Hope from Abroad in the International Medical Travel of Yemeni Patients
Beth Kangas

Studies of care-seeking behaviour have generally focused only on the medical facilities that are available within a country’s national boundaries. However, a growing number of patients worldwide are pursuing medical services outside of their own countries. The burgeoning literature on ‘medical tourism’ tends to offer the perspectives of the treatment destinations, not the experiences of patients. This paper examines the international medical travel of patients from the capital-poor country of Yemen. Families in Yemen often sacrifice greatly to seek the advanced, trustworthy technological medicine that is unavailable locally. The paper draws on interviews conducted with 71 Yemeni medical travellers in India and Jordan, as well as a survey of 205 doctors in Yemen about their disclosure practices regarding terminally ill patients. While perhaps an attractive option in today’s global world, the use of medical services abroad affects local perceptions: it perpetuates a lack of trust in local capabilities, invites criticism of the government for not providing care to its citizens and fosters the hope that a cure exists somewhere in the world.

Vignette: Abdul Rahman’s Impending Journey

Abdul Rahman, a 25-year-old student from rural Yemen, had barely completed his computer course when he became sick with cancer. One night, he felt uncomfortable, he recounted to me in Yemen’s central hospital in 1997. He got up from watching the nightly news, went into the bathroom, and vomited his whole dinner. The vomiting continued the next day. He went home to his family. From there, he alternated between his house and hospitals. Finally, Abdul Rahman visited the capital’s central hospital. After two doses of chemotherapy, he felt better. He left the hospital and stayed in a nearby hotel. The vomiting started again. Two friends carried him to the hospital. Abdul Rahman had been in the central hospital for seven days when I met him. His eyesight had started to blur, he said, and he had stopped urinating. ‘My body feels flabby,’ he added, ‘from seven days in bed without moving.’
Pointing to the intravenous drip, his mother said, ‘He eats only with this.’ Nothing was really working, they told me, the chemotherapy was taking a long time.

The family decided to treat Abdul Rahman abroad. Abdul Rahman explained: ‘Some people told us there is treatment abroad, machines that are better than chemotherapy. They work quickly. Within one or two weeks, [you improve] alhamdullilah [by the grace of God]. Many people advised us. They said, “You have to go.” Because they went to Jordan, many of them.’ Abdul Rahman continued: ‘And here, there is no care. You can’t find anyone in the hospital at night. In the morning, the doctor comes in, decides the medicine, and then leaves. If any complications occur, there is nobody around.’ Abdul Rahman and a close family friend were leaving that night for Jordan. ‘Because many people went there,’ he said, ‘and they came back fully recovered. They have strong medicine and concentrated care. Many people went from among us, from our village. They stayed for two weeks and came back completely cured. One went and did a kidney operation, another for the eyes.’

The family had sold their agricultural land, their livelihood, Abdul Rahman’s mother told me, for God to provide a cure for their only remaining child. Nine others had died long ago. ‘What to do?’ Abdul Rahman said, ‘The circumstances decide. I’m forced. For me, being treated in Yemen is better because it’s not expensive and it’s with my family. But what to do? Here, they couldn’t do anything for me. I’m forced to travel.’

My interview with Abdul Rahman and his mother was one of the hardest that I conducted. Just before I talked with them, the oncologist told me that he tried to discourage the trip abroad. Abdul Rahman’s cancer had spread throughout his body, the oncologist explained, with no hope of a cure. To the patient and family, I wished a successful return for Abdul Rahman. Meanwhile, I grieved for them, for the likely loss of a beloved last-remaining son, and the loss of their land, their sustenance.

Introduction

This paper examines people’s perceptions about the possibilities of technological medicine from Yemen, a Muslim country in the south-western corner of the Arabian Peninsula. At the time of my research and continuing today, medical treatments for cancer, heart disease, and other complicated conditions were unavailable in Yemen, a capital-poor country. In order to pursue advanced medical care, patients had to travel abroad. Families often sold their household assets and borrowed substantial amounts of money in order to provide care that they believed capable of prolonging life and alleviating suffering. Precise figures on how many Yemenis—and from which socio-economic groups—travelled for medical care were difficult to obtain. Estimates ranged from 40,000 to 200,000 annually out of a population at the time of approximately 17 million.

