



# GLOBAL AIDS

## RESPONSE PROGRESS REPORTING

### Country Progress Report

### Hashemite Kingdom of Jordan

January 2010-December 2011

## **Table of Contents**

- 1. Table of Contents**
- 2. List of Tables**
- 3. Abbreviations**
- 4. Status at a Glance**
  - 4.1 The inclusiveness of the stakeholders in the report writing process
  - 4.2 Status of the Epidemic
  - 4.3 Policy and Programmatic Response
  - 4.4 Core Indicators for GARP Reporting
- 5. Overview of the AIDS Epidemic**
  - 5.1 General Population
  - 5.2 Key Populations at Higher Risk
  - 5.3 Vulnerable Population Groups
- 6. National Response to the AIDS Epidemic**
  - 6.1 Prevention
  - 6.2 Treatment, Care and Support
- 7. Best Practices**
- 8. Major Challenges and Remedial Actions**
  - 8.1 Multisectoral Response
  - 8.2 Adequate Capacity
  - 8.3 Reaching Key Populations at Higher Risk with effective HIV prevention interventions
  - 8.4 Enabling Environment
- 9. Monitoring and Evaluation Environment**
- 10. Annex I:** Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS
- 11. Annex II:** National Commitments and Policy Instrument (NCPI)
- 12. References**

## **2. List of Tables**

**Table I: Reported Modes of HIV Transmission 1986-2011 (MoH/NAP)**

**Table II: Number of HIV positive persons – HIV testing sites 2010-2011 (MoH/NAP, 2011)**

**Table III: Drug abuse admissions to Public treatment centres in 2010 and 2011  
(MoH and PSD/AND)**

**Table IV: HIV Prevention Interventions (2010-2011)**

### **3. Abbreviations**

<b>AIDS</b>	Acquired Immune deficiency Syndrome
<b>AND</b>	Anti Narcotics Department
<b>ART</b>	Antiretroviral therapy
<b>ARV</b>	Antiretroviral
<b>BCC</b>	Behaviour Change Communication
<b>CBO</b>	Community based Organization
<b>CCM</b>	Country Coordinating Mechanism
<b>CRC</b>	Correction and Rehabilitation Centre
<b>CSO</b>	Civil Society Organization
<b>DoS</b>	Department of Statistics
<b>FSW</b>	Female Sex Worker
<b>GFATM</b>	Global Fund to Fight AIDS, TB and Malaria
<b>GNI</b>	Gross National Income
<b>HBV</b>	Hepatitis B Virus
<b>HCV</b>	Hepatitis C Virus
<b>HIV</b>	Human Immunodeficiency Virus
<b>IBBS</b>	Integrated Biological and Behavioural Surveillance
<b>IDU</b>	Injecting drug user
<b>IEC</b>	Information, Education and Communication
<b>ILO</b>	International Labour Office
<b>IRD</b>	International Relief and Development
<b>JHAS</b>	Jordan Health Aid Society
<b>JPFHS</b>	Jordan Population and Family Health Survey
<b>KAP</b>	Knowledge, Attitudes and Practices
<b>MSM</b>	Men who have Sex with Men
<b>MoE</b>	Ministry of Education
<b>MoH</b>	Ministry of Health
<b>Mol</b>	Ministry of Interior
<b>MoL</b>	Ministry of Labour
<b>MoPIC</b>	Ministry of Planning and International Cooperation
<b>MoSD</b>	Ministry of Social Development
<b>MoY</b>	Ministry of Youth
<b>M&amp;E</b>	Monitoring and Evaluation
<b>NAF</b>	National AID Fund
<b>NAP</b>	National AIDS Programme
<b>NCRA</b>	National Centre for the Rehabilitation of Addicts
<b>NSP</b>	National Strategic Plan
<b>NGO</b>	Non Governmental Organization
<b>OP</b>	Operational Plan

**OI** Opportunistic Infection  
**PLHIV** People Living with Human Immunodeficiency Virus  
**PSD** Public Security Department  
**RMS** Royal Medical Services  
**STI** Sexually Transmitted Infection  
**SATC** Substance Abuse Treatment Centre  
**TB** Tuberculosis  
**UNAIDS** Joint United Nations Programme on HIV and AIDS  
**UNICEF** United Nations Children’s Fund  
**UNDAF** United Nations Development Assistance Framework  
**UNDP** United Nations Development Programme  
**UNFPA** United Nations Population Fund  
**UNESCO** United Nations Educational, Scientific and Cultural Organisations  
**UNHCR** Office of the United Nations Higher Commission for Refugees  
**UNODC** United Nations Office on Drugs and Crime  
**UNRWA** United Nations Relief and Works Agency  
**VCT** Voluntary Counselling and Testing  
**WHO** World Health Organization  
**ZENID** Queen Zein Al Sharaf Institute for Development

## **4. Status at a Glance**

### **4.1 The Inclusiveness of the Stakeholders in the Report Writing Process**

The process of preparation and submission of the country progress report was primarily led by the National AIDS Programme, with technical and financial support provided by UNAIDS MENA-RST and in country. Moreover, assistance was provided through a third contractual partner to conduct interviews with key informants, collect data and further contribute to completion of the National Commitments and Policies Instrument (NCPI). The 2012 country progress report provides data on the status of, and response to the HIV epidemic in Jordan in the previous two years (January 2010- December 2011). Primary data was obtained from a desk review of relevant documents (policies, strategies, laws, guidelines, reports) and interviews carried out with key persons most knowledgeable about the topic.

A number of consultative meetings were held with senior staff at the National AIDS Programme to identify data needs and develop a plan for data collection and analysis early February, 2012. A total of 34 representatives from government, civil society, bilateral and multilateral agencies were contacted by phone and further interviewed to complete the NCPI.

The national consultation on the report was executed through a workshop held in the third week of March, inviting all stakeholders interviewed. A comprehensive presentation was delivered, and the NCPI findings were discussed and validated. Moreover, the draft report was circulated among all interviewees for any final comments before official submission.

### **4.2 The Status of the Epidemic**

*Jordan is still characterised by a low prevalence HIV epidemic, both among the general population and among key populations at higher risk of HIV exposure.*

*The total number of HIV positive cases registered within the period (1986-2011): **847** (29% Jordanians and 71% foreigners)*

*The total number of HIV positive cases registered in 2010 and 2011 is **36** (78% males and 22% females)*

*Sexual Contact remains the main mode of HIV transmission, accounting for almost 65% of HIV positive persons.*

*Until the end of December, 2011, a total of 99 Jordanian PLHIV had died of AIDS.*

### 4.3 The Policy and Programmatic response

Jordan's national response to HIV has been characterized by strong political commitment. The Ministry of Health established the National AIDS programme at the time the first HIV case was discovered in 1986. Jordan has endorsed the concept of the *three ones* and in 2005 launched the National AIDS Strategy for Jordan 2005 – 2009 outlining the key goals, objectives and initiatives for the response. A range of activities are being implemented under the umbrella of the NAP and in accordance with the National AIDS Strategy, including peer education and life skills programmes for young people, voluntary counselling and testing services (VCT), hotline, preliminary behavioural studies among vulnerable groups, and provision of free antiretroviral drugs to people living with HIV.

Technical support has recently been provided by UNAIDS to Ministry of Health during 2011 to update this document and develop a new national strategic plan, employing a participatory process involving all key national stakeholders. The new National Strategic Plan on HIV and AIDS (2012-2016) aims to continue and further guide Jordan's national AIDS response. Based on the thorough analysis of the existent epidemiological situation, key drivers and risk behaviours related to HIV transmission and the gaps and priorities of the national response to date, the NSP identified 5 key strategic areas for the period 2012-2016 (MoH/UNIADS, 2011);

- Strengthening the availability and reliability of strategic information for an evidence informed response
- Strengthening HIV prevention with a clear focus on key populations at higher risk
- Improving HIV case detection and scaling up coverage, utilization and quality of treatment, care and support for people living with HIV
- Creating a supportive legal and policy environment for an effective HIV response
- Building organizational, institutional and technical capacity for an effective national response.

***4.4 Indicator data in an overview table***

<b>TARGET ONE: Halve Sexual Transmission of HIV By 2015</b>		
<b>General Population</b>		
<p>1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*</p>	<p><b>N/A</b></p>	<p>Although a Jordan population and Family Health Survey (JPFHS) was executed in 2009, data on this indicator is only available from 2007.</p> <p>The 2007 JPFHS mainly collected information from ever- married women within the age group (15-49) about Knowledge of HIV and AIDS and methods of HIV prevention.</p> <p>All five questions listed in the numerator were addressed in addition to others on knowledge and prevention of HIV.</p> <p>Total number of respondents (15-24) years : 1, 512 (almost all have heard of AIDS)</p> <p>Percentages with right answers for each of the 5 questions:</p> <p>1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?            (15-24): <b>85%</b>            - 15-19: 80.2%            - 20-24: 85.8%</p> <p>2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?            (15-24): <b>51%</b>            - 15-19: 44.5%            - 20-24: 52.2%</p> <p>3. Can a healthy looking person have HIV?            (15-24): <b>64%</b>            - 15-19: 56.3%            - 20-24: 65.4%</p> <p>4. Can a person get HIV from a mosquito bite?            (15-24): <b>41.6%(No)</b>            - 15-19: 33.9%</p>



		<p>- 20-24:43.1%</p> <p>5. Can a person get HIV by sharing food with someone who is infected?</p> <p>(15-24): <b>71.4%</b></p> <p>- 15-19: 67.6%</p> <p>- 20-24: 72.2%</p> <p>* Composite indicator: The level of comprehensive knowledge of HIV prevention and AIDS (comprising questions 1-5):</p> <p>Ever married women in the age group (15-24): <b>12.9%</b></p> <p>- 15-19: 12.3%</p> <p>- 20-24: 13.0%</p>
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	N/A	This indicator is not available and not relevant to a country with low HIV epidemic like Jordan.
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	N/A	This indicator is not available and not relevant to a country with low HIV epidemic like Jordan
1.4 Percentage of adults 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 intercourse*	N/A	This indicator is not available and not relevant to a country with low HIV epidemic like Jordan
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	N/A	This indicator is not available and not relevant for a country with low HIV epidemic like Jordan
1.6 Percentage of young people aged 15-24 who are living with HIV*	N/A	This indicator is not available and not relevant for a country with low HIV epidemic like Jordan
<b>Sex Workers</b>		
1.7 Percentage of sex workers reached with HIV prevention programmes	N/A	Data source: Integrated Biological and Behavioral Survey*- preliminary analysis was done in 2010 for data collected in 2008. A total of <b>450</b> Female Sex workers from four main cities in Jordan, namely Amman, Zarqa, Irbid and Aqaba, participated in the study. Respondents were not specifically asked the questions listed in the numerator. Alternatively, they

