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# HIV/AIDS in Yunnan Province: A Study of Stigma and Support

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*SIT Study Abroad*

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# **HIV/AIDS in Yunnan Province**

## **A Study of Stigma and Support**

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**ABSTRACT:**

I conducted a qualitative study on the ability of peer-HIV-support groups in Kunming, China to lessen the effects stigma. There is a lack of quantitative studies of stigma in Yunnan, and no studies that address the ability of Kunming peer-groups to lessen the effects of stigma. Over the course of one month, I collected data via questionnaire, individual interviews, group interviews, and scholarly research. My study had sixteen participants (five female sex workers, seven former intravenous drug users, and four men who have sex with men).

My scholarly research revealed that peer-groups are an effective way to: disseminate knowledge to the general population, disseminate information to risk-groups, and battle HIV stigma. Numerous quantitative studies reveal the prevalence of HIV stigma in the general population and that there are numerous barriers to overcoming stigma. All surveyed participants had experienced some degree of discrimination, and participants all agreed that support groups were effective in decreasing their emotional/psychological pressures. From my research, I conclude that support groups can be used to ameliorate stigma in Kunming, and I propose that new HIV educational initiatives must simultaneously attack stigma and ignorance in order to effectively address stigma and HIV/AIDS as a public health issue.

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## I. INTRODUCTION

Yunnan province has the highest population of ‘people living with HIV’ (PLHIV) in China. Yunnan is at the forefront of the national HIV/AIDS epidemic. Out of interest in China’s HIV/AIDS public health situation, I started off my research by simply researching the reason behind Yunnan’s high HIV infection rates. After, looking into this question I became interested in the issue of stigma. My research revealed that stigma in China was extremely prevalent and I wondered what could be done to ameliorate its effects. I came across several papers that showed that peer-HIV-support groups had been used in Africa and North America to decrease the emotional/psychological distress that PLHIV experience. I hypothesized that peer-groups could also be used to ameliorate HIV stigma in Yunnan. Since the situation of PLHIV differs throughout the province, I chose to narrow my study by focusing on PLHIV in Kunming. By the end of my study I was able to prove my hypothesis and propose a method to make HIV/AIDS public health initiatives more effective in minimizing HIV transmission.

### **Background History of HIV in China**

HIV/AIDS remains one of the biggest public health issues facing China today. This is particularly evident in Yunnan province, which is has the largest HIV population in China. China’s first documented AIDS case occurred in 1985, when a foreigner died in Beijing. In the beginning of the epidemic, the Health Ministry focused on preventing HIV infection from abroad. All foreign students had to comply with mandatory AIDS screening. Moreover, before 1990 public health authorities labeled HIV as a disease of those who practice ‘abnormal’ sexual behaviors and the first cases of HIV were found among Yunnan injecting drug users (IDU).

Between 1991-2000, AIDS cases among Yunnan IDU reached epidemic

proportions. HIV infections were reported in all 32 provinces, autonomous regions, and municipalities. Drug users came to account for 60-70% of reported infections. During this time period, it was also finally revealed that large numbers of people had been infected through blood donation, particularly in Henan province (AVERT, 2012).

### **Golden Triangle**

The reason that Yunnan has the greatest number of HIV infections is because it is located at the center of the Southeast Asian ‘Golden Triangle’. This ‘Golden Triangle’ is a global center for production of opiates and methamphetamines. This region includes parts of Laos, Myanmar, Thailand, and Yunnan province. With optimum environmental conditions for the cultivation of the poppy (the active ingredient in opium), the production of opium in this region is driven by poverty and politics. Although China has attempted to crack down on drug trafficking in Yunnan province, poppy cultivation in the Golden Triangle is on the rise. In fact, 60-70% of the drugs that are trafficked in China pass through Yunnan province. The amount of intravenous drug use in Yunnan has also increased greatly in the last fifty years. One former IDU interviewee commented:

“Many people don’t have a lot of options. They don’t have a lot of family support or educational opportunities so they turn to drugs. This happens because poverty is such an issue. People turn to drugs to escape their lives...It is really easy to get drugs in Yunnan because we are a border area, and we are at the center of a huge drug ring. There are drugs coming here from everywhere: Thailand, Myanmar, and even India. Maybe today people have greater understanding of drugs, but there is still a huge problem... The drugs these days are much stronger than the drugs that were available in the past...and are also really cheap. In Yunnan, you can buy drugs for the price of a cabbage.”

