GLOBAL AIDS

RESPONSE PROGRESS REPORTING

Country Progress Report

Hashemite Kingdom of Jordan

January 2012-Decemeber 2013

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2. Abbreviations

AIDS Acquired Immune deficiency Syndrome
AND Anti Narcotics Department
ART Antiretroviral therapy
ARV Antiretroviral
BCC Behaviour Change Communication
CBO Community based Organization
CCM Country Coordinating Mechanism
CRC Correction and Rehabilitation Centre
CSO Civil Society Organization
DoS Department of Statistics
FSW Female Sex Worker
GFATM Global Fund to Fight AIDS, TB and Malaria
GNI Gross National Income
HBV Hepatitis B Virus
HCV Hepatitis C Virus
HIV Human Immunodeficiency Virus
IBBS Integrated Biological and Behavioural Surveillance
IDU Injecting drug user
IEC Information, Education and Communication
ILO International Labour Office
IRD International Relief and Development
JPFHS Jordan Population and Family Health Survey
KAP Knowledge, Attitudes and Practices
KPHR Key Populations at Higher Risk
MSM Men who have Sex with Men
MoH Ministry of Health
MoI Ministry of Interior
MoL Ministry of Labour
MoPIC Ministry of Planning and International Cooperation
MoSD Ministry of Social Development
M&E Monitoring and Evaluation
NAF National AID Fund
NAP National AIDS Programme
NCRA National Centre for the Rehabilitation of Addicts
NSP National Strategic Plan
NGO Non Governmental Organization
OP Operational Plan
OI Opportunistic Infection
PEP Post Exposure Prophylaxis
PLHIV People Living with Human Immunodeficiency Virus
PSD Public Security Department
RH Reproductive Health
RMS Royal Medical Services
SGBV Sexual and Gender based Violence (SGBV).

STI Sexually Transmitted Infection
SATC Substance Abuse Treatment Centre
SOPs Standard Operating Procedures
TB Tuberculosis
UNAIDS Joint United Nations Programme on HIV and AIDS
UNICEF United Nations Children's Fund
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Programme
UNFPA United Nations Population Fund
UNESCO United Nations Educational, Scientific and Cultural Organisations
UNHCR Office of the United Nations Higher Commission for Refugees
VCT Voluntary Counselling and Testing
WHO World Health Organization

3. Status at a Glance

3.1 The Inclusiveness of stakeholders in the Report Writing Process

The process of preparation and submission of the country progress report was primarily led by the Ministry of Health/ National AIDS Programme, with technical and financial support provided by UNAIDS MENA-RST and in country. Assistance was provided through a contractual partner to conduct interviews with key informants, collect data to complete the National Commitments and Policies Instrument (NCPI), and further write the report. The 2014 country progress report provides data on the status of, and response to the HIV epidemic in Jordan in the previous two years (January 2012- December 2013). Primary data was obtained from a desk review of relevant documents (policies, strategies, laws, guidelines, reports) and interviews carried out with key informants. Moreover, the midterm review process of the Political declaration targets that was conducted in 2013, including assessment of national targets and prioritization of interventions and resource allocations was also helpful.

A number of consultative meetings were held with senior staff at the National AIDS Programme to identify data needs and develop a plan for data collection and analysis in February, 2014. Representatives from government, civil society, and multilateral agencies were contacted by phone and further interviewed to complete the NCPI.

The national consultation on the report was executed through a number of small meetings to verify findings with MoH/ NAP, some NGOs, and also few UN agencies and NGOs involved in the humanitarian response to Syrian refugees.

3.2 The Status of the Epidemic

Jordan is still characterised by low prevalence HIV epidemic, both among the general population and among key populations at higher risk of HIV exposure (FSWs, IDUs and MSM).

*The total number of HIV and AIDS cases registered at MoH/NAP since 1986 and till end of 2013 is **1026** (28% Jordanians and 72% Non Jordanians).*

*The total Number of Jordanians and Non Jordanians tested positive for HIV in 2012 and 2013 is **83** and **86** respectively.*

*The cumulative number of HIV and AIDS cases registered at MoH/NAP for Jordanians till end of 2013 is **283** cases (80% males and 20% females).*

*The total number of HIV and AIDS cases registered in 2012: **16** (81% males and 19% females)*

*The total number of HIV and AIDS cases registered in 2013: **19** (84% males and 16 % females)*

Sexual Contact remains the main mode of HIV transmission, accounting for almost 71% of HIV and AIDS cases registered in both 2012 and 2013.

*The cumulative number of deaths among PLHIV, and till the end of December, 2013 is **107** - all cause mortality (78% males and 22% females).*

3.3 The Policy and Programmatic Response

Jordan's national response to HIV continues to be characterized by strong political commitment. The Ministry of Health established the National AIDS programme at the time the first HIV case was discovered in 1986. Jordan has endorsed the concept of the *three ones* and in 2011 received technical assistance from UNAIDS to develop a new national strategic plan, employing a participatory process involving almost all key national stakeholders.

The new National Strategic Plan on HIV and AIDS (2012-2016) aims to continue and further guide Jordan's national response to HIV, and identifies the following key strategic areas for the period 2012-2016:

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

The Jordanian Ministry of Health Strategic Plan (2013-2017);

The Ministry of Health developed its Strategic plan for the years 2013-2017. The strategic plan identifies nine thematic areas for work of the Ministry of health in the next five years: primary, secondary and tertiary heath care, financial management, human resource management, infrastructure, quality of health care services, regulation and supervision, knowledge management and leadership. The MoH continues to identify HIV and AIDS as a key area under primary health care/ control of communicable diseases, and further identifies three indicators to monitor it:

- Prevalence of HIV/AIDS,
- Prevalence of HIV/AIDS among the population group (15-24) years of age
- Proportion of HIV/AIDS patients who can get appropriate treatment for their illness.

United Nations Development Assistance Framework (2013-2017) - Jordan;

Efforts were in place to include HIV and AIDS in the newly developed UNDAF (2013-2017) - under the following:

Outcome 3: Jordan is providing equitable delivery of quality social services for all people/ Output 3.4 National institutions are better able to provide quality and equitable health care programmes to address communicable and non-communicable diseases.

Outcome 4: Jordan has institutionalised necessary policies and mechanisms for effective and inclusive participation of young people in social, cultural, economic and political life/ Output 4.3: National organisations are better equipped to institutionalise healthy lifestyle programmes including reproductive health for young people including most at risk groups (includes KPHR).

National Strategy for Women (2013-2017);

The Cabinet of Ministers endorsed the National Strategy for Women (2013-2017), which seeks to empower women at all fronts; socially, legally, politically and economically, and further guarantees their rights to a life free of all forms of violence and discrimination.

3.4 Indicator Data for GARP Reporting

Target One: Reduce Sexual Transmission of HIV By 2015		
General Population		
1.1Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	**N/A**	Data is available from the 2012 JPFHS which included a series of questions that inquired about women's knowledge about AIDS and their awareness of modes of transmission of the human immunodeficiency virus (HIV). In addition, respondents were asked if they knew of behaviors that can prevent the spread of HIV. While 99% of ever married women (11,352 respondents- age group 15-49) have heard of AIDS, knowledge of HIV prevention measures was low. Overall, only 13% of women have comprehensive knowledge about HIV and AIDS and less than 10% of ever married women age (15-24) have this comprehensive knowledge. - The percentage of women age (15-19) who say HIV can be prevented by the following (total number of respondents is 278): Using condoms (51.5%), limiting sexual intercourse to one uninfected partner (70.2%), using condoms and limiting sexual intercourse to one uninfected partner (40.5%). - The percentage of women age (20-24) who say HIV can be prevented by the following (total number of respondents is 1,207): Using condoms (57.6%), limiting sexual intercourse to one uninfected partner (82.1%), using condoms and limiting sexual intercourse to one uninfected partner (50.1%).
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	**N/A**	
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	**N/A**	

1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	**N/A**	
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	**N/A**	
1.6 Percentage of young people aged 15-24 who are living with HIV*	**N/A**	* Countries with generalized epidemics
Sex workers		
1.7 Percentage of sex workers reached with HIV prevention programmes	**Amman:** 76% **Irbid:** 94%	Data source: Integrated Biological and Behavioral Survey, 2013 - preliminary analysis of priority variables. An Integrated Biological and Behavioral Surveillance study was conducted in 2013 among FSWs in the three main cities: Amman, Irbid and Zarqa, employing RDS methodology. Analysis of priority variables for data from Amman and Irbid using RDS analyst is completed to date. The relevant questions analyzed aimed at measuring exposure to HIV prevention interventions and did not specify a time period. **Amman:** The total number of respondents: 361 The number of respondents who replied "Yes" to both questions: 275 **Irbid:** The total number of respondents: 101 The number of respondents who replied "Yes" to both questions: 95 - Data is also available on the total number of FSWs reached with any form of HIV and AIDS education in the kingdom in the previous two years: **1874 FSWs.**
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	**Amman:** 80% of the respondents (18-43 years of age) have reported using a condom the last time they had sex	Data source: Integrated Biological and Behavioral Survey- 2013 - Preliminary analysis of priority variables.