Expanding possibilities—both medical and geographical—complicated Yemenis’ decisions and ideals about how to provide good care to suffering loved ones. As Abdul Rahman’s story illustrates, expectations for technological medicine went beyond local offerings to what was available abroad. Services outside the country promised an improvement over the lack of results that existed locally.
However, individuals seeking medical care abroad had to figure out: Where exactly in the world to undergo brain surgery and other procedures, in which country and which medical facility? Who should accompany the patient, since the whole family could not afford to go? And, how could families cover the costs? In addition, the serious nature of the medical conditions requiring treatment abroad generated its own ambiguity: What exactly was wrong with the patients? What could, and should, be done for them? What else could be tried?

Much has been written recently about the worldwide pursuit of medical care abroad. However, the burgeoning literature on what has been referred to as ‘medical tourism’ (a term that I dislike for its suggestion of leisure and frivolity) tends to focus on Americans bypassing high costs at home or British and Canadian patients avoiding long waits (e.g., Eggertson 2006; Hancock 2006; Milstein & Smith 2006; Schult 2006). In the ‘medical tourism’ literature, technological medicine is generally spoken of as a consumer good. Treatment destinations are presented as offering attractive packages to patients disgruntled with their local medical care. As this paper stresses, however, technological medicine is more than a consumer good. Wrapped up with life and death, it is an emotional and moral good as well.

To explore the international medical travel of Yemeni patients, I draw on over two years of ethnographic fieldwork in and around Yemen (from 1996 to 1998). My data sources include: (1) interviews that I conducted with 71 Yemeni medical travellers in India and Jordan; and (2) my survey of 205 doctors in four governmental hospitals in Sanaa, the capital of Yemen, about their disclosure practices. This multi-sited exploration underscores the financial, physical and emotional burdens of pursuing the hope of treatment abroad.

I begin by outlining attitudes and experiences with local medical services. The next section discusses perceptions of the services existing abroad. I then look at the logistics involved in international medical travel, particularly the financing of medical journeys, the selection of a treatment destination and the air travel. The conclusion highlights the dilemmas that capital-poor countries such as Yemen face regarding the provision of technological medicine.

**Yemen: Lack of Facilities, Lack of Trust**

Yemenis usually gave two reasons for seeking medical care abroad: the lack of medical facilities in their country, and the lack of trust in existing services. Sophisticated medical equipment and skills to treat cancer, heart disease, kidney failure and complicated orthopaedic and neurological cases did not exist in the country. Doctors, along with family, friends and acquaintances, advised patients with these conditions to pursue intricate surgeries and radiotherapy outside the country. Awareness in Yemen of symptoms and susceptibilities to degenerative diseases—if not their actual prevalence—has increased over the years. The knowledge that these conditions needed to be treated abroad has also become more widespread. This awareness and knowledge, in turn, have contributed to an increase in international medical travel.

In addition, some medical travellers doubted that Yemen’s medical system could provide proper care, even if services existed. A number of interviewees travelled for
an accurate diagnosis after receiving several conflicting ones in Yemen. Others
travelled to correct errors that had occurred in their own country. Still others
underwent surgeries abroad to avoid any complications that might occur locally.

Doctors responding to my survey on disclosure practices (Kangas, in preparation, a)
acknowledged that their compatriots mistrusted local capabilities, and fully trusted
those abroad. One doctor referred to people’s ‘big confidence in the doctors of other
countries, and lack of confidence in Yemeni doctors’. Another doctor noted:
‘Most people do not depend on what Yemeni doctors say about the critical care of
the patient, but usually believe foreign doctors.’ Still another doctor referred to
the English adage, ‘Familiarity breeds contempt’ to explain people’s low perception
of Yemeni doctors. Yemenis, he said, could not believe that one of their own
could excel in medicine. Doctors worked in a demoralizing environment, aware
that their patients often doubted their abilities. Several doctors in Yemen
contrasted: ‘When a death occurs under the care of a Yemeni doctor, the family
blames the doctor. When the doctor is a foreigner [in Yemen or abroad], the family
blames the disease.’

