HIV and development challenges in Yemen: which grows fastest?

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Box 1. Yemen at a glance

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
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<tbody>
<tr>
<td>Literacy rate: females</td>
<td>31%</td>
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<tr>
<td>Life expectancy at birth: males</td>
<td>57.0</td>
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<tr>
<td>Physicians per 10,000 population</td>
<td>2.2</td>
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<tr>
<td>Contraception use: married women ages 15–49</td>
<td>23%</td>
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<tr>
<td>Access to safe drinking water:</td>
<td>17%</td>
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<tr>
<td>Urban population:</td>
<td>27%</td>
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<tr>
<td>Population below age 15:</td>
<td>46.2%</td>
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<tr>
<td>Fertility rate:</td>
<td>6.5 births per woman</td>
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</tbody>
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Yemen is epidemiologically classified as a country with ‘gradual growing accumulations of HIV infections and at least some high-risk groups identified’ (Jenkins and Robalino 2003). From 1997 to 2001, the top means of HIV transmission was heterosexual, at 77.3%, followed by homosexual transmission (16%), blood products (6.8%), and intravenous drug users representing a new risk group. The 1995 Strategic AIDS Plan of the Ministry of Public Health estimated there to be a total of 5000 sex workers and 25,000 homosexuals, with estimates of 150,000–170,000 sexually transmitted disease cases per year (UNAIDS 2004a).

In the Global AIDS Epidemic Report (UNAIDS 2004b), the adult (ages 15-49) prevalence rate for Yemen is estimated at 0.1% with the number of HIV-infected individuals ranging from 4000–12,000. The World Health Organization (WHO) suggests that a hidden epidemic is developing in Yemen, where for every known HIV case, at least 15 others lie undetected. The gender gap has closed. In 1995, the gender ratio of HIV-infected men to women was 4:1, in 1999 it was 2:1 and in 2000, it reached 1:1 (UNAIDS 2004a).

An increasing number of refugees—close to 70,000 Somalians and Ethiopians (Jenkins and Robalino 2003)—and close to 1 million Yemenis expelled from Saudi Arabia during the Gulf crisis (Busulwa 2001) expose new HIV risk factors by straining traditional behavioural controls. Gulf nationals also come to Yemen to take advantage of a lower priced sex trade due to poverty, desperation and lack of education (Al-Masmari 2005).

Sex workers in the capital reflect the economic poverty and disintegrating social order (Jenkins and Robalino 2003).

But HIV is not the only challenge facing Yemen. The International Monetary Fund (2002) identifies Yemen’s main issues as its high population growth, poverty, illiteracy, poor school enrolment, poor health coverage and growing water scarcity. The UNDP’s Human Development Index ranked Yemen 148th in 2003, 149th in 2004 and 151st in 2005, placing it as one of the least developed countries in the world. The decline is due to reduced state welfare activities, and reductions in the public sector workforce and in subsidies on basic goods in order to service international debt. Inefficient bureaucracy, failure to meet minimum standards of fiscal transparency and corruption are reasons why development funds were cut by a third by the World Bank in 2005 (IRIN 2005a). Per capita GDP is reported at between US$1,653 (WHO 2006a) and US$460 (World Bank in IRIN 2005a), with close to 40% of Yemenis being unable to obtain food and basic living requirements.

The population grows by 4.2% annually (UNAIDS 2004a), with infrastructure and development unable to keep pace. The Ministry of Interior has projected there are 12.7 million youth under the age of 19 from a population of 21.8 million in 2005 (58.3%). More than twice as many Yemeni women than men are illiterate, with rural areas having the highest rate at 85% (David 2000). With no teacher training, overcrowded classrooms, centralized decision-making and a strong influence of tradition, education is difficult to reform (Alzubaidi et al. 1998).

Seventy-five per cent of the country is threatened by waterborne diseases due to unclean drinking water (IRIN 2005b). Only 17% has access to clean water (IFAD 2006). This lack of water leads to urban migration, where the promise of economic sustainability is greater, yet where the same reality spells high-risk behaviour and unsafe decision-making to meet basic needs. Most of Yemen’s population is rural, and only 30% of the rural population has access to local health services (Jenkins and Robalino 2003) making HIV a low priority, especially when other concerns can be more immediately fatal.

