YEMEN REPUBLIC

UNGASS COUNTRY PROGRESS REPORT 2012
YEMEN
Narrative Report

Reporting Period: January 2010 – December 2011

TABLE OF CONTENTS

GLOSSARY OF TERMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARVS	Anti-retroviral drugs
GF	Global Fund
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MOHE	Ministry of Higher Education
MOE	Ministry of Education
MOPH&P	Ministry of Public Health and Population
MSM	Men Having Sex With Men
MTCT	Mother to Child Transmission
NAP	National AIDS Program – Ministry of Health
NGOs	Non Governmental Organizations
NPC	National Population Council
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSTC	Population Studies and Training center
STD	Sexually transmitted disease
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV.
UNICEF	The United Nations Children's Fund
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV
WHO	World Health Organization
MoLSA	Miniastry of Labour & Social Affairs
NTP	National TB Program

LIST OF TABLES

LIST OF FIGURES

1. STATUS AT A GLANCE

1.1 The inclusiveness of the stakeholders in the Report writing process

This annual country report has been prepared for Yemen for the years 2010 and 2011 through ongoing work between the Population Studies and Training Center (PSTC) in Sana'a University and the National AIDS Program (NAP) in Yemen. Preparation of this report was supported by the United Nations Joint Program on HIV (UNAIDS) and was marked with broad participation of various bodies and sectors involved in AIDS response. This report included valuable contributions from representatives of governmental and non-governmental organizations (NAP, UNAIDS, National Population Council (NPC), Al Saleh Foundation for Development, AID association, Sana'a University (PSTC), Yemeni Family Care Association (YFCA), Social services Association (SSA), Progressio International Organization, Abi Musa al-Ash'ari Association, Yemen Red Crescent Society (YRCS), Health management and Information center in the ministry of Public Health and Population (HMIC-MoPHP), Ministry of Education (MoE), Ministry of Human Rights (MoHR), Ministry of Labor and Social Affairs (MoLSA), HIV Care & Treatment Centers, World Health Organization (WHO), United Nations Higher Commissioner for Refugees (UNHCR), Ministry of Youth (MoY), United Nations Development Programme (UNDP), United Nations Children's fund (UNICEF), in addition to the representative of target groups and beneficiaries.

The report preparation has begun with holding an introductory workshop representing 27 participants from various stakeholders, governmental and non-governmental organizations, UN agencies on 6th of March 2012 at Sana'a University (PSTC), Annex (4). The workshop aimed to familiarizing the participants with the global and country 2012 AIDS reporting process and its significance, to discuss and define core indicators, the necessary steps for preparing the report and the role of each stakeholder in its preparation. As a result, procedures, responsibilities and tasks were identified and assigned to various stakeholders to collect data from relevant actors, and coordinate with other stakeholders in writing the report.

The 2011 political crisis in the country with its multidimensional profound consequences has negatively affected the implementation, monitoring and evaluation of HIV programme activities. One of the

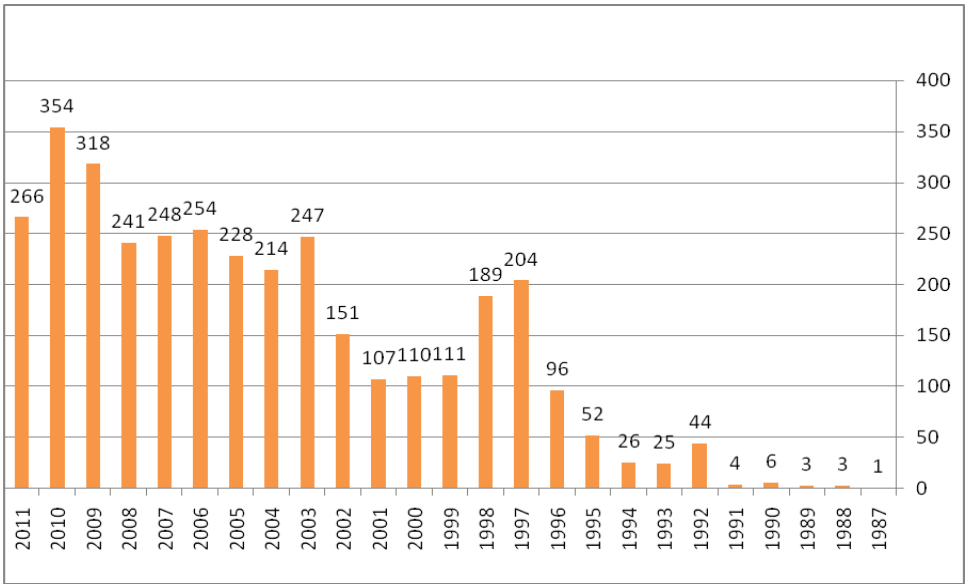
most challenges encountered in writing this report was the difficulty in obtaining accurate data for the year 2011.

Numerous interviews have been conducted with national stakeholders (including governmental agencies, civil society and UN agencies). The questionnaire was circulated to the full range of governmental sectors and civil society organizations (as workshop recommendations). In addition, the government's response was coordinated by the MoPH&P through the NAP, which sent an official letter to the relevant bodies and authorities calling for their cooperation in collecting the data required to write the report. Data collection for this report was commenced on 8th of March 2012. After completion of data collection and the draft 2012 National Progress Report was completed on 22nd of March 2012. A national workshop has been held on 24th of March 2012 to analyze and validate data with 27 representatives of the government, civil society organizations and UN agencies to make sure that it was developed in a participatory way and ensure equal chances for each stakeholder to transparently influence the final product and agree on the completed questionnaires and data collected. The second draft report has been reviewed and enrich with remarks and further inputs (Annex 5).

1.2 The Status of the Epidemic

Yemen is one of the countries with low prevalence of HIV (0.2%) in the general population according to 2011 HIV size estimates/NAP. However the evidence showed that Yemen is having a concentrated HIV epidemic among men who have sex with men (MSM) [8].
In comparison to 2009, the annual number of newly registered cases increased by 11% as 354 cases were reported in 2010 (Figure 1). This increase in the number of registered cases in 2010 is to a great extent due to the provision of HIV prevention services, referral for counseling and testing, care and support. While due to the political situation and conflict in the country during the year of 2011, the notification of new HIV cases was low and they reported 266.

Figure 1: Incidence of reported cases by year (1987 – 2011)



Furthermore, the 2011 reported HIV cases showed that 34% are females (Figure 2) and that around 81% of all the cases are aged 15-49 years (Figure 3).