	with a client; 33% of respondents were < 25 years of age and 67% > 25 years. **Irbid:** 67 % of the respondents (20-39 years of age) reported using a condom the last time they had sex with a client; 17% of the respondents were < 25 years of age and 83 % > 25 years.	**Amman:** Numerator: 269 Denominator: 356 **Irbid:** Numerator: 67 Denominator: 99
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	**N/A**	
1.10 Percentage of sex workers who are living with HIV	**0.45%** **Amman:** 0.6% **Zarqa:** 0.5%	Data source: Integrated Biological and Behavioral Survey-2013- preliminary analysis of priority variables. Data is available on the number of female sex workers who participated in the 2013 IBBS study and were tested for HIV; a total of 672 FSWs have been tested for HIV and three were found to be HIV positive (**0.45%)** **Amman:** Number of FSWs tested: 358 Number of FSWs tested positive for HIV: 2 **Irbid:** Number of FSWs tested: 102 Number of FSWs tested positive for HIV: Zero **Zarqa:** Number of FSWs tested: 212 Number of FSWs tested positive for HIV: 1
Men who have sex with Men		
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	**Amman:** 52% **Irbid:** 63%	Data source: Integrated Biological and Behavioral Survey- 2013- Preliminary analysis of priority variables (Amman and Irbid) A total of 656 MSM participated in the study. Analysis of priority variables for data from Amman and Irbid using RDS analyst is completed to date. The relevant questions analyzed aimed at measuring exposure to HIV

		prevention interventions and did not specify a time period. **Amman:** The total number of respondents: 313 The number of respondents who replied "Yes" to both questions: 164 **Irbid:** The total number of respondents: 133 The number of respondents who replied "Yes" to both questions: 84 -Data is also available on the total number of MSM reached in the previous two years with any form of HIV and AIDS education in various governorates: **842 MSM.**
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**N/A**	Data is available from 2013 IBBS on condom use by partner type the last time the respondents had anal sex with a male partner: **Amman:** (313 MSM surveyed)- Data is available on: 1. Condom use during last anal sex with a paying client: Reported condom use was low; only 19% of the respondents (44 respondents) who reported having ever received money in exchange for sex reported using a condom during last anal sexual intercourse. 2. Condom use during last paid sex: Condom use last time the respondent bought sex from a male partner was low (only 27.5% did); 72.5% did not use a condom (34 respondents). 3. Condom use during last time sex with occasional sexual partners: 85% of the respondents who reported having sex with occasional partners in the past six months (185)- reported NOT using a condom the last time they had anal sex. **Irbid:** (133 MSM surveyed)- Data is available on: 1. Condom use during last sexual intercourse with a paying client- *Although the number of respondents who reported ever selling sex was small (n=10), almost two thirds of them

		reported using a condom during the last anal sex with a paying client. 2. Condom use during last paid sex –N/A 3. Condom use during last time sex with occasional sexual partners: 92 % of the respondents who have responded to the question (119) reported using a condom the last time they had sex with occasional sexual partners; only 8% reported not using it.
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	**N/A**	
1.14 Percentage of men who have sex with men who are living with HIV	**0.2%** **Amman:** 0.2%	Data source: Integrated Biological and Behavioral Survey-2013 - preliminary analysis of priority variables. Data is only available on the number of MSM who participated in the 2013 IBBS and were tested for HIV; a total of 656 MSM have been tested for HIV; only one person was found to be HIV positive. **Amman:** Number of MSM tested: 313 Number of MSM tested positive for HIV: 1 **Irbid:** Number of MSM tested: 133 Number of MSM tested positive for HIV: Zero **Zarqa:** Number of MSM tested: 210 Number of MSM tested positive for HIV: Zero Data Source: MoH/NAP- Amman VCT: *Data is also available on the number of registered HIV and AIDS cases for Jordanians in the past two years- as per the mode of transmission: 2012: Total number of HIV and AIDS registered: 16 Percentage of MSM living with HIV: **3** (19%). 2013: Total number of HIV and AIDS registered: 19 Percentage of MSM living with HIV: **11** (58%).

TARGET 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015		
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	**N/A**	Data source: Reports of national NGOs which have implemented a "syringe distribution" community based programme in five main governorates in Jordan- the first structured NSP in the country. Data is only available on the numerator; a total of **71527** syringes have been distributed in 2013.
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	**N/A**	
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	**N/A**	
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	**N/A**	
2.5 Percentage of people who inject drugs who are living with HIV	**N/A**	Data Source: MoH/NAP- Amman VCT: *Data is available on the number of registered HIV and AIDS cases for Jordanians in the past two years as per the mode of transmission: 2012: Total number of HIV and AIDS registered: 16 Percentage of MSM living with HIV: **Zero** (0%). 2013: Total number of HIV and AIDS registered: 19 Percentage of MSM living with HIV: 2 (10.5%). Moreover, data relevant to the denominator is available from the two main public drug treatment centers: the Ministry of Health National Centre for Rehabilitation of Addicts (NCRA) and that from the Public Security Department- Substance Abuse Treatment Centre (SATC) and for all types of drugs, not only those injected. The total number of admissions for 2013 was 1051; all were tested for HBV, HCV and HIV. Test results for each are as follows: HBV (7 cases), HCV (57*) and HIV (None). *Possible duplication error.

Key population	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a) Men who have sex with men	Yes	2013	Not available to date
b) People who inject drugs	No		
c) Sex workers	Yes	2013	Not available to date
d) Other key populations—please specify which key population in the comments box.			

1) the definition used of the population;

Amman and Irbid:

MSM: Males age 18 and above who have had anal intercourse with another male at least once in the past six months in Amman (for Amman survey) or Irbid (for Irbid survey)

FSWs: Females age 18 and above who have received cash in exchange for sexual intercourse (vaginal or anal) at least once in the past month in Amman/ Irbid ((and also the city should be specific to the city where the survey is taking place)

2) the method used to derive the size estimate;

Mapping exercise in both cities

Multiplier Method- Unique object distribution

3) Site specific estimates for all available estimates. N/A to date.

TARGET 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**		
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	**N/A**	Data is only available on the numerator. Three HIV positive pregnant women received Antiretroviral medicine during the past 12 months to reduce the risk of MTCT. * All three HIV positive pregnant women were already on ART before their pregnancy.
3.1a Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	**N/A**	Data available is relevant to the numerator; None of the pregnant women living with HIV (registered cases) who gave birth in 2013 breastfeed.

3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	**100%**	Number of infants who received an HIV test within two months of birth, during the reporting period: one infant Number of HIV-positive pregnant women (registered cases) giving birth in the last 12 months: one woman
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	**N/A**	

TARGET 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015		
4.1 Percentage of adults and children currently receiving antiretroviral therapy*	**N/A**	Data is only available for the numerator; for the total number of patients with regular adherence to medications and as reported by treatment unit/ Amman VCT reports: Total number of adults and children currently receiving ART and with regular adherence to medication: 111 - 96 males and 15 females. Males (96): One child in age group (5-9) years The remaining 95 are in age group (15 years and older). Females (15): One child in age group (1-4) years, and another (15-19) year. The remaining 13 are in the age group (20 years and older).
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	**100%**	The reporting period is January 1 to December 31, 2013; the indicator was calculated by using the total number of patients who started antiretroviral therapy, any time during the 12-month period from January 1 to December 31, 2012. Numerator: 16 patients Denominator: 16 patients

TARGET 5: Reduce Tuberculosis deaths in people living with HIV by 50% by 2015		
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	**N/A**	Data is available on the numerator; none of the adults and children with HIV infection who received ART in accordance with nationally approved treatment protocol were started on TB treatment within the reporting year

TARGET 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries		
6.1 Domestic and international AIDS spending by categories and financing sources	**Total Expenditure/year:** 3,048,517.5 2012- 1, 968,902 USD 2013- 1, 079,615.5 USD International AIDS spending- GFATM: 1,048,517.5 USD 2012- 968,902 USD 2013-79,615.5 USD National AIDS spending: 2000000 USD 2012:1000,000 USD 2013: 1000,000 USD	International Spending has been calculated based on GFATM grant- expenditures for 2012 and 2013. National AIDS spending has been estimated by MoH, based on general expenditure on prevention, treatment and care, programme management and administration, infrastructure, incentives for human resources and research in 2012 and 2013.

TARGET 7: Eliminating gender inequalities		
7.1 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		Data is only available from the 2012 JPFH Survey. Overall, more than one third of women (36%) reported that they have experienced either physical or sexual violence. The percentage of ever married women aged 15-49 who have ever experienced physical or sexual violence, disaggregated by age group: 15-19 (37.5%) - (15-17(42.5%) and 18-19 (36.1%)), 20-24 (32.6%), 25-29 (39.3%), 30-39 (38.6%), and 40-49(33.1%). One-third (34%) of ever-married women age 15-49 have experienced physical violence at least once since age 15, and 13% have experienced physical violence within the 12 months prior to the survey; percentage of women who have ever experienced physical violence since age 15 (including violence in the past 12 months) - disaggregated by age group: 15-19 years (31.1%), 20-24 years (31%), 25-29 years (37.1%), 30-39 years (36.9%) and 40-49 years(31%). The most commonly reported perpetrator of physical violence is the current husband (57%). More than one in four (27%) women report physical violence by a brother, one in five (21%) women report physical violence by their father, and one in ten (10%) women report physical violence by a former husband.