As a result of the easy accessibility of drugs and the high prevalence of intravenous drug use in Yunnan, Yunnan province has been pushed to the forefront in China’s battle against the HIV/AIDS epidemic (Su, 2013)

## **II. METHODS**

I chose to qualitatively research the efficacy of support groups in addressing HIV stigma for PLHIV in Yunnan (specifically in Kunming). There is already a body of literature on stigma against and support groups for PLHIV, but there is not yet a great amount of research qualitative research about PLHIV in Kunming. I adopted this qualitative approach because of several research constraints and because I believe it addresses a new question.

### **Research Constraints**

These research constraints include time and access. That is, PLHIV are very marginalized and HIV is a politically sensitive topic in China. This makes it difficult to access PLHIV to interview. Moreover, I believe that one month is an insufficient amount of time to conduct a quantitative study of peer-groups in Kunming, without extensive funding. One challenge that researchers who study HIV/AIDS in Yunnan face is that people who participate in surveys expect to receive compensation (at least 50RMB per participant). If I had attempted a quantitative study I would have run into numerous difficulties: (1) accessing enough participants (2) personal travel costs and (3) compensating each individual who participates in the study. Because I was allied with FHI (an international NGO with numerous connections), I was able to access participants without paying any kind of compensation. However, if I had chosen to use a quantitative method, the participants that I had access to would have been insufficient. For these reasons (access and time) I chose to use a qualitative approach to explore issues of support and stigma in Kunming.

### **Research Environment**

I chose to study PLHIV in Kunming, because as the largest city in Yunnan Kunming allows me to get a sense of rural as well as urban discrimination. Many

Kunming residents are actually from other areas and six of the ten people I interviewed were originally from the countryside. If I had conducted all my interviews in the countryside, it is unlikely that I would be able to ask questions about stigma in the city. However, because I conducted my research in the city of Kunming I was able to ask rural to urban migrants about their experiences in the countryside and learn more about the differences between stigma in rural and urban areas. I interviewed IDU and FSW through Sunshine Homeland (an NGO that focuses on HIV/AIDS) and MSM through Yunnan Rainbow Sky Workteam (an NGO that focuses on HIV/AIDS).

### **Data Collection**

I chose to distribute questionnaires and conduct interviews because I believe that the face-to-face interactions are the best way to collect qualitative data. Questionnaires allow me to make sure that we cover all the questions about stigma that are most important to my study, while giving me a baseline to use in my face-to-face interviews. I modeled my questionnaire after a WHO questionnaire that has been used globally to measure stigma for PLHIV (Obermeyer, 2008). I adjusted the survey to fit my needs by adding questions about support, translated the survey into Chinese, and had a FHI employee Xinru Zhao helped me to edit my translation. Because I used a small sample size, I collected data quantitatively by conducting online research (primarily peer-reviewed journals). This quantitative research was important in helping me to analyze my own data and draw conclusions.

### **Sample Group**

I distributed my survey to sixteen people and personally interviewed seven of them. I also interviewed all sixteen people in a group setting. I interviewed people who belonged to each major risk group: seven IDU, four MSMs, and five FSW. Eight

respondents were men, eight were women, six were from the countryside and ten were from the city. I set out to build interpersonal relationships based on which I could better understand HIV Stigma in Kunming. Although building such relationships in a short time is difficult, working under the umbrella organization FHI allowed me to build relationships and make contacts that would have taken months to build on my own.

### **III. CHINA'S PUBLIC HEALTH CRISIS: HIV/AIDS**

HIV/AIDS is one of the leading challenges of public health in China. In 2002, UNAIDS estimated the number of PLHIV as being between 1 to 6 million. As a result, public health officials are working tirelessly to make sure that the epidemic does not become generalized. In 2002 UNAIDS estimated that if the HIV epidemic was to become generalized it would account for between 10 -20 million new HIV infections by 2010, making China the second highest HIV infected country (Bignami-Van Assche, 2004).

The 2002 UNAIDS estimates have not yet been met, but the public health threat is still very real. A recent 2012 UNAIDS report estimates China's PLHIV population at 780,000 and the documented new HIV infections at 39, 183 (far less than the 10-20 million new infections estimated in 2002). Nonetheless, HIV continues to be a serious public health risk. HIV cases resulting from sexual transmission increased from 33.1% in 2006 to 76.3% in 2011. The homosexual transmission rates also increased from 2.5% to 13.7% in that same time frame (Ministry of Health, 2012). These changing rates of transmission create concern that the epidemic will become generalized.

The discrepancy between the UNAIDS 2002 estimates and the 2012 realities are likely because of the unique Chinese social structure. The Chinese socio-political

climate is not very tolerant of high-risk behavior: multiple sexual partners, intravenous drug use or commercial sex work. Also, the community of IDU in Yunnan province is relatively small and isolated compared to IDU communities in other Southeast Asian countries. The comparatively lower levels of commercial sex work and the isolation of IDU in Chinese society can explain the low prevalence of HIV in China (compared to neighboring countries like Myanmar or Thailand). Nonetheless, the fact that clearly defined high-risk groups exist has created reasonable concern about a burgeoning generalized HIV epidemic (Ministry of Health, 2012).