		<p>were asked a number of questions that can be indicative of progress in implementing other basic elements of HIV prevention programmes, and they are as follows, disaggregated by age group:</p> <p>1. Proportion of respondents who know that corrective use of condoms is protective from HIV transmission:  Number of respondents: 430  - &lt; 25 years: 51.3%  - &gt; 25 years: 51.7%  Total: <b>51.6%</b></p> <p>2. Proportion of respondents who know whether a person can get HIV by sharing a meal with someone infected:  Number of 'NO' respondents: 429  - &lt; 25 years: 70.9%  - &gt; 25 years: 71.1%  Total: <b>70.1%</b></p> <p>3. Proportion of respondents who know that a healthy looking person can be infected with HIV:  Number of respondents: 425  - &lt; 25 years: 56.0%  - &gt; 25 years: 35.3%  Total: <b>40.9%</b></p> <p>4. Proportion of respondents who know that a pregnant mother can transmit HIV to her unborn child:  Number of respondents: 422  - &lt; 25 years: 84.2%  - &gt; 25 years: 81.2%  Total : <b>82%</b></p> <p>5. Proportion of respondents who know that a pregnant woman can transmit HIV to her unborn child through breastfeeding:  Number of respondents: 422  - &lt; 25 years: 60.5%  - &gt; 25 years: 50.3%  Total: <b>53.1%</b></p>
--	--	---

		<p>- Data is also available on the total number of FSWs reached out in the previous two years with any form of HIV and AIDS education in various governorates is:</p> <p><b>1345 FSWs.</b></p>
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	N/A	<p>Data is available from the IBBS* on respondents' condom use and as follows:</p> <ol style="list-style-type: none"> <li>1. Percentage of respondents who reported condom use the last time they had sex with a client partner: <b>69.1%</b> (of 433 respondents)</li> <li>2. Percentage of respondents who reported condom use the last time they had sex with a non client partner: <b>70.7%</b> (of a total of 307 respondents)</li> <li>3. Percentage of respondents who reported consistent condom use with client in the last 30 days: Number of respondents: 407 33.4% every time, 18.2% almost every time, 21.4% sometimes and 27.0% never).</li> <li>4. Frequency of condom use with non client partners in the last 12 months: Number of respondents: 319 35.7% every time, 39.8% almost every time, 11.6% sometimes and 12.9% never.</li> </ol>
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	N/A	<p>-Data from the IBBS* is available on the proportion of respondents who reported that they have ever had an HIV test (no time period specified):</p> <p><b>20.2%</b> of a total of 397 respondents.</p> <p>- <b>VCT</b> data indicate that 9 FSWs took the HIV test in the previous two years (2 in 2010 and 7 in 2011). All were tested negative for HIV.</p>
1.10 Percentage of sex workers who are living with HIV	N/A	<p>A total of 450 FSWs participated in the IBBS and all tested negative for HIV.</p>

<b>Men who have Sex with Men</b>		
<p>1.11 Percentage of men who have sex with men reached with HIV prevention programmes</p>	<p><b>N/A</b></p>	<p>Data source: Integrated Biological and Behavioral Survey*-  A total of <b>468 MSM</b> from four main cities in Jordan, namely Amman, Zarqa, Irbid and Aqaba, participated in the study.  Respondents were not specifically asked the questions listed in the numerator. Alternatively, they were asked a number of questions that can be indicative of progress in implementing other basic elements of HIV prevention programmes, and they are as follows, disaggregated by age group:</p> <p>1. Proportion of respondents who know that corrective use of condoms is protective from HIV transmission:  Number of respondents: 399  - &lt; 25 years: 20.6%  - &gt; 25 years: 31.8%  Total: <b>52.4%</b></p> <p>2. Proportion of respondents who know they can protect themselves by using condoms during anal sex:  Number of respondents: 403  - &lt; 25 years: 20.6%  - &gt; 25 years: 32.3%  Total: <b>52.9%</b></p> <p>3. Proportion of respondents who know whether a person can get HIV by sharing a meal with someone who is infected:  Number of 'NO' respondents: 379  - &lt; 25 years: 26.4%  - &gt; 25 years: 16.9%  Total: <b>43.3%</b></p> <p>4. Proportion of respondents who know a person can get HIV by injecting with a needle already used by someone else:  Number of respondents: 376  - &lt; 25 years: 43.1%</p>

		<p>- &gt; 25 years: 46%  Total : <b>89.1%</b></p> <p>5. Proportion of respondents who know that a healthy looking person can be infected with HIV:  Number of respondents: 378  - &lt; 25 years: 32.3%  - &gt; 25 years: 35.4%  Total : <b>67.7%</b></p> <p>6. Proportion of respondents who know that a pregnant mother can transmit HIV to her unborn child:  Number of respondents: 392  - &lt; 25 years: 33.4%  - &gt; 25 years: 37.8%  Total : <b>71.2%</b></p> <p>-Data is also available on the total number of MSM reached out in the previous two years with any form of HIV and AIDS education in various governorates is:  <b>1020 MSM.</b></p>
<p>1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</p>	<p><b>N/A</b></p>	<p>Data from the IBBS* is available on the following:  Number of respondents who report using a condom the last time they had sex with a commercial partner  - &lt; 25 years: 51.5%  -&gt;25 years: 65%  Total: <b>61%</b></p> <p>*Data is also available on the last time condom use with Non commercial partner (time was not specified in the question)  - &lt; 25 years: Number of respondents (193), 25.4% of which reported yes.  - &gt; 25 years: Number of respondents (183), 50% of whom have reported yes.</p> <p>Moreover, data is available on the following:  1. Number of commercial partners (exchange of sex for money) in the past six months:</p>

		<p>- &lt;25 years: Number of respondents:115 (None 47%, One 11.3%, two to three 12.2%, four to five 5.2% and greater than five 24.3%)</p> <p>- &gt;25 years: Number of respondents: 175 (None 28.6%, One 19.4%, two to three 22.3%, four to five 13.7% and greater than five 16%).</p> <p>2. Frequency of respondents' consistent condom use with commercial partners in the last six months</p> <p>- &lt; 25 years: Number of respondents: 56 (26.8% every time, 10.7% almost every time, 28.6% sometimes and 33.9% never)</p> <p>- &gt;25 years: Number of respondents: 141 (39% every time, 19% almost every time, 21% sometimes and 21% never)</p> <p>3. Frequency of respondents' consistent condom use with Non commercial partners in the last six months</p> <p>- &lt; 25 years: Number of respondents: 192 (12.5% every time, 9.9% almost every time, 20.8% sometimes and 56.8% never)</p> <p>- &gt;25 years: Number of respondents 188 (25.5% every time, 22.3% almost every time, 23% sometimes and 29.2% never)</p>
<p>1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results</p>	<p>N/A</p>	<p>Data from the IBBS* is only available on the proportion of the respondents who ever had an HIV test and it is not disaggregated by age group: Number of respondents: 425 Proportion who ever had an HIV test: 32.0%</p>

1.14 Percentage of men who have sex with men who are living with HIV	N/A	<p>Data from <b>VCT</b> records is available for the total number of MSM tested for HIV in the past two years:</p> <p>2010: 16 MSM were tested for HIV, of whom only one was HIV positive (6.25%).</p> <p>2011: 18 MSM were tested for HIV and all results were negative.</p> <p>-A total of 468 MSM who participated in the IBBS were tested for HIV. Only <b>one</b> tested positive.</p>
--	-----	---

<b>TARGET 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015</b>		
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A	<p>Data source: Integrated Biological and Behavioral Survey*-</p> <p>A total of <b>207 IDUs</b> from four main cities in Jordan, namely Amman, Zarqa, Irbid and Aqaba, participated in the study. Data is available on the following indicators:</p> <ol style="list-style-type: none"> <li>1. Ability to obtain new syringe if needed: 86% (202 respondents).</li> <li>2. Percent who mentioned this location as a place they knew of to obtain new, unused needles and syringes:</li> </ol> <p>Number of respondents: 207  49.8% pharmacist/ chemist, 17.9% drugstore, 10.6% health worker, 1.9% hospital, 1.9% drug worker, 8.2% other drug user and 6.3% from drug dealer.</p>
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A	<p>Data from the IBBS* is available on the following:</p> <ol style="list-style-type: none"> <li>1. Number of years of injecting:</li> </ol> <p>Number of respondents: 187</p> <p>-&lt; 25 years:</p> <ul style="list-style-type: none"> <li>- Less than or equal to two years: 72.2%</li> <li>- Three to five years: 27.8%</li> <li>- Six to ten years: 0%</li> <li>- Greater than ten years: 0%</li> </ul> <p>-&gt; 25 years:</p> <ul style="list-style-type: none"> <li>- Less than or equal to two years: 27.8%</li> <li>- Three to five years: 41.8%</li> </ul>

