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The Feminization of HIV/AIDS in Yunnan, China

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The Feminization of HIV/AIDS in Yunnan, China

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Abstract

The feminization of HIV is a global phenomenon in which more women are becoming HIV-positive. This not only has tragic consequences for those women but also signifies how HIV transmission in China is changing. Increased sexual transmission has given HIV the ability to move from at-risk groups, such as intravenous drug users and commercial sex workers, to the general population. Despite China's improved health policies and programs about HIV, this situation poses a serious public health issue allowed to perpetuate because of societal problems surrounding gender. These problems are compounded by socioeconomic inequality brought upon by economic change. While much research has been done on HIV in developing parts of the world as well as HIV and gender, few case studies based in Kunming have been done.

The goal of this study was to examine similarities in participants and trends in their responses based on gender. Seventeen HIV-positive individuals were interviewed with the help of Sunshine Homeland Project. Interviews revealed a stronger relationship between socioeconomic status and individual health with HIV than between HIV and gender. Even so, gender issues were recognized but the personal implications of them were not. These issues therefore need to be publicly recognized and addressed in order for there to be sustainable change. Participants' thoughts on emotional and mental health did reveal gendered expectations and experiences. Women were far more likely to experience depression, especially right after diagnosis. This highlights the need for greater psychological support in addition to standard anti-retroviral treatment, particularly for women. The lack of knowledge and availability of resources for HIV patients is also a serious issue that must be improved along with steps toward social equality for there to be any lasting change.

Key Words: Gender Studies; Global Health; HIV/AIDS Demography; Public Health

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Abbreviations

IDU	Intravenous Drug Users
MSM	Men who have sex with men
CSW	Commercial sex work
ACWF	All China Women's Federation
PLWHA	People Living with HIV/AIDS

Introduction

Health & Globalization

The way we manage health has evolved along with our understanding of disease. As scientific advancements have been made, we have come to understand that pathogens and their various modes of transmission are responsible for the spread of disease. While community and global disease prevention programs are in place, modern medicine stresses the role of the individual. For instance, people are often told to take cautionary measures in order to reduce individual risk for disease. While this method is effective, its scope is too narrow to account for why certain groups or populations are at greater risk than others. It overlooks larger mechanisms at work that could be responsible for disease propagation.

One such mechanism is globalization, which has not only been responsible for the spread of ideas, resources, and technologies, but also disease. For instance, early globalization in the form of trade by land and sea allowed for the rapid spread of pathogens (Sutherland & Hsu, 2013). This enabled epidemics and pandemics to take hold and alter the course of history on a global scale. Nowhere is this more evident than from outbreaks of plague and influenza in ancient and modern eras. Increased interconnectivity has made the spread of diseases that were once isolated to a particular region much easier (Wilson, 2001). Modern technologies have only accelerated the rate at which they travel, potentially leading to an international crisis as with the 2014 Ebola outbreak in West Africa.

Health & Urbanization

The reason people come into contact with these previously isolated diseases is because of urban sprawl. It is defined as a demographic shift caused by people migrating from rural to urban locales as well as differences in mortality and fertility rates in those places (Sutherland & Hsu, 2013). As the global population has increased, people have been

forced to move into regions previously uninhabited by humans. This puts families and communities in closer proximity to vectors, such as animals, insects, and water sources, that could be carrying unfamiliar disease (Wilson, 2001). Oftentimes these new environments are inhospitable with conditions that those vectors thrive in. One example is hot, tropical climates with rainy seasons that create perfect breeding conditions for mosquitoes carrying anything from malaria and dengue fever to Zika. As more people move into such a region, the more likely a disease is to be passed on to humans.

The likelihood of human to human transmission has increased with urbanization. Urbanization provides more opportunity for contact and exposure between people as they move around. For instance, diseases once confined to rural areas can be easily spread to urban centers (Sutherland & Hsu, 2013). The introduction of new diseases to new environments and migrants to unfamiliar endemic diseases can have tremendous consequences. The rise of urban centers also creates an environment for new risky behaviors to occur. On the other hand, urban centers also provide greater access to health education, condoms, disease diagnosis and treatment than in rural areas (Reyes, 2012). Urbanization therefore has tremendous influence for the global transmission and evolution of infectious disease. This is especially true in the face of the fact that as of 2009, the majority of the world population lived in cities rather than towns and rural areas (Sutherland & Hsu, 2013).

HIV/AIDS in China

While macro in scale, globalization and urbanization are very important to the HIV/AIDS outbreak in China. Globalization was essentially responsible for the introduction of HIV/AIDS to Chinese society. Urbanization was responsible for the spread of HIV/AIDS within Chinese society. This is especially relevant to China, which has experienced explosive economic growth within the past three decades. While this growth has improved the quality

of life, it has also created increasing wealth disparity. This change has catalyzed major social change throughout the country, particularly in cities, by giving rise to a growing middle class. In turn, this new social demographic creates new industries and demands while acquiring greater dispensable income. This increase in individual wealth is partially responsible for the first wave of HIV/AIDS to plague China.