		Sexual Violence: nine percent of ever-married women age 15-49 report having experienced sexual violence at least once in their lifetime- Percentage of ever-married women age 15-49 who have ever experienced sexual violence from their current or former husband, disaggregated by age group: 15-19 years (12.9%), 20-24 years (4.5 %), 25-29 years (10.3 %), 30-39 years (9.5 %) and 40-49 years(9.6%).Percentage who have experienced this sexual violence in the 12 months preceding the survey disaggregated by age group: 15-19 years (12.9%), 20-24 years (4.3%), 25-29 years (7.2%), 30-39 years (5.9%) and 40-49 years(5.5 %). Sexual violence is highest among women ages 18-19 (8%).

TARGET 8: Eliminating stigma and discrimination		
8.1 Discriminatory attitudes towards people living with HIV	**N/A**	

TARGET 9: Eliminate travel restrictions
9.1 *Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed*

TARGET 10: Strengthening HIV integration		
10.1 Current school attendance among orphans and non-orphans aged 10–14*	**N/A**	
10.2 Proportion of the poorest households who received external economic support in the last 3 months	**N/A**	Data is available on the number of PLHIV who receive financial aid from the Ministry of Social Development/ National AID Fund. A total of 13 PLHIV; (5) individuals (8) and families received monthly cash assistance from NAF in 2013.

4. Overview of the AIDS Epidemic

4.1 The Jordanian context

Jordan, an upper middle income country with a Gross National Income (GNI per capita) of USD 4, 670 (World Bank, 2012) and a total population of 6,530,000 inhabitants (females 48.5% and males 51.5%) (DoS, 2014). Jordan has a youthful society; 37% of the population is less than 15 years of age, and the number of students enrolled in all educational levels accounts for 30% of population (DoS, 2012). The Jordanian economy is considered a small economy, with a dominant service sector that accounts for almost 70% of the GDP and more than three quarters of job opportunities (JPRS, 2013). The economy did not contribute effectively towards the reduction of high unemployment rates (12.6%), especially among females (females (22.2%) and males (10.6%)) (DoS, 2013). Despite the remarkable educational attainment of Jordanian females, their participation in the Labor force is inadequate (13.2%).

Jordan has achieved remarkable progress in the area of healthcare over the past decade. Health services witnessed an enormous increase, with expansion in the number of hospitals and health care centers in all geographic locations in the country. This has reflected in progress made in important health indicators (i.e. life expectancy at birth, child and maternal mortality rates, birth rates, and eradication of some diseases such as polio). Jordan also has one of the highest rates of public health spending in the region (7.72% in 2011) – with the proportion of spending on primary, secondary and tertiary health care for the same year being 28% and 63.5% respectively. Although Jordan is experiencing an epidemiological transition, best characterized by the increased burden of Non Communicable Diseases (cardiovascular diseases, cancer, and diabetes), emergence of some communicable diseases (i.e. Hepatitis C, E and HIV, and drug resistant strains of some- such as TB) constitutes a concern (MoH/DCC, 2012), all bearing in mind the significant increase of the population brought about by forced migrations to Jordan since 2011. Additional challenges that the country is yet to address include: broadening the scope of health insurance services to include broader segments of Jordanian society, improving quality of health services, reducing the total fertility rate to attain the "Demographic Opportunity" and the major confront – the country's inability to generate sufficient financial resources to cover health care costs (HPC, 2013; MoH, 2013; MoPIC, 2013).

Syrian Crisis:

The escalation of the Syrian civil war and deteriorating security situation have led millions of Syrian nationals to flee and seek refuge into neighbouring countries, with an influx of more than 600,000 individuals into Jordan to date (total number of Syrian refugees registered with UNHCR is 587, 308[1]; males comprise (48.5%) and females (51.5%)). More than half of this population (53%) is less than 17 years of age (**Figure 1**). Approximately, 20% of Syrian refugees reside in refugee camps (the largest of which is Al Zaatari refugee camp in the north, hosting almost 120,000 Syrians); the vast majority of Syrians reside in non camp rural and urban areas (EPDF, 2014). The majority of those registered with UNHCR, and living outside camps reside in the four governorates: Mafraq, Amman, Irbid, and Zarqa (**Figure 2**) (UNHCR, 2014a).

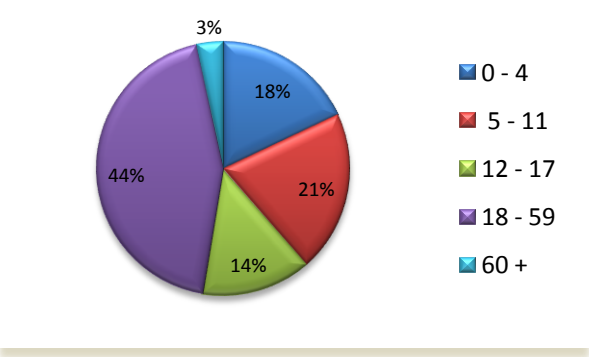

Figure 1: Registered Syrian Refugees- Age Profile (2013)

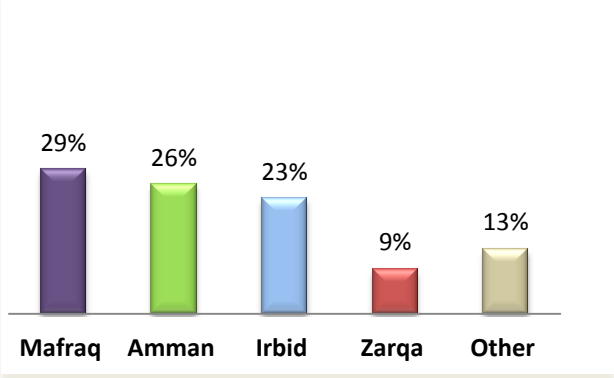

Figure 2: Registered Syrian Refugees outside camps- Governorate of Residency (2013)

[1] Ministry of interior estimates this number to be almost one million (EPDF, 2014).

Receiving this large number of refugees means an immediate increase of the Jordanian population by 8% (Jordan Population Growth Rate is 2.2%) (EPDF, 2014); expectation is for this number to continue to increase, with a possible larger and sudden influx, fuelled by the targeted violence in Syria, the collapse of public services in many areas and the increasing cost of living in the country (UNHCR, 2014b).

Jordan is not a signatory member of the 1951 Convention relating to the Status of Refugees; in absence of any international or national refugee instrument in force, the 1998 Memorandum of Understanding between UNHCR and the Government of Jordan regulates the roles and responsibilities of the Kingdom as a host country, immigrants themselves and UNHCR as an observer and sponsor, and ensures provision of protection and access to basic services (HPC, 2013; UNHCR, 2014a).

The burden of hosting the Syrian refugees and accommodating their immediate, interim and future needs has had a multifaceted impact on Jordan and host communities. The burden is best characterized by the direct costs of providing subsidized items (food- flour, water and fuel- gas and electricity), enrolment in basic, primary and secondary education, and the provision of primary, secondary and tertiary health care services. Indirect impacts of the crisis are best represented in the increased burden on public finance, worsened trade deficit and losses to vital economic sectors, exacerbating vulnerabilities for the underprivileged segments of the Jordanian population and deterioration of access to basic services in the most affected governorates (especially in the northern part of the country where the majority of Syrian refugees reside), as well as the negative effect on trade and the environment (MoPIC, 2013).

4.2 General Population:

In light of available evidence to date, Jordan continues to be characterized by a low prevalence HIV epidemic, with low levels of HIV both among the general population and the key populations at higher risk, namely Men who have sex with men (MSM), Female Sex Workers (FSWs) and Injecting Drug Users (IDUs).

Population data on the knowledge, attitudes and practices about HIV and AIDS is only available for women and girls in the age group (15-49) from the 2012 Jordanian Population and Family Health Survey which included a series of questions that inquired about women's knowledge about AIDS and their awareness of modes of HIV transmission. In addition, respondents were asked if they knew of behaviors that can prevent the spread of HIV. While 99% of ever married women (11,352 respondents- age group 15-49) have heard of AIDS, knowledge of HIV prevention measures was low. More than half of the women know that the risk of HIV infection can be reduced by using condoms and limiting sex to one faithful and uninfected partner, a slight increase from the 2007 DHS. Most ever-married women know that HIV can be transmitted from mother to child during pregnancy (84%) and during delivery (72%), but less than half know that HIV can be transmitted by breastfeeding. Misconceptions about HIV and AIDS were prevalent; only 37% of the women surveyed know that mosquito bites do not transmit HIV, and two thirds of them know that a healthy looking individual can be living with HIV. Overall, only 13% of women have comprehensive knowledge about HIV and AIDS; less than 10% of ever married women age (15-24) have this comprehensive knowledge (JPFHS, 2012).

