009

lescent secondary school Omani students and their utilization of health services. Results of the World Mental Health Composite International Diagnostic Interview Survey (2005). Report for the Ministry of Health, Sultanate of Oman.

The study of depressive symptoms among adolescent secondary school Omani students (2005). Report for the Ministry of Health, Sultanate of Oman.

Small group interactive sessions with special focus on existing practice and alternative course of action, human resources requirements, involving the community and identifying research gaps & Integrating research findings into proposed policies with reference to the Seventh Five year plan 2006-10 of Ministry of Health, Oman. Each group made a presentation of their recommendations.

Some of the issues and concerns raised by the participants were: to have a mental health policy for adolescents in the school health programme including mental health screening and evaluation, to promote discussion of mental health topics during the parents meetings, to provide trained psychologists and social workers in school, to involve all different media, community groups and other stakeholders in increasing awareness about mental health. This assessment could be combined with routine physical examination. and thus improve utilization of health services, activate health education activities through posters, open days, flyers and brochures and to integrate mental health topics in the curriculum.

The group identified the following existing research gaps which need to be addressed: need to conduct further longitudinal and cross sectional studies, as appropriate, to determine causality of mental illnesses, and outcome of interventions. They found a need to address the role of traditional healers, addiction in adolescents, reasons of school refusals/dropouts, child abuse, and stress amongst care givers and teachers.

As stakeholders they appreciated that the administrative plans are good on paper but requested for decisions and executions of the same to be hastened for better results. For the existing PHC system to support mental health they found it necessary to train medical doctors in mental health issues, to make available Psychiatrists in each PHC and to make available Child Psychiatrists in each region. They addressed the fact that there is at present no single law in mental health and human rights in GCC countries.

The participants were also concerned about the problems related to criminals, juvenile cases and corrective homes since the activities to tackle these, though present, are severely lacking and hence there is an urgent need to strengthen them.

Dr Rachel Jenkins, WHO Consultant, appreciated the genuine interest of the participants and their active interaction in the proceedings of this workshop which was highlighted by the issues of concern raised

(Continued on page 10)

"Some of the concerns raised were to have a mental health policy for adolescents in the school health programme including mental health screening and evaluation."

Mapping Bioethics Regulations in Oman

"The study on **'Bioethical Regulations'** was conducted in selected countries in the Member States of the UNESCO Arab Region that included Oman."

The Department of Research and Studies was a part of the project on Mapping of Bioethics Regulations 2007, in the member states in the UNESCO Arab Region. We present here the findings of this project which were submitted to the UNESCO.

Objectives

- To report the existence and the content of bioethical regulations in the UNESCO Arab Member States (Oman)
- To provide a comparative analysis on specific bioethical regulations in the region
- To identify fields of needs where national regulations to be further developed in the region

We discuss the objectives number 1 and 3 in this report.

Study Settings

The study was conducted in selected countries in the Member States of the UNESCO Arab Region that included Oman. The concerned experts were contacted.

Study Areas

- Regulations which were searched were as follows:
- National constitution, Law and National Decrees (Ministerial or presidential).
- National Guidelines and Codes.
- Regulations of professional associations and societies (with or without sanctions).

Any other possible national regulation.

The followings topics and issues were explored in this research:

- Human reproductive and therapeutic cloning
- Embryonic Stem Cells
- Genetic test
- Human Genome and Gene Analysis
- Research involving human subjects
- Organ transplant
- Assisted Reproductive Technology (ART)
- Pharmaceutical research
- Medical practices
- Abortion

Other Issues (Health Research/Surveys in MoH)

Study Tools

The researchers collected the data by:

- Searching legal and religious documents (Fatwa).
- Interviewing key informants as lawyers, consultants in the area of inquiry and any other person who can provide the required data.

The researchers used a semi-structured questionnaire established by UNESCO Cairo Office, which is composed of ten questions that covered each topic mentioned above.