History of HIV/AIDS in China

While the first case of HIV in China was reported in 1985, the first reported epidemic began in 1989 among intravenous drug users. The first cases were reported in China's southernmost provinces, Yunnan and Guangxi, which border Myanmar, Laos, and Thailand (Wang, 2015). This location puts them in direct contact with the world's second largest opium-producing region, the Golden Triangle, where drug trafficking is prevalent (AVERT, 2015). People who had accumulated dispensable income post 1979's Reform and Opening, were unaware of the dangers of heroin use, and had no knowledge of HIV began IDU. Sharing needles was a common practice that resulted in the rapid spread of the disease.

China's second epidemic primarily took place in central China during the 1990s. China enacted an imported blood ban during the 1980s, which led to the founding of blood and plasma clinics (Wang, 2015). Pharmaceutical companies illegally collected blood in rural, impoverished regions where poor people would happily sell their blood. Due to lack of knowledge and sterile procedures, equipment became cross-contaminated. Blood was taken, pooled together so that the plasma could be separated, and returned to donors (Wang, 2015). Blood donors were unaware of the fact that they had become infected, and many people donated multiple times for financial compensation. Over the course of eight years, more than 100,000 people became infected yet no one was found responsible (Wang, 2015). The outbreak's economic and humanitarian consequences were made worse by the government's

lack of transparency when handling the situation.

China's third outbreak originated from sexual transmission primarily among closeted members of the LGBTQA community. As the previous two outbreaks' causes became more tightly controlled, sexual transmission between MSM became the main mode of HIV transmission. As per tradition, men are expected to get married and have children to fulfill their familial duty. However, once closeted gay men fulfill this duty, they will pursue extramarital affairs in secret. If they contract HIV from a partner, they will often pass it on to their wives (Wang, 2015). Married women in this vulnerable position have little power to advocate for their own sexual health or reveal their husband's status. For example, asking a spouse to use a condom could imply infidelity or HIV infection, both of which are viewed as inadmissible (UN Women Asia and Pacific). Lack of education, gender inequality, societal norms, and fear of violence or abandonment prevent them from doing so (UNAIDS et al, 2004).

Commercial Sex Work

In recent decades, China's commercial sex industry has seen tremendous growth. Domestic demand has risen, particularly from wealthier sections of the population as they can afford to pay for prostitution (Sutherland & Hsu, 2013). Increased economic prosperity as well as China's increasingly disproportionate gender ratio have fueled this phenomenon. A combination of poverty, inequality, and mass migration have driven growth in the industry's supply sector. Most women who enter the sex industry are young migrant women from rural areas. They experience several factors that either push or pull them into this work sector. A poor quality of life in their rural hometowns, especially in regard to health and education, makes migration a more appealing option. This statement carries considerable weight taking into account that young rural women compose nearly half of China's suicides per year

(Sutherland & Hsu, 2013). Rural migrant women are also often told of the job opportunities available to them in cities where they can partake in the service industry for wages and autonomy far better than they would ever attain back home.

The same women often end up seeking employment in the sex sector for several reasons. A major factor is the ease of which someone can join the industry due to its informal and illegal nature. For instance, its low start-up costs and no taxation make it easy to join (Sutherland & Hsu, 2013). Women in CSW also usually earn more money compared to the average service worker or rural farmer. Such is the case in Thailand, where a CSW can earn up to three times as much as rural monthly wages (Sutherland & Hsu, 2013). While CSW do indeed earn much more annually, the supply is so high that wages are actually driven down. The very things that make sex work appealing and possible for these women are the same things that make them vulnerable to HIV/AIDS. The wives of men infected by sex workers also become vulnerable.

Gender Inequality

As previously mentioned, women are often not able to advocate for themselves, especially in regard to sexual matters, without fear of retaliation (Yi et al, 2014). While this is a global issue, it is exacerbated by China's socioeconomics, gender imbalance, and patriarchal society. Women are legally equal to men before the law. Several government organizations, such as the AWCF, are responsible for implementing gender policy, such as the Program for Chinese Women's Development (UN Women Asia and Pacific).

The reality women face is very different. For instance, China has lower relative enrollment in primary and secondary education for girls than South Africa, Botswana, Lesotho, and Kenya (Sutherland & Hsu, 2013). This signifies that in spite of its economic growth, China still has larger relative gender differences compared to those of several Sub-

Saharan African nations. This phenomenon is very concerning in regard to education, as higher levels of education can transform traditional ideas and empower women. Better educated women are also less at risk for domestic violence, including sexual violence, but are still never without risk. Disparities are also evident in employment. While more women have paying jobs, they are usually lower-level positions. Few women also occupy government positions, with only 6.1% of them held by women as of 2005 (Sutherland & Hsu, 2013). This fact not only highlights women's lack of political power but also casts doubt on the effect of institutions like the ACWF.

Feminization of HIV/AIDS

Gender inequality also manifests itself in the form of women's health. In the third wave of the HIV epidemic, sexual transmission became the primary mode of transmission. As of 2011, 63.9% of HIV infections in China were caused by sexual transmission with 46.5% being through heterosexual contact, 25% of which occurs between spouses, and only 17.4% through homosexual contact (UN Women Asia and Pacific). These statistics not only signify that heterosexual transmission is likely to become the dominant mode of transmission, but also illustrate how HIV poses a growing threat to the general population. The fact that the percent of women infected with HIV has doubled not only supports this but stresses the need for immediate actions addressing HIV and gender to be taken (UN Women Asia and Pacific).