Data on HIV prevalence in the general population is scarce in Jordan. Despite progress achieved to date, Jordan still does not have a reliable HIV surveillance system. Data available on HIV prevalence among the general population for the last two years is for officially registered HIV and AIDS cases in the country, as reported from various sources (Blood banks, Public hospitals, Private laboratories and hospitals, the Royal Medical Services and Voluntary Counselling and Testing centres available in the Kingdom).

HIV testing continues to be **Mandatory** for a number of population groups in Jordan, including blood donors (only Jordanians eligible), individuals working in the public medical sector and private hospitals, all army employees returning from the United Nations peace keeping missions, and individuals admitted to public treatment and rehabilitation centres for substance abuse. Moreover, Jordanian employees working in the public sector are also expected to take the HIV test before being hired and also those requiring HIV certificates for foreign work permits. Foreigners who want to obtain a residency permit for living, marrying a Jordanian citizen, work permits, or studies in Jordan are also required to take the test. It is important to highlight that the current practice of mandatory testing, and although defiant of public health evidence and international standards, is regarded as a best practice, nurturing a false sense of security and further driving the epidemic underground.

The total number of HIV and AIDS cases registered at MoH/NAP since 1986 and till end of 2013 is **1026** (28% Jordanians and 72% non Jordanians)**;** the total number of cases registered among Jordanians and non Jordanians for the years 2012 and 2013 is **83** and **86** respectively.

The cumulative number of HIV and AIDS cases registered for Jordanians since 1986 and till end of 2013 is **283** cases (80% males and 20% females). A total of 35 HIV and AIDS cases were registered in both 2012 and 2013 (**Table 1**); **16** cases (81% males and 19% females) in 2012 and **19** cases (84% males and 16 % females) in 2013, with majority of the registered cases being in the age group **24-44** years; 24-34 (46%) and 34-44 (29%). Up to December 2013, a total of **107** deaths were registered (78% males and 22% females) – all cause mortality.

Mode of Transmission- Registered HIV and AIDS cases - Jordanians	2012	2013	Total
Sexual Transmission	**12**	**13**	**25**
Heterosexual Transmission	9	2	11
MSM	3	11	14
IDU	**0**	**2**	**2**
MTCT	**1**	**0**	**1**
Blood Transfusion (abroad)	**1**	**0**	**1**
Unknown	**2**	**4**	**6**
Total	**16**	**19**	**35**

Table 1: Registered HIV and AIDS cases among Jordanians according to Mode of Transmission (MoH/NAP, 2012 and 2013)

Sexual Contact remains the main mode of HIV transmission, accounting for almost 71% of HIV and AIDS cases registered in both years. Injecting drug use contributes at 6%, and both Mother to Child transmission and blood remain minor modes of transmission (**Figure 3**).

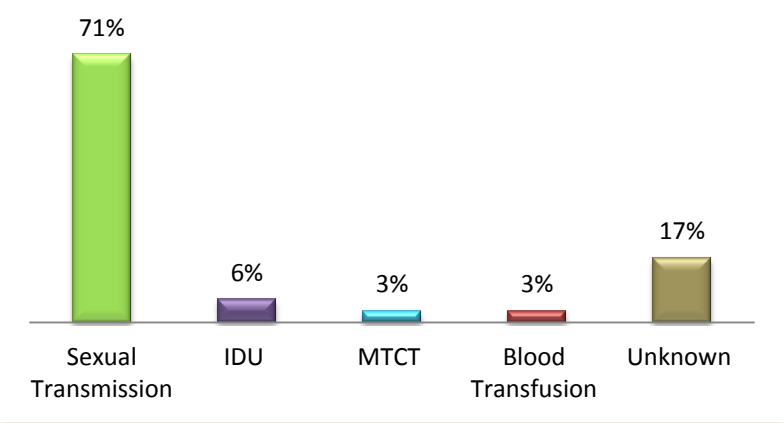

Figure 3: Registered HIV and AIDS cases among Jordanians according to Mode of Transmission (MoH/NAP, 2012 and 2013)

Data available from the MoH/NAP on the sexual mode of HIV transmission for the last four years is illustrated in **Figure 4**. Although heterosexual and male same sex sexual transmission contributed equally (47% each) to total number of cases registered in 2010, data for the years (2011-2013) show a gradual increase in the number of HIV and AIDS cases attributing to male same sex transmission, with the highest being registered in 2013. The significant increase witnessed last year can partially be attributed to implementation of the IBBS study among MSM, and the passing of information that went about it in the target communities- although there is not enough evidence to support this assumption.

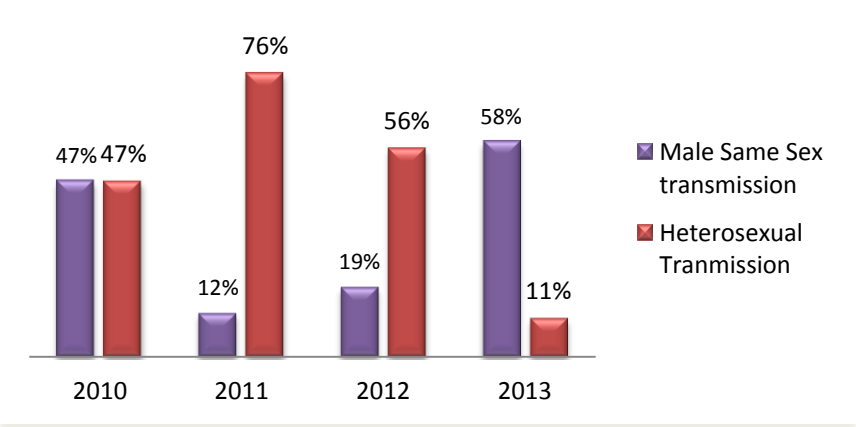

Figure 4: Sexual Mode of HIV Transmission- Jordanians (MoH/NAP, 2010- 2013)

NAP/ Hotline:

Analysis of data available from the hotline records (2013) indicates the following; the NAP/ Hotline service received a total of 222 calls in 2013. The majority of callers were in the age group 20-34 years, and the highest educational level attained by majority (83%) was a university degree. The majority of callers were single (73%), and males comprised (91%). Unsafe sexual practices were the most common risk behaviour reported, with 68% of the callers asking about risk of unsafe sexual practice (male having sex with a female (88%) and male having sex with male (12%)); the majority of those (79%) indicated that unsafe sex was inside Jordan. Additionally, 18% of the callers asked for information about HIV and AIDS (**Figure 5**).

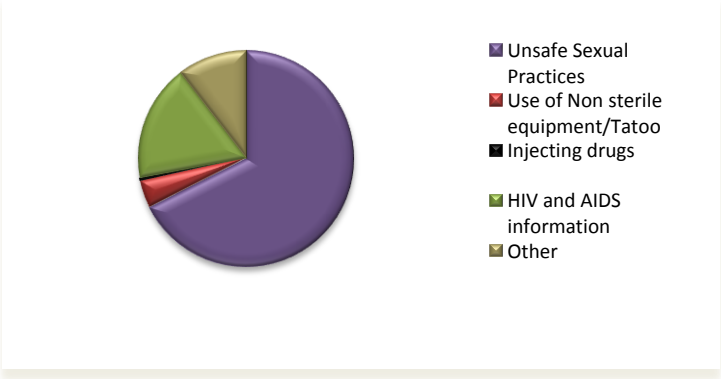

Figure 5: Risk Behaviours reported- MoH/NAP Hotline (2013)

4.3 Key Populations at High Risk of Infection:

An Integrated Biological and Behavioural Surveillance study was conducted in 2013, funded by the GFATM (Jordan's Round 6 proposal requirement). In light of the low prevalence epidemic in Jordan, it is vital to focus efforts on KPHR who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response.

The IBBS study was designed to measure the extent to which HIV is affecting KPHR (FSW and MSM), and to assess the potential for the virus to spread. Main objectives of the study were to provide an estimate of the prevalence of HIV among MSM and FSWs in the three main cities: Amman, Irbid and Zarqa and assess knowledge, attitudes and behavioural factors regarding HIV and AIDS. Moreover, the study aimed at providing an estimate of the sizes of these populations, all serving the purpose of generating evidence that will guide the design of HIV prevention interventions and establishment of services for these population groups. Moreover, this constituted an opportunity to strengthen research capacity of the national team.

Preparations for the study comprised execution of small scale, basic mapping exercises and conducting a number of key informant interviews in all three cities, to better inform the research design. Consequently, an RDS sampling method was employed. The study ran for three months (June- August, 2013). Analysis of data for priority variables identified for both Amman and Irbid is completed to date, using RDS Analyst software. More work on data analysis of all variables and report writing will be in place in the near future. The study findings available to date highlight key vulnerabilities and risks, but a number of factors restrict their generalisability to the broader population of

MSM and FSWs in the same cities and nationally (including possible bias in the sampling strategy and compromised in fully implementing all protocol particulars).