The Implementation Process

First we identified the Institutes, Hospitals, Departments and key Informants concerned or involved in bioethical regulations for research or medical practice and services. We designed a form which covered the following specific items:

Full contact details of the responsible persons and whether relevant bioethics topics are present and available. We sent an official letter to the identified key informants/ institutes in December 2007 explained the methodology of the study including background, objectives, study areas and explored topics & issues.

We re-contacted the respondents and also maintained follow-up on phone to get the maximum compliance and cooperation. After we collected the documents, we reviewed them intensively and appointments were made with the key informants to conduct the interview. The interviews were carried out with each key informant separately by using a semi-structured questionnaire designed by UNESCO.

Analysis of Research Results

Of the 11 Bioethics topics/issues investigated we mapped 6 topics which were referred to in the legitimate documents of either Royal decree, Ministerial Qarar. A draft of special guidelines was developed for two issues to regulate the Genetic test, Human Genome & Gene Analysis.

Genetic test, Human Genome & Gene Analysis

In College of Medicine & Health Sciences, SQU, the Oman Genetic Material Task Force was formed on March, 2006 and developed draft of special guidelines to regulate the genetic studies in Oman ensuring maximum benefits and protection of individuals, families and/the Omani society. It recommends a set of guidelines for genetic diagnosis and/research of trans-border exchange of genetic data, proteomic data and biological samples. Also, it recommends an independent committee to be appointed in-charged of monitoring and enforcing the implementation of the recommended guidelines and keeping accurate records.

Medical Practice

In Oman, the Code of Professional Conduct for physicians (of 2002 and updated in 2007) sets out the core standards of conduct expected from all physicians working in the health sector. It is to be noted that if things go wrong, patients who complain about the care or treatment they have received have the right to expect a prompt and appropriate response. A similar code for nurses and midwives was developed in 2005. It also mentioned the informed consent and provided for the confidentiality and privacy. 48 manuals and guidelines were also formulated for different medical disciplines. Several Royal Decrees were issued for the practice of Medicine and Dentistry in 1996, amendments were brought to some articles regarding the licensing of private hospitals in 1998 and Ministerial decisions were also issued setting the conditions and procedures for the Licensing of the Practice of Medicine and Dentistry in 1998 and for the investigation of complaints for alleged mismanagement of patients in 1999.

Organ Transplant

In Oman, organ transplantation is regulated by the Ministerial Decision no. 8 for 1994 which was approved by the Grand Mufti of Oman.

The donors are living, cadaver or brain-dead donors: the brain stem dead should be diagnosed and certified by 2 separate examinations for brain stem functions and each examination should be undertaken by 2 clinical consultants and at least one of them should be specialized in neurology, neurosurgery or anesthesia. Donors should have more than 18 years of age and be mentally normal. They should give a written consent and be informed about the consequences of donation, without pressure or inducement by financial, emotional or other personal gain, and they can withdraw their consent without limitation or condition. The donation should not affect their health and the recipient should be blood or non-blood relative to the donor.

Assisted Reproductive Technology

In Oman, ART is regulated by the Code of Practice for Assisted Conception Unit (ACU) of Muscat Private Hospital (MPH) in 2002 and all that under a religious background. IVF with donors, sperm, ova or embryo donation, surrogate mothers, embryo selection based on sex as well as embryo reduction are all prohibited. However, it allows preservation of sperms and embryos. As for prenatal diagnosis (PGD) it is not available since the prerequisite cytogenetic laboratories are not available.

Abortion

In Oman, the regulations on abortion depend on the fatwas: the fatwa of the Grand Mufti in Oman, the Decision made by the Islamic World Association regarding termination of pregnancy in cases of fetal congenital deformity, Mecca, 22-7-1410 H, and the fatwa issued by the Fatwa Committee in Kuwait, 29-9-1984. Indeed, the Administrative decision No.30/99 (Director General of Royal Hospital) and the Criminal Procedures Law (Royal Decree No.7/74: For Abortion) state that abortion is prohibited for social reasons and physicians shall not be terminate any pregnancy exceeding 120 days from the time of fertilization unless to save the mother's life from a danger resulting from gestation. The termination can be conducted by approval of both husband and wife if the gestation is less than 40 days

"In Oman, the *'Code of Professional Conduct for Physicians'* (updated in 2007) sets out the core standards of conduct expected from all physicians working in the health sector."

