BENEATH THE PEAK:
TOURISM DEVELOPMENT AND THE GLOBAL ECONOMY
IN A MOROCCAN MOUNTAIN COMMUNITY

By

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CHAPTER 7
HEALTHY ECONOMY?: TOURISM AT THE INTERSECTION OF HEALTH, WEALTH AND POWER IN AREMD

Introduction

The health risks and challenges faced by rural people in tourism development are immense; and for residents in Aremd, the health costs, consequences, and benefits of development lie at the intersection of global and local power and wealth. As national policies in Morocco promote tourism development as a means to alleviate rural poverty by integrating rural communities into the global economy, a dialectical relationship between health, wealth and power emerges. Income generation brought about by tourism revenues may improve access to health resources and services for some residents in rural communities. Yet, globalization (vis-à-vis integration into the global tourism economy) introduces a host of new health risks and challenges for residents, and social hierarchies within communities and households can lead to a differential distribution of health risks and inequitable access to health resources and services. Therefore, any investigation into the relationship between health and tourism development must interrogate how the new economy can contribute to the emergence of new health crises, and how health-related benefits and consequences are inextricably linked to power and wealth within the context of global, national, community and household relationships.

This chapter will examine how the new tourism economy in Aremd has introduced new health risks and vulnerabilities for residents, and how residents' health status intersected with wealth and power within multiple social domains. I will rely on two hierarchical systems prevalent in Aremd: a.) relationships between tourists and residents, and b.) gender relationships between men and women, to present the
complex ways in which power relationships directly influence health-related behaviors and decision-making. I will focus on the context of two health scenarios relevant to tourism development, diet culture and sexual relations, in order to position resident’s risk and vulnerability to chronic illness and infectious disease within the socio-historical context of power and wealth in Aremd. This chapter aims to shed light on the context-dependent nature of global tourism mechanism directed at rural development, and the direct effect that tourism development has on the health status of rural people.

Information from this chapter will demonstrate that the popularity of tourism development as a vehicle to alleviate rural poverty in Morocco makes it necessary to examine the complex linkages between globalization and health in order to identify and address the health effects associated with economic, technological, political, social, cultural and environmental change.

The relationship between tourism and health is of particular relevance in Aremd because rapid tourism development has positioned the village in a globalized economy that has been characterized by uneven socio-economic development. World-wide, there is a substantial disparity in the wealth (and health) resources between rich and poor countries, and the global distribution of mortality and morbidity reflects the differential distribution of global wealth (Parker 2002; Elmendorf 2002). There is a growing gap in the distribution of wealth within both rich and poor nations, and the differential distribution in health resources at the national level can result in exacerbated differences in health status within the national population (Harris and Seid 2004). Even among people living together in a single household or community, power differentials between individuals can result in unequal access to health resources and an inequitable
distribution in the risk of illness and disease (Doyal 2002). Privileged populations and individuals are not exempt from health risks and vulnerabilities, however. Development-based economic changes are deeply rooted in processes of globalization that affect the lifestyles of people and generate ‘transition risks’ and health costs for people engaged in economic development (WHO 2002; Harris and Seid 2004).

As the country of Morocco experienced an economic, demographic, epidemiological and social transition, the health effects of economic change became apparent. Since achieving independence in 1954 and implementing structural adjustment programs and free trade policies soon after, the national population increased from nearly nine million in 1950 to more than 30 million in 2002 reflecting an annual population growth rate of .4 percent in rural areas and 3.5 percent in urban areas (World Resource Institute 2008). Life expectancy at birth increased to 70.5 years for females and 66.8 years for males in 2002 from 47 years in 1962. Infant and juvenile mortalities decreased, from 92/1000 and 69/1000 in 1982 to 42/1000 and 46/1000 in 2005, respectively (WHO 2008). Availability and access to vaccines, antibiotics and other medical resources dramatically reduced the rate of infectious diseases such as polio, diphtheria, leprosy, tuberculosis, rubella, pertussis, rubella, tetanus and yellow fever (WHO 2007; WHO 2010a, 2010b).

At the same time however, more than 21,000 adults and children in Morocco were infected with the HIV/AIDS virus by 2008 (UNAIDS). Researchers also suggest that a ‘nutrition transition’ in Morocco has led to epidemic proportions of overweight people (body mass index (BMI) > 25 kgm⁻²) and obesity (BMI > 30 kgm⁻²) as well as the emergence of lifestyle-related health problems such as diabetes and cardiovascular
disease (FAO 1998; Benjelloun 2002; Rguibi and Belahsen 2004; Popkin and Larsen 2004). Among adults, the overweight population increased from 26% in 1984 to 36% in 1998, with higher rates among females (32% in 1984 and 45% in 1998) than among males (19% in 1984 and 25% in 1998). Obesity increased from 4% in 1984 to 10% in 1998, and was reportedly higher among urban populations (30% in 1984 and 40% in 1998) than rural populations (20% in 1984 and 29% in 1998). Forty percent of urban women were reportedly obese in 2000. Overweight and obesity in adults was associated positively with economic status (Tazi et al 2003; Benjelloun 2002). In addition, nine percent of children under three were reportedly obese in 1997; yet under-nourishment persisted among children less than five years old with a 23% rate in stunting and 10% underweight in 1997 (Benjelloun 2002; WHO 2006).

A 2000 study reported nationwide diabetes prevalence of 6.6%. However, researchers project a prevalence rate of ten percent to account for the majority of diabetes cases in Morocco which are undiagnosed and untreated (Nahid and Abdellilia 2006; Moktar et al 2003; Rguibi and Belahsen 2004; Benjelloun 2002). Despite significant increases in development-related illness and disease, only fifteen percent of the population receives health insurance and more than half receive healthcare from the public sector where resources are lacking and facilities are often inadequate (Nahid and Abdililah 2006).

The general health status of the national population reflects the world-wide epidemiological shift away from nutrient deficiency and infectious pathologies toward a high prevalence of chronic and degenerative diseases that are associated with more sedentary industrial lifestyles and urbanized diets (Omran 1971). In a recent survey,
more than thirty percent of urban students between 13-15 years old reported watching television, playing video games or participating in other ‘sitting’ activities for more than three hours per day (WHO 2010c), and data from the ‘Tourism and Television’ chapter in this dissertation revealed that television-watching was the most salient activity for rural women in Aremd.

Although official health statistics related to residents in rural areas are lacking in comparison to urban populations, it can be assumed that rural people are vulnerable to the same adverse health effects of economic change as residents in urban areas, if not more. In the contemporary globalized economy, transportation and communication networks connect rural areas to urban nodes of international development (Sassen 2007; 2006a; 2006b; 2001). This is particularly the case in the tourism economy where rural people participating in tourism development must rely on urban centers that serve as the central hub for tourist arrivals and departures. Therefore, people living in the most remote areas are not only affected and impacted by urban phenomenon, they are likely to experience urbanized phenomenon within a structurally less powerful context due to geographic, economic and socio-cultural restraints and with significantly fewer resources than their urban counterparts. This fact underscores the need to understand the mechanisms central to tourism development at the global, national, community and household contexts in which these mechanisms operate.

**Theoretical framework**

Although the precise definition of globalization has been debated (Held 2005), the concept has generally been used to describe the transnational economic, social and political interconnectedness that prevail in contemporary world affairs (UNDP 1997). Processes of globalization have been facilitated by recent advancements in
transportation and communication technologies that allow humans, capital, labor, products, services, information, communication, ideas and cultural practices to move across long distances within ever-decreasing amounts of time (Giddens 1990; Robertson 1992; Harvey 1990; Castells 1996; Lee 2002; Eastwood 2002:224). The outcomes or effects of globalization have been equated with economic growth, increased wealth, improved living conditions and enhanced well-being, and a liberal democracy (Dollar 2001; Feacham 2001). More recent scholarship has pointed out the costs, risks, challenges, and consequences of the world-wide intensification in human social relations by highlighting the erosion of social and environmental conditions, widespread economic insecurity, the global division of labor, the accelerating spread of consumerism, and the exacerbation of the gap between rich and poor (Luttwak 1999; Korten 1999; Cornia 1999; McMichael and Beaglehole 2000; Vlassoff and Moreno 2002; Robinson 2004; Harris and Seid 2004; Baum 2003; Berlinguer 1999). This body of research has shown that the intensification of globalization during the last half century has not only distributed economic benefits to distant locales, it has also facilitated the world-wide spread of risks and threats in virtually all human domains.

McMichael and Beaglehole (2000) outline the 'primary health risks' imposed by globalization: income differentials that create and maintain poverty-associated conditions for poor health, flexible labor markets that perpetuate poor working conditions and environmental hazards, environmental degradation and pollution, smoking-related diseases stemming from the globalization of the tobacco industry (see also Wagnleitner 1994), diseases of dietary excess from image-based marketing of food products, proliferation of car ownership, widespread obesity, expansion of the
international drug trade, spread of infectious disease due to expanded travel, and increasing prevalence of depression and mental health disorders. According to McMurray and Smith (2001) globalization fosters deteriorating health through changing lifestyles and unhealthy living conditions as economies shift away from subsistence agriculture to a cash economy that is characterized by urbanization, excess consumption and more sedentary lifestyles. They link 'diseases of globalization' to lifestyle factors such as smoking and alcohol consumption, excess body weight, lack of exercise, consumption of inexpensive processed and imported foods that are high in refined fat, salt and sugar, and inadequate health education.

Scholars also warn that global food trade policies restructure diets and launch a 'nutrition transition' that generates new patterns of disease that represent a shift away from nutrient deficiency and infectious diseases toward higher rates of heart disease and cancer, the so-called 'diseases of affluence' (Omran 1971; Popkin and Larsen 2004; Diaz-Bonilla et al 2002; Hawkes 2005). In the World Health Report (2002), the World Health Organization refers to the health effects of changing patterns of living that result from agricultural and trade policies that restructure food processing and production as a 'risk transition.' As Kennedy, Nantel and Shetty (2004) explain, "globalization is having a major impact on food systems around the world...[which] affect availability and access to food through changes to food production, procurement and distribution... in turn bringing about a gradual shift in food culture, with consequent changes in dietary consumption patterns and nutritional status that vary with the socio-economic strata". Hawkes (2005) identified how specific agricultural and trade policies promote poor quality diets characterized by refined vegetable oil and highly-processed
foods that contribute to a world-wide epidemic of overweight, obesity and diet-related chronic diseases such as heart disease, diabetes and some cancers. She argues that the consumption of foods high in fats and sweeteners is increasing throughout the developing world, while the share of cereals is declining and intake of fruits and vegetables remain inadequate.

