

HIV/AIDS in Yemen

A summary briefing

Dr Rogers Busulwa

Dr Rogers Busulwa holds a medical degree and a Masters of Medicine in Community Practice from Makerere University and a Masters qualification in Health Policy, Planning and Financing from the London School of Hygiene and Tropical Medicine. He has considerable experience of working to support district health services both in Uganda and Rwanda and has undertaken extensive research into HIV/AIDS.

He is currently a Health Advisor in Sana'a with International Cooperation for Development, a programme of CIIR.

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CIIR, Unit 3 Canonbury Yard
190a New North Road
London N1 7BJ, UK
Charity no. 294329

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Located on the southern tip of the Arabian Peninsula, Yemen is bordered by Saudi Arabia to the north, Eritrea and Djibouti to the southwest and the Sultanate of Oman to the east. The southern western and south-eastern borders lie in the waters of the Red and Arabian seas respectively. The country has a population last estimated at 16 million (1994), with an urbanisation rate of 36 per cent, and one of the world's highest population growth rates, of 3.7 percent.¹

The present day Republic of Yemen was formed on 22 May 1990 by the merging of the former Yemen Arab Republic to the north, and the Democratic Republic of Yemen to the south. The country has a GNP per capita of US\$ 300² and was dealt a severe blow by the expulsion of close to 1 million Yemeni migrant workers from Saudi Arabia at the start of the Gulf Crisis in 1990. In addition to a fall in revenue inflow from the lost remittances, this resulted in a large population of destitute returnees in the country. Implementation of structural adjustment programmes since 1995 has resulted in increased food and fuel prices³. Many development agencies now report that poverty is deepening, with increases in numbers of beggars on the streets.

Health indicators are poor, with infant mortality at 96 per 1,000 live births, and a maternal mortality rate of 1,400 per 100,000 pregnancies. The total fertility rate stands at 6.4, with life expectancy at birth being 54 and 55 for males and females respectively. There is a high rate of illiteracy, with 36 and 79 per cent of males and females over the age of 15, respectively, being unable to read or write.² A recent report showed that 52 per cent of children were stunted, 13 per cent wasted and 46 per cent underweight.⁴

According to WHO estimates, per capita health expenditure in Yemen for 1997 stood at US\$ 33, equivalent to 3.4 per cent of GDP. However only 37.9 per cent of this expenditure was public, 62.1 per cent being private money. The net result was that government spending on health was only 3.3 per cent of total public expenditure, a proportion that is the fourth smallest among World Health Organisation (WHO) member states.⁴

Context

The HIV/AIDS epidemic, which emerged two decades ago, has become the leading public health problem in many developing countries. According to UNAIDS, HIV/AIDS can devastate whole regions, knock decades off national development including reversals in life expectancy and infant and child survival gains, and widen the gap between rich and poor countries. By the end of 1999 the epidemic had already claimed 19 million lives with 34 million others living with the Human Immune deficiency Virus (HIV), with the grave likelihood that most of these would die from the disease in a decade or so.

While the epidemic is most severe in sub-Saharan Africa, no region of the world has been spared. Some success stories are beginning to emerge from sub-Saharan Africa, where the epidemic has been most severe. In Uganda, and Zambia there is evidence that the epidemic is beginning to come under control, with declining general population prevalence rates. In Senegal, which is 95 per cent Muslim, successful intervention has kept the prevalence rates stable at below 2 per cent over the past 10 years. In Thailand, where the adult infection rate was estimated at 2.15 per cent at the end of 1999, successful efforts at controlling heterosexual transmission have been undermined by unchecked spread through injecting drug use and unprotected sex between men.⁵

A summary of the global adult prevalence data provided by UNAIDS for the end of 1999⁵ is presented in the Table 1. below:

Table 1. Global HIV/AIDS situation summary as at the end of 1999⁵

<i>Region</i>	<i>Adult HIV prevalence (%)</i>	<i>No. Persons, HIV-infected</i>	<i>AIDS deaths, 1999</i>
Sub Sahara Africa	8.57	24,500,000	2,200,000
Caribbean	2.11	360,000	30,000
North America	0.58	900,000	20,000
South and South East Asia	0.54	5,600,000	460,000
Latin America	0.49	1,300,000	48,000
Western Europe	0.23	520,000	6,800
Easter Europe and Central Asia	0.21	420,000	8,500
Australia & New Zealand	0.13	15,000	120
North Africa & Middle East*	0.12	220,000	13,000
East Asia & Pacific	0.06	530,000	18,000
GLOBAL	1.07	34,300,000	2.8 million

* This estimate based largely on old 1994 data. True 1999 rates were probably higher.