Figure 2: Distribution of Reported HIV cases by Sex, 1987 – 2011

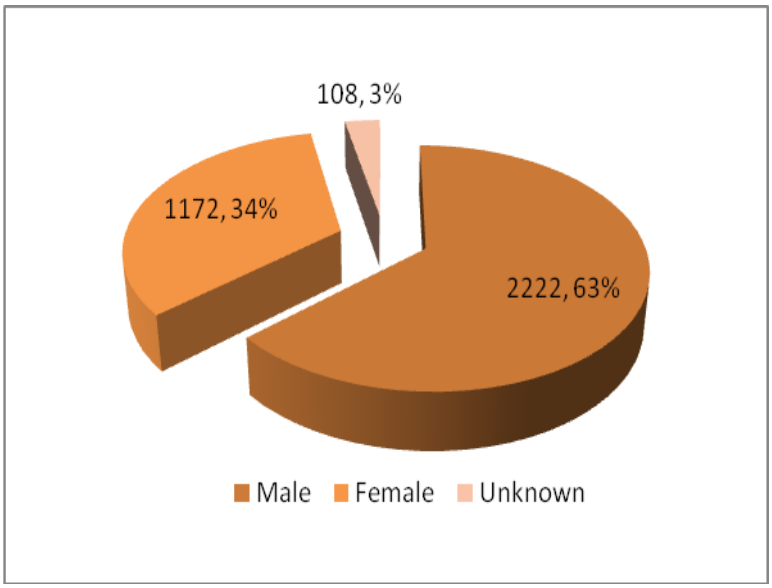
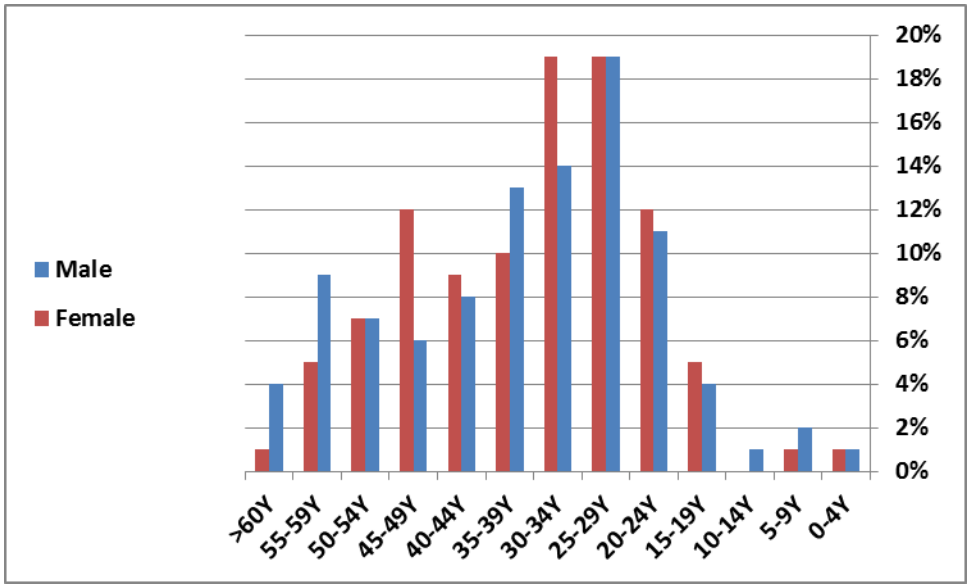


Figure 3: Age - gender distribution of 2011 reported HIV cases



Heterosexual transmission accounts for the majority (83%, 87% & 86%) of the reported HIV cases, with the next most frequent mode of transmission (9%, 8% & 7%) being homosexual transmission and (3%, 3% & 5%) of the cases being transmission from mother to child for 2011, 2010 and 2009 respectively (Table 1).

Table 1: Distribution of 2011, 2010 and 2009 HIV cases by mode of transmission

Mode of Transmission	Distribution of 2011				Distribution of 2010				Distribution of 2009			
	Gender		Total		Gender		Total		Gender		Total	
	Male	Female	#	%	Male	Female	#	%	Male	Female	#	%
blood Transmission	3	8	11	**4**	3	7	10	**3**	5	1	6	**2**
Heterosexual	**146**	**75**	**221**	**83**	**207**	**100**	**306**	**87**	**170**	**104**	**274**	**86**
homosexuals	23	0	23	**9**	27	0	27	**8**	21	0	21	**7**
using Injection	1	1	2	**1**	0	1	1	**0**	0	2	2	**1**
MTCT	7	2	9	**3**	8	1	9	**3**	8	7	15	**5**
Total	**180**	**86**	**266**	**100**	**245**	**109**	**353**	**100**	**204**	**114**	**318**	**100**

1.3 The Policy and Program Response

The HIV prevention activities in Yemen started in 1987. However, these efforts and activities have been boosted significantly since 2005 after adopting a comprehensive approach within a national strategy for prevention of HIV and care for PLHIV. This strategy, stresses on combating stigma and discrimination, and emphasizes on integration of relevant sectors responses. Such sectors include: the health care sector, including infectious diseases prevention programs, education, social welfare, prisons and immigration services. NAP works to enhance cooperation and coordination between all governmental and non-governmental entities under this strategy that constitutes the framework to develop relevant joint policies and action plans for health promotion and prevention of HIV and other sexually transmitted diseases.

However, in 2011 as a result of the political crisis in the country and its significant negative impact on activities, health facilities which provide AIDS services not exempted and some of them were collapsed. There were many difficulties and challenges, which are related primarily to the provision of health services and insufficient epidemiological data to report HIV cases. The challenges also included limited human resources, limited skills, poor procurement and supply management systems, and limited participation of civil society. Moreover, the available government support was affected due to the changing priorities of the government during the crisis to be more focused on other areas such as internal displaced population (IDP), and emergencies in terms of provision of basic services including water, electricity, food and fuel. This was resulted ultimately on the scarcity of resources for the NAP. Fortunately, the Global Fund at this phase supported the continuity of treatment and care services for the period from January 2011 to December 2012.

In 2010, with the support of the Yemeni Government and the Global Fund and a number of civil society organizations, the NAP along with its partners in the National Population Council (NPC) and the non-governmental organizations have successfully made good achievements in the past period till the end of 2010. These achievements are seen through the national response and actions made as follows:

1- Scale up of the ART services to cover five centers/sites in the main cities in the country, in which new there centers/sites were opened in Hadramout, Hodeida and Taiz governorates to provide services to patients with HIV related illnesses during 2010

2- Scale up of the HIV testing and counseling (T&C) services, and new five sites were opened in 2010 to become 27 T&C sites (at NGOs and health facilities) with a total of 10,594 beneficiaries from these services in same year.
3- Providing services to prevent HIV infection from an infected mother to child, and assessment of four more PMTCT sites has been done.
4- Mobilizing community for HIV testing through a national campaign on the occasion of the World AIDS Day;
5- Developing the Integrated Management of Adult and Adolescence Illness manual (IMAI) and updating the Antiretroviral Treatment and Care Guidelines for Adult and Children.
6- Creating a website for the three programs (AIDS, Tuberculosis and Malaria) supported by the Global Fund;
7- Expanding the condom promotion and distributing services;
8- Supplying ARVs for PLHIV among Yemenis, refugees and Yemeni expatriates;
9- Reviewing the national priorities and targets to achieve Universal Access targets towards prevention, treatment, care and MDGs. [6]
10- Conducting a number of studies and surveys in 2010 /2011, as follows:
    - Mapping and Population Size Estimates among key populations at higher risk (MSM & FSW) in five major cities, Yemen, August 2010.
    - Bio-Behavioral Survey among Female Sex Workers (FSW) in Hodeida, 2010.
    - HIV sentinels sero-surveillance among pregnant women attending ANC clinics in four Governorates, Yemen, 2010.
    - Assessment of Vulnerability to HIV within the context of trans-border migration and mobility in the geographic area of the Red sea and the Gulf of Aden (Qualitative analysis), UNAIDS, April 2010
    - Study to detect HIV among TB patients, in four governorates, 2009.
    - Study related to HIV Transmission, Existing HIV-related services and social vulnerability among of PLHIV, Yemen, Sana'a and Aden, 2011.
    - National survey to determine the knowledge, attitudes, beliefs and practices (KABP) of young people, NPC & UNAIDS, 2010
    - Assessment of the situation of Woman and Girls Living with HIV (WLHIV) in Sana'a & Aden , UNAIDS, 2011

- Bio-Behavioral Survey among Men who Have Sex with Men in Aden and Hodeida governorates, UNAIDS, 2011.
- Assessment study for the capacity and capability of prisons provide care, counseling and testing services for prisoners.

