Country Progress Report

-Hashemite Kingdom of Jordan-

Report to the Secretary General
Of the United Nations on the
United Nations General Assembly Special Session
On HIV/AIDS

January 2008 – December 2009

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I. Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BSS	Behavior Surveillance Survey
CBO	Community Based Organization
CCM	Country Coordination Mechanism
CRIS	Country Report Information System
CSW	Commercial Sex Worker
ECD	Early Childhood Education
ER	Emergency Room
FHI	Family Health International
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, TB and Malaria
GOJ	Government of Jordan
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
IDU	Injecting Drug User
IEC	Information, Education and Communication
KAP	Knowledge, Attitude and Practice
M&E	Monitoring and Evaluation
MARPS	Most – at – Risk Populations
MENA	Middle East and North Africa
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Interior
MSM	Men who have Sex with Men
NAC	National AIDS Committee
NAP	National AIDS Program
NAS	National HIV/AIDS Strategy
NCPI	National Composite Policy Index
NGO	Nongovernmental Organization
PLHIV	People Living With HIV
PMCT	Prevention of Mother-to-Child Transmission
ROMENA	Regional Office for the Middle East and North Africa
SBC	Strategic Behavior Communication
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UOJ	University of Jordan
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WAD	World AIDS Day
WHO	World Health Organization

II. Status at a glance

a. the inclusiveness of the stakeholders in the report writing process

The preparation and submission of the 2010 UNGASS report was led by the Ministry of Health/National AIDS Program and the United Nations Theme Group on HIV/AIDS, with the financial support of UNAIDS. A contract was initiated in December 2009 with a third party consultant to conduct a desk review of available literature, collect and collate existing data, consult relevant stakeholders and draft the report. Interviews were carried out with government officials and representatives of civil society for input into the narrative section and the National Composite Policy Index.

An UNGASS support committee was formed in late 2009 exclusively to support and guide the preparation of this report. Members of the committee included senior officials from the National AIDS Program and representatives of government and civil society. The committee met regularly during the development of the report, completed the National Composite Policy Index and provided feedback, support and guidance throughout the process. The names and positions of the UNGASS support committee members can be found in Annex III of this report. Interviews for the NCPI were also conducted with additional government and non-government organizations and agencies.

The 2010 UNGASS report for the Hashemite Kingdom of Jordan was endorsed at a Validation Workshop held on February 23, 2010 in Amman, Jordan, under the auspices of His Excellency, the Minister of Health. Representatives of government and UN agencies, NGOs, CBOs and PLHIV attended the half-day workshop and participated in working group and plenary discussions to validate the narrative report, the indicator data and the NCPI.

b. the status of the epidemic

- Reported number of Jordanians living with HIV at the end of 2009: 122
- Reported number of Jordanians who have died of AIDS as of December 2009: 90
- Number of cases reported in 2009: 14 cases; 13 male and 1 female
- UNAIDS/WHO/ UNICEF 2008 Epidemiological Fact Sheet on HIV and AIDS for Jordan estimates that HIV prevalence among adults and children is <1000
- Populations most-at-risk: In a low prevalence setting such as Jordan, prevention efforts focus on sex workers, men who have sex with men and people who inject drugs.

c. the policy and programmatic response

Jordan is executing a multi sectoral response to HIV/AIDS, led by the National AIDS Program and guided by the National AIDS Strategy. Through the extensive collaboration of all stakeholders, Jordan has succeeded in meeting the three main requirements to scale up towards universal access: ***one*** agreed HIV/AIDS Action Framework - the National AIDS Strategy - which provides the basis for coordinating the work of all partners, ***one*** national AIDS coordinating authority - the Country Coordination Mechanism - that has a broad-based, multi-sectoral mandate and ***one*** agreed country-level monitoring and evaluation system. The key focuses of the National AIDS Strategy are the prevention of the spread of the virus and the treatment, care and support of PLHIV.

The programmatic response to HIV/AIDS in Jordan is currently funded by two key sources; the GOJ annual budget and Global Fund. The first Global Fund grant was a result of the Round 2 call for proposals in 2002, and provided support to the NAP from November 2003 to October 2006. The second grant, accounting for approximately 36% of total HIV/AIDS spending in Jordan, commenced in July 2007 and will continue until mid-2012. The main strategies of the program are to collect, analyze and use strategic information related to the spread of HIV/AIDS and the national response to the epidemic in Jordan; to prevent HIV transmission in Jordan; to create an enabling environment in which an effective national response to HIV/AIDS can take place; and to provide care, support and treatment for PLWHA, thus mirroring the objectives laid out in the National

AIDS Strategy. A key element of the program supported by Global Fund is to strengthen the role of civil society organizations in supporting these objectives.

d. UNGASS indicator data in an overview table

Indicators	Value	Comments
National Commitment and Action		
1.Domestic and international AIDS spending by categories and financing sources	Domestic: $1,245,000 International: $1,854,000	Available data are not classified by spending categories
2.National Composite Policy Index	-	See Annex II
3.% of donated blood units screened for HIV in a quality assured manner	Numerator = 175012 Denominator = 175012 **Indicator value = 100%**	• Documented standard operating procedures for HIV/AIDS screening are followed for every unit of blood • All laboratories undergo an External Quality Assurance Scheme Source: National Blood Bank Records
4.% of women and men with advanced HIV infection receiving antiretroviral therapy		Not available
5.% of HIV positive pregnant women who received antiretroviral medication to reduce the risk of mother to child transmission	Numerator = 0 **Indicator value = 0%**	• No reported HIV positive pregnant women • Source: NAP records
6.% of estimated HIV positive incident TB cases that received treatment for TB and HIV	Numerator = 0 **Indicator value = 0%**	• No reported HIV positive TB cases • Source: MOH records
7.% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	-	Not applicable
8.% of most at risk populations who received an HIV test in the last 12 months and who know their results	-	Not available
9.% of most at risk populations reached by prevention programs	-	Not available
10.% of orphaned and vulnerable children whose households received free basic external support in caring for the child	-	Not applicable
11.% of schools that provided life skills - based HIV education within the last academic year	-	Not available
Knowledge and Behavior Indicators		
12.Current school attendance among orphans and non orphans aged 10-14	-	Not applicable

13.% of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		Not available
14.% of most - at - risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	-	Not available
15.% of young women and men aged 15-24 who have had sex before the age of 15	-	Not available
16.% of adults aged 15-49 who have had sex with more than one partner in the last 12 months	-	Not applicable
17.% of adults aged 15-49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	-	Not applicable
18.% of female and male sex workers reporting the use of a condom with their most recent client	Numerator = 115 Denominator = 225 **Indicator value = 51%**	Source: Preliminary BSS Data
19.% of men reporting the use of a condom the last time they had anal sex with a male partner	-	Not available
20.% of injecting drug users reporting the use of a condom the last time they had sex	-	Not available
21.% of injecting drug users reporting using sterile injecting equipment the last time they injected	-	Not available
Impact Indicators		
22.% of young women and men aged 15-24 who are HIV infected		Not available
23.% of most - at - risk populations who are HIV infected	Numerator = 0 **Indicator value = 0%**	BSS and NAP records of CSW and MSM
24.% of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	Numerator = 65 Denominator = 68 **Indicator value= 96%**	Source: NAP records
25.% of infants born to HIV - infected mothers who are infected	Numerator = 0 **Indicator value = 0%**	• No infants born to reported HIV infected mothers • Source: NAP records

III. Overview of the AIDS epidemic

The first HIV case was discovered in Jordan in 1986. As of December 2009, the cumulative total number of all HIV/AIDS cases detected in Jordan was 713, of which 212 were Jordanian nationals, 90 of whom are now deceased. Among all Jordanian cases, sexual transmission remains the main mode of infection, accounting for 60% of all infections, followed by blood and blood products for 28% of reported cases, 2% through injecting drugs, 4% by vertical transmission, and 6% unknown. The age groups most

affected among reported cases are those between the ages of 20-29, 30-39, and 40-49 years old. These age groups represent 26%, 34%, and 14% of all cases respectively. 81% of all infected persons are male. Of the reported cases among Jordanians, 57% are in the capital Amman, with Irbid and Zarka the next highest governorates with 15% and 13% respectively. 22% of the cases are believed to have been infected inside Jordan, 74% outside of Jordan and 5% of cases are undetermined.[1]

There are currently no reported HIV infections among multi-transfused patients, military personnel, TB patients or pregnant mothers.[2]

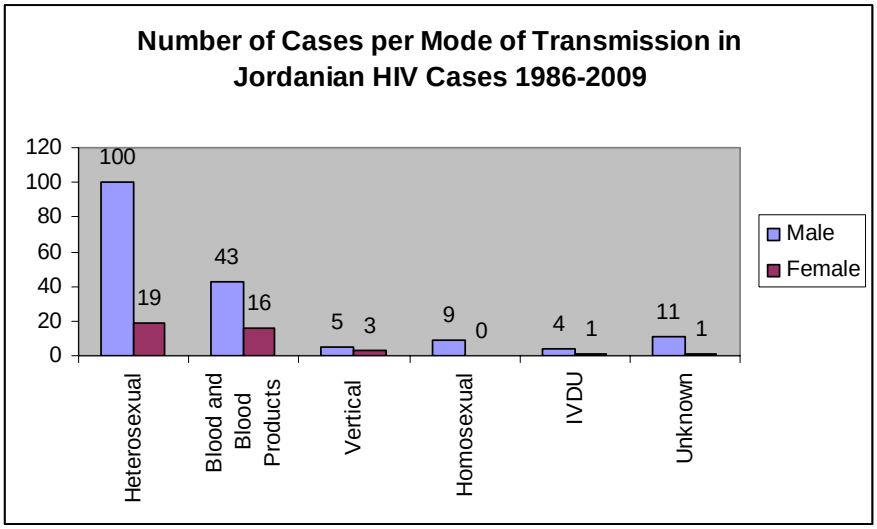

Figure 1: Number of Cases per Mode of Transmission in Jordanian HIV Cases 1986-2009