		<p>- Six to ten years: 23.8%  - Greater than ten years:6.6 %</p> <p>2.Frequency of injecting last month by age:  Number of respondents: 176  - &lt; 25 years:  More than twice a day: 25.7%  About once a day: 5.7%  Weekly but not every day: 28.6%  Monthly but not every week:40.0%  - &gt; 25years:  More than twice a day: 24.1%  About once a day: 14.2 %  Weekly but not every day: 31.2%  Monthly but not every week:30.5 %</p> <p>3.Number of different injecting partners in the past month:  Number of respondents: 154  24.0% none, 5.8% one, 38.3% two to three, 18.2% six to nine and 13.6% reporting partners equal or greater than ten.</p> <p>4.Proportion sexually active in the past 12 months:  Number of respondents: 186  -&lt; 25 years: 65.8%  - &gt; 25 years: 63.5%</p> <p>5.Number of commercial partners in the last 12 months:  Number of respondents: 164  - &lt; 25 years:  58.6% none, 3.4% one, 24.1% two to four and 13.8% five or more  - &gt; 25 years:  74.8% none, 6.7% one, 11.8% two to four and 6.7% five or more.</p> <p>6. Frequency of condom use with commercial partners in the past 12 months:  Number of respondents: 49  38.8% every time, 14.3 % most of the time, 12.2 sometimes, 34.7% never</p> <p>7. Number of non-regular sexual partners in the past 12 months:  Number of respondents: 162  - &lt; 25 years:  59.4% none, 9.4% one, 6.3% two to four and 25% five or more.  - &gt; 25 years:  65.4% none, 8.5% one, 13.8% two to four and 12.3% five or more.</p> <p>8. Frequency of condom use with</p>
--	--	---



		<p>non regular partners in the past 12 months:  Number of respondents: 59  38.9% every time, 5.1% most of the time, 13.6% sometimes and 42.4% never.</p>
<p>2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected</p>	<p><b>N/A</b></p>	<p>Data is available from the IBBS* on the following:</p> <ol style="list-style-type: none"> <li>1. Proportion of respondents who shared needle last time they injected:  Number of respondents: 203  61.1% of them reported using a needle or syringe that had previously been used by someone else.</li> <li>2. Frequency of sharing needles in the past month:  Number of respondents: 198  15.2% always, 22.7% most times, 4.0% about half the time, 27.3% occasionally and 30.8% responded never.</li> <li>3. Frequency of injecting with a needle that no one else had ever used in the past month:  Number of respondents:192  24.0% every time, 14.1% almost every time, 43.2% sometimes and 18.7% never.</li> <li>4. Frequency of cleaning needles and syringes:  Number of respondents: 193  33.7% every time, 23.8% almost every time, 22.8% sometimes and 19.7% never.</li> <li>5. Frequency of giving, lending, selling or renting a needle or syringe to someone else after already using it:  Number of respondents:201  7.5% every time, 16.4% almost every time, 46.8% sometimes and 29.4% never.</li> <li>6. Frequency of frontloading (injecting with a syringe after someone else had squirted drugs into it from his/her syringe) in the past month.  Number of respondents:192  16.7% every time, 12.5% almost every time, 33.9% sometimes and</li> </ol>

		<p>37.0% never.</p> <p>7. Frequency of sharing cookers, vials, containers, cotton/filter, or rinse water: Number of respondents:194 25.3% every time, 16.0% almost every time, 34.5% sometimes and 24.2% never.</p> <p>8.Frequency of drawing drug solution from a common container shared by others in the past month: Number of respondents:200 23.5% every time, 23.5% almost every time, 30.5% sometimes and 22.5% never.</p>
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	<b>N/A</b>	<p>Data is available from the IBBS* on the following:</p> <p>1.Proportion of respondents who have ever had an HIV test: 26.9% of a total of 182 respondents</p>
2.5 Percentage of people who inject drugs who are living with HIV	<b>N/A</b>	<p>- <b>VCT</b> data indicate that only one HIV positive case was diagnosed for an IDU in 2011.</p> <p>- A total of 201 IDUs participated in the IBBS in 2008. All tested negative for HIV.</p>

<b>TARGET 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths</b>		
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	<b>N/A</b>	Data is only available on the numerator; only one case was reported for an HIV positive pregnant woman who received ARV drugs during the past 12 months to reduce mother-to-child transmission.
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	<b>N/A</b>	
3.3 Mother-to-child transmission of HIV (modelled)	<b>N/A</b>	

<b>TARGET 4: Have 15 million people living with HIV on antiretroviral treatment by 2015</b>		
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	<b>N/A</b>	Data is only available for the numerator; the total number of eligible adults and children currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol is <b>108</b> . No estimate is available for the number of eligible adults and children.
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	<b>Indicator Value =100%</b>	Data is only available from VCTs on the total number of HIV positive cases diagnosed within the period January 2010 until December 2010: 19 cases were diagnosed within this time period and all were eligible and are currently on treatment.

<b>TARGET 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>		
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	<b>Indicator Value: Zero%</b>	Zero HIV positive incident TB cases in the past two years

<b>TARGET 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries</b>		
6.1 Domestic and international AIDS spending by categories and financing sources	<p>International AIDS Spending: GFATM: <u>1,157599</u> USD 2010: 723767.521 2011: 433831.479</p> <p>National AIDS spending: <u>2000000</u> USD 2010:1000,000 2011: 1000,000</p> <p>Total Expenditure: <b><u>3,157599</u> USD</b> 2010:1, 723767.521 2011:1, 433831.479</p>	<p>International Spending has been calculated based on GFATM grant-expenditures for 2010 and 2011.</p> <p>National AIDS spending has been estimated by MoH, based on general expenditure on prevention, treatment and care, programme management and administration, infrastructure, incentives for human resources and research.</p>

<b>TARGET 7: Critical Enablers and Synergies with Development Sectors</b>		
7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and M&E)	<b>NCPI Completed</b>	

7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	<b>N/A</b>	The only nationally representative data is available from the 2007 Jordanian Population and Family Health Survey. The percentage of ever married women ages: 15-49 who have experienced various forms of violence perpetrated by their husband, ever or in the 12 months preceding the survey- Number of respondents: 3,444 1. Physical violence: 20.6% ever, 3.2% often, 9.0 % sometimes and 12.2% at least once. 2. Sexual Violence: 7.6% ever, 1.7% often, 3.9% sometimes and 5.6% at least once. 3. Physical and/or Sexual violence: 23% ever, 4.1% often, 10.5% sometimes and 14.6% at least once.
7.3 Current school attendance among orphans and non-orphans aged 10–14	<b>N/A</b>	This indicator is not available and not relevant for a country with low HIV epidemic like Jordan
7.4 Proportion of the poorest households who received external economic support in the last 3 months	<b>N/A</b>	

\* Limitations of the IBBS data collected for the three population groups at high risk – MSM, FSWs and IDUs:

- Data is only available from four main governorates in Jordan, namely Amman, Irbid, Zarqa and Aqaba and thus it is not nationally representative.

-Information on the sampling methodology is sparse. Although Respondent Driven Sampling was employed, data was not sufficient to conduct the data analysis using RDS specific software.

-Information on eligibility criteria for recruitment into the study has not been made available for all three groups. In the case of FSWs, no data is available on whether the sample recruited was for street based or residential FSWs, and whether they were required to have sold sex within a defined time frame.

-Information on all logistics of study execution were also not available, namely on who conducted the survey, who the interviewers were and level of involvement of NGOs or civil society organizations.

- Interpretation of data is hampered by issues related to the study methodology and the validity of data, the matter that restricts its generalisability to the larger population of all MSM, IDUs and FSWs in the country.

## **5. Overview of the AIDS Epidemic**

**Globally**, the HIV epidemic constitutes one of the most critical and wide spread public health challenges. While the **Middle East and North Africa region** is still characterized with an overall low HIV prevalence, recent data published situates MENA among the top two regions in the world with the fastest growing HIV epidemic (UNAIDS, 2011). Available data on HIV epidemics in the Middle East and North Africa region indicates a continuing increase in the number of people newly infected with HIV, the number of people living with HIV and the number of people dying from AIDS related causes. Additionally, limited HIV data derived from existing research indicates that unprotected sexual practices (including between men) and the sharing of non-sterile drug injecting equipments remain the primary drivers of HIV transmission. Most new HIV infections in the region are among men; in 2010 women comprised an estimated 41% of adults living with HIV, many of whom have acquired the infection from their spouses (WHO/UNAIDS/ UNICEF, 2011).

**Jordan** is a Middle Eastern, upper middle income country with a Gross National Income (GNI per capita) of USD 4, 340 (World Bank, 2011). Jordan's 2010 statistics indicate that the population is about 6.1 million (51.5% males and 48.5% females). Despite Jordan experiencing an epidemiological transition in the pattern of disease, best characterised by a remarkable shift from communicable to chronic non communicable diseases (cardiovascular diseases, cancer, diabetes and chronic respiratory infections), the emergence of new communicable diseases like HIV, Hepatitis C and E constitutes a burden on the health system in Jordan (MoH/CCD, 2010).

Jordan is characterized by a low prevalence HIV epidemic, with low levels of HIV both among the general population and the most at risk population groups including Men who have sex with men (MSM), Female Sex Workers (FSWs) and Injecting Drug Users (IDUs). Despite low prevalence, a number of socioeconomic and political factors fuel the silent spread of the epidemic.

Jordan's population reflects a **youth bulge** with youth under the age of 15 comprising almost 37.3% of the population, and those under the age of 30 years comprising 57% (DoS, 2010a). Although the absolute poverty has decreased, wide **income inequities** still exist among various population groups and governorates. The **unemployment** rate in 2010 was 12.5% (10.4% males and 21.7% females). Non Jordanian workers in 2009 constituted 13.1% of the workforce (71% are Arabs- mainly Egyptians, Syrians and Iraqi and 29% are non Arabs) (DoS, 2010a). Jordan's natural resources are limited and the country heavily relies on external aid and remittances from Jordanians working abroad (UN/MoPIC, 2010). A large number of men are seeking employment opportunities outside of Jordan where they are more likely to have extramarital contacts, thus increasing their exposure to sexually transmitted infections. Some sectors in Jordan are more likely to place workers at a higher risk of contracting HIV; sectors that employ young people in unskilled jobs and those of male dominant work environments such as factories in which women are more vulnerable to exploitation and sexual assaults and sectors employing migrant labours, leaving them at the mercy of their employers (ILO, 2011).

Despite considerable progress achieved to date in the field of human rights, some population groups are still highly **discriminated and marginalized** in society. Key populations at higher risk (IDUs, MSM and FSWs) still experience legal and societal discrimination and harassment (**Penal Code, Public Health Law and Laws and regulations pertaining to the Usage and Administering of Drugs and Mental Illness**).