All surveys including local epidemiological and behavioral studies have confirmed old evidence indicating the need for HIV comprehensive preventive programs targeted FSW and MSM.

The focus on the preventive approach in Yemen is still a priority for the Government in the long term. In addition, there is a great need to increase these activities in response to the new needs, and to enable access to groups at higher risk.

1.4 UNGASS Indicator Data in an Overview Table

No	Indicator	Results	Source	Remarks
	A: General population			
1)	Indicator 1: Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	5.6% (15-24 Year) 6.3 % (Males 15-24) 4.9 % (Females 15-24)	KABP(2010)	Out of those who ever heard about HIV, the percent of young Yemeni (age 15-24) who gave a correct answer on the 5 questions was 5.6 % . Among females aged 15-24 the percent was 4.9 % and among males 15-24 it was 6.3 %
2)	Indicator 2: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	No data		No related data on this indicator
3)	Indicator 3: Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	1% aged 15-49	KABP (2010)	The respondents in this indicator were only Males 15-49 (1528). Only 1% (17/1528) males respondents reported they have had sexual intercourse with more than one partner in the past 12 months
4)	Indicator 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*	18% aged 15-49	KABP (2010)	Among (17) of the males respondents who reported that they had sexual relationships with one or more partners in the past 12 months , only 3 were reported that they used condom during their last intercourse [15]
5)	Indicator 5: Percentage of women and men aged 15-49 who received an HIV test in the past 12 months	No data		No related data on this indicator

	and know their results			
6)	Indicator 6: Percentage of young people aged 15-24 who are living with HIV*	No data		The indicator is irrelevant to Yemen's epidemic context as the country has a low prevalence of HIV
	B: Sex workers			
7)	Indicator 7: Percentage of sex workers reached with HIV prevention programmes.	34.22% (age 15-49 Year)	BBS -FSW(2010)	NO data disaggregated by age (The percentage of FSW who they know where they can go if they wish to receive an HIV test is 34.55% (104/301) & 33.89% (102/301) for those who had been given condoms in the last twelve months. The Composite indicator 34.219%.
8)	Indicator 8: Percentage of sex workers reporting the use of a condom with their most recent client	34.88%	BBS -FSW(2010)	NO data disaggregated by age. Based on the survey among 301 FSWs in 2010 in Hodeidah, 105/301 = (34.88%) had used condoms with their most recent client,. [11]
9)	Indicator 9: Percentage of sex workers who have received an HIV test in the past 12 months and know their results	5.98%	BBS -FSW(2010)	The biobehavioral survey among 301 FSWs in 2010 in Hodeidah, carried out, 18/301 (5.98%) had tested for HIV in the past 12 months and know their results.[11]
10)	Indicator 10: Percentage of sex workers who are living with HIV	0%	BBS -FSW(2010)	NO data disaggregated by age. There were no HIV positive cases , among FSW (301) tested for HIV in this study Whereas the bio-behavioral HIV survey in 2008 among 244 FSWs revealed an HIV prevalence of 1.23% (3/244).[17]
	C: Men who have sex with men			
11)	Indicator 11: Percentage of men who have sex with men reached with HIV prevention programmes	For < 25 year: 55% For 25 year +: 49%	*BBS MSM (2011)*	55% of respondents < 25 year reached with HIV prevention programme(know where they can go for HIV test , and they have been given condom) while only 49% for the age 25 years and more bio-Behavioral survey among 261

				MSM in 2011 in Aden and, Al-Hodeida,
12)	Indicator 12: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	For < 25 year : 15.9 % For 25 year +: 23.7 %	*BBS MSM (2011)*	23.7% at the age 25 year +: had used condom last time they had anal sex with a male partner. 18.6% had Condom used in anal sex with male partner in the last 6 months (32/172).
13)	Indicator 13: Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	For < 25 year : 19 % For 25 year +: 43%	*BBS MSM (2011)*	Respondents aged less than 25 year have low access to HIV testing (31/163 = 19%) than those who are 25 year old and more (41/95 = 43%)
14)	Indicator 14: Percentage of men who have sex with men who are living with HIV	For < 25 year : 3.1 % For 25 year +: 11.1% All age groups 5.9%	*BBS MSM (2011)*	Percentage among the age group 25 year and more is higher (10/90=11.1%) than those who are less than 25 years old (5/163=3.1%) HIV prevalence in all age groups is (15/252= 5.9%)
15)	Indicator 15: Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No data		No data available to report on this indicator.
16)	Indicator 16: Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No data		No data available to report on this indicator.
17)	Indicator 17: Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	No data		No data available to report on this indicator.
18)	Indicator 18: Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	No data		No data available to report on this indicator.
19)	Indicator 19: Percentage of people who inject drugs who are living with HIV	No data		No data available to report on this indicator.
20)	Indicator 20: Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child	2011: 2.13% 2010: 2.13% 2009: 1.25%	Prevention Unit (PMTCT, PEP&USP) -NAP	In 2010&11 (17) pregnant women received antiretroviral prophylaxis to prevent MTCT out of 800 HIV pregnant women estimated per year for each (17/800)

	transmission			In 09 (10) pregnant women received antiretroviral prophylaxis to prevent MTCT out of 800 HIV pregnant women estimated per year (10/ 800)
21)	Indicator 21: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	2011: (14.3%) 2010: (50%) 2009: (88.9%)	Prevention Unit (PMTCT, PEP&USP) -NAP	In 2009&2010 the number of infants who did virological test was high (8&9,)due to the availability of PCR test which is not the case on 2011 (only 2) The number of HIV positive pregnant women given birth in the last month was 14, 18 & 9 in 2011,2010 and 2009 respectively.
22)	Indicator 22: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	No data		No data available to report on this indicator.
23)	Indicator 23: Percentage of eligible adults and children currently receiving antiretroviral therapy*	2011: Total : 13.9% Sex: Males 8.4% Females 5.5% Age: <15 1.1% 15+ 12.8% 2010: Total : 15% Sex: Males = 5.6% Females =5.8% Age: <15 = 1.1% 15+= 14.3% 2009: Total : 8% Sex: Males = 5.5% Females = 2.% Age: <15 = 0.52 % 15+= 7.4 %	(NAP) ART&CARE unit	2011: Total: 13.9% (625/4500) Sex: Males (378/4500) Females (247 /4500) Age: <15 =51/4500= 1.1% 15+ =574/4500=12.8% 2010: Total : 15% (531/3450) Sex: Males 330/3450 = 5.6% Females 201/3450=5.8% Age: <15 = 38/3450= 1.1% 15+= 493/3450= 14.3% 2009: Total : (274/3450) =8% Sex: Males 191/3450= 5.5% Females 83/3450= 2.% Age: <15 = 18 /3450= 0.52 % 15+=256 /3450=7.4 %
24)	Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2009: 62% 2010: 61%	(NAP) ART&CARE unit	2009: 85/140 = 62% 2010: 257/423 = 61% NO data available by Age , sex disaggregation
25)	Indicator 25: Percentage of estimated HIV-positive incident TB cases that received treatment for both	2011: 19% 2010: 14%	(NAP) ART&CARE unit	As 2009 study among TB patients on sentinel sites, The prevalence of HIV among TB patents was 1.75%. The estimated number of