### **Yunnan Risk Group**

The Yunnan HIV/AIDS epidemic primarily affects three different risk groups: men who have sex with men (MSM), female sex workers (FSW), and intravenous drug users (IDU). The risk of HIV transmission during anal intercourse is higher than other types of sexual intercourse putting MSM at a higher risk for HIV. FSW are at risk for HIV because they have multiple sex partners. Moreover, IDU are at high-risk for HIV infection if they share needles (CDC, 2013). A former IDU described his experience being part of an IDU community as the HIV epidemic spread in the following way:

“I was a drug user for over twenty years. It was really a sad situation. I think the only reason that I survived is that I have such a strong will to live. Of the people who I started out doing drugs with I am one of the few who is left living ... Sometimes they would overdose or combine too many different drugs. You can easily die just from drug related complications without facing HIV, but of course some people died of HIV.”

These risk-groups have their risk of transmission magnified by Chinese social-cultural factors. There is comparatively low ability of FSW in Yunnan to insist upon condom use by clients. This is due to many factors: the relative poverty of FSW, a cultural aversion to condom use, and inability of FSW to self-advocate and insist upon condom use. IDU in Yunnan are also put at greater risk for HIV transmission by

a culture of needle sharing. FSW and IDU are put at further risk because these risk – groups generally have lower levels of education. This may be because IDU and FSW risk groups attract people with few educational and life opportunities. In Yunnan, more than 80% of FSW have fewer than 8 years of education. Conversely, MSM come from many different educational backgrounds and many are highly educated. Simply put, the risk-groups of Yunnan are put at risk for contracting HIV not only by Yunnan’s location in the Golden Triangle, but by Chinese socio-cultural factors (Bignami-Van Assche, 2004).

## **IV. PEER-GROUPS**

### **Peer Groups Effectively Disseminate Knowledge to the General Population**

The effectiveness of peer-groups in attacking the stigma in the general population, disseminating knowledge of HIV transmission, and lessening the effects of stigma on the lives of PLHIV has been demonstrated in numerous studies. One study done in Malawi tracked the gradual decrease of stigma as a result of peer-groups targeting rural adults. At the 6 month and 18 month post-evaluation. Researchers found that knowledge and hope about the epidemic had increased. Hope refers to a fatalistic view toward the disease (believing that the HIV epidemic cannot be quelled). Also, the amount that people blamed people living with HIV decreased. Peer groups were effective in Malawi because they allowed researchers to work from within the community. Peer educators became integrated into the community and stayed in the community full-time. Peer educators were contacted by 58% of adults with questions about HIV. Where other educational initiatives were unsuccessful, peer educators succeeded. These peer-educators reached the “gate-keepers” of society. By targeting adults the study targeted the “gate-keepers” of tradition. By educating adults, peer-educators also educate the children who are raised by these

adults. By educating the “gate-keepers” they effectively undermine those traditional concepts, which bolster the HIV epidemic and detrimentally affect the lives of PLHIV (Kaponda, 2011). I believe that this same strategy could be potentially be used in China to educate those who are unreached by other existing public health initiatives.

### **Peer-Groups Effectively Disseminate Knowledge to Risk-Groups**

Peer-groups are also important in disseminating transmission knowledge to HIV risk-groups who may be mistrustful of institutions. Disseminating HIV/AIDS knowledge and prevention techniques to members of unique populations requires interpersonal methods of information dissemination. Unique populations primarily bond through interpersonal relationships. The research of Svenkerud et al. reveals that creating a feeling of safety, trust, and respect is very important when working with unique populations particularly IDU and FSW. It is also very important that populations perceive educators as being “insiders” rather than “outsiders.” For instance, FSW are more likely to listen to peer-educators who are former- FSW (Svenkerud, 1998).

One MSM interviewee utilized his “insider” status to great effect:

“ There are times when all you can think about is the fact that you are sick, but I choose to have a positive outlook. Think about our world today. There are earthquakes, hurricanes, and all kinds of natural disasters. Anything can happen at anytime, so I choose to think about today. How can I make the most of the time that I have today. I choose to be hopeful. I choose to think about the way that I can use my positive status to help other people dealing with the same issues, and I have had the chance to help many people.”

Peer-leaders are effective because they share the same experiences and struggles.