**PLHIV** are particularly vulnerable with restricted enjoyment of their rights due to a number of social barriers that continue to fuel their marginalization in society. Although PLHIV who are aware of their seropositive status are granted free antiretroviral therapy and treatments for opportunistic infections through MoH/NAP, stigma and discrimination of the health care providers in general restricts their utilization of health services, especially dental health services and secondary and tertiary medical care<sup>1</sup>.

A recently completed study to assess the extent to which current Jordanian legislation and policies are in tune with international standards pertaining to HIV and AIDS in the workplace revealed that the Jordanian legislation does not explicitly discriminate against PLHIV, however, some significant discrepancies were highlighted between ILO Recommendation 200- and the legal requirements under the Jordanian law, mainly pertaining to mandatory HIV testing for Jordanians and migrant workers. Moreover, the study findings revealed that neither does the Jordanian Labour law nor the Social Security law explicitly list HIV as an occupational disease or injury that warrants compensation. The study recommended more legislative efforts to be in place through amending existing laws/ adopting a separate law dedicated entirely for PLHIV, going hand in hand with initiatives aimed at increased awareness on HIV and changing dominant perceptions that fuel stigma and discrimination (ILO, 2011).

**HIV testing** in Jordan continues to be **mandatory** for the following: blood donors, individuals working in the public medical sector and private hospitals, all army employees returning from the United Nations peace keeping missions, and individuals admitted to public treatment and rehabilitation centres for substance abuse. Moreover, employees working in the public sector are also expected to take the HIV test before being hired and those requiring HIV certificates for foreign work permits. Mandatory testing appears to be rarely imposed on the new employees in the private sector; the private sector rarely entails a medical clearance certificate for employment, however, it might constitute a prerequisite for medical insurance coverage that is many times provided by the employer. Foreigners staying in Jordan for a period that exceeds three months/ those applying for a work or residency permit have to provide the department of foreigners and borders with a medical clearance certificate from MoH which includes HIV test. In case of a positive test result, MoH/NAP will inform the Minister of Interior, and the course of action is deportation of the HIV positive foreigner.

Client initiated HIV testing is made available through **Voluntary counselling and testing services** provided through the 12 centres distributed throughout the Kingdom and the private medical sector. The most active VCT is that located in the capital Amman, with individuals accessing it from distant governorates, thus minimizing stigma and discrimination they might be subjected to in their localities. The significant number of VCT centres available did not translate into an increased utilization of the services provided due to a number of structural, operational, logistical and social barriers such as: understaffing, limited technical capacity of the staff available to provide quality services, and inadequate space and poor infrastructure. Moreover, it was also highlighted that VCT services are generally not

---

<sup>1</sup> Personal communication with a group of 8 PLHIV in Amman; March, 2012.

promoted sufficiently among key populations at higher risk and other vulnerable groups, many of whom are concerned about the confidentiality of the services available and stigma and discrimination.

To date, Jordan's national response to HIV has been characterized by a strong political commitment, best evident with the establishment of the National AIDS Programme in 1986 and its sustainable funding through national and international sources, including the Global Fund to Fight AIDS, Tuberculosis and Malaria. Jordan has endorsed the concept of three ones and in 2005 launched its first National AIDS Strategy (2005-2009). Efforts in the last two years focused on the development of a new national strategic plan, covering the period 2012-2016.

Additionally, the UN system in Jordan has established the **UN Theme group on HIV** which includes representatives from the following UN agencies: UNFPA, UNDP, UNESCO, ILO, UNICEF, UNODC, UNRWA, UNHCR, WHO and UNAIDS. The theme group is chaired by UNFPA. The group's main responsibilities are to advocate and promote an expanded, multisectoral response to HIV including issues of human right, help strengthen the country's capacity to cope with the HIV epidemic and increase the UN Country team understanding of HIV and AIDS and its commitment to the national response. Building on the mandate of each the represented UN agencies, the UN Theme group on HIV provides technical and financial support to a number of government and civil society institutions to implement a wide range of activities on HIV and AIDS and across various sectors.

Since the first case for an HIV positive person was registered in Jordan in 1986 and until 2011, a total of **847** cases for HIV positive persons were registered, of which 247 (29%) were Jordanians and 600 (71%) foreigners. Up to December 2011, 99 people had died of AIDS. The number of officially reported cases does not necessarily reflect the actual HIV epidemic in the country since it is mostly based on tests carried out among specific population groups required to do the test.

A total of **36** cases for HIV positive persons were registered among Jordanians in the past two years (78% males and 22% females), of which 53% were infected inside Jordan and 48% infected abroad. In 2010, a total of **19** new HIV positive cases were registered (16 males and 3 females) and **17** cases in 2011 (12 males and 5 females). The majority of the HIV positive persons (50%) were in the age group (25-34) years (27.8 % (25-29) years and 22.2% (30-34) years).

**Table I: Reported Modes of HIV Transmission 1986-2011 (MoH/NAP, 2011)**

Reported mode of HIV Transmission	1986-2009	2010	2011	Total	%
Heterosexual	117	9	13	139	56.3%
MSM	10	9	2	21	8.5%
Injecting Drug Use	5	0	1	6	2.4%
Blood and Blood Products	59	1	1	61	24.7%
Mother to Child	8	0	0	8	3.2%
Unknown	12	0	0	12	4.9%
<b>Total</b>	<b>211</b>	<b>19</b>	<b>17</b>	<b>247</b>	
<b>%</b>	<b>85.4%</b>	<b>7.7%</b>	<b>6.9%</b>	<b>100%</b>	<b>100%</b>

**Table II: Number of HIV positive persons – HIV Testing sites 2010-2011 (MoH/NAP, 2011)**

HIV testing Site	2010	2011	Total	%
Public Hospitals	3	5	8	22.2%
Public Laboratories	1	0	1	2.8%
Private Hospitals	6	1	7	19.4%
Private Laboratories	2	1	3	8.3%
Central Blood Bank	2	1	3	8.3%
VCT centres	5	9	14	39%
<b>Total</b>	<b>19</b>	<b>17</b>	<b>36</b>	<b>100%</b>

Heterosexual transmission remains the main mode of HIV transmission, accounting for 56.3% of the cases. A considerable proportion (24.7%) of all HIV positive persons have been infected through blood and blood products, the majority of which were infected abroad in the early stages of the epidemic, since the national screening policy and standard operating procedures mandate screening of all donated blood for key pathogens, including HIV in Jordan. MSM mode of transmission contributes at 8.5%. Data available indicates that injecting drug use and mother to child transmission are minor modes of HIV transmission in Jordan.

Furthermore, data presented here has to be interpreted with extreme caution. Jordan does not have a reliable HIV surveillance system, and data available is for HIV positive cases reported from public (including blood bank and Royal Medical Services) and private hospitals and laboratories, and VCT centres; blood samples for all positive results are sent to the MoH central laboratory for confirmatory testing. A total of 7,163 HIV antibody tests were carried out in the central laboratory in the past two years (3797 in 2010 and 3366 in 2011); 336 of which were conducted through VCTs (142 in 2010 and 194 in 2011). Despite the low number of tests carried through VCT centres, they account for 39% of the HIV positive cases detected. Moreover, data provided here is subject to recall and desirability biases; asking



the patients to recall past events and report their true risky practices which are highly stigmatized in a conservative culture like that of Jordan is very contentious.

*Consequently, this data is not representative of and might underestimate the real magnitude of the HIV epidemic in the general population and among key populations at higher risk.*

### **5.1 General Population**

Data on HIV and AIDS knowledge, attitudes and practices is generally scarce in Jordan. National data on HIV and AIDS, sexually transmitted infections and domestic violence is only available from the 2007 Jordan Population and Family Health Survey and only for women in the reproductive age (15-49) years. The JPFHS conducted in 2007 indicated that only 13% of the ever married women in the age group (15-49) had a comprehensive knowledge of HIV prevention and transmission (knowing that both condom use and limiting sex partners to one uninfected person are HIV prevention methods, being aware that a healthy looking person can have HIV, and rejecting the two most common misconceptions – that HIV can be transmitted through sharing food and mosquito bites) (DoS, 2008). The last JPFHS was carried out in 2009, and provided information mainly on fertility and its determinants, family planning, childhood mortality and nutrition among women and children (DoS, 2010b). Efforts are currently in place preparing for the 6<sup>th</sup> JPFHS that will be executed this year.

### **5.2 Key Populations at Higher Risk**

#### ***1. Injecting Drug Users***

Data on injecting drug use is scarce in Jordan as no proper population size estimation or extensive research was done in the past. Of the total number of 274 HIV positive persons diagnosed until December, 2011, only 2.4% was attributed to injecting drug use (MoH/NAP, 2011) and only one positive HIV case was diagnosed for a person who injects drugs in 2011. IDUs in Jordan are strongly criminalized and marginalized population group. The last two years have witnessed a decrease in injecting drug use and a significant increase in addiction to hashish and psychotropic drugs<sup>2</sup>.

Drug treatment services in Jordan are available from both the public and private sectors. Data obtained from the two main public drug treatment centres: the Ministry of Health National Centre for Rehabilitation of Addicts (NCRA) and that from the Public Security Department- Substance Abuse Treatment Centre (SATC) indicate that heroin is the main opiate injected. Addiction to heroin constitutes 23% of all drug abuse admissions in the past two years, 58% of who inject the drug. Details are provided in the table below:

---

<sup>2</sup> Personal Communication with PSD/AND Specialists; Amman, February, 2012.

**Table III:** Drug abuse admissions to Public treatment centres in 2010 and 2011(MoH and PSD/AND)<sup>3</sup>

Cases admitted	National Centre for Rehabilitation of Addicts (MoH)				Substance Abuse Treatment Centre (PSD)			
	2010	2011	Total	%	2010	2011	Total	%
Number of drug abuse admissions	491	471	962	100%	421	497	918	100%
Heroin Addiction	149	75	224	23.3%	54	152	206	22.4%
Heroin Addiction be injecting	93	47	140	62%	27	82	109	53%
Heroin Addiction by inhaling	56	28	84	38%	27	70	97	47%

Of all the cases admitted for heroin addiction by injecting, 22% were tested for HIV at MoH (NCRA), and all results were negative. All those admitted to the PSD (SATC) tested negative for HIV.

