DEVELOPMENT DISCOURSES OF HIV/AIDS IN YEMEN

A Thesis
submitted to the Faculty of the
Graduate School of Arts and Sciences
of Georgetown University
in partial fulfillment of the requirements for the
degree of
Master of Arts
In Arab Studies

By

Cassandra Filer, B.A.

Washington, DC
May 3, 2010
DEVELOPMENT DISCOURSES OF HIV/AIDS IN YEMEN

Cassandra B. Filer, B.A.

Thesis Advisors: Fida Adely, Ph.D. and Irene A. Jillson, Ph.D.

ABSTRACT

This paper is a study of discourses related to HIV/AIDS development programming in Yemen. It is situated within Hakan Seckinelgin’s problematization of the global governance of HIV. It analyzes how development workers addressing HIV/AIDS in Yemen conceptualize their approaches and objectives to HIV/AIDS initiatives and situates these amongst alternative discourses, identifications, and interpretations of cultural and religious contexts. The author argues that 1) global HIV/AIDS discourses influence national and local HIV initiatives in ways that transform systems of knowledge, attempt to shape and delimit individuals’ behaviors and self-identifications, and mute possibilities for development programs to meet local needs of people living with and affected by HIV; 2) efforts of development workers to situate HIV in Yemen in cultural or religious contexts have potentials to hinder as well as help formulate effective HIV/AIDS programming; and 3) Sheikh Abdul Majid al-Zindani’s alternative HIV/AIDS discourse in Yemen is functioning as a bridge between Yemenis’ needs and the restricted possibilities of global development efforts.
# Table of Contents

List of Acronyms .................................................................................................................. iv

Introduction ............................................................................................................................ 1

Chapter I: Alternative Discourses: Voices from the Yemeni Print Media ..................... 25

Chapter II: Transnational Governmentality and the Shaping of PLWH ................. 44

Chapter III: Culture and Islam: Framing HIV/AIDS in Yemen ................................. 82

Conclusion ............................................................................................................................ 107

Appendix I ............................................................................................................................ 110

Appendix II .......................................................................................................................... 112

Appendix III ....................................................................................................................... 113

Bibliography ....................................................................................................................... 114
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENA</td>
<td>Middle East &amp; North Africa</td>
</tr>
<tr>
<td>DW</td>
<td>Development worker</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-Based Organization</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>PCT</td>
<td>Prevention, Counseling and Testing</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Preventing Mother-to-Child Transmission</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>NAP</td>
<td>National AIDS Program</td>
</tr>
<tr>
<td>NPC</td>
<td>National Population Council</td>
</tr>
<tr>
<td>NBTRC</td>
<td>National Blood Transfusion and Research Center (NBTRC)</td>
</tr>
<tr>
<td>MoPHP</td>
<td>Ministry of Public Health and Population</td>
</tr>
<tr>
<td>MARP</td>
<td>Most at-risk population</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting drug user</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex worker</td>
</tr>
<tr>
<td>MSW</td>
<td>Male sex worker</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial sex worker</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
</tr>
<tr>
<td>HARPAS</td>
<td>HIV/AIDS Regional Program in the Arab States</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint UN Program on AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commission for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YAR</td>
<td>Yemen Arab Republic</td>
</tr>
<tr>
<td>PDRY</td>
<td>People’s Democratic Republic of Yemen</td>
</tr>
</tbody>
</table>
Introduction

The building was a bit old and worn-down. I sat, comfortable in my black abaya and my favorite orange hijab, conversing with a local public health worker. He reminded me of many Yemeni men I knew – humble, polite, and kind. He patiently answered my questions, making sure that I understood his English and that I had written every number he read to me of the many statistics his office kept on HIV/AIDS. His tone was courteous and subdued until I asked him why he was interested in working to address HIV/AIDS in Yemen. With this question his eyes lit up and he looked at me:

It’s exciting! The issues, the tasks, they keep me busy! The years passed quickly and I didn’t feel them. But there are still many things to be done!

Many of the people I interviewed for this project voiced similar passion and dedication to their work, proud of what they had accomplished, and determined to do much more.

******

This paper is a study of discourses related to HIV/AIDS development programming in Yemen. Situating my study within Seckinelgin’s problematization of the global governance of HIV, I analyze how development workers addressing HIV/AIDS in Yemen conceptualize their approaches and objectives to HIV/AIDS initiatives and situate these amongst alternative discourses, identifications, and interpretations of cultural and religious contexts. I argue that

- global HIV/AIDS discourses influence national and local HIV initiatives in ways that transform systems of knowledge, attempt to shape and delimit individuals’ behaviors and self-identifications, and mute possibilities for development programs to meet local needs of people living with and affected by HIV;
• efforts of development workers to situate HIV in Yemen in cultural or religious contexts have potentials to hinder as well as help formulate effective HIV/AIDS programming;
• a prevalent alternative discourse in Yemen is functioning as a bridge between Yemenis’ needs and the restricted possibilities of global development efforts.

Background of HIV/AIDS Programming in the MENA Region

Yemen is considered a low HIV-prevalence country. HIV/AIDS programming has become a greater focus in the last decade for many Arab countries, including Yemen. Yemen unified in 1990 to form the Republic of Yemen. Before that time, HIV/AIDS national programs were established in both countries in 1987. The first case of HIV was reported in the northern Yemen Arab Republic (YAR) in 1987, which led to the creation of the National AIDS Program (NAP) in Sana’a. A program also began in 1987 in the southern People’s Democratic Republic of Yemen (PDRY), which also discovered its first case of HIV that year. Many other countries also established AIDS programs the same year. One of my informants explained the founding of the NAP in the PDRY as a response to the World Health Organization’s (WHO) announcement that all members establish such a program.

---

For most countries in the Arab world, Development Co-operation Directorate (DAC) and multilateral funding disbursements towards controlling the spread of HIV/AIDS began to approach their present amounts between 2003 and 2005 (See Figure 1). Jumps in disbursements parallel the publications of two reports by the World Bank, both of which recommended that MENA countries take action against HIV/AIDS.

Figure 1: HIV Funding 2002 - 2007

Literature documenting and reporting on HIV/AIDS in the Arab world has produced a steady discourse for the past decade intimating that HIV prevalence rates in the Arab world are much higher than evidence suggests. The deficiency of reliable surveillance date and mechanisms in most Arab countries allow a considerable degree of flexibility in how HIV prevalence is presented. This lack of information is often used to point to an invisible threat to the Arab world.

---

The World Bank published reports on the situation of HIV/AIDS in the Arab world in 2003, 2004, and 2005. The central theme throughout all three was that governments in the Arab world need to address HIV/AIDS before it became a general epidemic.

Most MENA countries are still at an early stage of the HIV infection with a 0.3 percent regional prevalence. What makes the HIV/AIDS epidemic particularly lethal is that it remains invisible for a long period of time and has an incubation period of five to eight years, separating HIV infection from the AIDS stage. As has happened in other countries, if action to prevent this is not taken early, MENA countries face the risk that the HIV infection will spread through the general population. The option of waiting to act until the HIV prevalence rate rises further in the general population would be a costly one. By that time, a general epidemic would be well on its way and, as shown by the international evidence, it would then be too late to prevent the inevitable increase in human sufferings as well as associated losses in economic growth.\(^\text{10}\)

The WHO defines a generalized epidemic as an HIV prevalence of more than one percent in the general population, and a concentrated epidemic as HIV prevalence of more than five percent amongst specific population groups. UNICEF reports that HIV has become a generalized epidemic in almost every country in sub-Saharan Africa,\(^\text{5}\) and in ten countries in the Caribbean and Latin America.\(^\text{6}\) In the Arab world, only Djibouti and Sudan are reported to be experiencing generalized HIV epidemics.\(^\text{7}\) The suggestion that it is likely that HIV prevalence will become generalized, regardless of context, performs an important function in development literature. Indeed, development organizations addressing HIV/AIDS, particularly international and bilateral organizations, have historically used the same patterns of language to draw attention to HIV/AIDS and to motivate support for HIV/AIDS programs throughout the world. The strategies used by international organizations in 1998 are being used today to pressure Arab governments into action.


\(^{6}\) Ibid, 2.

At the beginning of the HIV epidemic, as described by Elizabeth Pisani, governments and funders were donated funds to fight HIV in Africa, but not a lot of them were interested in giving money to help their own socially marginalized groups;\(^8\) HIV rates were understood to be the highest in populations of men who have sex with men (MSM), sex workers, and injecting drug users (IDU).\(^9\) Pisani, describing her experiences working for UNAIDS at its inception in 1996, wrote that at the time, HIV organizations believed that, in most populations outside of Africa (as well as many inside of Africa), it was not likely that HIV would make the big jump into the general population.\(^10\) Initiatives outside of Africa were therefore needed to meet the needs of people more likely to be affected by HIV - sex workers, MSM, and IDUs. Organizations like UNAIDS were faced with the dilemma of how to find urgently-needed funding for a highly-stigmatized disease. Thus, in order to motivate donors into action, organizations began to employ intense rhetoric to dramatize the situation and globalize the issue. Pisani described the task of finding funding for programming outside of Africa: “to find money for other [non-African] continents, we had to beat things up a bit. When a journalist talks about ‘beating it up,’ they mean making a mountain out of a molehill.”\(^11\) To create a big story, HIV had to be portrayed in specific ways that would make people respond.

One way of catching the public’s attention was using language that portrayed HIV as threatening to everybody in the world. Roger England points out that “HIV is a major disease in southern Africa, but it is not a global catastrophe, and language from a top UNAIDS official that

---


\(^10\) Pisani, 26; Since that time, as mentioned previously, HIV epidemics have become generalized in 10 countries in the Caribbean and Latin America, as well as in sub-state regions, including Washington, DC.

\(^11\) Pisani, 22.
describes it as ... a ‘potential threat to the survival and well-being of the people of the world’ is sensationalist. One simple word portrays that idea: global. Karen M. Booth explains: “To define a crisis as global is to assert that the problem is immediate and urgent and that it should be everyone’s top priority... The adjective also frightens; it suggests that everyone is under threat.” Synonyms would not be as efficient. “International,” for example, portrays relationships between states. “Global” transcends states – erases them – so that what is threatening to everyone is also the responsibility of everyone. The personal relationship everyone has with HIV is reinforced by the frequent use of “global” in titles of organizations: The Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global HIV Vaccine Enterprise; the Global Network of People Living with HIV/AIDS.

Even with the low-prevalence of HIV in the Arab world, speaking about a “global” crisis automatically casts the Arab world into a situation of crisis. The first sentences of Sufian’s “HIV/AIDS in the Middle East and North Africa: A Primer” asks the reader “Have the Middle East and North Africa largely escaped the global AIDS epidemic?” The inclusion of the word “global” already answers her question – no, they have not. Already, the “global” scope of HIV calls for action. One of the discursive effects of the use of the word “global,” therefore, is the implication that the entire populace of the Arab world is at imminent risk. This implication obfuscates the urgent need for programs directed at populations socially and politically considered illegal, immoral, or abject in parts of the Arab world, in order to legitimize and encourage HIV initiatives.

14 Sufian, 6.
That is not to suggest that HIV programming initiatives directed at such populations do not exist in the Arab world, as they do and, in many cases, like Iran’s programs for IDUs and International HIV/AIDS Alliance’s program for MSM in Morocco, Algeria, Tunisia, and Lebanon, have been declared quite successful. The manner in which governments address HIV/AIDS vary, as do the political, economic, and public health factors that influence these decisions.

UNAIDS ranks the Middle East and North Africa (MENA) area as the region with the second lowest estimated adult prevalence rate in 2008 at 0.2%, after East Asia with 0.1%\textsuperscript{15}. Furthermore, 84% of people living with HIV/AIDS in the MENA region, as of 2007, live in Sudan\textsuperscript{16} (Table 1). Thus the nature of the epidemic is of a decidedly different scale in the majority of Middle Eastern countries.

\textbf{Table 1: Estimated HIV Prevalence in Adult Population}\textsuperscript{17}

\begin{table}[h]
\centering
\begin{tabular}{l|c}
\hline
Country & Estimated HIV prevalence in adult population \\
\hline
Saudi Arabia & 0.00\% \\
Lebanon & 0.50\% \\
Morocco & 1.00\% \\
Oman & 1.50\% \\
Somalia & 2.00\% \\
Tunisia & 0.00\% \\
Sudan & 0.00\% \\
Yemen & 0.00\% \\
\hline
\end{tabular}
\end{table}


The Global Fund and Yemen

The Global Fund to Fight AIDS, Tuberculosis and Malaria was founded in 2002 as a unique organization to attract, manage, and disperse funding for programming related to the three diseases. Presently almost 90% of HIV/AIDS funding in Yemen is Global Fund support (see Table 2 above). Before the Global Fund program on HIV in Yemen, funding came initially for a prevention program from the Embassy of the Netherlands, and from training and research conducted by WHO, UNICEF, UNFPA, UNDP, and the Yemen Association for Prevention of

---


AIDS. Additionally, Progressio, a British NGO, has been focusing on HIV in Yemen since the mid-1990s. HIV/AIDS programming in Yemen greatly increased with the involvement of the Global Fund in 2005, however. Therefore, to understand how the Global Fund functions in Yemen, it is necessary to understand the Global Fund.

Global Fund resources are mainly allocated to low-income countries, and only upon request by individual countries. The Yemeni government and Ministry of Public Health and Population (MoPHP) initiated Yemen’s involvement with the Global Fund, and the government of Yemen is generally praised by regional UN and bilateral development workers (DWs) as a proactive country in its attention to HIV/AIDS.

The Global Fund tries to address gaps in national efforts towards prevention and treatment of the three diseases while also strengthening health care systems. Recipient countries are expected to develop their own programs that involve civil society and private sector participation. From the perspective of two of my informants, Yemen’s program was not structured towards Yemen, but rather consisted of generic objectives used in other countries. They attributed this to both the lack of research done on HIV in Yemen as well as to the Country Coordinating Mechanism (CCM) not taking into account research that had been conducted; from their perspectives, little information was gathered or used to inform a program to fit Yemen’s needs.

---

22 Informant interviews.
Informants described the CCM as a committee that consists of the Minister of Health, representatives from WHO, other UN organizations, and representatives from the international donor community, such as GTZ. Representatives were appointed from each of these organizations, as well as from NGOs, private sector parties, bilateral agencies, academic/educational organizations, people living with HIV, and the Ministry of Religious Affairs to the CCM. The Deputy Minister for the Ministry of Planning and International Cooperation (MPIC), the Ministry through which Global Fund funding is routed, is also a member of this committee. The CCM is a requirement of the Global Fund. As one interviewee explained, “People living with HIV are members by compulsion – it is not a mature process, but more autocratic. The Minister of Health comes in and says ‘We will do it this way,’ and everyone else says ‘Yes, sir.’”

The CCM develops the program proposal with the help of technical assistance. The Global Fund encourages solicitation of technical assistance from UNAIDS, WHO, or other national or international partners with experience in strategic planning. Once the program proposal is submitted, the Global Fund technical review board, made up of 40 experts from around the world, decides if proposed programs are technically sound and likely to succeed. Their job is to review proposals for technical merit and to “ensure they reflect current

---

23 Ministerial decisions within the MoPHP are often discussed at qat chews, and not at the Ministry or gathering of the CCM. Thus, if members of the CCM were invited to and attended the Minister of Health’s qat chew, then perhaps the CCM would function more closely to how the Global Fund intended.  
knowledge of international best practice." This is a somewhat ambiguous statement which allows for fluidity and heterogeneity in comprehensions of international best practices, which in turn allows for understandings of “best practices” to change based on best practices cited in evidence-based practice reports. Decisions are therefore made based on understandings of “best practices” from different contexts, and not necessarily based on “best practices” of the country in question, particularly when there has not been a lot of research based in that country.

The Global Fund measures progress against the Paris Declaration and shares many of its principles, including focuses on ownership, accountability, and results. It uses performance-based funding for time-bound targets. Yemen’s key grant performance indicators are constructed to meet the following four objectives:

**Objective 1** – To enhance HIV/AIDS prevention, care and support capacity among government and Civil Society Stakeholders.

**Objective 2** – To create awareness of HIV/AIDS and other STIs among general population and identified vulnerable and high risk groups and to reduce risk behavior

**Objective 3** – To develop capacity for ongoing infection and behavioral surveillance

**Objective 4** – To increase coverage of HIV safe blood for transfusion and to establish and enforce national blood safety standards

Grants can be renewed after year 2 and year 5, which allows countries to stop and propose new program outlines if indicators are not being met.

---

28 For a list of key performance indicators for Yemen, see Appendix II.
Yemen was awarded a Global Fund grant for a lifetime budget, which covers the 5 years of the program, of 14.7m USD in 2005. The National AIDS Program (NAP) and the National Population Council (NPC) were the principal recipients from mid-2005 until mid-2007. At that point the performance indicators were not being met; poor performance was attributed to “lack of technical experience, procurement delays, bureaucratic delays in approvals, and poor co-ordination with the Ministry of Public Health and Population.” The Global Fund gave the CCM a choice in 2007: find a different main recipient for the funds, or the funding would be stopped. They chose the UNDP, and in 2008, UNDP became the principal recipient and NAP, NPC, and the National Blood Transfusion and Research Center (NBTRC) sub-recipients.

The Global Fund grant ends in September 2010, which means that UNDP in Yemen is currently under a lot of pressure to use the funding available in a short amount of time. They are required to follow the original contract, which is legally-binding. The Global Fund agreements incorporate mechanisms to change programs if, during the process, implementers find that previously agreed-upon actions do not make sense. However, making changes is a lengthy process: one must submit a report, then the CCM must approve it, then the Global Fund reviews it. One DW explained to me that “It is a long and complicated process. And the stakeholders [CCM] are well-entrenched. They don’t want their funding decreased.” In other

---

29 Global Fund, Yemen Grant Scorecard, Grant Number YEM-305-G03-H (17 MAR 2005), http://www.theglobalfund.org/grantdocuments/3YEMH_760_361_gsc.pdf
31 “In exceptional circumstances or special emergencies, governments and national counterparts may request UNDP to manage [Global Fund] grant(s). In these contexts, the organization serves as “Principal Recipient of last resort”… UNDP’s role as Principal Recipient is always for a limited time, during which it helps build the capacity of one or more national candidates to enable them to assume the management of grants.” UNDP, “UNDP-Global Fund Partnership,” UNDP: HIV/AIDS, available from http://www.undp.org/hiv/focus04.htm; Accessed 28 APR 2010. An informant told me that UNDP is managing Global Grant Funding for 23 countries.
words, any changes could take funding away from one organization to give to another, but also
risks not being approved which would take away all funding. Furthermore, the time restraints
to spend disbursements before September 2010 do not allow for such a procedure in practice
even if it exists in theory. Thus, time limits and stakeholder involvement limit the abilities of
Global Fund recipients in Yemen to suggest changes to the 2005 proposal. However, it was also
suggested to me that the national counterparts do not have capacity for major changes in
programming, which further renders changes a moot point.

Primary Funders and Organizations Addressing HIV/AIDS in Yemen

Recipients and partners budgeted into the original Global Fund contract in Yemen
include the offices under the Yemeni Ministry of Public Health and Population (NAP, NPC, and
NBTRC) with UN agencies (UNDP, UNICEF, UNFPA), and WHO, as well as the Netherlands
Embassy and the Yemen Association for Prevention of AIDS, a local NGO. Additionally, 10
government ministries and departments and 4 national NGOs prepared HIV/AIDS plans. The
Round 8 proposal specified sub-recipients as the NPC; 6 Yemeni NGOs: al-Islah, al-Salah,
Yemeni Women’s Union, Defense Organization, Media Organization, and Jam’iyyah al-Tubbiah;
and 2 PLWH support groups:32 AID Association in Sana’a and Life Impulse in Aden. One of
UNDP’s main goals as primary recipient has been to improve communication between
recipients. They also hope to integrate the three governmental departments addressing HIV
(NAP, NPC, and NBTRC) into one department.

32 CCM/Yemen, 57.
Additionally, there are programs in Yemen that are not funded by Global Fund, such as those implemented by Progressio and Marie Stopes International, both private non-profits based in Britain. Progressio has been working in Yemen since 1974. They started working on issues surrounding HIV/AIDS in Yemen in the mid-1990s, and in 2003 began focusing on developing capacities of local NGOs, many with an HIV/AIDS focus. Progressio reports that they have six foreign DWs in Sana’a, Hodeida, and Aden as of April 2010. Marie Stopes International, as of January 2010, does general work to reduce stigma, have targeted two slums for HIV/AIDS awareness in Mukalla, and have a peer education training program in Sana’a for barbers and hotel workers. Addressing HIV/AIDS is also one of the core values of Marie Stopes International.