[1] National AIDS Program Records, December 2009
[2] National AIDS Program Records, December 2009

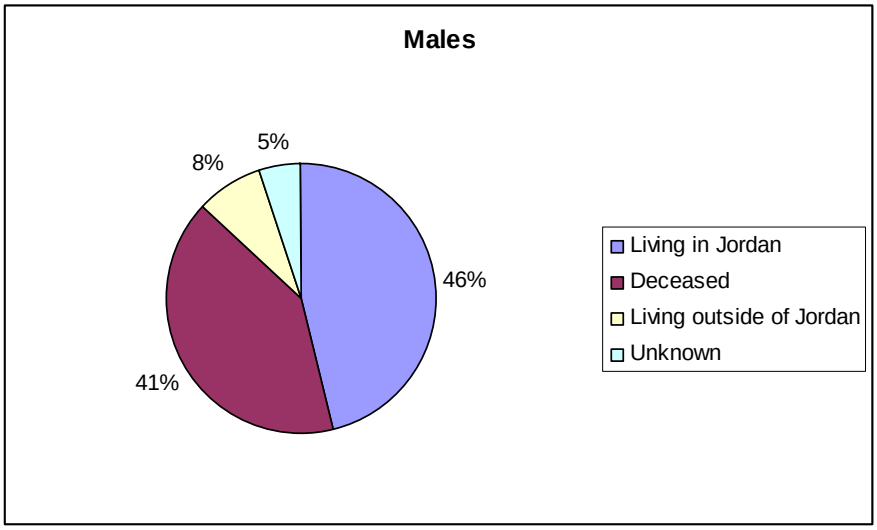

Figure 2: Current Status of Jordanian Male HIV Cases

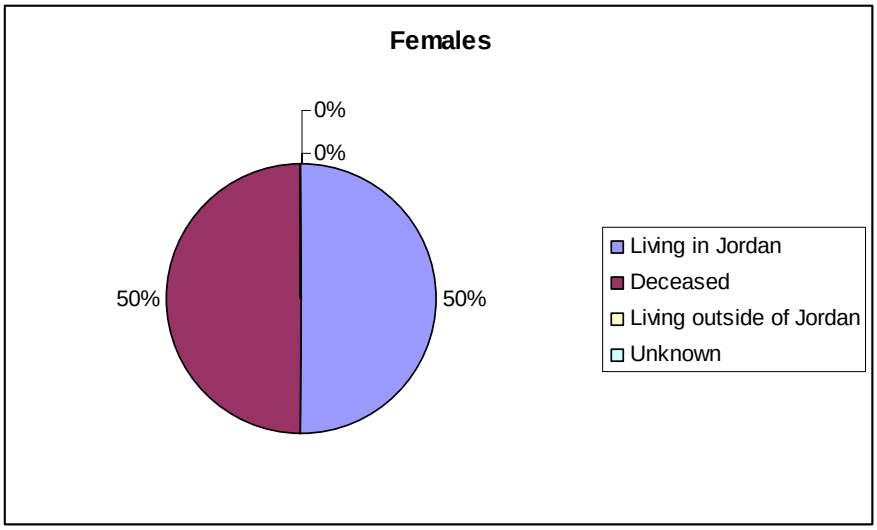

Figure 3: Current Status of Jordanian Female HIV Cases

Though STIs are considered to be an increasing health problem in Jordan, there is limited access to information on STI rates. A small - scale survey of 1,204 women attending obstetric and gynecology services in government hospitals and family planning clinics in 2003 showed rates of 0.7% for Gonorrhea and 1.2% for Chlamydia. The National AIDS Program reports that HIV prevalence amongst STI patients to date has not shown any cases of HIV infection; however it is recognized that these figures are

derived from limited samples. [3] In Jordan, cervical cancer accounts for only 2% of female cancers ranking 13th to 16th among female cancers in the years 2000 to 2004.[4]

Additionally, there is overall consensus in Jordan that the presences of sex workers, injecting drug users and unprotected sexual contacts between men, in addition to broader vulnerability factors, such as large scale mobility due to labor and/or regional conflict and the increased exposure of employees in industrial zones, have implications on the capacity to halt the epidemic. Efforts have been made in the past few years to gather concrete information on prevalence and behavior among vulnerable groups in order to discern the trend and dynamics of the epidemic in Jordan. However, further research is needed and failing to address these factors could lead to increased prevalence rates in the future. [5] The World Bank in its 2005 report 'Preventing HIV/AIDS in the Middle East and North Africa: A Window of Opportunity' estimates that, if left unchecked, the prevalence rate in Jordan could reach 3.7% by 2015 and that if the epidemic reaches this level the economic and social effects would be considerable which would ultimately impact on the capacity to deliver on the Millennium Development Goal 6 to reverse the spread of HIV/AIDS.

[3] FHI/MOH/Family Health Group/University of Jordan *Prevalence of Reproductive Tract Infections in Women attending Selected Urban OB/GYN Clinics in Jordan*, 2003
[4] National Cancer Registry, 2008
[5] National AIDS Program, *Survey of Risk Behavior in Populations Potentially at Risk of Sexually Transmitted Infections in Jordan*, 2008

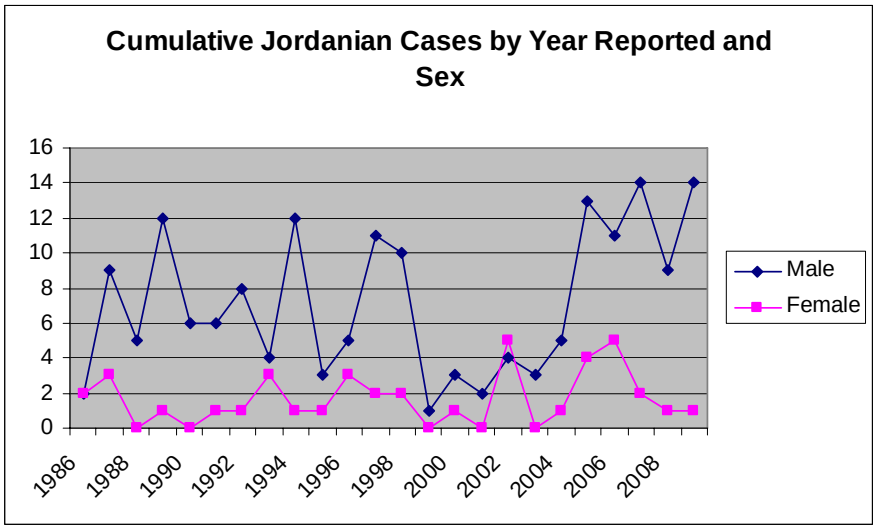

Figure 4: Cumulative Jordanian Cases by Year Reported and Sex

IV. National response to the AIDS epidemic

POLICY

The Jordanian Government and Royal Family have consistently supported the national response to HIV/AIDS which was initiated in 1986 through the establishment of the National AIDS Program, under the Directorate of Disease Control in the Ministry of Health. The *National AIDS Strategy 2005-2009* is a national blueprint for action for Jordan's response to HIV/AIDS, developed by a range of stakeholders – including the National AIDS Committee and the National AIDS Program, other government agencies, UN organizations and international and national non-governmental organizations. The NAS contains an operational plan which includes formal program goals, clear targets, a detailed budget of cost per programmatic area, indications of funding sources and an M&E framework. It's strategic objectives are to collect, analyze and use strategic information relating to the spread of HIV/AIDS and the national response to the epidemic in Jordan, to prevent transmission of HIV in Jordan, to provide care, support and treatment to PLHIV and to create an enabling environment in which an effective national response to HIV/AIDS can take place. All NAP partners have aligned their programs to the strategy. In 2010, the NAP will lead the process of updating the National AIDS Strategy for the coming five years.

The National AIDS Strategy divides target populations into primary and secondary groups. Primary groups include sex workers, men who have sex with men and injecting drug users. Secondary groups include youth, frequent travelers, military and uniformed services, workers in certain sectors (health, tourism and transportation), prisoners, refugees and street children. Cross cutting issues include HIV and poverty, the protection of human rights, the involvement of PLHIV and addressing stigma and discrimination. Target populations were identified through focus group discussions, KAP surveys, a rapid assessment in prison settings, feed back from organizations working with vulnerable populations, educational outreach programs and field visits.

The Ministry of Education has included HIV/AIDS in the middle and secondary school curriculums (grades 6 through 12). Young men and women receive the same information on basic facts, modes of transmission and means of prevention. Jordan has also integrated HIV/AIDS into general development plans such as the National Development Plan and sector-wide approaches such as those developed by the Higher Population Council, the Higher Council for Youth and the Public Security Directorate, which includes the Prison Department, the Anti-Narcotics Department, the Criminal Investigation Department and the Security Prevention Department. Programs implemented among uniformed services include behavior change communication, HIV testing and counseling, STI services and treatment, care and support. Testing is mandatory for peacekeeping forces as they deploy and return.

To increase coordination and cooperation, and improve coherence of policies and programs in order to more effectively address HIV/AIDS and TB, Jordan formed the National AIDS Committee in 1986, followed by the Country Coordinating Mechanism (CCM) in 2002. The CCM has terms of reference and a defined membership with government, private sector and civil society representatives, including PLHIV, and meets regularly. These meetings provide an opportunity for civil society to influence decision making and strengthen donor coordination to avoid parallel funding and duplication of efforts in programming and reporting. The chair of the CCM is the Secretary General of the Ministry of Health.