In a 2001 newspaper interview, the newly appointed Minister of Health
commented on the state of Yemen’s medical system:

Almost from its inception…the health system has suffered from numerous structural
and service delivery problems including poor quality of services, low staff morale, lack
of essential drugs, inadequate levels of running costs, low efficiency, underutilization,
leakage of resources out of the system into private hands, lack of rationalization of
service usage, and lack of equity in the distribution of facilities and manpower.2

Yemen faced many challenges in providing healthcare for its population. The World Food Programme Country Outline Strategy (WFP 2001, pp. 5, 7)
noted that Yemen was among the world’s poorest, measured not only by its per
capita Gross Domestic Product (GDP)—which decreased from $525 in 1990 to $350
in 2000—but also by most measures of the quality of life. The UNDP
Human Development Report for 1999 (UNDP 2000) ranked Yemen 148th out of
174 countries. Healthcare in Yemen for that year was limited to 16% of the
population. The country had one of the highest maternal mortality rates in the world
(1,400 per 100,000). It also had very high rates of infant and under-five mortality
(estimated at 76 per 1,000 and 105 per 1,000 live births, respectively).

The most prevalent diseases in the country in 1996, for example, were infectious
diseases, not those requiring treatment abroad. Deaths in children under five were
due mainly to diarrheal dehydration, malnutrition, birth-related problems and
parasitic infections such as malaria (Central Statistical Organization [CSO] 1997,
pp. 186–187). These widespread health problems—requiring relatively simple
medical technology to treat—were best cared for in primary healthcare units,
based locally in villages and neighbourhoods. However, the country’s rugged
topography made it difficult to provide primary, preventative care to its
predominantly rural population. The country had 35,000 villages and hamlets of
fewer than 350 inhabitants (World Bank 1996). Providing a health facility in each
hamlet was too costly to be viable. In addition, many rural Yemenis bypassed primary
healthcare facilities as the centres were poorly staffed, suffered a chronic lack of drugs and supplies, and had a poor reputation (World Bank 1996).

Political and economic developments in the 1990s directly affected Yemen’s medical system, and patients’ access to medical care. The unification of former North and South Yemen in May 1990 had embittering results for people in former South Yemen. The medical system of the North, based more in the private sector, replaced the country’s socialist system of medicine. Patients suddenly had to pay large sums for what had been free, including life-prolonging treatments abroad. Shortly after unification, when Yemen supported Iraq instead of Saudi Arabia during the build-up to the Gulf War, approximately 800,000 Yemeni migrants (UNICEF 1993, p. 37) were expelled from Saudi Arabia and other Gulf countries, creating additional pressure on already strained health facilities. Furthermore, Gulf countries discontinued donor support to various health projects. Four years after unification, a civil war between former North and South Yemen produced additional economic turmoil. In April 1995, the government introduced structural adjustment reforms, which decreased the money available for local health services and subsidies for treatment abroad.

Doctors in Yemen recognized that the limited capabilities contributed to people’s scepticism of the local medical system. In our 1997 interview, an official at the Ministry of Public Health expressed the frustration that doctors experienced over the lack of medical necessities:

> When a patient arrives in the emergency room and you don’t have the available facilities to help him, the necessary drugs to save him, you are tied. You can’t give him anything. I have worked a lot at [the central hospital] in the emergency room. And, I have visited hospitals. The doctor knows he wants to do something, but he can’t. He can only gaze at the patient.

Physicians knew that, while possible treatments existed in technological medicine, they could do little.