Peer-groups are a successful way not only to battle stigma and psychological pressure, but also to train new peer-group leaders. When PLHIV see another successful PLHIV, they can be inspired to become advocates themselves.

### **The Efficacy of Peer-Groups for Battling HIV Stigma**

The ability of peer-groups to lessen the impact of stigma on PLHIV has been documented numerous times and I personally observed this occurring at the peer-groups that I visited. Most PLHIV received their primary emotional support from peer-groups/friends rather than from family. A study of 82 HIV positive men (over the course of 7.5 years) showed that those with higher support satisfaction were less likely to develop the AIDS virus. One MSM interviewee displayed this kind of satisfaction. He stated,

“I have a lot of hope for my future, and I know that if I take care I can still live a good quality of life. I personally feel that I am very lucky that all my family and close friends know about my HIV status and they support me. I have never felt like they discriminated against me or made me feel guilty because of my status. My job, my family, my life... actually I think that I'm quite fortunate!”

This kind of support satisfaction and positivity is directly correlated with better long-term health (Greene, 2003).

In fact, a study of sixty-eight depressed HIV positive men determined that there is a clear link between peer-support groups and psychiatric health. In fact, of the sixty-eight men who were part of the study those involved in peer-support groups showed significantly lower levels of distress after the group meetings and at long-term follow up (J, 1993). A study of HIV positive women over the course of seven years found that depression could be an indicator of earlier death and lower CD4 counts (Ickovics, 2001). That is to say, peer-groups have great positive emotional, psychiatric, and health outcomes for PLHIV and help to lessen the negative effects of stigma on PLHIV by giving them a better quality of life.

## V. STIGMA PREVALENCE

### Prevalence in General Population

The prevalence of discrimination against PLHIV has been documented many times. A 2002 survey of 840 pregnant women and 780 health professionals revealed just how prevalent HIV stigma is in Yunnan province. The survey revealed that 30% of doctors did not want to treat HIV positive patients. 60 % of health care professionals and 75% of pregnant women would keep away from an HIV positive acquaintance. 23% of health professionals and 45% of pregnant women believed that HIV was a disease that only affects ‘low class and illegal’ people. Moreover, 48% of health professionals and 59% of pregnant women believed that PLHIV should not be allowed to get married (Hesketh, 2005). In a group interview with former IDUs at Sunshine Homeland project people agreed,

“When people find out that we have HIV, they become afraid of us. They don’t want to eat with us. They don’t want to touch us. They are afraid that they will become sick and die.”

This 2002 study is corroborated by the 2009 China Stigma Index survey involving more than 2,000 PLHIV. 32% of respondents said that their status had been revealed without their consent. 41.7% indicated that they had experienced severe HIV-related discrimination. 14.8% said that they had been refused employment opportunities. 11.9% of pregnant women living with HIV had been pressured into having an abortion because of their HIV status. 26% of medical staff, 35 % of government officials, and 36% of teachers all displayed a discriminatory attitude towards someone once they learned of their positive HIV status (UNAIDS, 2009). Moreover, because HIV/AIDS is associated with behaviors that are socially disapproved of people with HIV face double-stigma. They are discriminated against

not only for their HIV status, but because they have a disease which is associated with high risk-groups (Hong, 2008).

One MSM who I interviewed explained the difficulties of living with double-gradient stigma by saying:

“In China, there are two kinds of stigma for us. The first is the stigma against gay people the second is the stigma against HIV positive people. In fact, both these things work together. When someone finds out that you are a homosexual they don’t even want to speak with you. China is becoming more open, but people are still very scared of homosexual people and discriminate against them. Being HIV positive on top of being gay really can make life hard, but I have hope.”

## **VI. BARRIERS TO ADDRESSING STIGMA**

Barriers to addressing HIV Stigma are essentially barriers to controlling the HIV/AIDS epidemic. Stigma encourages PLHIV to conceal their status, not seek treatment, and not be tested for HIV. The discrimination (both institutional and personal) that PLHIV face encourages them to refuse to deal with their HIV status (whether being tested or seeking treatment). When HIV goes untreated and unacknowledged it can be easily passed on to others. PLHIV who refuse to acknowledge their HIV status (and seek treatment) can pose a significant threat to the general population. However, a cultural framework that makes PLHIV afraid to seek care can only serve to amplify HIV transmission. Talking with peer-group leaders at Sunshine Homeland revealed that fear of discrimination can prevent people from seeking support for their condition by participating in a peer-group for fear. One peer-leader explained,

“There are many people who are afraid to come... Sometimes we visit places that we know people with IDU problems frequent. I often go to places where people have these kinds of problems. A lot of people are too afraid to come to this kind of group. They are afraid that other people will find out about it and discover that they are HIV positive.”