"The purpose of an Ethical Committee is to safeguard the dignity, rights, safety, justice beneficence , confidentiality and well-being of all actual or potential research participants."

from the time of fertilization, but if the gestation exceeds 40 days and is less than 120 days, then the termination of pregnancy shall only be conducted if it is strictly done for fetal-lethal malformations or maternal-underlying medical diseases, when pregnancy threatens the mother's life. Furthermore, it is to be noted that a special consent form is used: both husband and wife should consent after being counseled by the treating physicians and two obstetricians' signatures are needed. In case of fetal malformation, the signature of one pediatrician/neonatologist is requested and in case of maternal diseases that of a specialty physician is required. Two of the above three physicians should be of honest Muslim faith.

Research Involving Human Subjects and Other Issues

(Health Research/Surveys in MoH)

The MoH started the National "5-Year Health Development Plans" since 1976. Also it had established the Department of Research and Studies under the Directorate General of Planning since 1991. It draws the research plan, prioritization of research, is involved in spreading of the research culture & ethical considerations and development of technical capabilities of potential researchers and research teams. The 7th "5-Year Health Development plan (2006-10)" has 30 domains in different priority areas including research and studies.

Specific "Health Research Policy" was promulgated by Ministerial Decision in 1999 and updated in the seventh plan.

Ethical Committees (EC) and ethical review system need to be developed to ensure the broadest possible coverage of protection for potential research participants and contribute to the highest attainable quality the science and ethics of biomedical research. The purpose of an EC in reviewing biomedical research is to contribute to safeguard the dignity, rights, safety, justice beneficence alongside informed consent or assent for who are incompetent, confidentiality and well-being of all actual or potential research participants. Therefore, the MoH in Oman established the "Research & Clinical Studies Committee" in 1998 by Ministerial Decision and the committee members developed the "Guidelines for Submission of Research Protocols for Review and approval of the Research & Clinical Studies Committee". The committee relies mainly on Helsinki Declaration to resolve any ethical conflict in research involving human subjects.

Bioethics Regulations Gaps

Human Reproductive & Therapeutic cloning and Embryonic Stem Cells issues are not present in Oman and therefore the regulations have not been developed. Also there are no currently available specific regulations for pharmaceutical research.

Conclusions

It is obvious from our mapping results that some gaps existed in bioethics regulations which need to be addressed. Even the existing regulations need to be reviewed, updated, and be much more comprehensive, covering a wider spectrum of issues. Based on these results, we recommend formulation of a **"Bioethical Committee"** to bridge the gaps of missing regulations in collaboration with the international agencies.

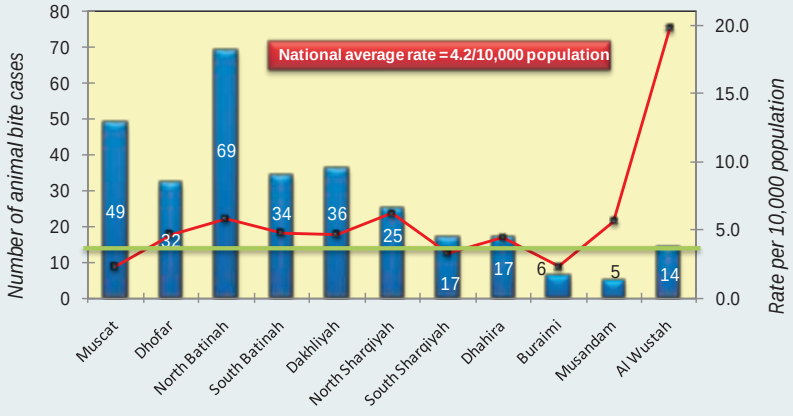
(Continued from page 7)

by them and the recommendations to tackle them. However since some suggestions, though good, would have to wait some time depending on availability of resources, Dr Jenkins urged the participants to focus on what is readily achievable and suggested that the next logical step was to clarify those interventions which would be possible to implement soon within existing resource plans, especially establishment of intersectoral committees, training of primary care physicians in mental health, improved dialogue between different levels in the health system, and inclusion of mental health in health promotion in schools and in the community.