Though Jordan's legal-regulatory framework is supportive of the National AIDS Strategy in some ways, some laws and the legal vacuum in some crucial areas may have a

limiting impact. Throughout 2008, the National Center for Human Rights conducted three workshops to review general legislation in the Kingdom and examine its capacity to protect the rights of PLHIV. The workshops covered health, medical and educational policies, disciplinary actions and labor laws, social security regulations and civil rights and responsibilities and considered the compatibility of these policies with global standards. PLHIV are not specifically mentioned in Jordanian legislation though they may be able to benefit from the interpretation of a number of laws. For example, disciplinary laws stipulate harsher punishment for rapists who infect their victims with syphilis, social security and labor laws contain articles securing compensation and sick leave for employees who fall ill in the workplace and prison regulations allow for the transfer of prisoners in poor health to medical facilities for treatment. [6] There are no anti discrimination laws pertaining to education or the workplace; on the contrary, laws sanctioning the dismissal of "persons with communicable and infectious" diseases, can be, and are, used to deny PLHIV employment and educational opportunities. Testing is mandatory for non-Jordanians applying for work permits in Jordan and Jordanian nationals seeking employment within government agencies.

Jordan has followed up on commitments towards universal access made during the high level AIDS review in June 2006, and the national strategy and national HIV budget were revised accordingly. Size estimates for the main target populations have been updated, though it is difficult to detect true numbers. However, there are reliable estimates of the current and future needs of the number of adults and children requiring antiretroviral therapy. HIV program coverage is monitored by sex and population groups, including CSWs, IDUs, MSM, youth, prisoners and refugees. The Jordanian Ministry of Health provides free, anonymous, confidential counseling and testing for anyone seeking these services. Social support is provided by the MOSD, and ARVs and treatments for opportunistic infections are covered by the public health insurance plan. Non-Jordanian spouses of Jordanian citizens are included in this coverage scheme and have access to the HIV treatment, care and support system. Non-Jordanian, HIV positive persons who are not married to a Jordanian national are denied residency, as the Kingdom cannot commit the resources necessary to cover their care.

[6] National Center for Human Rights, *Technical Workshop Report*, 2008

Prevention

With the ultimate goal of maintaining low prevalence in the country, current efforts have focused on health education, training of health care providers, surveillance, laboratory and blood safety, expanding VCT, care and support, and behavioral research. General IEC messages focus on sexual abstinence, faithfulness, reduction of the number of sexual partners, avoidance of commercial sex and the injection of drugs, testing for HIV, greater acceptance of PLHIV and universal precautions for health workers. Condom use is not actively promoted among the general public. Available data collected over the past few years show somewhat of an improvement in general knowledge of HIV/AIDS and methods of prevention (see studies below).

Jordan has a policy to promote HIV prevention for young people - both in and out of school – and for vulnerable subpopulations. IEC for vulnerable populations includes targeted information on risk reduction and HIV education, stigma and discrimination reduction, condom promotion, HIV testing and counseling and reproductive health. HIV education is available at the secondary –school level for both young men and young women and in teacher training programs.

Blood transactions in Jordan are now fully centralized and units undergo universally standardized mandatory testing. Screening of donated blood is fully operational at 100% in all facilities in Jordan. Additionally, 100% of facilities report that all therapeutic injections are administered with new, disposable, single use injection equipment.

The following NAP – supported prevention activities and related knowledge and behavior studies were conducted in 2008 and 2009:

MOST-AT-RISK POPULATIONS

Prevention Activities among Most-At-Risk-Populations

Reaching the most vulnerable groups with information and services remains an intimidating challenge. Small scale activities such as formative research among sex workers and outreach to prisoners and drug users have recently been initiated. Due to a range of factors, including stigma and marginalization, access to these populations continues to be a difficult and complex task that requires wide collaboration with non

governmental organizations. There are currently 57 such organizations working with the National AIDS Program in different areas of the Kingdom to implement prevention programs. With the support of the Global Fund, a core group of NGOs and CBOs were trained on HIV/AIDS and the development of IEC materials. These organizations then conducted 75 outreach programs for MARPs (CSW, MSM, IDUs and taxi drivers). A total of 1,974 most at risk persons received educational sessions in 2008 and 2009.

IEC for MARPS includes targeted information on risk reduction and HIV education, stigma & discrimination reduction, condom promotion, HIV testing & counseling and reproductive health, including STI prevention & treatment. Needle exchange programs for MARPS are not available and condom distribution programs rely exclusively on external funding. Even when funding is available, condom distribution is very difficult due to the conservative nature of Jordanian society and the complications faced in reaching MARPS. In 2009, the target of the Global Fund grant was 150,000 condoms distributed. However, only 31% of the target was achieved, with 46,200 condoms distributed.

Knowledge and Behavior among Most-at-Risk-Populations

In 2009, a Behavioral Surveillance Survey was carried out among taxi drivers, female sex workers, men who have sex with men and intravenous drug users. The main goal of this study was to establish a data base of the behavioral and biological data, and identify trends in behavior, of high risk groups that influence the HIV epidemic in Jordan, contributing to a sustainable establishment of second generation surveillance in Jordan. This is expected to help construct an advocacy package for policy makers that would support HIV prevention and care in Jordan. Though the BSS was completed in 2009, the data is pending analysis and will be included in the 2012 UNGASS report.

Knowledge and Behavior among Prisoners

A Rapid Assessment was carried out in prison settings in 2008 by the NAP and Public Security Department, with the support of UNODC. The main objective was to describe the overall drug and HIV situation in prisons in an effort to guide the development of a comprehensive package of response. The assessment showed that 90.1% of male and female prisoners and 100% of prison workers had heard of AIDS. Knowledge on modes

of transmission was quite high among prisoners, with 91% responding affirmatively when asked if HIV can be transmitted through unprotected sexual contact, 85.6% responding affirmatively when asked if HIV can be transmitted through needle sharing while injecting drugs, 92.3% responding affirmatively when asked if HIV can be transmitted through contaminated blood and 64.1% responding negatively when asked if HIV can be transmitted through shaking hands with a person infected with the virus. Of the prison workers, 97.1% responded affirmatively when asked if HIV can be transmitted through unprotected sexual contact, 93.7% responded affirmatively when asked if HIV can be transmitted through needle sharing while injecting drugs, 98.3% responded affirmatively when asked if HIV can be transmitted through contaminated blood and 74.5% responded negatively when asked if HIV can be transmitted through shaking hands with a person infected with the virus. When asked if they had engaged in sexual contact while in prison, 2.8% of prisoners responded that they had, with 21.7% of those reporting using a condom during that encounter. Regarding drug abuse and related risky behaviors for contracting HIV, results indicate that 36.8% of the inmates have used drugs and psychotropic substances in their lifetime, 95% of inmates and 87.7% of staff indicate that oral intake is the most frequent method of substance abuse and 23.1% of IDUs report sharing syringes with others. [7]

HEALTH WORKERS

Prevention Activities among Health Workers

Regarding blood safety and infection control activities, 167 medical staff and health workers from the public and private sectors were trained in 2009 on universal precautions to prevent the spread of infection and protect health workers in the workplace. Infection control quality assurance guidelines have been developed, and field visits are used to monitor the application of blood safety and infection control measures among those who received the training.

[7] MOH, PSD, UNODC *Survey on Drugs and HIV/AIDS in Correction and Rehabilitation Centers*, 2008

Knowledge and Behavior among Health Workers

Knowledge and Attitude studies conducted in April and October of 2008 among health workers in the Jerash and Balka governorates yielded startling results. In the Balqa study among 164 health workers, 97.3 % of the respondents knew that HIV can be transmitted through unprotected sex with an infected person and 92.3% that sharing syringes with an infected person could transmit the virus. However, 93.9% reported that coughing and sneezing were also modes of transmission and 94% believed that HIV could be contracted while using a public toilet. Conversely, only 5.3% of the respondents were aware that HIV is transmittable from mother to child. 91.6% knew that no vaccination exists for HIV, but 28.2% believed that there is a cure. A considerable proportion of the respondents (29.3%) believed that patients living with HIV/AIDS should not be allowed to continue working. [8]

In the Jerash study among 525 health workers, a good proportion of the respondents knew that unprotected sexual contact and sharing needles with a person infected with HIV can lead to transmission of the virus (97.1% and 99%, respectively). 89.1% knew that coughing and sneezing were not modes of transmission; however 32.6% believed that HIV can be transmitted through a mosquito bite and only 38.9% knew that breastfeeding was a mode of transmission. 90.5% knew that there is no cure for HIV/AIDS.[9]

These studies heavily underscore the need for upgraded and more comprehensive educational programs for health workers. The programs should be tailored to provide necessary technical information as well as influence the opinions of health workers to allow for more effective support of PLHIV, contribute to decreasing the stigma associated with the condition and promote early screening. At the very least, health care providers need to able to appropriately contend with issues of risk assessment and infection control, with their knowledge and practices regarding HIV/AIDS directly affecting the quality of care given to their patients.[10]

[8] MOH, *HIV – Related Knowledge, Attitude and Risk Perception among Health Workers in Balqa Governorate*, 2008
[9] MOH, *HIV – Related Knowledge, Attitude and Risk Perception among Health Workers in Jerash Governorate*, 2008

COLLEGE STUDENTS

Knowledge and Behavior among College Students

In a KAP study involving 1887 college students (mean age = 20.3 ± 2.7) in the Balqa governorate in 2008, the majority of participants correctly responded to questions relating to transmission of HIV through sexual intercourse, sharing syringes with an infected person and from mother to fetus. However, 67.3%, 57.6% and 51.1% respectively, believed that sharing food with PLHIV, sneezing/coughing and mosquito bites were possible routes of infection. Only 35% of the respondents said that they would provide care in their home to a male or female relative affected by HIV/AIDS, 32 % said that PLHIV should not be allowed to study in school and 25 % that they should not be allowed to teach. Only 25 % would eat a meal with a person infected with HIV. Although 54.4 % of the respondents said that they would prefer to keep it a secret if a relative was infected, 78% were of the opinion that a married individual should not keep their HIV status from their spouse. 6.2% reported that they knew someone affected by HIV/AIDS. Regarding behavior, 17.2% of those surveyed reported being sexually active, up from 7% in 2001[11], with 6.4% reporting previously testing for HIV. 22.1% (86% males and 14% females) reported having at least one previous sexual experience. The mean age for the first sexual experience was 17.7 years. Of those who reported being sexually active, 45.7% reported use of a condom, up from 40.3% in 2006 [NAP, 2006]. Of the sexually active males, 7% reported having a sexual experience with a male partner[12], down from 10% in 2005.[13]