The limited capabilities of the local medical system, and people’s low opinion of it, increased the desirability of medical services abroad. A specialist practising in Yemen’s central hospital commented: ‘If you take medical services as a 12-story building, we are at the fifth or sixth floor. People would prefer to go to the top floor, anywhere they can afford it.’

Many interviewees in Jordan and India said that they resented having to travel for medical care. They wanted the government to improve local medical capabilities. For example, a governmental employee treating his wife’s cancer in Mumbai (formerly ‘Bombay’) lamented: ‘I’ll be paying people back for five or six years. And, why? If only we had doctors and such in the beginning, during the first two years [of her illness]!’ Many medical travellers said that they would prefer to spend their money in their own country rather than on high costs elsewhere. A 56-year-old woman expressed a common sentiment: ‘I want Yemen to learn medicine. I love Yemen. Why would we want a faraway country to treat us for everything? It’s better to spend money inside the country, not outside. However, I do want to live, not die.’ Medical travellers recognized discrepancies in the affordability of medical care abroad. For instance, one man, after spending a week and $800 in
Mumbai only to learn that his daughter’s operation would cost an impossible $4,200, commented: ‘For the financially able, they can be treated abroad. But for people like us, it’s better to stay [in Yemen] and die.’

Abroad: Visible Results

As Abdul Rahman’s story illustrated, the clear, visible results that patients achieved abroad motivated others to travel. For example, one couple said that they visited a Mumbai infertility specialist on the recommendation of a woman who, after 16 years of marriage, had finally given birth to three children. A 40-year-old man said that he travelled to Jordan to treat the dislocation in his spine because, ‘Many friends and relatives went to Jordan. Their cases were bad. They returned, improved.’ A 27-year-old woman in Mumbai said that future medical travellers ‘will see me in a different condition from the one when I left them. This will make them eager [to travel].’

Individuals did not always distinguish the medical conditions involved. In the paper’s vignette, for instance, Abdul Rahman likened the recoveries of others from kidney and eye disorders to his own possibilities regarding cancer. A surgeon in Sanaa with years of experience treating cancer cases stressed to me the important differences: ‘True,’ he said, ‘with a heart condition, the patient might leave the country in a coma. After a valve replacement or open-heart surgery allows increased blood circulation, he then comes back looking fully healthy. Cancer cases, however, rarely experience similar recoveries.’ Doctors in Jordan and Mumbai said that they wished that the Yemeni patients who arrived with untreatable conditions had either travelled sooner, before their conditions deteriorated, or lived out their last days in Yemen with their families.

The visible results of others were more convincing than the words of Yemeni doctors regarding the futility of travelling. Accepting the words of doctors—who were known to make mistakes on basic medical conditions—and later learning that something could have been done, would be extremely unsettling. For example, doctors in Yemen, including a Cuban heart specialist, told one family that their son’s heart condition was too far along for treatment, locally or abroad. The family decided to send him to Jordan anyway since he was miserable in his present situation. The young man returned completely recovered, with his life and only a scar. Stories like his motivated others to seek care abroad, even when doctors said it was futile.

The Role of Social Gatherings

Regularly occurring social gatherings within Yemeni society helped promote treatment abroad and define ideals of proper patient care. I described these ‘qat sessions/chews’ in an earlier paper: ‘Almost every afternoon of every day, but especially on the weekend (Thursday and Friday, in Yemen), men and women in Yemeni society gather for nearly four hours to chew qat (*Catha edulis*), the mildly stimulating leaves of a domestically grown tree. In these same-sex gatherings, which usually take place in someone’s home, people sit together, comment on everyday life, and pursue more focused topics’ (Kangas 2002, pp. 48–49). Socializing—more than
the qat—was the main objective of these gatherings (Varisco 1986, p. 5; Weir 1985, p. 149). Qat sessions, which allowed information to be exchanged among diverse groups of people, played a key role in perpetuating international medical travel. People returning from abroad reported on their journeys. Details were exchanged about medical cases and treatments inside and outside the country.