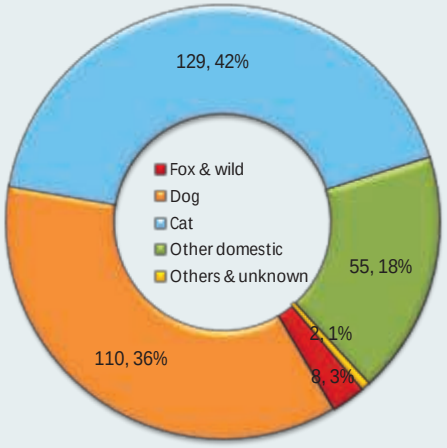
Animal Bite Surveillance Data

First quarter: January to March 2009

Notified animal bites by Regions (# & annualized rate/10,000 population)



Notified animal bites by type of animal (# / %)



Brief Summary & Observations on

Communicable Disease Surveillance Data: First quarter - January to March 2009

Group A Diseases & Syndromes

- AFP: Eight AFP cases were reported of which 3 were from Muscat (Mutrah, Bowsher and Seeb), 2 from South Sharqiyah (BBB Ali, Al Kamil Wa Wafi) and 1 each from Dhofar (Salalah), North Batinah (Shinas), North Sharqiyah (Ibra). These were later classified as 2 cases of *'Guillian Barré Syndrome'*, 2 as myositis and the rest 4 as *Acute Disseminated Encephalomyelitis* (ADEM), *Arthritis*, *Synovitis* and *Periodic Paralysis*. All 8 cases were fully vaccinated with no residual weaknesses after 60 days of follow-up.
- Fever & Rash illness: Of the total 157 cases reported, 3 were classified as clinical cases. A 4 years old child was confirmed measles case from Rustaq Wilayat (South Batinah). He was fully vaccinated. A 10 months old child from Khaboura Wilayat (North Batinah) was confirmed as Rubella case. No CRS case was reported in Q1 of 2009.
- Meningococcal infections: No case of meningococcal meningitis was reported in first quarter of 2009.
- Hib Meningitis: A 7 months old child from Saham Wilayat (North of Batinah) was confirmed as Hib meningitis and was fully vaccinated.
- Pulmonary Tuberculosis: Of the reported cases, 27 were sputum positive and 4 were sputum negative.
- Food poisoning: No major episode of food poisoning was reported during this period; however 6 minor episodes with 21 cases were reported.

Group B Diseases

- Meningitis: Six cases of bacterial meningitis other than Nm and Hib were reported; of these 4 were from Muscat Region, one from north Batinah and one from Dhahira while 1 case of viral meningitis and 6 cases of unspecified meningitis were reported in Q1 2009.
- Viral Hepatitis: Of the total 222 reported cases of viral hepatitis 43 were unspecified, 175 of Viral Hepatitis A, 2 of Acute Hepatitis B and 2 of Hepatitis C.
- Pertussis: 10 clinical cases were notified.
- Brucellosis: 18 cases were reported, 17 of them are from the endemic Dhofar Governorate.
- Leishmaniasis: No case of Leishmaniasis was reported in Q1 2009.
- HIV [AIDS]: 14 new HIV infections were diagnosed and 7 AIDS cases were reported among the HIV carriers.

Group C Diseases

- Varicella: In the 1st quarter a total of 8607 cases of chickenpox were reported.
- Mumps: 195 cases of clinical mumps cases were reported and 5 were serologically confirmed (IgM positive).