MARRIED WOMEN

Knowledge and Behavior among Married Women

In Jordan, women are generally considered to have high basic knowledge of HIV. In a 2002 survey, 97% of women were aware of HIV/AIDS[14]. In a 2007 survey among 10, 876 ever-married women in Jordan, 99% knew of AIDS. 5.5% did not know of AIDS or if AIDS could be avoided and 5.1% believed that there was no way AIDS could be avoided. When asked to spontaneously mention ways to avoid HIV/AIDS, 38.3% and 6.8% reported that limiting sexual relations with their spouse and limiting the number of sexual partners

[11] Johns Hopkins University, *Youth Survey: Knowledge, Attitudes and Practices on Reproductive Health and Life Planning*, 2001
[12] MOH, *Knowledge and Attitudes towards HIV/AIDS Among College Students in the Balqa Governorate*, 2008
[13]NAP, *Report on the National KABP survey on HIV/AIDS among Jordanian Youth*, 2005
[14] Measure DHS, *Demographic and Health Survey*, 2002

respectively, could help them avoid becoming infected with HIV. Avoiding sex with persons who have multiple partners, avoiding sex with a person who injects drugs and avoiding blood transfusions were mentioned as prevention techniques by 27.3 %, 9.7% and 55.9%, respectively. When prompted with three aspects of AIDS prevention behavior, 53.2% (up from 33% in 2002)[15], 86.2% and 43.3%, respectively, reported that using condoms, limiting sexual intercourse to one uninfected partner who has no other partners and abstaining from sexual intercourse will prevent infection with HIV. It was found that knowledge of these means of prevention were highest among urban women, women with higher levels of education and women living in wealthier households. There was a particularly strong relationship between education and knowledge of condom use as a means of HIV prevention; 28% of women with no education cited using condoms as a means of preventing HIV compared to 61% of women with a higher than secondary education. 66% of women knew that a healthy looking person can have, and transmit, the HIV virus. This figure represented a significant increase from a similar survey in 2002, when only 46% of women reported knowing this. 40% and 79.4% of respondents rejected the two misconceptions that HIV can be transmitted by mosquito bites and shaking hands, respectively. While 86% of respondents knew that HIV could be transmitted from mother to child during pregnancy and 74% knew that it can be transmitted during delivery, only half (51%) knew that it can be transmitted through breastfeeding. In 2002, these fractions were 70.1%, 54.6%, and 42.3%, respectively.[16] Although knowledge of HIV transmission during pregnancy and through delivery was positively correlated with a woman's education, there was no relationship between education levels and knowledge of transmission of HIV through breastfeeding.[17]

ENGAGED COUPLES

Knowledge and Behavior among Engaged Couples

In an HIV/AIDS Knowledge and Attitude survey among engaged couples (mean age = 28.3), conducted in 2008 by the NAP in the governorate of Zarqa (which accounts for 13% of all HIV cases in Jordan), 98% of the male and female respondents had heard of AIDS. Regarding modes of transmission; sex with an infected person, blood transfusion

[15] Measure DHS, *Demographic and Health Survey*, 2002
[16] Measure DHS, *Demographic and Health Survey*, 2002
[17] Department of Statistics, *Jordan Population and Family Health Survey 2007*, August 2008

and sexual contact among men were provided as answers by 96%, 96%, and 89% of the target group respectively. Only 39% of the males and 45% of the females reported that HIV infection can occur through breast feeding. About 28% of the males and 16% of the females stated that HIV can be contracted through a mosquito bite and around 9% of the target group believed that there is a vaccine against AIDS. [18]

SCHOOL STUDENTS

Prevention Activities among School Students

In 2009, 782 peer educators from the educational sector were trained to conduct outreach educational programs in schools from the public and private sectors. Over 34,695 youth in school settings were reached and educated in more than 50 schools, universities and colleges. Advocacy workshops on HIV/AIDS were conducted targeting community and governmental leaders, youth and school teachers. During these activities, various IEC materials (peer educator guidelines, brochures, pamphlets …etc.) were distributed to youth and youth leaders.

MASS MEDIA

Prevention Activities with the Mass Media

A communication strategy was developed in 2009 after the recruitment of two consultants and the organization of a three day consultative workshop for members of the media. Various mass media campaigns have since been launched across Jordan.

Treatment, Care and Support

The National AIDS Strategy promotes treatment, HIV testing and counseling, psychosocial care, referral and non-AIDS related medical care for PLHIV, including pediatric cases. The Care and Treatment Management Center within the National AIDS Program monitors the treatment and care of PLHIV and identifies present and future needs. ARVs are ordered based on the requests of this management center. Counseling is offered based on guidelines developed in 2003 and updated in 2006 with the support

[18] MOH, *Knowledge and Attitude Towards AIDS among Proposed Couples*, 2008

of FHI. The center also refers PLHIV for necessary support from other governmental services - such as social services or financial support from the Ministry of Social Development - and NGOs or CBOs. There is a system in place for quarterly medical exams, home visits, distribution of first aid kits, nutritional awareness and training on how to safely handle blood and other bodily fluids. PLHIV receive TB screening, TB preventive therapy and TB infection control.

Overall, there are 12 public sector VCT centers throughout the Kingdom, four of which operate hotline services. Records show that, of those who access VCT services in Jordan, 33.4% complete the testing and counseling process. Hotline services are most commonly favored by those seeking VCT services due to the high sensitivity of issues discussed in VCT. Most VCT attendees reported contacts with sex workers as the reason for attending VCT services[19]. In 2009, 242 home – based care visits were conducted by the Care and Treatment Management Center to PLHIV.

Referral of PLHIV for non-AIDS treatment has proven complex though it is covered free of charge by the national government insurance plan. Health workers continue to refuse to treat HIV positive persons, particularly when interventions require invasive procedures. In December 2009, in an effort to remedy this impediment to medical care for PLHIV, focal points were appointed in the obstetrics and gynecology, pediatrics, ophthalmology, dermatology and internal medicine departments, as well as the ER, at Bashir Hospital (the principal government hospital in Amman). It is expected that their presence will facilitate the referral of HIV/AIDS patients and their subsequent access to health and medical care. To further address issues of stigma and discrimination, 1,233 key community and government leaders and health workers attended sensitization sessions in 2009.

There are currently no systems in place for HIV referral or care and support in the workplace.

[19] National AIDS Program, 2007

V. Best practices

The following are considered best practices regarding the implementation of prevention, treatment and care measures in Jordan:

- Ensuring the sustainability of ARV provision by supplementing grant funding through the government's annual budget. Cost sharing with the Global Fund has increased from 20% to 30%.
- The development of a media strategy for HIV prevention, one of the goals outlined in the 2008 UNGASS report for Jordan.
- To help support the effective referral of HIV/AIDS patients within the public sector, focal points were assigned to the obstetrics and gynecology, pediatrics, ophthalmology, dermatology and internal medicine departments as well as the Emergency Room in Bashir hospital December 2009.
- Increased community participation and partnership for prevention activities in 2008-2009, one of the goals mentioned in the 2008 UNGASS report for Jordan.
- The development and production of capacity building guidelines for CBOs and NGOs on the creation of M&E structures and the development of management, finance, procurement and supply systems.

VI. Major challenges and planned remedial actions

The key challenges to HIV efforts outlined in Jordan's 2008 UNGASS report continue to hinder the national response. To a great extent, these challenges stem from a socio-cultural, traditional context where condoms are promoted only as a family planning method, high-risk behaviors are not officially acknowledged and the consequences for some of those behaviors are severe, including imprisonment. However, some anticipated remedial actions outlined in the 2008 UNGASS report for Jordan have since been implemented. The NAP has worked to improve its relationships with NGOS and to build their capacity, a media sector policy was developed in 2009 and the first BSS was implemented in Jordan.

Other challenges continuing to face HIV/AIDS efforts in Jordan can be summarized as follows:

- Stigma and discrimination towards PLHIV and members of vulnerable groups by society, including health care workers to some extent. There are also a limited number of NGOs willing to work directly with PLHIV and high risk populations.
- Limited access to vulnerable subpopulations (FSW, IDUs, and MSM, for example). This has led to limited access to services for high risk groups, a low demand for available services and inadequate knowledge surrounding HIV/AIDS.
- An M&E system that remains weak and the need for further capacity building for NAP staff and partners.
- Insufficient regulations and policies supportive of public and community action in transmission reduction as well as the promotion of equal access to services. For example, there is a reluctance to promote the widespread use of essential preventive materials such as sterile injecting equipment or condoms.
- Lack of private sector involvement in the delivery of HIV/AIDS prevention and control services, as well as a lack of knowledge regarding guidelines, activities and objectives of the NAS leading to some private sector activities that fall outside the planned framework.
- Poor information management, in particular the limited experience in Jordan of second-generation surveillance. Jordan's first experience in BSS was in 2008 and many challenges were faced.

It is expected that the 2010 revision of the NAS will take into account the above - mentioned challenges and that innovative approaches will be required to address them. However, there are no concrete plans or remedial actions currently in place.

Deleted: ¶

VII. Support from the country's development partners

Jordan's development partners provide technical support and interventions complementary to the Government's efforts to tackle HIV and AIDS.

To further develop and strengthen coordination and partnership with NGOs, CBOs, civil society and other concerned organizations, 275 persons received training on advocacy in 2008 with the support of the Global Fund. Workshops were then held for government leaders, policy makers, legislators and leaders of governorates to ensure multi-sectoral partnership towards, commitment to, and involvement in, HIV/AIDS treatment, care and support.

Also with the support of Global Fund, meetings were organized to review and support civil society strengthening, and to prepare for a capacity assessment for CBOs and NGOs. A plan was developed to strengthen capacities on HIV, advocacy skills, proposal writing and organizational networks. In a number of workshops held throughout 2008 and 2009, 768 CBO and NGO representatives were trained to strengthen their technical capacity and to facilitate access to prevention, health care, and social services for PLHIV.