Surveyed doctors recognized that conversations during qat sessions helped persuade people to send even hopeless cases outside the country. One doctor stated: ‘People’s words, especially in qat gatherings, about the capabilities abroad make the patient and non-patient think of going abroad, even if some cases don’t require [it]’ Another doctor noted family members’ ‘belief from qat sessions that abroad there is mythical medicine.’ From qat sessions, people saw, heard and generalized about the treatment possibilities existing elsewhere.

In addition, during qat sessions, people evaluated the medical care that family members and facilities provided. Details helped shape ideas about what constituted ‘good’ care. Financially able households that opted not to send critically ill family members abroad invited social criticism. Although families without resources were excused, some still sacrificed to try everything possible. A surveyed doctor said that families might take an incurable case abroad, ‘under pressure from the society surrounding them that they fell short with their patient and should have traveled with him to remove any doubt.’ Should a patient die abroad, the family could reassure themselves, and others, that they had held nothing back.3

Medical capabilities existing abroad provided hope when local medical services could offer little. A doctor explained that families might send incurable cases abroad, ‘because hope does not die.’ Another doctor stated: ‘Although the case is incurable, there still remains some hope for the patient and his family. Even if it is very small, they search for it no matter where.’ Still another doctor referred to a proverb: ‘The perplexed holds onto any tree.’

Logistics of Going Abroad

Medical travellers varied in their knowledge of what they would experience abroad. For instance, the husband of a woman in Mumbai undergoing a biopsy of the tumour in her uterus said: ‘We knew India before we saw it. We knew everything: how to take a taxi, how to speak to them, how to deal with them. We had that information because of the large number of patients who go to India. We knew the price of water, we knew the price of a taxi.’ Although this couple knew the logistical details, they did not anticipate the time involved. Rather than returning home following the biopsy as planned, they were in their seventh week when I met them. While all medical travellers shared general logistical requirements, their differing medical conditions produced divergent costs, lengths of stay and outcomes.

This section focuses on three logistical aspects of medical journeys: covering the expenses, selecting a treatment destination and travelling. Medical travellers generally left with a specific amount of money for food, lodging and medical expenses. When costs escalated, they telephoned home to request additional sums. Such requests further challenged families who had already struggled to cover the initial
journeys. The financial dimensions of treatment abroad extended the resources and obligations of families and the state beyond local borders.

Meanwhile, treatment destinations reflected varied geographical imaginaries, people’s ideas about the world around them. Rather than simply choosing a bordering country as some patients worldwide do, Yemeni medical travellers selected a destination based, in part, on its reputation, familiarity and/or historical and political connections. While a circulation of information existed in Yemen, medical travellers were not equally involved in this circulation.

Financing Medical Travel

Treatment costs in Jordan were almost unfathomable, especially compared to the cost of medical care in Yemen, and the cost of living in general. The smallest amount that interviewees paid was around $1,000; this was for a businessman’s check-up in which, happily, everything was found to be fine. The second smallest amount was $1,700; this family had sold their animals in order to treat the tumour behind the wife’s eye. Unfortunately, because of the unanticipated high costs, they returned to Yemen after completing only the initial diagnostic tests.

Other amounts were tremendous: $5,000 to remove a 55-year-old woman’s non-functioning kidney in order to protect the remaining one (a procedure that could have been done in Yemen, if properly diagnosed); $6,000 for a cardiac valve replacement for a 65-year-old farmer. One family spent over $50,000 in Germany to begin selecting the related donor for the mother’s kidney transplantation; they completed the process in Jordan at much lower costs. Even if these sums were exaggerated to indicate a willingness to sacrifice or to produce a more heart-wrenching story, the accurate amounts would still far exceed Yemen’s per capita GDP at the time of $350. Medical expenses in Mumbai were generally less than in Jordan; however, Yemenis in Mumbai tended to have fewer financial resources.