Globalization not only restructures the nature of agri-food systems, it alters the quantity, type, cost and desirability of foods available for consumption and facilitates a convergence in consumption habits (as is commonly assumed in the "Coca-Colonization" hypothesis). Dietary convergence is characterized by increased reliance on a narrow base of staple grains, refined oils, salt and sugar, and a lower intake of dietary fiber" (Kennedy, Nantel and Shetty 2004:9). According to the Food and Agriculture Organization (FAO) diets in countries more integrated into the world economy are converging in terms of primary commodities (Bruisma 2003). Convergence is mainly driven by income and price. On the other hand, dietary adaptation refers to "increased consumption of brand-name processed and store-bought food, an increased number of meals eaten outside the home and consumer behaviors driven by the appeal of new foods available" (Kennedy, Nantel and Shetty 2004:9) is driven by globalized labor patterns, lifestyle changes and ideological shifts.

From a health perspective, globalization presents a double-edged sword comprised of a recipe of threats and benefits that improve health in some circumstances and threaten it in others. The World Health Organization states, ‘the benefits of globalization are potentially enormous, as a result of increased sharing of ideas, culture, life-saving technologies, and efficient production processes,’ and at the same time the
organization warns, 'globalization is under trial, partly because these benefits are not yet reaching millions of the world's poor, and partly because globalization introduces new kinds of international challenges' (WHO 2001:1). The majority of the benefits of development most often fail to reach millions of the world's poor because globalization and development do not occur evenly and equally. In most cases, global flows travel along multi-scalar nodes and networks that are created and defined according to broad and minute systems of power (Sassen 2007, 2006; Ferguson 2006; Robinson 2004; Harvey 2005). Uneven growth results in unequal socio-economic development and a differential distribution in the benefits and consequences of development. Access and control over the benefits of development are concentrated in the hands of the elite while the disadvantaged are oftentimes left out. As structural adjustment programs and conditional lending policies mandate a reduction in public expenditures, including health services, the adverse health effects of development are exacerbated among those who cannot afford to pay for privatized health resources and services. This causes the vast majority of the poor, in both rich and poor countries, to experience double exposure to both health disorders that arise out of impoverished conditions as well as the health consequences of development (Koren 1999; UNDP 1999; Cornia 2001; Vlassoff and Moreno 2002).

Differences in health status between different social groups were identified by William Farr as early as the 19th century, and in most cases, health differences were referenced to socio-economic class and socio-economic factors such as education, income, and occupation (Whitehead 2000). During the late 20th century, questions regarding inequality and health moved beyond class and began to address other forms
of social inequality such as gender and race (Correa 1994; Mundigo 1995; Macintyre 1996; Bird and Reiker 1999; Doyal 2002; Sen et al 2002; Krieger and Smith 2004). While socio-economic factors are still identified as some of the strongest and most consistent predictors in health and mortality, social factors such as gender and race remain significant when they are characterized by socio-economic inequality. Theoretical approaches that situate patterns of pathologies within the context of power relationships has led to groundbreaking scholarship such as Paul Farmer’s work, *Pathology of Power* (2006), which shed light on how gender inequity is one of the reasons that so many women die from AIDS. From this perspective, health status reflects the social context of an individual’s experiences in a stratified society because social processes affect individual access to health resources such as education and prevention, diagnosis and treatment of illness, and awareness of health related risks and behaviors. Therefore, inequality can exacerbate biological exposures and vulnerabilities to disease, increase the risks of mortality and morbidity, intensify the severity and consequences of illness, and multiply experiences and implications of ill health. In this way, power relationships directly affect exposure and health outcomes for people and can contribute to differences in health status.

The relationship between inequality and health is of particular relevance in the context of tourism development in rural communities because tourism markets are characterized by uneven development and the tourism economy relies on human mobility and social encounters. Researchers have already identified a causal relationship between disease, travel, and migration. Some argue that the ‘globalization of disease’ began in the 15th century when European explorers and traders facilitated
the world-wide spread of infectious diseases such as smallpox, measles, yellow fever, plague, typhus, influenza, hookworm, yaws, leprosy, schistosomaisis and malaria (Robertson 1992; Lee 1999; Walt 2000). In the contemporary era, Dollar (2001) argues that the health effects from globalization are most clearly the result of travel and migration, and Diaz-Bonilla and colleagues (2002) argue that ‘increases in international travel, tourism, and food trade will transport new disease- producing pathogens from one continent to another. The relationship between tourism and the spread of HIV/AIDS has received particular attention from applied health organizations and scholars. Weisbrot and colleagues (2001) contend that ‘the spread of the AIDS pandemic is itself partly as a result of increased trade and travel associated with globalization,’ and researchers with the World Health Organization and the World Tourism Organization (Abbott 1992; Broring 1996; Ford 1990, 1991; Forsythe 1998) report that there is a positive correlation between increasing incidents in HIV/AIDS and increasing tourist arrivals.

Research on the social hierarchies embedded in tourism economies has revealed the social complexities of power and inequality in tourism development. Early scholarship in tourism studies presented the politics of tourism policy, planning and practice as a neo-colonialist model (Britton 1983, Alcock 1983; Palmer 1994; Hall 1994, 2000; Nash 1989; Milne 1998), and this body of research paved the way for later researchers to address the composite nature of power relations and the complex strategies of individual and collective methods for negotiation and engagement that characterize capitalist tourism economies (Picard and Wood 1997; Oakes 1998; Hollinshead 1998; Cheong and Miller 2000; Bianchi 2006). A growing number of tourism
scholars are now beginning to examine how the tourism economy articulates with pre-existing inequalities and power inequities, particularly gender and race (Kinnaird and Hall 1994; Sinclair 1997; Aitchison 2003; Ghodsee 2005; Rankin 2005). Evidence from this body of tourism studies positions the tourism economy at the nexus of power relationships that are pervasive from the global arena to the household unit. Since health and power are inextricably linked, it can be expected that power systems in tourism development will influence the distribution of risks, vulnerabilities and resources and affect the health status of residents in Aremd in vastly different ways.

Methods

Information in this chapter is based on seventeen months of ethnographic research in Aremd from 2007 to 2008. While living in a household in the village, I conducted participant-observation and informal interviews with residents, tourists and tourism operators. Information was obtained from residents through case studies with eighteen primary informants in three primary households (twelve women aged from eighteen to approximately sixty years and six men aged twenty-five to forty years). Sampling selection of residents is covered in the Methods section of this dissertation. Information was collected from tourists via convenience sampling of forty-six visitors in the village. Information was also gathered from two transnational tour companies and three independent (unregistered) foreign tour operators. Information regarding residents’ diet, eating habits, medical ailments, and the availability of food and health resources was obtained through direct observation while living in the village. Information regarding sexual activity was received through informal interviews.

Data in this study is qualitative in nature; no nutritional analysis was performed on food items, and no laboratory or medical confirmation of infectious disease or chronic
illness was available. Furthermore, deeply rooted taboos against discussing sex and illness may have compelled some residents to provide personal information as that of an acquaintance, and my personal status as an unmarried woman undoubtedly influenced the nature of the information provided by residents, as well as sample selection. Despite the inability to accurately quantify data, in-depth interviews and case studies still provided valuable information on the social context of the intersection of power dynamics and the distribution of health risks and resources. Information provided by this study can shed light on practical considerations for the health consequences of tourism development within complex and stratified communities, and it will illuminate the need for clinical research on tourism-related illness in rural Morocco.

**Globalized Health in Aremd**

At the time of research, the HIV/AIDS epidemic was beginning to receive a significant amount of national attention and governmental funding in Morocco. In Aremd however, health issues related to diet and lifestyle were most apparent. Food played a central role within the socio-cultural fabric of the community because meals represented the only activity where genders and generations merged. For the most part, daily life in Aremd was segregated according to sex and age.\(^40\) Men and women generally spent their days apart while they performed gender-based activities. Most men left the village early in the morning to engage in tourism labor, perform men’s agricultural duties, or congregate with other men in the Imlil market. Women spent their day in the home performing domestic chores, preparing meals, conducting agricultural tasks assigned to women, or watching television. Time expenditures were also patterned along

\(^{40}\) For more on this, refer to the chapter ‘Keeping Moroccan Time’
generational divisions; young children spent their days in school or playing along the river bed with other children, older boys usually spent their time among tourists to learn the ropes of the new economy while older girls stayed in the home with their mothers to learn the ropes of marriage and domestic skills. Elder men congregated at the mosque while elder women stayed in the home to supervise the labor of their daughter in laws. At meal time however, families and friends assembled together.

In most cases, meals consisted of a tajine stew or a cous cous platter prepared by women in the household. Meal preparation represented the bulk of women's work as families consumed five meals each day; a minor breakfast, followed by a major breakfast, a major lunch (emklee) which followed the mid-day prayer, a minor lunch, and a major dinner (emensee) which took place late at night after the fifth and final prayer of the day. For every meal, a large plate was positioned at the center of the table and the congregants ate the food from the singular plate using only their right hand. Sharing meals not only reinforced social bonds among family and friends, it also reflected the social arrangements that organized household and community members. In some households, family members freely ate together. In most households however, eating habits revolved around a highly patriarchal social arrangement. In these households, the speed and the quantity of food taken from the plate reflected the social positioning of the household member.

In one particular household, for example, household members ate the vegetables first and then the meat was unequally allocated to individuals by the female head of household. In every extended-family household in Aremd, food resources in the home were controlled and allocated by the female head of household. Non-perishable items
were kept in a storage room and the female head of household was the only women who possessed a key to access the food. Most of the time, refrigerators were also locked in the room. Daughter in laws needed to request access, and this reinforced and reflected their mother in law’s higher status in the home. The allocation of meat during meals also reflected the authority of the mother in law. Meat, or tifeeyee, was the most important part of the meal. Ish tifeeyee, or ‘eat meat’ was a popular gesture to welcome guests and family members during meals. One male resident expressed the importance of meat by emphasizing, ‘There are no vegetarians in Morocco!’ To allocate the meat to household members during meals, the female head of household separated the meat into portions and distributed it to individuals. In every case, men and boys received a hefty allotment first. She then allocated a serving to herself, her daughters and her daughter in laws, respectively. Grand daughters were the last to receive their share, and on several occasions, young girls did not receive any meat at all. During one late night meal, a ten year old girl waited tentatively to receive her portion of meat. She watched her mother retrieve her younger brother who had fallen asleep in front of the television, and her mother forced her brother to eat the remainder of the meat. The girl received nothing. In addition, some girls were occasionally chastised by their mothers for eating too fast, and the same mother would prod her son to eat more. Son preference was most evident during meal times, yet it was largely unacknowledged by women. All women stated that they treated, and loved, their children equally. Through observation it was quite clear that the allocation of meat was not equal among sons and daughters, yet it did not necessarily imply that mothers loved their children unequally. It was a reflection of hierarchical gender norms and practices that not only affected each
residents’ ability to make choices regarding the quantity food they ate, but gender norms and values also affected how residents chose to allocate household food resources among men and women as well as boys and girls.