In addition to the 2 local support groups for PLWH supported by the Global Fund, I heard about the formation of other support groups for PLWH in Dhamar and Hodeida, but as far as I understand, they are not yet supported by the Global Fund. Informants emphasized that the Yemeni government made the establishment of health-related NGOs fairly simple, which made them feel that their efforts were supported by the government.

Finally, UNHCR has had programs in the past, and Medicins Sans Frontiers – Spain was planning HIV programming in January 2010, although I did not concentrate on the work of organizations addressing refugee issues, which is their area of focus. This list is not exhaustive; the main associations that were mentioned to me as active in HIV/AIDS work in Yemen are in cities, and the majority of Yemeni NGOs receiving Global Fund support are in Sana’a and Aden.

---

33 An interviewee reported that typically 95% of Progressio’s development workers are from the global South.
A 2010 UNAIDS report\(^{34}\) states that Yemen has 14 HIV Voluntary Testing and Counseling (VCT) sites throughout Yemen, with plans to open six more. Five of these are in Aden. Some of the original VCT centers had been closed because they were not geographically situated – sites were chosen without assessing the appropriate nature of the site. Now more have opened, including some in NGOs instead of government buildings. Services are only available in cities that enjoy relative stability and government control, which means that VCT and ART are not available in Sa’ada or in other areas considered dangerous. However, the government did buy a mobile VCT unit, which brings access to more remote areas outside of major cities. Additionally, a national Preventing Mother-to-Child Transmission (PMTCT) program began in early 2009, establishing four PMTCT sites.\(^{35}\) There are five antiretroviral therapy (ART) sites located in Sana’a, Aden, Hodeida, Taiz, and al-Mukalla.\(^{36}\) However, CD4 tests are only available in Sana’a and Aden, which, according to informants, is contingent on whether each machine is functioning.

**Why Yemen?**

I started researching development discourses around HIV/AIDS in the Arab world, and then in Yemen, as a result of past personal experiences: two years organizing adolescent health activities with a concentration on HIV/AIDS in Gabon (2003 – 2005), and two years living and working as a teacher in Aden and Sana’a, Yemen (2006 – 2008). During my time in Yemen, I would occasionally see red ribbon banners. Some of my students were HIV/AIDS peer

---


\(^{35}\) Ibid, 9.

\(^{36}\) Ibid, 9.
educators. My research and experiences made me curious about how programming was conducted in a low-prevalence, conservative Muslim country such as Yemen.

As is the case with many other Global Fund recipient countries, the government in Yemen has only recently received support to develop its infrastructure to address HIV/AIDS. It is at an interesting, formative stage of its HIV/AIDS projects. Yet, setting up a systematic, multi-leveled response to HIV/AIDS is just one task among many other pressing health and development priorities. The infant mortality rate in Yemen is 75/1000 live births; the under-5 mortality rate is 100/1000 live births, and the maternal mortality rate is 370 per 100,000 live births, which is one of the highest in the world. One third of the population does not have access to clean drinking water, and 16% lives on less than 1USD a day. In addition to these health and development indicators of serious socioeconomic and health issues, tens of thousands of refugees come to Yemen every year fleeing conflict in East Africa, and the Yemeni government has been facing two different separatist movements, the recently-concluded one in Sa’ada resulting in 100,000 internally displaced people. Furthermore, Yemen is under increasing pressure from the US to focus attention on those members of al-Qaeda in the Arabian Peninsula who operate from within Yemen’s borders. Given all of these challenges, my research arose from the following questions: How do government and development organizations place HIV/AIDS programs into their agendas? How prevalent is HIV? How much research has been done on prevalence and local knowledge and understandings around HIV, and how does that figure into HIV/AIDS programming? How are programming approaches in

---

Yemen different, if at all, than in other areas of higher prevalence? How do culture and religion figure into programming initiatives?

**Research Design and Methods**

This work is a critical discourse analysis of development reports, international and Yemeni media, and DWs’ narratives about HIV in Yemen. It is limited to examination of possible power-knowledge relations that present in the texts of my written and spoken sources, and the theories that result are my own interpretations of these texts. My primary sources were reports from international organizations, Yemeni newspaper articles, and interviews with 25 people, located both inside and outside of Yemen, who work with HIV/AIDS programs in Yemen or in the Arab world. My interviews were held from December 2009 to March 2010, and most primary source documents were produced in the last five years.

This is an open-ended qualitative study of a moment in HIV/AIDS programming in Yemen. My research does not present a complete picture of development discourses in Yemen, but rather a limited sample from a moment in time. I am not a specialist in public health or policy, and thus this study was not conducted to inform either field. Rather, it is an ethnographic and media-based study that aims to better understand potential ways that global knowledge around HIV is incorporated into Yemeni HIV programming. Moreover, given the limited scope of my research, my analysis does not offer ways in which discourses circulate or how, or if, they affect lived realities. I offer no practical suggestions or solutions, but only questions and points for discussion.
I conducted the majority of my interviews in Sana’a and Aden over a three week period, from the end of December, 2009, to mid-January 2010. Interviews were mostly conducted in English and lasted from 30 minutes to two hours. I recorded most of my interviews, but took notes for others depending on participant preferences. A number of additional interviews were conducted over the phone between December 2009 and March 2010. I used a semi-structured, modular question sets based on the affiliation of the informant. Identification of informants was purposive and snowballing. My main research questions were: 1) How do DWs at international, national and local organizations characterize HIV/AIDS in Yemen? and 2) How do DWs and donors describe the roles of their organizations in addressing HIV/AIDS in Yemen?

All of the people I interviewed and whose insights, opinions, and experiences structure this paper, work to address HIV/AIDS or family health in Yemen in some capacity. Most of them have made careers out of health and/or development work, but some of them are volunteers. Some of those interviewed are familiar with Yemen as one out of a number of countries of focus in the region. However, the majority of my informants live in Yemen and address HIV/AIDS on a national or local level. I refer to all of my informants as DWs (DWs) with the understanding that they are participants in projects to develop Yemen’s capacity to address HIV/AIDS.

The number of people working on these projects is not large. For this reason, I have tried throughout this paper to disguise any identifying factors of informants in relation to

---

38 I completed the Institutional Review Board process to guarantee that my research respects the dignity and agency of all parties involved.
39 There are some transcriptions in which I corrected the English grammar of my informants in order to make the excerpt easier for the reader to follow, as well as to better protect the identity of the informant. I was careful, though, not to change the meaning of any quotation.
40 See my interview guide in appendix I.
quotations and narratives I cite. If I felt an element or aspect of an informant’s identity was relevant within the context of the discussion, I situated the information in general terms. For example, if I felt that it was relevant to distinguish Yemeni informants from non-Yemeni informants, I made that distinction, but only when that informant became a significant factor in relation to possible patterns among informants’ points of views. The following chart outlines the numbers of individuals I interviewed at different types of organizations, but does not specify their nationality. All of my informants living in Yemen were either Yemeni, or from the global south.

Table 1: Informant Affiliations and Locations

<table>
<thead>
<tr>
<th></th>
<th>Multilateral agencies</th>
<th>Bilateral agencies</th>
<th>Yemeni government agencies</th>
<th>International NGOs</th>
<th>Yemeni NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person works outside of Yemen</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Person works inside Yemen</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

Theoretical Framework

In focusing my analysis on development discourses, I recognize Norman Fairclough’s claims that discourse “may have constructive and transformative effects ... and that more general processes of current social change often seem to be initiated and driven by changes in discourse.”\(^{41}\) Thus whereas this paper concentrates more on words than on actions, this is done with the understanding of the power that narratives of DWs have to determine programming outcomes and that those outcomes are experienced in people’s quotidian realities. Moreover,

Fairclough’s claims take on further resonance when applied to Hakan Seckinelgin’s work on global governance of HIV.

This paper is theoretically conceptualized within Hakan Seckinelgin’s framework as articulated in his book *International Politics of HIV/AIDS: Global Diseases – Local Pain*. In this work Seckinelgin argues that 1) a system of global governance of HIV was created by international policies made by international organizations; 2) HIV interventions are structured to follow these global policies without considering how people experience global policies within local contexts. In this process, particular actors and processes are institutionalized as relevant for interventions; and 3) in the institutionalization of subjectivities that may or may not apply to a local context, people become objects, in the forms of patients or risk groups, of expert medical knowledge. This process of medicalization, or the transformation of disease as social phenomenon into a strictly medical experience, presents challenges to people living with the disease.  

Accordingly, Seckinelgin unpacks the term “global disease” as a reference to HIV to indicate implicit mechanisms of control over the production of knowledge, discernment of expertise, and the agency of subjects as well as practitioners of development:

*The common language of ‘global disease’ has been an important reference point for international policy actors. Mechanisms that have constructed this system are the grounds of producing a certain relationship within which experts emerge as the dominant figures, people living with disease and their contextual experiences disappear to re-emerge as statistical information, the agency of certain actors becomes prioritized for policy interventions, and a certain knowledge base demarcates what can be done. In this sense the international system, or the governance system, on HIV/AIDS not only manages but constitutes the agency of certain actors in the relevant domains of policy. It is important to question this process and the common sense it produces from the perspective of infected and affected people who are living with the disease...*  

---

43 Seckinelgin, 7.
As it points to disjunctures between how people experience HIV and global governance structures, Seckinelgin’s framework allows me to analyze narratives of DWs with an understanding that many practices and conceptualizations, particularly of risk groups, awareness practices, formation of NGOs for PLWH, and specific terms used, did not originate in Yemen. Rather, these are historical products developed and employed in vastly different social, political, economic, and cultural contexts. Such products are included in what Seckinelgin calls the trope of *we know what works*, which “both indicates location of the power within the international policy domain and initiates the process of incorporation by justifying the implementation of the policies covered by that statement.”

This trope is manifest in the Global Fund’s technical review board and their criterion for approval based on “international best practice.” Thus, the discourse that emerges from global HIV governance, when applied in Yemen, has the potential to directly impact development practices and projects in Yemen in different ways. The question, then, becomes whether subjectivities around which global HIV governance is constructed are relevant and appropriate for Yemeni contexts.

In limiting my scope of analysis to Yemen, I use Ferguson and Gupta’s concept of transnational governmentality. Foucault originally formulated the concept of governmentality to describe the extensive ways in which governments try to direct a population’s conduct by calculated means, drawing attention to “all the processes by which the conduct of a population is governed: by institutions and agencies, including the state; by discourses, norms, and

---

44 Seckinelgin, 98.
identities; and by self-regulation, techniques for the disciplining and care of the self." His explanation focuses on how the state, including sub-state institutions, develops and implements such a system of control through in large part the construction of expert knowledge and the delineation of acceptable discourse. Given the role of non-state actors in “governing” certain areas of expertise, control, and/or discourse, Ferguson and Gupta extend Foucault’s scope of governmentality to forms of government being set up on a global scale:

> These include not only new strategies of discipline and regulation, exemplified by the WTO and the structural adjustment programs implemented by the IMF, but also transnational alliances forged by activists and grassroots organizations and the proliferation of voluntary organizations supported by complex networks of international and transnational funding and personnel.

Seckinelgin’s concept of global HIV governance, accordingly, is a product of transnational governmentality.

Ferguson and Gupta describe a key element of transnational governmentality as “the outsourcing of the functions of the state to NGOs and other ostensibly nonstate agencies...” That is not to suggest that the state and international organizations are necessarily in complete accord or opposition, but it does alleviate a common conception that state institutions and international agencies and NGOs are working under separate and independent directives. Moreover, transnational governmentality is a theoretical tool that allows for the existence of different discourses within an overarching framework formulated by the intersection of international funding and regulations with national and sub-national institutions and contexts.

---

46 Ibid, 115.
48 That said, different institutions allow for different possibilities and restrictions in terms of program management and focus.
A final central concept to this paper is the formulation of what Helen Epstein calls “non-knowledge,” meaning unreliable or non-existent data used to map and ‘handle’ a situation that is not well-understood. The concept of “non-knowledge” becomes particularly resonant when viewed as a tool of international expertise, as conceived of by Timothy Mitchell and Hakan Seckinelgin.

Outline of Chapters

Chapter I examines alternative narratives on HIV/AIDS found in Yemeni print media. It traces discourses that exist alongside global development narratives in an attempt to better contextualize the latter, and to consider local meaning construction and social, political, and economic implications of discourse.

In Chapter II, I trace the formation of bodies-with-HIV from invisible imaginaries of development discourses to fully-realized PLWH. I utilize Ferguson and Gupta’s concept of “transnational governmentality,” to conceptualize how international organizations in collaboration with the state identify, classify and target people via discourses of medicalization in order to shape them into predefined identifications.

Chapter III looks at how DWs negotiate issues of Yemeni culture and of Islam, and in doing so, potentially shape development priorities and practices. Within this context, the ways in which development discourses in Sana’a interact with the alternative HIV narrative of Sheikh Abdul Majid al-Zindani are studied.

---

Finally, I conclude with an evaluation of the study, including possible implications, the study’s weaknesses, and suggested areas for further study.
Before focusing on how development practitioners conceptualize HIV/AIDS in Yemen, it is useful to look at alternative narratives of HIV in Yemen. The definitions and descriptions presented by DWs can vary, but are generally influenced by global HIV/AIDS discourses. This chapter casts light on narratives within the Yemeni press that provide alternatives to international representations of HIV/AIDS. Understandings of HIV in Yemen are certainly not limited to epistemological constructions of development practitioners and organizations. An examination of a spectrum of competing narratives provides a context to better understand, through similarities and differences, the narratives of DWs. It is not possible within the scope of this thesis to investigate all, or even most, of the varied conceptualizations that different people hold around HIV/AIDS in Yemen. However, focusing on a sampling of alternative narratives found in Yemeni newspapers presents the possibility of adding depth to our understanding of the broad epistemological field around HIV in Yemen.

Any newspaper article can be understood as attempting to depict, and in doing so advance, a certain version of reality. This chapter therefore examines how HIV is contextualized within social, economic, and political representations of Yemeni realities. Through engagement with discourses other than those produced by development practitioners, it is possible to understand some of the narratives that DWs try to challenge, delimit and reconstitute, and how various conceptualizations around HIV interact in mediated discursive fields. The presence of alternative voices calls attention to not only what dominant narratives of HIV express, but also what they leave out, ignore, or suppress.
In analyzing the multiple discourses at play within Yemeni print media, I base my methodology on Norman Fairclough’s claims that discourse “may have constructive and transformative effects ... and that more general processes of current social change often seem to be initiated and driven by changes in discourse.”\(^{51}\) Articles about HIV/AIDS are poised to both reflect and shape opinions and ideas within Yemeni society. The actual reach of print media is limited by its availability in more rural areas, high illiteracy rates, and preferences for radio and television. Nonetheless, print media is an official record and public narrative about HIV and a source of information to be shared, discussed, and debated by diverse segments of the population. Furthermore, the Yemeni government recognizes the constructive and transformative potentials belonging to newspapers as can be discerned from the rising frequency of governmental restrictions on press freedoms in Yemen.\(^{52}\) International and national organizations addressing HIV/AIDS in Yemen also acknowledge the powerful influences of discourse – and specifically journalistic discourse -- as evidenced by their campaign to educate journalists and encourage them to reproduce development narratives in newspapers, radio programs, and television reports.\(^{53}\)

\(^{51}\) Fairclough.

\(^{52}\) The Center of Training and Protection of Press Freedoms, a Yemeni NGO dedicated to defending the rights of journalists, recently published a report detailing Yemeni government violations against local and international newspapers, including “threatening and intimidation, arresting, assaulting, unfair trials, interrogation and arbitrary firing on journalists and opinion writers, to confiscating and seizing newspapers and blocking news websites and blogs.” Furthermore, 2009 “witnessed the biggest campaign against the press in Yemen that included the confiscation of around eight local newspapers and seizing international newspapers at the airport such as the Al-Quds newspaper.” Ali Saeed, “Violations against Press Freedom and Journalists on Rise,” Yemen Times, 24 Dec 2009, available from [http://yementimes.com/defaultdet.aspx?SUB_ID=33262](http://yementimes.com/defaultdet.aspx?SUB_ID=33262); Accessed 22 Jan 2010.

Development Discourses in the Media and Workshops for Journalists

Within the past few years, HIV has been a regular topic in the Yemeni media, and the contexts and viewpoints presented around HIV have varied significantly. The most prevalent articulations of HIV/AIDS presented in these newspapers were reports about the activities of mostly international organizations. Articles reporting on initiatives supported by international associations such as the Global Fund or United Nations agencies have increased in past years. This increase is not only reflective of the expanded activities of these organizations addressing HIV/AIDS, but also of a concentrated effort by HIV/AIDS initiatives to target awareness activities at journalists, a common practice in development and health initiatives. One article describes a workshop for journalists held in October 2009 entitled "Transformational Leadership: Workshop on HIV Media Messaging." It notes that journalists were given lectures on

the scientific basics of the HIV, efforts and challenges of combating the disease in Yemen, and HIV statistics in the Arab world. They also talked about sensitive issues in the Arab media like HIV and drugs. They presented testimonies of HIV patients, how HIV is treated in Arabic journalism and blogs, the nature of drug addiction and its roots, and the 12 steps program and the support groups for the most vulnerable groups. Documentaries were shown about Arab HIV patients, and cinema and HIV. Also... [they] presented a lecture about the role of the UNDP in managing the grant of the international fund to fight HIV.

It is clear from the report that international and national discursive norms around HIV were presented in an attempt to educate journalists about how to understand HIV scientifically as well as socially. By concentrating a large portion of the conference on non-scientific

“knowledge,” DWs not only educated journalists about HIV, but situated scientific information

---

54 I have searched nine different Yemeni newspapers and Saba News, the Yemeni national press agency, for articles from 2005 – 2009, discussing HIV/AIDS within the context of Yemen. The Arabic language newspapers I have examined are 26 September, which is published by the government in Sana’a, Al-Gomhoriah, published by the military in Taiz, al-Sahwa, from the Islah party in Sana’a, al-Ayyam and Yemen Hurr from Aden, RayNews from Sana’a, plus three English language newspapers, the Yemen Times, the Yemen Observer, and the Yemen Post, all published in Sana’a. I concentrated on narratives which presented alternatives to development discourses, which amounted to about 30 articles. All translations are mine.

within systems of values and ideals that, in effect, instructed journalists how to portray HIV in the media.

Yet, despite such efforts, alternative perspectives are still present, and as such, relevant to understanding development narratives of HIV/AIDS in Yemen. Having sifted through the bulk of articles available on the Internet concerning international and national HIV/AIDS programs from 2005 - 2009, I found discourses of blame, reform, distrust, conspiracy, and defiance. Some articles concentrated specifically on HIV, while others mentioned HIV as a peripheral to other main topics, such as dowry prices. Nonetheless, the alternative discourses around HIV found in Yemeni newspapers offer samples of active constructions of local meanings around HIV, which illustrate some of the ways that HIV is politicized outside of, and sometimes in opposition to, development discourses. Numerous anthropologists have produced extensive studies on blame in relation to HIV and how the understanding of widespread causal explanations is crucial to the success of HIV programs.56 While thorough examination of these links exceeds the confines of this paper, these alternative voices are crucial to understanding the local landscapes onto which global narratives of HIV are situated. This chapter focuses on these alternative voices, Before focusing on these qualitative variations, let us consider the many articles that report numbers and statistics with or without editorializing.

Just the Facts

Articles reporting on HIV/AIDS initiatives forwarded by the government, international, or local organizations generally issue facts and figures. Very often these articles are short blurbs reporting recently updated statistics from the National AIDS Program and focal points in different governorates. Most of the articles I reviewed, from both Arabic and English language, give precise numbers of HIV cases reported in Yemen, and sometimes gave numbers of HIV cases in different provinces. For example, it is typical for such an article to report the most recent data released about the presence of HIV in a province in the following format: “7 more AIDS cases were discovered in Hodeida during this period, bringing the number of people living with the disease in the province to 204, including two children, 25 women, 107 men, all Yemenis; 31 foreigners and 29 unidentified cases.”

While articles reporting statistics, laws, and program initiatives were common, reports focusing on people who are living with HIV in Yemen, however, are infrequent. Such quantitative presentations impart an impersonal view that neither attributes blame nor sympathy. The use of the passive voice “were discovered,” suggests a natural situation that does not change nor require a response. In contrast to how DWs teach journalists to report on HIV, these articles remove HIV from society and reduce it to numbers and science.