Cancer patients required particularly vast expenses and time: over two months and $7,800 to treat a 42-year-old high school director’s cancer of the tongue; $14,000 for two trips to treat a 55-year-old woman’s breast cancer—$9,000 for an initial five-month visit and $5,000 for a four-month visit two years later; and $40,000 for three visits over four years for lymphoma cancer. The latter patient, a 40-year-old artist, died in the Jordanian hospital where he had been receiving chemotherapy.

The uncertain treatment costs and durations made financing medical care abroad especially difficult. The high school director, for example, had travelled alone, thinking that his medical condition was simple and easily treatable. In Jordan, doctors discovered that he had cancer and needed to stay several months. He ended up transferring additional money from Yemen. A family of four travelled hastily to treat their 11-year-old son’s leg cancer. They stayed seven months and spent $12,000. In addition, they missed out on their shop’s earnings during the busy holiday shopping season.

Several medical travellers indicated that they were covering their expenses with household income from their qat production and/or the money that they had earned
in the Gulf countries. One man explained how he paid the $15,000 for his eight-month stay in Mumbai to treat his slipped disk: ‘We had money. We were forced to spend it. I couldn’t move. If we didn’t have money from the qat and from before [he and his father worked for 17 years in Saudi Arabia], I would have remained as I was. If I were a governmental employee with a salary of 7,000 or 8,000 riyals [$53 or $61], it would not have been enough, especially since I have five children. Even if the government gave me $700 or $800 assistance, it’s not enough. Even [if it were] $2,000 or $5,000, which they don’t give.’ Despite his own abilities, this man recognized the inadequacy of governmental assistance for the less fortunate.

Six of the 46 interviewees in Jordan (and none in Mumbai) said that their employers were paying their medical expenses. The Aden Refinery—which sent five of these medical travellers to Amman—was particularly generous to its employees and their family members. In 1997, for example, the Refinery spent $500,000 on medical treatment abroad (al-Tajammu’, 5 January 1998). The Refinery’s representative in Jordan took care of arrangements: patients were met at the airport, transported to an apartment, given money for lodging, taken to a hospital and treated, without ever seeing the bills.

Families without the ready finances or employer support sold household assets, borrowed money, received charitable donations, and/or received governmental assistance. Women in nine households had sold their gold jewellery to help cover costs. Gold was a common investment in Middle Eastern societies, especially when banks were considered unreliable. Other household assets included cars, farm animals, a house, store, land and ‘things’. More research is needed on expectations and practices in Yemeni society regarding selling assets, and borrowing and donating money.

Seven interviewees in Jordan and three in Mumbai received approximately $500 in governmental assistance. In the 1990s and particularly after the 1995 reforms, government subsidies for treatment abroad decreased, both in the total number of individual subsidies and the overall amount granted (from $2,500 per patient prior to 1993 to $500). While substantial in total, governmental assistance did not cover even 10% of what families needed (al-Haruji 1998). The long bureaucratic process discouraged many interviewees from applying for assistance, especially for only two aeroplane tickets and $500. Severe cases such as cancer simply could not wait. In our 1997 interview, an official at the Ministry of Public Health recognized the obstacles that cancer patients faced: ‘People fighting enemy cells,’ he commented, ‘also fight bureaucratic [routines].’

**Selecting a Treatment Destination**

Unlike the border-crossing for medical care (e.g., Guendelman’s 1991 and Casner & Guerra’s 1992 work on the two-way flow of patients between Mexico and the United States), Yemeni medical travellers did not simply go to neighbouring countries. They chose from an array of countries, based on their needs and abilities. For instance, one man working in Saudi Arabia who collected his son from Yemen in order to treat his eye condition recounted: ‘The doctor told us, “Travel to any country, Jordan, Iraq, Egypt, or any country you choose.” We chose India because it
had the lowest costs. We couldn’t go to Iraq because Saudi Arabia would then refuse to let me in.’ For this man, costs and political consequences influenced his selection.