	TB and HIV			TB cases per year in Yemen is 14,000 The number of TB/HIV cases was 34 and 47 on 2010&2011 respectively 2011: 47/245 = (19%) 2010: 34/245 =(14%) 2009: No data available at NAP NO data available by Age , sex disaggregation
26)	Indicator 26: Domestic and international AIDS spending by categories and financing sources	2011: (1.613.920 $) , the government spent (381.395$) 2010 : (2.210.998$) the government spent (130.233$)		In 2011; Fund grant, (1.613.920 $) were received and spent on HIV programs and interventions under the auspices of the government and NAP. In addition, the government spent (381.395$) from its budget. In 2010; Fund grant, (2.210.998$) were received and spent on HIV programs and interventions under the auspices of the government and NAP. In addition, the government spent (130.233$) from its budget.
27)	Indicator 27: National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Refer to the text		Refer to the text.
28)	Indicator 28: 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	No Data		No related data on this indicator.
29)	Indicator 29: Current school attendance among orphans and non-orphans aged 10–14*	No Data		No related data on this indicator.
30)	Indicator 30: Proportion of the poorest households who received external economic support in the last 3 months	No Data		No related data on this indicator.

2. OVERVIEW OF THE EPIDEMIC

Yemen is among the world's least developed countries with GNP per capita of USD 674 (Ministry of Planning, 2005). In spite of achieving some economic development over the past decade, poverty among the population is still high with 34% of the total population and 18% are living in extreme poverty. Poverty is more widespread in rural than urban areas.

HIV prevalence in Yemen is estimated at 0.2%, classifying the country as low prevalence country in the general population, while it is moving towards a concentrated epidemic among MSM. The majority of transmission is attributed to sexual transmission whether hetero- or homo- sexual. Heterosexual transmission accounts for about 62% of the HIV cases, while about 7% of the new infections are attributed to homosexual transmission among men. By the end of December 2011, a total of 3502 cases were reported to NAP. However, the estimated number of HIV cases in Republic of Yemen is 30000 (2011 HIV size estimates/NAP).

A mapping and size estimation study of MSM and FSW was conducted in capital cities of five governorates. These included Sana'a, Hedeida, Mukalla, Aden and Taiz. The estimated total number of FSWs in all five areas surveyed ranged between 9,084 and 14,134, while that of MSM is between 7,990 and 11,819. Based on the population age 15 – 49 years for females and 10 – 59 years for males, the proportion of FSW and for MSM in each governorate was calculated. Extrapolating from the estimates in the five governorates and based on the total population of females aged between 15 and 49 the estimated number of FSW in Yemen is 58,934. For MSM the national median proportion is between 0.61% and 1.47% with the estimated number of MSM being 44,320 [12].

Bio-behavioral survey was conducted in Hodeida city using the respondents driven sampling method targeting 301FSWs and the results revealed 0% HIV. Though no HIV infection, study reveals major behavioral risk factors being low age of sexual debut, low condom use among FSW, 34.88% had used condoms with the most recent client, and 65.1% they do not use condom. The study has shown that the FSW have a very low comprehensive knowledge of HIV and only a small proportion perceive themselves at higher risk of contracting HIV

infection. This calls for intensive and comprehensive prevention and care outreach to this group [11].

Also Bio-behavioral survey was conducted in Aden and Hodeida, among 261 MSM in 2011. The mean age of participants was 23.8 (95% CI, 17.8-29.8) years. 22.7% have ever been married while 8.2% are still in marital union. HIV prevalence was 5.9% (95% CI, 4.8-7.3). Only 25.8% have been tested for HIV in the last 12 months and received back the results. 27.8% had comprehensive knowledge about HIV preventive measures and rejected common misconceptions. In 31.4% of cases, either the participants or their sexual partner(s) have reported STI symptoms in the past 12 months. About 1 % (95% CI, 0.1-9.2) reported injecting drugs in the past 12 months. The reported consistent condom use in past six months was less than 10% with different partners (including commercial sex). Only 20% (95% CI, 15.8-25) reported condom use in their last anal sex [9].

In Additional, 798 pregnant women were tested for HIV and Syphilis in 2007 in Aden and Sana'a cities where only two pregnant women tested positive for HIV (0.25%) and 16 for Syphilis (2%). In the second HIV sero-surveillance survey in 2010, NAP has expanded the geographical coverage into 4 major cities in Yemen, where 1,422 pregnant women enrolled in survey, only one tested positive for HIV giving an overall proportion of 0.07%.
Data from sentinel sero-surveillance studies carried out in 4 governorates of Taiz, Hodeida, Sana'a and Aden; HIV among 1137 incident TB patients was at median HIV prevalence of 1.75% and 0.7% for 2010 and 2006 respectively.

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 Political Leadership & Supportive Policy Environment

Yemen has many of the provisions contained in the Constitutions, as well as other laws and regulations that work to provide security for human rights and protect individuals from discrimination in education, employment and health care. Yemen is the third Arab country (after Djibouti and Sudan) in terms of important achievements in the field of legislations dealing with the protection of people living with HIV. Therefore, the Law of PHIV Rights and Protect the Community from HIV Infection in 2009 is considered a great accomplishment. Also,

good progress has been made in a national response to the HIV epidemic over the past years.

However, the political support of leaders and policy makers is still weak as mentioned in the annual report of 2009, including the inadequacy of official and religious speeches in addressing AIDS, and the lack of full commitment to provide health care for PLHIV in some health institutions; lack of financial support. The political commitment to address HIV and AIDS is represented by the following:

1- Establish and provide financial support to AIDS & STI Control Programme, including integration of NAP's annual plan into the MoPH&P plan.
2- Increase the number of NGOs that have licenses from the MoSAL and implemented HIV and AIDS activities, where the number of these NGOs has reached 20 by the end of 2011 in various governorates of Yemen.
3- Review and update the National Strategic Framework to Combat HIV and AIDS for the period 2009-2015 that will support the achievements of national objectives, targets, UA and MDG's.
4- Improve HIV response in terms of protection and human rights for PLHIV by the Security and health authorities.
5- Integrate HIV messages within health messages manual adopted by the National Center for Health Education and Media in January 2010.