Decision-making for food production and purchase was also influenced by gender norms and practices. In Aremd, men were responsible for the material well-being of the family. In the past, men managed and controlled agricultural production which relied on a household division of labor that included women. During the last decade however, tourism has become the primary economy in Aremd and most households have come to rely on tourism based income to meet the material needs of the household. Men’s gendered role as ‘providers’ positioned them as household income-generators. Women’s participation in income-generating activities was considered shameful by most residents because it was perceived as a consequence of men’s failure to fulfill their gendered obligation to support their household. Social norms also prohibited women from venturing into markets and from interacting with non-relative men; these ideologies imposed a serious impediment in a market-centered economy rooted in hosting strangers. With limited access to money and market space, women in tourism-supported households needed to rely on male household members to purchase food for the household.

Exclusive access and control over market spaces and financial resources concentrated decision-making for production and consumption into the hands of men. As previously mentioned, most men were absent from the household for the majority of the day, and men who worked as guides were oftentimes absent for several days or weeks at a time. While in Imlil or with tourists, men congregated in cafes to eat together.
and they therefore did not rely on household food. Because of this, many women and children relied on a bare-bones food supply in their household. One man in his forties justified his household’s spartan food storage by explaining, ‘If I buy a lot of food, they will eat, eat, eat.’ He believed that, in his absence, the women in his household spent their days lounging and watching television. ‘If I bring a lot,’ he explained ‘there will still be nothing left at the end of the day.’

Through income-generation, men not only controlled the quantity of food in their household, they also controlled the quality and diversity of food resources for household members. As households shifted from a primarily agricultural economy to a tourism-based economy, a dwindling number of the households continued to manage a modest collection of livestock and subsistence crops. Agricultural production not only provided food and a meager income for households, food produced in agriculture was largely accessible to everyone in the household because the entire household participated in agricultural production. Women fed and watered livestock (chickens, goats, sheep, turkeys, rabbits and cows). Men slaughtered the animals, and the refrigerated meat and organs were accessible to women who prepared meals for the household. Elderly women milked cows, churned butter and produced a wide range of foods from various stages of fermenting milk. Women gathered eggs laid by wandering chickens as needed. Several households managed small plots of agricultural land on terraced fields that male household members carved into the mountainside. Subsistence crops included barley, corn, beans, peas, tomatoes, eggplant, onions, potatoes, and turnips. Wealthier families also managed small cash-crop orchards of apples, cherries, walnuts and peaches. Agricultural land was managed by men, yet most women and children
participating in harvesting and women oftentimes received a share of the harvest for personal use. In the household I lived in, for example, the male head of household allocated a 100 pound bag of walnuts to female household members who assisted in harvesting the lucrative cash crop. Women also incorporated a portion of the fruit and vegetable harvests into the meals they prepared during the day. In addition, children from households with orchards climbed family trees to snack on fresh fruit, and thorny blackberry bushes used to contain goat herds provided snacks for passersby every June. Agricultural production provided greater accessibility to food resources for all household members. Despite this, livestock animals were becoming increasingly unpopular due to extensive labor demands that conflicted with time demands imposed by tourism labor and ideas about modernity that associated livestock with rurality.\(^{41}\) One elderly couple reported that access and use of agricultural food had decreased significantly in recent years, and they blamed diminishing land resources, the emerging money economy, and cultural changes brought about by tourism.

Few residents lamented the loss of agriculture because it was considered an unfavorable livelihood due to intensive labor demands and residents' perceptions that, compared to globalized tourism-based livelihoods; agriculture is a last resort for residents who lacked essential skills of modernity to participate in the globalized tourism economy.

Agriculture was associated with rurality and illiteracy. Literacy was a form of social capital and a source of status and prestige. A souvenir merchant in the village stated that men in agriculture ‘have a mind like the animals.’ New ideologies coupled with land

\(^{41}\) Chapter six addressed the temporal conflicts that emerged between the two economies.
scarcity further discouraged residents from engaging in agricultural livelihoods. Rapid population growth (600 in 1980 to 1500 in 2000) imposed considerable pressure on land resources that were already scarce in the sloped mountain terrain. Many residents complained that agriculture was no longer a viable livelihood because there was not enough land to support the village. A male guide in his thirties explained that his father did not have enough land to distribute to all of his sons. Without an inheritance, he was forced to earn a living as a guide for tourists. After achieving considerable financial success as a mountain guide, he was able to purchase a small segment of land from his less-fortunate brother who had inherited land. He joined a growing number of capitalist land-owners who converted agricultural land into tourism spaces such as cafes and bed and breakfast accommodations.

Agriculture has also received negative attention from state officials and environmentalists who blame agriculture and pastoralism for erosional degradation in the mountainsides that has contributed to increasing incidents of deadly landslides throughout the area (Funnel and Parrish 1998). The new tourism economy, policymakers and environmentalists claim, will alleviate pressure on natural resources by transitioning residents away from agriculture toward a 'more sustainable' tourism-cash economy (United Nations 2003; World Bank 2008) and a safer landscape.

The shift away from agriculture was also expedited by the opportunity to earn quick income from tourism rather than engage in a long-term and, what is perceived to be, a more risky investment agricultural production. One man compared his goat herd to tourists, 'I take tourists into the mountains for one day and I earn more than if I take the goats for one month. I never know how much I will get when I take the goats to the
market. Goats are too much work.' Cows were also considered too labor intensive when compared to the availability of inexpensive ultra-pasteurized milk sold in boxes in the market. Care and maintenance of cows was part of women’s gendered division of labor. Women needed to cut, haul and store heavy loads of fodder to last through the winter season. One young woman married to a successful tour guide explained why she refused to work with animals; ‘why should I work every day to milk the cow, carry grass to the top of the mountain, and dirty my clothes when my husband can buy the milk in the market?’

The outcome of income generation through men’s labor and the availability of cheap food in the market was evident in household meals. Despite the abundance of olives throughout Morocco, food prepared in Aremd households were saturated with cheap imported vegetable oils. Cereal staples produced in the village, such as barley and corn, were also being replaced by packaged cereal products imported into the market. In the past, women made cous cous from whole barley grown in the village, yet few women in the village retained knowledge of the laborious process of milling the grains or hand-rolling barley dough into minute balls. After an intensive cous cous-making lesson, an elderly woman led me to an abandoned hydro-powered mill hidden under overgrown blackberry bushes. She explained that it was much easier for men to buy the processed cous cous (imported from France) than for women to spend the entire day making it at home.

Government subsidies in Morocco, which represented a significant portion of government expenditures, enabled particular processed foods such as refined flour, sugar and table oil to be more affordable, and thereby more accessible, to consumers
(Tyner and Arndt 1996). Easy access to imported and refined foods from the market launched a ‘nutrition transition’ away from foods that were once produced in Aremd or obtained through trade with nearby villages in different ecological clines.

Ease of access and affordability were not the only drivers stimulating dietary change, imported and processed foods symbolized the culture of modernity, globalization and men’s financial success. Purchased food reflected men’s financial success and their ability to fulfill their gendered obligation to support their household. Men who worked in tourism returned to tehri homes each evening with plastic bags full of items they purchased from the market. Empty hands and pockets reflected failure.

In the household I lived in, the children congregated along the roof-top terrace each evening and waited to catch sight of male household members as they ascended the mountain slope to return to the village and their homes. If they identified their father, brother, uncle or cousin carrying a bag, they erupted into a celebration and quickly notified the women in the household. Everyone gathered together to await the men’s arrival and receive what they purchased in the market. The most common items included fruits, vegetables and meat as well as plastic bags of cous cous, white rice, flour and pasta, large plastic bottles of vegetable oil, paper boxes of ultra-pasteurized milk, enormous blocks of white sugar, several small boxes of Chinese ‘gunpowder’ tea, and a box filled with paper packets of tajine seasoning that included artificial dyes and seasonings.

Market foods not only reflected men’s financial success, they also represented a culture of modernity and evidence that the household was participating in a globalized culture. Three tour guides made jokes after they found me harvesting wild greens from
a river bed with another woman in the village. One man laughed, 'Did you leave America to eat poor food?' Later, the young man explained that the greens were for people who did not have any money to buy food. Regardless, I continued to join the woman and harvest greens from the river bed, several elders in the community asked why I liked eating the greens. I described how the greens resembled a food in the United States that was particularly popular in the southern region where I was from. This was surprising to them, and one elderly woman explained that the river greens were once a popular in the village, yet it had fallen out of favor due to the availability of imported foods and stigmas that associated it with poverty and out-dated tradition. In Aremd, local foods and agricultural production were valued as part of village identity and heritage while at the same time devalued as 'backward' and 'behind.'

When I visited cafes in Imlil and shared meals with men, they oftentimes assured me that they liked the same foods that I liked. On one occasion a young man in his twenties insisted that we drink a Coca Cola and share a salad and French fries. While eating in cafes, most men consumed copious amounts of sweet tea. Yet, at least three young mountain guides began buying bottled water, a product that was primarily marketed toward tourists and the success of which is evident by the plethora of plastic bottles that littered the village and the mountain trails. The men stated that they preferred to drink the imported bottled water over the fresh mountain runoff that passed through the village because the bottled water tasted better. They also repeated tourists' concerns over contaminants and bacteria.