HIV is only one of several blood borne infections that can be transmitted through injecting drug use. Hepatitis C is another pathogen transmitted largely through percutaneous exposures and thus can be used as a proxy of risky drug injecting practices (Abu Raddad et al., 2010). The screening executed as part of the biological and behavioural study on drug use and HIV, HBV and HCV prevalence in all 13 Correction and Rehabilitation centres (CRCs) in 2011 indicated that among the 2666 inmates screened for HIV, HBV and HCV, 40 tested positive for HBV, 95 tested positive for HCV and none tested positive for HIV (MoH/PSD/ UNODC, 2010). Among those tested positive (HBV and HCV), 8% indicated previous experience in injecting drug use; an observed association was found between injecting drug use and HBV and HCV infections collectively (although not indicating a causal relationship between the two variables). *Although presence of HCV infection in an IDU population does not inevitably imply that HIV is destined to have a considerable prevalence in this population, alternatively, and since both infections share the same mode of transmission, a high HCV prevalence in an IDU population implies the potential for HIV transmission along the same route (Abu Raddad et al., 2010).*

Data from the 2008 IBBS study (although interpreted with great caution due to the study limitations) highlights some alarming signs that can contribute to an increased risk of HIV infection among IDU respondents. A total of 207 persons who inject drugs participated in the study, the majority of which are older than 35 years (19.6% (18-25), 17% (26-30), 24.7% (31-35) and 38.7% older than 35). The majority have been injecting heroin for 3-5 years (MoH/NAP, 2010).

<sup>3</sup> Data made available from specialists in both the MoH/NCRA and PSD/SATC; Amman, February, 2012.

### *Knowledge of HIV and AIDS:*

Generally, the IDU study population level of knowledge on HIV and AIDS is inadequate. Almost half (53%) of the respondents knew that condom use is an HIV prevention method and half of them (47%) rejected misconception that HIV can be transmitted by sharing a meal with a person living with HIV. Almost all (96%) of the respondents indicated that the use of non sterile needles can lead to HIV transmission.

### *Unsafe injecting practices among IDUs:*

Frequency of injection was generally not very high; almost a quarter (24%) of all respondents injected more than twice a day, and 12.5% reported injecting about once a day. The remaining two thirds injected weekly or less. Sharing of needles or syringes was reasonably high with almost two thirds (62%) of the participants reporting sharing of needles or syringes the last time they injected. 38% of the participants reported having 2-3 different injecting partners in the past month and almost 30% reported 6 or more. A quarter (24%) reported injecting alone.

Frequency of sharing needles and syringes in the past month ranged from 4% sharing half the time, 15% always sharing, 23% most times, 27% occasionally and 31% have never shared. Smaller percentages were reported for giving or lending syringes or needles to others (7.5% every time, 47% sometimes and 29% never). The study participants' ability to obtain new syringes if needed was explored; the majority of the participants indicated it was easy to acquire clean syringes, with the pharmacist/chemist being the most frequently mentioned place for purchasing them, followed by the drug store at 50% and 18% respectively.

Other high risk injecting behaviours reported by the participants were: frontloading (injecting with a syringe after someone else had squirted drugs into it from his/her used syringe) and sharing of cookers, vials, containers, cotton/filter or rinse water. Almost two thirds (63%) of the IDU participants reported frontloading (17% always, 13% almost every time and 34% sometimes). Sharing of other injecting equipment was reported by almost three quarters of participants (25% always, 16% almost every time and 35% sometimes).

### *Unsafe Sexual Behaviour among IDUs:*

Two thirds (64%) of the study participants reported being sexually active in the past 12 months. Almost half of all respondents had had more than one sex partner in the last year (15% (2-3), 24% (4-9) and 8% 10 or more sex partners). A quarter of the respondents indicated having one regular partner in the past year, few (10%) reported having 2-3 and (10%) 4-9. A third of the respondents reported having one commercial partner in the last year (6% one, 16% 2-4 and 8% 5 or more). Moreover, few respondents admitted having had same sex relationships with other men (12 percent of the 53% who responded to this question) in the past year. Reported condom use with non regular partners in the past year indicates that almost half of the respondents reported having used a condom "every time" or "most of the time". Slightly higher frequency rates were reported for those using a condom with commercial partners. "Never" using a condom with commercial and non regular partners in the past year was reported at 35% and 42% respectively.

A small scale KAP study was also conducted by a local NGO (Future Guardians) with support from UNODC and in collaboration with NAP and PSD. The study targeted a total of 214 IDUs in Jordan's four main governorates: Amman, Zarqa, Irbid and Aqaba. Many of the study participants were using other types of substances besides injecting heroin (66% psychotic pills, 35% hashish, 6% alcohol and 2% glue). The study revealed that the participants' level of knowledge on HIV and AIDS and Hepatitis C is inadequate. Almost two thirds of the participants knew that contaminated blood and sexual contact with an HIV positive person can transmit HIV. Only half of them knew these facts for HCV. More than half (57%) and (76%) respectively were unaware that sharing needles is a means of HIV and HCV transmission. Additionally, some alarming findings on IDUs' risk taking behaviours were revealed. Two thirds of the respondents admitted sharing needles in the last seven days and further sharing cookers, vials, containers and rinse water. Only 7% of the study sample indicated the use of a condom in the last sexual intercourse. Moreover, only 15% of the study participants did an HIV test; results for all were negative (MoH/PSD/ UNODC/ FG, 2011).

*Results of the IBBS (although interpreted with caution) and the KAP study highlight a number of unsafe injecting practices and risky sexual behaviours among this key population at higher risk, thus mounting the possibility of a potential increased HIV prevalence among them/ their partners in the future. A small overlap with MSM was evident.*

## **2. Men who have Sex with Men**

Despite the increase in data available on Men who have Sex with Men and HIV in MENA region, very little data is available from formal research on MSM in Jordan. Sex between men is not officially illegal in Jordan, but socially, MSM remains a hidden and stigmatized population group due to the conservative nature of the culture and dominant social norms. Data available from NAP indicate that MSM contribute to 8.5% of all HIV positive cases diagnosed since 1986. In 2010, 47% of HIV positive cases were for MSM and 12% in 2011. Of the total 468 MSM who participated in the 2008 IBBS study, only one person tested positive for HIV (MoH/NAP, 2010). More data is available from the IBBS on the following:

### *Knowledge of HIV and AIDS:*

The majority of the respondents have heard of HIV, and only one fifth have not. The proportion of the respondents who knew that condom use can protect from HIV transmission was only half of the respondents; 42% did not know this piece of information (65% of whom are older than 25 years of age). Some misconceptions on HIV modes of transmission were also evident; only 44% of the respondents knew that a person cannot get HIV by sharing a meal with an HIV positive person and almost a third of them were not aware that a healthy looking person can be living with HIV and that a mother can transmit HIV to her unborn child.

### *Unsafe Sexual Behaviour among MSM:*

Results of the IBBS study reveal some important insights on risk behaviours among the MSM study population. Three quarters of the participants (74%) were in the age group (13-30) years. Data available reveals an overlap of MSM risk behaviours and heterosexual sex; almost 35% of the participants were

married, and either living with spouse (29%) or with another female partner (4%). Two thirds of the participants (65%) were not married, of whom 34% are still living with a female partner. This data further demonstrates the social pressure exerted on MSM to get married and have families, thus masking reality about their sexual preferences. Three quarters of the study participants were sexually active in the past six months (80% of those who were the receptive partner have had sex with more than one partner, and also 95% of those who were the insertive partner). Acts of oral sex were admitted by a significant number of respondents with the majority having more than one oral sex partner (31% with 3-5 and 33% with 10 or more partners).

Many respondents (64%) indicated sexual engagement with commercial partners (without indication whether the respondent was the one buying or selling sex), ranging from one commercial partner (16%) to a maximum of 5 or more (19%); of all those engaged, 61% indicated the use of condom at the last sexual intercourse. Consistent condom use with commercial partners in the last six months was considerable, with 36% reporting its use every time, 17% almost every time, 22% sometimes and almost a quarter reporting never. Participants also reported on sexual engagement and condom use with non commercial partners; 63% of the respondents reported not using a condom the last time they had sex with a non commercial partner. Data on consistent condom use in the past six months reveals that 43% of the respondents have never consistently used a condom. The remaining 57% reported some sort of consistent use (19% every time, 16% almost every time and 22% sometimes). The reported frequency of lubricant use was high, with almost 78% reporting its use (63% every time or almost every time, and 16% using it sometimes).

*Although interpreted with caution, data from the IBBS study reveals some useful insights on risky sexual behaviour among the MSM group, such as multiple sex partners, low condom use and existing overlap with heterosexual relationships, all of which place MSM as a key population at higher risk of exposure to HIV themselves and furthermore its transmission to the general population.*

### **3. Female Sex Workers:**

Sex work is prevalent all over MENA and its forms are altering rapidly due to changes in socioeconomic and political conditions and the utilization of various means of modern communication (Abu Raddad et al., 2010). Female sex work is prevalent in Jordan, and limited is the data available about the dynamics of sex work, their level of awareness on HIV and risk taking behaviours. Findings of an informal qualitative assessment conducted in the context of developing the NSP 2012-2016<sup>4</sup> revealed that sex work is present and well organized in the country and involves Jordanian and foreign female sex workers. It ranges from organized prostitution to individual women engaging in sex work or transactional sex. Sex workers may operate from bars, hotels and nightclubs, with most working from private houses or apartments. Street based sex work is very limited. Sex work is illegal in Jordan. In 2010, a total of 21 *prostitution* felonies were registered (DoS, 2010a).

---

<sup>4</sup> Qualitative assessment was conducted by consultant Joost Hoppenbrouwer in form of eight focus group discussions and some interviews with sex workers in the context of developing the NSP 2012-2016; Amman, 2010.