The precision of the numbers as presented leaves little room for doubt that HIV affects Yemenis. However, the itemization of people living with HIV into sex, age and nationality, dehumanizes the people listed and redefines them as HIV in the province of al-Hodeida. That is

---

to say, rather than portraying people living with HIV, these articles describe HIV living in people. The quantitative reports thus remove all stigmas, as well as compassion, from their depiction of HIV because they remove the disease itself from people’s lives and from Yemeni society and function in a similar manner as lists of casualties from natural disasters or wars. The disease becomes something hidden and isolated among 204 unknown people. Sometimes such articles add that the estimated number of HIV cases in Yemen is ten to thirty people for every one known case. However, when the article does not mention that experts estimate many more people to be living with HIV, which some articles do not, then the implication is that the HIV-positive population is limited to the number of people given. Such strictly quantitative representations of HIV, when not contextualized by additional information, can also suggest that HIV cannot be transmitted or that it was never transmitted – just uncovered. This approach contrasts greatly with the World Bank discourse discussed in the introduction, which portrays HIV as a threat to everyone. In these local and national articles, HIV is neither threat nor call to action, but rather detached scientific information. Nonetheless, these articles reinforce basic facts: HIV affects men and women, adults and children, foreigners and Yemenis.

**Not a Yemeni Problem: Economics, Vice and the Other**

That articles which quantify HIV/AIDS in Yemen distinguish between foreigners and Yemenis is important because one of the most common beliefs about HIV/AIDS in Yemen, as reported by informants, is that “it is not a Yemeni problem.” One of the main narratives found in Yemeni news media places blame on foreigners for bringing HIV into Yemen and often for its

---

spread in Yemen. Here a strain of the development discourse and the alternative narratives intertwine. The generally accepted story about HIV in Yemen, as articulated in newspaper articles as well as by UN workers, international NGO representatives, and the National AIDS Program affiliates, is that African refugees brought HIV to Yemen with the massive influx of Ethiopians and Somalis in the 1990s. One newspaper article explains:

> Until recently, statistics indicated that the number of non-Yemenis living with HIV/AIDS outweighed the number of infected Yemeni citizens. This led many to blame the disease’s prevalence on immigrants or Yemenis travelling abroad. "With up to 0.7 percent HIV prevalence, Yemen has the third highest HIV rate in the region, after Sudan and Djibouti," said George Ionita, advisor on HIV/AIDS for the UNICEF Middle East and North Africa region. The NAP’s Abdul Hamid al-Suhaibi noted that, before 2000, there were more cases among foreigners than among Yemenis, but added, "Now, Yemeni cases have increased."59

The belief, then, that HIV came from refugees and immigrants, stems from the statistics on HIV that were sought and available at the time. Foreigners must test HIV negative to receive work visas. Refugees are mostly supported by UNHCR, the Red Cross and Red Crescent, and therefore are subject to different monitoring and testing systems that were potentially broader and more comprehensive than Yemeni monitoring systems. Indeed, even in 2010, HIV statistics for Yemen are not comprehensive.60 Furthermore, many of my informants question whether greater numbers of reported cases among Yemenis were a sign of increased prevalence or more widespread testing with more funding and initiatives over the last decade. Moreover, Somalia has a low reported HIV prevalence rate at 0.5%,61 and while Ethiopia has a reported prevalence rate

60 For a detailed discussion of Yemeni HIV prevalence and the knowledge produced around data gained and data lacking, see Chapter II.
of 2%. Yemen is considered to host many more Somali refugees because the government has recognized Somalis on a *prima facie* basis since 1992.

The *Yemen Observer*, one of the English language newspapers from Sana’a, printed articles in two consecutive years with contradictory information: in 2008, an article stated that “Some Yemenis blame neighboring countries for the spread of AIDS to Yemen, and use past statistics to show that as the number of refugees entering Yemen has grown, the number of those infected with the virus has risen. But many experts deny that there is any such connection.” Yet, eight months later, the same newspaper printed the following: “The number of AIDS cases soared in Yemen... during the first quarter of this year... Official reports noted that the main reason behind the surge is linked to the flow of African migrants into Yemen... “ These conflicting public records, as well as the vagueness of refutations, can blend with a general awareness that HIV prevalence is high in “Africa” and negative connotations of Somali refugees, to strengthen the link between HIV and African refugees in collective Yemeni imagination.

Many articles take up this point, focusing on refugees as the source of HIV’s presence in Yemen. Some link refugees to HIV implicitly, such as an article from 2006 quoting a nurse from

---

the main hospital in Aden, al-Jumhoria Hospital, in which she explains, “I work in internal recovery and there was a sick Ethiopian woman infected with the AIDS virus and we didn’t know of her illness.” There was no reason within the context of the article, which was about nurses not being informed about the HIV status of patients, to specify the nationality of the HIV positive patient. References such as these correlate HIV with African refugees, reinforcing the idea that HIV is not a Yemeni problem. These implicit references in the press name or distinguish rather than explicitly blame, which leads readers to draw implicit links between African refugees and HIV.

Alternately, some articles explicitly focus on the reasons for the “appearance” and spread of HIV/AIDS in Yemen. They point to refugees and male tourists from the Gulf as a/the primary cause. An important aspect of these articles is that, while the blame is not focused exclusively on African refugees, it is still directed at non-Yemenis. In the few articles that do apportion blame for bringing HIV to Yemen, both African refugees and Gulf tourists are represented as people whose presence in Yemen is undesirable and destructive to current social and economic structures. HIV is depicted in such articles as one of the various manifestations of the negative roles of these groups in Yemen.

Articles focusing on refugees usually do not mention HIV unless they seek to articulate negative aspects of refugees’ residence in Yemen. For example, an article entitled “Refugees... Additional Burdens” explains that “the large number of refugees that Yemen receives daily constitute an additional economic burden on Yemen, and additionally bring several infectious

---

diseases including AIDS.⁶⁸ HIV is not the focus of the article, but is cited as a social and public health aspect of the presence of refugees. In this example, refugees import destructive diseases to Yemen. Here, HIV is seen as a physical aspect of African refugees. Upon reaching Yemen, however, this physical aspect becomes social; the manner of transmission remains unspecified yet the virus is no longer isolated to the body of the refugee, but “infects” Yemenis. Indeed, HIV becomes a factor that itself acts against Yemenis and the state of Yemen via economic and social burdens. These narratives collapse together anxieties about the Other with the idea of HIV, which results in the redefinition of HIV as non-Yemeni.

To illustrate how some narratives further position HIV in relation to illegality and the threatening Other, I consider two other articles. Printed within a month of each other in the *Yemen Post*, these articles use the exact same wording to report on an increase in HIV/AIDS in Yemen:

> Official reports noted that the main reason behind the surge [of HIV] is linked to the flow of African migrants into Yemen while other reasons were linked to other diseases such as diabetes and Tuberculosis. In addition, high rates of unemployment and poverty besides other illegal acts committed by illegal migrants and refugees such as robbery (sic), wine trade and trafficking were considered among reasons behind the increase.⁶⁹

The articles do not clarify the links between any of the cited causes and an increase in HIV in Yemen. The “link” between HIV and African migrants clearly signifies that African migrants are entering already infected with HIV, but the other links are not as transparent in their implications.


Neither article explains how HIV could have increased because of its links to diabetes and TB, let alone the relationships between HIV and unemployment and poverty. The illegal activities listed are exclusively connected to “illegal migrants and refugees,” which references back to “African migrants” (emphasis mine) while also sorting African migrants into categories of “illegal” or “refugee.” This correlation between HIV and illegal activities is never clarified in the article. The implication, however, is that people from the Horn of Africa come with HIV, and then spread HIV to Yemenis by corrupting them via illegal activities that would not take place without the migrants. Moreover, the articles claim that illegal migrants and refugees are also responsible for illegal activities not clearly linked to the spread of HIV, such as robberies.

Once again, these reports construct a view of society in which HIV is an attribute of an Other, but these articles additionally merge concepts of illegality into the Other-HIV model. This addition advances the notion that the presence of HIV in Yemen is attacking the social and moral pillars of the country. These articles also allow that Yemenis can contract HIV, while simultaneously excusing Yemenis living with HIV from the acute blame placed upon African migrants living in Yemen - regardless of their HIV status. The only factors or circumstances that would allow Yemenis to contract HIV in this explanation are those of unemployment and poverty, which suggests that should a Yemeni contract HIV, that person would be a victim of his or her socio-economic situation. Africans in Yemen, however, are depicted as importing and spreading vice with HIV and HIV with vice.

---

70 The Yemeni government automatically grants all Somalis arriving in Yemen refugee status, but those arriving from other countries in the Horn of Africa, such as Ethiopia or Eritrea, must apply for refugee status. Upon arriving in Yemen, these nationals are there illegally until applying for and receiving asylum. This policy results in a lot of illegal immigrants from the Horn of Africa in Yemeni prisons. Khaled Al-Hilaly, “Yemen Examining Its Policy of Offering Somalis Automatic Asylum,” Yemen Times, 24 Dec 2009, available from [http://yementimes.com/defaultdet.aspx?SUB_ID=33253](http://yementimes.com/defaultdet.aspx?SUB_ID=33253); Accessed 22 Jan 2010.
People from the Horn of Africa are not the only foreigners depicted as coming to Yemen to spread HIV and other ills. Another category of Other painted as unsavory and hazardous to Yemeni society is that of Arab Gulf males. One article points out that after 9/11, tourists from the Gulf increased in Yemen due to the difficulties of traveling to Europe or the US. Unlike migrants and refugees from the Horn of Africa, the articles do not connect the presence of tourists from the Gulf with the spread of HIV. Rather, the practice of what is called az-azoaj as-siahi, or marriage tourism, along with more straight-forward forms of prostitution, is the social ill brought by men from the Gulf to remote areas and poor communities in Yemen.

Like people from the Horn of Africa, male tourists from the Gulf are implicitly blamed for importing HIV into Yemen as well as spreading HIV via the vice they also import. In these discourses, HIV becomes defined as vice itself. It is not a virus, but a collection of foreign practices that can corrupt, abuse, take advantage of, and trick good but poor Yemenis. Both of these narratives about refugees, and Africans more broadly, as well as males from the Arab Gulf remove Yemenis from any active part in the spread of HIV. Yemenis only appear as victims in these very dichotomous constructs of good and innocent Yemenis versus bad and guilty foreigners. This opens a possibility of acknowledgment and tolerance for Yemenis living with HIV, but condemns non-Yemenis as unwelcome intruders in Yemen. HIV, stealing, drugs, alcohol, and prostitution are classified as imports and not authentically Yemeni. As such, HIV-

73 Ray New, ““Al-qadamoun min alkharj en’ashoun al-isaba bi-marad al-aids.”
as-Other becomes an affront to Yemeni society and a threat to collective identity. These discourses call upon Yemenis to unify against foreigners; HIV becomes a call to xenophobia.

Another approach using the same HIV-as-Other lens takes a further step, citing both Other and vice, but concentrating on vice. For example, another article that did not as stringently allocate the spread of HIV to non-Yemenis traces the route of the virus from refugee camps to cities such as Sana’a, Aden and Taiz through “the proliferation of nightclubs, as well as a very uncontrolled tourism, which played a major role [in the spread of HIV].” It mentions migrants from the Horn of Africa and refers to male tourists from the Gulf, but centers on nightclubs. The article then proceeds to recount how the interviewee, a doctor at al-Jumhuria Hospital in Taiz, “stressed the importance of educating young people about the dangers of HIV on the family, society and the economy.” It therefore allows the possibility of Yemenis attending nightclubs and, by extension, participating in activities which could transmit HIV.

This narrative differs from the previous ones discussed, not only because it implicates Yemenis as possessing agency in the spread of HIV, but also because it uses HIV to criticize nightclubs. HIV becomes a warning, a tool. The doctor seeks not to educate young people about HIV as an issue concerning the physical health of individuals, but presents HIV as something that would harm the lives of those around young people. The author invokes social pressures and responsibilities to prescribe risk-free behavior. Contracting HIV thereby makes one an irresponsible member of one’s own family, of society, and of the nation. Therefore, this narrative, like the previous, paints HIV as un-Yemeni.

75 Ibid.
HIV is constructed as an indicator of societal ills that can be remedied if all Yemenis “adhere to prevention through the teachings of Islam and the traditions and benign customs that protect everyone from diseases and epidemics.” In other words, Yemenis can avoid HIV by becoming more Yemeni. Islam and traditional culture will protect them from HIV and other diseases. This could be construed as a case of traditional society bracing itself against the modern, but that would be overly-simplistic. Rather, indigenous culture is called upon to protect and help people adapt to social and physical ills. The article appears less of a postulate on what Yemen is, but more of a treatise on what Yemen could become. The audience is urged to help create a healthy society by taking responsibility for each other, by avoiding nightclubs, by upholding benign traditions and discarding any harmful ones, and by being good Muslims. The article is about HIV, but the resulting discourse is very quotidian advice. Even though HIV is not portrayed as an acceptable or tolerable presence, nonetheless the acknowledgement that HIV can affect Yemenis situates the discourse as one of reform.

Reform and Local Solutions

While almost any discourse that identifies a problem can be considered a call to action, and therefore a discourse of reform, articles that pinpoint specific actions for readers to take generally overlap with development discourses in calling upon people to behave in a specific manner. For example, another article describes a protest held by young people in Dhamar calling for the lowering of the price of dowries. They reasoned that the high cost of dowries delayed many young people from marrying, which could lead to unsanctioned sexual relations,

76 Ibid.
and would raise risks of contracting HIV. Lower dowry prices would therefore provide protection from HIV by facilitating moral behavior. That article resembles the former closely as it encourages Yemenis to avoid risky behavior and to follow traditional Muslim norms. Once again, vice and HIV are constructed as almost equivalent, with HIV serving as a social representation of immorality.

Another consistency between development narratives of HIV in Yemen, and the article cited above, is the manner in which both point to poverty in explaining how HIV is transmitted. Several development practitioners I spoke with mentioned high dowries and other economic factors as leading to pre-marital sexual relations and thus concerns about HIV. Yet, DWs addressing HIV have not, to my knowledge, called for the lowering of dowries in Yemen. The perspective presented in this article exemplifies how local issues, including HIV, can be addressed using local solutions that have emerged from outside of global HIV governance frameworks.

**Contestations to Global HIV Discourses**

Throughout all of the narratives discussed thus far, HIV has not been contested as a phenomenon present in the country; rather its shape and circumstances of transmission in Yemen and Yemeni society is variously presented. Yet, newspapers also provide space to question the very origins and existence of HIV/AIDS. An example of a more extreme departure from the discourses found amongst DWs about HIV is related by an editorial published in *al-Gomhoriah*, a government newspaper, in November 2009. The editorial, entitled “Epidemiology

---

Industry!!,” asserts that AIDS, along with other “epidemics” such as Anthrax, Ebola, Mad Cow, Rift Valley Fever, and both Bird Flu and Swine Flu, are lies propagated by the pharmaceutical industry “to find a market for their drugs... Just as... companies and arms dealers... raise wars in the world to find a viable market for their products.” The author claims that after being hit by terror, panic and fear about AIDS, “things have gradually faded and... there is no mention of AIDS.” He cites confirmation of this pharmaceutical conspiracy from a doctor in Los Angeles, and criticizes the “collusion of the media, the World Health Organization [WHO], and some scientists.”

This narrative completely contradicts those of DWs and organizations and directly labels HIV/AIDS programming illegitimate and manipulative. Conspiracy theories in mainstream Arab media are commonplace, and conspiracy theories around HIV circulate widely in the US and around the globe. This particular narrative demonizes supra-national hegemonic organizations, including the WHO and is one of the most extreme narratives I have come across in Yemeni newspapers. While it is difficult to gauge how many people agree with this author’s perspective, another narrative concerning HIV in Yemen that firmly contradicts general development discourses has many adherents.

---

79 Ibid.
80 Ibid.
81 Ibid.
82 Mohammed el-Nawawy and Adel Iskandar, Al-Jazeera: The Story of the Network that is Rattling Governments and Redefining Modern Journalism (Cambridge, MA: Westview Press, 2003), 60.
85 There is a long tradition of conspiracy theories around HIV, and many have been printed in newspapers across the globe.
This alternative discourse is most prevalent in Yemeni newspapers and originates with Sheikh Abdul Majid al-Zindani. Sheikh al-Zindani claims that he discovered a cure for AIDS in 2006. “He explained that the drug produced after twenty years of scientific research is effective without any toxic or side effects... pointing out that [this research] was [conducted] under the auspices of King Abdul Aziz University in Saudi Arabia.”\(^{86}\) An interview with Husni al-Goshae, the Deputy Director of the Science and Technology Hospital in Sana’a and member of al-Zindani’s research team, was published in January 2009 in the *Yemen Post*. Al-Goshae stated that ten pharmaceutical companies had expressed interest in manufacturing the drug.\(^{87}\) At that time, this team of scientists claimed to have cured 36 patients, and that they were waiting on the patent to negotiate the manufacture of the drug.

This narrative directly challenges the legitimacy of the development discourses concerning HIV associated with international organizations or the Yemen National AIDS Program that I encountered in Yemen, because it declares HIV curable, and in doing so, questions the expertise of DWs in national and international organizations. The Sheikh calls his medicine “*at-tub al-naboee*,” or Prophetic medicine, because the medicine “was inspired from a Hadith (saying) or Prophet Mohammed (PBUH), prophetic traditions.”\(^{88}\) At first glance, the Sheikh’s assertion versus the dominant international discourse around HIV/AIDS from international organizations may seem easily reducible to a religion-versus-science binary. Yet,

---


\(^{87}\) Hakim AlMasmari, “Interviews: Dr. Husni al-Goshae, Deputy Director at the Science and Technology Hospital and University Professor,” *Yemen Post*, 12 Jan 2009, available from [http://www.yemenpost.net/63/InvestigationAndInterview/20081.htm](http://www.yemenpost.net/63/InvestigationAndInterview/20081.htm); Accessed 8 Dec 2009.

the two general discourses overlap in many places, influence each other, and each has served the purposes of the other.

Al-Zidani’s claim to have an herbal cure for HIV is highly influential in constructing understandings and actions around HIV/AIDS in and outside of Yemen. The claims that HIV is curable, put forth by the Sheikh, have their epistemological foundations in Islam as well as Yemeni social, economic and political conditions. The effects of this narrative on the programs of national and international development organizations addressing HIV have been particularly profound, and more attention will be focused on this narrative in chapter three. For now it is important to acknowledge its existence and the very powerful role it plays in contesting the expertise of international and state experts and opinions around HIV/AIDS.

**Conclusion**

In this chapter I sought to examine different conceptualizations around HIV in Yemen that appear in Yemeni newspapers. By understanding some of the subjectivities around HIV that are present and publically communicated in Yemen, development narratives can be understood as competing threads that must react to other ideas within discursive fields.\(^89\) The progression of narratives further and further from standard discourses by international development organizations exemplify how HIV is not only understood as a health issue in Yemeni society, but can be separated from or collapsed under other concepts to articulate social, political, and economic anxieties, visions, and ideals. As will be demonstrated in Chapter

---

III, alternative narrations of HIV have the ability to transmit needs and desires of people living with and affected by HIV that hegemonic development discourses may overlook or restrict.
Chapter II: Transnational Governmentality and the Shaping of PLWH

One striking element present in both development literature on the region and in the conversations I had with many informants was the manner in which bodies hosting HIV were labeled as “invisible.” Indeed, the term, much like the symbol of Ralph Ellison’s novel Invisible Man, has been used throughout the history of HIV/AIDS discourse to signify social alterity and a demand for recognition. There exists within the history of this term in relation to HIV, therefore, a power differential in which the sub-altern desires recognition, which the hegemon refuses. Populations employ the term “invisible” in self-reference and as a project to self-identify and gain recognition in mainstream society.

This dynamic is reinforced by historical processes of HIV/AIDS activism and organizing which shaped a lot of what is now global HIV policy. For example, in the US, many of the policies and reforms around HIV emerged out of community organizing on the part of the LGBT community and community health advocates. Communities who considered themselves “invisible” to society, including the US government and the healthcare system, worked to become visible and recognized, supported and respected. Epstein used “invisible” in the title of her book The Invisible Cure to point to grassroots social mobilization as part of a solution in HIV programming that public health experts had been ignoring or overlooking in African contexts. For Epstein, “invisible” pointed to something that seeks, or should be allocated, recognition.