Alcohol was also gaining popularity among some men in Aremd, despite Islamic prohibitions that forbid alcohol consumption. Tourists often brought beer and liquor from
Marrakech into the village, and they frequently shared their beverages with the male residents that worked with them. Tourists also discarded partially consumed bottles of alcohol where they were easily found by children and women. In one extreme example, a full-size bus full of Spanish tourists parked in the Imlil market place for several days. The tourists stocked the bus with beer and liquor, and the bus served as a temporary bar for some male residents to make clandestine purchases. Like Coca Cola and bottled water, alcohol consumption was associated with a European lifestyle. When I offended a young man by acting surprised after learning he had a girlfriend, he angrily argued, 'I have girlfriends, and I drink beer. I am the same as a European man!'

While women's interactions with tourists were limited compared to men's, women also associated particular foods with the globalized lifestyles they observed on television programs. The Tourists and Television chapter describes how televised cooking shows were immensely popular among women in Aremd. Cooking shows integrated women's gendered role to prepare and cook meals as practiced in Aremd with globalized lifestyles associated with the culture of modernity. I met a newly married young women in Aremd who, like many women, spent the majority of her day watching cooking shows hosted by urban women who wore expensive clothes while using state of the art kitchen appliances to produce elaborate cakes and casseroles. When I initially arrived in the village, she repeatedly asked me for an American cookbook and insisted that we make a pizza together. When we finally made the pizza together (using ingredients from a box I purchased from a chain grocery store in Marrakech), she sent her nephew to the market to buy us a Coca-Cola. When he returned, the three of us ate pizza, drank Coke and watched television together. Later, I prepared a tray of deviled
eggs for her household. The older women in the household were disgusted by the texture of the classic American dish. Yet, she insisted that she liked the egg and mayonnaise combination, despite the concentrated look on her face as painstakingly she chewed and swallowed each egg. Marriage to a tourism-worker enabled her to opt out of the agricultural lifestyle practiced by her mother and sisters in her natal household and move closer to the lifestyles televised into her home by government subsidized satellite broadcasting. Remnants of her lifestyle littered the outside of her home: empty cans of Nido powdered milk, diapers, plastic food packaging and other refuse that reflected her husband's income and her participation in a globalized economy.

While economic changes stimulated new food habits, old food habits were also affected by prosperity. This was particularly evident in the daily consumption of sugar. Once a luxury item offered to families during marriage proposals, sugar had become a staple food in the village as it has throughout Morocco and the world (Travis 2008; Mintz 1986). Sweet tea, or atay, held a central role in the dietary culture of the village. Soo atay, or 'drink tea', was a social invitation and the beverage was the primary means for welcoming guests in the household, and it was oftentimes the only beverage available to children. While living with a family, I participated in the same eating and drinking rituals as household members. I documented my eating and drinking habits during one day and learned that I had consumed thirty-six four once glasses of the sugary beverage.

I eventually discovered that sugar consumption was not limited to atay. The brown syrup we poured on bread cakes in the morning was not honey, as the beehive on the label indicated, but a gelatinous processed sugar product that tasted similar to honey.
The family added sugar to many glass of milk and cup of coffee that I drank every morning. It was sprinkled over the fresh fruit I snacked on during the day. Sugar products such as cookies, cakes, candies and sodas were also the most popular item sold in small store-fronts in the village, called hanoots, that catered to residents. Hanoots were a popular hang-out for children and the area surrounding the store was usually littered with plastic packaging from small single serving size treats. In the absence of cookies and candy, small children sucked on sugar cubes throughout the day.

Sugar had become the most salient food item in residents’ diets. Government subsidies and rising incomes helped increased availability and use of the global commodity, while information regarding the dangers and side-effects of sugar consumption was relatively absent. As a result, the health effects of excessive sugar consumption was becoming apparent.

**Diets in Transition**

Toothache was a very common health complaint among women in the village. Nearly every woman I met suffered from some form of dental problem, from tooth pain to shocking oral abscesses that swelled the entire face. During the weekly market in the nearby village of Asni, women were always congregated outside of the make-shift dental office, mouths stuffed with cotton and appearing delirious with pain. The absence of dental services in the village coupled with women’s reliance on men to consent and pay for dental services compelled women to delay dental care until reaching a medical emergency. Many of the elderly women in Aremd had lost all of their teeth, and some women as young as thirty years old opted to have all of their teeth removed and replaced with dentures in order to alleviate or avoid dental pain. This was a risky
decision, however, because women needed to rely on men to pay for the procedure. In at least one case, a man paid to have his wife's teeth removed, but he never followed through on his promise to buy her dentures.

Tooth loss and decay created more than discomfort alone, they imposed additional restrictions on the type of food people were able to eat. Residents suffering from significant toothache and loss struggle to chew hard and semi-hard foods that were produced in the village such as walnuts, peaches, apples and meat. Therefore, dental carries led to increased reliance on purchased food.

Tooth-loss and decay also impacted self-esteem. When I arrived at a household for the first time, I met a twenty year old woman who was married to a tourism worker. She covered her mouth with her hand whenever she spoke. Eventually she told me that the whiteness of my teeth made her feel embarrassed and ashamed of the condition of her teeth.

Boys and girls also suffered from dental ailments. In one household, the two youngest children of four had only rotten remnants of their front teeth. The gums of the oldest of the two, aged four, were bloody and inflamed. Men also suffered from tooth loss and decay, but access to the market and control over income allowed men to seek out and pay for dental services as they needed them. Many young mountain guides carried small bags of toiletries, similar to tourists' bags, that included a toothbrush and toothpaste. During a conversation about tooth decay in the village, a man stated that he once bought toothbrushes to his children, but they would not use them. He complained that, unlike the routines he observed among tourists, oral hygiene was not part of the daily regimen in the village. He pointed out that although children attended a state-
funded school in Aremd, the school curriculum did not provide health education or information about the health consequences from sugar.

In addition to dental problems, it is likely that the prevalence of sugar in the diet has contributed, or will contribute, to problems associated with diabetes. Residents referred to diabetes as ‘sugar disease’, yet confusion surrounded the causes and consequences of the problem. Only a few residents in the village had received an official diagnosis of diabetes. This is not surprising since residents seldom sought medical attention outside of an emergency; so it can be expected that diagnostic rates would be low.

A woman in her forties became increasingly ill during the latter part of my research in Aremd. After several weeks, she was unable to perform agricultural labor or domestic chores. Since her daughter had married into another household and her teenage sons were too young to marry, she was left with the entirety of household chores and her illness brought the house to a standstill. Her husband eventually sent her to the clinic in Imlil. According to her, she was diagnosed with diabetes, yet she did not receive treatment or a care plan; she was simply advised to refrain from drinking atay, the highly sweetened tea beverage. Nonetheless, abstaining from tea consumption was virtually impossible for her because it was women’s gendered responsibility to prepare and serve atay for guests and household members. In Aremd, it was considered extremely inhospitable and suspicious if the host did not also drink the beverage they served. By the time I left the village, the woman was bedridden and her daughter temporarily returned home to take over her household responsibilities.
As previously mentioned, statistical studies in 2000 indicate that diabetes is on the rise in urban areas in Morocco, and most cases are left undiagnosed and therefore, undocumented (Nahid and Abdelillia 2006; Moktar et al 2003; Rguibi and Belahsen 2004; Benjelloun 2002). As the economy in Aremd shifts from agricultural production to income generation in the tourism economy, and residents in Aremd adopt similar consumption and lifestyle changes, it can be expected that residents in Aremd will experience, or are already experiencing, the same diabetic consequences as residents in urban areas.

Economic transition also changes daily and seasonal activity patterns. Tourism development has led to an increasingly more sedentary lifestyle for many residents in Aremd, particularly for women. The ‘Tourism and Television’ chapter revealed how television-watching has become the primary activity for women in households supported by tourism; time spent in the fields was being replaced by time spent watching television. Men’s income from tourism enabled female household members to opt out of undesirable agricultural labor, and women who did not participate in agricultural development were able to acquire status and prestige among other women in the village by adopting transnational lifestyles and consumptive habits that were similar to those broadcasted into their homes via satellite.

The physical effects of economic transition were immediately evident at the onset of research. During the first week of fieldwork, I met a woman in her forties while I was descending the mountain slope. She was visibly winded while she rested under the shade of a walnut tree. She explained that she used to walk the pathway everyday to bring the family cow to the pasture in the river valley. Her daily routine changed after
her husband sold the cow; she no longer needed to venture down to the valley each
day. She described how it had become extremely difficult for her to ascend the pathway
from the riverbed to her home.

Lack of exercise not only prevented some women from travelling long distances in
the sloped terrain, it also affected visitation patterns within the village. During a fervent
gossip session, a young woman who married a tourism-worker complained that her
older sister, who married a farmer, never came to visit. I pointed out that she didn’t visit
her sister either. She argued that it was too difficult for her to walk upslope to her
sister’s house at the top of the village; if her sister can haul fodder up and down the
mountain slope, then it was easier for her to be the one to visit. Changing labor patterns
had a direct effect on physical conditioning for women, and sedentary lifestyles brought
about by women’s alienation from household production was taking a toll on their
bodies.

None of the women expressed positive sentiments toward agricultural labor
however, and most women described agricultural duties as extremely difficult and
pointed out the negative effects caused by agricultural work such as blisters, calluses,
cuts, bruises, sunburn and fatigue. Yet, women who worked in agriculture expressed
pride for their contribution to household production, and they sometimes criticized
women who opted out of agricultural labor by blowing out their cheeks to imitate a
fattened face and performing a duck-like walk.

Many men were also able to opt out of agricultural labor, yet the nature of tourism
labor and access to market spaces provided men with additional opportunities to
maintain active lifestyles. Few men in Aremd were overweight or obese. While mountain
guides often complained about the physical fatigue that resulted from guiding tourists through the mountains, they also boastfully compared their physical stamina to European male clients who usually struggled to climb the trails. Even unemployed men were able to acquire some form of daily exercise because, unlike women in the village, men were free to trek up and down the mountain to spend their day in the Imlil market and congregate with other men and tourists. In this way, gendered labor patterns and gender power relations articulated with daily exercise routines and resulted in differential experiences among men and women.

Spatial barriers and information deficits affected health-related decision-making and behaviors for residents. High levels of illiteracy among women and farmers contributed to low health awareness. Without knowledge of written French or Arabic, residents were unable to read prescription directions and contraindication warnings. In addition, linguistic barriers prevented residents who spoke Tachelhit exclusively from acquiring health information from national public service announcements and educational resources that were communicated in Arabic and French languages. Furthermore, limitations on mobility prevented women from accessing health resources since social norms prohibited women from leaving the village and venturing to the clinic in the Imlil market or to the hospital in the urban city of Marrakech two hours drive away.