Following are some of the activities undertaken by the Kingdom's development partners:

UN THEME GROUP ON AIDS

The UN Joint Team is comprised of the representatives of 8 UN organizations (WHO, UNDP, UNFPA, UNHCR, UNODC, UNESCO, UNRWA, UNICEF) and is currently chaired by UNICEF. The main function of the UN Joint Team is to coordinate the national response to HIV/AIDS and to support the implementation of the UN Learning Strategy on HIV/AIDS. Support from the UN Theme Group on AIDS to the national response to HIV/AIDS in 2009 included technical support to improve the reporting of sexually transmitted diseases and case diagnosis, support to the Antinarcotics Department which is responsible for collating and analyzing data from drug treatment service providers, the development of educational resource material and guidelines and a needs assessment for education sector response, training of service providers, awareness promotion among adolescents and youth and the establishment of a national hotline for drug abuse, the development of a national drug policy, training of the Ministry of Health staff and civil society institutions on planning and managing community based services to reduce HIV, and training of media professionals in HIV/AIDS reporting. The UN also supported the National AIDS Program both financially and technically in the planning and implementation of the activities commemorating World AIDS Day and in the development of the UNGASS report for Jordan.

Technical support will be provided to the NAP in the review and formulation of the National AIDS Strategy in 2010.

NON-GOVERNMENTAL ORGANIZATIONS

NGOs responding to HIV/AIDS issues in Jordan include Caritas Jordan, Arab Bridge Center for Human Rights and Development, The Family and Child Protection Society, and Bushra Center for Studies and Research. Throughout 2008 and 2009, NGOs supported national efforts to prevent HIV/AIDS by holding lectures and other activities in schools for teachers and students, conducting awareness sessions on HIV/AIDS and related human rights issues within civil society, conducting outreach visits to, and training for, vulnerable groups, organizing KAP studies with MARPS, providing VCT services and organizing prevention and risk reduction campaigns.

FURTHER SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS

- Outreach to vulnerable groups
- Capacity building of NGOs working in HIV/AIDS - related issues
- Research and surveillance
- Monitoring and evaluation, including provision of software, capacity building and technical support
- Assuring the sustainability of financial resources
- Technical and logistical support for the implementation of HIV/AIDS control activities
- Access to ARV medication and assuring the continuity of discounted rates
- Facilitating exchanges with countries facing similar social, economic and geographical conditions
- Evaluation of activities implemented by consultants and recommendation of appropriate adjustments where weaknesses are found

VIII. Monitoring and evaluation environment

In 2007, the National AIDS Program, with technical and financial support from USAID through FHI, developed its national M&E plan, which included well-defined indicators for

all the activities implemented by the NAP and its partners. The plan also includes a data collection strategy which addresses routine program monitoring, behavioral surveys, HIV surveillance and research studies. It contains guidelines for data-collection tools, a strategy for assessing data quality, a data analysis strategy and a strategy for data dissemination and use. 10% of the total HIV funding is earmarked for M&E activities.

Assessments are usually conducted quarterly, semi annually or biannually depending on the indicator being measured. Impact indicators are assessed every 3-5 years. The national M&E unit, based in the National AIDS Program, collects data from all partners and conducts the assessment. Data sharing mechanisms include ad hoc reports on activities, regular reports on a quarterly or semi annual basis, operational research and health facility surveys. Other mechanisms include site monitoring visits, meetings with partners and the overseeing and follow-up of activities by the M&E Unit. M&E data are entered on a national database managed by the NAP and are used for resource allocation and program improvement. The 2010 revision of the NAS will rely heavily on available M&E data.

In the past year, M&E training was conducted at multiple levels. Ten National AIDS Program staff members and fifty-eight government focal points and members of civil society received such training. However, further capacity building is necessary at all levels to ensure effective and timely data collection, analysis and dissemination.

Annex 1

Consultation process for the Country Progress Report on Monitoring the Follow-up to the Declaration of Commitment on HIV/AIDS

Hashemite Kingdom of Jordan

1) Which institutions were responsible for filling out the indicator forms?
A third-party consultant, Ms. Jenine Jaradat, under contract with the UN worked in close collaboration with the NAP.

2) With inputs from
Ministries: Yes
Health – Education – Religious Affairs
Civil society organizations: Yes
People living with HIV: Yes
Private sector: No
United Nations organizations: Yes
Bilaterals: No
International NGOs: Yes, very limited

3) Was the report discussed in a large forum? Yes

4) Are the survey results stored centrally? No

5) Are data available for public consultation? Yes

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?
Name / title: Jumana Haj Ahmad, Adolescents Specialist, UNICEF
Date: March, 2009
Tel: 00962796111838
Email: jhajahmad@unicef.org

Annex 2

National Composite Policy Index Questionnaire

Hashemite Kingdom of Jordan

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: Jumana Haj Ahmad, UNICEF

Tel: 00962796111838

Email: jhajahmad@unicef.org

NCPI Data Gathering and Validation Process: Throughout December 2009, interviews were conducted with five government officials and eight members of civil society. Responses were compiled and the relevant sections sent by email to all respondents for their comments before finalization.

NCPI Respondents:

Part A

Organization	Names/Positions	Responded to Section:				
		AI	AII	AIII	AIV	AV
Ministry of Health	Dr. Bassam Hajawi/Director of Communicable Disease Control and Director of National AIDS Program	x	x			
Ministry of Health	Dr. Assad Rahhal/Deputy Manager of National AIDS Program	x	x	x		x
Ministry of Health	Dr. Rajai Al Azza/Head of STI Division and VCT Management Center				x	
Ministry of Health	Dr. Jamal Anani/Director of National Center for the Rehabilitation of Addicts	x	x	x	x	x
Anti Narcotics Department	Lt. Colonel Anwar al-Tarawneh/Head of Judicial Police Division	x	x	x	x	x
Ministry of Health	Ahmed Nasrallah/NAP			x	x	x
Ministry of Health	Khaled Ibrahim/NAP			x	x	x
Higher Council for Youth	Mohammed Jaradat			x	x	x
Ministry of Health	Dr. Karim Ilyas/Director of Blood Bank	x	x	x		
Ministry of Education	Mohammed al Kiswani	x	x			
Ministry of Religious Affairs	Iyad al Qodeh	x	x			

Part B

Organization	Names/Positions	Responded to Section:			
		BI	BII	BIII	BIV
UNICEF Jordan	Jumana Haj Ahmad/Adolescents Specialist	x			
UNICEF Jordan	Maha Homsi/ECD-Protection Specialist	x			
UNODC Jordan	Saja Amasheh/Program Assistant	x			
UNHCR Jordan	Dr.Sameh Youssef/Senior Public Health Officer	x			
Bushra Center for Studies and Research	Jehan Murjan/Director		x	x	x
Representative of PLHIV	Anonymous		x		x
Future Guardians	Marwan Odetallah/Board Member and Trainer		x	x	x
Future Guardians	Asma Obeidat/Trainer		x	x	x
UNFPA	Layali Abu Sir			x	x
Jordan Association for Family Planning and Protection	Wafa Nafe	x	x		
UNESCO	Hanan al Omari			x	x
Friends of Global Fund	Rawan Abaneh			x	x
Representative of PLHIV	Anonymous	x	x		
International Medical Corps	Lina Al Hadid	x	x		
Jordan Red Crescent	Dr. Nawal Khreishan	x	x		

Part A – administered to government officials

I Strategic Plan

1. Has the country developed a national multisectoral strategy to respond to HIV?

Yes **Period covered:** 2005- 2009

The *National AIDS Strategy* is a national blueprint for action for Jordan's response to HIV/AIDS developed by a range of stakeholders – including the National AIDS Committee and the National AIDS Program, other government agencies, UN organizations and international and national non-governmental organizations. It has four strategic objectives:

- To collect, analyze and use strategic information relating to the spread of HIV/AIDS and the national response to the epidemic in Jordan
- To prevent transmission of HIV in Jordan
- To provide care, support and treatment to PLHIV
- To create an enabling environment in which an effective national response to HIV/AIDS can take place

The main objective of the National AIDS Program for the year 2010 is to update the National AIDS Strategy for the coming 5 years.

1.1 How long has the country had a multisectoral strategy?

Various strategies have been in place since the National AIDS Program was established in 1989; however, the 2005 strategy is considered the most comprehensive.

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

Sectors	Included in strategy	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labor	Yes	No
Transportation	Yes	Yes
Military/Police	Yes	Yes
Women	Yes	No
Young People	Yes	No
Other:		
Tourist	Yes	No
Culture	Yes	No
Religion	Yes	No

If NO earmarked bugets for some or all of the above, explain what funding is used to ensure implementation of their HIV-specific activities.

There are no distinct budget lines to cover HIV activities for the different sectors. The government's annual budget covers many activities and costs for the different sectors including staffing and overhead costs for the National AIDS Program, some treatment costs etc. This helps to ensure sustainability of programs and activities.

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

	Target populations	
a	Women and girls	Yes
b	Young women /young men	Yes
c	Injecting drug users	Yes
d	Men who have sex with men	Yes
e	Sex workers	Yes
f	Orphans and other vulnerable children	Yes
g	Other specific vulnerable subpopulations: taxi drivers, children born to HIV positive mothers	Yes for taxi drivers; PMCT planned for next year
	Settings	
h	Workplace	Yes
i	Schools	Yes
j	Prisons	Yes
	Cross – cutting issues	
k	HIV and poverty	Yes
l	Human rights protection	Yes, through addressing stigma and discrimination, providing treatment, care and support for PLHIV.
m	Involvement of people living with HIV	Yes
n	Addressing stigma and discrimination	Yes
o	Gender empowerment and/or gender equality	No

1.4 Were target populations identified through a needs assessment?

Yes. Target populations were identified through focus group discussions, KAP surveys, a rapid assessment in prison settings, feed back from organizations working with vulnerable populations, educational outreach programs and field visits.