As can be seen from the table, in the North Africa / Middle Eastern region, the infection rates are still relatively low, with estimates of adult prevalence rates averaging 0.12 per cent. However, it should be noted that because of lack of up-to-date data, this average was of mostly old estimates, dating back to 1994, and thus, the true rates may be higher. In the specific case of Yemen, the 1994 figure used by UNAIDS for the 1999 estimate was an adult prevalence of 0.01 per cent, with no record of AIDS-related deaths.

HIV/AIDS in Yemen

Yemeni culture is strongly influenced by Islamic religious teaching. Pre and extra-marital sex are forbidden, and sexually transmitted diseases (STDs) are generally stigmatising. The stigma attached to HIV/AIDS is particularly strong, and people known to be HIV

positive or to develop AIDS have often been rejected by their immediate and extended families. It is widely believed, that premarital sexual activity among Yemenis is very low, and that the traditionally strong sanctions against extramarital sex, have been effective in keeping things this way. However, the diagnosis of other STDs in health facilities across the country suggests a significant occurrence of extramarital sex.

The true magnitude of the HIV/AIDS problem in Yemen has not been accurately determined, but there are indications that it is a growing problem. The cumulative number of HIV/AIDS cases reported to the National AIDS Programme (NAP), as of December 2000, stood at 874.⁷ These are cases diagnosed by laboratory tests performed on people applying for travel visas, clinically ill AIDS patients, during screening of blood for transfusion, and from samples taken from prison inmates. As in most developing countries, the number of registered cases in Yemen is just the tip of the iceberg.

A retrospective look at the data points to the development of the HIV/AIDS problem in the country. The number of HIV cases reported to the NAP has been increasing sharply, with a fourfold increase between 1994 and 1995, and a five-and-a-half-fold increase between 1995 and 1996. The role of possible improvements in the reporting system in this increase is unclear. However, using the WHO EPI model, the UNAIDS Yemen programme estimated that in 1997 alone, 3,083 new HIV infections occurred.⁸

Another possible inference can be made from the HIV rate among blood donors (see Table 2 and Figure 1). The sero-positive rate in this large pool increased threefold in absolute numbers from eight in 1998 to 23 in 2000, while the total number of tests reported to the NAP declined over the three years. Therefore, the percentage increase was even greater, at **sevenfold**, from 0.04 per cent in 1998 to 0.28 per cent in 2000.^{7,9,10} This is probably the more credible available indication of an increase in HIV prevalence in Yemen.

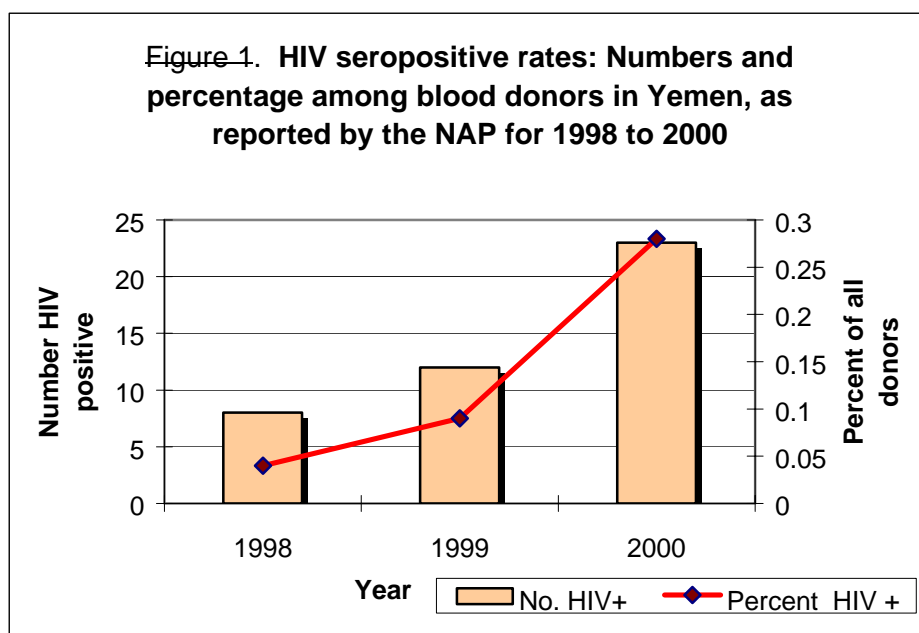
Nonetheless, the uncertainty around this estimate, including questions of sampling error and multiple donations by HIV infected persons, simply underlines the need for accurate and systematic HIV/AIDS surveillance in Yemen. Such surveillance would need to represent the general population as well as specific special high-risk and vulnerable groups within it, such as: patients with STDs and TB, men who have sex with men, commercial truck drivers and commercial sex workers.