Consequently, dealing with the stigma that PLHIV face serves not only help them accept their HIV status, but also aids public health initiatives in decreasing HIV/AIDS transmission.

### **Lack of HIV Education in the General Population**

Since stigma undermines public health initiatives to control HIV/AIDS, new initiatives must both improve educational outcomes (persistence of HIV transmission misconceptions and government inability to implement educational initiative) and attack existing stigma (negative attitudes about PLHIV, indifference in the general population, and stigma at an institutional level). A 2008 UNAIDS China surveyed over 6,000 Chinese people, revealed that lack of knowledge of HIV is still a huge problem. 48 % of respondents believed that one could become infected from a mosquito bite, 18% believed that one could become infected from a cough or a sneeze, and 48% believed that they could become infected from sharing a meal (Ministry of Health, 2012).

Most of the general population is unaware that PLHIV can live for many years without contracting the AIDS virus. One interviewee commented on this phenomenon stating:

“Here in this building with these friends I feel no stigma, but out there in the world it’s a different story. When people find out that you have HIV they avoid you. They are worried about catching the disease. All they know about HIV is that you can die from it.”

Although PLHIV can live very full and productive lives with the right treatment, ignorance about the disease creates exaggerated fears of transmission. Without knowledge of actual transmission or the possibility of living with HIV, stigma against PLHIV persists (AVERT, 2012).

### **Central to Local Problems of Educational Infrastructure**

Educational infrastructure must be improved in order for government educational initiatives to have the necessary effect. In 2004, a State Council document recommended a mass education campaign among the general population. The campaign would teach people about HIV transmission and how to oppose stigma and discrimination. The document states that an effective HIV response was important to China and its people. Nonetheless, local authorities do not always implement the central government's educational policies. This lack of implementation can happen for various reasons, but often occurs because of a lack of resources. There is a severe lack of qualified teachers (especially outside of urban areas) and of teaching materials (especially in minority languages) to adequately implement central government policy (AVERT, 2012).

### **Negative Attitudes about PLHIV**

Better educational initiatives are the first step towards dealing with the HIV epidemic, but are insufficient for adequately dealing with the discrimination that PLHIV face. Hong et. al, found from their study that even when an individual fully understands the modes of HIV transmission they might still refuse to sit near to an infected individual because "I would feel dirty in my heart." To reduce stigma educational campaigns need to move past simple 'knowledge education' and address the feelings, fears, and cultural beliefs that augment stigma (Hong, 2008).

### **Indifference Toward Educational Initiatives**

In fact, it is these very same fears, feelings, and cultural norms that can thwart the success of 'knowledge education' initiatives. Because PLHIV are viewed as 'dirty' and 'other,' there is a generalized indifference toward HIV education initiatives. When HIV is seen as a problem of 'other' people, educational campaigns

fail to reach the general population who feel that they are not susceptible to HIV infection due to the belief that only ‘bad’ or ‘dubious’ people will contract HIV. One girl involved in the Hong et al. study states, “these things are on the newspaper, but I don’t like to read them.” One of the greatest barriers to successfully addressing the HIV epidemic in Yunnan is the fact that even when appropriate educational campaigns are mounted the general population is indifferent.

Therefore, it is necessary not only to educate people about HIV transmission but also to attack the cultural norms and fears that stigmatize and otherize both the disease and the people living with it. To date, I am not aware of Chinese public health initiatives that simultaneously address HIV ignorance and discriminatory attitudes in the general population. Because of demonstrated efficacy of peer-groups in the aforementioned Malawi study, I suggest that peer-groups for members of the general population can help initiatives to both educate and end stigma (Hong, 2008).

### **Stigma at an Institutional Level**

Discrimination at an institutional level (government and health care institutions) also acts as a barrier to successfully controlling the epidemic by undermining trust in institutions that may aim to aid PLHIV. In 2006, police publicly humiliated more than 100 FSW in Shenzhen by forcing them to march through the streets handcuffed while their names were publicly announced to a crowd of bystanders. After the public humiliation sex workers were summarily incarcerated without trial (French, 2006). Detained sex workers are forced to endure extremely poor conditions. Current detention practices systematically increase the risk of HIV for FSW (Tucker, 2010). Although laws exist that protect PLHIV, they are not always enforced on a local level. In fact enforcement of laws that deal with intravenous drug use or sex work systematically strip away the human rights of individuals while

increasing their risk for HIV.