HIV/AIDS and Stigma

Across the globe, strong stigma surrounds HIV/AIDS due to lack of understanding and association with taboo or criminal behavior. When a community first encounters HIV/AIDS infection, there is little knowledge about it. Lack of education or misinformation leads to the

development of irrational fear, behaviors, and misconceptions surrounding the disease and people who have contracted it. These misunderstandings lead to discrimination against these people, creating a culture of silence and fear surrounding the disease. This not only affects the HIV-positive population but also affects the efficacy of HIV prevention and treatment programs. For instance, people will be reluctant to be screened for HIV or seek treatment, which can further the spread of disease. Individuals' livelihoods are also affected, often causing people to lose jobs, reputation, familial support, etc.

Stigma is reinforced by taboo and criminal associations to HIV. As previously discussed, a common method of transmission is through sex. In more conservative societies, such as in China, sex and homosexuality are taboo topics that people avoid. Anything associated with them also becomes taboo to discuss. Many behaviors associated with contracting HIV are also viewed negatively because of their criminal and therefore immoral nature. For instance, a common method of contracting HIV is through drug use or sex work. People with HIV become guilty by association with other members of society often believing that they deserved to contract it because of their behavior.

History of China's Healthcare System

The history of China's healthcare system mirrors that of the sociopolitical changes that began in the mid-twentieth century. Prior to the founding of the People's Republic of China, healthcare was not universal. Health services that were available focused on urban areas with 75% of coverage going to urbanites (Wang 2015). This system was revolutionized by the use of barefoot doctors, who were responsible for providing primary and preventative care to much of rural China. This system ended along with the commune system. While the barefoot doctor system was praised by foreigners and responsible for increasing village health service coverage to 90%, it was largely regarded as a failure (Wang 2015). Since the

level of education required for barefoot doctors was relatively low, their care may have unknowingly contributed to the spread of disease.

China's healthcare system became more decentralized following the barefoot doctor system. It currently depends on funding from central, county, and city governments for funding, which makes providing uniform healthcare difficult if local governments are unable or unwilling to provide funds (Sutherland & Hsu 2013). In a sense it has also returned to the pre-barefoot doctor era because healthcare funding is largely funneled into urban locales. According to Sutherland & Hsu, city hospitals received 50% of subsidies while county and township hospitals only received 9% and 7% of funding respectively in 2002 (2013). This regional inequality affects the quality and accessibility of care. For instance, low rural healthcare coverage combined with out-of-pocket health expenses makes care unaffordable for many rural farmers. Many people are also wary of being overcharged for hospital visits and unnecessary prescriptions, which further discourages people from seeking treatment.

HIV and Healthcare

As expected, the nature and stigma of HIV creates unique challenges for healthcare prevention and treatment programs. As of 2003, the Four Free One Care policy was established. It provides free antiretroviral treatment for HIV/AIDS patients, free voluntary counseling and testing, free testing for newborns to prevent mother-to-child transmission, schooling for HIV/AIDS orphans, and care often in the form of economic assistance for HIV/AIDS patients (Sutherland & Hsu 2013). These services have increased general knowledge about HIV and led to the greatest number of people accessing antiretroviral treatment as of 2013 (Sutherland & Hsu 2013). China also implemented the World Health Organization's 2013 HIV treatment guidelines, which requires treatments to keep patient CD4 counts above 500 (Sutherland & Hsu 2013). While this is a difficult objective to meet,

it has helped decrease HIV/AIDS-related death.

However, combating HIV still faces many obstacles in a society that has difficulty openly acknowledging that it is an issue. Other barriers to HIV prevention often come from local governments. Since each level of government has its own degree of autonomy, there tends to be a lack of coordinated effort (Sutherland & Hsu 2013). Measures targeting individuals for speaking out about HIV/AIDS or participating in illegal activities associated with HIV also pose a problem (Sutherland & Hsu 2013). These actions fuel fear toward HIV/AIDS and do not address the root of the socioeconomic factors that allows HIV/AIDS to flourish. The central government's tight control of non-governmental organizations also limits the amount of external aid that can be given to aid HIV/AIDS patients.

Methods

Justification for Research

A qualitative research project was conducted to examine gender as it relates to HIV/AIDS in Yunnan, China. While there has been considerable research on the HIV/AIDS epidemic in China and the relationship between HIV/AIDS and gender worldwide, very little qualitative research has specifically focused on HIV/AIDS and gender in China. The goal of this project was to reveal gender disparities, if any, between HIV-positive men and women's experiences, knowledge and availability to resources for vulnerable groups, and analyze socioeconomic trends that responsible for responses. A qualitative research approach was chosen because of the unique perspective it can offer and because of several constraints this project faced.