90 World Bank, “Preventing,” xii, 44; Sufian, 7.
The act of recognizing the successes of these movements, and the act of “recognition” in itself, inherently suggests the rendering of respect and dignity.

In Yemen, however, calls to action and support from the WHO, World Bank, and international organizations strongly influenced the inception of HIV/AIDS programming. As previously mentioned, one informant attributed the establishment of the NAP in the PDRY to an obligation for all members of the WHO. This is not to suggest that the Yemeni government did not make HIV programming initiatives; before Global Fund support, the Yemeni NAP had “expressed need for international training and capacity-building”92 for years. Yet, without international support, the Yemeni government did not have the capacity to implement extended HIV/AIDS programming and support. Thus, instead of bottom-up demands for recognition from activists, interventions in Yemen are organized top-down, but with the hopes of arriving at the same point: transforming the “invisible” into the recognized, empowered “visible.” I argue in this chapter that these discursive dynamics, as described to me by DWs, point to a development project of finding or uncovering people living with the virus, then shaping them to fit an international model of people-living-with-HIV (PLWH)-as-activists. I trace these narratives from the explanations made about prevalence, to the formulation and targeting of risk groups, to the creation of individuals absorbed into HIV/AIDS programming who symbolize a progressive and democratic state and society. The chapter ends with an overview of how the new HIV law in Yemen codifies elements of development discourse visions of PLWH formation.

---

As mentioned in the introduction, almost 90% of funding\textsuperscript{93} for HIV/AIDS in Yemen comes from the Global Fund, and there are specific behaviors and indicators that DWs must meet in order for funding to continue. In general, modalities of verticality, the taken-for-granted imagined spacial frames of Foucauldian governmentality that place the state “above” civil society, community, and the family, have simply been stretched to encompass new transnational realities.\textsuperscript{94} With so many Yemeni national and local organizations and individuals relying on Global Fund support, the conceptualization of a transnational hierarchy fits the discussion here about HIV/Aids in Yemen. However, a generalized theorization of top-down transnational governmentality should allow for contestations, particularly on behalf of the government. That said, many DWs change jobs between institutions, most moving from national or bilateral agencies “up” to positions with international organizations. Thus the configurations of power and situated viewpoints among employees of different institutions overlap, intermingle, and are constantly in flux. However, they generally operate within a structure of top-down hierarchy. It is for this reason that Ferguson and Gupta’s notion of transnational governmentality is fitting for this discussion of development discourses in Yemen.

The narratives within these discourses often delineate expectations for how individuals with HIV should behave and what identifications they should accept as their own. This process begins with discourses around HIV prevalence rates in Yemen and the categorization of at-risk and vulnerable populations.

\textsuperscript{93} CCM/Yemen, 25.
\textsuperscript{94} Ferguson and Gupta, 116.
Locating HIV in Yemen: Mapping Spaces of Non-Knowledge

Still within its beginning phases, HIV/AIDS programming in Yemen can be characterized as a search for knowledge. This is strongly reflected in international and national HIV/AIDS workers’ tendencies to refer to people or things hidden, invisible, under the table, or silent. DWs particularly use these adjectives to characterize prevalence rates in Yemen and the number of people infected with HIV but not registered with the National AIDS Program (NAP). The concepts of visible or invisible/silent, hidden or found invoke questions about the epistemological foundations of knowledge of HIV in Yemen. If bodies with HIV are hidden or invisible, how is their existence known? Furthermore, if “invisible” populations are not proclaiming themselves invisible, and thus calling for a change of their social situation, what are the implications of other forces labeling populations as “invisible” and seeking to recognize groups as identified by non-members of those groups?

In addition to questions of what is known and not known, the descriptors used express relations and interactions. Emphasizing or characterizing knowledge, such words as invisible or hidden imply that there is also knowledge that is visible or has been found. Thus, continuing with the example of people with HIV, DWs can see or have found/identified some people with the virus. This has been done through surveys, mandatory and voluntary testing, and reports from hospitals. However, the use of the passive “hidden” suggests that an unknown person or force actively hides bodies infected with HIV. The unknown “doer” can be the people living with HIV themselves, because they are aware of their status or fearful, for a variety of reasons, to seek treatment from the National AIDS Program. It can also refer to the social norms and mores
that incite this fear. Nevertheless, the use of the word hidden to describe people with HIV constructs the task for DWs to find or identify them.

A similar dynamic operates within the use of the term invisible. The term itself requires a point of reference – a seer. DWs, in using the term, are the people privileged with the power to see. The authority of this power delineates the field of vision, and with it, who is sought. In other words, the use of these terms implicitly relegates DWs to the job of locating, finding, and pinpointing where bodies with HIV are in terms of geography, lifestyle, sexual partners, occupations, socio-economic class, minorities and marginalized communities. The manner in which DWs seek to locate people with HIV determines who will be found; it both sets limitations on where and who to look for, as well as presupposes identifications for those bodies that are found.

According to most of my informants, as well as the literature on HIV/AIDS in Yemen, a lot is not known about HIV/AIDS in Yemen, especially concerning prevalence rates. As one informant explained to me,

Prevalence is very difficult to track, because we haven’t been consistent in tracking changes in sero-prevalence in the country.... Within the general population it has remained almost stable. But we know that within some subpopulations, there may be increasing rates. But we can’t actually track it down because we cannot find every subpopulation and in time. So it is quite difficult.

Although most DWs agree that the general prevalence rate falls between 0.1 and 0.3%, most workers’ greater concerns lie with rates among at-risk and vulnerable populations. Testing the general population is not difficult and various informants assured me that HIV tests, such as for pregnant women, blood donors, and TB patients are done routinely. However, another DW explained a weakness in the surveillance of the general population. This informant, a worker at
an international organization, found cause to doubt the reliability of data even for the general population:

Even when we took these measurements within the general population, for example, antenatal mothers -- they just pick sites that can provide this kind of data. But you don't know where [to conduct HIV prevalence surveys], because these infections are within certain pockets. Those people may not be actually attending to where the data collection points are. So you may be missing out on the whole picture.

The understanding of “general population,” then, is restricted to the 47% of women who have access to antenatal care at least once during a pregnancy and others geographically and economically capable of obtaining health services at a regional hospital. That said, HIV prevalence data for the region is generally considered very unreliable, which adds to both the tendency and the necessity of DWs to construct programming initiatives based on information that they do not have.

Additionally, one DW at a bi-lateral organization reported a large discrepancy between NAP figures and local numbers on a visit to a governorate outside of Sana’a:

We could not rely on the available information... We tried to get an update from the NAP program, which is the program responsible for updating the prevalence rate, but they gave us different figures... To give you an example: There were around 300 cases of HIV-AIDS [reported by NAP for this governorate] and at the governorate I went back and checked with the head officers of HIV-AIDS in the governorate. He said “No, we just have three cases.” And I asked him about these [300] cases [that were] reported and he said “No, I don’t know about them.” So how can you rely on this data?

Only one person presented me with such a scenario of vastly divergent numbers. What I wish to draw attention to with this quote is not the possible inaccuracies of the surveillance system, which are evident given the lack of research conducted in the past, but rather the informant’s perceptions of its unreliability. Nationally, surveillance is an aspect of HIV/AIDS programming that is targeted for improvement in 2010 with a quarter of a million dollars of Global Fund

---


96 Sufian, 1.
Thus, while HIV prevalence rates in Yemen are known to not be founded upon solid scientific research, my informants expressed varying degrees of uncertainty and doubt concerning them, and few accepted the given prevalence rate as absolute fact. However, often the amount of confidence they articulated in official data often bore a direct relationship to their expressed support for the direction of programs and use of funds by the government. Thus, those that conveyed confidence in the statistics and who did not point to discrepancies also communicated confidence in the utility and progress around the programming initiatives they were connected to and the general allocation of funding. For example, one government employee stated that “There is still low prevalence -- less than 0.2%. But a lot of information regarding vulnerability is needed. We need other studies to confirm our statistics.” This statement reveals confidence in government statistics; the informant discusses a need for studies to help remove others’ doubts about the reliability of statistics, emphasizing the informant’s own confidence in the reliability of government data.

At the other extreme, however, were two DW interviewees who viewed available data, or lack thereof, as a major determinant in shaping programming. They reasoned that a lack of reliable statistics led to programming that was ineffectual and aimless. One informant at a bi-lateral organization described donor money in Yemen going to “cut-and-paste work they are doing in Africa and some other countries,” which took the forms of “prevention of HIV-AIDS and stigma reduction, and it's not appropriately directed to the basic research and baseline

---

97 Information from informant interview.
98 This is not to say that other factors did not influence their support for the direction of government programs, but rather that those who articulated such support typically voiced less skepticism about official prevalence data. Those who questioned the uses of funding the most were Yemenis who worked with international organizations and were not responsible for decisions regarding the Global Fund HIV/AIDS portfolio. Thus, they were situated in such a way that allowed them the freedom to speak freely, and their criticism did not reflect upon their own positions.
research that can identify the problem. We need now to identify the problem. Where is the problem? Is the problem that big?” This person, in citing manifestations of global HIV governance, called for an HIV/AIDS project that was specific to Yemen and its needs, particularly in the context of other health issues. A different informant at an international organization discussed the difficulties of obtaining local knowledge about HIV/AIDS, but insisted nonetheless that understanding how people perceive HIV was key. Otherwise, “we will just look at the surface of things without looking to the rooted reasons behind this phenomenon.”

The variations on how DWs conceptualize prevalence rates of HIV in Yemen are indicative of how different people negotiate the “hidden,” or the knowledge that is inaccessible. These negotiations point to a central tenet of knowledge production around HIV/AIDS in Yemen, which is the formulation of what Helen Epstein calls “non-knowledge.” She connects Adriana Petryna’s work on government-fabricated health statistics around the Chernobyl disaster to the realm of HIV/AIDS:

‘A catastrophe whose scale was unimaginable, difficult to map, and ‘saturating’ became manageable’ through a particular dynamic of ‘non-knowledge,’ which enabled specialized authorities to deploy whatever programs they wished and obscured the mistakes they made.\footnote{Epstein, 185.}

The situation in Yemen is the reverse – rather than an overwhelming catastrophe, HIV is, as one informant expressed, “a disease which is nonexistent in Yemen” compared to Uganda or Zimbabwe. Yet the dynamics of information are parallel. Given the difficulties in conducting reliable HIV surveillance, DWs have had to develop programming founded on information that they do not have. “Non-knowledge” claims infuse belief systems around who has HIV and where these people are located, which then inform general and targeted interventions. These
negotiations of non-knowledge are particularly pertinent in directing programming, as was outlined by the informants who problematized the current prevalence data.

Yet, with questionable data in many areas, DWs implement many programs without necessarily being held responsible for their effectiveness or relevance to different areas and populations in Yemen since the information needed to evaluate such programming is not available. This relates to Seckinalgin’s argument that global HIV governance systems have the capacity to take away DWs’ agency to determine local programming. Global Fund processes, as outlined in the introduction, necessitate a project framework that, for a country without the capacity to conduct a lot of research on how HIV is manifest in local contexts, is founded on non-knowledge.

This suggestion is supported by another informant’s explanation that non-knowledge or unreliable data serves a function within the international donor system, in that prevalence numbers and the identification of targeted groups demonstrate to donors a country’s motivation to address HIV.

But still the number gives... [a picture of] HIV AIDS in the country. Then you can move in order to keep this low prevalence or in order to know the real number, the real prevalence... [the uncertain number] allows you to ask for help from outside the country.

The need to formulate a proposal to address HIV/AIDS in Yemen using estimates and adhering to conceptualizations of international best practice suggests not only the production and incorporation of non-knowledge into development discourses, but also alludes to international framings of what is considered appropriate, relevant, and legitimate knowledge. The unavailability of reliable data produces a system that necessitates the construction of non-knowledge around HIV as a demonstration of government motivation in order to obtain the...
backing to legitimate initial claims. At the same time, they are required by the Global Fund to pursue specific programming categorizations and interventions assumed relevant in Yemen, again without taking into account local contexts. A pertinent example of this is the categorization of most at-risk and vulnerable groups.

Standard procedure for HIV/AIDS programming in a “low-incidence country” like Yemen is, as one interviewee related, “you map the population – the risk groups. Then you start targeted interventions.” Indeed, this is standard practice for development work in general, and a critical aspect of disease prevention. In developing initiatives to address HIV, it is necessary to understand who is most at risk for contracting HIV, and where to find such individuals, in order to try to assist and support such populations.

In public health as in any field, mapping is a method of organizing knowledge. It at once makes certain categories and understandings visible, while making others invisible. James C. Scott explains how the project of mapping obscures and invents knowledge, changing the situation “to the reality they presumed to observe,” but never changing it enough to fit the representation portrayed on the map:

Certainly forms of knowledge and control require a narrowing of vision. The great advantage of such tunnel vision is that it brings into sharp focus certain limited aspects of an otherwise far more complex and unwieldy reality. This very simplification, in turn, makes the phenomenon at the center of the field of vision more legible and hence more susceptible to careful measurement and calculation. Combined with similar observations, an overall, aggregate, synoptic view of a selective reality is achieved, making possible a high degree of schematic knowledge, control, and manipulation. [emphasis mine]

The project of mapping allows for the production of new categories and definitions of populations. Physical space and physical bodies of inhabitants are newly configured to testify

---

101 Scott, 11.
to how HIV/AIDS occupies Yemeni space. On a map of Yemen, the governorates of Aden, Taiz, Hadramaut, Hodeidah and Sana’a and Hajjah are the spaces with more reported cases of HIV.

FSW and MSM were widely reported to me as the most at-risk populations (MARPs) for HIV. IDUs were mentioned by a few informants. Some said that they were an at-risk population, others said they might be, and many said that they were not a significant at-risk population in Yemen. Nonetheless, IDUs are listed as a MARP in Yemen’s 2008 Global Fund Grant proposal.¹⁰²

One informant told me that MARPs are global categories, an assertion which is supported by Yemen’s Global Fund reporting procedures that require documenting the number of MARPs – SWs, MSMs, and IDUs-- reached during every round.¹⁰³

The construction of these categories is epidemiological and based on risk behaviors, as opposed to imaginings of bounded risk groups. Historically, these terms evolved from initial categorizations of gay men, prostitutes, and intravenous drug users, as being more at-risk than other groups. Such categorizations glossed over the nuances and complicated realities of how HIV is spread and stigmatized populations labeled at-risk. The categories that emerged and which are used today – SWs, MSMs, and IDUs – seek to target behaviors rather than identities. Interventions concentrating on these categories, once deemed contextually relevant, are particularly essential to fighting the spread of HIV and supporting the human rights of such individuals by access to health information and treatment. These categories are also sub-altern groups, and thus are more likely to be subjects of structural violence that makes health-seeking behavior more difficult. Global HIV/AIDS programming concentrates on these populations

¹⁰² This proposal was drawn up by the country coordinating mechanism (CCM), made up predominately of 10 Yemeni government employees, as well as four members of NGOs and four multi-lateral and bilateral development partners in-country. CCM/Yemen, 22.
¹⁰³ UNICEF.
¹⁰³ CCM/Yemen, 31.
because experience has shown that individuals who practice these behaviors are the most in need of assistance and support. However, what makes them potentially ineffectual, if not harmful, in the Yemeni context is the social elision of difference between identity and practice, and the general connotations of immorality and deviance attributed to both.

Other at-risk populations named during interviews were migrants/returnees, refugees, mobile populations (truck drivers, fishermen), women, street children, youths, the poor and marginalized. The 2008 Global Fund report for Yemen explains that “Most AT Risk Populations (MARPs) associated with high risk of HIV transmission are SW, MSM, IDUs, whereas vulnerable groups are women, youths, fishermen, prisoners, migrant workers and poor people.” These categories are extremely inclusive: 35% of Yemenis live below the poverty line, nearly 50% of the population in Yemen is under 15, and certainly about half of the population is composed of women. These categorizations leave few outside potential programming targets, generating further non-knowledge to support generalized interventions.

Furthermore, the category of “migrants” typically assumes lower economic classes. As Akeroyd asks “Other mobile populations include expatriate consultants, aid workers, pilots, journalists, tourists, businessmen, civil servants, and others: but where are the detailed (let alone repeated) studies of those occupational categories?” Given the high degrees of stigma

---

104 CCM/Yemen, 22.
and discrimination towards HIV in Yemen, and the implications of deviance and immorality associated with HIV, at-risk and vulnerable groups bear the discursive label of diseased bodies. Indeed, the only populations that do not officially qualify for HIV/AIDS program targeting are middle- and upper-class men who do not have sex with other men, yet can have sex with female sex workers. A map of at-risk and vulnerable groups would thus also be a map outlining and reinforcing normative moral, socio-economic and political patriarchy in Yemen. Broad systems of classification based predominantly on social and economic vulnerabilities have the potential to produce and enforce additional vulnerabilities while upholding dominant inequalities within Yemeni society. In addition to potentially reinforcing hegemonic power structures, the mapping of at-risk groups also presents possible discursive identifications of individuals who are subsumed within such classifications, which is discussed in the next section.

**Targeting MARPs: A Shop without Customers**

As mentioned previously, populations considered most at-risk are, in addition to the HIV virus itself, considered *hidden* or *invisible* within Yemeni society. The low-prevalence of HIV in Yemen provides an alien and challenging context to some international experts. One DW explained his experience to me with a metaphor of business:

> ... Yemen, it is the first country where I've worked that has been [a] low prevalence setting. Low prevalence doesn't make it any simpler, but very complex. I worked in countries where the epidemic level is very high and you open a shop and you have customers. In Yemen, you should look for the customers. And because of the cultural context, it is quite complex to find those people. They are not trusting at all.

The metaphor of a shop and customers evokes a conceptualization of HIV/AIDS programming and treatment as a product for consumption, but a product that is not selling. The contextualization of HIV/AIDS programming within a metaphor of business reflects global
corporate culture looking for a new market. It also suggests that development itself is a business, with constructions of non-knowledge used to justify and perpetuate the presence of international experts. This concept is also supported by a DW’s explanation, as cited in the introduction, of not being able to change Global Fund programming practically because stakeholders did not want funding decreased. However, the informant comparing HIV programming to business went on to suggest that the problem to overcome is not the development project as conceptualized by the speaker. Rather than DWs adapting approaches to Yemen, instead the interviewee describes changing Yemenis to accept the pre-conceptualized formula of HIV/AIDS programming for at least the targeting and testing stages: “So... you have to target these people. Then you get these people tested and you get these people enrolled and trusting in the system. This is how you can get them to where you have set up your services... It is not business as usual.” To the interviewee’s credit, the individual acknowledged that HIV/AIDS programming in Yemen cannot be conducted as it is in higher-prevalence countries, and in our conversation spoke about offering services “in places that are very disguised” to the general public, giving the example of needle exchange programs in Iran. However useful that could be, the initial classification and targeting models were never questioned. These models based around MARPs are what I wish to problematize in this section.

The dynamic of merchant-customer and searcher-hidden are similar to that of patient-doctor by implication of perspective. The merchant wants a customer, the searcher wants the hidden to emerge in the form that the searcher imagines, the doctor wants a patient. In all of these relationships, the former defines the identification of the latter as dependent on and submissive to itself. The dynamic points to the process of the medicalization of HIV and the
systems of control implicit within discourse and programming structures. Peter Conrad described the process of medicalization as the following:

"Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession. Medicalization occurs when a medical frame or definition has been applied to understand or manage a problem."

HIV is a medical condition, and it must be understood as such on a variety of levels. However, the tension of the medicalization of HIV in international development interventions in relation to social and local contexts, knowledge and identifications is well-articulated by Hakan Seckinelgin:

The concept sets out a process that works at two levels: at one level social concerns are gradually subsumed under the medico-scientific frame of reference. More and more aspects of social relations by which people make sense of their lives are considered under the categories of medicine, in relation to ill health, risk groups and their associated medical solutions. At another level, the process is also implicitly about the creation of generic patients with particular problems as categorized by the experts. Here, people are not only repositioned as patients, but they are also gradually abstracted from their social contexts and the local knowledge systems. This double move is evident in the existing HIV/AIDS interventions. In the process of delivering prevention messages or discussing treatment-related issues, the assumed superiority of the Western knowledge on medicine reasserts itself as a justification for initiating the programmes which need to be implemented and for which compliance is expected from the patients in order for the disease to be dealt with.

The informant’s business metaphor describes a plan for this process in the presumed authority of the expert and the expectation of compliance on behalf of members of the population considered at-risk. Yet the DW’s narrative also speaks to the difficulties that DWs in Yemen have had in abstracting people from their social realities and implementing the medicalization process. This does not suggest that the motives of this person were not compassionate; this DW wanted to find and help people to learn about HIV and how it could affect them.