A total of 450 FSWs participated in the 2008 IBBS study, findings of which highlighted the following (MoH/NAP, 2010):

*Knowledge of HIV and AIDS:*

Almost 44% of the respondents did not know that condoms can protect from HIV transmission, and a quarter indicated that a person can get HIV by sharing a meal with an HIV positive person. Only 42% of the respondents knew that a healthy looking person can be an HIV positive person. Only 15% were not aware that a mother can transmit the virus to her unborn child and almost half of the respondents knew that an HIV positive mother can transmit the virus to her newborn through breastfeeding.

*Unsafe Sexual Practices:*

The majority of the FSWs involved in the study were married and living with their spouses or with another sexual partner. Around a quarter of them started receiving money for sex when they were below the age of 20 years. The mean number of clients in the past week was 4-5 clients, with an overall 70% reported condom use with the last client, and an overall 30% consistent condom use with clients in the past month reported.

*As evident from the findings, the level of knowledge of HIV and AIDS among the FSW study population is inadequate. Moreover, unsafe sexual practices are present, best represented by low condom use and multiple sexual partners.*

*\*An important highlight is the vulnerability of the sexual partners of MSM, IDUs and FSWs clients to HIV infection. Women's vulnerability requires significant attention since many of the risk behaviours in our society are practiced by men who eventually infect their wives (Abu Raddad et al., 2010).*

## **5.4 HIV and Vulnerable Population Groups**

### ***1. Correction and Rehabilitation Centres' Inmates:***

A number of small scale KAP studies were conducted among CRC inmates in the past two years. The first was a cross sectional biological and behavioural study on drug use and HIV, HBV and HCV prevalence carried out in all 13 CRCs in Jordan in 2010. A total of 2666 inmates participated in all stages of the study (MoH/PSD/ UNODC, 2010).

The second was an evaluation study carried out in 2011 by NAP and PSD with support from UNODC in two main CRCs in Jordan, namely Om Al Lulu and Al Mowaqqar CRCs. The study evaluated two HIV prevention interventions implemented: a training of trainers and peer education programme executed among CRC inmates in the same year. The study included 167 inmates and 109 CRC staff members (MoH/ PSD/ UNODC, 2011).

*Knowledge of HIV and AIDS:*

General knowledge of those participating in the first study was inadequate; knowledge of the modes of transmission for both HIV and Hepatitis B and C ranged between 51%-70%, and 37%-46% respectively. The assessment of inmates' beliefs of drug abuse in CRCs showed that around 9% believed that substance abuse is prevalent and 19% agreed that physical assaults exist among inmates. 20% believed that sexual practices also exist. 8% of the study population revealed injecting drug use and were also aware that injecting drug use can be a means for transmission of HIV and both HBV and HCV. The second evaluation study carried out revealed an increase in participants' knowledge of HIV and modes of transmission after implementation of the HIV educational interventions (99% of the CRC staff and 97% of inmates indicated an increased knowledge of modes of transmission).

*Unsafe injecting practices and sexual behaviour:*

The studies revealed some risky and unsafe practices among inmates in both CRCs. The inmates admitted the existence of unsafe sexual practices (20%), drug use (9%) and engagement in sexual practices (3%) in CRC premises (MoH/PSD/ UNODC, 2010). Moreover, findings of the evaluation study revealed that around 15% of inmates and 12% of workers believe that inmates have sexual practices while in CRCs, and 4% of inmates admitted having had sex during their stay (MoH/PSD & UNODC, 2011).

*CRC inmates constitute a vulnerable population group with data available, although limited, revealing inadequate knowledge of HIV and AIDS and existence of unsafe practices among them. More efforts need to be in place to study this population group and design evidence informed prevention interventions that are effective in halting any possible spread of HIV.*

## **6. National Response to the AIDS Epidemic:**

### **6.1 Prevention**

A number of HIV prevention interventions were initiated in Jordan since a significant amount of time and are still in place to date: screening of all donated blood, inclusion of HIV health education in the curriculum of secondary school students, continued professional development of health care providers on new treatment guidelines and protocols are only to mention a few. *HIV prevention* efforts were mostly managed by the MOH/NAP in the past two years, with an increased support from various governmental, nongovernmental, bilateral and multilateral organisations (Mol/PSD, MoE, RMS, IRD, JHAS, ZENID, Qudorat Society, Positive Vision Association, Bushra centre for studies, Family and childhood protection society, Mena Friends of Global Fund, JHAS, UNODC, ILO, UNFPA, UNESCO, UNICEF, UNHCR, WHO and UNRWA), and a broad involvement of a range of population groups, including media personnel, religious and community leaders, youth, and Iraqi refugees (guests). The involvement of civil society organizations facilitated the reach out to a total of **3679** individuals from key populations at higher risk with various HIV prevention activities (1345 FSWs, 1020 MSM, and 1314 IDUs).

Additionally, the development of a draft policy on HIV and AIDS and World of Work in 2011 constitutes an important success, setting out international standards pertaining to the workplace, with the aim of strengthening prevention efforts and facilitating access to treatment, care and support measures for persons living with HIV (ILO, 2011).

Despite the reasonable achievements in implementing HIV prevention activities among the general population and population groups at higher risk in the past two years, data on the comprehensiveness and effectiveness of the various interventions that aimed at awareness raising and attitude and behaviour change is scarce. Moreover, emphasis is on the collection of quantitative data in this regards with minimal consideration of the qualitative aspects of interventions implemented.

The following table summarizes data available on the main HIV prevention interventions executed in 2010-2011:



**Table IV:** Summary- HIV Prevention Interventions (2010-2011)

<b>HIV Prevention Interventions (2010-2011)</b>			
<b>Activity, Service, Commodity</b>	<b>Message Content</b>	<b>Delivery Mode</b>	<b>Target Population/Setting</b>
HIV Prevention Interventions for the General Population (including vulnerable population groups)			
1. A draft policy on HIV and AIDS and World of Word was developed last December by employers, workers and involved stakeholders.	<i>The National Policy</i> developed is based on Recommendation 200 which sets out international standards pertaining to the workplace, with the aim of strengthening prevention efforts, facilitating access to treatment, care and support measures for persons with HIV. The issue of mandatory HIV testing is still under debate.	-- ----	PLHIV, employers, workers and involved stakeholders.
2. Increased involvement of the Civil Society Organizations in HIV Prevention efforts	- Community mobilisation for an effective national response - Capacity building of CSOs on HIV education, advocacy, and implementation of outreach programmes targeting various population groups including key populations at higher risk.	-NAP facilitated seminar at MoH  -NAP led training workshops	-41 community leaders/ CBO representatives  -16 NGOs and CBOs.
3. Reproductive Health Education	Reproductive health/ healthy lifestyle including HIV and AIDS.	Trainings and awareness raising sessions at Community based organizations	-Training workshops targeting women and youth from both genders in Amman, Mafraq, Madaba, Zarqa and Jordan Valley -Awareness raising sessions for a total of 800 youth (males and females)
4. HIV and AIDS Education	HIV and AIDS Education Stigma and Discrimination VCT services	Trainings and educational sessions in various settings	- Educational sessions for members of the army in the United Nations peace keeping mission - Educational sessions for new employees joining the RMS- an average of 10,000 annually - Training programme for a total of 71 media specialists - Training a core team of MoE and MoH staff -Training of 60 scout leaders in schools on life skills for HIV prevention - 256 peer educators from public

			<p>and private educational institutions and community leaders trained on peer education and HIV health education, reaching out to almost 15000 youth in public and private schools, youth clubs, universities and colleges.</p> <ul style="list-style-type: none"> <li>- Educational sessions for unemployed youth and vulnerable women (widowed, divorced, house maids) in Irbid governorate*</li> <li>- Educational sessions for university students in Irbid governorate*</li> <li>- Vulnerable Iraqi women in Zarqa governorate trained and reaching out to 250 women from their communities.</li> <li>- Educational sessions implemented for 100 Palestinian Refugee Camps' Leaders</li> <li>- 140 religious leaders reached with 5 educational sessions</li> <li>- Distribution of 20,000 information booklets to promote Iraqi refugees and asylum seekers' access to governmental health services.</li> </ul>
5. Awareness raising campaign on the dangers of drugs	The dangers of drugs and their impact on the physical and mental health of individuals and their psychosocial wellbeing.	University settings	University students (University of Jordan, Jordan University of Science and Technology and Al Yarmouk University).
6. Humanitarian Campaign for Health Impact	"I live my rights and respect other peoples' rights" & "My Health is my culture , colour, art and sport"	Community based awareness sessions and message through the press, TV, radio and social networks	A Health Carnival was executed by MENA Friends of Global Fund bringing together public and private sectors, civil society, athletes, artists and activists to convey health messages including those on HIV and AIDS and the rights of PLHIV.
7. Voluntary Counselling and Testing for HIV	Know Your infection status	VCT centres	All members of the public; a special emphasis on key populations at higher risk.
HIV Prevention Interventions targeting Key Population Groups at Higher Risk			
1. Condom distribution programmes		Community based organizations – Outreach programmes	A total of 40,000 male condoms were distributed among key populations at higher risk (FSWs, IDUs and MSM)
2. HIV Testing and Counselling	Know your infection status	VCT centres	An initiative to encourage a total of 120 Key Populations at higher risk