Table 2 provides details about each of the study sites, including HIV prevalence figures for both MSM and FSWs study populations.

City	Amman		Zarqa		Irbid		Total
KPHR	**MSM**	**FSW**	**MSM**	**FSW**	**MSM**	**FSW**	
Sample Size	313	358	210	212	133	102	1328
HIV +	**1**	**2**	**0**	**1**	**0**	**0**	**4**
Total/city	671		422		235		
Total MSM	656						
Total FSW	672						
HIV Prevalence- MSM	0.2%						
HIV Prevalence- FSW	0.45%						

Table 2: IBBS study – MSM and FSWs- Numbers and HIV Prevalence (MoH/NAP, 2013)

Men who have Sex with Men

Preliminary findings of priority variables analysed for MSM reveal the following:

Amman:

The total number of participants in the study was 313 MSM. The majority of respondents (67%) were within the age group 18-25 years and almost 80% of them have completed secondary (33%) or higher than secondary/equivalent education (48%). 61.5% of the respondents were Jordanian and the remaining 37.5% were from other nationalities. The participants were asked about the types of drugs used; alcohol was the most common substance reported; 72.5 % of the participants reported having tried alcohol, followed by Hashish (13%). Psychotropic tablets came next, and only 2.4% reported having tried heroin. Almost 6% of the respondents reported having injected any of the drugs mentioned in the last twelve months.

Sexual History: numbers, types of partners and condom use

A quarter of the respondents reported ever having received money in exchange for sex, with the mean age reported for first having received money for sex being 17.6 years. One third (35%) of respondents who reported ever having received money in exchange for sex reported having 2-5 clients in the past six months, 27.5% more than 5 clients, 26% reported one and 11% had none. An important finding in this regards is that the majority (89.4%) of the respondents who reported ever receiving money in exchange for sex with a man reported first doing so at the age of **19 years** or less. Condom Use- only 19% of the respondents who reported having ever received money in exchange for sex reported using a condom during last sexual intercourse. Moreover, and with regards to frequency of condom use in the past six months, only 4.4% reported "always" using a condom; 52% reported never using it, and 27% reported its infrequent use.

Additionally, 9.4% of respondents reported ever paying a partner in exchange for sexual intercourse; 25% of respondents who reported ever paying a partner in exchange for sexual intercourse reported paying only one partner, and a quarter (25%) have paid 3-5 partners. Condom use last time the respondents bought sex from a

male partner was low; 72.5% of respondents (n=34) reported not using a condom. Moreover, and with regards to frequency of condom use in the last six months with paid partners, only 8.3% reported that they and their partners used condoms consistently. 52% reported never using it.

Occasional partners: 36% of respondents reported not having any occasional sexual partners in the past six months; 17.5% reported having one, 42% reported 2-5, and 4.6% reported more than five. (85%) of the respondents who reported having sex with occasional partners in the past six months reported NOT using a condom the last time they had sex. Frequency of condom use: 57.4% of respondents who reported having sex with occasional partners in the past six months reported never using a condom and only 3.6% reported always using it.

Sex with a female: 29.5 % of the respondents reported ever having sexual experience with a female. One third of the men who ever had a female sexual partner did not have one in the last six months; 35% had one, and the remainder had two or more female partners. Only 13% of respondents who reported having had sex with a female partner during the past six months reported using a condom; 87% did not. With regards to frequency of condom use: 2.5% of the respondents who reported having had sexual intercourse with a female partner during the past 6 months reported never using a condom; only 2% reported using it at all times.

Findings on exposure to Interventions; 52% of the respondents in Amman answered yes to both questions, on whether they were aware of NGOs providing services to help with health concerns and whether they were provided with HIV information or a condom by an NGO outreach worker or a peer educator.

Irbid:

The total number of participants in the study in Irbid was 133 MSM. The majority of respondents (83.5%) were within the age group 18-25 years, and almost 87% of them have completed secondary (50%) or higher than secondary/equivalent education (37%). 84.5 % of the respondents were Jordanian, and 15.5 % were from other nationalities. The participants were asked about the types of drugs used; once again, alcohol was the most common substance reported; 69 % of the participants reported having tried alcohol. Psychotropic tablets came next. 9.4% of the respondents reported having tried hashish and only 1.5% reported having had tried heroin. Almost none (.01%) of the respondents reported injecting any of the drugs mentioned in the last twelve months.

Sexual History: numbers, types of partners and condom use

Only 9.4% of the respondents reported ever having received money in exchange for sex with a man, with the mean age reported for first receiving money for sex being 17.6 years. Moreover, the majority of these reported having had 2-5 or more than 5 clients in the past six months. Of the small number of respondents who reported ever selling sex (n=9), the majority also reported that they had first done so at the age of **19 years** or less;

Condom use-although the number of respondents who reported ever selling sex was small, almost two thirds of them reported using a condom during the last sexual intercourse with a client. Frequency of condom use; only 22% of respondents who reported having ever received money in exchange for sex in the past six months reported always using a condom. 8.9% reported using it frequently while 17% reported its infrequent use. 10% of them reported never using it.

Moreover, findings show that only 2.8% of the respondents reported ever paying a partner in exchange for sexual intercourse.

Occasional Partners: 83.5 % of the respondents reported having had more than five occasional sexual partners in the past six months; almost 12% have had 2 – 5 and 4.6% have had none. 92 % of the respondents who have had sex with occasional partners in the past six months reported using a condom the last time they had sex ; only 8% reported not using it. Moreover, and with regards to frequency of condom use with occasional partners in the past six months, 88 % reported Always using a condom and only 10% reported its infrequent use. None reported never using it.

Sex with a female: 86 % of the study participants reported ever having sexual experience with a female, with an average number of four different female partners in the past six months. 22.6% of the men who reported ever having had a female sexual partner reported two female partners in the past six months, 20% reported three, 13.2 % reported four and 8.9% reported five female partners. Condom use was high with 87.3 % of respondents who have had sex with a female partner during the past six months reporting its use. With regards to frequency of condom use- 79% of the respondents reported always using a condom in the past six months; moreover, 9% reported its frequent use while 10% reported never using it.

Findings on exposure to Interventions, 63% of the respondents in Irbid answered yes to both questions; on whether they were aware of NGOs providing services to help with health concerns and if they were provided with HIV information or a condom by an NGO outreach worker or a peer educator.

Female Sex Workers:

Preliminary findings of priority variables analysed for FSWs reveal the following:

Amman:

A total of 358 FSWs participated in the IBBS study in Amman. 53 % of the respondents have completed secondary/equivalent (39%) or higher than secondary/equivalent (14%). Almost 29% of the study participants have completed primary/equivalent education. 89 % of the respondents were Jordanian and the remaining 11% were from other nationalities. According to marital status, 36% of the participants were currently married, 32% divorced and only 20% were single, never married.

Sexual History: numbers and types of partners and condom use

The majority of participants (59%) reported 2- 5 male clients the last day worked; 30% had one client and 10% have had more than five; the average number of clients the last day worked was almost three. 80% of the respondents have reported using a condom the last time they had sex with a client. Moreover, 50% of the respondents' reported that their last clients were Jordanian nationals.

51% of the respondents reported sexual intercourse with more than five male clients in the past month; 43% reported 2-5 clients and 2.3% reported sexual intercourse with one client. The mean number of clients in the past month was almost nine. The Mean number of regular male clients for the participants who have had sexual intercourse within the past month was almost four; (80%) of them have had 2-5 regular male clients and (16%) have had more than five.

Moreover, 43% of the respondents reported having had more than five "one-time" clients in the last month; and 23% reported having 2-5. 20% reported having had one "one-time" client while 13% have had none; the average number of "one- time" clients last month was almost six.

The mean number of non paying partners the participants have had sexual intercourse with in the past month was almost two; 68% of them have had sex with one non paying partner in the past month and 23% have had sex with two. 8% had zero non paying partners in the past month.

Means through which the respondents usually find clients: 42% mentioned madams as one of the top three places they find clients, 37% mentioned pimps, 28% mentioned bars, 27% mentioned streets and 17% mentioned hotels.

Irbid:

A total of 102 FSWs participated in the IBBS study in Irbid. Almost 85% of the study respondents have completed secondary/equivalent (62%) or higher than secondary/equivalent (23%). 13.4% have completed primary/equivalent educational level. The majority of the respondents were Jordanian (85 %). Marital status of the respondents; 45% of the respondents were currently married, 35% were divorced and 20% were widowed.

Sexual History: numbers and types of partners and condom use

The majority of participants (98 %) have had 2- 5 male clients the last day worked; 2% have had one client only. Average number of clients the last day worked was almost three. Two thirds (67 %) of the respondents reported using a condom the last time they had sex with a client. Moreover, 43 % of the respondents' reported that their last clients were Jordanian nationals.

The majority (82%) of the respondents reported sex with 2-5 clients and 18 % of them reported it with more than five male clients in the past month. The average number of clients in the past month was almost five. The average number of regular male clients for the participants who reported sexual intercourse within the past month was almost four; 90% of them have had 2-5 regular male clients in the past month and 7 % have had more than five.