Khattab (2005) discusses women’s vulnerability in the Middle East region, given that the majority of AIDS cases are in the 20–39 year age group, with the highest levels in the 20–24 year group. She premises that the socialization process in the region...
is governed by traditional values, ill-founded beliefs, stigmas and the misinterpretation of religious texts, leading women to be financially dependant, lacking in skills, education and the same socialization afforded to men, making the exercise of control difficult.

Many men, unwilling to wait for years before having sanctioned sex with future partners, have sex with other men as substitutes for women. While forbidden by religion and law, same-sex activity is reported in Yemen (Jenkins and Robalino 2003), with these same men having unprotected sex with women serving as the epidemiological bridge to the wider population (UNAIDS 2004b).

Finally, WHO (2003) estimates that 70–90% of adult males, 30–50% of adult females and 15–20% of children under 12 consume khat daily. This plant leaf, legal to consume, is a classified drug. Up to 50% of household incomes are diverted to khat purchases (WHO 2003). This contributes to poverty and diminishes life options, increasing vulnerability to HIV.

While this development context makes for a challenging picture, one very positive asset is the government’s commitment to HIV. The National Strategic Framework for the Control and Prevention of HIV/AIDS addresses eight key areas (see Box 2) in its multi-partner and multi-ministry approach to prevention and treatment.

Dr Fawzia, the Program Manager of the National STD and HIV/AIDS Program (interview by author, July 2005), explains that the National Strategic Framework is firmly supported by the Yemeni government and raises no moral dilemmas. She states that Muslims have an obligation to educate themselves and that addressing their health and well-being includes HIV and, for some, may include the use of condoms. While Islamic guidance is part of HIV education, the reality is that individuals cannot and do not always act morally (Hasnain 2005). Dr Fawzia adds that it is not considered the government’s role to judge the morality of behaviour, but that it does fall within their mandate to protect against disease and enable informed decision-making.

A crisis line operating as of July 2004 accommodates calls about sex, sexually transmitted infections and AIDS in the capital as part of the Program’s activities. A voluntary counselling and testing centre operates in Sana’a, and while there is no available treatment, the clinic does give free medicine for opportunistic diseases and provides pre-test and ongoing post-test counselling. These same services are now offered in testing centres in other governorates. Large scale campaigns in schools, universities, prisons, factories, youth sport clubs and refugee camps are being undertaken and include condom discussion and issues of stigmatization.

Political, cultural and religious leaders have been and continue to be lobbied on the importance of addressing HIV. A member of parliament, who is also a prominent Sheikh, organized an HIV Support Group for positive Yemenis and has publicly and frequently spoken out on the issue, advocating for more rights and recognition for positive citizens. Two other groups have received official government approval, one being led entirely by positive Yemenis demonstrating political advocacy on their own behalf.

While infection surveillance and data collection is still low, continued surveillance into behaviours that lead to transmission have included data on attitudes, behaviours and knowledge. Information about risk groups, prevalence levels and means of infection point to resource, information and development gaps, and provide direction in education and training interventions for professionals, students and the general public. Human resource capacity is being addressed in a number of ways. For example, the Faculty of Medicine and Behavioral Sciences in Aden regularly trains medical students in HIV care, management and ethics, inviting speakers from a number of non-governmental organizations, and is increasingly including social and development issues like domestic violence as part of the medical curriculum.

Despite the harsh difficulties of managing HIV without anti-retrovirals, there is a plan to begin providing medication to a small cohort of people through global initiatives in the coming months. While thousands will still go without, this initiative represents an incentive to provide accurate prevalence data and to begin to demonstrate hope in the treatment of patients who formally had none.

Compared with other neighbouring Gulf countries, Yemen has developed the framework for a very comprehensive national AIDS programme. Other Gulf countries, some having almost 30 times the GDP of Yemen, have not yet seriously acknowledged and addressed HIV to this extent. The biggest strength of the Program is that HIV is considered as an issue of development and not a purely medical issue that needs to be contained. The Program seeks to prevent HIV by tackling the very social issues that allow it to thrive, to curb its spread where it does exist, and finally to promote and protect the rights and dignity of HIV-positive Yemenis.

The biggest challenge is that the development drawbacks are so severe, persistent and have long roots. At the moment, HIV rates appear to be manageable compared with marginal development gains, but for how long? Through political and economic marginalization, partly due to Yemen’s perceived ties to terrorism, and its status as a delinquent and corrupt debtor, the HIV situation is likely to worsen. Without the help of increasing international donor support, regional investment from neighbouring countries and the inclusion of Yemen into the global community, thousands will be vulnerable to HIV if they do not die of other causes first.
References