Communicable Disease Surveillance Data: *By Month*

First quarter: January to March 2009

Priority Communicable Diseases	2009				2008			
	Jan	Feb	Mar	Total	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sep	Q4 Oct-Dec
Group A Diseases								
Cholera	-	-	-	0	-	-	-	-
Plague	Never reported							
Yellow Fever	Never reported							
Meningococcal Infection	-	-	-	0	1	-	1	1
H. influenzae type b, meningitis *(Hib)*	-	-	1	1	-	1	1	0
Rabies	-	-	-	0	-	-	-	-
Malaria (*Imported Cases*)	23	30	39	92	103	281	335	247
Pulmonary Tuberculosis (*sputum positive*)	7	9	11	27	15	33	30	18
Group A Syndromes								
Acute Flaccid Paralysis [Polio]	3	3	2	8	17	4	2	9
Fever & Rash-Illness	59	41	58	158	173	320	209	148
Clinical Cases	2	1	-	3	1	5	4	2
Measles (*IgM positive*)	1	-	-	1	4	3	1	-
Rubella (*IgM positive*)	-	-	1	1	-	3	1	-
Congenital Rubella Syndrome [CRI]	-	-	-	-	-	[1]	-	-
Severe Acute Respiratory Syndrome *(SARS)*	Never reported							
Acute Haemorrhagic Fever Syndrome	-	-	-	0	-	-	-	-
Food Poisoning (*Infectious origin*)	10	17	9	36	80	159	170	60
Group B Diseases								
Bacterial Meningitis *(other than Hib & Nm)*	1	1	4	6	3	16	8	11
Viral Meningitis	-	-	1	1	-	-	-	-
Other Meningitis (*unspecified*)	1	-	5	6	12	8	7	13
Acute Viral Hepatitis (*Total*)	52	76	94	222	192	259	189	186
Acute Viral Hepatitis A	44	66	65	175	103	11	4	133
Acute Viral Hepatitis B	1	1	-	2	9	-	-	7
Acute Viral Hepatitis C	-	1	1	2	2	-	-	2
Acute Viral Hepatitis D (*amongst B positive*)	-	-	-	0	-	-	-	-
Acute Viral Hepatitis E	-	-	-	0	-	-	-	3
Acute Viral Hepatitis (*unspecified*)	7	8	28	43	78	248	185	41
Typhoid & Paratyphoid Fever	4	5	7	16	9	24	18	14
Clinical Pertussis [IgM positive]	1	4	5	10 [0]	18 [0]	30 [2]	17 [3]	6 [0]
Trachoma (*active*)	-	8	5	13	14	23	19	16
Brucellosis *(human)*	10	6	2	18	17	35	22	19
Leishmaniasis Cutanious (CL)	-	-	-	0	1	3	2	1
Leishmaniasis Visceral (VL)	-	-	-	0	-	-	-	-
Schistosomiasis (*intestinal*)	-	-	-	0	-	-	-	-
Pulmonary Tuberculosis (*sputum negative*)	1	2	1	4	9	11	8	6
Extra-pulmonary Tuberculosis	10	9	9	28	28	32	22	29
Leprosy	-	-	-	0	-	1	-	1
HIV [AIDS]	5 [2]	5 [3]	4 [2]	14 [7]	23 [9]	11 [8]	13 [7]	19 [3]
Group C Diseases and Syndromes								
Influenza Like Illnesses (*ILI*)	52473	42312	58352	153137	10952	11829	7041	13152
aLRTI & Pneumonia *(childhood)*	247	254	272	773	5055	3240	2914	4896
Acute 'Watery' Diarrhoea *(childhood)*	8125	10208	12255	30588	12092	7540	5266	7045
Chickenpox	2499	2802	3306	8607	21381	21772	7378	4747
Clinical Mumps [Sentinel sites-IgM positive]	67 [1]	60 [3]	68 [1]	195 [5]	209 [20]	187 [27]	120 [11]	418 [3]