To overcome barriers to health-related resources in the market, some women began to use me as a way to access the market. I became a courier between Aremd and the Imlil pharmacy. Women came to the household where I lived and gave me the empty box of their medication, and most of the time, money to buy the medication was inside the box. I took the boxes to the pharmacy during my next visit to the Imlil market.
and delivered the refills to the women when I returned to Aremd. Women oftentimes asked to borrow or buy over-the-counter products such as sunscreen to protect them from burns while working in the fields, band-aids for cuts and bruises (usually incurred by agricultural labor), and aspirin for headaches.

Some women broke social norms and defied their husband’s authority in order to obtain medical treatment. As described in the ‘Gender and Kinship’ chapter in this dissertation, a pregnant woman left the village and descended the mountain in the middle of the night to reach the hospital and deliver her baby. She challenged her husband’s decision that she would deliver the baby at home, a decision he maintained although she had already experienced two emergency Cesareans and the loss of a newborn during delivery. Women who chose to challenge norms are still faced with limited access to cash income to pay for medical services or for transportation to the location where services are offered. Therefore, medical decisions were oftentimes left to men who controlled household income, and women’s health seldom took priority in household finances.

Men who were absent from the household for long periods of time were oftentimes ill-informed of women’s medical needs. I visited a young woman while she agonized over an abscessed tooth. She was married to a successful souvenir merchant and her household was among the wealthiest in the village. Despite the abundance of luxury items in the household, such as a satellite television, new furniture and linens, and a washing machine, she was unable to access the health services she needed. Ironically, her husband returned to the home in the evening with a bag of bandages he purchased at the pharmacy to cover a large blemish that erupted on his face. On a different
occasion, I discovered that the women and children living in the household I stayed in were battling a severe head lice infestation. The women were using household detergents to treat the infestation, and one woman had developed a very painful rash on the back of her scalp and down her neck. Motivated by self-interest, I purchased lice shampoo for the entire household, which cost approximately ten USD. Later that evening, an unmarried male household member returned from Lmlil with a new cell phone and pair of shoes which cost more than forty USD. I asked him why he did not buy lice shampoo for the women and the children. He replied that he unaware that there was a problem with head lice.

It is important to note that women did not always inform men about their health needs or ask for medical assistance. Several women I spoke to did not consider their own health as a priority in the household. When I asked women why they did not inform their husbands and ask for help, they blatantly stated that they did not want to create a problem in the household. The Gender and Kinship chapter explained that women moved into their husband’s household when they married, and after marriage, they must rely on their husband and his family members to meet their needs. This would make it in a woman’s best interest to gain and maintain favor from her husband and his family members. Expensive health costs would generate an economic burden in households with limited income.

Many men in the village did pay for health care and medicine for women in the household. Regardless, women did not have autonomy to make their own decisions over their health needs because they did not have opportunities to generate income to pay for medical services and participate in health-care decision-making. Women’s
alienation from tourism development placed them in a position where they were structurally dependent on male household members, or temporary anthropologists, to meet their health needs; and this placed women’s health in a precarious position.

The complex interactions between tourism, power, wealth and health shaped the distribution of the benefits and consequences of dietary and nutritional change in Aremd. Macro structural forces, such as tourism development policies aiming to advance globalization and integrate rural economies into the global economic system led to uneven development and an inequitable distribution of development-based benefits and opportunities among residents, particularly between men and women. As the village economy shifted away from agriculture toward tourism-based production, women’s role in agricultural production was becoming obsolete and social norms prohibited women from participating in the tourism economy. Control over income and access to markets provided men with greater access and control over food purchases, dietary decision-making and health services; and many women came to rely on men to for their nutritional and health needs. Yet, men’s participation in the tourism economy and long-term exposure to tourist lifestyles also affected dietary behaviors and decision-making. Interaction with tourists enabled men to acquire beneficial health information habits, such as dental care and maintenance, but it also promoted negative health behaviors and practices such as alcohol consumption and reliance on imported processed foods. Furthermore, globalization and the availability of income through tourism contributed to a shift in lifestyle behaviors and consumer desires in households. Widespread consumption of (and preference for) market foods over food produced in agriculture was fueled in large part by government subsidies that made refined foods,
such as sugar, more affordable to low-income families and televised marketing associated processed and imported foods with modernity and globalized lifestyles. For women in Aremd, modern convenience and prestige came at the cost of dependency and loss of control over the quality and quantity of food in their diet. Women who continued to engage in agricultural labor and food production had greater access and control over food through their participation in agricultural labor, yet participation in agricultural labor came at the cost of lower status and prestige among other women. Dietary changes, particularly increased consumption of subsidized sugar, generated negative health effects such as advanced tooth decay and increased vulnerability to diabetes. Although men also shared the same health risks and vulnerabilities brought about by tourism development, the consequences were concentrated among women because women could not access income and market spaces that were necessary to control their diet and/or seek out medical services. The experiences of residents represented in this chapter demonstrate that the intersection of tourism development processes with systems of power and wealth led to gendered patterns in dietary changes and health consequences which reflected the socioeconomic and cultural context in which tourism policies operate.

**Tourism and HIV / AIDS**

Power inequities in tourism are oftentimes played out in sexual relationships. When sex interacts with the disproportionate distribution of power and wealth in tourism development, it is likely to result in a disproportionate distribution in the health risks and vulnerabilities that come with sexual activity (Farmer 2003; Van der Kwaak and Wegelin-Schuringa 2006). This is most evident in interactions between tourism workers and tourists, as well as between tourism workers and their spouses.
Most tourists in Morocco are members of a wealthy minority of global elites originating from rich nations such as France, England, Spain, Australia and the United States and are thereby free to cross most international borders. People become tourists after they have accumulated enough wealth to allow them to suspend labor activities and take a holiday, or vacation, to engage in recreational activities. While in Morocco, tourists obtain services from tourism workers, most of whom are in a structurally less powerful position than their clients.

In contrast to their clients, most tourism workers in Aremd were uneducated men with large extended families and overwhelming financial obligations to fulfill their gendered role as a household provider. The majority of men were forced to work illegally in the tourism industry because they lacked the financial and social resources they needed to obtain legal permitting and licensure or long-term contracts for stable employment. Tourism workers in Aremd were not permitted to freely cross international borders without securing significant financial sponsorship abroad. Therefore, it should not be surprising when the financial and social insecurity experienced by residents in Aremd is matched with financial prosperity and social liberty experienced by tourists, a power imbalance emerges; and power inequities can operate within sexual relationships that take place between male residents and their clients.

Power inequities between tourism workers and tourists can generate health risks and vulnerabilities for workers who engage in sexual relations with their clients. Workers risks and vulnerabilities are commuted to residents in their village, particularly women, because tourism workers are in a structurally more powerful position within their
household and community. Power dynamics within sexual relations are particularly relevant in terms of sexually transmitted infections such as HIV/AIDS.

Until recently, research into sexually transmitted infections in the Arab-Muslim and North African context was particularly lacking and most research has been concentrated in Egypt (Hind et al 1999). In Morocco, the Ministry of Health estimates 600,000 new cases each year (Elharti et al. 2002; Ryan et al. 1998). Increasing presence of STIs diagnoses indicates prevalence in high-risk sexual behaviors. Manhart et al’s (2000) research in the cities of Tangier, Khenifra and Sali identified clear gender differences in understanding the risks associated with sexual activity and in understanding health-care-seeking behavior. Like Aremd, Khenifra is a rural village located in a mountainous area that was sustained by agriculture. Through interviews, Manhart and colleagues found that STIs were viewed as women’s illnesses, and men with STIs reported feeling victimized by women. Within their sample, men had more extensive informal information sources for STD than women and men had greater access to treatment, for both social and economic reasons.

The HIV/AIDS epidemic has received particular attention in Morocco. More than 21,000 adults and children in Morocco were infected with the HIV/AIDS virus by 2008, and more than 40 percent of HIV positive residents were between 30 and 39 years old (UNAIDS). More than eight percent of AIDS cases were counted in metropolitan areas with a 60% concentration in the four largest provinces of Morocco including Marrakech province which accounted for sixteen percent of active cases, second only to Agadir which is another popular tourist destination (MAP 2009; WHO 2008). In 1988, the Moroccan National AIDS Control Programme response initiated a national strategic plan
to monitor and control the spread of HIV, to inform and protect residents, and provide services for people who were infected with the virus. Nearly ten years later, the Ministry of Health conducted a qualitative study in 1996 in order to enhance information, education and communication strategies in the national STD/HIV program. More recently, the 2002-2005 National Strategic Plan budget included US$ 20 million to address prevention (36% of allocation), impact reduction (33% of allocation) and related activities (31% of allocation). The Moroccan government received additional international support from the United states (USAID), France and the German Agency for Technical Cooperation (GTZ) amounting to US$ 9.23 million during a four-year period (March 2003 to February 2007). The implementation of the 2007-2011 National Strategic Plan determined objectives and targets for “universal access” (http://data.unaids.org/pub/FactSheet/2008/sa08_mor_en.pdf). During this time, the Moroccan government developed partnerships with thematic nongovernmental organizations such as the Moroccan chapter of the Pan African Organization for the Fight against AIDS (OPALS), the Moroccan League for the Control of Sexually Transmitted Infections (LM-LMST), the Moroccan Association of Youth against AIDS and the Moroccan Association for Solidarity and Development, all of which play an active role in activities to raise awareness and contribute to the AIDS response (http://data.unaids.org/pub/Report/2008/jc1348_morocco_response_highlights_en.pdf). The Moroccan Association for the Fight Against AIDS (ALCS) is one of Morocco’s leading NGOs addressing HIV/AIDS and is a key member conducting advocacy and implementation for the Moroccan Ministry of Health’s national HIV/AIDS initiatives, funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria. It was one of the
first organizations to advocate and provide highly active anti-retroviral treatment to people living with HIV/AIDS.

Government programs and related NGOs came under fire from the Justice and Development Party (PJD) for ‘promoting condom use’ and for reaching out to marginal populations, such as sex workers and men who have sex with men (http://berkleycenter.georgetown.edu/resources/organizations/the-moroccan-association-for-the-fight-against-aids). PJD was the largest opposition political party in Morocco, and the party’s political platform was centered on Islam and Islamic democracy. In the national parliamentary election that took place during field research in September 2007, the PJD party won only 46 out of 325 seats. Despite low national support, the PJD party was the most popular party in rural areas. Residents in Aremd likened their vote for the PJD as common sense.