3.2 Prevention Programs

The NAP has reached a great achievement in collaboration with partners from the government, UN, International and civil society organizations during the last period until the end of 2010 in various fields, including the following:

Awareness Activities

HIV health education is currently provided through NAP, NPC & NGOs. There is some improvement on people attitudes towards PLHIV comparing to 2009 due to awareness raising activities including the production and distribution of printed materials, a travelling drama theatre, lectures and seminars, and HIV and AIDS health education campaigns targeting high schools and institutes of higher education. In 2010, the number of beneficiaries was 156,276 persons from different community segments, school and university students, journalists and employees of the armed forces and security.

Although these activities addressed the general population, but also focused in reaching vulnerable and key populations at higher risk through some NGOs. Accordingly, the Behavioral Change and Communication Strategy and the messages for awareness-raising on HIV in dealing with these groups were developed but not yet used.

Moreover, awareness raising activities were evaluated to measure their effectiveness and impact through the survey employed a random sample with built-in age and gender among a selected sample of 3000 of the national population aged fifteen to forty nine. These were selected randomly from 11 governorates, covering both urban and rural areas of Yemen. The findings generated from the survey suggest that although the vast majority of respondents are aware of HIV and modes of transmission, misconceptions do exist and these remain a cause for concern. Low education, living in a rural area and older age groups were significantly associated with poor knowledge and some of the common misconceptions about HIV.

HIV Testing and Counseling

Testing and Counseling (T&C) has formed the priority number 6 in the "National Strategy Framework". in 2010, there was updated the National testing and counseling guideline and training manuals supporting by the WHO to ensure the confidential testing. Moreover, NAP has establish provider initiated approach for testing and counseling (PITC) which has been integrated within a number of health facilities and NGOs.

There are 27 T&C centers are available by the end of 2011. A growing access to services was observed but still limited reaching a cumulative number of 5,181 clients tested through VCT and PITC sites in 2010.

These services still need to be accessed by populations at higher risk, although 4% of MSM and 2% of FSW have accessed to T&C centers through the NGOs in 2010.

Condoms Use

Condom promotion and distribution are being carried out by family planning and reproductive health facilities. Under the family planning and reproductive health programmes, a total of 1.2 million male condoms were distributed.

Prevention of Mother-to-Child HIV Transmission (PMTCT)

Prevention of mother to child transmission is priority number 7 in the National Strategy Framework. A national PMTCT program was launched in early 2009 which resulted in the establishment of four PMTCT sites within ANC clinics in Sana'a, Aden and Lahj governorates. A scaling up of PMTCT services has been planned and a needs assessment was conducted in 4 new ANC clinics in Sana'a, Mukalla, Hodeida and Taiz, but not yet launched.

By the end of 2011, HIV testing was conducted in both ANC clinics and delivery rooms while not the case in 2009. The number of pregnant women who received HIV testing were 4,753 representing 1% out of estimated pregnant women per year.

In 2011, more strategic information regarding the key populations at higher risk has been available. HIV is epidemic among studied MSM in Aden and Hodeida. Risk behaviors are frequent and preventive measures are not utilized. There is a risk of transmission of HIV and other STIs to female partners of MSM. Specific socially accepted and large scale effective interventions are needed to prevent further expansion of HIV epidemic among MSM in Yemen.

Both TB and HIV have cross interactions on NAP and NTP programmes. Increase HIV in population is expected to result into increase in HIV-related morbidity in TB patiets. The collaboration has started between two programmes and the national ART guidelines for adult and children have included new policy consideration to decrease the burden of tuberculosis and HIV in populations affected by both diseases. Furthermore, TB and HIV policy has been developed in 2011 and aimed to reduce HIV and TB transmission and decrease the burden of tuberculosis and HIV in populations affected by both diseases.

3.3 Care and Treatment

Yemen is facing a serious challenge in meeting the need for health care as a result of the increase in population and the spread of various diseases, including HIV / AIDS. Coverage with health services is realized in urban areas and concentrated in major cities. The private sector provides about 60% of health services; however these services are not affordable nor always accessible to the majority of the

population residing in rural areas (75% of population). Many health facilities suffer from lack of equipment and staff, and operational budgets that affect the ease of access to health services including medical drugs. About 26 percent of all health facilities lacks drugs; 24 percent lacks the equipment; 17 percent without operating budgets, and 7 percent without health staff (Annual report of the country - Yemen 2009).

Treatment and care for PLHIV formed the priority number 9 in the "National Strategy Framework". With support from the Global Fund, five treatment and care sites for PLHIV were opened in the five major governorates that have highest prevalence rates, and ARVs is provided for free to PLHIV. Recently, NAP with the support of the WHO has updated the treatment and care guideline taking in to consideration the new recommendations of CD4 count of 350/mm3 and less to enroll patients on ART. Also a consultative meeting to review and update "patients monitoring tools" was conducted with ART team from the five governorates.

Access to HIV treatment and care services still limited in the country although the coverage has improved to 14% of people living with HIV (based on population modeling) in need of ART are currently receiving it comparing to 2009 which was 6%. Furthermore, there are 1,207 PLHIV have received OI prophylaxis and/or treatment by the end of 2011.

4. BEST PRACTICES

4.1 The political commitment

There are a political commitment and support for AIDS response in Yemen. The persistent awareness creation and advocacy activities have led to an increased level of political commitment. There is high level of government official participation in HIV and AIDS national and regional conferences and meetings; particularly the leaders in the Ministry of Health. Furthermore, there is increasing the government allocation to assure sustainability of treatment and care services.

4.2 Civil Society Organizations

Currently, there are four PLHIV Associations and Network in the major governorates are involved in AIDS responses. These Associations are built their capacities in the awareness raising and advocacy on HIV and AIDS, stigma reduction, strategic planning and resource mobilization mechanisms by support of NAP, NPC, UNAIDS, UNDP and Progressio (Int'NGO).

T&C and HIV surveys among populations at higher risk (FSW & MSM) was conducted in collaboration with CSO, and this provided opportunities for further CSO involvement in designing comprehensive preventive programmes among these groups.

4.3 Involvement of PLHIV

Although there is still a high level of stigma and discrimination against PLHIV in Yemen, however the National AIDS program continues its interests to involve PLHIV in various activities to ensuring their rights and informing them of their duties. The most important PLHIV participations are as follows:

- Involving the PLHIV as implementers for the training courses, workshops and participating on local and regional meetings on HIV and AIDS, behavior-change initiatives, providing them with information and data and epidemiological indicators, and encouraging them to present work-papers and interventions about the services provided to them, their rights and duties.
- Involving PLHIV in the decision making bodies and attending regular meetings of the country coordinating mechanism (CCM).
- Involving the PLHIV in development of plans, technical and financial reports at the NAP and civil society organizations.
- Involving PLHIV in the implementation of research studies conducted during 2010 and 2011.
- Involvement of PLHIV in the monitoring and evaluation for the implemented treatment and care services.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 Challenges

1. ***Limitation of Strategic Information****:* Although there are some epidemiological and behavioral strategic information regarding identified key populations at higher risk, including knowledge, attitudes, practices and behavior survey (KAPB), bio-behavior surveys (BBS), mapping and size estimates for FSW, MSM, but there is still limitation of strategic information among other groups such as prisoners, people on the move (Migrants, refugees, and internal mobile population).