Communicable Disease Surveillance Data: *By Regions*

First quarter: January to March 2009

Priority Communicable Diseases	Total	Muscat	Dhofar	North Batinah	South Batinah	Dakhli-yah	North Sharqi-yah	South Sharqi-yah	Dhahira	Buraimi	Musan-dam	Al Wustah
Group A Diseases												
Cholera	0	-	-	-	-	-	-	-	-	-	-	-
Plague	Never reported											
Yellow Fever	Never reported											
Meningococcal Infection	0	-	-	-	-	-	-	-	-	-	-	-
H. influenzae type b, meningitis *(Hib)*	1	-	-	1	-	-	-	-	-	-	-	-
Rabies	0	-	-	-	-	-	-	-	-	-	-	-
Malaria (*Imported Cases*)	92	32	33	5	5	6	1	5	3	-	-	2
Pulmonary Tuberculosis (*sputum +ve*)	27	8	1	9	4	-	1	1	1	-	1	1
Group A Syndromes												
Acute Flaccid Paralysis [Polio]	8	3	1	1	-	-	1	2	-	-	-	-
Fever & Rash-Illness	158	11	12	34	30	33	8	17	10	2	-	1
Clinical Cases	3	1	-	1	-	1	-	1	-	-	-	-
Measles (*IgM positive*)	1	-	-	-	1	-	-	-	-	-	-	-
Rubella (*IgM positive*)	1	-	-	1	-	-	-	-	-	-	-	-
Congenital Rubella Syndrome (*CRS*)	0	-	-	-	-	-	-	-	-	-	-	-
Severe Acute Respiratory Syndrome *(SARS)*	Never reported											
Acute Haemorrhagic Fever Syndrome	0	-	-	-	-	-	-	-	-	-	-	-
Food Poisoning (*Infectious origin*)	36	9	-	7	1	4	13	2	-	-	-	-
Group B Diseases												
Bacterial Meningitis *(other than Hib & Nm)*	6	4	-	1	-	-	-	-	1	-	-	-
Viral Meningitis	1	1	-	-	-	-	-	-	-	-	-	-
Other Meningitis (*unspecified*)	6	-	-	2	1	2	-	1	-	-	-	-
Acute Viral Hepatitis (*Total*)	222	8	28	9	1	10	32	118	2	10	2	2
Acute Viral Hepatitis A	175	4	21	3	1	6	21	107	2	8	1	1
Acute Viral Hepatitis B	2	-	-	-	-	-	-	2	-	-	-	-
Acute Viral Hepatitis C	2	-	-	1	-	1	-	-	-	-	-	-
Acute Viral Hepatitis D (*amongst B +ve*)	0	-	-	-	-	-	-	-	-	-	-	-
Acute Viral Hepatitis E	0	-	-	-	-	-	-	-	-	-	-	-
Acute Viral Hepatitis (*unspecified*)	43	4	7	5	-	3	11	9	-	2	1	1
Typhoid & Paratyphoid Fever	16	2	-	1	1	2	-	-	-	-	9	1
Clinical Pertussis [IgM positive]	10 [0]	3	1	1	2	1	2	-	-	-	-	-
Trachoma (*active*)	13	-	-	-	3	5	5	-	-	-	-	-
Brucellosis *(human)*	18	-	17	1	-	-	-	-	-	-	-	-
Leishmaniasis Cutanious (CL)	0	-	-	-	-	-	-	-	-	-	-	-
Leishmaniasis Visceral (VL)	0	-	-	-	-	-	-	-	-	-	-	-
Schistosomiasis (*intestinal*)	0	-	-	-	-	-	-	-	-	-	-	-
Pulmonary Tuberculosis (*sputum negative*)	4	1	1	-	-	1	-	-	1	-	-	-
Extra-pulmonary Tuberculosis	28	3	14	4	1	1	2	2	2	-	-	-
Leprosy	0	-	-	-	-	-	-	-	-	-	-	-
HIV [AIDS]	14 [7]	4 [3]	0 [1]	4 [1]	1 [1]	1 [1]	0 [1]	1 [0]	-	2 [0]	1 [0]	-
Group C Diseases and Syndromes												
Influenza Like Illnesses (*ILI*)	153137	27862	11332	25306	15564	26416	9210	12302	12039	6537	4550	2019
aLRTI & Pneumonia *(childhood)*	773	186	87	34	64	166	71	125	12	18	1	9
Acute 'Watery' Diarrhoea *(childhood)*	30588	3532	1110	6846	4001	6301	1683	3119	2456	705	324	511
Chickenpox	8607	1523	673	840	960	1374	331	867	1235	110	484	210
Clinical Mumps [IgM positive]	195 [5]	47	25 [1]	19 [1]	22 [2]	26 [1]	10	18	23	3	2	-