			(FSWs and MSM) residing in the Zarqa governorate to do the HIV test.
3. HIV and AIDS Education	HIV and AIDS basic education Safer practices to prevent HIV transmission Stigma and Discrimination VCT Services	Community based sessions and outreach programmes	- 1100 IDUs reached with various awareness raising messages in Amman, Zarqa, Irbid and Aqaba governorates - 1345 FSW reached in Amman, Zarqa, Irbid governorates - 1020 MSM reached in main governorates in Jordan - 25 women who have sex with women (age 18-24 year) reached in Amman
4. Provision of medical insurance and treatment programmes for key populations at higher risk	-----	JHAS clinics	JHAS offered free comprehensive medical insurance for a number of MSM and FSWs contacted through their outreach program
5. Community outreach programme for IDUs	Dangers of drugs, unsafe practices, information on drug treatment centres and awareness on HIV, modes of transmission and VCTs	NGO led outreach programme	214 IDUs reached out with various messages/ distribution of IEC material on dangers of drugs.
6. Livelihood alternatives to commercial sex	--	IRD/ Local NGOs	20 FSWs were economically empowered through microfinance projects
HIV Prevention Interventions targeting Health Care Providers			
1. Specialized training on universal precautions for Infection control, followed by field monitoring visits	Standard precautions and infection control guidelines for health care settings	Infection Control division at MoH,	Health care staff at 58 Health facilities, including the blood bank
2. HIV and AIDS Education	HIV and AIDS education with a focus on treatment and care for PLHIV	Health care facilities	- Training of 85 MoH health care providers (General practitioners, nurses and other ancillary staff). - Training of all health care providers at the Jordanian Health Aid Association
3. Capacity building of Health care providers on management of sexually transmitted infections	Syndromic approach to the management of patients with STI symptoms, and the treatment of STIs (WHO guidelines)	Health care facilities	120 MoH physicians and health workers
4. General training on disease surveillance with a special focus on STIs	Disease surveillance (focus on STIs)	UNRWA- 24 health centres	50 medical officers and 50 nurses
5. Educational sessions on promotion of condoms	Enhanced promotion of condom use among key Populations at higher risk	Health care facilities	Four seminars were conducted for a total of 92 health care providers

*\*Male condom promoted*

## 6.2 Treatment, Care and Support

The ministry of Health/ National AIDS Programme is the sole entity responsible for the provision of free of charge treatment for all Jordanian PLHIV in the country. The Care and Treatment unit (part of Amman's, the capital VCT centre) monitors the HIV patients' diagnostic and prognostic indicators in accordance with national guidelines (Plasma CD4 and CD8 counts and viral load testing, TB and Hepatitis B and C screening), TB preventive therapy and TB infection control. Moreover, it provides antiretroviral therapy and medications for opportunistic infections' for all eligible Jordanian PLHIV. Until the end of 2011, the cumulative number HIV positive persons enrolled in ARV treatment was **108** (86 males and 22 females), 91 of whom were regular patients and 17 adhering to the medication irregularly; only two patients were under 15 years of age. Only first line drug regimens are available, and although there have been no evident signs of drug resistance, some patients suffer from side effects, the matter that necessitates changing to a different first line ARV treatment. Changing to second line regimens in the near future is currently under debate<sup>5</sup>.

Furthermore, the Treatment and Care unit responds to other medical needs of PLHIV (quarterly medical examinations, distribution of first aid kits, referral to other medical care providers and condom distribution). In 2010, a hospital referral system was activated through appointing a focal person at Al Basheer government hospital to facilitate PLHIV access to needed medical care. The unit further responds to many of the psychosocial needs expressed by PLHIV through individual counselling sessions, home based-care programme and referrals to other social services. Over the past two years, a total of 213 home visits were executed. The unit also facilitates the patients' acquirement of financial support from the National Aid Fund/Ministry of Social Development and other available sources (donations from some well off patients). During the past two years (2010-2011), a total of 20 PLHIV received financial support from NAF/MOSD and on a monthly basis (40 JD/month). Moreover, PLHIV accessing the unit receive general awareness on nutrition and healthy lifestyle and on measures of safe handling of blood and other bodily fluids.

---

<sup>5</sup> Personal Communication with NAP/VCT and a group of group of 8 PLHIV in Amman; March, 2012.

## **7. Best Practices**

- Creation of an Association for People Living with HIV in Jordan. PLHIV comprise the majority of members of the association (50 members- 36 males and 14 females). The association represents PLHIV in various dealing. Moreover, the association facilitates networking among the group members and supports attainment of their basic needs. The association succeeded in securing a 40,000 USD fund from the Ministry of Social Development for capacity building purposes. Additionally, the association succeeded in reaching out to a significant number of MSM, some IDUs and FSWs with effective HIV prevention interventions.
- Expansion of successful partnerships among the various stakeholders, such as NAP's partnership with the Public Security Department (AND and CRCs) and with local NGOs facilitating effective reach out to most at risk and vulnerable population groups with various HIV prevention interventions.
- Establishment of a special department for Public Health of Correction and Rehabilitation Centres. The department is allied with the Primary Health Care directorate at the Ministry of Health. The department has an open vision for including primary prevention interventions that tackle existent unsafe practices among inmates in all 13 CRCs in Jordan.

## **8. Major Challenges and Remedial Actions:**

### **8.1 Multisectoral Response:**

- HIV does not constitute a priority on the national agenda of decision makers. Low HIV prevalence and the existing socio-political situation in the country, fuelled by financial hardships and regional instability hardly recognise the crucial role for prioritising HIV prevention in the country. MoH/NAP will take the lead and involve all sectors to prioritise the national response. In light of the PSD/AND revising their National strategy to fight drugs, NAP will provide the required assistance to include HIV and AIDS as an important thematic area in the amended version for the years 2013-2014.
- The coordination and commitment of the various UN Theme Group members on HIV, to devote time and resources to address and integrate HIV and AIDS as an important developmental matter has been a challenge. It has been agreed that this constitutes a priority area for improvement in 2012. Moreover, the UN Country Team has included HIV in the new draft UNDAF document (2013-2017).
- The important role of the private sector in the national response to HIV is very limited. Moreover, and in light of the new development in Jordan's ineligibility to apply for the Global Fund (Transitional Funding Mechanism), UNAIDS will support NAPs' resource mobilisation efforts in country with a special focus on the private sector, utilising available Corporate Social Responsibility structures.
- The involvement of the civil society organisations in the national AIDS response was significant in the past two years. More emphasis should be placed on improving their capacity and active engagement in the processes of planning, execution and monitoring and evaluation of various interventions, nurturing an improved sense of ownership of the matter.

### **8.2 Adequate Capacity**

- The NAP is responsible for overseeing and monitoring the work of all VCTs in the country, with the main VCT in Amman taking the lead in data collection, analysis and final reporting. Despite the availability of official documentation forms, many are not completed properly. Reporting to the main VCT from various governorates is scarce, with only four VCTs submitting their reports in 2010 and only two in 2011. A new policy was adopted to overcome this challenge, comprising building the capacity of responsible staff on data collection, analysis and reporting.
- Technical capacity of the staff working in VCTs requires improvement. Capacity building efforts should focus on updating the staff's knowledge on new scientific information on HIV and AIDS, including treatment protocols and guidelines and programmes for psychosocial counselling skills' improvement.

- There is a need to improve the quality of existent drug treatment and rehabilitation programmes. There is strong opposition for introducing important components of Harm reduction programmes for IDUs, especially by the Anti Narcotics Department. Moreover, very scarce are the allied health professionals needed in fields of psychology, clinical psychology and occupational therapy. More collective efforts should advocate for introducing harm reduction programmes in the near future.
- The rapid identification and treatment of Sexually Transmitted Infections (STIs) is an important element in controlling HIV; a number of effective interventions to control STIs exist, including syndromic management of genital ulcer disease and urethral discharge, syphilis testing of pregnant women and individuals diagnosed with other STIs are only a few. Services for STIs are a critical component of comprehensive HIV prevention and reproductive health programmes, providing an opportunity to offer provider initiated HIV care and treatment interventions. (WHO/ UNIADS/UNICEF, 2011).  
Data on Sexually transmitted infections is very scarce in Jordan, thus prohibiting the accurate interpretation of HIV epidemiological risk factors. Moreover, findings from a recently completed STIs Case management assessment showed that the prescription of treatments is mostly based on the history of illness with low rates of medical examination and a weak counselling component.<sup>6</sup> More efforts need to focus on improved management, documentation and reporting on STIs in the future.
- A number of challenges that prevent the development of an effective national M&E system were highlighted; limited number of professionals with required M&E expertise in Jordan and at NAP/MOH, lack of necessary tools to gather data and lack of a management information system to store and analyse data to further guide the national response. Moreover, the high turnover of NAP's partners' staff (mainly relevant NGOs) and lack of sustainable financial resources are also contributing factors. A modest response to all this was a training conducted by MoH in 2010 for a group of 77 staff members from MoH and various partner organizations on M&E basic concepts, data collection methods and report writing. In light of development of a new National Strategic Plan on HIV and AIDS for Jordan (2012-2016), work is in place to develop a monitoring and evaluation system that best monitors and evaluates the national response for the coming five years.

### **8.3 Reaching Key Populations at Higher Risk with Effective HIV Prevention Interventions:**

- Data on key populations at higher risk is very limited in Jordan. Proper population size estimations and more investment in surveillance and robust research is required; reaching the hidden IDU, MSM and FSW populations in Jordan to better understand transmission dynamics, and existing behaviours that increase the risk of exposure to HIV, and better support the design

---

<sup>6</sup> MoH/NAP. Unpublished findings of an assessment on STI case management.

and implementation of more effective HIV prevention and care interventions in the future. Moreover, and as many of the IBBS study respondents have indicated never having had an HIV test (73% IDUs, 63% MSM and 80% of FSWs) there is a need to improve available VCT services and promote their use through the most effective means among members of key populations at higher risk.

- Many of the prevention efforts that aim at knowledge, attitude and behaviour change are not based on theories of behaviour change and thus have very limited impact on targeted populations. Moreover, there is a need for creating new effective IEC materials or utilizing whatever is available from internationally renowned sources after tailoring them to Jordanian social context. Although a media strategy exists for the same purpose, there is a need to revitalize its implementation through various media channels.
- Challenges existed in successful condom distribution to the targeted populations in the past two years, the matter that led to moving this HIV prevention component to the directorate of mother and child health and its distribution through reproductive health programs. A total of 514 thousand condoms have been distributed in 2010. More efforts are required to promote and distribute condoms, especially among key populations at higher risk. The involvement of civil society organisations in this regards is crucial.