2. ***Limited Programme Coverage****:* With approximately 75% of the population living in rural areas (CSO, 2004) the coverage of testing and counseling and ART services and other prevention programs are located in urban areas. Where services do exist, there is a weak coordination, integration and referral system which has been identified and planned to be addressed.

3. ***Failure to Address Needs of key Populations at higher risk:*** Delay initiation of intervention programs towards key populations at higher risk because of limited implementation of strategic and bio-behavioral surveys.

4. ***Stigma/Discrimination:*** Stigma and discrimination continues against PLHIV and key populations at higher risk. Efforts are being continued to be addressed.

5. ***Weak integrated HIV services within TB services:*** Although HIV sero-prevalence among TB patients was conducted twice to detect prevalence, the coordination among the two programs and delivery standards need strengthening.

6. ***Weak Monitoring and Evaluation Systems and Capacities:*** Both national M&E systems and program evaluation capacities remain weak with scanty M&E expertise in Yemen. Although National M&E on AIDS response was developed there is a need to build a comprehensive National M&E Plan and training programs. There is also a significant need to strengthen National M&E systems, supervision and monitoring.

5.2 Remedial measures

The approach needs to institutionalize public private partnerships, where the public sector should assume its stewardship role, including provision of standardized guidelines, availability of treatment facilities, provision of financial resources and oversight in monitoring and evaluation.

The NGO / academic sector should be engaged to be made be responsible for ensuring availability and delivery of services.

The Ministry of Public Health and Population needs to mobilize resources for provision of availability of services including on interrupted supply of ARVs and to do more efforts for health system strengthening. The building capacity for the workers in HIV programme should continue in the coming years focusing in new subjects related to HIV prevention and control.

5.3 Opportunities

- ***National Political Commitment to HIV**:* The first National Strategic Framework, was developed in 2002, and the subsequent one in 2009 reflected government's political commitment through the support of the process and the endorsement of the documents by the top leadership. The government has also been closely involved in participating in the various HIV programs at national and governorate level. In the other hand, the parliamentarian has agreed and endorses the PLWH right law.

- ***The political commitment*** is becoming more obvious through the increased National Funding allocated to HIV program through the MoPH&P for the year 2011.

- ***Civil Society Organizations:*** The establishment of PLWH associations in the main four governorates was a great achievement during the last three years as well as a networking of PLWH. PLWH are actively engaged in AIDS response including leadership ,building capacity, advocacy, decision making , stigma and discrimination reduction, as an expert patients, psycho-social support ect.., and lately the associations were able to develop their own yearly plan in line with the NSF & national target,

- ***Population at higher risk:*** Under the GF grant, NAP with the assistant of WHO and UNAIDS consultants managed to conduct mapping and size estimates of FSW''s, MSM in five of the major governorates in Yemen. A Bio-behavioral surveys among FSW's in Adev &Al-Hodeida governorate.

6. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Several development partners, bilaterals and donors have aligned their fiscal cycles in line with the country national planning and budgeting cycle. Through the UNDAF, many UN agencies are also making efforts to harmonize their fiscal and planning cycles in line with the national planning and budgeting cycles. This will effectively align the development resources from these agencies in line with national planning cycles [1].

The UN agencies supported collectively the development of the National Strategic Plan on HIV and sexually transmitted diseases, 2009-2015, including plan costing, and making a framework for monitoring and evaluation.

With the support of UN agencies NAP has been able to significantly mobilize an effective health response towards AIDS and strengthen the existing HIV related systems in the country.
Total funding in support of the national response on AIDS for 2010 and 2011 amounted to almost 2.210.998 USD and 1.724.674 USD respectively in the following main areas:

1. Health care and treatment for PLHV (GF, WHO).
2. Providing testing and counseling services (GF, UNICEF).
3. Capacity building and greater involvement of PLHV in the design, implementation and evaluation of HIV national policies and programs (GF, UNDP, UNAIDS).
4. HIV prevention in the community of men who have sex with men in Aden (GF, NDP, UNAIDS).
5. National and local communication campaigns implemented and advocacy and educational materials distributed (GF, UNDP, UNICEF, UNAIDS, WHO).

6. Strategic partnership with media to ensure constant, appropriate and targeted messages on HIV and AIDS in the public domain established (GF, UNDP, UNAIDS, UNICEF).
7. Development of new multi-sector National AIDS Strategy and National AIDS Strategic Plan (2009-2015) that will support the achievement of targets for Universal Access (GF,WHO,UNAIDS).

7. MONITORING AND EVALUATION ENVIRONMENT

The report outlines a range of strategies to strengthen M&E systems, capacities and processes and these include the following:

- ***Enhancing the Capacity of the NAP Monitoring and Evaluation Unit:***
  There are currently two M&E Officers within the NAP and this has improved the system to a certain extent. However, this has proved inadequate to maintain the level and quality that is required to maintain and sustain the monitoring and evaluation systems. Within the NAP, a small unit for M&E have been established comprising of One Senior M&E Officer, 1 Surveillance Officer and 2 Monitoring and Supervision Teams. M&E system at governorates level need to be strengthen. ,

- ***Strengthening Monitoring and Supervision:***
  To strengthen the HIV Implementing Partners capacity for M&E, 2 M&E and supervision teams established within the NAP to work with partners to assess capacities, identify weaknesses, and strengthen systems and processes at the implementation level.

- ***Building National and Program M&E Technical Capacity:***
  Two levels of capacity building have been conducted, firstly with National M&E Personnel to strengthen overall capacity to manage M&E systems and processes and support partners. The second level of capacity building will be through the supportive supervision and ongoing training programs to be offered through the NAP on programmatic monitoring and evaluation. It will be as continuous to the previous efforts which have been taken to improve the M&E and surveillance system in 2010-2011.

- ***Strengthening HMIS:***
  Efforts will be put in place to integrate HIV reporting within the overall HMIS systems which is currently being strengthened

through health system reform initiatives and health system strengthening.

- ***Strengthening M&E Plans:***
  To date there is no coordinated HIV M&E system in place. on 19-20 December 2011 national stakeholders from government , CSO ,private sector and PLHIV were met to review the progress made by the country towards the achievement of the universal access and HLM targets, review and update the national operational plane (NOP) 2012-213 and agreed on the new targets and indicators , therefore , there is a need to revised National M&E Plan to accompany the NSP&NOP.

- ***Creating Standardised M&E Tools:***
  Technical assistance from UNAID recruited in 2010 to develop M&E tools and records in consultation with program partners.
  Following to the adoption of the tools, it has been included in ongoing M&E training and again it will be reviewed by the Supervision teams during their visits and adapted accordingly.