Communicable Disease Surveillance Data: *By Wilayat*

First quarter: January to March 2009

Region / Governorate	Wilayat	AFP	Measles	Rubella	Meningococcal infection	Viral Hepatitis A	Viral Hepatitis B	Malaria	Pertussis [IgM +ve]	TB Total	TB Sputum positive
Muscat	Muscat							1	1	1	
	Mutrah	1						9		1	
	Bawsher	1				3		8	2	1	1
	Seeb	1						14		5	3
	Al Amerat					1				2	2
	Qurayat									2	2
Dhofar	Salalah	1				2		4		10	
	Taqah									1	
	Mirbat							1			
	Thumrait					3		3		1	1
	Sadha										
	Rakhyut									1	
	Dhalkut							24		2	
	Shaleem					15					
	Muqshan										
	Mazyoona					1		1		1	
North Batinah	Sohar							2	1	4	2
	Suwaiq									4	3
	Saham					1				4	4
	Shinas	1									
	Liwa					1		3			
	Khaburah			1		1				1	
South Batinah	Rustaq		1					2		2	1
	Barka							2	2	2	2
	Musanah										
	Nakhl										
	Wadi Maawil									1	1
	Al Awabi							1			
Dakhliyah	Nizwa					2		1	1		
	Samail							1		1	
	Bahla							1		1	
	Izki					3					
	Adam					1		1			
	Al Hamra										
	Manah							1			
	Bidbid							1			
North Sharqiyah	Ibra	1							1		
	Mudaibi									1	1
	Bidiyah					19		1	1	1	
	AL Qabil					1					
	Dima Wa Al Tayeen										
	Wadi Bani Khalid					1					
South Sharqiyah	Sur					7	1	1		1	
	Jalan Bani Bu Ali	1				58	1	1			
	Jalan Bani Bu Hassan					36		2			
	Al Kamil Wa Al Wafi	1				6		1		2	1
	Masirah										
Dhahira	Ibri					2		2		4	1
	Yankul							1			
	Dhank										
Buraimi	Buraimi					8					
	Mahda										
	Sunaina										
Musandam	Khasab									1	1
	Daba Al Biya					1					
	Bukha										
	Madha										
Al Wustah	Haima					1		1			
	Duqum							1			
	Mahoot										
	Al Jazer									1	1
Total		8	1	1	-	175	2	92	10	59	27