30% of the respondents reported having had one "one-time" client in the last month, 30% reported 2-5 and 40% reported having had none "one-time" clients. The mean number of "one-time" clients the last month was one.

The average number of non paying partners the respondents has had sexual intercourse with in the past month was almost one; 76.4 % of respondents reported sex with one non paying partner and 23.6 % with 2-5.

Means through which respondents usually find clients: 75% mentioned cafes as one of the top three places they find clients, 55% mentioned madams, 55% mentioned pimps, 36% mentioned streets, 17% hotels and 8.4% mentioned bars. 25% mentioned other.

Injecting Drug Users:

No studies were conducted among IDUs in the last two years. Drug treatment services in Jordan are available from both the public and private sectors. Data available from the two main public drug treatment centres: the Ministry of Health National Centre for Rehabilitation of Addicts (NCRA) and that from the Public Security Department-Substance Abuse Treatment Centre (SATC) continue to indicate that heroin is the main opiate injected. Details are provided in **Table 3**:

Cases admitted/ Year	National Centre for Rehabilitation of Addicts (MoH)		Substance Abuse Treatment Centre (PSD)		Total		Total
	2012	2013	2012	2013	2012	2013	
Number of drug Abuse Admissions	504	597	578	599	1082	1196	2278
Heroin Addiction	110	171*	96	136	206*	307	513
Heroin Addiction by Injecting	69	108	77	98	146	206	352
Heroin Addiction by Inhaling	41	63	19	38	60	101	161

Table 3: Number of Inject Drug cases admitted to Public Treatment Centres in 2012 and 2013 (MoH and MoI/ AND, 2012-2013)

Heroin Addiction comprises almost 23% of admissions to both national treatment centres in the last two years; 19% of admissions in 2012 and 26% of admissions in 2013, respectively. Addiction by injection constituted almost 69% of all cases of heroin addiction admitted. Furthermore, all those admitted into both centres were tested for transmissible diseases: HBV, HCV and HIV. The total number of tests carried out in both years was 1943 tests; 46% in 2012 and 54% in 2013. All test results were negative for HIV; 9 test results came positive for HBV and 57* positive for HCV[2]. Hepatitis C is transmitted largely through percutaneous exposures and thus can be used as a proxy of risky blood injecting practices (Abu Raddad et al., 2010).

It is important to highlight that admission for heroin addiction to PSD/ SATC mandates “at least” a one month stay at the centre while this policy does not apply at MoH/NCRA.

[2] *Duplication error reported; same person admitted to both public centers in the same year.

4.4 Syrian Refugees:

The Jordanian Ministry of Health, together with assistance from UN agencies (UNHCR, WHO, UNFPA and UNICEF) and a number of national and international partners are ensuring provision of primary, secondary and tertiary health services to Syrian refugees both in camps, and outside in urban and rural areas (WHO, 2013).

The Syrian refugee health profile is that of a country undergoing epidemiological transition with a high burden of Non Communicable Diseases. Data for 2013 indicate that NCDs accounted for 17% of clinic visits in Jordan; main causes of morbidity were cardiovascular diseases (38% of visits), diabetes (24%), and lung diseases (14%) (UNHCR, 2014c). Communicable diseases also remain a public health concern with a measles outbreak in Jordan in 2013, a polio outbreak in Syria, and TB notification cases being threefold greater among Syrians in the country (MoPIC, 2013).

HIV Epidemic in Syria (2010-2011):

Available data on the HIV epidemic in Syria (2010-2011) indicate a low prevalence epidemic, with very low levels of HIV among the general population and key populations at higher risk of infection. Between 1987 and December 2011, a total of 762 HIV and AIDS cases were reported; in 2010 and 2011, 66 and 69 new cases of HIV and AIDS were reported, respectively, with sexual contact being the main mode of HIV transmission. HIV trends showed a slow but steady increase of new reported HIV cases over time, with a dominant heterosexual mode of transmission (63%), homosexual or bisexual transmission (10.5%), blood and blood products (8%), Injecting drug use and Mother to child transmission contributing at 5% each. Main drivers of the epidemic indicated: poverty, labor migration and mobility, human trafficking, an increased exposure to globalised world, the changing behavior of youth in general, and increased vulnerability of young disadvantaged population groups. KPHR remained a main contributor (UNAIDS, 2012).

Syrian Refugees: Increased vulnerability…

Data available from various sources, including that from service providers and findings of some assessments that have been carried out among Syrian refugees in Jordan highlight their experience of a number of unique challenges, trying to cope with psychosocial stress, meeting basic needs and becoming accustomed to their host community. Evidence available show that Syrian ***women and girls*** are particularly vulnerable.

Intimate partner/domestic violence continues to be the form of SGBV most commonly reported, both inside and outside camps. Sexual violence is assumed to be under reported due to stigma and fear of retribution. The risk of an increase in harmful coping mechanisms including increased exposure of women and girls to survival sex, amid their limited access for livelihood opportunities and basic services constitute a challenge.[3] Additionally, evidence available reveal high rates of early marriage; early marriage is a culturally accepted practice for many Syrian refugees, with common beliefs that married girls and women gain more respect and lessen the financial burden on their families, dismissing the reality of its long-lasting health consequences (UN Women, 2013; SGBV Briefing Note, 2014).

[3] Personal Communication, UNFPA, 2014. Although no data is available on the magnitude of survival sex or rape, a number of cases have been documented for women seeking post abortion care- (post abortion management for the months of February and March, 2014: 41 cases in Al Za`tari camp only); an assumption can be made in that these cases of unwanted pregnancies might possibly have resulted from either rape or unsafe sex.

5. National response to the AIDS epidemic

5.1 Prevention

The Jordanian Ministry of Health continues to provide a number of HIV prevention interventions in the country; MoH's continued routine Surveillance (i.e. Blood bank, Chest diseases and Immigrants Health directorate, Drug treatment and rehabilitation centres) and sustained provision of the Hotline and VCT services. Most HIV and AIDS education and outreach activities were implemented by NGOs in the past two years (mostly in 2012) with financial support from GFATM grant and technical support of the National AIDS programme. Main target communities and population groups: KPHR (MSM, FSWs and IDUs), women and girls, and youth in schools and at universities. Data available from some of the NGOs indicate that a total of 842 MSM, 1874 FSW and 796 IDUs (including small number of non Jordanians: Iraqi and to a lesser extent Syrian refugees) were reached with various HIV prevention interventions in the past two years.

Utilisation of media was remarkable. In 2012, the UNTG on HIV led the production of a high quality TV series entitled "Red Ribbon", supported by a social media campaign- to raise awareness on HIV and AIDS among youth. The initiative was led and mostly funded by UNESCO, and comprised technical input from active UNTG members to production and quality assurance of the content of six TV episodes produced by Ro'ya TV. In addition, a parallel Face book page (https://www.facebook.com/RedRibbonJO) was established and moderated by some UNTG members.

The Higher Council for Youth (HCY), with technical and financial support from UNFPA facilitated the implementation of the "Healthy Lifestyle" initiative among youth, including reproductive health (STIs and HIV/AIDS). The Higher Council infrastructure with 143 centres distributed all over the kingdom, availability of supervisors, and ability to reach 60-70 thousand youth annually constitutes an opportunity for reaching youth with effective HIV prevention interventions in the future. The HCY expressed the need for more technical assistance and resources to address this important matter.

Concerted efforts were also in place in both years to raise awareness on dangers of drugs and their impact on the physical and mental health of individuals and their psychosocial wellbeing. There was good cooperation between the PSD/ AND and Centre for Rehabilitation of addicts and various ministries, namely: MoE, MoI, MoSD, MoH, especially in the area of preventive drug educational programmes, with a component on infectious diseases –HIV, HBV and HCV. The awareness raising programmes implemented targeted various population groups, especially youth, and utilized various settings and communication channels (schools, universities, HCY centers, media (i.e. radio, TV, Social Media – FB page). Moreover, two outreach programmes for IDUs were implemented by a national NGO in 2013; the first covered the four governorates: Amman, Zarqa, Irbid and Jerash and the second further included Al Mafraq. A total of twenty outreach workers were trained specifically for this purpose, and were able to reach a total of 264 IDUs (364-new and repetitive) with awareness raising messages on HIV; moreover (71527) syringes and (7647) condoms were distributed.

The Association for PLHIV was active in implementing a number of activities in 2012, including HIV prevention interventions for some KPHR and also providing support to PLHIV, and combating stigma and discrimination. The association is no more active, partially due to financial constraints.

Continued professional development of health care providers was evident in both years (mostly in 2013). The humanitarian response to Syrian refugees constituted an opportunity to build capacities of national health care providers; Syndromic management of STIs and clinical management of rape were two extensively addressed training topics.