In the past 10 years, numerous forms of institutional discrimination have been reported in China. Such discrimination includes: banning PLHIV from education, marriage, child-bearing, military service, employment in service related occupations, and medical treatment (Hong, 2008). One former IDU that I interviewed described numerous experiences with institutional stigma at health care facilities and with health care providers. She said,

“I remember one time going to the doctor’s office for a check up and the nurse came out wearing a mask, a full gown, and gloves. She was so afraid of getting sick ... Doctor’s and nurses all try to keep away from us, but there was one doctor who treated me really well. I felt like we were friends. But one time I bumped into him outside of the office and he pretended not to know me ...I think that he doesn’t want people to get the idea that he associates with people with HIV.”

This woman’s story is not unique many PLHIV are discriminated against at health care institutions. This kind of discrimination further discourages PLHIV from seeking medical care or getting tested. All these forms of discrimination against PLHIV serve only to augment the stigma that exists in the general population and undermine public health efforts to control transmission.

Some of the methods that local governments have used to enforce the Anti-Drug Law also serve to augment stigma at an institutional level. The Anti-Drug law (although purported to protect the rights of IDU) expands the power of the police and infringes upon the rights of IDU. One study of 33 current and former IDU who had spent time in compulsory “drug-treatment” centers revealed that the anti-drug law has been used to punish not rehabilitate. At compulsory drug detention centers, detainees are forced to work up to 18 hours a day, while undergoing forcible unassisted drug withdrawal. In 2009 UNAIDS estimated that there are up to 500,000 people detained at these ‘treatment’ centers. Although the Chinese government has taken some positive steps by introducing more methadone clinics and needle exchange programs

(there are currently more than 1,000 needle-exchange programs), the success of these programs is undermined by the existence of compulsory drug detention centers.

Drug detention centers serve not only to augment stigma and discrimination and undermine trust in government institutions, but they also create an unbreakable cycle that increases the impact of HIV and TB. There is little treatment of opportunist infections inside the detention centers so PLHIV who fall ill may not survive prison conditions. Moreover, TB (known as the twin of HIV) often goes untreated in detention centers. This results in a negative cycle where IDU become infected with TB in the detention center and then infect the general population upon their release. Moreover, many detainees with HIV/AIDS who might otherwise survive, die from opportunistic infections that could have been treated if they were not detained. The unscrupulous enforcement of the anti-drug law serves to undermine trust in government institutions and act as a barrier toward successfully addressing the HIV/AIDS epidemic (Human Rights Watch, 2010).

## **VII. RESULTS**

### **Comparative Stigma (Intersections between Education and Stigma)**

My research agrees with and supports the already existing body of research on stigma in China revealing that stigma is still a large problem for PLHIV. Through my own questionnaire and interviews I discovered interesting things about: the intersection between educational level and stigma and the necessity and insufficiency of peer-groups. I had some novel findings on comparative stigma. I found that the IDU and FSW groups that I interviewed experienced comparatively more stigma than the MSMs.

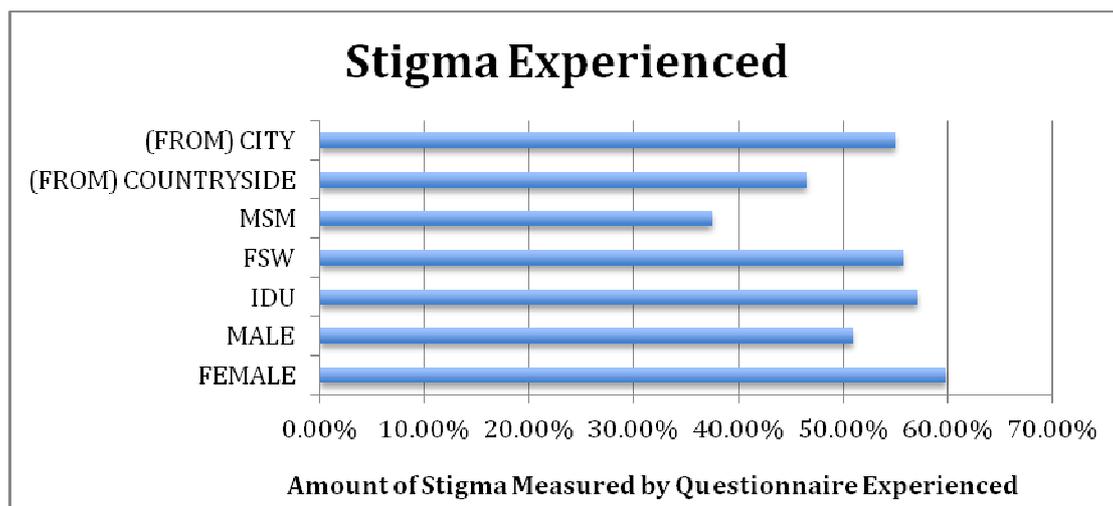


Figure 1 Stigma Experienced by Different Groups According to Demographic



Figure 2 Comparative Stigma Experienced by Groups According to Demographic

I noticed that the MSM group was much easier to understand than the IDU and FSW groups, because they spoke very standard *Putonghua* opposed to the *Kunminghua* that most of the IDU and FSW used. I looked at the questionnaires that each person had filled out and discovered that the MSMs had all finished university. I hypothesize that the reason that the MSMs that I interviewed experienced comparatively lower levels of stigma is because their societal position shields them from certain kinds of stigma. Because they are educated, employed, and interact with many other people who are of a similar background, they do not experience the same stigma that one would expect in an impoverished countryside area.