Nonetheless, the DW’s conceptualization of the process and its implications on the lives and

---

109 Seckinelgin, 76 – 77.
agency of people targeted are constructed within a restricted lens; the conceptualization of
“customer” stems from the dominant narrative of HIV/AID aids and its expertise? Individuals
discursively conceived as “customers” are identified based on sexual behaviors divorced from
contextual realities, including the individuals’ desires to self-identify in relation to such
categories.

In Yemen, DWs repeatedly informed me that the most significant risk groups were FSW
and MSM. These categorizations group individuals by interpreting sexual practices as closely
linked to medical conditions. HIV/AIDS programming then focuses on these practices by
expanding the focus to those engaging in such behaviors. The practice of seeking out the
“hidden” MARPs, the process of “identifying” and “targeting” inherently construct social
categories defined by behaviors considered deviant sexually, socially, and religiously. It is only
after those who partake in such behaviors are found that the socio-economic conditions
surrounding the behaviors are examined. This approach has potential pitfalls which are
particularly problematic for targeted groups. Even though DWs take precautions to protect the
people with whom they work, such as the suggestion for a “disguised location” from which to
offer services, the approach and intent to reveal, if only to themselves and colleagues,
behaviors that people do their best to kept hidden should be examined.

As articulated by the majority of the DWs addressing HIV/AIDS in Yemen with whom I
spoke, the accepted approach to programming is to access/find/locate/identify “members of
at-risk populations,” which DWs specifically understand as FSW and MSM in Yemen. This
project of recognition, or rendering the “invisible” visible, is an attempt to not only define and
classify people based on their deviant sexual behaviors, but also asks individuals to redefine
their own self-perceptions and self-definitions into the boundaries of these categories. To that effect, the approach can be understood as more of an attempt to label and expose, rather than recognize. The term “recognize” suggests sharing of power, listening to voices previously unheard, letting the sub-altern speak. Recognition suggests agency, understanding, dignity, and respect. Development discourses in classifying individuals within categories deemed socially and religiously abject do not so much “recognize” as they do define others without their active recognition. Indeed, there is evidence that the objects of such efforts resist such identification.

Numerous informants told me about attempts to organize workshops for FSW in Sana’a. According to my informants’ understandings, unlike many other countries, in Sana’a and most of the north, sex workers do not occupy specific public places. Instead they are found in private homes and are reachable only with help from others, like taxi drivers. I was told that DWs in Sana’a had managed to make contact with FSWs and a date and place for a workshop was agreed upon. The workshop was a secret and its title did not allude to sex work. The night before the workshop, the women who were to participate canceled. My informants explained that the women did not trust the DWs. They were afraid that they would be arrested or exposed.

The reasons that female sex workers remain hidden to the public were understood by everyone with whom I spoke as a fear of social and governmental punishment, such as arrest and public scorn. Explanations around this incident pointed to “fear” and “trust” rather than “risk.” DWs painted the reluctance of the women to participate as a problem in their heads,

rather than the reality on the ground. In other words, they used a discourse of “external rationality” to frame the women’s cancellation, removing their own actions from power configurations. Tim Mitchell describes “external rationality” as the tendency of development organizations to imagine themselves as rational players standing outside the country and its configurations of power. 111 In doing so, DWs in this case denied the possibility that participation in their workshops, occupying a public space configured by DWs for sex workers, could have any negative repercussions on these women. To gather publically for a workshop, even if in a secret location under disguised pretenses, would put them at risk of being “exposed.” Attending the workshop would involve allowing strangers control over their public identities and reputations. It would also be submitting to a definition of a sex worker.

Susan Craddock points to “the tendencies to theorize ‘third world’ women as undifferentiatedly oppressed and universally victimized... One way to address this tendency... is in remembering that all individuals have latitude for resistance, even though latitude comes in highly varying degrees.”112 This point becomes salient when applied to the situation of the women in Sana’a who would not attend the workshop. Refusing to attend the workshops could have potentially been an effort to retain agency over their public and private self-projections. Such control is necessary when contextualized within the conservative norms of Sana’a and fears of governmental, religious, and social reprisals. Even if people know that an individual is a sex worker, to publically claim such a label in Sana’a is by and large unimaginable due to general social and religious norms and expectations.

One informant from explained to me that an international NGO working in Yemen had changed it programming from an initial approach on most-vulnerable groups to a more general campaign focused on mainstreaming media messages and public awareness about HIV/AIDS. One of the reasons cited for this change was “the danger of reinforcing... stereotypes around how HIV is spread that over-concentrates on the most at-risk groups.” This change reflects an awareness of potential problems that arise in directing attention and resources towards the activity of categorizing, identifying, and targeting particular groups, because of the inadvertent message communicated to people who are not the objects targeted. The acute focus on FSW and MSM can be read as proof or evidence that HIV is caused by immoral behaviors. If one practices neither of those behaviors, then one is not at risk of contracting HIV. This was certainly a significant insight, particularly within a context where many people understand HIV as a problem of foreigners and not one that affects practicing Muslims. Furthermore, that this programming change took place in an international NGO, rather than an organization that relies on Global Fund support, is also significant. Yemen’s Global Fund “Objective 2”\textsuperscript{113} requires targeting high risk groups, and therefore recipients of Global Fund support do not have the same programming options as do separately-funded organizations. Global Fund support requires targeting of populations internationally understood to be MARPs.

Susan Craddock elucidates that “the portrait of seropositivity emerging from studies focusing on these ‘risk groups’ both drives and substantiates this depiction [of MARPs], the numbers leaving apparently little room for interpretation,”\textsuperscript{114} emphasizing that the pre-conceptualization of risk groups stands beyond interpretation or contextualization. The

\textsuperscript{113} See Appendix II.

\textsuperscript{114} Craddock, 160.
structural exigencies of international development discourses and expertise concerning
HIV/AIDS in general, and of the Global Fund in particular, disallow alternative configurations of
risk groups. Yet, the employment of these categories, as Craddock continues, situates

\textit{Disease and diseased bodies vis-à-vis dominant norms of conduct, morality, and social order... the impact of these moral organizing principles influences the kinds of 'facts' sought in medical research, and consequently determines the kinds of bodies prescribed as dangerous. Hence, the age-old paradigm of a sexually transmitted disease as a disease of deviant men and promiscuous women.}\footnote{Ibid, 160.}

Consequently, MARP categorizations as they stand reinforce social perceptions of deviancy and
immorality, while eliding differences between socially-defined sexual deviancy and physical
disease. The narrow focus of the category of FSW and MSM confines these classified individuals
and identifies them as belonging to this category.

It is worth noting that the first step of the project of identifying female sex workers is to
classify women as sex workers, as opposed to other possible classifications, such as
underprivileged women, marginalized women, runaways, divorcees, etc. Refugees or
individuals living in certain neighborhoods understood to be poor who practice commercial sex
work are categorized as refugees or poor or marginalized, labels which contain and
communicate a greater sense of their socio-economic conditions and struggles than the
category of FSW. Alternative classifications also remove connotations of blame or illegality and
have the potential of supporting (rather than alienating individuals from) associations with
greater collective identities, such as communities of nation, region, neighborhood or Islam.
Indeed, one of my informants suggested clinics for marginalized women, rather than specifically
for sex workers, claiming that a similar model is used in Iran. If classifications cannot be avoided, then alternative categorizations should also address issues that surround HIV, such as poverty and disempowerment, and suggest more comprehensive approaches than awareness workshops targeted to sex workers.

**Imagining MSM and IDUs**

FSW, and MSM and IDUs are conceptualized, following global HIV/AIDS guidelines, as the groups who practice the most risky behaviors. Yet, interviewees did not explain to me how, outside of Aden, MSM were identified or targeted by HIV/AIDS programming. Besides the plethora of anecdotal information of same-sex relations amongst young male and fishermen populations, as well as one workshop and past presentations to groups of MSM in Aden, MSM generally remained a discursive category whose boundaries and members had not yet been imagined by DWs. However, systems of classification allowed for the categorization of MSM under alternative labels, such as poor or youth or migrants.

For example, while most of the people who have tested positive for HIV in Yemen within the last few years were reported as returnee workers, returnees are nonetheless classified, according to my informants, as “vulnerable” populations. Unlike MARPs, vulnerable populations are categorized by socio-economic contexts rather than social, sexual, or moral deviance. Migrants are considered vulnerable because of the economic necessity of working abroad. While DWs have explained to me that FSWs usually turn to sex work out of economic necessity

---

116 I could not find documentation of such clinics, but Iran’s triangular clinics which address drug abuse intervention (harm reduction), STI treatment and HIV care propose a model of targeting more than one kind of “patient,” which works to un-identify clients entering and leaving such places.
as well, the MARP categorization of FSW is privileged by DWs over the vulnerable group categorization. The same is not true for MSM. Development discourses did not try to sub-categorize MSM amongst returnees. Interviewees would explain, if asked, that migrant workers probably acquired HIV from sexual relations with women or men. The same rule applied to other categories of vulnerable groups, such as fishermen, truck drivers, and refugees. Finally, while a lot of efforts have been made to target FSW inside and outside of Aden, I did not hear about similar attempts outside of Aden to address MSM. It could be argued that more efforts need to be made to identify, target, and incorporate MSM into development initiatives around HIV/AIDS, but there is a possibility that those targeted would respond in similar ways as women identified as sex workers in Sana’a. Alternative conceptualizations of classifications that include MSM could be a worthwhile investigation.

The third global category of MARPs is IDUs. The resiliency of MARP categorizations becomes evident in the search for IDUs in Yemen. As previously mentioned, all informants defined most-at-risk groups in Yemen as sex workers, being mostly female, and MSM. Many of my informants did not classify IDUs as a relevant at-risk population in Yemen, but a handful of them did. One informant told me that MARPs are the same throughout the world. Yet, another explained that the definitions of at-risk populations are fluid:

*The definitions [of MARPs] of course are changing because of our understanding of the epidemic. The definitions are changing, because we used to believe because it is a low prevalence setting that probably there may be some people more at risk. We just said, probably, probably. But until we carried out studies, formative studies and in-depth studies, that’s when you can understand that actually these populations exist and we have marked them out and consistently you will find... female sex workers and men having sex with men. And in some cities now we are finding injecting drug users. So this is coming up, I would say.*

---

117 Some of my informants explained that many sex workers were the products of social circumstances like early marriage followed by divorce.
A different informant gave me similar information, but added that the people they have been finding who could be categorized as IDUs have all practiced in isolation. This meant that they did not share needles, and therefore could not constitute a high-risk population for HIV infection. The divergent accounts emphasize the authority of global HIV/AIDS discourse via expectations that IDUs should be a targeted group, despite the lack of evidence that they exist in large numbers or that their behaviors are the same behaviors of IDUs in other places.

International programming for HIV/AIDS has created the MARP triptych, which drives development programming around HIV/AIDS in Yemen. Accepting these classifications as the most relevant and useful groupings in Yemen, and then attempting to locate pre-supposed populations, is a funding requirement and part of the global definition of HIV/AIDS development work. However, when locally contextualized, such efforts enforce stigma towards these targeted populations and attempt to impose predetermined and socially alienating identifications upon individuals. This project of identifying and targeting populations as MARPs has also been difficult to realize outside of Aden, a city with social spaces that are more similar to other regions outside of Yemen where projects were accomplished. The difficulties of targeting MARPs, and the hidden structures of dominance and violence that accompany such projects, suggest the need to conceptualize more respectable and equitable approaches to HIV/AIDS interventions.

**Reaching MARPs in Adeni Spaces**

In the course of my research I learned that multiple surveys and some workshops were held with FSWs and with MSM. I was also informed that most, if not all, of these exercises were
The city of Aden itself was a British colony and protectorate. Upon gaining independence, Aden and other governorates commonly referred to as “the South” united as a socialist state at their 1967 independence from the British. During the socialist era, Aden developed quite separately from the rest of the south. The southern state united with the north of Yemen in 1990. Although a lot of changes have taken place in the city of Aden over the last twenty years to make it more culturally and socially akin to life in the rest of the country, many differences in lived social realities remain. One of these differences relates to how people occupy public space and, specifically, the profusion of nightclubs in the city of Aden.

Most nightclubs feature a live band, female dancers and other women, many of whom presumably exchange sexual acts for money. Male sex workers (MSW) are also present, but not in as great of a proportion. The clientele, servers, and management in these spaces are almost exclusively male, with the occasional exception of female servers and tourists. Alcohol is available and freely consumed. These spaces are not openly discussed, and patronizing these establishments is not typically admitted or talked about publically outside of the establishments themselves. Everyone within a nightclub would be considered socially deviant by the general public. Thus, these public spaces of congregation make “finding” sex workers easy relative to the same project in other regions of Yemen, as one informant explained:

> Even bars are not a common thing except in places like Aden... Aden in just a few places. It's only Aden of course. So, actually, we've carried out enough studies in Aden, and the interventions in Aden are working because it's a different sort of community in Aden as compared to the rest of Yemen. That doesn't mean that Aden is more vulnerable, no. The lifestyle in Aden is a bit different from the lifestyle in the rest of the country.

Nobody offered explanations as to how information gained in Aden was relevant throughout the rest of the country, although mobility may be one factor. I was told of one prevalence survey conducted with sex workers:
As for sex work, a single study has been done... but it is not yet available from the government for publication. The results of the study did not show very high prevalence [of HIV amongst sex workers]. I don’t know if you have seen the survey. The government stopped publication of the survey, but the survey shows no level of prevalence. I believe [the prevalence of HIV amongst the sex workers who participated] is below 1%. [The survey was conducted] among... about 400 sex workers.

However, based on discussions I had with DWs in Aden, the cited narrative was incorrect about the nature of the survey. Two surveys were carried out in Aden by DWs with nightclub employees, including any worker from managers to servers to janitors. In 2002, 509 people were voluntarily tested, with the result of 0.5% HIV prevalence. Another voluntary study of nightclub workers was conducted in 2009, with 613 people tested and 0% prevalence. It is not clear whether or not these surveys even included sex workers, or if they were strictly male employees. However, testing everyone who work in these spaces that are labeled as socially deviant resonates with newspaper articles that connect nightclubs to vice and vice to HIV.

Throughout my discussions with DWs within and outside of Yemen, interviewees often stressed that HIV/AIDS programming efforts in Yemen had successfully conducted surveys and workshops with sex workers as well as MSM. The implication was that development projects in Yemen had overcome exceptional obstacles in carrying out work with groups considered religiously illegal in a conservative Muslim country. Successes of interventions with FSWs and MSM could also suggest that such classifications are not as problematic in Aden. They also demonstrate Yemeni commitment and pressures to meet global standards and the protocols of international organizations. Indicator 2.3\textsuperscript{119} in Yemen’s list of Global Fund Key Grant Performance Indicators specifies the “number of high risk vulnerable persons reached with IEC [Information, Education and Communication] activities,” and work in Aden around HIV allows

\textsuperscript{118} Informant interview in Aden.
\textsuperscript{119} See Appendix II.
development practitioners to meet this indicator. Even though DWs remain unable to meet the expectations of global HIV/AIDS protocol in targeting sex workers and MSM in other areas of Yemen, the structures of expectations, including how populations are categorized, remain unquestioned. One reason for this lack of problematization could be successes in Aden in targeting FSW and MSM, which allow expectations to be met in a space where such expectations work well, thus allowing indicators to be fulfilled and funding for HIV/AIDS programming to continue. However, outside of Aden the absence of such spaces poses particularly challenges and risks.

Emerging Shapes of PLWH

Concentrating on finding the hidden people considered to be members of high-risk populations in Yemen was explained to me by one informant as the most efficient form of prevention: “If you focus on finding the people by testing and counseling and then treating the people, then you will be doing 80% of the preventive programs.” If everyone living with HIV is on anti-retroviral therapy (ART), then the viral load will be kept at low levels, significantly reducing the chances of infecting others with the virus. The catch-22 is, of course, that stigma around HIV/AIDS is so prevalent that the “finding” and “testing” become extremely difficult. Once individuals test positive for HIV, they can face significant discrimination within society as well as from many health care providers. ART treatment is available in five cities: Sana’a, Aden, al-Hodeidah, Taiz, and Mukalla. ARV therapy is free, but transport to one of these five cities can prove costly and difficult. Furthermore, some people choose to receive treatment in a different city in order to maintain anonymity.
HIV/AIDS development discourses in Yemen follow the stages of “identifying” and “locating” populations considered hidden with the subsequent step of testing. The moment of testing positive for HIV becomes a transformation from invisible to visible, with DWs, and by extension, international organizations and the state, acting as the seers. Even if people test anonymously in voluntary counseling and testing (VCT) centers, a positive result still puts people within the sphere of influence of counseling and treatment programs and enhances national surveillance data. However, it does not mean that everyone who tests positive will accept the services offered or participate in organizations for PLWH.

The act of registering with the National AIDS Program (NAP) allows access to anti-retroviral therapy (ART) and general care. Members of AID Organization, an NGO of PLWH, described starting ART as a significant step in becoming fuller members of Yemeni society. They emphasized the transformative effect that access to free ART had in Yemen. With ART came people’s ability to “go out,” because before treatment became available in November 2007, testing positive for HIV meant waiting “for the disease to end their lives; they stayed at home.” The extreme importance of the availability of ART cannot be over-emphasized. At the inception of the NGO on July 19, 2007, members numbered around fifteen; today the membership is around 250 people, according to board members. The Global Fund lists the number of people receiving anti-retroviral therapy in Yemen as 189\textsuperscript{120} as of December 1, 2009, which is a conservative estimate compared to reports of 400 people on ART by some of my interviewees.

With this availability, as members of this NGO explained to me, came new hope, new self-perceptions, and the occupation of new space.

From my discussion with board members living positively, to “go out” upon the arrival of ART meant not only leaving their houses but incorporating themselves into their communities, particularly via the organization. One DW explained the organization and general efforts to empower PLWH as “providing a space for them” to communicate and contribute their opinions and needs to programming and policy-making procedures. The metaphor of space aligns with the materialization from hidden or invisible beings to newly-defined, visible and three-dimensional entities. Upon testing positive and then actively seeking ART, PLWH acquire weight and shape and faces. The next step, as repeatedly characterized by a number of my informants, is for PLWH to undergo training in order to find a voice, or to share their new identity with others. DWs have articulated this as “people coming forward,” “recognizing themselves,” “exposing themselves or... their status,” and “those people who are happy to be identified in that way.” Then, as one informant explained, after forming an organization, “We need them to speak freely, so we need to build capacity in regards to sharing their experience with others outside.” The acts of “recognizing oneself” or “being identified” strongly suggest that at the final stage of this re-definition and re-identification process, from a “hidden” entity to visible person with a voice, the individual must accept a persona molded, in part, by development forces and their model for PLWHs.

Even though registration with NAP and membership in an organization does not require revealing one’s status to friends and family, the process still necessitates reconciling HIV/AIDS development discourses with social and religious discourse. This new role makes individuals
eligible for acceptance from other members of PLWH organizations, and for leadership responsibilities, along with training and travel abroad, with local organizations for PLWH. Newly identified PLWHs effectively become a part of the project of the state and international organizations, and as such, are encouraged to function within this discourse. These countable members and PLWH organizations prove to the Global Fund and other potential funders that HIV/AIDS programming in Yemen is following the path determined by global norms and expertise around HIV. Leaders of organizations for PLWH become symbols of successful HIV/AIDS development programs, but also embody advances in pluralism and human rights. Indeed, they personify a modern, progressive, and democratic Yemen given that social conditions and government allowances are necessary in order to self-present as living with HIV. Active PLWH organizations and members also mark that the medicalization process is complete in that alternative discourses must be rejected in order to retain funding from international donors -- an issue I will discuss further in the next chapter.

The shaping of these new identities is especially evident in the formation of NGOs assisting PLWH, and in DWs’ descriptions of how PLWH are ushered through the process. Different informants explained programming goals involving PLWH as being able “to integrate them in the response,” “build them to take the lead... and build their capacity,” to encourage them“ to say we are HIV patients,“ and as “slowly bringing them together as a small group.” Repeatedly, DWs spoke to me about PLWH being “built” and “encouraged.” Another informant described the process of convincing people living with HIV to form an organization:

[I needed] to bring some people who are HIV-positive, to say that... these people [are] HIV positive. They want to establish an association just for them... it was very difficult for me to convince first the people living with HIV. “Now you have to make an association for you and this is an association. It will be like, you will be the master. You will be the president. You will be the vice president. You will be the media, and you will have control of this association. You have the right to ask for your rights... to get the social services
and health services from the government. You will not get all these rights unless we establish an organization. So it was very difficult to start and establish and convince people living with HIV to start this association.