Using religion as a backdrop, PJD heavily criticized the programs for promoting a Westernized ‘condom culture’ and failing to represent the Islamic character of Moroccan society or regard Morocco as an Islamic country." The PJD also launched a campaign against a cartoon book aimed to make youngsters aware of the danger of AIDS, and party leaders condemned the authors for presenting the condom as a safe option and for using a mosque as a background to some of the cartoons. The PJD also targeted programs that promoted tourism development and blamed tourism for the spread of HIV/AIDS in Morocco. According to the PJD, "fidelity to religion and marriage" are the way to fight AIDS, which it described as "divine punishment"(Abderrahim El Ouali 2006).
I inadvertently confirmed the PJD’s representation of Western ‘condom culture’ after I accidentally displayed a strip of multi-colored condoms while sitting at a table in a café with a group of men. I pulled the condoms out of a small pocket in my book bag while rummaging through it. To break the awkward silence, I attempted to explain how I obtained the condoms; that there was an HIV/AIDS awareness booth set up in a park at my university, they handed out condoms along the walk way, I took them and shoved them in my bag to be nice to the people who were working there. I forgot they were in my bag and here they are in Morocco … As I rambled through my story, a man in his thirties interrupted, ‘it is a school, not a pharmacy. If you are there to study, why would they give you condoms? Maybe books, not condoms.’ As I tried to explain that the school had a pharmacy and perhaps the booth was in some way associated with the pharmacy the incredulous looks on the men’s faces told me that they either thought I was delivering a pack of outlandish lies or I did, in fact, come from a ‘condom culture.’

Surprisingly, residents’ ideas about the condom culture promoted by the U.S. and other countries were associated with residents’ perception of American relations with Israel. During a conversation about condom-use and prostitutes at a café in the commercial center of Asni, one hour drive outside of the village, a man in his thirties remarked that condoms were necessary to avoid most STIs, but not HIV/AIDS. He explained that the campaign to promote condom-use as a means to protect oneself from HIV/AIDS was fabricated by a Jewish man who owned a condom factory. The story described how the condom factory was about to go out bankrupt. In order to save his business, the Jewish factory-owner devised a means of promoting condoms by associating HIV/AIDS with sex and claiming that condom use would protect individuals
from the disease. Since the U.S. and Israel are closely allied, the United States supported his campaign and implemented programs to promote condom use worldwide. As a result, the factory prospered and the Jewish man became very rich. His story incensed a middle-aged American woman who had joined our conversation. She angrily argued that she personally knew people who had died of AIDS, and that she was insulted that he would deny that the disease existed. He clarified that he was not denying that the disease existed, only that it was not acquired through sex. I returned to the village and asked several residents if they had heard of the story. Everyone did. I then asked if they believed the story; Most of the residents replied that it was impossible to know for sure, but it was likely.

Controversy surrounded residents’ ideas about condom-use and HIV/AIDS. Condoms were largely associated with sex outside of marriage (to avoid pregnancy) and sex with prostitutes (to avoid disease). These associations led to a logical extrapolation that married people did not need to use condoms, and this perspective was reinforced by the PJD. Both residents and the PJD argued that making condoms accessible to unmarried individuals would encourage premarital sex, and married couples should not need to use condoms unless they are unfaithful. Therefore, if one partner were to suggest using a condom, it would imply that they were unfaithful, or that they were accusing their partner of being unfaithful. Shame associated with condom-use discouraged men from acquiring condoms which were available at the nearby pharmacy and clinic in Imlil. In fact, sex-workers were residents’ primary source for condoms. According to two men in their thirties who worked in tourism, sex-workers
sold condoms to their clients, and the condoms usually cost more than transactional sex.

Access to condoms was particularly limited for women since women were forbidden to venture into market spaces where pharmacies, clinics, and healthcare workers were located. In addition to spatial barriers to access condoms, possession of condoms would seriously jeopardize a woman’s reputation in the village since condoms were associated with prostitution and sex outside of marriage. Nonetheless, none of the women interviewed stated a desire to acquire or use condoms, but this was likely due to inadequate education about transmission and insufficient awareness of the HIV/AIDS epidemic in Morocco.

It was evident that residents’ ideas, knowledge and awareness of STIs, condoms, and HIV/AIDS was the result of the dearth of educational resources available within the confines of the village; and this reflected the structural positioning of the village within the global and national arena. During the time of research, HIV/AIDS awareness campaigns were just beginning to gain momentum in Morocco. Yet the vast majority of the informational resources were concentrated in urban areas, such as Marrakech. This imposed limitations on residents who spent the majority, if not all, of their time in the village. Men visiting Marrakech would have more exposure to informational resources than women who were unable to venture into the urban area without being accompanied by a man. Men working in tourism were more likely to acquire information from tourists (who originated from wealthy countries that have invested heavily in HIV/AIDS education) than women or men who worked in agriculture. Furthermore, simple exposure to HIV/AIDS programs and informational resources was insufficient
because the majority of the information about the disease that reached the village was relayed in French and Arabic languages. This created a communication barrier for residents who spoke only Tachelhit or Moroccan Arabic, as well as residents who were illiterate. Informational resources included printed materials, such as a French/Arabic banner displayed in Marrakech, radio PSAs, and television commercials broadcast by transnational companies.

While watching television with a group of women, a young woman changed the channel during an HIV/AIDS PSA. I asked the women if they knew about the disease and if they were concerned. The women identified AIDS, known as SIDA in Morocco, as a disease in Marrakech and among tourists. This was logical since the socio-cultural (and linguistic) backdrop of the PSAs on the television was centered on urban settings and lifestyles. PSAs never portrayed a rural Berber woman contracting the disease from an unfaithful tour-guide husband, for example. This led women to believe that they were not at risk of contracting the disease. Inadequacies in the distribution of educational resources forced women and many men in Aremd to rely on word of mouth information, and word of mouth information oftentimes included misinformation and mythical stories, such as the tale of a Jewish man who owned a condom factory.

**Sex, Power and Tourism**

The outcome of information deficits and inadequacies in health resources experienced by residents further exacerbated power differentials that characterized economic inequality between residents in Aremd and their clients. Since residents were situated in a structurally less powerful position than their tourist counterparts, they were more vulnerable to the risks imposed by tourist behaviors, including risky sexual behavior. Morocco’s proximity to wealthy European countries such as France and
England made it a popular, and convenient, destination for European tourists. Discount airlines, such as Ryan Air and Easy Jet, offered direct flights at a discount (London to Marrakech direct cost ten pounds/20USD in 2007) making Morocco an affordable destination for low-budget weekend travelers, many of which were impulse travelers who arrived alone. Low-budget solo travels were the primary clientele for guides who did not have an active contract with a tourism agency or who needed to work illegally. Without the assistance of a tourism company in Morocco, solo travelers usually arrived without an itinerary or pre-arrival information and could therefore easily come to rely on inexpensive services provided by a local guide. In Aremd, many unemployed guides spent their time loitering at taxi stands awaiting the arrival of solo tourists who were usually beleaguered from the intensity of the urban Marrakech destination and, apart from a travel guide, they were usually clueless about local accommodations and services and generally uncommitted to a specific itinerary. The taxi stand in Imlil offered a daily supply of independent shoe-string budget tourists, and the tourists were usually greeted with a swarm of over-eager guides offering services that included ‘authentic’ Berber accommodations in their home and informational tours into the village and mountainside.

It may be safe to assume that most tourists arriving in Morocco did not intend to participate in sexual relations during their stay. However, information gathered in Aremd is consistent with findings from previous research in other parts of the world that indicates that sexual relations are a common touristic activity. Ford’s (1991) research in Torbay, England found that nearly one quarter of tourists who participated in the study had engaged in sexual activity with a person whom they just met while on holiday;
nearly half of those who had engaged in sex while on holiday had sex with locals (the remainder had sexual relationships with other tourists). More than a third of the respondents indicated that they were more likely to engage in casual sex on vacation than at home, and even tourists who were reportedly in a steady relationship indicated that they were more likely to engage in external sexual activities while on vacation. Less than half of all sexual activity while on vacation involved the use of a condom, and three-quarters of female tourists who had sex with residents in Torbay did not use a condom, compared to 42% of male tourists. Forsythe (1998) found that tourists are generally more adventurous on vacation than they are at home, and they tend to take risks that they otherwise would not take at home. According to Forsythe, tourists may drink more, use drugs, and/or take sexual risks. In addition, a minority of so-called "sex tourists" travel specifically to engage in sex with the local population.

For tourists, vacations are terminal liminal periods when participate in activities that deviate from normative behaviors at home (Burns 1999; Ryan and Hall 2001). Yet, tourists eventually return home and reaggregate into their customary routines. Tourism workers, on the other hand, are perpetually immersed in tourist culture and are persistently exposed to tourist's liminal behavior and risk-taking. It is therefore likely that tourism workers, as well as their families, will be disproportionately affected by HIV/AIDS risks presented by tourist sex behaviors. For example, a UK study found that both male and female tourism workers have more sex partners (usually with tourists) and more casual sexual relationships than the resident population (Ford 1990). When tourists engage in unprotected sex with local residents they create a bridge for HIV/AIDS to travel from the tourist’s origin to their vacation destination, and their local
sex partner creates a bridge between the tourist and the partner's community and household. Therefore, tourists who engage in unprotected sex with residents not only represent a risk to their partner, they also impose risks to the partner's family and all subsequent sexual contacts that the local person may have.

In Aremd, contracts between a male tourism worker and a client tourist lasted from a single day to more than two months. Chapter six described how residents working as guides or drivers needed to accompany and accommodate their client twenty-four hours a day throughout the duration of their contract. Oftentimes, male tourism workers spent more time traveling with and caring for their clients than they spent in their household with their family; and in many cases, the extended-stay client was a solo-traveler.

During my first visit in Aremd, I stayed in a small bed and breakfast owned by a resident household, and I met a young French woman who also planned to spend her entire summer vacation living in the village. Like her, I made my accommodation arrangements through one of the male household members who worked as a guide. My arrival with the young man angered the woman, and her temper flared as I arranged my belongings in a room next to hers. I learned later that she was touring Morocco alone and established an informal guiding contract with the resident tourism-worker after he solicited her in Marrakech. She eventually developed a sexual relationship with him and after the week-long contract terminated, she opted to spend the remainder of her summer in the village. The guide's family assumed that, like me, she was a client, yet her clandestine arrangement with the guide enabled her to stay in the bed and breakfast for free. When I returned the following summer to conduct pre-dissertation research, I asked about the woman, and the young man replied that he attempted to telephone her...
several times but he never heard from her again. However, his arrangement with her was not unique. Throughout the duration of my dissertation research, the young man’s clientele primarily consisted of young and attractive female tourists travelling alone. In one particularly complicated situation, he unsuccessfully attempted to juggle two tourists at the same time.