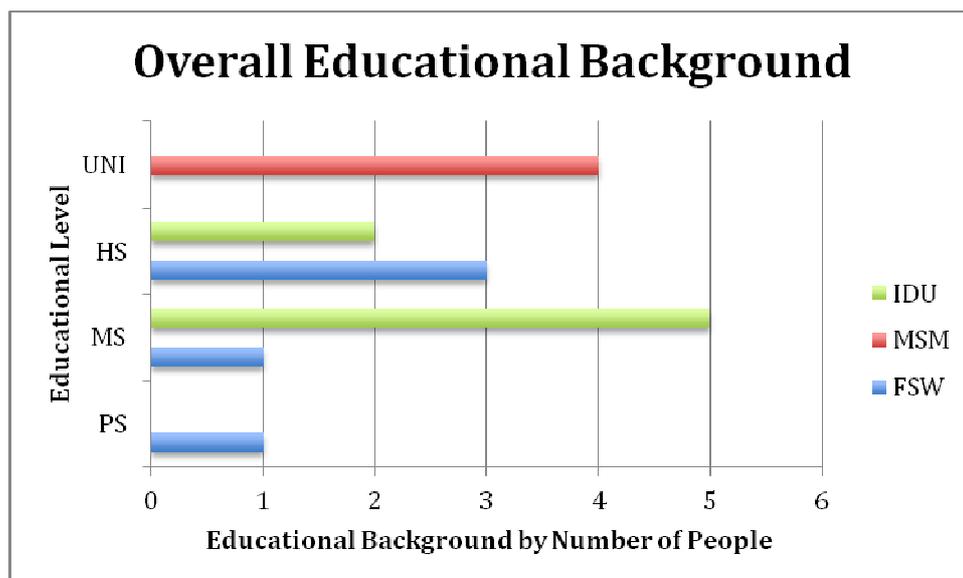


Figure 3 Educational Level of Members of Different HIV Risk-Groups

### Sources of Psychological Support for PLHIV

Aside from interesting findings about the educational/social background of certain risk-groups and the ways that this can augment or ameliorate stigma, I discovered that peer-groups act as a primary support mechanism. All the participants who completed the questionnaire indicated that (aside from medical treatment) they were most in need of psychological and emotional support. At the Sunshine Homeland IDU peer-group, leaders do this by moving past simply providing support during the peer-group itself but by becoming involved in the daily lives of group members.

Peer-group members at Sunshine Homeland are involved in one another's daily lives in numerous ways. Peer leaders visit group members in their homes. Some group members visit Sunshine on an almost daily basis. One woman explained, "I try to come when I have free time. It's fun and I like being with other people who are going through the same thing." At the center, they make daily meals so that people can drop by and eat together. If peer-group members are having difficulties communicating with their family, peer-leaders offer counseling and conflict resolution

services. Sunshine Homeland also provides financial support for group members. On the fourth floor of the building there is a small arts/crafts gallery where the handicrafts of PLHIV are sold. These handicrafts supplement group member's income and provide financial support. This is particularly important since discrimination in the workplace against PLHIV persists. At Sunshine Homeland I observed the way that peer-groups can become involved in the holistic well-being of PLHIV and act as a primary source of support.

It is thus unsurprising then that fourteen of the sixteen people I surveyed agreed that they received their primary emotional and psychological support from friends and other PLHIV. The people that I interviewed individually used words like "family" or "friends" to describe their peer-group, and several people in the IDU group told me that being part of their peer-group had changed their life. In fact, one peer-group member described their peer-group to me by saying:

"We receive a lot of support from this peer-group... We are like a little family. We support each other and I can be very open with these people... "We cook together, we eat together, and have become the closest of friends. There's nothing I can't say"

Although my own survey and scholarly research reveal that peer-groups can lessen stigma, it is necessary to examine the shortcomings of peer-groups in addressing the effects of stigma.