5.2 Treatment, Care and Support:

Commitment of the Jordanian Ministry of Health to provide all necessary -free of charge- health services, including ARV *treatment and treatment of opportunistic infections* for all eligible Jordanian patients with HIV-related illness, including for non-Jordanian spouses of Jordanian citizens continues to date. Centrality of ARV treatment initiation and maintenance is characterizing - all provided through the MoH/ treatment unit based at the central VCT in Amman. It is worth highlighting that community-based HIV testing and counseling for key populations, with linkage to prevention, care and treatment services, although recommended, is not available to date. The Treatment unit monitors the HIV patients' diagnostic and prognostic indicators in accordance with national guidelines (Plasma CD4 and CD8 counts and viral load testing, TB and Hepatitis B and C screening), and prescribes treatment, in line with WHO 2010 Guidelines (and that of Mayo clinic), and on a monthly basis. Only first line regimens are available; patients suffering side effects necessitate changing to a different first line ARV treatment.

Until the end of 2013, a total **111** patients were enrolled in ARV treatment- **regular** adherence patients- with a male to female ratio of almost 6:1 (MoH/NAP, 2013). The treatment unit monitoring of patient indicators is thorough, and this best reflects in high success rate of treatment (minimal OI and other relapses). In absence of PMTCT programmes, data is only available on the number of HIV positive pregnant women who received antiretroviral medicine during the past 12 months to reduce the risk of MTCT. A total of **three** HIV positive pregnant women did so; all three were already on ARVs before their pregnancy. Moreover, early infant diagnosis is only provided for infants of HIV positive mothers with known status. Only **one infant**, born to an HIV-positive woman received a virological test for HIV within 2 months of birth during the reporting period. Strong collaboration of the TB and HIV national programmes is significant; in the last two years, **none** of adults and children with HIV infection who received ART in accordance with nationally approved treatment protocol was started on TB treatment.

Additionally, the treatment unit provides PLHIV with a number of services, including home based care and psychosocial support. Moreover, it provides non-HIV-related medical care, and referral to support services, including social services provided by Ministry of Social Development/ National AID Fund (NAF). In 2013, a total of 21 counselling sessions were conducted for families of patients. Moreover, a total of 13 referrals and follow up to MoSD/ NAF were in place, facilitating access of five individuals and eight families to monthly cash assistance.

6. Best Practices:

Jordan's launch and adoption of a national Policy on HIV and AIDS and World of Work (2013), marks an important accomplishment towards a comprehensive national response and the protection of rights at work in Jordan. Jordan is the **first** country in the Arab region to adopt a national policy since an international labour standard on HIV/AIDS and the world of work was adopted at the 99th Session of the International Labour Conference in 2010. The policy provides a means for coordination among all involved actors, including the government, employers' and workers' organizations and civil society, with inclusion of organization for people living with HIV to catalyze prevention of HIV transmission and alleviate its impact on the world of work. The Policy applies to all workers, under all arrangements and at all workplaces- including migrant workers, and further contributes to efforts promoting decent working conditions and elimination of all forms of discrimination in the workplace.

The Policy specific objectives are:

- ✓ Protecting and promoting rights at work, and fundamental rights and equality in access to employment for people living with HIV.
- ✓ Reducing stigma and discrimination in the workplace.
- ✓ Supporting the legal review process, including amendments of national legislation to comply with international standards
- ✓ Ensuring that workers, their families and dependants have access to HIV-related prevention, treatment, care and support at and through the workplace.
- ✓ Ensuring a safe and healthy working environment within the standards of decent work.

A Technical Committee on HIV and AIDS and World of Work was established to support policy implementation and monitoring. The Technical Committee is chaired by Ministry of Labor, with strong coordination with the Ministry of Health/ National AIDS Programme, and includes representatives from a number of national stakeholders.

7. Challenges and Remedial Actions:

- ✓ Although Ministry of Health covers almost one third of the costs incurred by the National AIDS programme annually (running costs, staff and provision of other commodities- including ARVs), it has been highly reliant on funding from GFATM in the past 10 years. Jordan was deemed ineligible to apply for GFATM - Round 11 funding cycle, but submitted a "Continuity of Service" application which granted MoH/ NAP a total of almost 160, 000 USD (159, 231) for the period (January 2013- December 2014), covering almost 40% of the cost of pharmaceuticals (ARVs) and health products and commodities (non pharmaceutical) for the total number of PLHIV registered till end of 2012.
- ➢ In light of the limited funding available, MoH decided to cover the remaining 60% of the costs of pharmaceuticals from MoH budget, so as to ensure continued provision of –free of charge- ARVs and treatment for opportunistic infections for all eligible Jordanian PLHIV, including newly identified cases in 2013 and onwards. MoH will continue to cover costs related to screening of all donated blood for key pathogens, including HIV, and provision of voluntary counseling and testing services throughout the Kingdom. Moreover, it will continue to cover all costs related to monitoring the HIV patients' diagnostic and prognostic indicators. On the contrary, the limited resources available and existent restrictions that prevent funding NGOs from MoH budget will diminish MoH support for many HIV prevention interventions, especially those targeting KPHR. In light of all this, there is a need to revitalize the national multisectoral HIV coordination committee to better encourage and coordinate efforts of all stakeholders, including that of the private medical sector and CSOs. Resource mobilization, and at all levels is key to identify resources that will sustain and improve work of NAP and the main stakeholders in the future.

- ➢ A major challenge and key area addressed in Jordan's national strategic plan on HIV and AIDS is scarcity of strategic information; biological data on HIV and STIs to identify and monitor trends among KPHR and behavioural data to identify risks and vulnerabilities. In addition, the need for improving the technical capacity in this field among government and NGO technical staff and programme managers was highlighted.
- ✓ The recently designed and implemented Integrated Biological and Behavioural Surveillance study constituted an opportunity to build national research capacity to an extent, benefiting from assistance of an international expert in the field. Moreover, and despite the challenges encountered and the limited genralisability of the findings which are available to date, they still contribute to better knowledge of the

epidemic among KPHR (MSM and FSW) in the three main cities included, and will contribute to the evidence base of future interventions.

- In Jordan, the number of NGOs working in the area of HIV and AIDS is small and their capacity is limited. Moreover, many have been reliant on GFATM funding (through MoH/NAP), and have minimally invested in resource mobilization at the national, regional and international levels. To date, and although this continues to constitute a challenge to implementation of quality HIV prevention interventions, especially targeting Key Populations at Higher Risk of infection, a number of actions were in place.

- ✓ Capacity of some national NGOs working in the area of HIV prevention for the key populations (MSM and IDUs) was strengthened through participation in regional workshops; a UNAIDS workshop on design, execution and monitoring of programmes for Men who have sex with Men, and participation in the regional Harm Reduction conference and workshops conducted by MENHARA. Additionally, some NGOS expressed efforts to integrate HIV and AIDS awareness raising in existing programmes; i.e. child safety and protection, youth employability programmes, and others that focus on Syrian refugees. Few NGOs succeeded in securing funding for their programmes (IDUs).

- The comprehensiveness and quality of existent drug treatment and rehabilitation programmes provided by the two main public treatment centers constitute a challenge. Limited harm reduction interventions are in place: Information, education and communication (IEC) on HIV transmission through injecting drug use, HIV testing (and also HBV and HCV), and referrals to treatment all exist. There is strong resistance to introducing **Drug substitution treatment**, especially by the Anti Narcotics Department; centrality of services at the capital, Amman restrict a medically supervised provision of treatment, and lack of a comprehensive programme that includes psychosocial and behavioral pillars of therapy, are all hampering the introduction of OST in the public rehabilitation centers.

- ✓ Implementation of a pilot Syringe distribution programme is considered a success; the PSD/AND granted security coverage for a national NGO to implement a pilot Syringe distribution programme in five governorates in the kingdom. Moreover, and with regards to the policy environment that facilitates access of addicts to harm reduction interventions available, the proposed amendment of the national Law of Narcotic Drugs and Psychotropic Substances by PSD/AND during the reporting period is remarkable: the change proposes that first-time possession cases become eligible for treatment programs rather than penalization when detained for drug-related offences.

- The low prevalence HIV epidemic, in light of other uprising priorities (with significant emphasis on the humanitarian response to Syrian refugees) and limited awareness of importance of focusing on HIV prevention constituted a challenge for an effective UN support to the national response to HIV throughout. The UNCT support, in advocacy efforts and bringing protection standards for vulnerable population groups in Jordan more in line with international human rights conventions and standards is vital (including KPHR and PLHIV).

- ✓ Despite concerted efforts in 2013 to rejuvenate and further improve the Joint UN Team on AIDS and implement a joint programme to support the national response, success was limited. A temporary modality for UNCT support to the national response to HIV was in place; this comprised integration of HIV and AIDS in annual plans of relevant UNDAF- youth and social protection- working groups.

8. Monitoring and Evaluation Environment

Monitoring and Evaluation for HIV and AIDS is among responsibilities of the Communicable Disease Directorate/ National AIDS Programme (DCC M&E unit). Routine programme monitoring entails an active case reporting mechanism, employed by all health care providers in the kingdom (RMS, public and private laboratories and hospitals, VCT centres, drug treatment and rehabilitation centres and blood banks). Moreover, regular reporting is requested from HIV focal points in the 12 health directorates and from VCT centres distributed all over the kingdom, on progress and challenges to implementation of HIV related interventions. Key partners are also requested to provide monthly/ quarterly reports to the DCC M&E unit.