Communicable Disease Surveillance Data: *Age Distribution*

First quarter: January to March 2009

Priority Communicable Diseases	Total	Age groups in years								
		< 1	1-4	5-9	10-14	15-19	20-24	25-34	35-45	45+
Group A Diseases										
Cholera	0	-	-	-	-	-	-	-	-	-
Plague	Never reported									
Yellow Fever	Never reported									
Meningococcal Infection	0	-	-	-	-	-	-	-	-	-
H. influenzae type b, meningitis *(Hib)*	1	1	-	-	-	-	-	-	-	-
Rabies	0	-	-	-	-	-	-	-	-	-
Pulmonary Tuberculosis (sputum positive)	27	-	-	-	1	3	5	7	2	9
Group A Syndromes										
Acute Flaccid Paralysis [Polio]	8	-	5	3	-					
Fever & Rash-Illness	158	52	66	20	5	4	4	4	1	2
Clinical Cases	3	1	2	-	-	-	-	-	-	-
Measles (*IgM positive*)	1	-	1	-	-	-	-	-	-	-
Rubella (*IgM positive*)	1	1	-	-	-	-	-	-	-	-
Congenital Rubella Syndrome (*CRS*)	0	-	-	-	-	-	-	-	-	-
Severe Acute Respiratory Syndrome *(SARS)*	Never reported									
Acute Haemorrhagic Fever Syndrome	0	-	-	-	-	-	-	-	-	-
Food Poisoning (*Infectious origin*)	36	4	6	6	6	5	1	6	1	1
Group B Diseases										
Bacterial Meningitis *(other than Hib & Nm)*	6	1	3	-	-	-	-	1	-	1
Viral Meningitis	1	-	1	-	-	-	-	-	-	-
Other Meningitis (*unspecified*)	6	1	-	2	-	-	-	1	2	-
Acute Viral Hepatitis (*Total*)	222	5	88	79	28	5	9	5	1	2
Acute Viral Hepatitis A	175	2	78	68	21	1	3	2	-	-
Acute Viral Hepatitis B	2	-	-	-	-	1	-	1	-	-
Acute Viral Hepatitis C	2	-	-	-	-	-	-	-	1	1
Acute Viral Hepatitis D (*amongst B positive*)	0	-	-	-	-	-	-	-	-	-
Acute Viral Hepatitis E	0	-	-	-	-	-	-	-	-	-
Acute Viral Hepatitis (*unspecified*)	43	3	10	11	7	3	6	2	-	1
Typhoid & Paratyphoid Fever	16	1	-	-	2	1	1	4	2	5
Clinical Pertussis [IgM positive]	10 [0]	8	-	1	1	-	-	-	-	-
Trachoma (*active*)	13	3	1	6	1	-	1	-	-	1
Brucellosis *(human)*	18	1	5	4	4	1	2	1	3	1
Leishmaniasis Cutaneous (CL)	0	-	-	-	-	-	-	-	-	-
Leishmaniasis Visceral (VL)	0	-	-	-	-	-	-	-	-	-
Schistosomiasis (*intestinal*)	0	-	-	-	-	-	-	-	-	-
Pulmonary Tuberculosis (*sputum negative*)	4	-	-	-	-	-	-	-	-	4
Extra-pulmonary Tuberculosis	28	-	-	-	4	3	3	8	2	8
Leprosy	0	-	-	-	-	-	-	-	-	-
HIV [AIDS]	14 [7]	-	-	-	-	2 [0]	2 [1]	3 [2]	3 [1]	4 [3]

Note:

- *The quarterly data are **'provisional'** & should be scrutinized & verified by the focal point of communicable diseases (Epidemiologist) at the provincial level. The data would be finalized. after receiving feedback.*
- *From year 2009, Group C data are compiled from computerized database by certain grouping of ICD-10 codes (Source: Nabd Al Shifa, DGIT, MoH)*
- *Tuberculosis, Leprosy & HIV [AIDS] data are for nationals only.*
- *All notified cases of Malaria are imported cases.*
- *(i) = imported case.*

"The wisest mind has something yet to learn."

Sultanate of Oman
Ministry of Health

Address for Communication:

Directorate General of Health Affairs

Ministry of Health HQ, PO Box 393, PC 113,

MUSCAT , Sultanate of Oman

Tel: + (968) 24 600808

Fax: + (968) 24 696099

E-mail: dg-ha@moh.gov.om

Visit: http://
www.moh.gov.om

Your contribution is valuable to us:

Please write to us concerning your ideas and experiences, sharing them with a wider audience could benefit others, leading to new ideas, techniques and policies and helping to avoid struggling with problems others have already solved.

Note to contributors:

While submitting articles related to studies conducted in Oman, the authors should attach a copy of the approval of ethical committee/research committee of the institution or the Regional Directorate.

Your opinion matters to us. Any suggestions to improve the contents and the design of this Newsletter will always be gratefully received.

Citation should be according to the following example: Ministry of Health Oman, National Response Strategy for HIV/AIDS in Oman, Comm & Dis Surv Newsletter, 2008; 17 (1): 1-6.

Editorial Board

Concept, layout & Design
Dr Shyam Bawikar

Back issues of this Newsletter are posted in PDF format on...

http://www.emro.who.int/emrinfo/oman-newsletter.asp
http://www.moh.gov.om/ ...Reports & Publications

Disclaimer

The statements of facts and opinions expressed in the articles of this newsletter are solely those of the respective authors and or contributors.

This quarterly Newsletter is published by
Directorate General of Health Affairs,
Ministry of Health, Oman

Sponsored by

gsk GlaxoSmithKline