The summary of the results of HIV tests in Yemen, reported by the NAP in between 1998 to 2000 is presented in the table and figures below.

Table 2. Results of HIV tests reported by the Yemen NAP^{7, 9, 10} during 1998-2000

Group	1998			1999			2000		
	# Tested	# HIV +ve	% HIV +ve	# Tested	# HIV +ve	% HIV +ve	# Tested	# HIV +ve	% HIV +ve
TB Patients	188	1	0.53	130	9	6.9	103	2	1.94
Prisoners	147	39 ^a	26.53^a	623	21	3.4	2,065	5	0.24
Prostitutes	88	4	4.5	73	2	2.7	37	0	0
STD patients	585	17	2.9	534	5	0.94	284	5	1.76
“Out migrants” ^b	219	4	1.82	2,073	14	0.68	1,179	14	1.18
“In-migrants” ^c	4,124	32	0.77	9,925	24	0.24	5,819	31	0.53
Blood donors	19,813	8	0.04	13,134	12	0.09	8,175	23	0.28

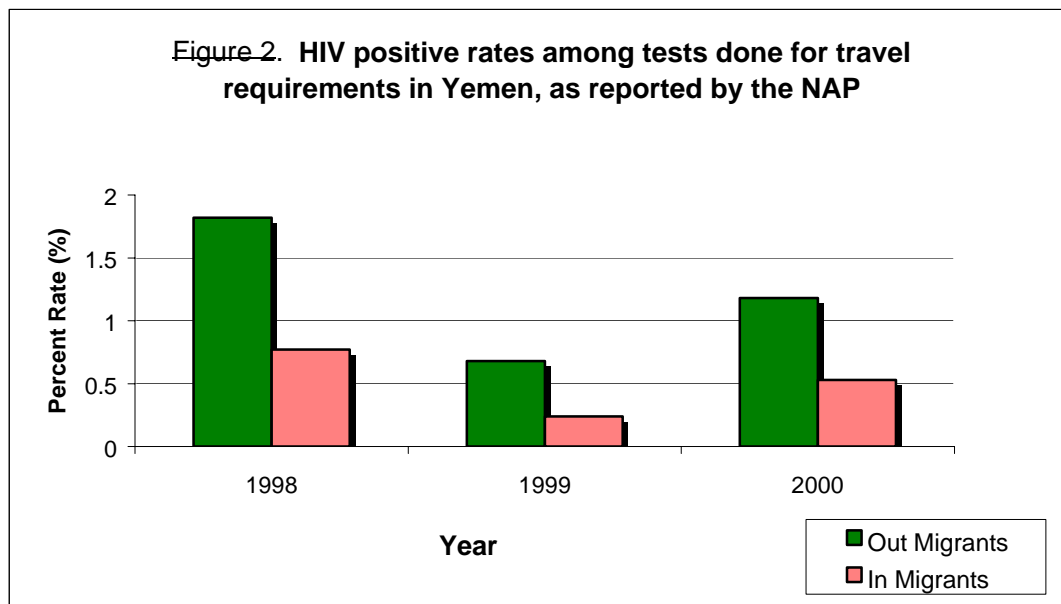
Notes: ^a These were all prisoners from outside Yemen
^b The Out-migrants were Yemenis seeking exit visas for travel purposes
^c The In-migrants are non-Yemenis seeking Yemeni Residency visas.