1.5 What are the target populations in the country?
The National AIDS Strategy divides target populations into primary and secondary groups. Primary groups include sex workers, men who have sex with men and injecting drug users. Secondary groups include youth, frequent travelers, military/uniformed services, workers in certain sectors (health, tourism and transportation), prisoners, refugees and street children.

1.6 Does the multisectoral strategy/action framework include an operational plan?
Yes

1.7 Does the multisectoral strategy/action framework or operational plan include:

a. Formal programme goals? Yes
b. Clear targets and/or milestones? Yes
c. Detailed budget of costs per programmatic area? Yes
d. Indications of funding sources to support program implementation? Yes
e. Monitoring and Evaluation framework? Yes

1.8 Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy?
Active involvement

***IF active involvement*, briefly explain how this was done:**
Civil society was involved in the drafting of the National AIDS Strategy, its endorsement and its implementation. The National AIDS Program announced through the media that it was looking for partners within civil society. Partners had to meet certain criteria regarding registration and infrastructure. Fifty-seven CBOs and NGOs were chosen to work with the NAP and 1/3 of the Global Fund budget was spent on the 95 contracts drawn up with these organizations.

1.9 Has the multisectoral strategy been endorsed by most external Development Partners (bi-laterals; multi-laterals)?
Yes. They were involved in the consensus workshop where it was endorsed.

1.10 Have external Development Partners aligned and harmonized their HIV and AIDS programmes to the national multisectoral strategy?
Yes. All partners are required to align and harmonize their programs to the strategy.

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/ United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach?
Yes

2.1 IF yes, in which specific development plan is support for HIV integrated?

a. National Development Plan Yes
b. Common country assessment / UN development assistance framework Yes
c. Poverty reduction strategy No
d. Sector-wide approach Yes**.** Examples are: The Higher Population Council, the Higher Council for Youth and the Public Security Directorate, which includes the Prison Department, the Anti-Narcotics Department, the Criminal Investigation Department and the Security Prevention Department.

2.2 If YES, which specific HIV related areas are included in one or more of the development plans?
HIV prevention: Yes
Treatment for opportunistic infections: Yes
Antiretroviral treatment: Yes
Care and support (including social security and other schemes): Yes
HIV impact alleviation: N/A
Reduction of gender inequalities as they relate to HIV prevention, care and support: Yes
Reduction of income inequalities as they relate to HIV prevention, care and support: Yes
Reduction of stigma and discrimination: Yes
Women's economic empowerment: No

3. Has the country evaluated the impact of HIV and AIDS on its socioeconomic development for planning purposes?
Yes.

3.1 *IF YES*, to what extent has it informed resource allocation decisions?
Rating: 3

4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc?
Yes

4.1 *IF YES*, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?
Behavioral change communication: Yes
Condom provision: No
HIV testing and counseling: Yes
STI services: Yes
Treatment: Yes
Care and support: Yes

***What is the approach taken to HIV testing and counseling?**
Testing is mandatory for peacekeeping forces as they deploy and return.

5. Does the country have non discrimination laws or regulations which specify protections for most at risk populations or other vulnerable subpopulations?
No.

5.1 Which populations?
Not applicable.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most at risk populations or other vulnerable subpopulations?
No. Anyone can anonymously access free VCT and other HIV-related services without fear of persecution.

7. Has the country followed up on commitments towards universal access made during the high level AIDS review in June 2006? Yes

7.1 Have the national strategy and national HIV budget been revised accordingly? Yes

7.2 Have the estimates of the size of the main target populations been updated? Yes. Estimates have been updated, but it is difficult to know true numbers.

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?
Yes, there are estimates of current and future needs.

7.4 Is HIV program coverage being monitored? Yes
By sex? Yes **By population groups?** Yes

If yes, for which population groups? Sex workers, IDUs, MSM, Youth, Prisoners, Workplace, Refugees

Briefly explain how this information is used: It is used for program and intervention planning and development, estimations, fundraising

Is coverage monitored by geographical area? Yes; in the 12 governorates.

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities and logistical systems to deliver drugs? Yes, there is a system in place. Health needs are consistently assessed and addressed by the Ministry of Health.

Overall, how would you rate strategy planning efforts in HIV programs in 2009? Rating: 8

Since 2007, access to most-at-risk populations has somewhat improved, BSS and the M&E system have been strengthened and there is greater capacity building of NGO and CBO staff. There is an increase in the number of CBOs and NGOs partnering with the National AIDS Program. There is a multisectoral approach to the implementation of HIV programs.

Challenges include shortages in human and financial resources; difficulties in reaching MARPS, a conservative society that resists discussions on HIV, lack of regulations that

clearly protect MARPS and PLHIV, including, for example, when it comes to employment.

II Political support

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic forum at least twice a year? Yes

President/Head of government No

Other high officials Yes, including His Excellency, the Minister of Heath and the Secretary General of the Ministry of Health, who is also the chair of the Country Coordinating Mechanism.

Other officials in regions and/or districts Yes. Mayors and heads of governorates often patron and attend events.

2. Does the country have an officially recognized national multisectoral AIDS management/coordination body? (National AIDS Council or equivalent)?
Yes. Jordan created the Country Coordinating Mechanism (CCM) in 2002 to continue and strengthen the work of the National AIDS Committee which was formed in 1986. The goal of the CCM is increased coordination and cooperation, and improved coherence of policies and programs, to more effectively address HIV/AIDS and TB. The chair of the CCM is the Secretary General of the Ministry of Health, Dr. Deifallah Al Lawzi.

2.3 *IF YES*, does it:

- **have terms of reference?** Yes
- **have active Government leadership and participation?** Yes
- **have a defined membership?** Yes **How many members?** 33
- **include civil society representatives?** Yes. **How many?** 5
- **include people living with HIV?** Yes **How many?** 1
- **include the private sector?** Yes
- **have an action plan?** Yes
- **have a functional Secretariat?** In progress
- **meet at least quarterly?** Yes
- **review actions on policy decisions regularly?** Yes
- **actively promote policy decisions?** Yes
- **provide opportunity for civil society to influence decision making?** Yes
- **strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?** Yes

3. Does the country have a national mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes? Yes

Main achievements include expansion of the membership to include civil society and PLHIV, the creation of operational guidelines and terms of reference, the securing of two

Global Funds grants since 2002, fundraising with other donors including the UN and raising awareness on the strategic plan and HIV/AIDS policies among stakeholders.

Challenges include a high turn over in members and instances where the guidelines of the CCM are not always followed, especially in the case of M&E.

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?
One-third of the budget

5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services Yes
Technical guidance/materials Yes
Drugs/supplies procurement and distribution No, this is the responsibility of the Ministry of Health
Coordination with other implementing partners Yes
Capacity-building Yes

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?
A review occurred about 3 years ago but no amendments to laws or policies were undertaken.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Deportation of non-Jordanians found to be HIV positive
Pre – employment testing of government workers
Lack of anti stigma and discrimination laws and policies especially where concerning job security and access to education

Overall, how would you rate strategy planning efforts in HIV programs in 2009? Rating: 8

Since 2007, achievements have included continuous higher political commitment towards HIV prevention and other interventions and the involvement of high level officials in the implementation of HIV-related activities.

The main challenge remains that, because Jordan is a low prevalence country, other health needs take priority in government budget allocations.

III Prevention

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

1.1 *IF YES*, what key messages are explicitly promoted?

A	**Be sexually abstinent**	Y
B	**Delay sexual debut**	N
C	**Be faithful**	Y
D	**Reduce the number of sexual partners**	N
E	**Use condoms consistently**	N
F	**Engage in safe(r) sex**	N
G	**Avoid commercial sex**	Y
H	**Abstain from injecting drugs**	Y
I	**Use clean needles and syringes**	N
J	**Fight against violence against women**	Y
K	**Greater acceptance and involvement of people living with HIV**	Y
L	**Greater involvement of men in reproductive health Programs**	N
M	**Males to get circumcised under medical supervision**	N
N	**Know your HIV status**	Y
O	**Prevent mother to child transmission**	N
	Other: blood safety, universal precautions for health workers	Y

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

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?
Yes.

2.1 Is HIV education part of the curriculum in primary schools? No

secondary schools? Yes
teacher training? Yes

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?
Yes

2.3 Does the country have an HIV education strategy for out-of-school young people?
Yes

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?
Yes

3.1 *IF YES*, which sub-populations and what elements of HIV prevention do the policy/strategy address?
Services vary across the country, depending on the specific population at risk. Services are delivered by a range of providers, including community organizations, government organizations and health services.

	IDU	MSM	Sex Workers	Clients of Sex Workers	Prison Inmates	Other Populations
Targeted information on risk reduction and HIV education	**Y**	**Y**	**Y**		**Y**	**Taxi drivers**
Stigma & discrimination reduction	**Y**	**Y**	**Y**		**Y**	**Taxi drivers**
Condom promotion	**Y**	**Y**	**Y**	**Y**		
HIV testing & counseling	**Y**	**Y**	**Y**	**Y**		
Reproductive health, including STI prevention & treatment	**Y**	**Y**	**Y**	**Y**		

Vulnerability reduction (e.g. income generation)

Drug substitution therapy

Needle & syringe exchange

Overall, how would you rate policy efforts in support of HIV prevention since 2009: Rating: 7

4. Has the country identified specific needs for HIV prevention programmes?
Yes. It has been determined that there is a need to focus prevention efforts on most-at-risk-populations and mother-to-child transmission.