As this narrative demonstrates, the establishment of organizations of PLWH has not been undertaken by people living with the virus. Indeed, one of my informants pointed this out to me and expressed deep concern with the process. The current structure trains PLWH on what they need, what programming should be carried out, and who in the Ministry of Health and network of international, bi-lateral and local organizations has the power to help them. This is the inverse of the organic ideal of PLWH having the agency to determine their own needs, programming initiatives, and having the power to solve problems as an organization instead of directing complaints to a member of the Ministry of Health.

The goals of such projects are to incorporate PLWH into the programming process, as well as to put a voice, and eventually a face, on to Yemenis living with HIV. The hoped-for outcome would be PLWH determining their place, their rights, and best practices in Yemen, as well as humanizing the disease in order to decrease stigma and discrimination and to increase awareness. The projected conclusion is, as I was repeatedly told, fully-functioning organizations composed entirely of HIV-positive members. Programming initiatives involving the creation of networks of and support groups for PLWH, as well as the use of PLWH to reach MARPs, are included in the 2009 Global Fund Yemen Report. Moreover, involving PLWH is, according to UNAIDS, a central tenet of international HIV/AIDS development guidelines. Thus, in addition

---

121 CCM/Yemen, 19.
122 The Greater Involvement of People Living with HIV and AIDS (GIPA) “principle is the backbone of many interventions worldwide. People living with, or affected by HIV are involved in a wide variety of activities at all levels of the fight against AIDS; from appearing on posters, bearing personal testimony, and supporting and counseling others with HIV, to participating in major decision- and policy-making activities.” From UNAIDS webpage, “Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA),” UNAIDS, available from http://www.unaids.org/en/PolicyAndPractice/GIPA/default.asp; Accessed 25 Mar 2010.
to the envisioned assistance, support, and agency that such organizations provide PLWH, formation of PLWH organizations signify motivation and progress to funders.

Various DWs spoke to me about their concerns surrounding the achievement of PLWH organizations. One informant emphasized that there does not yet exist a “real” organization of PLWH, as none of the organizations originated from efforts of desires of PLWH, nor are any of the governing boards composed entirely of PLWH. Another individual confided to having been discouraged by national and international DWs from training a PLWH organization to function independent of sero-negative people. The interviewee believed that voiced opposition to moving too quickly was a result of worries that sero-negative people will lose their jobs as sero-positive people take over the management of HIV/AIDS programming in Yemen. Thus, although many of my interviewees envisioned the existence of organizations of and by solely PLWH, some interviewees felt that not everyone supported this. The establishment of such organizations, however, would meet global standards of commitment and progress and would reflect well on HIV/AIDS development programming in Yemen.

The existing structure of development and health workers dictating if and how PLWH should organize and function parallels the structure of international donors determining Yemeni HIV/AIDS programs as portrayed by a couple of my informants. One talked about how the Yemeni government does not have ownership over the programming:

*It’s the donor and international organizations work and the government is just coordinating for the donors and international organizations but they haven’t ownership. They... are not leading the process... it’s a global policy and not a specific policy for Yemen. I think the government of Yemen should develop a strategy for HIV-AIDS in Yemen by itself. In the meeting... they will talk to you about strategy but in reality, this strategy was developed by partners. It is developed by donors... So it’s developed for Yemen; it’s not specific for Yemen... Unless the government has the ownership to develop a strategy for HIV/AIDS, I think in eight to ten years there will be a big problem.*
This narrative situates HIV/AIDS programming initiatives in a similar position as PLWH in that both are being told what and how to do things by “outsiders” (people not Yemeni, or people not sero-positive). Another informant described similar concerns:

[International players] need to support and back people, not to lead them, because if we lead them today, they will fail tomorrow because they rely on us and this is happening - thirty years of international support, but different forms, from the leadership [of] the donors led... to people being reliable on [donors]... This is another thing I think.

This parallel structure of relationships and questions of agency and dependence highlight aspects of transnational governmentality. Some DWs in Yemen perceive international and national forces as defining and controlling HIV/AIDS programming. Similarly, such a dynamic possibly shapes the vision of progress for PLWH in Yemen and the power of sub-governmental institutions to structure how PLWH represent themselves, their needs and their desires. However, as the second quote suggests, if these structures have been in place for the last thirty years without a change, then how can anyone expect them to change? After systems are in place, how possible is it for people, be they DWs in Yemen or PLWH in local organizations, to redefine and reconfigure structures, identities and understandings to fit their own needs and circumstances? The structuring of national and local institutions by outside forces to resemble models considered successful in other contexts assumes either that these models will function independently once the external constructive supports are removed, or that an endless commitment and external pressure to perpetuate development models that do not necessarily meet the needs or desires of the people they address is needed. This predicament is built into the structures of the Global Fund, which requires that certain guidelines be followed, identities presumed, and institutions formed within a specific amount of time in order to retain financial...
support. Must it be a choice between the Global Funds’ visions of HIV/AIDS support mechanisms or nothing?

**The New AIDS Law: Codifying Identifications**

Law has a historic connection to public health in relation to infectious diseases. The act of quarantine has been used for centuries, and still is today, to try to limit the spread of infectious diseases such as tuberculosis and SARS. Countries, such as the United States, reserve the right to enforce quarantine and isolation on individuals and enact other health measures to safeguard the health and welfare of their populaces. Additionally, some countries, including Yemen and Saudi Arabia, restrict visas to HIV-positive individuals. The US and China just ended this restriction in 2010. UNAIDS and the United Nations Centre for Human Rights, however, issued guidelines in 1996 and 2006 outlining positive laws, or laws that permit or oblige action, with a focus on protecting human rights. These guidelines include unlinked surveillance testing and voluntary testing, with exceptions only by judicial authorization.\(^{123}\) This document is strongly reflected in Yemen’s new law for HIV, but there are some exceptions.

Throughout my fieldwork, almost every informant referred to a recent success of a new law addressing HIV, making Yemen the third country in the region after Djibouti and Sudan\(^ {124}\) to have passed into law protections around HIV/AIDS.\(^ {125}\) The new law provides many necessary protections for PLWH, including articles that prohibit employers from firing people from their

---


\(^{124}\) Al-Ariqi.

\(^{125}\) Yemen Parliament, Law to Protect the Community from HIV and AIDS and to Protect the Rights of People Living with HIV/AIDS (7 Dec 2009).
jobs on account of their HIV status,\textsuperscript{126} provide HIV positive children with the right to an education,\textsuperscript{127} and guard people’s rights to treatment\textsuperscript{128} and confidentiality.\textsuperscript{129} However, the law passed in parliament on August 29, 2009, is only structured to guard the rights of PLWH as long as those rights do not interfere with the state’s regulation of their bodies. Although most of it functions to guarantee the human rights of PLWH, it also stipulates the monitoring of all bodies with HIV by the state, in some cases through criminal law.

The bill requires in Article 17 that, upon initial diagnoses, the individual must go to the competent authorities or experts (al-	extit{jhaat al-mokhtasa}) to receive treatment (al-’alaaaj), counseling and awareness.\textsuperscript{130} The bill makes treatment mandatory, but defines neither what “treatment” must mean, nor does it specify the standards by which “competent authorities” are to be identified. Considering the existence of a treatment center at al-Iman University, this article does not force people who test positive for HIV necessarily to register with the National AIDS Program. Penalties for not complying with Article 17 are imprisonment for not more than six months or a fine of not less than 100,000 YER,\textsuperscript{131} which is approximately 480 USD,\textsuperscript{132} a large sum of money. The new law also states that premarital testing is mandatory.

A UNDP presentation given in Amman, Jordan, discusses the Yemeni law, pointing out that these two laws could not be changed, and thereby suggesting that the following laws were not desired or approved by UNDP:

- Pre-marital mandatory testing couldn’t be avoided.

\textsuperscript{126} Yemen Parliament, Article 6.
\textsuperscript{127} Yemen Parliament, Article 10.
\textsuperscript{128} Yemen Parliament, Article 17.
\textsuperscript{129} Yemen Parliament, Article 13.
\textsuperscript{130} Yemen Parliament, Article 17.
\textsuperscript{131} Yemen Parliament, Article 17.
\textsuperscript{132} Exchange rate (19 Apr 2010).
Obliging PLWH to receive treatment, support and awareness could not be changed but the need is to provide treatment and services, doctors are prone to withhold their care.\textsuperscript{133}

The presentation further emphasizes that it is difficult to reach perfect legislation and that they “have to avoid an all or none approach.”\textsuperscript{134} These laws, as UNDP recognizes, could be used to infringe on individuals’ human rights. It should, however, be pointed out that it is doubtful that the Yemeni government has the capacity at present to enforce pre-marital testing, and that the ambiguities around obligatory treatment do not necessitate registration with the NAP or ART. The use of criminal law in the bill, however, has a greater potential to endanger individuals’ human rights.

Along with possible punishments for neglecting to seek treatment, the bill stipulates that a person living with HIV should not do anything that could pass the virus to another person, and that the infection of another person with HIV can be subject to legal penalties. It does not stipulate whether or not the PLWH should be aware of their status for the law to be relevant. Whereas in the past PLWH could be imprisoned for having HIV, this new law stipulates the circumstances for which a person can be imprisoned for having HIV.

UNAIDS issued a policy brief in 2008 on the criminalization of HIV transmission, which urges lawmakers to avoid passing criminal law in relation to HIV, instead applying criminal laws in cases of intentional transmission.\textsuperscript{135} Yemen is certainly not the only state to pass such laws,

\textsuperscript{134} Ibid, slide 15.
as this brief was issued in response to laws formulated both inside and outside the United States.\textsuperscript{136} Furthermore, the brief asserts that the reasons advanced for criminalizing transmission are to punish harmful conduct and prevent HIV transmission. Yet, it insists that “except in the rare cases of intentional HIV transmission, applying criminal law to HIV transmission does not serve these two goals.”\textsuperscript{137} Indeed, the ambiguity of the Yemeni law holds the potential to persecute people unaware of their HIV status, or PLWH who engage in consensual acts with partners aware of the risks.

Many of my informants found the bill a victory, but worried that it would not be enforced. The board members of AID Association, an organization of PLWH, said that they were happy to have the bill and that their members had worked for three months to get it passed. When I asked how it will change things, members told me that “it will not change things, but it is good to talk about rights. Before, no one was talking about HIV, but now in Parliament, everyone knows.” They emphasized that many countries do not have a similar law, but unlike other DWs who stated this with pride, members of AID Organization explained that other countries do not have laws like this because they are not necessary in other countries: “This rule was necessary in Yemen because of lack of awareness.”

What is marketed as a law guaranteeing the rights of PLWH is actually, according to some people living with the virus, an exercise to increase awareness amongst political leaders and amongst the public in general. However, even though it is not certain if or how these articles will be enforced, the law itself can be interpreted as codifying adherence to the

\textsuperscript{137} UNAIDS, “Policy Brief,” 2.
formations of PLWH envisioned within development discourses. The law supports formation of such identifications in stipulations on testing, treatment, and the role of NAP to train PLWH to raise awareness about HIV among other PLWH and the community.¹³⁸

**Conclusion**

In this chapter I have traced how development discourses conceptualize the invisible and hidden through non-knowledge to qualify for international aid and comply with the restrictive uniform requirements of funding organizations. The definitions, interventions, and uniform goals and measurement apparatuses of the Global Fund and other international, bi-lateral and national agencies function on multiple levels to not only dictate identifications of target groups, but to limit and control the ways in which DWs themselves are able to envision HIV/AIDS, the bodies the virus inhabits, and the programs that address such bodies in Yemen. The formation of organizations to support people living with HIV have developed in a manner replicating the formation of development initiatives addressing HIV/AIDS in Yemen, with both assembled according to the expectations and importations of models instituted in different contexts and conditions. Finally, the new law to protect PLWH strengthens many rights of PLWH, while also potentially strengthening the state’s control over their bodies, which would make alternative identifications and actions outside those prescribed by development organizations and ministries difficult or even unlawful.

The individual living with HIV that emerges from development discourses in Yemen stands as a poster child for development and for Yemen, signifying commitment to democratic

¹³⁸ Yemen Parliament, Article 24.
principles of human rights, provision of health care, and social pluralities that have been interwoven into global conceptualizations around the disease. The achievements embodied by these individuals function to disguise the restrictions on how a person who tests positive for HIV is allowed to self-identify if he or she wants access to ART, to stay out of prison, or simply to keep his or her job. The following chapter considers these discursive constructions around HIV in Yemen within contexts of culture and religion.
Chapter III: Culture and Islam: Framing HIV/AIDS in Yemen

As discussed in the previous chapter, some DWs addressing HIV/AIDS in Yemen expressed concerns about the degree to which programming efforts have sufficiently and conceptually engaged in the unique aspects of how HIV/AIDS is understood and manifest in Yemeni society. When I asked DWs about what, if anything, made HIV/AIDS programming unique in Yemen, I received many different answers; some responded according to prevalence, stigma, institutional capabilities, and the early stages of programming that Yemen is enacting relative to other countries. Many others, Yemenis and non-Yemenis alike, outlined cultural and religious beliefs and practices and their potential connections to HIV/AIDS. Indeed, discussions of culture and religion frequently colored responses to other questions, particularly around prevalence, stigma, discrimination, and successful programming initiatives.

In this section I examine how different DWs frame cultural and religious attributes of the spread of HIV in Yemen. I also explore the manner in which the frame produced by HIV/AIDS programming in Yemen as discussed in Chapter II is bridged to Islam and Islamic practices. It is within these amplifications, extensions and transformations that I take into account a significant counter-discourse to HIV/AIDS in Sana’a, that of Sheikh Majed al-Zindani’s alleged treatment and cure for AIDS.

The last chapter considered knowledge production and the discursive formation of PLWH in Yemen as functions of transnational governmentality and as directed by international, national and local players. DWs are influenced by a wide-range of powers and players, including donors, politicians, religious figures, and each other. It is not within the scope of this paper to map, or even comprehend, every force that shapes the discourses of DWs, but by focusing on
culture and Islam, it is possible to consider how contestations around local contexts have the potential to shape development discourses of HIV/AIDS in Yemen.

Culture

In discussing Yemeni “culture,” my informants mostly spoke about shared belief systems, social practices, and religion. The boundary between “culture” and “Islam” was manifest as fluid and porous in many conversations I had with DWs. One informant expressed that “traditional cultural norms... are very linked to traditional Islamic norms... the two cannot really be pulled apart.” Nonetheless, in this section I concentrate on social practices of gender segregation and qat-chewing as predominantly cultural practices because my informants defined them as part of the cultural context of Yemen (rather than specifically part of the religious context).

Informants depicted Yemeni culture as both helping and hindering HIV/AIDS programming in Yemen. In general, various DWs connected HIV/AIDS awareness projects to more general development concepts, especially issues of gender and sex-segregation. While emphasis on gender inequalities are standard components of global HIV/AIDS development discourses, the degree of gender inequalities in Yemen, measured by UN and other international agencies, is one of the most severe in the world. This framework connecting HIV/AIDS efforts to one of Yemen’s most highlighted and discussed “development challenges”

as portrayed by international organizations and international media\textsuperscript{140} is thereby necessary and unavoidable in development discourses.

In this vein, one of my informants expressed concern about expectations for women to discuss sex and negotiate condom usage with their husbands:

\textit{The early education of girls - and maybe this is the Arab context and not just the Yemeni context – is that they’re always asking girls... to discuss and negotiate for other issues. But she is a young girl! She can’t ask. This is aib [shameful]. You can’t ask. Because her mother has also grown up this way. The mother didn’t ask to negotiate issues, and she reflects the upbringing she had as a girl onto her daughter. Maybe this is the culture that... continues from one generation to another. Of course it’s hugely improved now in society and it is not like before, but still we are talking about girls in rural areas, not in the main areas, not in Sanaa, not in the main cities... Young women or young girls, what do you expect?}

This DW is at once situating girls’ empowerment as an issue relevant to HIV/AIDS, and arguing that conventional approaches to HIV/AIDS work with females are inappropriate and ineffectual in Yemen. Records of people who have tested positive for HIV in Yemen show more males than females.\textsuperscript{141} That fact, combined with the lack of information about HIV prevalence in rural areas suggests that the connection between girls’ empowerment and HIV/AIDS is cemented by non-knowledge. Yet, the connection the speaker makes declares that: 1) to address HIV/AIDS in


\textsuperscript{141} Reports of known cases of HIV in Yemen from 1987 – 2009 show 34% females, 62% males, and 4% not documented: UNGASS, 2.
Yemen, work must focus in part on girls’ empowerment; 2) therefore, support for HIV/AIDS projects will mean support of girls’ empowerment; 3) generic approaches will not work; rather, people creating and implementing programming should understand the cultural context, i.e. should be Yemeni. Furthermore, international concerns for gender equality can add resonance to this narrative.

Another interviewee explicitly mentioned women’s lack of empowerment as an impediment to the prevention of AIDS. While the former is Yemeni, the latter is an international worker, neither Arab nor Muslim, working in Yemen. The foreigner framed the subject in a slightly different manner, using broad statements like “Women are very simple. They don’t go out of the home. Men are the ones going out and infecting their wives... If someone has been infected, women may not talk with the men due to the inequality between them. The man is dominating.” The generality of these statements exemplifies sweeping summaries of “third world women” often found in HIV/AIDS development discourses. By not specifying, unlike the former interviewee, how gender inequalities can manifest in manners unique to Yemeni or Arab culture, the latter informant contradicts the previous DW’s call for Yemeni expertise, thus legitimizing contributions of international experts in facing the intersection of gender inequalities and HIV in Yemen.

In addition to couching claims to expertise within narratives on culture, interviewees also offered essentialized discussions of Yemeni culture. Three people, all Yemeni and all working for different organizations made very general statements indicating that Yemeni

---

142 Epstein, 94; Craddock, 163.
culture and Yemeni people possessed certain knowledge and viewpoints that were a benefit to addressing HIV/AIDS. The first informant is the same Yemeni from the previous narrative:

"I know the cultural and social context for Yemen. I know my society and my people. And I know how they are very simple and very sociable when you come to them in a clear, simple way... You have to listen to them. So... I know my people. So social and cultural context is very important to them."

This DW stresses that Yemenis will be open to learning about HIV/AIDS and, by extension, Yemeni society and culture is not closed and static. Another informant said the following:

"Yemen is a great country. Really, there is a great culture here in Yemen. We can do a lot of things in Yemen. People they can understand [ideas] easily here. When I went to Morocco, to Algeria, they are doing very well with their [HIV] patients. But I feel like in Yemen also, we can do better than these situations [in other Arab countries]. If you are asking people [to listen], you will get a good response."

Again, the informant emphasized how Yemeni culture and society are peopled by individuals who “can understand,” who are smart and open to dialogue, learning, and helping others.

Finally, the third informant situated HIV/AIDS work within a framework that encompassed general development and security, funding and group characteristics of Yemenis, stating that:

"I think we need to address these issues through dialogue and through development work... wise people live everywhere in Yemen. This is my feeling and I am optimistic. Also [we need] support from friends without conditions."

All three of these informants outlined severe obstacles and challenges to HIV/AIDS programming in Yemen, but also generalized about the capacities and willingness of Yemenis to address HIV/AIDS and the development issues surrounding such programming. These explanations were all directed at me, a foreigner who came to Yemen to question DWs about their understandings and opinions of HIV/AIDS programming, thus are at least in part assurances of local capacities. However, their mutual impetus to offer testimonies to the

---

143 This interview took place in Yemen at the beginning of January 2010, during which time there were frequent conflicts in the north between the government and supports of al-Houthi, separatist demonstrations in the south that often resulted in violence, as well as the closing of the US, British, French embassies and Japanese consulate and restricted services at the Spanish embassy because of threats from al-Qaeda in the Arabian Peninsula. See “Embassies Shut after ‘Yemen Lost Track of Arms Truck,” BBC News, 4 Jan 2010, available from [http://news.bbc.co.uk/2/hi/8439892.stm](http://news.bbc.co.uk/2/hi/8439892.stm); Accessed 25 Mar 2010.
attributes of Yemeni culture points to the political structures within which they operate. An assumed need to posit sweeping statements about Yemeni culture suggests the existence of counter-narratives that reflect negatively on the abilities of Yemeni culture to adapt to realities of HIV, and in doing so, calls into question the abilities of Yemeni DWs to effectively implement HIV/AIDS programming. The final sentence in the last narrative calls for funding “from friends without conditions,” emphasizing a desire for more agency and independence which would allow for the Yemeni government and Yemeni DWs to meet their needs as they see fit.