### **Insufficiency of Peer-Groups to Completely Ameliorate Stigma**

From the questionnaire responses I conclude that: while most of the PLHIV surveyed are receiving their primary psychological support from their respective peer-groups, these groups still do not take away the psychological pressures that they experience due to their HIV status. This is why out of sixteen participants only two felt that they were currently receiving adequate medical, financial, and emotional support. I argue that it is not enough for PLHIV to only receive support to deal with

the stigma they face, but the stigma itself must be eliminated. I propose that educational initiatives must first attack ignorance and stigma before all PLHIV will feel that they are receiving adequate support.

My interviews gave me a lot of quantitative data showing not only the presence of stigma, but how difficult is to live with HIV. My interviews also revealed how stigma compounds that difficulty. One former IDU explained the difficulties of living with HIV to me, she stated:

“When I found out I was HIV positive. I cried every single day. I was so depressed. I thought about suicide. It was just difficult. I’ve already had two miscarriages, and everyday was just so hard. I would lie in bed and I couldn’t sleep.... I also have TB and one month after I started taking the TB treatment my leg started to go lame. The doctors don’t know what’s wrong with my leg, but I can’t walk anymore...My family doesn’t know I have HIV. My old friends don’t know either. In the past I had some really bad experiences when I told people that I had HIV... I don’t dare to tell my family that I am HIV positive. If they knew that I was positive, I can’t imagine what would happen. Perhaps it’s because I fear that the stigma in the countryside would be worse than the city, but I don’t dare tell my family my status. I don’t even dare to return home, because they might find out that I have HIV.”

This girl’s story gives a view into the spiral of fear, depression, and hopelessness that many PLHIV experience on a daily basis. Her story shows the importance of psychological/emotional support and can be used as an example of the possible impact that peer-groups can have. This same girl recently married a different member of the peer-group and has found a pseudo-family in her relationships with other members of the group. Her current psychological state has improved greatly and the peer-group is helping her deal with the psychological/emotional stresses of being ill.

Nonetheless, my results also revealed the limitations of peer-groups to deal with the complexities of living with HIV. Only nine of the sixteen respondents felt that the emotional/psychological support they were currently receiving had improved their quality of life. This response indicates that the complexities of living with HIV may require more than just peer-groups. However, a deeper analysis along demographic lines further supports my findings on comparative stigma by risk-group.

Five out of seven (approximately 71%) of IDU, zero MSM, and four out five (80%) of FSW believed that the support they received had increased their quality of life. This supports my hypothesis that MSM experience comparatively less stigma. I would argue that MSM did not believe that the support they were receiving had improved their quality of life, because of their relative ability to shield themselves from daily stigma (due to their high-levels of education and comparatively high-social status compared to the other risk-groups surveyed). Notwithstanding, the fact that not all participants believed that the support they were receiving had improved their quality of life, ultimately reveals the urgent necessity of destroying the stigma against PLHIV.

## **VIII. CONCLUSION**

In conclusion, stigma against PLHIV poses a threat to everyone by creating a cultural framework that augments HIV transmission. To address this problem I propose that educational initiatives must be two-pronged: (1) address knowledge gaps and (2) address the problem of stigma. I argue that peer-groups are invaluable resources for decreasing the psychological and emotional effects of discrimination on PLHIV. Moreover, peer-groups can also be effectively used to disseminate knowledge to the general population and move past problems of indifference to non-personal educational campaigns. It is important to note that peer-groups do not only provide psychological support for PLHIV, but in doing so create better health outcomes for PLHIV. My personal findings from interviews and the questionnaire I distributed convince me of the severity of stigma faced by PLHIV living in Yunnan province and also of the necessity to reduce this stigma. I hypothesized that support groups could decrease the effects of stigma. My findings agree with this hypothesis. From my reading of other scholarly research, I conclude that stigma can be evaluated

not just from a moral standpoint but as a public health risk, since stigma poses a threat to all by magnifying the impact of HIV. When PLHIV are afraid to be tested/treated for HIV because of discrimination, HIV/AIDS public health initiatives are undermined. In sum: attacking stigma, addressing ignorance in the general population, and providing trusted support networks for PLHIV will help PLHIV adequately deal with HIV-related stigma, their HIV status, and ultimately minimize HIV transmission.

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#### Suggestions for Further Study:

Future study on HIV in Yunnan province could be expanded to include countryside areas. A visit to Ruili or Dehong would be very useful to get an idea of the kind of stigma that exists in an area with high HIV prevalence. Also, it would be useful to make a visit to a countryside area without high HIV prevalence and compare the stigma that exists. It would be interesting to interview the family members of PLHIV who attended peer-support groups and find out how they feel the peer-group had impacted the lives of their family members. Future study could also be expanded to look at peer-groups quantitatively throughout all of Yunnan province.