***IF YES*, how were these specific needs determined?**

- Review of National AIDS Strategy by key stakeholders at a multi-sectoral consensus workshop in June 2009
- Annual review of the National AIDS Strategy by the National Aids Program and stakeholders
- Trainings and outreach conducted with MARPS
- BSS surveillance
- VCT updates and reports

4.1 To what extent has HIV prevention been implemented?

HIV Prevention Component	The majority of people in need have access
Blood safety	Agree
Universal precautions in health care settings	Agree
Prevention of mother-to-child transmission of HIV	NA
IEC on risk reduction	Don't Agree
IEC on stigma and discrimination	Don't Agree

reduction			
Condom promotion		Don't Agree	
HIV testing and counseling	Agree		
Harm reduction for injecting drug users			NA
Risk reduction for men who have sex with men		Don't Agree	
Risk reduction for sex workers		Don't Agree	
Reproductive health services including sexually transmitted infections prevention and treatment		Don't Agree	
School-based HIV education for young people	Agree		
HIV prevention for out of school	Agree		
HIV prevention in the workplace		Don't Agree	

Overall how would you rate the efforts in the implementation of HIV prevention programs in 2009? Rating: 6
Since 2007, there has been increased NGO and CBO involvement and outreach activities for MARPS and out-of-school children have spread.

However, there is still much work to be done with MARPS, including size estimation and harm reduction programs. MARPS are extremely difficult to reach; they face high stigma and discrimination and denial that they even exist.

IV Treatment, care and support

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care).

Yes. The National AIDS Strategy promotes treatment, HIV testing and counseling, psychosocial care, referral and non- AIDS related medical care for PLHIV.

1.1 *IF YES*, does it address barriers for women? No

1.2 *IF YES*, does it address barriers for most at risk populations? Yes

2. Has the country identified the specific needs for HIV treatment, care and support services? Yes.

If YES, how were these determined?

The Care and Treatment Management Center within the National AIDS Program monitors the treatment and care of PLHIV and identifies needs. ARVs are ordered based on the requests of this management center. The center also refers PLHIV for necessary support from other governmental services - such as social services or financial support from the Ministry of Social Development - and NGOs or CBOs. There is a system in place for quarterly medical exams, home visits, distribution of first aid kits, nutritional awareness and training on the safe handling of blood and other bodily fluids.

***IF YES*, to what extent have the following HIV and AIDS treatment, care and support services been implemented?**

HIV treatment, care and support service	**The majority of people in need have access**
Antiretroviral therapy	Agree
Nutritional care	Agree
Pediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for people living with	Agree
HIV and their families	

Home-based care		N/A
Palliative care and treatment of common HIV related infections	Agree	
HIV testing and counselling for TB patients	Agree	
TB screening for HIV-infected people	Agree	
TB preventive therapy for HIV-infected people	Agree	
TB infection control in HIV treatment and care	Agree	
Cotrimoxazole prophylaxis in HIV infected people	Agree	
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	
HIV treatment services in the workplace or treatment referral systems through the workplace		Don't Agree
HIV care and support in the workplace (including alternative working		Don't Agree

arrangements)

Other: Financial support to families with very low socioeconomic status	Agree

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?
No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs?
No

Overall how would you rate the efforts in the implementation of HIV treatment, care and support programs in 2009? Rating: 8

85% of patients have undetectable viral loads. This has led to their ability to marry and have children, which in turn lowers stigma and discrimination against them and keeps families together. Once treatment begins, patients remain committed to taking their medications.

However, referral of PLHIV for non-AIDS treatment is very difficult, though it is covered by the national government insurance plan. Health care workers continue to refuse to treat HIV positive persons, particularly when invasive procedures are required.

Costs of medications remain high due to the fact that, because Jordan is a low prevalence country, many pharmaceutical companies will not invest here.

5. Does the country have a policy or strategy to address the additional HIV or AIDS-related needs of orphans and other vulnerable children (OVC)?
Not applicable

V Monitoring and evaluation

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?
Yes. **Years covered**: 2007- 2012

1.1. *IF YES*, was the M&E plan endorsed by key partners in M&E?
Yes. The M&E plan was endorsed by government partners and NGOs.

1.2. *IF YES*, was the M&E plan developed in consultation with civil society, including people living with HIV?
No.

2. Does the Monitoring and Evaluation plan include?

a data collection strategy	Yes
If yes, does it address:	
routine program monitoring	Yes
behavioral surveys	Yes
HIV surveillance	Yes
evaluation/research studies	Yes
a well-defined standardized set of indicators	Yes
guidelines on tools for data collection	Yes
a strategy for assessing data quality	Yes
a data analysis strategy	Yes
a data dissemination and use strategy	Yes

3. Is there a budget for the M&E plan? Yes.

3.1 If YES, what percentage of the total HIV program funding is budgeted for M&E activities? 10%

3.2 *IF YES*, has funding been secured? Yes

3.3 If YES, are M&E expenditures being monitored? Yes

4. Are M&E priorities determined through a national M&E system assessment? Yes

If YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves.

Assessment is usually conducted quarterly, semi annually or biannually depending on the indicator. Impact indicators are assessed every 3-5 years. The National AIDS Program collects data from all partners and conducts the assessment.

5. Is there a functional M&E Unit? Yes

5.1 *IF YES*, is the M&E Unit/Department based:

in the NAC (or equivalent)? No
in the Ministry of Health? Yes
elsewhere?

5.2 *IF YES*, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff: 24

Position:	Full time / Part time	Since when?
NAP Manager	Part time	2007
Public Health Physician	Full time	2003
Community Medical Specialist	Full time	2000
Public Health Officer	Full time	1995
Public Health Officer	Full time	2006
Registered Nurse	Full time	2000
Psychologist	Full time	2000
M&E Officer	Full time	2006
M&E Officer	Full time	2006
Public Health Officers (12)	Full time	1 – 10 years
Social Worker	Full time	2009

Health Educator	Full time	2005
Media Officer	Full time	2003

Number of temporary staff: 5

Position:	Full time / Part time	Since when?
Social Worker	Full time	2003
M&E Officer	Full time	2007
M&E Officer	Full time	2005
M&E Officer	Full time	2008
IT personnel	Full time	2007

5.3 *IF YES*, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E reports?
Yes.

***IF YES*, briefly describe the data sharing mechanisms:**
Partners submit their M&E data and reports to the National AIDS Program. These include ad hoc reports on activities, regular reports (mostly on a quarterly or semi annual basis), operational research and health facility surveys. Other data sharing mechanisms include site monitoring visits, meetings with partners and the overseeing and follow-up of activities by the M&E Unit.

Challenges include delayed or non-reporting and limited resources mean that M&E activities depend on donors. Even when resources are available, it is difficult to locate national M&E experts to support the process.

6. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?
No.

7. Is there a central national database with HIV related data? Yes

7.1 If YES, briefly describe the national database and who manages it.

A computerized system for VCT, mostly managed manually then entered on Excel sheets. It is managed by the NAP.

7.2 If yes, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?
Yes.

7.3 Is there a functional Health Information System?
National level Yes
Sub-national level Yes
***IF YES*, at what level(s)?** Directorate level

8. Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data?
No

9. To what extent are M&E data used:

9.1 In developing/revising the national AIDS strategy? Rating: 4

Monitoring and evaluation data was used extensively to help guide the MARP condom distribution strategy.

Challenges include the fact that partners do not always understand the value of M&E and this leads to weak reporting.

9.2 For resource allocation: Rating: 4

Monitoring and evaluation data was used to estimate the number of people who would require ARVs in the coming year. The estimation was correct, the budget allocated was exact and no medications were wasted.

9.3 For program improvement? Rating: 4

Full time staff was increased according to M&E data and projections. The data was used to identify program gaps and positions were created to cover those gaps.

10. Is there a plan for increasing human capacity in M&E at national, subnational and service delivery levels? Yes, all levels**.**

10.1 In the last year, was training in M&E conducted:

At national level? Yes
If yes, number trained: 10 (NAP staff)

At sub-national level? N/A

At service delivery level including civil society? Yes
If yes, number trained: 58 (government focal points and civil society)

10.2 Were other M&E capacity-building activities conducted other than training? No

Overall how would you rate the M&E efforts in the implementation of HIV programs in 2009? Rating: 7

Since 2007, M&E reporting forms have been developed, there has been extensive training of staff and stakeholders on M&E and the national M&E plan is updated annually. A protocol for BSS was developed, though the data has not yet been analyzed.

Though partners and stakeholders are showing a greater commitment to reporting, M&E concepts are still not fully understood. Further documentation of programs and activities is required and it is necessary to do more to ensure data quality. Training on software, including CRIS, is essential.

Part B – administered to representatives from civil society organizations, bilateral agencies and UN organizations

I. Human Rights

1. Does the country have laws or regulations that protect people living with HIV against discrimination? No

2. Does the country have non discrimination laws or regulations which specify protection for most-at-risk populations and other vulnerable subpopulations?

Yes, there are specific non discrimination laws to protect women and young people (such as the Domestic Violence Law, for example). Regarding mobile populations, an agreement between Ministry of Health and UNHCR allows Iraqis to be treated at primary health care facilities at the same rates as non-insured Jordanians. However, these laws and policies are not fully implemented and there are currently no mechanisms in place to enforce them.

Regarding IDUs, they are not arrested or condemned if they seek treatment at rehabilitation centers and are not found to be dealing drugs. No laws exist to protect other populations deemed by Jordan to be most-at-risk for contracting HIV; namely sex workers and men who have sex with men.

3. Des the country have laws, regulation, or policies that present obstacles to effective HIV prevention, treatment, care and support for most at risk populations and other vulnerable subpopulations?

Yes. For migrant and refugee communities, the regulation that currently poses the greatest obstacle to effective HIV treatment, care and support is the deportation of non-Jordanians when and if found to be HIV positive.

The fact that sex work is a criminal activity in Jordan may prevent sex workers from approaching services and disclosing information on risky behavior.

For young people, accessing prevention services may be difficult due to regulations that require parental approval for youth under 18 to approach primary health care and reproductive health clinics.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

No, the National AIDS Strategy is based on a human rights approach to managing HIV, but it is not explicitly mentioned.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations? No

6. Has the Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and program implementation?

Yes, but in a very limited manner that is not systemized. The Country Coordination Mechanism includes a representative of people living with HIV, but not most-at- risk populations. Some activities are implemented with the participation of PLHIV or sex workers when external funding is available but they are not sustained. There is still very high stigma within the government and the Jordanian society at large regarding sex workers, men who have sex with men and injecting drug users and there are no policies in place to protect them if they do seek out opportunities to participate.