On the other side of the spectrum, other DWs depicted Yemeni culture in negative terms and as an object that development projects must correct and modernize. For example, one foreign informant described Yemeni culture and society to me in terms of strict adherence to physical punishments outlined in Shari’a law, citing that “Few people get a good quality education. Here most people are educated in religious schools. If a man has sex apart from his wife, [Yemenis think that] both should be stoned to death.” After explaining that people in Yemen refused to admit that HIV existed, this individual commented that “societies which are not evolved tend to behave like this.” Such a framing of Yemeni culture and HIV is similar to the more positive cultural characterization above because they both essentialize culture and, in doing so, simplify its links to development. Contested conceptualizations of Yemeni culture factor directly in imaginings of what the best programming, and who the best experts, for HIV/AIDS could be in Yemen.

Another element of culture that informants articulated as relevant to HIV/AIDS in Yemen was the segregation of sexes. The idea, which is also reflected in development literature about HIV/AIDS and the Arab world, was discussed by one foreign informant as containing both
positive and negative possibilities in relation to what are considered risk behaviors in the
spread of HIV:

I say that the youth are not very vulnerable like the rest of the world. It is just because here culture plays a
role in preserving virginity, and the preservation of virginity is very important in this part of the world. And
unless you want to die, you should not attempt (laugh)... I think that it is key in protection from HIV. But
because of that... the men don't have... access to the female population. That leaves them again more
vulnerable to having sex with other men. And because of the culture, men being together and women
being separate and locked up... [men having sex with men] becomes very easy I would say. Because if you
are moving with men in a group... the police will never mind about you.

The informant’s characterization of sex segregation as both positive and negative allows for
ambivalence in addressing Yemeni culture. This ambivalence demonstrates that Yemeni culture
contains positive elements that are already compatible with this individual’s framework for
addressing HIV/AIDS in Yemen. It was not clear from the interview whether the informant
understands the segregation of sexes as actively encouraging sex between men, or only
providing a safe environment for such encounters. Nevertheless, the segregation of sexes is
portrayed as a protection against HIV for women and a potentially risky social structure for
men.

Many informants articulated anecdotes of fishermen having sex with each other, but
this concern with MSM focuses on males belonging to a specific occupation, whereas the
narrative about sex segregation and the risks created for men implicates any male member of
society. Even though the informant specified later during our interview that only a small
percentage of Yemeni men would probably engage in same-sex relations, nonetheless the
narrative directly connects Yemeni cultural norms of sex segregation to MSM.

This informant’s conceptualization of sex segregation and MSM, as well as the silence of
other informants on MSM in particular, point to ambiguities in Yemen surrounding MSM and its
links to HIV. As suggested in the previous chapter, the poorly-defined notion of MSM within
HIV/AIDS programming in Yemen leads to a general inclination for most DWs to employ categories of risk and vulnerable groups that are easier to classify by occupational or economic factors. The most salient element of the above narrative is that this non-Yemeni informant conceives of culture as facilitating or encouraging, rather than forbidding, same-sex relations. This narrative is in contrast with the general silences of DWs in relation to imaginings of how and where MSM exist as part of quotidian Yemeni society. Regardless of the degree to which this narrative corresponds or does not correspond to how MSM in Yemen may understand their own realities, it exceeds most DW’s declarations of the existence of MSM by contemplating how MSM negotiate cultural norms in Yemen. In doing this, the relevance of targeting MSM for interventions, and thus the narrator’s presence in Yemen, is reinforced. Moreover, it designates sex segregation as potentially harmful to men because it not only opens a space for perceived risky behavior, but its ability to render same-sex relations invisible potentially hinders DWs from locating and identifying MSM.

The same informant who linked sex segregation to same-sex practices went on to also identify qat as an impetus for same-sex sexual relations, saying that “this congregation and eating qat together... also ... promotes such behavior, like men having sex with men because they are together... again, not all groups will do that.” A different informant, again someone who is not Yemeni, related similar ideas but linked the effects of qat to the situation:

But qat seems to reduce inhibitions. The small sense of euphoria, the small high increases the possibilities of risky behavior. I have read development workers talking about, particularly amongst adolescents and young men who don't have access to much income but do [have access] to qat - because practically every male in Yemen chews qat – [but these young men], because of cultural [structures] don't have access to women, and through qat chewing may engage in risky behavior with their fellow adolescent males. This is all quite anecdotal stuff. I haven't really read much stuff about it. So there is a potential link between qat and the cultural phenomenon of qat chewing and increased risky behavior.
As this interviewee states, there is no documented scientific link between qat and sexual arousal. Other Yemeni and non-Yemeni informants addressed the potential role of qat as related to HIV/AIDS in Yemen, but most of them pointed to positive potentials. Two people said that it probably played a protective role in that people chose qat instead of injection drugs or alcohol. One compared qat to alcohol, saying that when consuming alcohol, men might choose to go to discotheques to find women, whereas when most men are done chewing qat they go home. Another informant pointed to the practice of information-sharing that takes place at qat chews, and the National Population Council has produced ashtrays with HIV/AIDS awareness slogans on them in order to potentially facilitate conversations about HIV during qat chews.

Overall, most DWs emphasized that studies have not been directed towards determining connections between qat-chewing and risky behaviors and, while informants articulated the folk claim that one effect of qat is an increased libido, they downplay the potential significance of qat in the spread of HIV. That said, the significance of qat in Yemeni culture and society is highly contested both nationally and internationally. Many people criticize qat for cutting down on productivity, wasting money, negatively impacting health, and using deteriorating water reserves. Others point out that the qat trade is responsible for a large part of the economy, keeps jobs in rural areas, and is important for civil and political society. Foreigners often fetishize the chewing of qat in tourist photos and travelogues. Descriptions of Yemen are also quick to link qat to all of Yemen’s challenges, and invoke the narcotic quality of

qat to undermine the legitimacy of Yemeni government policies and decisions. The diverse ways of conceptualizing qat and its roles in Yemeni culture and society potentially color the ways in which it can be associated with HIV/AIDS. It is possible that people who are not familiar with qat or its effects might conflate its significance in relation to HIV/AIDS. In a similar vein, one Yemeni DW had very strong feelings about qat and spoke about plans to organize a campaign in Yemen against it. This individual hypothesized a causal relationship between qat and the spread of HIV/AIDS, drug use, alcohol use, depression, harassment, and possibly the high birth rate in Yemen:

**DW:** This is what we want to do - to study this link between HIV/AIDS and qat because qat is related to poverty and poverty is related to HIV/AIDS. This is one of the problems - qat is changing the behavior of the people, which means the people... think... [qat is part of their] culture, but the one who has qat... can be more active sexually and... they will try to seek [sexual activity] after qat. Also qat is related now to tablet drugs... of course I can't say scientifically, but this is what we notice. It appears [with] a lot of people. They take tablets like... Valium... with qat. Some people use alcohol with qat. And of course with alcohol, they will try to have sex with anyone. Also, qat is changing the behavior of people. That means after they chew qat, in the beginning they start to be very active; they are talking, thinking, and then they go to the silent period... After the silent period they start to be depressed. And if you have this changing your behavior, that means you are not okay. That means you can do behavior negatively which can be harassment...

**Me:** And that's from the depression?

**DW:** Yeah, this is one thing. The other thing is that the one who is chewing qat, he cannot sleep. That means, if you don't sleep - this is what was during the second world war in German: they saw that the birth rate was rapidly increasing and it was because of electricity.

**Me:** Because of the electricity?

---

DW: Yes, there was no TV .. no other entertainment. That means the people they slept together. And I think the same [thing happens] with people who chew qat because they don’t sleep. So they think about many other things.

This extensive quotation illustrates this individual’s negative characterization of qat more than any tenable connections between HIV/AIDS and the plant. Both foreigners and Yemenis often have strong opinions, suspicions, and beliefs about qat, and these emotive forces surrounding a highly contested traditional practice in which a majority of Yemenis participate are bound to manifest themselves in different ways. Thus, discursive connections of qat to HIV could speak more to an individual’s framing of qat than to HIV as a central concern. Nevertheless, discourses connecting qat to HIV can potentially affect programming initiatives targeting either. At the point of my field research, though, qat sessions were used as spaces for peer educators to introduce the topic of HIV, which speaks more to the importance of qat chews in community dialogue and information sharing than to the physical effects of qat itself.

Islam: Competing Discourses around HIV

The initiative that most of my informants cited as being the most successful and “powerful” program addressing HIV/AIDS in Yemen is the incorporation of imams and moshadaat into programming. This approach is part of a global trend to integrate religious leaders and Faith-Based Organizations (FBOs) into the work of development initiatives, many

---

to positive results. Incorporating religious leaders serves to contextualize HIV/AIDS programming into local norms and discourses. In my discussions with DWs in Yemen, their discussions of Islam mostly addressed the role of Yemenis’ perceptions of Islam in both creating and, through the program with religious leaders, offsetting stigma.

While the scope of this paper is not wide enough to examine how DWs and religious leaders worked together to link HIV/AIDS and Islamic discourses in Yemen, it is clear from my informants that, in references to Islam, they are referring to discursive connections made between shared community beliefs and lived practices. Thus, the terms “Islam,” “Islamic” and “Muslim” are used here to refer to collective identities and shared understandings as interpreted by my informants and other Yemenis. Therefore, the signifier “Islam” can refer here to a multitude of fluid and divergent concepts. The aim of this discussion, however, is not to define these terms but to understand how different people are framing development agendas as they relate to religious discourses.

Most of my informants connected Islam to stigma around HIV and discrimination towards PLWH, and particularly towards women living with HIV. One international informant explained the connection between risk and stigma as follows:

>In Yemen,] there is little risk perception... there is an attitude of denial. They are not even concerned that they are at risk. They believe that they are in an Islamic state. They live according to Islamic teaching. They deny even the existence of promiscuous sexual activities. They relate...HIV to sexual activities, and they

believe that they are living according to Islamic teaching and [therefore] they are safe. They believe [HIV] is not their concern.

This particular narrative is an extreme example of ways in which some DWs essentialize Yemeni attitudes to HIV and Islam. However, varying degrees of this particular discourse are widespread amongst both Yemeni and foreign DWs. The strategy, inherently connected to these discursive connections, becomes making HIV a concern of Yemeni people.

In order to integrate HIV/AIDS into people’s perceptions as a reality of their own social landscape, it is necessary to transform the dominant social discourse of Islam and HIV. Programming with religious leaders thus targets the people who form the discourse. One informant explained that the goal is to make “religious [leaders] stakeholders and make the religious people part of the process; convert them.”\(^{148}\) Marriam-Webster’s first definition of “convert” reads “to bring over from one belief, view, or party to another.”\(^{149}\) The idea of conversion reinforces the action of actually changing beliefs and, in making religious leaders “part of the process,” shaping Islamic discourses to suite the objectives of DWs. In some respects it can be understood as making religious leaders DWs and, as such, agents of global health.

Another informant compared the presentation of HIV grounded in a religious discourse with one grounded in a scientific one:

> If you get imams and moshidat to be engaging with HIV AIDS issues... it gives an official face to dealing with the problem in a compassionate and open way. That is a very different approach than Mr. X. from WHO coming in and talking to you about HIV and AIDS from a very academic or scientific kind of background. We are trying to highlight text from the Koran that talk about compassion. [The religious leaders] talk about care and making the link between that and being a good Muslim...

\(^{148}\) Italics mine.

The information and ideas about HIV are communicated by an Islamic leader and are aligned to a message about how to be a good Muslim. According to this informant, presenting HIV as the concern of international DWs is not as effective. An Islamic discourse is co-opted and utilized to change how Yemenis understand HIV and how they treat people living with HIV. The idea is that by changing one’s mentality and behavior towards HIV and PLWH, one reaffirms and reinforces a self-identification of being a “good Muslim.” Such a method is not new, but becomes particularly relevant when seen in relation to the other predominant discourse around HIV/AIDS in Yemen, examined in the next section, which is also couched in an Islamic framework. Furthermore, within the overarching development discourse in Yemen, there are divergent narratives surrounding Islam, stigma, and identification.

As the previous chapter discussed, DWs are engaging in a discursive project to call upon Yemenis who have contracted HIV to identify themselves as such to the state and to conform to outlined self-representations, such as FSW or MSM, which contain moral markers. At the same time, DWs are framing a discourse that categorizes HIV as a health problem, as opposed to a morality problem. One informant told me that “what I like in [religious leaders’] message is that we should address [PLWH] as sick people. We don't care how they’ve been infected from a sexual relation. It is not our problem. [Our] problem is that we have sick people and to respect them.” Another DW explained that “Even in our holy Koran it is mentioned: AIDS is like hepatitis. It's like diabetes. It's a disease [by which] anyone can be infected...” Thus, religious leaders encourage people not to be concerned about how a person got infected, but instead to focus on his or her identification as a patient, as a person who suffers from an illness. The utilization of religious leaders to categorize HIV as a health issue has the potential to contradict
or conflict with efforts to put at-risk folks into categories that, in Yemen, can ultimately be read as moral – or passing moral judgment – about sex and deviant sexual relations.

This approach of engaging religious leaders and concepts is understood by a number of people I interviewed as walking a line between supporting and emphasizing a specific framing of HIV by religious leaders, and suppressing other potential viewpoints religious leaders could offer in relation to HIV, and particularly around risk behaviors. This dilemma is neither new nor unique to Yemen or Islam. A UNFPA report articulates one of the tensions religious leaders face in working on HIV/AIDS initiatives:

> What they are confronted with is a basic moral dilemma: in terms of what it is that religious leaders are supporting and fighting for. Are they promoting a culture of permissiveness or an environment of spirituality when they fight to eliminate stigma and discrimination and provide universal access?  

DWs in Yemen reported varying degrees of acceptance of the discourse proffered to religious leaders. For example, some imams accepted the use of condoms to prevent the transmission of HIV, but most informants said that the majority of religious and political leaders viewed condoms as encouraging “illegal relations.” One informant explained it thus:

> I think it is very difficult for most religious leaders to find a way to support unequivocally programming for HIV. I think many of them will... support access for treatment and prevention of stigma and harassment, but I think, like we said, the behaviors are haram... and how do you get around that? Well, it’s not as if they’re going to open their arms and say “well MSM are people and ...” I don’t see that happening.

This space of contradiction between multiple and divergent Islamic discourses around HIV in Yemen becomes more visible in a story related to me by one DW. This individual spoke about a campaign to “change the behavior of pharmacy workers” in how they marketed and sold condoms. According to this person, pharmacists typically ask customers seeking to buy

---

condoms whether they intended to use the condoms for family planning or illegal relations as a way of limiting immoral behavior. The campaign was aimed at changing the behaviors of pharmacists in order to facilitate the availability of condoms. Religious leaders took part in the campaign and, according to my informant, used the following story about the life of the prophet to encourage pharmacists to change this practice:

Someone came to the Prophet Mohammed and said, “I had an illegal relation.” [The prophet] said “Maybe you kissed [her] cheek.” He said “No, I had an illegal relation.” He said “Maybe you hugged her.” So [the prophet] gave him many excuses and he wanted to prove to him that if he did something like this, [you] should not talk with anyone... you should keep silent... and it’s not our business in the end... to learn what people are doing.

The message in the story to pharmacists was to not ask customers how they would use condoms purchased because it is not their business. This story was followed by reasoning that if people are going to have unsanctioned relations, then at least they can use condoms to try to prevent additional harm from such encounters.

Efforts to engage religious leaders in HIV/AIDS programs seek to remove stigma and blame from PLWH and identify PLWH as patients, rather than deviants. However, as many of my informants have suggested, the definition of someone living with HIV and someone who has practiced illegal behaviors are often collapsed upon each other. Thus hiding one’s positive status is the only way to guard one’s status as a good Muslim. Even the previous narrative told about the prophet encourages such silences. To consciously practice Islam as conceptualized by this example, one should keep silent. This exposes a gap in the development discourse around HIV: there are many ways to demonstrate and affirm that one is a good Muslim in relation to people living with HIV, but how does an individual living with HIV affirm his or her social and self-identification as a good Muslim? The most dominant alternative discourse in Yemen, and particularly in Sana’a, offers a resolution to this predicament.
Counterframing HIV: How Prophetic Medicine Shapes Development Discourses and Initiatives

Sheikh Abdul Majid al-Zindani is a well-known political and religious figure in and outside of Yemen. He founded the Institute for the Scientific Inimitability of the Quran and Sunnah, which was based at King Abd al-Aziz University in Jeddah in the 1980s. He additionally established and leads al-Iman University in Sana’a and is head of the consultative council for Islah, the main Yemeni Islamic political party. He is widely known and respected throughout Yemen. However, Sheikh al-Zindani was named by the US as a "specially designated global terrorist" in 2004 for ties to Bin Laden in the 1980s, and President Saleh has publicly defended him saying: "Sheikh al-Zindani is a rational, balanced and moderate man and we know him well, and the Yemeni government guarantees [his actions], and I guarantee his character."152

Al-Zindani also opened a treatment center for AIDS patients in Sana’a in 2005, and announced at a World AIDS Day event at Sana’a University in 2006 that he had discovered a cure for AIDS. One of my informants described al-Zindani’s proclamation as follows:

Normally, we have a celebration or official day for HIV in December. In 2006, as I told you, we organized it at the University... and then without invitation, [al-Zindani] came. The minister started talking and [al-Zindani] interrupted and he said that he could help. I didn't like the way he behaved at that time, because we didn't invite him.

Al-Zindani therefore not only contested the development discourse for HIV/AIDS treatment by offering an alternative narrative, but presented his alternative treatment at a NAP event,

thereby co-opting the legitimacy of the National AIDS Program, and by extension the Yemeni government, the Global Fund, the UN agencies and all other organizations in participation that day. Al-Zindani made further legitimacy-claims in suggesting that an American doctor had substantiated his claims, and later that “the medication’s effectiveness has been tested by a specialized medical team at King Abdul Aziz University and in US Marine labs.” In both legitimacy-claims, al-Zindani relied on medical experts from the United States to substantiate the efficacy of his herbal treatment. Yet, in pointing to the US, al-Zindani is at once offering the most substantive demonstration of legitimacy possible in gaining supposed verification from a national system that had labeled him as a terrorist, but also subverting the paradigm that locates the West as the most medically advanced and scientifically industrious region. As an academic who has concentrated years linking science to Islam, al-Zindani also, in claiming a cure for HIV/AIDS, effectively collapsed binaries associated with science/religion like West/Arab world and traditional/modern. In announcing a curative treatment for HIV, al-Zindani presented a plethora of redefinitions. The human immune deficiency virus went from deadly or chronic to curable. Yemen became a site for medical tourism with HIV positive people, particularly Muslims, coming to al-Iman University’s treatment clinic. Al-Zindani became a healer and humanitarian. Islam becomes a central element to HIV/AIDS treatment.

The dialectic between al-Zindani’s discourse around HIV/AIDS and those of DWs’ is primarily and ostensibly one of scientific proof. Given al-Zindani’s stature in Yemen and in the region, my informants generally avoided saying a lot about his treatment, but almost everyone I

155 Ghaleb, “Controversial Sheikh.”
asked stressed that there is no proof. Al-Zindani portends that his herbal cure is derived from a haddith that he will not share with the public until the drug has been legally registered and has received a patent.\textsuperscript{157} That makes the treatment only available to people who go to al-Iman University for each dosage. The medicine for HIV, which my informants who had followed the treatment in the past described as “coffee and spices and soda,” is the same medicine and dosage as those for diabetes and hepatitis. The treatment for cancer is the same herbal mix, but the doses are increased. One Yemeni informant expressed his concern and frustration with the al-Zindani’s treatment thus:

\textit{We heard a lot of this. I mean medicine, if you discover medicine or a treatment you need to go to the scientific institutions to test it [so they can] let you know if you are doing this the right way or not... Nobody knows what’s happening and you know, if you need to benefit from this medicine you need to go [to al-Imam University] to take the medicine there. They won’t give you any medicine... so you don't know what’s in it. That is my humble answer. I cannot trust these things with. I mean, he should apply a scientific approach to test and to make sure [the medicine works]...}

\textit{And I heard one story from a Saudi doctor [about a man who] found himself HIV positive, and he heard about this sheik. He visited him and [al-Zindani] gave him [medicine] for a while... and finally al-Zindani told him that you are fine. Now, you can live a normal life with your wife and you can do whatever and the guy did because this is a sheikh and he got what he was looking for. And he trusted him. Then after a few years, the guy had been again to Saudi Arabia and they did a test... and they told him you are HIV positive. He said, “I am already from [al-Zindani] and he told me that I am fine,” ... and he they said no. You are not well...}

\textit{And [al-Zindani] was talking about charitable work. Why doesn't he share it? I mean, ask some international experts to come if he's really willing to help.}

This informant emphasizes the need for scientific proof and relates an anecdote suggesting that al-Zindani’s treatment could mislead people, keep them away from ART, and facilitate the spread of the virus to others. It is important to note that this informant did not directly criticize the Sheikh himself, but rather quoted the opinion of another person. A non-Yemeni DW had learned the following from PLWH:

The treatment didn’t result in any improvement even after a long term use. Most of them will just waste their money and time coming from a different places - even from abroad. They mention the history of some of PLWH they knew who died at an early stage of illness, while receiving treatment at al-Iman University, before the launch of ART in Yemen a few years back. Most PLWH stop the treatment with Sheik al-Zindani when they start medical care and support and get more information through attending workshops on how to lead positive lives with the virus. They witness that PLWH on ART live longer than those on Sheik al-Zindani’s treatment at the university.