Research Constraints

Constraints were due to limited financial and human resources as well as time. Normally, a quantitative research project would require some form of compensation to reimburse participants for their contribution. This would have become too costly for the number of participants required by a quantitative study. Another major challenge facing this project was in finding willing participants to interview. PLWHA is a highly marginalized social group in any society, especially a more one as in China. This situation makes accessing the target population very challenging as HIV/AIDS patients already face incredible social stigma. Their participation in such a study could further alienate them from the rest of society if they not only identify themselves but also speak out. Both of these constraints were alleviated with my academic advisor's help. His contacts enabled interviews to be organized with the aforementioned vulnerable population without any cost. Yet another constraint was time. This study was given a month to be completed, which is an insufficient

amount of time for completing a quantitative research project.

Research Site

Research was conducted in Kunming, China. Kunming was chosen as the research site because of its diverse population, location, and the researcher's accessibility to resources. Kunming provided a unique urban landscape from which a large pool of participants of all socioeconomic backgrounds and life experiences could be drawn upon. Since Kunming is still very much a developing city, the effects of China's rapid economic development over the past three decades are reflected in its inhabitants' experiences. This is particularly true in regard to how increasing dispensable income has often been channeled into easily accessible drug use by China's growing middle class. Kunming's location in the midst of the Golden Triangle makes this of particular concern.

Data Collection & Analysis

Data was collected over the course of two days at Sunshine Homeland Project through formal interviews. Sunshine Homeland Project was founded by the Yunnan/Australia Red Cross in Kunming to to aid and decrease HIV contracted by IDU. Participants' responses were written down by the researcher using a laptop and each interview was recorded with the participant's permission. A total of seventeen HIV-positive patients randomly selected by Mr. Zhang were interviewed. The participant pool consisted of six men and eleven women who had contracted HIV/AIDS through intravenous drug use or an infected partner. The first day of interviews began in the afternoon and consisted of a joint interview with two female patients. The second day of individual interviews was held over the course of a full day. Each interview averaged 20-30 minutes and was translated with the help of Wuxia. This process became more streamlined as interviews were conducted, with the researcher and

translator aiming for consistency and detail in questioning while also being conscientious of participants' time.

Questions were written, translated, and edited by the researcher, SIT staff, and the translator. They were divided into sections and asked as they applied to each interviewee. The first set of questions was designed to gather demographical information on each interviewee, such as family background, age, education, etc. The second set of questions was meant to collect information on their HIV history and was tailored according to their experience. For instance, IDU were asked questions relevant to their past drug use. All interviewees were asked for their perspective on systematic, societal constructs surrounding HIV/AIDS in the third set of questions. Questions aimed to gauge the availability and interviewees' knowledge surrounding various resources for HIV patients. Their responses were meant to show whether necessary resources exist, what improvements need to be made, and how each interviewee's background influences his/her answer. Participants' responses were analyzed by the researcher to search for trends in data and understand the implications of these trends.

Additional background material was gathered from SIT's library at Yunnan Minzu University, lectures from medical professionals, academic texts, and online resources. This material was used to better understand HIV/AIDS in Yunnan as well as China's healthcare system. It was also used to look at past research projects' strengths and weaknesses to better focus and execute this project.

Research Concerns

While this project has given the researcher invaluable research skills and a better understanding of field work, it has faced many shortcomings. One such challenge is the reliability of interviewees' responses. For instance, it is likely that former drug users' responses were not always entirely truthful. All interviewees' responses must be analyzed

with some degree of skepticism because of the sensitive nature of the questions asked. Many questions were associated with topics taboo to discuss in China. Such topics include past criminal behavior, sexual relationships, domestic disputes, etc.

Another concern regarding this project is the unique circumstances of two of the interviews. As previously mentioned, the first interview was a joint interview. The two interviewees appeared to have known each other beforehand and would discuss responses with one another throughout the interview process. While this may have masked each individual's thoughts, it may also have made them more comfortable in answering sensitive questions. In a later interview, an interviewee's child was present which is likely to have influenced the way she responded to questions. In both cases, responses were either taken into account with these unique circumstances or discounted in the data analysis.

Results& Discussion

Participants' Demographics

A total of seventeen HIV-positive patients, including six men and ten women, were interviewed. The average age of interviewees was 44.76-year-old with nine of the seventeen patients between 40 to 49 years of age. Participants' had varying levels of education with two completing elementary school, nine completing middle school, and six completing high school. All participants' highest level of education reflected China's compulsory education program, which requires students to attain at least a middle school education. None of the participants attended university. All but two participants were or had been married to a spouse. One of the two identified as a lesbian with previous sexual encounters, and the other did not disclose any information regarding her marital status. Twelve of the married participants had one or more children, with two of those participants losing their child to HIV. There are no apparent trends among participants' gender and level of education or marital status.

The overwhelming majority of participants were not currently employed, which enforces the harsh reality of discrimination HIV patients face. Before their diagnosis, all participants had worked in some capacity. All participants but one had previously been employed in blue collar jobs, such as the clothing industry, hospitality services, or manufacturing. Only two of the participants continued to work, one as a migrant fish farmer and another as a travel planner. Both of these participants were male but it is unclear as to whether they still work because of their gender or the independent nature of their work.