7. Does the country have a policy of free services for the following?
HIV-related care and support interventions: Yes
Anti-retroviral treatment: Yes
HIV prevention services: Yes

Given resource constraints, what steps are in place to implement these policies? Include information on restrictions or barriers to access for different populations:

The National AIDS Program within the Ministry of Health provides free counseling, testing, and treatment and care services and there are guidelines and protocols to guide the provision of these services. VCT staff is very well trained and anecdotal reports show that confidentiality during testing is very high, at least at the central level. Periphery VCT sites may not as reliable in protecting confidentiality. In either case, the ability of individuals to withhold their HIV status decreases significantly after they are found to be carrying the virus.

It is widely recognized that PMCT needs to be strengthened as women currently do not have access to counseling and testing services in prenatal clinics. Condom distribution and needle exchange programs for most-at-risk populations are also not available, other than scattered outreach programs for sex workers which provide free condoms. Adolescents and singles may not have access to reproductive health clinics where free condoms are distributed as a method of birth control.

Regarding injecting drug users, some IEC on risk reduction may be available at treatment centers affiliated with prisons, but women IDUs have no access to these centers. Women who are caught using drugs are sent directly to prison and they rarely approach Ministry of Health or private treatment centers voluntarily.

8. Does the country have a policy to ensure equal access for women and men to prevention, treatment, care and support?

Yes. The National AIDS Strategy does not discriminate between men and women, and mentions gender as a crosscutting issue. However, socioeconomic factors such as poverty, lack of education, fear of stigma and discrimination, or lack of power in relationships may inhibit women from having full access to services.

In particular, to ensure access for women outside the context of pregnancy and childbirth?

Yes, the National AIDS Strategy ensures prevention, treatment and care services for all Jordanians.

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes, the National AIDS Strategy ensures prevention, treatment and care services for all Jordanians. However, implementation of this policy is challenging. The government of Jordan provides strong, comprehensive services in terms of treatment for PLHIV. However, stigma and discrimination by physicians, the community and workplaces prevent PLHIV and most-at-risk populations from fully accessing these services.

9.1 Are there differences in approaches for different most-at-risk populations? No, standard services are provided to all.

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

No. The Jordanian government tests citizens who are applying for government or military positions and foreign nationals applying for work permits.

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee? N/A

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

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV related issues within their work: Yes
- Focal points within governmental health and other departments to monitor HIV related human rights abuses and HIV related discrimination in areas such as housing and employment: No
- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts: No

13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work? No

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

Legal aid systems for HIV and AIDS casework: No
Private sector law firms or university based centers to provide free or reduced-cost legal services to people living with HIV: No

Programs to educate, raise awareness among people living with HIV concerning their rights: Yes, but they are very limited.

15. Are there programs in place to reduce HIV related stigma and discrimination? Yes, but they are very limited and are not sustainable.

IF YES, what types of programmes?
Personalities regularly speaking out : No
School education : Yes
Media : Yes

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009? Rating: 4

Key achievements include a high level of commitment by the National AIDS Program, confidentiality of VCT and good quality of services provided to PLHIV by the National AIDS Program.

The fact that HIV prevalence in Jordan is very low, and that the subject is still a highly taboo one among policy makers, renders HIV/AIDS a low priority issue. Government officials, private and public sector medical staff, schools, private and public institutions and employers require further sensitization on HIV/AIDS and protecting the rights of PLHIV. National human rights organizations and women's groups must be involved in policy design and laws need to be amended to clearly spell out protections for PLHIV and most-at-risk populations.

II. Civil Society Participation

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation? Rating: 3

Civil societies invite top leaders to patron and attend HIV-related events and activities, including workshops, in order to gain support and strengthen advocacy efforts. The recommendations of civil society are taken into account during planning and implementation of national HIV programs and activities. However, outside of the Ministry of Health, national level support for HIV/AIDS is still weak.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts) Rating: 2

Local NGOs and CBOs were not heavily involved in, or informed on, issues concerning the National AIDS Strategy.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included

a. in the National AIDS strategy? Rating: 1
b. in the national AIDS budget? Rating: 3

c. national AIDS reports? Rating: 1

4. To what extent is civil society included in the monitoring and evaluation of the HIV response?

a. developing national M&E plan? Rating: 2
b. participating in the national M&E committee/working group responsible for coordination of M&E activities? N/A
c. M&E efforts at local level? Rating: 3

NGOs and CBOs are willing to contribute more to M&E efforts; however funding remains a challenge and further capacity building and coordination with the national M&E department at the National AIDS Program is necessary. It is currently not common practice to share national reports with NGOs and CBOs.

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of diverse organizations (eg networks of people living wih HIV, organizations of sex workers, faith-based organizations)? Rating: 3

Organizations are diverse to some extent; however more organizations need to work directly with MARPS, especially MSM and IDUs. Faith-based organizations could provide strong support; however they need to be made more aware of the importance of working with vulnerable populations.

6. To what extent is civil society able to access:
a. adequate financial support to implement its HIV activities?: Rating: 2
b. adequate technical support to implement its HIV activities?: Rating: 2

NGOs and CBOs in other countries in the region appear to receive greater technical support regarding outreach, M&E, implementation challenges...etc. Financial support is available; however it is difficult for civil society to access because of bureaucracy, especially within the UN system, and technical weaknesses. NGOs sometimes become frustrated and focus their efforts on issues other than HIV/AIDS.

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

Prevention for youth : 25-50%
Prevention for IDU : less than 25%
Prevention for MSM : less than 25%
Prevention for sex workers : 51-75%
Counselling and Testing : less than 25%
Reduction of Stigma and Discrimination: over 75%
Clinical services (OI/ART)*: N/A. This is the responsibility of the Ministry of Health
Home-based care: N/A
Programs for OVC: N/A

Overall, how would you rate the efforts to increase civil society participation in 2009? Rating: 8

Since 2007, support of civil society participation has increased significantly. Civil society staffs have been invited to participate in internal and external conferences and workshops. They have been included in the Country Coordination Mechanism and the UNODC Task Force for IDUs and HIV/AIDS. The National AIDS Program supports networking efforts among NGOs, CBOs and UN agencies.

Challenges include the need for greater civil society participation in M&E. National HIV/AIDS reports need to be shared and the contributions of civil society highlighted.

III Prevention

1. Has the country identified the specific needs for HIV prevention programs? Yes

How were these specific needs determined?
Through meetings and feedback sessions conducted with NGOs, MARPs and PLHIV and the field experiences of civil society organizations.

1.1 To what extent has HIV prevention been implemented?

HIV Prevention Component	The majority of people in need have access	
Blood safety	Agree	
Universal precautions in health care settings	Agree	
Prevention of mother-to-child transmission		Don't Agree
IEC on risk reduction	Agree	
IEC on stigma and discrimination reduction	Agree	
Condom promotion	Agree	
HIV testing and counseling	Agree	
Harm reduction for injecting drug users		Don't Agree
Risk reduction for MSM		Don't Agree
Risk reduction for sex workers	Agree	
Reproductive health services including sexually transmitted infections prevention and treatment		Don't Agree
School based HIV education for young people		Don't Agree
HIV prevention for out of school young people		Don't Agree

HIV prevention in the workplace	Don't Agree

Overall, how would you rate the efforts in the implementation of HIV prevention programs in 2009? Rating: 8

Achievements include greater participation of PLHIV and MARPS in program planning and implementation. Challenges include financial constraints when implementing programs to support MARPS who want lifestyle changes and the lack of direct support to IDUs and MSM.

IV Treatment, Care and Support

1. Has the country identified the specific needs for HIV treatment, care and support programs? Yes

How were these specific needs determined? Discussions with PLHIV, civil society and other stakeholders.

HIV Treatment, Care and Support Service	**The majority of people in need have access**
Antiretroviral therapy	Agree
Nutritional care	Don't Agree
Pediatric AIDS treatment	Agree
Sexually transmitted infection management	Agree
Psychosocial support for PLHIV and their families	Agree
Home based care	Agree
Palliative care and treatment of common HIV related infections	Agree
HIV testing and counseling for TB patients	Agree
TB screening for HIV infected people	Agree
TB preventive therapy for HIV infected people	Agree
TB infection control in HIV treatment and care facilities	Agree
Cotrimoxazole prophylaxis in	Agree

HIV infected people	
Post exposure prophylaxis	Don't Agree
HIV treatment services in the workplace or treatment referral systems through the workplace	Don't Agree
HIV care and support in the workplace	Don't Agree

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2009? Rating: 7

Achievements include monthly financial support provided to PLHIV as of mid-2009**,** the regular availability of ARVs, strong psychosocial care and support from the National AIDS Program, and the inclusion of PLHIV in most activities.

PLHIV report that they receive excellent treatment, care and support from the National AIDS Program. However, outside of the program, they face tremendous health care obstacles. Many public and private sector physicians refuse to treat PLHIV, admission into hospitals is a very complicated process and even simple procedures, such as dental extraction, are difficult to access. PLHIV also reveal that they are facing government resistance to the idea of establishing a society to represent themselves and their interests.

Annex 3

List of UNGASS Support Committee Members

Government Representatives

- Dr. Bassam Hajawi, Director of Communicable Disease Control and Director of the National AIDS Program
- Dr. Assad Rahhal, Deputy Manager of the National AIDS Program
- Dr. Rajai Al Azza, Head of the STI Division and VCT Management Center
- Dr. Jamal Anani, Director of the National Center for the Rehabilitation of Addicts
- Lt. Colonel Anwar al- Tarawneh, Head of the Judicial Police Division of the Anti Narcotics Department

Civil Society Representatives

- Jumana Haj Ahmad, UNICEF Adolescents Specialist
- Marwan Odetallah, Board Member of Future Guardians
- Jehan Murjan, Director of the Bushra Center for Studies and Research