UNAIDS provided assistance to MoH in 2012, through a national consultant to develop a Monitoring and Evaluation Guide, in line with the National Strategic Plan on HIV and AIDS and its Operational Plan (2012-2016), with the aim of guiding HIV and AIDS monitoring, evaluation and surveillance activities in Jordan. The Guide is intended mainly for use of Jordan's Ministry of Health National AIDS Programme managers, M&E managers, and National AIDS Programme staff especially those with M&E responsibility at national and governorates level. Intended users also include partner organisations involved in the multisectoral national response.

The planning and execution of the IBBS study in 2013 has contributed, to an extent, to building national capacity in the area of HIV Surveillance and research, and generation of data that will help design of future programmes. Technical assistance has also been provided by UNAIDS to Ministry of Health/ National AIDS Programme in 2012, conducting an M&E training workshop for staff from MoH and relevant stakeholders, to build national capacity on a number of M&E topics- utilizing UNAIDS newly developed training tools on "Monitoring and Evaluation for HIV/AIDS programmes in concentrated and low level epidemics". The training pre and post tests showed an almost 13% increase in the level of knowledge of participants. Recommendations highlighted the need for better designed training workshops in the future, tailored to specific needs of the partner organizations, and with emphasis on both theory and the practical aspects of M&E.

Despite progress made, challenges to HIV and AIDS monitoring and evaluation expressed earlier still persist; the high staff turnover at MoH/NAP and partner organisations, lack of a management information system to store and analyze data and further guide the national response, limited capacity and specialisation of staff and lack of sustainable financial resources are all present to date.

9. Syrian Refugees- Response to AIDS Epidemic:

HIV and AIDS are addressed in work of a number of working groups involved in the humanitarian response to Syrian refugees, namely: Health working group led by UNHCR, WHO and UNFPA, and the two sub working groups on Reproductive Health (RH) and Sexual and Gender based Violence (SGBV). The groups which involve UN agencies, national and international partners aim at promoting coordination and collaboration among implementing agencies and relevant stakeholders, including the affected populations, and ensuring that appropriate standards of programmes and services are in place in context of the humanitarian response to Syrian refugees in Jordan.

Achievements to date:

- ✓ A significant number of those interviewed in preparing for the country progress report have expressed the need for more concerted efforts to address HIV prevention and enable access to confidential treatment and care for those in need- quoting one nice statement:

"HIV is a Priority because we forget it!"

- ✓ Standard procedures to prevent infections and ensure blood is screened for key pathogens including HIV are largely in place, (IAWG, 2013)[4] and in cooperation with national blood banks.
- ✓ HIV education; HIV education has been addressed in a number of awareness raising activities of the RH and SGBV working group partners, mostly targeting women and girls and youth. HIV and AIDS are addressed in the context of "healthy life style" and "sexually transmitted infections".
- ✓ Condom availability and distribution; limited availability and distribution of condoms in health facilities and NGOs, both inside camps and outside, partially attributed to cultural sensitivity.
- ✓ Capacity building of a significant number of relevant health care providers on the following: Clinical management of Rape, Syndromic management of Sexually Transmitted Infections, and case management for survivors of SGBV.
- ✓ Establishment of SGBV and Child Protection emergency Standard Operating Procedures (SOP)s
- ✓ Strong promotion for application of appropriate standards in prioritized RH health programmes and services (ensuring implementation of Minimum Initial service Package (MISP) and Clinical management of rape (CMR) standards) among all reproductive health care providers.
- ✓ Development is underway of the Gender Based Violence Information Management System (GBVIMS) with linkages to the refugee registration database; enabling safe and confidential data collection and generating evidence.

[4] Findings of an assessment carried out by The Inter-agency Working Group (IAWG) on Reproductive Health in Crises conducted of priority reproductive health services—a standard of care for humanitarian emergencies, known as the Minimum Initial Services Package (MISP) for reproductive health—in Jordan during March 2013

Existent Challenges:

- Limited access to HIV counseling and testing inside camps and outside; limited availability of HIV- Rapid test kits in health facilities/settings inside camps.

- Lack of a structured mechanism/ official agreement that ensures access of PLHIV from among the refugee population to ARVs and treatment for opportunistic infections. Existent (MoH and MoI) regulations restrict entry of PLHIV into Jordan and further deport foreigners once their positive HIV status is known; MoH is committed to ensure safety of refugees and facilitates their access to treatment, but discussions are currently in place, facilitated by UNAIDS, among all parties - to agree on a structured modality for provision of treatment and care for PLHIV from among the Syrian refugees (safe and confidential manner)[5].

- Data is generally very scarce; more assessments need to be in place- KAP studies among Syrian refugees in camps and outside to generate evidence that can help in identifying relevant HIV risks and vulnerabilities among various population groups (youth, vulnerable women and men and KPHR).

- Although HIV Post Exposure Prophylaxis medication is available as component of the Rape Kit, a number of factors restrict its utilization. The HIV PEP medications available are not registered at Jordanian Food and Drug Administration. Moreover, MoH staff knowledge of PEP is limited. A national Sexual Violence protocol is available, but it does not include emergency contraception and HIV PEP.

- HIV prevention interventions for KPHR among Syrian refugees are minimal if existent at all, both inside camps and outside. A number of initiatives targeting vulnerable girls and women are in place (economic empowerment, protection, psychosocial counseling and STI education), mainly in Zarqa and to some extent in Irbid and Amman.

- The development of the SGBV management information system, in addition to available Health information system, although helpful, but constitutes "Parallel" systems to what is already in place. Given the reality that the conflict in Syria will not come to an end in the near future and that many services are provided by MoH hospitals and health centers, and to minimize the scattered effort, an integration of these into the national health information system is preferable.

  **More thorough assessments need to be executed on various aspects of the above, to generate more evidence that will help identify and prioritize effective interventions in the area of HIV and AIDS.

[5] No official data available on the number of HIV positive persons from among the Syrian refugees, although discussions in preparing for the report have highlighted encountering some.

10. Annex I:

NCPI - PART A [Government officials]

Organization	Contact Person	NCPI Sections					
		A.I	A.II	A.III	A.IV	A.V	A.VI
Ministry of Health	Dr. Bassam Al Hijawai/Director						
Ministry of Health/NAP	Dr Assad Rahhal/ Deputy manager of NAP Mr. Ahmad Nasralla Mr. Abdulla Hanatleh						
Ministry of Health/NAP-VCT and treatment unit	Dr. Hydar Khasawneh/Director Ms. Ibtisam Kannan						
Ministry of Health/ Chest Diseases and Immigrants Health Directorate	Dr Khalid Abu Rumman/Director						
Ministry of Health/ National Centre for Rehabilitation of Addicts	Dr. Jamal Anani/ Director						
Ministry of Health/ Directorate of Blood Bank	Dr. Karim Yarfas/ Director						
Ministry of Labour	Mr. Sherine AL Tayeb/ HIV focal point						
Higher Council for Youth	Mr. Jamal Khreisat/ Director of Youth Affairs						
Higher Population Council	Dr. Sawsan Al Majali/ Secretary General						
Ministry of Interior/Public Security Department – Anti Narcotics Department- Substance Abuse Treatment Centre	Colonel Mazen Magableh/ Director						

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

Organization	Contact Person	NCPI Sections				
		B.I	B.II	B.III	B.IV	B.V
National Centre for Human Rights/ Monitoring & Ending Violations Unit	Mr. Taha Maghareiz/AIDS focal person					
Bushra Centre for Studies	Ms. Jihan Mourjan/Director Ms. Maram Al Nabulsi					
Family and Childhood Protection Society	Mr. Fadi Dawagreh/ Project Coordinator					
Nour Al Hussein Foundation/ Family Health International	Dr. Manal Al Tahtamouni/ Director					
Friends of Development and Investment Association	Mr. Ali Noubani /Director					
Curves centre for Training and Research	Mr. Ayman Omar/Director					
Family Protection Association	Ms. Amal Al Wahdan/ Director					
HIV and Law Project	Mr. Mohammad Al Nasser/ Lawyer					
Forearms for change Centre	Ms. Sahar Al Shamayleh					
Arab Bridge Centre for Development and Human Rights	Dr Amjad Shammout/ Manager					
IRD	Dr. Uma Kandalayev/ Country Director Ms. Mona Hamzah/ Health Project Manager					
UNHCR	Dr Ann Burton/ Senior Public Health Officer					
UNFPA	Ms. Layali Abusir Ms. Yasmine Al Tabba					
Y Peer	Ms. Darein Abu Lail/ Coordinator					
UNFPA/ Emergency and Humanitarian Response	Dr. Shible Sahbani/Humanitarian Coordinator Ms. Maysa Al Khateeb/ Emergency RH Officer					
WHO	Dr. Sabri Gmach/ Public Health Officer					

11. Annex II – *National Commitments and Policy Instrument (NCPI)*

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