The same DW said that in trainings,

*We are not encouraging people to go to Sheik al-Zindani’s center for treatment. We are informing them that there is no curative treatment for HIV, and instead we encourage them to seek medical follow-up and ART treatment based on their conditions. So we are discouraging it; even the relevant government offices NAP and NPC are also promoting medical care and support and discouraging the attempt for herbal curative with Sheik Al-Zindani.*

Thus, according to these two informants, DWs addressing HIV/AIDS generally discourage people from seeking treatment at al-Iman University, which directly challenges the validity of al-Zindani’s discourse. Whereas al-Zindani allowed space for the overlap and coexistence of his and developmental frameworks conceptualizing HIV, the general development narratives in Yemen dismiss al-Zindani’s treatment and, in doing so, discursively signify his treatment as false and in opposition to ART treatment. Development discourses endorse the binaries that al-Zindani discursively problematizes by favoring science to Islam, Western experts to Yemeni sheikhs, and global medicine to herbal treatments.

*Both the development institutions and al-Zindani’s frameworks utilize Islam, but in significantly different manners. In contrast to the former, al-Zindani’s narrative does not call upon people to self-identify or categorize themselves by an illness or any behavior associated with an illness, such as behavior structured around acts deemed Islamically and socially immoral. Since the same treatment is used for a number of illnesses, it is never necessary to reveal one’s status. The situation appears similar to the ideal emphasized by DWs to religious leaders: treating PLWH as people who are sick, as with any other illness. If no one has to*
declare his or her HIV status, then the collapse of the differentiations between HIV-positive and deviant never takes place. On the contrary, the identification activated by getting treatment at al-Iman is the categorization of being Muslim and of having faith in prophetic medicine and the sheikh.

Al-Iman University then becomes a space where people who have tested positive for HIV can congregate without accepting the categorization as deviant that society might give or the identification as a MARP and/or PLWH that the health and development industries offer. In this space, they are Muslims who are sick. Most of the members of AID Organization started health-seeking treatment at al-Iman, and now some members go to al-Iman to talk to people about HIV and ART. Al-Iman becomes an extra step in the PLWH identification process, attracting people with a promise of anonymity and in some respects reinforcing, rather than questioning, their piety. Al-Iman University offers treatment for HIV to foreigners and non-Muslims and is free for everyone,158 and the Sheikh's influence in Yemen as a political leader and spiritual guide are irrefutable.159 It brings people who are aware of their status but who, for whatever reasons, do not want to register as positive at a government institution, into a safe space where they can learn about more options. Members of AID organization who go to al-Iman to tell people about ART told me that “everyone says they have hepatitis C” instead of HIV. One member explained that “they are afraid of each other.” Another said that when AID

members ask people to come with them to NAP, people often think they are trying to bring them to jail.

In addition to locating people living with HIV at al-Iman University, development programs have also adapted a health worker training initiative to target the hospital and mosques near al-Iman because the university’s presence draws people living with HIV. While al-Zindani tried to frame his own discourse within that of development organizations, development organizations emphasize the distinction between ART and al-Zindani’s treatment. Yet, at the same time development initiatives react to and interact with al-Zindani’s alternative narrative as seen in programming decisions and initiatives which specifically use the spaces he has created for outreach and targeting.

Furthermore, when approaching people in spaces belonging to al-Iman, or people who ascribe to al-Zindani’s narrative, DWs rarely related directly contradicting al-Zindani. The inability of DWs to openly declare negative opinions of al-Zindani’s claims of a cure suggests that DWs in Yemen operate within a hegemonic political structure of Islamic discourse. Within such a structure, al-Zindani’s Islamic expertise renders his own treatment as unquestionable, thereby limiting development discourses. To contradict al-Zindani’s expertise would undermine the legitimacy of development discourses. Al-Zindani’s cure can be understood, and indeed celebrated, as a Yemeni and, moreover, Islamic solution to HIV. To question the legitimacy of the treatment of al-Zindani could be interpreted among some as questioning the authority and legitimacy of Islam. This is particularly resonant in the either-or framework of HIV treatment, supported by DWs, of “Western” global health expertise v. Yemeni Islamic natural treatment. However, understood as a local or regional node of hegemony, al-Zindani’s narratives can be
understood as seeking to incorporate the contesting discourse of development towards HIV into his own realm of influence. Understood in this context, al-Zindani’s cure also operationalizes a process of medicalization; people with HIV are abstracted from realities, such as practical needs to live and work outside of Sana’a, or the circumstances under which they contracted and must live with HIV, when on his treatment.

Yet, although members of AID Organization contested the effectiveness of al-Zindani’s narrative, they do not necessarily compel individuals to choose ART or the herbal treatment. Rather, ART and al-Zindani’s medicine are options that can be accepted or rejected independently. Some people chose to take both treatments. One AID member explained that “For 1.5 years I took [al-Zindani’s] medicine. After I went to NAP. Some people did get good results from the sheikh. If [a member of AID] sees them at Iman University - if someone is there from AID organization, he will ask the other AID member to please stop going to the university for treatment.” Thus, members of AID claimed that some people benefitted from al-Zindani’s treatment, while also claiming that many people died on his treatment. One member concluded that “Some [people] do both; if you’re not sure, you can do both [treatments].” At the same time, one member claimed that AID organization members discourage each other from seeking treatment at al-Iman.

What is more, one informant explained that people at the NAP have said that they have noticed that people who take both treatments do better than people who are only following ART. This individual’s stance was that PLWH are suffering, and there are no side effects from [al-Zindani’s] treatment... Some people [in international development organizations] are opposing the treatment. That means that [PLWH] are losing treatment from the program... There is no evidence that it is curative, as Zindani says [it is], but why not?
This informant offered that international development organizations might discourage al-Zindani’s treatment for fear the combination of medications could affect ART.

Not scientifically verified and outside the realm of conventional medicine, al-Zindani’s treatment could be defined as complimentary or alternative medicine (CAM). The efficacy and importance of CAM has been recognized more and more internationally, and efforts have been made to incorporate CAM with ART in other countries.\textsuperscript{160} Thus, the possibility of combining ART with al-Zindani’s treatment is, from a medical point of view, reasonable. The potential barrier to acknowledging such a partnership, however, lies much more in the politics to which development discourses are attached. Al-Zindani’s label as a terrorist in the US could prevent public imaginings of how ART and CAM, two opposing but overlapping discourses, could combine to better treat Yemenis living with HIV.

Two of the most dominant general discourses in Sana’a around HIV/AIDS interact with and react to each other in ways that work to increase awareness amongst PLWH of both programs. Al-Zindani’s treatment contests significant aspects of general development discourse in Yemen around HIV/AIDS, and some informants framed al-Zindani’s treatment as dangerous and misleading. Yet, it is also arguable that al-Zindani’s herbal “cure” facilitated HIV/AIDS treatment programs in general by opening up space for people who tested positive for HIV to occupy outside the gaze of the state. Moreover, as Gregory Johnson points out, the fact that the Sheikh acknowledges the existence of HIV and “refuses to ignore the problem, unlike many that argue that Muslims do not contract the disease,”\textsuperscript{161} already plays an important role.

\textsuperscript{161} Johnson.
Conclusion

Development discourses in Yemen must continuously negotiate aspects of society considered traditional, cultural, and/or religious. The manners in which DWs narrate HIV/AIDS within the contexts of these social elements hold practical and political ramifications. Discourses of culture and religion both shape HIV/AIDS development programming and are shaped by it.

These factors become particularly relevant in considering the role of Sheikh Abdul Majid al-Zindani in relation to HIV/AIDS development initiatives in Yemen. While development narratives have sought to set a discursive distance between themselves and al-Zindani, development practices began to occupy physical spaces next to and surrounding al-Iman University, al-Zindani’s place of practice. The silence and discouragement projected by DWs concerning al-Zindani’s treatment are contradicted by development actions and practices. What development discourses construct as a hindrance manifests as a help in both locating PLWH and drawing attention to the existence of HIV. Furthermore, while it is known that some PLWH subscribe to both discourses, and therefore are concurrently on both treatments, some DWs may quietly support both as well.

The ambiguous and non-judgmental space that al-Iman opens to PLWH, and the religious and community affirmations offered by the treatment, should not be ignored by DWs. However, given the intensely political nature of development work and HIV, perhaps silence and quiet acceptance are the few positions that DWs can assume within the present structures of transnational development governmentality.
Conclusion

I undertook this project to investigate how HIV/AIDS development work was being discursively shaped and manifest in Yemen, particularly amongst other development challenges and demands. The period and scope of my research was limited. My conclusions are based on discourse analysis and my interpretations of this discourse are based on my own position vis-à-vis this discourse, rather than an assessment of actual practices and programs. In presenting my analysis, I do not give suggestions or propose policy. Instead, I question some of the categories, processes and structures that people come to accept as normal.

Through the course of my research, I came to see patterns in how many informants conceptualized the aims of HIV/AIDS work in Yemen, particularly in trying to meet global programming ideals and country indicators. While the entire process deserves examination, I especially question the adaption of global categories of most-at-risk populations given the lived realities of vulnerable Yemeni citizens and the implications of such categorization. I theorized in this paper that enforcing global categories of MARPs, particularly of female sex workers, presented numerous potential problems characterized by enforcing identities of legal deviance and immorality on women which could also actively alienate women from community affiliations of piety and neighborhood acceptance and support. That is not to suggest that individuals who practice high-risk behaviors should not be targeted, but rather to question the methods, and the implications of given methods, by which such individuals are targeted. However, in order to better understand these issues, more in-depth study is necessary around marginalized women in Yemen, situations that lead women to sex work, how ideas about HIV circulate amongst these women, and particularly how different women who practice sex work
self-identify in different circumstances. Additional research on these, as well as alternative approaches, could prove productive.

Furthermore, I did not discuss important topics like condoms or gender in depth, which are figure significantly into HIV/AIDS programming in relation to social perceptions and quotidian realities in Yemen.

Had I more time in the field, I would have focused more on PLWH receiving al-Zindani’s treatment, with or without ART, as well as to general perceptions and understandings of HIV within these communities. In addition, I believe it is important to examine the health, social, economic, and political effects of treatment availability at al-Iman, both to people living and affected by HIV, as well as to the neighborhood in general and students of the university. This is a topic that deserves serious further study, particularly in the form of ethnography. Al-Iman is in itself a highly politicized space that US commentators often link, correctly or not, with terrorism. Ethnographic research would therefore provide methods to achieve more nuanced information and experiences.

Throughout my research period, I learned more about some of the institutional struggles that many of my interviewees regularly faced, including weaknesses of the Yemeni Health Ministry and the bureaucratic struggles of Global Fund grant management, particularly in relation to time limits to spend grant money and pressures to meet Global Fund requirements. In other words, working to address HIV/AIDS in Yemen is not an easy job. At the same time, I listened to many positive and encouraging narratives about HIV/AIDS efforts in Yemen, to which I did not give full voice in this paper. The many DWs whom I interviewed demonstrated unquestionable commitment towards improving institutions and systems in
order to better equip Yemenis to protect themselves from HIV. I remain extremely grateful for their generosity and kindnesses.

The last question I asked all of my informants asked them to predict what HIV/AIDS programming would look like in Yemen in five to ten years. Answers varied, and most hinged explicitly on funding and management issues. Many people directly correlated development programming to the control of the virus, offering explanations equating the amount of HIV/AIDS efforts to management of an epidemic, which aligned with discourses of threat found in development literature. Others were optimistic based on general progress and determination amongst Yemenis towards HIV/AIDS initiatives. While the future of development efforts around HIV/AIDS in Yemen remains especially cloudy given the end of UNDP’s position as primary recipient of Global Fund support in September 2010, it would be difficult to imagine an end to Global Fund support, and particularly ART treatment. Like the many DWs I interviewed, I hope that Yemen continues to strengthen its health structures and worker capacities to better assist HIV/AIDS programming, to heighten support of the ideas and efforts of DWs and PLWH, and to open spaces to be filled by programming more fashioned to local needs.
Appendix I

Development Narratives of HIV/AIDS in Yemen

Interview Guide

Background

1. How did you become interested in HIV/AIDS in Yemen/the Arab world?

HIV/AIDS in Yemen

2. What is your understanding of the current prevalence of HIV/AIDS in Yemen? Have there been any changes in the last 5 years?
3. How would you describe HIV/AIDS related stigma in Yemen? Have there been any changes in the last 5 years?
4. What are the highest-risk groups in Yemen for HIV infection? Have these changed at all in the last 5 years?

Role of Organization

5. How have Yemenis’ perceptions of HIV/AIDS changed in the last 10 years?
6. How is your organization addressing HIV/AIDS in Yemen?
   a. When did your organization begin HIV/AIDS projects in Yemen?
   b. Can you tell me about your organization’s decision to begin work on HIV/AIDS in Yemen?
   c. What are your organization’s current projects addressing HIV/AIDS?
   d. How have your organizations’ HIV/AIDS programs changed since they began?
   e. What impact do you think your organization has made on HIV/AIDS in Yemen? What have your HIV/AIDS projects changed?
7. How do people in the community react to you and your organizations’ HIV/AIDS projects? In general, do people respond to you or the projects differently than they did five years ago?

Development practitioners in Yemen

Development practitioners outside of Yemen
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>111</td>
<td>work on HIV/AIDS in Yemen?</td>
</tr>
<tr>
<td>c.</td>
<td>What are your organization’s current projects addressing HIV/AIDS?</td>
</tr>
<tr>
<td>d.</td>
<td>How have your organizations’ HIV/AIDS programs changed since they began?</td>
</tr>
<tr>
<td>e.</td>
<td>What impact do you think your organization has made on HIV/AIDS in Yemen? What have your HIV/AIDS projects changed?</td>
</tr>
</tbody>
</table>

7. Does your organization conduct HIV/AIDS projects in any other Arab states? If so, ...
   a. How, if at all, does the HIV/AIDS situation in Yemen differ from other Arab countries? (prevalence, risk groups, stigma, social perceptions)
   b. How do your organization’s HIV/AIDS projects in Yemen differ from HIV/AIDS projects you conduct in other Arab countries?

The Future of HIV/AIDS Programs in Yemen

8. What do you think the HIV/AIDS situation will be in Yemen in ten years? (prevalence, stigma, risk groups)
   a. How do you think the role of your organization towards HIV/AIDS in Yemen will change, if at all, in the next ten years?
   b. What decisions could be made to improve the HIV/AIDS situation in Yemen in the next ten years?

9. Is there anything else you would like to tell me?
Appendix II

Key Grant Performance Indicators

Goal 1: To ensure that the HIV prevalence rate amongst the general Yemeni population and high risk and vulnerable groups will be stabilized, and that the internationally recognized rights of PLWHAs, including entitlement to humane medical care, are upheld.

Objective 1 – To enhance HIV/AIDS prevention, care and support capacity among government and Civil Society Stakeholders.

Indicator 1.1 – Number of service deliverers trained in IEC, BCC community outreach, VCT, STD, ART, care and support.

Indicator 1.2 – Number of PLWHA receiving antiretroviral combination therapy.

Indicator 1.3 – Number of PLWHA receiving opportunistic infection prophylaxis and treatment

Indicator 1.4 – Number of people receiving VCT

Indicator 1.5 – Number of local NGOs participating in a formal civil society coordination network for HIV/AIDS activities

Objective 2 – To create awareness of HIV/AIDS and other STIs among general population and identified vulnerable and high risk groups and to reduce risk behavior (combined Obj 2 and 3 of proposal)

Indicator 2.1 – Number of sites offering services to high risk groups

Indicator 2.3 – Number of high risk vulnerable persons reached with IEC activities

Indicator 2.2 – Number of national and governorate leaders and decision makers reached by advocacy activities

Objective 3 – To develop capacity for ongoing infection and behavioral surveillance

Indicator 3.1 – Number of sentinel sites for HIV surveillance operational

Indicator 3.2 – Number of staff trained in behavioral surveillance

Objective 4 – To increase coverage of HIV safe blood for transfusion and to establish and enforce national blood safety standards

Indicator 4.1 – Number and percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national guidelines

Indicator 4.2 – Number of service deliverers trained on blood safety

---

Appendix III

Figure 2: Incidence of Reported Cases of HIV by Year (1987 - 2009)

Bibliography

Abdullah, Abdulwahed. “Yemeni HIV Patients Face the Media.” Yemen Times (2 NOV 2009),

Akeroyd, Anne. “Sociocultural Aspects of AIDS in Africa: Occupational and Gender Issues.” in AIDS in
Africa and the Caribbean (ed G Bond, J Kreniske, I Susser and J Vincent) Boulder: Westview

Al-Ali, Abdul Hadi Naji. “Hala AIDS fi al-Yemen wa al-mala hea al-lylea sabab inbasharahou 1549.”al-
Ayyam (22 Aug 2005) http://www.al-ayyam.info/Default.aspx?NewsID=2a1de787-c8d8-41b6-
bc4d-f86a80025135 (Accessed 15 Nov 2009).

Al-Ariqi, Amel. “Draft Law to Protect Rights of HIV/AIDS Patients.” Yemen Times (6 Jul 2009), accessed on
BNET: http://findarticles.com/p/news-articles/yemen-times-sanaa/mi_8204/is_20090706/draft-
law-protect-rights-hiv/ai_n52150603/, (Accessed April 20, 2010).


AlMasmari, Hakim. “Interviews: Dr. Husni al-Goshae, Deputy Director at the Science and Technology
Hospital and University Professor.” Yemen Post (12 Jan 2009),

Almasmari, Hakim. “Sheikh Al-Zindani Surprises Medical Experts by Officially Announcing AIDS
Medication.” Yemen Post (14 Apr 2008), http://www.yemenpost.net/25/LocalNews/20081.htm,

al-Qadhi, Mohammed Hatem, “A Silent Threat in Yemen.” Choices. UNDP(Dec 2001),
20, 2010).

Interviewed by Hakim Almasmari, Yemen Post (28 Apr 2008),

2009).

Ashrafi, AbdulWahd. “Bab medyna dhmar etalebou bi-tkhafyd al-mohour.” Yemen Hurr (7 May 2008),
2009).


---


Hersh, Joshua. “The World is Qat.” The New Yorker (19 Feb 2010),

“HIV and AIDS Trainer.” Progressio Job Vacancy Announcement, Progressio (AUG 2006) 2,


Hughes, Nesya H B. “Yemen and Refugees: Progressive Attitudes but Policy Void.” FMR 16 (Jan 2003),


Jones, Cliff. “10 Year Old’s Divorce Challenges Traditions in Yemen.” Sideways News (23 Mar 2010),


Johnson, Gregory D. “Profile of Sheikh Abdul Majid al-Zindani.” Terrorism Monitor 4, 7 (6 Apr 2006), posted on The Jamestown Foundation,


Mshana, Gerry, Mary L. Plummer, Joyce Wamoyi, Zachayo S. Shigongo, David A. Ross, Daniel Wight. “‘She Was Bewitched and Caught an Illness Similar to AIDS’: AIDS and Sexually Transmitted Infection Causation Beliefs in Rural Northern Tanzania.” *Culture, Health & Sexuality* 8:1 (Jan. - Feb., 2006), pp. 45-58.


Yemen Parliament. Law to Protect the Community from HIV and AIDS and to Protect the Rights of People Living with HIV/AIDS (7 Dec 2009).