A curious finding is that all participants said that they were residents of Kunming. Nobody shared that they had migrated from another location, whether that be another city or rural hometown. This seems at odds with the lower level kind of work all participants had. However, participants could have all been Kunming natives and part of the same

socioeconomic class. Misinterpretation on both the participants and interviewer side of things could also contribute to these findings.

Participants' HIV History

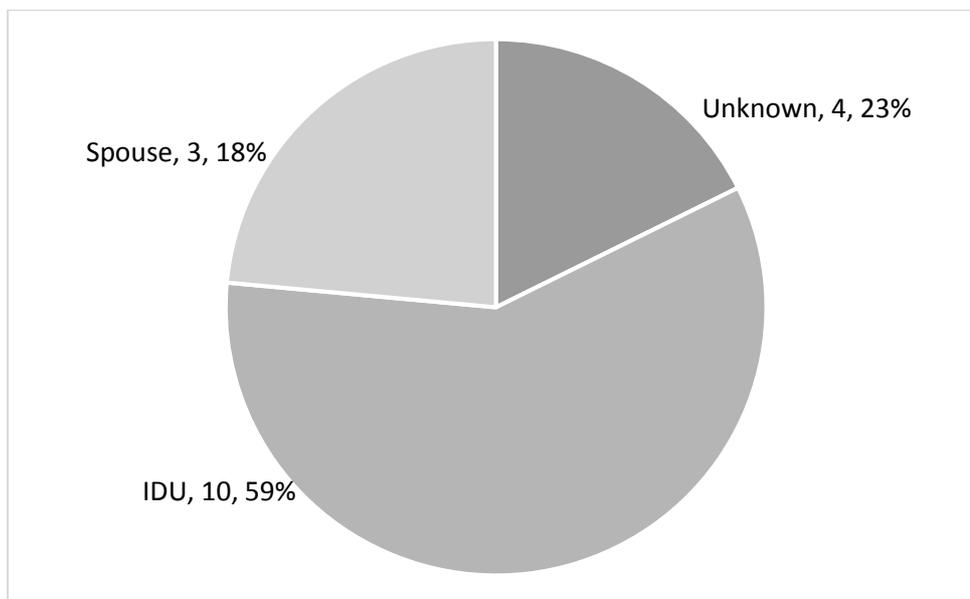


Fig 1. Case study participants' mode of HIV contraction.

The vast majority of participants had little to no knowledge of HIV prior to infection. Three participants shared that they had no knowledge of what the disease, twelve said that they had heard of it but did not understand it in detail, and two stated that they had a good understanding. This is not an unusual finding and matched expectations. While years of diagnosis vary widely, the average amount of time each interviewee has lived with HIV is 7.35 years. The majority of participants were former IDU drug users, which combined with their age and the beginning of the epidemic puts most of them in their teens or early twenties when they became infected. Male participants shared that they began using because they had enough money and it was something that their friends were doing. Female participants shared similar stories but also hinted at more gendered advertising for drug use. For instance,

two women said that they were told drug use had medicinal properties or could help with weight loss, which encouraged them to try IDU.

Since the interview site was founded for drug users, most of the participants were former drug users. Women who contracted HIV from their husbands revealed that their husbands had been drug users, hence their association with the site. Of the 15 participants who were or had been married, 14 had spouses who were also HIV-positive and 1 had a spouse that was not HIV-positive but was aware of their partner's HIV-status. The majority of people whose spouse was also infected were diagnosed at the same time. In all cases of spousal transmission, the disease went from husband to wife, reinforcing societal power dynamics especially in regard to sex. Interestingly, women typically began experiencing symptoms before their husbands, prompting both to get tested. While this was not part of the study, it would be interesting to see how supportive each partner is of each other and whether there are any feelings of guilt depending on gender. It is likely that there are such feelings, especially for couples who lost children to HIV.

Twelve participants had one child or more, the majority of which were unaware of their parents' HIV status. The children ranged in age from ages 8 to 27 and had varying degrees of dependence on their parents. All participants said that there was little household dialogue about HIV aside from what their children learned in school. The few children who were aware of their parents' status were often unaware of any details aside from the fact that when their parents aren't feeling well, it associated with HIV. This finding is extremely troubling as education in any form is the most effective preventative method. While the reasons as to why there is little to no dialogue about HIV and sexual relationships for that matter are understood, they must be addressed. The consequences of individuals' uneducated decisions are evident in the HIV-related deaths of the two aforementioned children.

One finding that was of interest was that out of the 12 participants' whose parents were still living, 7 of them had parents that were aware and supportive of their child's HIV-positive status. Four participants' parents were entirely unaware, and the remaining three were aware to some extent but had never been explicitly told of their child's HIV status. There were no apparent gender-based trends, with both men and women having parents with varying levels of awareness and support. For instance, participants' whose parents were unaware said that they did not want to trouble their elderly parents with this knowledge. Their behavior falls along typical lines of filial piety expected of all Chinese children. These findings were a bit surprising considering Chinese society's high value of female purity and strong associations with inappropriate sexual female conduct with HIV. Liberal city attitudes as well as traditional strong family values could be responsible for this deviation.