While living alone in the village I frequently became acquainted with other women who also visited the village alone, some were simply tourists aiming to experience the countryside and others were pursuing a relationship with a male resident. Several times, after learning that I was conducting long-term research in the village, female tourists used me as a resource to soundboard their ideas, thoughts and feelings while they embarked on an exciting, yet uncertain, relationship with a resident in the village. Sometimes I was interrogated with a line of questioning, ‘would you ever date a Moroccan man?, Do you think a relationship would work between a Berber man and a non-Berber woman?, Do you think a Berber man can respect a woman?, What is it like to interact with the family?, Do you think his family would accept a foreign woman?, Do you need to cover your hair when you enter the house?, Do the women like you?’ In some circumstances, women indicated that they were considering a long-term relationship that could potentially lead to marriage. This was the case with a forty-year old French woman who was in an eight year relationship with a male tourism worker from Aremd. She initially hired him as a guide during her first visit to Morocco, and she has returned to Morocco twice a year, ever since. Despite the duration of their relationship and several visits to the village as a ‘tourist’, she had never met his family or entered his household.
In other cases, women were pursuing short-term relationships that were not expected to continue after their departure. A Spanish woman in her twenties came to Aremd with a resident tourism worker. After her arrival, he introduced her to me and abruptly left. Within a few days, the woman became disgruntled and left the village alone. She invited me to meet her in Marrakech, and when I arrived, she introduced me to her new guide who was a man she met in the city. It was clear that the line between ‘guide’ and ‘date’ was quite blurry. When I asked her to clarify the exact arrangement she had made with the Moroccan man, she explained that he had approached her while she was visiting a popular plaza called Djemna El Fna. He offered ‘guiding services’, and she accepted. As it turned out, his services included accompaniment to dinners and night clubs during her solo vacation. She paid for everything.

Djemna El Fna, or ‘the plaza’, is a central location in Marrakech where tourists and Moroccan nationals intermix. In Aremd, male tourism workers assumed that single women, tourists and nationals, visit Djemna El Fna to seek out men to accompany them on their vacations. They referred to this as ‘fishing’, and the men caught in the plaza are referred to as ‘fish’. During a visit to Marrakech I ran into a resident from Aremd, and he invited me to lunch. When we arrived at the café, however, he wanted to sit at an inside table in a dark, dank corner. When I asked why we couldn’t eat at a table outside, he replied ‘people will think I am your little fish.’ The assumption that single women in Djemna El Fna are looking for male companionship made evening visits to the festive, carnival-like plaza unbearable for solo female tourists who actually desired to spend their vacation alone. While walking through the plaza, I experienced incessant cat-calls, solicitations and sometimes physical groping from men. It seemed unlikely that the
annoyances would lead to a successful connection, yet the plaza was an ideal location to connect with tourists and many men found success.

In the Imlil market, I met an American woman in her fifties who was filing for divorce from a 30 year-old Moroccan man she met in the Marrakech plaza. He lived with his family in one of the villages that connected to the Imlil market. They initially met in Djemna El Fna and maintained contact via internet after she returned to the U.S. He proposed to her through a webcam, and she returned to Morocco and married him. She used her life-savings to buy land and build an elaborate house in the middle of a scenic village that was less than a half hour drive to Imlil. After one year of marriage, the house was nearly complete. Against her wishes, his family moved into the house and she eventually found him engaging in sexual relations with the young housekeeper she hired. She filed for divorce and learned that he was entitled to half of everything. She moved to a more populated village along the main road to Marrakech and he remained in the house with his family. By the time I met her, she had spent more than three years and several thousand dollars in attorney fees trying to settle her divorce. For better or for worse, she was a very popular woman in the village where she lived. Not only was she the only American in the community, she had considerable more wealth than the rest of the residential population. She owned a car, and her apartment was equipped with running water, appliances, air conditioning, and a host of additional luxury items. She liked to drink alcohol. Needless to say, her house was a popular hang-out for poor young men living in a mundane remote village. Unlike other women in the community, she had boyfriends and casual sex. Near the end of my field research, she was in the process of transitioning boyfriends by ending a relationship with a flighty young man and
embarking on a new relationship with an older, and seemingly more committed, married man. She told me that she did not use condoms, and when I questioned the wisdom of unsafe sex she replied, 'I would know if they were sick.'

Regardless of the availability of financial and social resources that have been made available to the American woman in her home country, she chose to take considerable risks while living in Morocco, and the outcome of her risk-taking behavior was likely share not only with her partners, but with her partner's family members as well. I questioned the woman's new boyfriend about his wife and wondered if his wife cared that he spent his time with another woman. He replied that sometimes she gave him a hassle, but there was really nothing she could do. Unable to earn her own income, his wife was economically dependent on him. He kept a flock of sheep and refused to buy a washing machine because his wife 'needed to be busy to stay out of trouble.' Ironically, the house they lived in was initially owned by her family who used the property as part of a dowry to help their daughter succeed in a highly competitive marriage market. Marriage was become more competitive for women because men's marriage options were increasing as a result of increased mobility, urban migration, and the arrival of tourist women. As a consequence, women's options dwindled as urban migration decreased the male population in the village and women needed to compete with tourist women. Restrictions on women's mobility and prohibitions against social relations with non-relative men generated difficult circumstances for women to seek out a spouse outside of the village or with tourist men.

Apart from verbal complaints, the man's wife was virtually powerless to protest against his openly adulterous relationship with the American woman. It is very likely
that, due to the dirth of educational and health resources available to women in the area, she was largely unaware that her husband’s infidelity was not only socially and emotionally harmful, but it imposed a considerable threat to her health as well.

In Aremd, an openly adulterous relationship would have been considered unacceptable. Yet, many residents (men and women) engaged in clandestine relationships behind closed doors. A male Peace Corps worker in a nearby village who spent the majority of his time with tourism workers told me that guides in Imlil have constructed a gradient scale that correlated nationality with the likelihood to have sex; Dutch women were considered most likely and surprisingly, American women were considered the least likely.\(^{42}\) In time I was able to identify some of the more sexually-active tourism workers, either as a result of the men testing their luck with me or through observation and conversation.

A few guides introduced me to their secret ‘tourist’ girlfriends because they thought I needed a friend, or they needed me to keep her occupied while they worked with other tourists. On two occasions I was approached by perplexed female tourists who wanted me to explain why their guide offered them a ‘free’ trip to the Sahara desert if they returned to Morocco. Remote and rural areas, like Aremd, were popular destinations for sex tourism because Moroccan laws forbid unmarried couples to share a hotel room. This law was usually upheld in the urban center of Marrakech where police were known to enforce the restriction, yet rural accommodations seldom enforced the law and accepted the prohibited arrangement.

\(^{42}\) This ordering may have been modified to avoid offending the American Peace Corps Worker.
Although relationships with foreign women were considered shameful by village standards, tourist girlfriends were also a status symbol for men in Aremd. Relationships with foreign women not only symbolized men’s direct participation in a globalized culture, the woman’s decision to be with a Moroccan man over a European or American man was also a testament to their sexual supremacy over the richer, more powerful, Euro-American counterparts. This was illustrated through a colorful conversation with a lively guide in his thirties. ‘Do you know why they come here to be with us?’ he asked me, ‘because we satisfy. How many times can a European man go?’ I refused to answer. ‘Just once, right? A Berber man can go many, many times. Too many times ... Sometimes it is too much for his wife, and he must go to the tourist as well.’ Sexual superiority over European men was a sentiment shared by many men in Aremd (see also Rabinow 1977). Sexual superiority was a form of dominance over those who formerly occupied Morocco through colonialism and continue to occupy the country and its inhabitants through integration into the global economic system.

The majority of overt sexual encounters between residents and tourists took place between male residents and women. However, Marrakech and surrounding areas have received international notoriety as a same-sex tourist destination for men and it is therefore likely that same sex encounters were more prevalent than they appeared to be. Homosexual relationships are forbidden in Islam, and therefore information regarding homosexual interactions between residents and tourists was less accessible than interactions between men and women. Only two men in the village revealed that they participated in same-sex activities at least once, and both residents described the arrangements as consensual. On one occasion however, a guide in his twenties arrived
with a very demanding, older Hungarian man. After several days with the man, the
guide approached me, and with tears in his eyes, asked me if there was any way I could
find work for him in the United States. He stated that he could not bear to be a guide for
that much longer. I pointed out that the Hungarian man seemed very hostile, and that I
could help him find a different tourist to take his place. He replied that the man was a
regular client, and he could not afford to lose the business until he found another job. A
few months later, I discovered that the Hungarian man managed a website that hosted
photos from his time spent in the village. In one of the photos, the man had his arm
around the young guide who stoically held a stuffed animal. Beyond simple suspicion,
there was no evidence to indicate that the resident was engaging in sexual activities
with the lone male traveler. Yet, the economic power held by the older Hungarian
obviously made it impossible for the impoverished young guide to say no to his
demands. In light of the economic power differentials between residents and tourists,
male tourism workers are situated in a precariously vulnerable position when they are
forced to meet the demands of an unethical and exploitative client, either male or
female, in order to fulfill their gendered obligation to meet the material needs of their
household and family.

**Tourism, Sex and Gender**

Tourism workers act as a bridge between the tourist and their household and
community; and when tourism workers engage in risky sexual behaviors with tourists
(either willfully or coerced), the risk is passed on to the worker’s household members
and their community. While male tourism workers in Aremd were in a structurally less
powerful position relative to foreign tourists, they wielded considerable economic and
social power within their households and communities, this was particularly the case
within the unequal gender relationships between women and their husbands. The 'Gender and Kinship' chapter in this dissertation illustrated the patriarchal hierarchies that characterized gender relations in Aremd; in many ways, women were socially and economically dependent on male household members. Previous research has shown that not only are women more biologically susceptible to infection than men (Kost et al. 1991), but economic dependency and unequal gender relations place women at higher risk because they are less able to negotiate safer sex with male partners and this increases women's vulnerability to STIs (Gupta 2000). In Aremd, dependency reduced women's capacity to exert agency within their husband's household, and lower status diminished women's capacity to protect themselves from sex-related vulnerabilities and risks. Furthermore, women elevated their status in the household by producing children. Therefore, safer sex through condom use presents a double-edged sword because it can protect women from infection while virtually eliminating women's opportunity to gain prestige through motherhood.