In Kangas (2002, pp. 44–47), I presented a historical overview illustrating how local and international political and economic developments in the twentieth century affected the treatment destinations available to Yemenis. Preferred treatment destinations changed over time, with one country always dominating (cf. Kangas 2002, pp. 48–49). Countries needed to be politically and economically accessible, I noted; they also had to be associated with the ability to cure (p. 57).

A clear economic and social hierarchy existed in the choice of destinations. At the time of my research, Mumbai and sanctioned Iraq offered the least expensive care. Jordan and Egypt were more costly, but also more popular. Germany was seen as providing excellent, but expensive, care. While desirable, Britain and the United States were accessible only to a few wealthy businessmen or high-level government officials. Saudi Arabia, which offered good care at costs comparable to Jordan and Egypt, was inaccessible to many Yemenis. Yemeni-Saudi relations became strained when Yemen sided with Iraq during events leading up to the Gulf War. Visas required political and/or social connections.

For some medical travellers, the destination was obvious: they chose a country where they (or others close to them) had been successfully treated. Other medical travellers followed recommendations, especially the advice received in qat sessions. Still others—based on my observations in the central hospital of Yemen—knew only that they wanted to go ‘abroad’. When hospital committee members asked where they wanted to go (so that the appropriate aeroplane tickets could be issued from the government), they replied, ‘Anywhere.’ They left the final decision up to the doctors, who usually chose Jordan as a general, all-purpose, and trustworthy treatment destination. At times, members of the hospital medical committee also tried to discourage patients from their initial selections. The doctors promoted Jordan over Saudi Arabia because no visa was required. They said that costs would be lower than in Germany. They stated that Amman offered a safer environment than Moscow, which suffered economic hardship and crime.

Interestingly, interviewees in Jordan viewed India as far, while those in Mumbai saw India as close. The flight times to Amman and Mumbai were almost comparable. The degree of familiarity with Mumbai influenced its perceived proximity. Historically, former South Yemen—the governorates where the majority of interviewees in Mumbai resided—had far more contact with Mumbai and India than did former North Yemen (the governorates of most interviewees in Jordan). After Aden was captured by the British in 1839, it was administered from India until 1937. Even after the British withdrew from Aden in 1967, Indians remained, including as doctors in hospitals.

Air Travel

Air travel, while enabling medical journeys, also aggravated conditions. The cramped seats prevented orthopaedic cases from extending their limbs. Low blood-oxygen
levels from the cabin’s decreased atmospheric pressure could trigger heart attacks. A sales manager for Yemen’s national airline told me that patients had to obtain medical authorization certifying their fitness for travel. Certification was necessary, he explained, in order to avoid the cost and disruption of either returning to the originating airport or diverting to another country to administer emergency medical care. Patients, he continued, often waited in Yemeni hospitals until their conditions stabilized enough to endure a flight.

The sales manager went on to delineate three levels of care that the airline provided. At the simplest level was a wheelchair for patients to move between the airport and aeroplane. For immobile patients, the airline positioned stretchers across three seats, at times covering the costs of the additional tickets. Two patients on my Jordanian Airlines flight from Sanaa to Amman, for example, travelled on stretchers; one was unconscious. Flight attendants told me that flights from Yemen to Jordan routinely serviced stretcher cases. Airlines arranged for an ambulance to await these patients at the arrival airport. At the third level of care, the airline provided oxygen, and an isolated section that allowed an accompanying doctor to monitor the patient’s condition and administer necessary medication. The separate section also shielded the other passengers from disturbing medical conditions. The manager hoped that, rather than criticizing the airline, passengers upset by moaning patients or unsightly injuries would imagine their own brothers, fathers or mothers in these situations, and commend the airline for helping them reach their treatment destinations.

An oncologist in Mumbai with long experience in treating Yemeni patients remarked: ‘Every planeload [from Yemen to Mumbai] consists not of tourists, but patients. Isn’t that sad?’ Airlines were doing what they could to assist patients who could not be treated locally. However, they could only do so much. ‘In Yemeni society,’ a religious scholar told me, people ‘travel and sometimes die in the airport, and sometimes arrive and then die.’ A 55-year-old woman undergoing medical care in Mumbai remarked of her compatriot travellers: ‘Everyone is being treated. Some get treatment. Some leave without treatment . . . and some die in the plane.’