Improved education efforts about HIV could also be responsible. Several participants shared that while their parents had initially not understood or been accepting of their diagnosis, they became more understanding once they were told more about it. For instance, one woman stated that her parents came with her to several classes at Sunshine Homeland Project to learn more about HIV. Together, they were able to not only become better informed about HIV but come to a better understanding of how to manage the disease together. Initially, I was curious as to whether parents offered support or not, provided they were aware, had anything to do with whether their child had children of his/her own. However, there were no consistent trends evident from the interviews.

Participants' medicine regimen was standard according to China's existing HIV Four Free One Care policy with no obvious deviations based on gender. Eleven participants took oral medication once daily, five took oral medication twice daily, and one participant was not currently on medication. All participants on medication took a combination of three kinds of pills that vary according to his/her prescribed regimen. *Kelizhi*, *lamifuding*, and TDF were

among some of the most common drugs mentioned. All but one participant received their medication for free from a local hospital or the Chinese CDC. Only one participant stated that she had to pay approximately 1500 CNY per month for her medication because it was provided by a clinic specialized in infectious disease. In the course of their diagnosis, only two of the sixteen patients taking medication have had to adjust their drug regimen due to drug resistance or complications from the drugs' side effects. While both of these individuals were women, it is unclear as to whether this change was gender-related. In all likelihood, pre-existing risk factors, overall health status, and variance in drug adherence were more likely to be causes.

Participants' Health



Fig 2. Case study participants' self-assessed physical and mental health ratings.

Overall, the participants' self-described both their physical and mental health as fair. In regard to physical health, five participants stated that they had not yet experienced any symptoms or outbreaks characteristically associated with HIV and are considered in "good" physical health (Fig. 2). Ten participants were considered in fair physical health as they have

only experienced one to two symptoms, with the most common being lack of energy, low immunity, and weight loss (Fig. 2). Six were HCV patients. According to Figure 2, two individuals shared that they had more serious complications, such as liver problems related to hepatitis C co-infection, skin festers due to outbreaks, meningitis, etc.

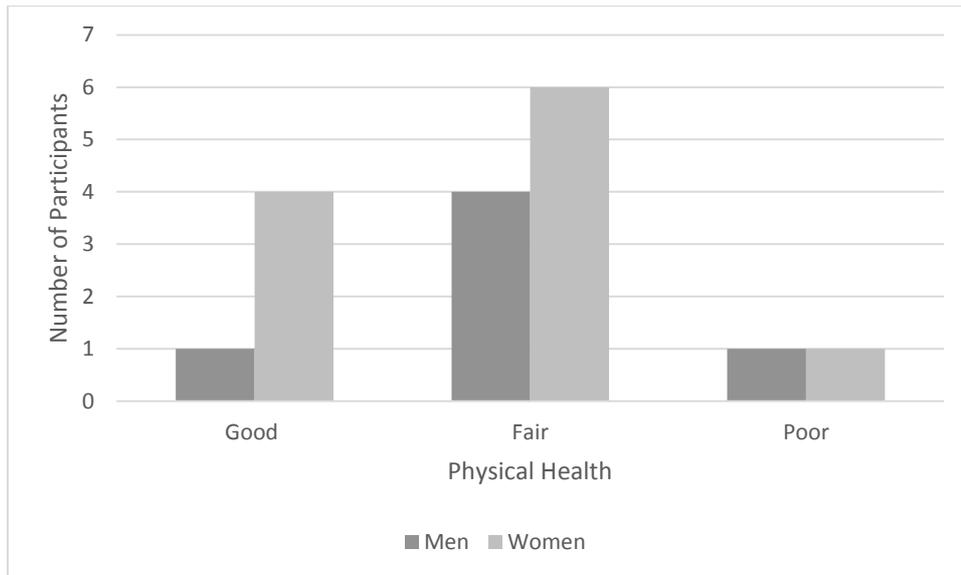


Fig 3. Participants' self-assessed physical health according to gender.

Upon first glance, it would be easy to conclude that male participants in this case study were more susceptible to more serious physical complications due to HIV. Men experienced greater physical symptoms in proportion to women. For instance, approximately every two female participants to one male participant would have been equal. According to Figure 3, that would mean that a greater number of men consider themselves in fair to poor physical health compared to women with the same rating. However, further analysis reveals that participants' physical health has a stronger association with the amount of time they have been living with HIV. For instance, a common trend found in this participant pool is most people appear to develop complications around year nine. Six of the participants who reported mild to severe symptoms had reached year nine or greater. Two of those participants had also been forced to change their medication regimen. This suggests that the

progression of the disease along with individual risk factors causes is responsible for physical health and does not have a relationship to gender. Further studies with a larger participant pool would be required for more conclusive results.

Participants' emotional and mental health seemed to be much better than their physical health. More than half of the participants classified their emotional and mental health as fair in which they have not experienced depression or any psychological problems associated with HIV (Fig. 2). Participants that classified their emotional and mental health as fair often shared that they were initially depressed when diagnosed. They had difficulty accepting their diagnosis, voicing that there should be more support for newly diagnosed HIV patients as that is an unstable time in their lives. Only one interviewee stated that he was currently suffering from chronic depression as a result of HIV, which was classified as poor emotional and mental health depicted in Figure 2.