Socio-economic inequality not only affected women's ability to negotiate safer sex and protect themselves from sex-related risks, it impeded women's ability to leave an adulterous husband in order to protect herself from infection. In Aremd, divorce imposed the risk of losing economic support and a place in society. Although many women stated that they would like to leave their husband, only one woman left her husband during my field research term. She stated that she left in protest of his adulterous activities with tourists and Moroccan women in Marrakech. She left his household and walked uphill to return to her natal household in the village. However, many women in Aremd were originally from distant villages, and they came to Aremd when they moved
into their husband’s household after marriage. These women lacked the social resources they needed to leave their husbands if they needed to. As Doyal (2002:239) points out, ‘In a situation where they have few options to support themselves, many women may feel compelled to stay with a male partner even when this is putting their own life at risk. A refusal to participate in unsafe sex may mean the withdrawal of material support leaving a woman and her children with no alternative means of survival.’

Social norms that place women under the authority of their husband exacerbated power differentials created by economic inequality. According to patriarchal interpretations of Koranic law, a woman is under the authority of her husband, and Islamic law supports the principles of sexual consent while mandating sexual obedience by the wife (Orobu loye et al.1993). When sex falls under the decision-making authority of the husband, women cannot easily refuse sex to their husbands and practice an ‘abstinence only’ approach to HIV/AIDS prevention. For many men in the village, women’s obligation to remain sexually available to the husband was a key part of marital relationships. Sex outside of marriage was forbidden, and therefore, married men considered sex an entitlement. A tourism worker in his twenties explained, ‘I work and I pay for the house, her food, the clothes, everything. When I come home, if I need to lay with her, why should she say no to me??’

The risks imposed by gender norms that mandate sexual obedience are further compounded by a ‘culture of ignorance’ and the demand that women remain virgins until marriage. The culture of ignorance dictates that so-called ‘good’ women are ignorant about sex and should assume a passive role in sexual relations. Unlike men
who openly discussed their sexual escapades, both in within and outside of marriage, few women in Aremd were willing to discuss their sexual experiences. The culture of ignorance creates a barrier for communication that not only impedes the dissemination of information about HIV/AIDS risk reduction and negotiating safer sex (Gupta 2000), it discourages women from seeking out information about sex-related risks and vulnerabilities. Women who conformed to the culture of ignorance were referred to as 'clean' women, which referred to sexual morality rather than hygiene. At the same time, masculinity was characterized by sexual aggression and fecundity. Men were expected to be well informed about matters regarding sex despite a dirth in resources for men and boys to obtain information. Without resources, men and boys needed to rely on experience obtained through sexual experimentation. One man described how, as a teenager, he engaged in sexual experimentation with a female resident who was also in her teens. According to him, they engaged in alternative sex behaviors, such as anal, oral and 'thigh' sex in order to avoid pregnancy or rupturing her hymen. Cultural demands for girls to remain virgins until marriage, and the necessity to provide proof of virginity by bleeding during first intercourse compelled unmarried residents to practice sex behaviors, such as anal and oral sex, that increased their vulnerability to HIV/AIDS infection.

Most male informants stated that the primary sources for sexual information and experimentation were tourists, prostitutes, and married women. Previous research has claimed that for married women in Morocco, like many women in the developing world, vulnerability and risk to STIs such as HIV/AIDS is largely determined by their husband's behavior (Kamenga et al. 1991; Mbizvo 1996; Boerma et al. 2002; Sanchez et al. 2003;
Harvey et al. 2002; Ryan et al. 1998). Wegelin-Schuringa (2005) reports that, worldwide, more than eighty percent of women infected with HIV contracted the disease from a male partner, and the partner is usually their husband. Without discounting the staggering statistics, it is important to note that some women may exert agency to undermine patriarchal arrangements in order to exercise their sexual desires and this may also place their husbands at risk. As previously mentioned, men working in tourism can be absent from their households for as long as two months. The majority of married women lived in their husband’s extended family within his household and remained under the authority and supervision of their mother in law. However, a growing number of women lived in single-family type households, and they lived alone during their husband’s absence. Three men in Aremd claimed that their first sexual experiences took place with married women who invited them into their home while their husband was away. None of the women in Aremd shared personal experiences with adulterous relationships, nor were they willing to allege that other women in Aremd participated in adulterous sexual activities. However, several women agreed that infidelity was a problem among women in other villages. This perspective was reinforced after news reached Aremd that a woman in Agersewal was caught in the act when her husband returned home early, and residents engaged in debates regarding the appropriate course of action. Some argued that he should divorce her and return her to her family, while one man claimed that it was in the best interest of her children to simply beat her as a deterrent against future transgressions. Regardless of the validity of the Agersewal story or the credibility of men who claim to have had sex with married women, HIV/AIDS awareness approaches that position men as sexual aggressors and portray women as
asexual, ignorant and faithful run the risk of overlooking women’s sexual agency and ignoring how women can also transmit STIs and impose risks to their husbands and community members.

At the time of research, there was no obvious evidence or reports of HIV/AIDS among residents in Aremd. However, educational resources emphasizing the necessity for testing was relatively absent. Therefore, it is unlikely that the presence of HIV/AIDS would be detected before symptoms of the disease began to manifest. Even then, few residents in Aremd possessed the financial resources to pay for health services outside of a medical emergency. In light of findings by the World Health Organization that indicate a positive correlation between increasing tourist arrivals and increasing reports of HIV/AIDS, it can be assumed that the steady increase in tourist arrivals in Aremd, coupled with high risk sex behaviors, will invariably result in the emergence of HIV/AIDS in the host community. In the absence of preventative behaviors that have resulted in the overall lack of educational resources, residents will be left to rely on early detection and treatment to avoid secondary complications and prevent further transmission of the disease.

Early detection relies on the individual’s ability to recognize the infection, and detection of asymptomatic infections relies on regular screening (Aral et al., 1996; Holmes and Ryan, 1998). This creates more serious implications for women than men because, like other health services mentioned earlier, women experience social and financial barriers for acquiring sexual health services. The majority of Moroccan public health physicians are still male (Manhart et al 2000), and none of the facilities available near Aremd specialize in women’s health. The absence of specialized services and the
unavailability of female physicians can affect women’s willingness or ability to seek treatment for gynecological ailments. ‘I will not allow a man to see my wife without clothes,’ one forty year old resident proclaimed after he confided that, despite three children together, he had never seen his own wife without her clothes. The idea of another man screening his wife in the nude and inserting a speculum into his wife’s vagina was tantamount to having sexual relations.

For men, it was difficult to perceive wealthy foreigners as vectors for disease. Representations of foreigners on popular transnational dramas broadcast via satellite into households in Aremd never addressed, or even mentioned, the global HIV/AIDS epidemic. Unlike women in Aremd, most female tourists visiting Aremd did not suffer from advanced tooth decay, and health complications arising from dietary and lifestyle habits were likely treatable or managed in the tourist’s country of origin. Tourist’s bodies did not reflect a lifetime of rigorous agricultural labor or overexposure to sun, wind and harsh detergents. Most tourists used expensive crèmes, soaps, and lotions on their skin and hair to maintain youthful and healthy appearances. While inspecting wrinkles on his face, a tourism worker in his late twenties remarked, ‘In the mountains, we get old quick,’ and residents in Aremd often commented that tourists remained youthful longer than they did. Income generation in the tourism economy was expected to bring the material benefits needed to live and look like the tourists, and few residents were aware of tourism-based health consequences looming in the future. When I asked residents if they were concerned about the growing HIV/AIDS epidemic in Morocco, the ultimate response was virtually unanimous; residents shrugged and said ‘Insha’Allah’ or ‘god-
willing, a popular saying that refers to the belief that everything is left to divine providence.

An Unhealthy Economy

The apparent and potential health effects of tourism-based development present some clear implications for the need to address the health consequences of tourism development in rural communities like Aremd. Health status of rural people in tourism development face the worst of both worlds, diseases of poverty and diseases of affluence, while educational and health resources in rural areas remain insufficient and inadequate. Policy-makers and economic planners advocating for tourism development as a means to alleviate poverty in rural communities need to account for the long-term health effects of global economic integration and the contexts in which they operate. This necessitates an awareness of the medical and social costs associated with the health consequences of economic change such as degraded diets, obesity, diet-related chronic diseases such as diabetes and tooth decay, and infectious diseases such as HIV/AIDS, and how vulnerability and risk to health consequences are is distributed differentially within populations. Health practitioners and educators in developing locales need to look beyond narrowly defined health initiatives to address how health status is rooted in complex systems of power that affect individual access and control over health-related resources and how power inequities affect an individual’s capacity to engage in autonomous decision-making in terms of personal health and wellness. Standardized programs in health education and prevention are likely to fall short in reaching those who need it the most.

Quantitative studies need to determine the extent of the costs and consequences of tourism development in rural communities in Aremd in order to identify how
inequality, behaviors and beliefs exacerbate vulnerabilities and risks to disease, and
data analysis needs to account for the variables that define the broader relations of
power that provide the foundations for social inequality. In locales like Aremd, gender
norms, ideologies and inequalities within the community and household create different
health experiences for men and women and generate dramatically different health
outcomes. Gender inequities and cultural constructions of masculinity and femininity
dictate various roles, rights, and responsibilities, and this necessitates the development
of gender-specific approaches to disease intervention and treatment. At the national
level, differential distribution of health services and resources has created economic,
social, spatial and linguistic barriers for poor rural residents, particularly women. Public
service announcements and educational campaigns in French and Arabic will fail to
reach monolingual Tachelhit-speaking residents. Clinics and hospitals in market areas
and cities are inaccessible to residents who are forbidden to enter market spaces and
urban areas. Within the international arena, power differentials between tourists and
residents impose considerable health risks for male tourism workers whose livelihood
depends on accessing income by meeting the demands of tourists who engage in high
risk behaviors while on vacation. Contemporary economic arrangements that generate
an equitable distribution in technological, productive and consumptive resources can
improve the health status of the world’s populations and lend truer meaning to a
‘healthy’ economy.