8. REFERENCES

1. Cherabi, K. and Karouaoui, A. (2010). *Survey of HIV Vulnerability and cross border Mobility in Yemen, UNAIDS, April.*
2. Global AIDS Response Progress Reporting 2012 UNAIDS.
3. Global AIDS, Republic of Yemen (2010). *UNGASS Country Progress Report, Narrative Report.*
4. Global Fund Round 10 HIV Proposal. Single Country Applicant Sections HIV.
5. Global Fund Round, (2012). *Organization Participation in Yemen Humanitarian Response Plan 2012.*
6. Ministry of Public Health and Population, Republic of Yemen (2009). *The National Strategy for Control and Prevention of HIV 2009-2015. January.*
7. Ministry of Public Health and Population, Republic of Yemen (20٠٩). *The Operational Plan of the National Strategy for the Control & Prevention of HIV and STIs in Yemen for the period 2010 to 2011. November.*

8. Ministry of Public Health and Population, WHO, Republic of Yemen (2011). *EMRO HIV Surveillance 2011(1)1-3-2012*.
9. National AIDS Programme and Iran research economic, (20١1). *Bio-Behavioral Survey among Men who Have Sex with Men in Yemen Second draft: December 5th.*
10. National AIDS Programme and NTCP, Yemen (20٠٩). *Survey that achieve to detect HIV among T.B patients, in 4 governorates.*
11. National AIDS Programme and WHO, Yemen (2010). *Bio-Behavioral Survey among female Sex worker in Hodeidah, from June to December.*
12. National AIDS Programme, Yemen (20١٠). *Mapping and Population Size Estimates among Most at Risk Populations in Five Major Cities, Yemen, August.*
13. National AIDS Programme, Yemen (20١٠). *Survey of HIV sentinel sero-surveillance among pregnant women attending ANC clinics in 4 Governorates.*
14. National AIDS Programme, Yemen, Report (20١1), (20١٠), (2009) and (2008).
15. National Population Counselin, Yemen (2010). *KABP study on HIV.*
16. Sana'a University, population studies and training center, Yemen (2011). *Survey HIV Transmission, Existing HIV-related services and social vulnerability of PLHIV, Yemen, Sana'a and Aden, conducted by Dr.Abdulhameed Ahmed Dawod and others, NAP Superior, from WHO.*
17. Stulhofer A and Bozicevic I (2008). *HIV bio-behavioral survey among FSWs in Aden, Yemen. An unpublished report.*
18. The World Bank/UNAIDS/WHO. *Characterizing HIV Epidemiology in the Middle East and North Africa;Time for focus; Middle East and North Africa HIV Epidemiology Synthesis Project.*
19. United Nations Development (2011). *Assistance Framework Republic of Yemen 2012-2015 Sana'a, January.*

9. ANNEXES

Annex1: National Composite Policy Index questionnaire

NCPI Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:

With the collaboration and support of the UNAIDS and NAP/MOPH&P the NCPI data have been gathered. NAP has leaded the participatory process through distributing formal letters to the Stakeholders (Government, CSO & PLHIV NGOs) asking their collaboration and facilitate the national consultant task and to provide the required data for the report.

The first stage of data collection was the Introductory Workshop that had been conducted on March 06, 2012 in PSTC, Sana'a University with the participation of national stakeholders. The workshop aimed to introduce the process of developing the country AIDS report including the methodology that will be used to develop the report and deep explanation and discussion have been conducted on the data gathering tool (NCPI Questionnaire) to ensure the validity of the gathered data.

On March 08, 2012, the NCPI questionnaire Part A has been distributed electronically to government officials and totals of 19 questionnaires are gathered (see Annex 2), and also on the same date the NCPI questionnaire Part B has been distributed electronically to civil society organizations, bilateral agencies, and UN organizations and totals of 13 questionnaires are gathered (see Annex 3).

On March 24, 2012, the stakeholders have been invited to the Validation Workshop in PSTC, Sana'a University to involve on the participatory process on analysis, selected targets and the validation of the collected data and indicators.

Draft narrative report shared with the NAP, UNAIDS Country Office & RST/MENA for revision and based on their comments the final narrative report has been developed and submitted.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
Not applicable

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

Not applicable

Annex 2: NCPI- PART (A) Respondents

NCPI - PART A : List of government officials

No	Organization	Names/ Positions	Respondents to Part A					
			A.I	A.II	A.III	A.IV	A.V	A.VI
1	Ministry of Health-NAP	Dr.Abdulhameed Al-Sohebe- Director of NAP	A.I	A.II	A.III	A.IV	A.V	A.VI
2	Ministry of Health	Dr. Nora Mahdi -Director of Information	A.I	A.II	A.III	A.IV	A.V	A.VI
3	Ministry of Health	Mr. Shawki Abbasid -Thawra Hospital	A.I	A.II	A.III	A.IV	A.V	A.VI
4	Ministry of Health	D. Nasreen Alsaidi - Department of Dental	A.I	A.II	A.III	A.IV	A.V	A.VI
5	Ministry of Health- NAP	Dr. Mayada Faisal Nabih- Head of Treatment& Care Unit	A.I	A.II	A.III	A.IV	A.V	A.VI
6	Ministry of Health -NAP	Mr. AbdelHafez Al wared – Head of Surveillance Unit	A.I	A.II	A.III	A.IV	A.V	A.VI
7	Ministry of Health -NAP	D. Entsar Thabet-	A.I	A.II	A.III	A.IV	A.V	A.VI
8	Ministry of Health-NAP	D. Mohammed Alhabub \ Director of Medicines Support	A.I	A.II	A.III	A.IV	A.V	A.VI
9	Ministry of Health -NAP	D. Yassin Abdel Wareth \ Advisor	A.I	A.II	A.III	A.IV	A.V	A.VI
10	University of Sana'a (PSTC)	D. Ahmed Al-Haddad -Director of Study & Training Center	A.I	A.II	A.III	A.IV	A.V	A.VI
11	Ministry of Higher Education	D. Mohammed Mcard -Researcher	A.I	A.II	A.III	A.IV	A.V	A.VI
12	Ministry of Education	Ms. Huda Al suneny - School Manager of Girls	A.I	A.II	A.III	A.IV	A.V	A.VI
13	Ministry of Education	Mr. Abdullah Alhamzi -Director of School Health Care	A.I	A.II	A.III	A.IV	A.V	A.VI
14	Ministry of Education	Mr. Mohammed Mujam- Training office Officer	A.I	A.II	A.III	A.IV	A.V	A.VI
15	Ministry of Social Affairs and Labour	Mr. Imran Abdullah-General Manager	A.I	A.II	A.III	A.IV	A.V	A.VI
16	NPC-AIDS Unit	Mr. Ahmed Al Ramah- Finance & Administrative Officer	A.I	A.II	A.III	A.IV	A.V	A.VI
17	NPC –AIDS Unit	Mr. Jawad al-Shaibani – Unit Activiy	A.I	A.II	A.III	A.IV	A.V	A.VI
18	NPC-AIDS –Unit	Ms. Abeer Abu-Rass -Technical Officer	A.I	A.II	A.III	A.IV	A.V	A.VI
19	NPC-AIDS Unit	Mr. Farhan Radman -Deputy of the unit AIDS	A.I	A.II	A.III	A.IV	A.V	A.VI

Annex 3: NCPI- PART (B) Respondents

NCPI –PART B: List of Civil society organizations, bilateral agencies, and UN organizations