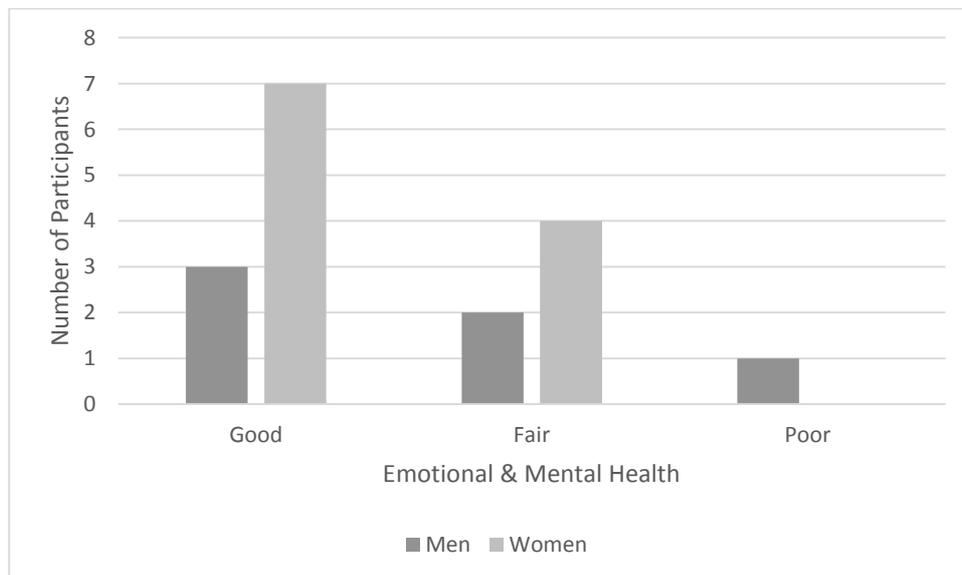


Fig 4. Participants' self-assessed emotional and mental health according to gender.

Participants emotional and mental health therefore does not appear to be significantly influenced by gender. Participants' rankings are approximately proportional (Fig. 4). It is interesting to note that the only individual who recognizes themselves as suffering from chronic depression is male. Even though the case study's sample size is relatively small,

women are normally considered more susceptible to depression and psychological problems. This is especially true in Traditional Chinese medicine, in which women are more likely to suffer from Yang deficiency and/or Yin excess resulting in depression (Wang, 2015).

In comparison to participants' physical health responses, their emotional and mental health responses were much simpler. There were very few details aside from the brief mention of feeling down or possible depression. I am curious as to why this is. A likely reason is Chinese society does not normally recognize mental health or address existing mental health issues. Psychology is still developing in a sense with many mental health issues viewed more as social issues. Another reason is the Chinese concept of *mianzi*, or face. People are generally not inclined to bring up problems, especially those of a personal nature, in order to save face. Such could be the case in this study.

Participants' Views on HIV & Gender

Overall, participants' views on HIV and gender suggested that there are no differences in HIV-positive men and women's experiences. The majority (10 participants) stated that there were no differences. The remaining participants shared varying responses. One person suggested that each individual has his/her own unique experience due to their personality and mode of contraction, and therefore he couldn't definitely answer. Several individuals stated that experiences differed because women's anatomy and physiology make them more susceptible to the disease. Men tend to be infected more by contact with CSW. Only two individuals stated that they were unsure as to whether there were differences or not. Responses did not appear to be gendered with both men and women making similar arguments for their views.

However, when asked if men or women are more likely to experience stigma, many participants had responses that contradicted their previous statements. Seven individuals

stated that women, especially those with children, were more likely to experience greater stigma due to HIV status, yet five of the same participants had previously stated that there were no gendered differences in experience. The remaining participants shared that neither gender experienced greater stigma as everyone has the same disease. They therefore all shoulder the same amount of stigma and discrimination. No one stated that men faced greater stigma.

This contradictory finding is very intriguing. Even though they were not the majority, the seven aforementioned individuals recognize that women are more likely to face greater stigma. However, they don't see how that stigma would influence women's experiences. Even female participants did not recognize how their lives were being affected despite knowing they were viewed differently as HIV-positive and female. A possible explanation is that people, including women, recognize systematic problems within their society related and unrelated to HIV. However, because they live in the midst of it, they may not see how or to what degree it impacts their lives. For instance, treatment based on gendered ideas and norms may just be seen as unchangeable parts of life rather than larger systematic problems. On the other hand, participants may recognize how experiences are gendered but be unwilling to share their thoughts. This could account for the majority of people who said there were no differences or were unsure of how to respond. Again, further research and more participants are needed to reach stronger conclusions.

The result that female participants were in good to fair mental health contrasts with yet another finding. All male participants said that HIV-positive women by far were more likely to be depressed than HIV-positive men. This enforces the idea that women do not have the same experiences as men. The greater stigma they face makes them more likely to develop depression, which is supported by the fact that more women than men developed

depression as some point in their diagnosis (Fig. 4). This result could come from many factors, such as sexism and Traditional Chinese medicine ideology.