#### **8.4 Enabling Environment:**

- HIV testing continues to be Mandatory for a number of population groups. UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. More advocacy efforts are required to change the policies in place and to nurture voluntary testing (that is accompanied by counselling for the patient and referral to medical and psychosocial services whenever needed), which is more likely to result in behaviour change to avoid HIV transmission (WHO, 2005).
- Drug abuse is criminalised in Jordan. An important advancement is a recent amendment proposed in the draft law on Narcotic Drugs and Psychotropic substances containing not to raise public interest litigation on the drug abuser caught for the first time, conditional upon transfer for treatment in the specialized PSD/AND rehabilitation centre and keeping a temporary register for him/her. If adopted, this amendment will facilitate the access of the drug abuser to available services (including HIV prevention interventions).
- Stigma and discrimination continue to fuel marginalisation of PLHIV in society and curtails enjoyment of their rights. More effective interventions are required to overcome this challenge at the level of the general public and that of PLHIV themselves. More emphasis is required to raise awareness on HIV and AIDS and change attitudes and behaviour of the general public (with an emphasis on health care providers). Moreover, more involvement of PLHIV in national activism is to be nurtured.



## **9. Monitoring and Evaluation Environment**

Despite achievements attained in the last two years in monitoring and evaluating the national AIDS response, challenges still exist in developing a National M& E system functioning across a range of sectors (governmental and nongovernmental organizations), various service delivery areas and at different levels of implementation (central and directorate levels). Most of existent monitoring and evaluation efforts focus on programme activity monitoring and programme evaluation. NAP has an M&E plan that is based on the GFATM funded programme, with a specific set of objectives, service delivery areas and indicators; almost 7.5% of the GFATM fund is allocated for M&E purposes.

There is no specialized M&E unit for HIV, and the work is mainly dependent on a core team (4 full time and 15 part time staff members) from NAP at the central and directorate levels and some active NGO staff members. Full time staffs allocate almost 15% of their time for M&E. A Country Coordinating Mechanism Committee is in place and includes representatives from the government, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses and people living with the diseases. The CCM mainly oversees and guides implementation of various programmes under the GFATM AIDS and TB grants.

HIV surveillance is mainly based on case reporting from the various public and private hospitals and laboratories, blood bank and VCT centres. Data is also collected on various demographic characteristics of the patients, possible mode/s of transmission. Additionally, data is gathered on various clinical aspects of patients on ART. NAP has an HIV and AIDS focal point in each of the twelve health directorates in Jordan. HIV and AIDS data is centrally located and analyzed at NAP.

Moreover, data on HIV is also available from a limited number of small scale quantitative and qualitative studies, mainly conducted among key populations at higher risk in the past two years. In 2008, the first Integrated Biological and Behavioural Surveillance was carried out among Key populations at higher risk (female sex workers (FSWs), injecting drug users (IDUs) and men who have sex with men (MSM)) and for which the data was analyzed in 2010. The study included a total of 1,125 participants (450 FSWs, 468 MSM and 207 IDUs) and was executed in four main governorates in Jordan, namely, Amman, Irbid, Zarqa and Aqaba. Although the study findings provide some useful insights on these population groups, interpretation of the study findings has to be carried out with immense caution due to methodological challenges (sampling methodology, eligibility criteria for participants' recruitment and the actual execution of the study), undermining the internal validity and generalisability of the findings to the larger key populations at higher risk in the country. The NAP is currently preparing for execution of a second IBBS in the current year.

## **10. Annex I:**

### **NCPI - PART A [Government officials]**

Organization	Name/ Position	Respondents to part A					
		A.I	A.II	A.III	A.IV	A.V	A.VI
Ministry of Health/NAP	Dr. Bassam Al Hijawai /Director						
Ministry of Health/NAP	Dr Assad Rahhal/Deputy Manager of NAP Mr. Ahmad Nasralla Mr. Abdulla Hanatleh Ms. Sahar Al shamayleh						
Ministry of Health/NAP-VCT	Dr Hydar Khasawneh Mr. Mohammad Al Bashiti Mr. Yousef Al Najjar						
Ministry of Health	Dr Naser AL Adham/Head of CRC Public Health department						
Ministry of Health	Dr. Jamal Anani/ Director of the National Centre for Rehabilitation of Addicts						
Ministry of Education	Mr. Mohammed Kiswani/AIDS focal person						
Ministry of Islamic Affairs	Dr. Abdel Rahman Bdah/ AIDS focal person						
Royal Medical Services	Dr. Mohammed Al Zoubi						
Ministry of Tourism	Ms. Hana Kharabsheh						
Ministry of Youth	Mr. Mohammad Jaradat						
Ministry of Interior/Public Security Department – Anti Narcotics Department	Brigadier Anwar Al Tarawneh/ Colonel Mazen Magableh / Director of Substance Abuse Treatment Centre						

## NCPI - PART B [Civil Society organizations, Bilateral agencies, and UN organizations]

Organization	Name/ Position	Respondents to part B				
		B.I	B.II	B.III	B.IV	B.V
Positive Vision Association	Mr. Samer Al Mahmoud/Director					
National Centre for Human Rights	Mr. Taha Maghareiz/AIDs focal person					
Queen Zein Al Sharaf Institute for Development	Ms Sawsan Al Majali/ Director Ms. Tahani Shahrouri /Project Manager					
Jordan River Foundation	Ms. Iman Aqrabawi/ Project Manager					
Bushra Centre for Studies	Ms. Jihan Mourjan/ Director					
Qudorat Society	Ms. Maha Abu Libdeh/ Director					
MENA Friends of Global Fund	Ms Rawan Ababneh/Director					
Family and Childhood Protection Society	Mr. Fadi Dawagreh/ Project Coordinator					
Jordanian Red Crescent	Ms. Zeina Al Masri / Project Coordinator					
Jordan Nursing Council	Ms. Isa Nioashi / Coordinator					
Jordan Health AID Society	Ms. Abeer Al Natour / AIDS project coordinator					
Caritas	Ms. Soufia Nafa/ Coordinator					
Family Development Association	Ms. Fatima Zomer/ Coordinator					
Friends of Development and Investment Association	Mr. Ali Noubani /Director					
Aman Association	Dr. Mahmoud Sarhan/Director					
Jordanian Scouts and Guides Association	Mr. Khalil Amaireh					
Jarasia Association	Ms. Jalillah Smadi /Director					
Jordanian Woman Association	Ms. Nisreen Sarhan / Director					
Future Guardians Association	Ms. Abeer Shoriqui /Director					
Church Council	Mr. George Hazou/Director					
Jordan Association for Family Planning and Protection	Ms. Wafa Naffa / Communication officer					
IRD	Ms. Mona Hamzah/ Health Program/Director					
UNFPA	Ms. Layali Abusir					
UNODC	Ms.Yasmine Refaat HIV Project Officer and Mr Amjad Al A'darbeh/Project Coordinator					
UNRWA	Dr. Ali Nimer					
ILO	Ms Michela Martini Regional Specialist for HIV/AIDS					
WHO	Dr Nada Al Ward Sub-Regional EHA Coordinator					

### 11. Annex II: NCPI

## **12. References:**

1. Abu-Raddad, L., Akala, F., Semini, I., Riedner, G., Wilson, D. and Tawil, O. (2010). *Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa*. World Bank, 2010. Available at: [http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/06/04/000333038\\_20100604011533/Rendered/PDF/548890PUB0EPI11C10Dislosed061312010.pdf](http://www.wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/06/04/000333038_20100604011533/Rendered/PDF/548890PUB0EPI11C10Dislosed061312010.pdf) , accessed on March 2<sup>nd</sup>, 2012.
2. **Department of Statistics, (DoS) Jordan** (2008). *Jordan Population and Family Health Survey 2007*. Amman: Department of Statistics.
3. **Department of Statistics (DoS), Jordan** (2010a). *Jordan Statistical Year Book 201*.
4. **Department of Statistics, (DoS) Jordan** (2010b). *Jordan Population and Family Health Survey 2009*. Amman: Department of Statistics.
5. **ILO**, (2011). *HIV and the Workplace in Jordan: "Analysis and Priority Setting in relation to policy and practice on HIV and AIDS and the Workplace in Jordan"*, 2011.
6. **MoH, USAID, FHI, UNAIDS and WHO** (2005). *National Strategic Plan on HIV/AIDS in Jordan (2005-2009)*. Amman: Ministry of Health, National AIDS Programme
7. **MoH/CDD** (2010). *Annual Statistical Report (2010)*. Amman: Ministry of Health, Communicable Disease Directorate.
8. **MOH/NAP** (2010). *Preliminary Unpublished Results of Integrated Biological-Behavioural Surveillance Study*. Unpublished preliminary data. Amman: Ministry of Health, National AIDS Programme.
9. **MoH/NAP, PSD and UNODC** (2010). *Preliminary unpublished results of a biological and behavioural assessment on drug use and HIV, HBV and HCV prevalence in all 13 CRCs in Jordan*. Amman: Ministry of Health, National AIDS Programme.
10. **MoH/NAP, PSD and UNODC** (2011). *Unpublished results of the evaluation of drug use and HIV prevention programmes in Om Al Lulu and Al Mowaqqar CRCs in Jordan*. Amman: Ministry of Health, National AIDS Programme
11. **MoH/NAP and UNAIDS** (2011). *National Strategic Plan on HIV/AIDS in Jordan (2012-2016)*. Amman: Ministry of Health, National AIDS Programme
12. **MoH/NAP, PSD, UNODC and Future Guardians NGO** (2011). *The Knowledge, Attitudes and Practices of group of IDUs on HIV, HCV and Drugs*, Study Report, Jordan 2011.
13. **MoPIC/UN**, 2010. *"Keeping the Promise and Achieving Aspirations, Second National Millennium Development Goals Report Jordan 2010*.
14. **PSD/ AND** (2009). *National Strategy to Fight Drugs*. Amman: Public Security Department, Anti Narcotics Department.
15. **UNAIDS**, (2011). *Middle East and North Africa Regional Report on AIDS, 2011*.
16. **World Bank**, (2011). *Jordan Country Data*. Available at: <http://data.worldbank.org/country/jordan>, accessed on January 30<sup>th</sup>, 2012.
17. **WHO, UNIADS and UNICEF**, (2011). *Global HIV/AIDS Response- Epidemic update and health sector progress towards Universal Access- Progress Report 2011*.
18. **WHO**, (2005). *Scaling up HIV Testing and Counselling Services: A Toolkit for Programme Managers*. Available at: <http://www.who.int/hiv/pub/vct/counsellingtestingtoolkit.pdf> , accessed on March 2<sup>nd</sup>, 2012.

LX