No	Organization	Names/ Positions	Respondents to Part B					
			B.I	**B.II**	**B.III**	**B.IV**	**B.V**	**B.VI**
1	AID association	Mr. Khaled Al Hajbe\ Vice Chair	B.I	B.II	B.III	B.IV	B.V	B.VI
2	AID association	Mr. Ali Al Alkami-Chief Financial Officer	B.I	B.II	B.III	B.IV	B.V	B.VI
3	AID association	Mr. Akram Aljawe-Activaty	B.I	B.II	B.III	B.IV	B.V	B.VI
4	Center of social services	Ms. Rasena Yaseen Abdullah -Director	B.I	B.II	B.III	B.IV	B.V	B.VI
5	Yemeni Family Care Association	Mr. Adel Salah - Coordinator	B.I	B.II	B.III	B.IV	B.V	B.VI
6	Yemeni Family Care Association	Ms. Samira Al-Dbaiby-Director of Testing and Counseling	B.I	B.II	B.III	B.IV	B.V	B.VI
7	Red Crescent	Mr. Salah al-Din Ibrahim \ Director of Training	B.I	B.II	B.III	B.IV	B.V	B.VI
8	Association of Reform	Mr. Saeed Al kamel-Director of Health	B.I	B.II	B.III	B.IV	B.V	B.VI
9	Yaman Foundation for Health Development	Mr. Faress Al Wael-Director of Children Care	B.I	B.II	B.III	B.IV	B.V	B.VI
10	Abi Musa al-Ash'ari Association	Mr. Abdo Al Mansub-Director	B.I	B.II	B.III	B.IV	B.V	B.VI
11	Abi Musa al-Ash'ari Association	Mr. Fikray Al kadsy-Vice Director	B.I	B.II	B.III	B.IV	B.V	B.VI
12	Abi Musa al-Ash'ari Association	Ms. Wadad Al Azazy-Progresso	B.I	B.II	B.III	B.IV	B.V	B.VI
13	Education	Ms. Raja Albrky	B.I	B.II	B.III	B.IV	B.V	B.VI

Annex 4: Participations of the Introductory Workshop of Report

List of Participation in the Introductory Workshop –6th of March 2012.

No	Organization	Names	Positions
1.	Ministry of Health-NAP	Dr.Abdulhameed Al-Sohebe	Director of NAP
2.	Ministry of Health-NAP	Dr. Mayada Faisal Nabih	Head of treatment& Care Unit
3.	Ministry of Health-NAP	Mr. Abdul Hafez Al Wared	Head of Surveillance Unit
4.	Ministry of Health-NAP	Dr. Entesar Aboud Thabet	Head of Prevention Unit
5.	Ministry of Health-NAP	Dr. Yaseen Abdul Warth	M&E Adviser - NAP
6.	Ministry of Health	D. Nora Ahmed Mahdi	Director of Information Unit
7.	University of Sana'a (PSTC)	D. Ahmed Al-Haddad	Director of the Center
8.	Center for Population Studies	Mr. Ayman Haddad	Library Director
9.	AID association	Mr. Khaled Al Hajby	Vice Chair
10	AID association	Mr. Ali Alalkami	Chief Financial Officer
11	Yemeni Family Care Association	Mr. Adel Salah	Coordinator
12	Yemeni Family Care Association	Ms. Samira Al-Dbaiby	Director of Testing &Counseling
13	Red Crescent	Mr. Salah al-Din Ibrahim	Director of Training
14	Youth Welfare (PSTC)	Mr. Fouad Ashwal	Coordinator
15	Youth Welfare	Mr. Walid Seathrey	
16	Youth Care University	Ms. Sana Al Gufi	Students
17	Youth Care University	D. Marwan Taher	Coordinator activities
18	Youth Welfare	Ms. Bushra Farhan Sharabi	Youth
19	Ministry of Higher Education	D. Mohammed Mcard	Researcher
20	Ministry of Education	Mr. Amin Dibwan	Teacher
21	University of Imran	Mr. Yasser Dawod	Student's Officer
22	University of Sana'a	Mr. Adel Al Brkany	-
23	University of Sana'a	Mr. Usaam AlsaB	-
24	UNAIDS	D. Fouzia Abdullah Gharamah	UNAIDS Country officer
25	UNHCR	Dr. Wafa Al Shaibane	Health Assistance Officer
26	UNDP	Dr. Fuad AlSabri	HIV &AIDS Program officer
27	UNDP	Mr. Loay fadael	HIV&AIDS Project coordinator

Annex 5: Participations of Validation Workshop of Report

List of Participations in the Validation Workshop-24 March 2012

No	Organization	Names	Positions
1.	Ministry of Health &Population	Dr.Abdulhameed Al-Sohebe	Director of NAP
2.	Ministry of Health &Population	Dr. Mayada Faisal Nabih	Head of treatment& Care Unit
3.	Ministry of Health &Population	Mr. Abdul Hafez Alwared	Head of Surveillance Unit
4.	Ministry of Health &Population	Dr. Entesar Aboud Thabet	Head of Prevention Unit
5.	AID association	Mr. Khaled Al Hajby	Vice Chair
6.	AID association	Mr. Ali Alalkami	Chief Financial Officer
7.	Yemeni Family Care Association	Mr. Adel Salah	Coordinator
8.	Yemeni Family Care Association	Ms. Samira Al-Dbaiby	Director of Testing &Counseling
9.	Abi Musa al-Ash'ari Association	Mr. Abdo Al Mansob	Director of the association
10.	Social Services Association (SSA)	Ms. Rasena Yaseen Abdullah	Director of the association
11.	NPC	Mr. Jawad al-Shaibani	activities unit
12.	NPC	Ms. Abir Abu-Rass	Technical officer -AIDS UNIT
13.	NPC	Mr. Farhan Radman	Deputy of the unit AIDS
14.	NPC	Mr. Ahamed Al Rammah	Finance and administrative officer - AIDS UNIT
15.	Ministry of Higher Education	D. Mohammed Mcard	Researcher
16.	Ministry of Education	Ms. Huda Alsuneny	School Manager for Girls
17.	Ministry of Education	Mr. Abdullah Alhamzi	Director of school Health Care
18.	Ministry of Education	Mr. Mohammed Mujam\	Training office
19.	UNAIDS	Dr. Fouzia Abdullah Gharamah	UNAIDS Country Officer
20.	UNDP	Dr. Fuad AlSabri	HIV &AIDS Program officer
21.	UNDP	Mr. Loay fadael	HIV&AIDS Project coordinator
22.	WHO	Dr. Araij Taher	RH Officer
23.	Youth Welfare (PSTC)	Mr. Fouad Ashwal	Coordinator
24.	Center for Population Studies	Mr. Aiman Haddad	Library Director
25.	Center for Population Studies	Mr. Shawki Abbasid	Thawra Hospital

Annex 6: Domestic and international AIDS Spending

Domestic and international AIDS spending by categories and financing sources

Organization\Year	2010	2011	Comments
Ministry of Public Health & Population	130.233 $	381.395 $	
WHO	209.302 $	30.698 $	
UNICEF	460.000 $	100.000 $	
GF	0	351.385 $	
UNDP	0	38.000 $	
UNAIDS	164.473 $	202.938 $	
NCP	312.000 $	86.000 $	
UNHCR	90.000 $	90.000 $	
Progresso (Int'l NGO)	158.919	136.169 $	
MSF (MEDECINS SANS FRONTIERES)	844,990 $	308,089 $	
Total	2.210.998 $	1.724.674 $	