**Conclusion**

In today’s interconnected world, medical advances affect communities and countries even when the capabilities do not exist locally. Awareness of offerings available abroad affects the local medical system and the expectations for local governments. It also perpetuates a sense of hope and generates quandaries about when to stop pursuing care. As this paper has demonstrated, the reliance on advanced medical services abroad can create doubt regarding the abilities of medical personnel and services inside the home country. Patients such as Abdul Rahman, motivated by the results that they have seen in others as well as their dissatisfaction with the progress of their conditions, may seek medical care outside the country even when doctors advise against it.

The provision of technological medicine poses challenges for governments. Capital-poor countries such as Yemen face difficult decisions about where to spend scarce resources. Government leaders need to respond to the appeals of their
populace for technological medicine. They must also attend to the high priority primary health care needs of their countries. The neo-liberal policies of influential international organizations, such as the World Bank (1993), have encouraged governments in developing countries to concentrate on treating and preventing the spread of communicable diseases, such as malaria and tuberculosis. Sophisticated medical care, such as that for cancer and heart disease, stated the World Bank, should be left to the private sector. The private sector, they reasoned, has the capital and incentive to obtain, and maintain, the costly medical equipment and skills.

However, leaving the care of non-communicable medical conditions to the private sector is insufficient. As in many countries in recent years, Yemen experienced a dramatic increase in private medical facilities, which were seen as attractive ventures for businessmen. Private sector investment in health services rose from 100 million Yemeni riyals in 1993 to almost YR15 billion riyals in 1995 (UNDP 1996, p. 17). However, Yemenis often criticized private hospitals for hiring unqualified foreign physicians and focusing on the money rather than the patients. Newspaper articles described debilitating mistakes that occurred. In our 1997 interview, the Minister of Public Health at the time recognized that the ministry needed to scrutinize private medical facilities.

Moreover, neither the public nor private sector in Yemen offered radiotherapy, organ transplantation and other sophisticated medical capabilities. As this paper has stressed, having to seek medical care outside the country is an unsatisfactory solution. International medical travel burdens patients and family members—physically, financially and emotionally. Many Yemenis with whom I spoke said that they would prefer to remain in Yemen for treatment; their families would be nearby, the costs would be less and the logistics would be less extensive than with treatment abroad. In addition, individuals criticized what they saw as the government’s inadequate efforts to provide care.

Advances in medicine can make treatment options seem almost endless, suggesting there is always one more thing to try. Medical care ‘abroad’ can seem limitless as well; if the desired results are not found in one treatment destination, there is another country to try. The main constraint to these vast medical and geographical possibilities is a household’s financial capabilities. However, in Yemen as elsewhere, financial inabilities are not always compelling constraints when weighed against the life or suffering of a loved one. People who travel abroad for medical care do not do so necessarily because they can afford it. They are not buying a treatment vacation package, as ‘medical tourism’ would suggest. Rather, they are pursuing the hope of a better situation than they now have, at whatever the cost.

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Notes

[1] As with most Yemeni patients and family members, Abdul 1. Rahman referred to his medical condition as a 'tumour'. His oncologist used the word 'cancer' with me. Most Yemenis avoided the word 'cancer' (saratan, in Arabic) because of the devastating consequences the disease implied. In Kangas (in preparation, a), I discuss the preference in Yemen to avoid speaking directly about upsetting information. Terminally ill patients, for example, are generally not told about their conditions. In this paper, I use the term 'cancer' rather than 'tumour,' without specifying the type of cancer.


[3] In Kangas (in preparation, b), I discuss moral aspects of seeking medical care abroad. While the topic was included in my initial submission to Anthropology & Medicine, anonymous reviewers found the discussion to be under-developed.

References

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