Because of the small sample sizes for the sub-groups, and the possibility of non-representative sampling, little by way of trends can be deduced from the above figures with regard to HIV rates among TB patients, prisoners, prostitutes, and STD patients.

As Table 2. shows, in the case of testing related to immigration, the HIV-positive rate among out-migrants was more than twice that among in-migrants, for each of the three years. Given that virtually all the out-migrants are Yemenis, and the in-migrants are from other countries, this data suggests that the long-held perception in Yemen that HIV/AIDS is an external threat that can, and should be controlled by immigration procedures, has long been overtaken by reality. The HIV rate is already higher among Yemenis than among the non-Yemenis tested for visas. This brings into question the rationale and

effectiveness of the policy of using visa access restriction to control the spread of HIV in the country. This data is represented graphically in Figure 2.



Other Sexually Transmitted Diseases (STDs)

Because of the absence of a good surveillance system, information on other sexually transmitted diseases (STDs) is also vague. The Ministry of Health estimates that 150,000 infections occur every year, but the basis and validity of this estimate is not clear. In 1998, HIV sero-prevalence among STD patients was found to be 3.7 per cent. Other non-officially acknowledged testing reportedly found a rate of 6.6 per cent (67/1010) of HIV among STD patients in one large city. Twenty per cent of the Yemeni population is estimated to be infected with Hepatitis B, a disease which although much more infectious, generally has similar routes of transmission to HIV. While Yemen's Central Health Laboratory estimates that 80 per cent of blood is screened for HIV and hepatitis B before transfusion, independent observers believe the figure to be closer to 50 per cent.

There is as yet no comprehensive overarching national policy for control of HIV in Yemen. Confidentiality for people living with HIV/AIDS (PLWAs) is still not well addressed at the policy and operational levels. Under current practice all laboratories are required to report to the NAP all HIV positive cases, including the identity of the persons. Clinical care of AIDS cases is also generally poor. Health staff are untrained with regard to providing PLWAs with clinical care, and as a result, many health workers express unwillingness to nurse persons infected with HIV. This fear appears to stem from lack of knowledge and information, with risk of infection from HIV being seriously exaggerated. Nevertheless, there is evidence of gradual change and some clinicians are advocating for better clinical care of PLWAs. One director of a tertiary level government hospital in Sana'a has indicated willingness to host an AIDS care unit at his hospital.

The National AIDS Programme (NAP)

The National AIDS Programme holds the responsibility for leading and implementing national plans and policy in relation to HIV and AIDS. It currently falls under the Primary Health Care (PHC) general directorate, under the Service and Care division of the Ministry of Public Health and Population (MoPHP).

Until now, the NAP has managed to carry out only a limited range of activities. Participation by civil society organisations has been recent, and likewise limited. The NAP suffers several constraints including: a low level of skills and capacity to undertake planning, write funding proposals, undertake operational research and elaborate policy proposals. Other constraints include: a relatively low priority within the structure of the MoPHP resulting in limited financing from the government, high turnover of staff leading to a lack of continuity and inadequate office space, equipment and transportation.

As a result of constraints faced by the NAP its recent activities have consisted mainly of small-scale awareness activities focused on new doctors, teachers, secondary school students and *Sheikhs* in Sana'a and other governorates. To a more limited extent, the NAP has been involved in surveillance, counseling, providing training in STD management, and in a recent UNAIDS-sponsored research study, exploring knowledge attitudes, beliefs and practices (KAPB) related to PLWAs in Sana'a.

Civil society organisation involvement

Some Yemeni non-governmental organisations (NGOs) have already been involved or expressed interest in HIV/AIDS activities. Those already active include the Yemen Association for Prevention of AIDS (YAPA), the Yemen Family Care Association, Partners for Development (PAD). The mass media has run stories on HIV/AIDS from time to time. Other organisations which have expressed keen interest in HIV/AIDS work include: the Girl Guides and Scouts Associations, the Teachers Association and the Charitable Society for Social Welfare (also referred to as 'Islah').

The ICD Yemen Programme is currently developing its work to include a programme of support to local organisations working on HIV/AIDS issues. Current plans include the recruitment of a person specialised in HIV/AIDS work to identify priorities with local partners, to provide training and support to awareness raising and information provision.

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