Availability and Efficacy of Resources

When asked about resources available to women and children related to HIV care and education, domestic abuse, and support, participants were unsure of how to respond. Many stated that they did not know or hinted to large, well known groups. For instance, several participants suggested that the ACWF was responsible for helping HIV-positive women with care and issues with domestic abuse. Others suggested police, volunteer organizations like non-governmental organizations, or hospitals. Some stated that laws existed for these purposes but were unable to specify which laws or how they were enforced. This kind of ambiguity was frustrating and concerning. While organizations exist to address these kinds of issues, the lack of awareness of them makes them of no use.

Some participants that threw out the names of these organizations did not always appear confident in those institutions ability to carry out their duties. For instance, one male participant was very vocal. He shared that while the AWCF, police, and government exist to enforce policies and law, he was skeptical of their efficacy. In regard to abuse as it relates to HIV, he said that seeking help from these organizations was a temporary measure but abuse would always continue. Women could actually experience even more serious abuse as a result of seeking help from these kinds of organizations. He suggested divorce would be a more permanent and effective method while also acknowledging the social stigma associated with divorced women.

The lack of knowledge about resources and doubt surrounding known resources is troubling. While many people are aware of the issues that exist, they are unable or unwilling to address them. This situation stems from many factors, one of the most influential being

the concept of face. Many people and organizations are unwilling to address problems until their face becomes threatened and they are forced to take measures. The willingness of actually addressing the root of problems rather than addressing symptoms of it is also highly contested. Willing people or organizations often face obstacles in following their own agenda if that agenda is not managed by the government. This reactive method of dealing with problems, particularly health issues, is detrimental and ultimately does more harm than good.

Conclusions

Health is a cornerstone to any society's economic, political, and educational infrastructure. This is why preventative medicine and management of crippling disease, like HIV, is so important. It is easy to see just how destructive and devastating an outbreak can be not only to the community it directly affects but the global community as well. Changes in how a population is affected, such as feminization of HIV, also carry important implications. China's rise as a global force has not only made it a significant economic power but a new center for public health. While China has made major improvements to its healthcare system and the way it handles epidemics, many systematic and cultural barriers stand in the way of further progress. Many of these obstacles are related to how gender and relationships are constructed. The root of the problem lies in patriarchal ideals, which have created an unequal gender dynamic and manifested as serious societal issues.

These issues affect Chinese women from all walks of life, particularly those living with HIV. Surprisingly, this case study's results did not entirely reflect this. The majority of participants did not know or were apathetic to gender issues and HIV, which only enables said issues to persist. Participants who did recognize gender issues alluded to the idea that HIV-positive women, especially those with children, experience greater social stigma and discrimination than their male counterparts. This finding was more aligned with ideas from existing literature and Mr. Zhang from the Sunshine Homeland Project. Both state women's inferior social position and economic dependence put them in a vulnerable position where they are unable support themselves and shamed for seeking necessary help. While challenges women face specific to HIV must be addressed, these issues will never go away unless the larger systematic problems are addressed as well.

Studies that could be conducted in the future include:

- The same study with a larger sample size for more conclusive results

- Examining gender and HIV in a rural location
- Comparing gender and HIV in urban and rural locations
- Comparing women's experiences across IDU, CSW, and spousal HIV transmission

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Appendices

Appendix A: Interview Questions for HIV-positive Patients in Kunming

A. Background: age, education, family, job, hometown (ie migration?) etc.

a. HIV/AIDs:

- i. How did you contract HIV?
- ii. When were you diagnosed with HIV?
- iii. Were you aware of what HIV was and how it was contracted before your diagnosis? Now?
- iv. What prompted you to get tested?
- v. How frequently do you get treated?
- vi. Who provides your treatment? How expensive is it?
- vii. How is your physical and emotional health? What is your outlook on the future? (Greatest hopes, greatest fears)
- viii. Does your family and parents support you?

b. Intravenous Drug Users (IDU):

- i. When did you start using drugs? How did you come into contact with them? How old were you?
- ii. Did you share needles?
- iii. Did you use condoms during sex?

c. Former Sex Workers (FSW):

- i. When did you start working as a CSW? How did you come into contact with this line of work? How old were you?
- ii. What kind of venue did you work at/what kind of partners did you have? (Multiple or steady)
- iii. Did you use condoms during sex?

- iv. Did you ever face partner violence?
- d. Women Infected by Partner (WIP):
 - i. How long were you together/married? How old were you?
 - ii. Did you use condoms during sex?
 - iii. Did you ever face partner violence?
 - iv. Do you have a child?

B. Questions to be addressed:

- a. How do the female and male Chinese HIV/AIDS patient experiences differ?
- b. What is the male patient and doctor perspective of female patients' experience?
- c. Do female Chinese HIV/AIDS patients face greater stigma than male patients? If so, what socioeconomic factors are associated with this?
- d. What educational programs are in place for female HIV/AIDS patients and female target populations at risk? Are they effective, and if not what kind of implementation gaps need to be addressed? What sociopolitical and economic factors are responsible for this?
- e. What domestic violence resources exist for females at risk? Who are they provided by? Are they effective, and if not what kind of implementation gaps need to be addressed? What sociopolitical and economic factors are responsible for this?
- f. What resources exist for HIV/AIDS patients who are mothers and have children?
- g. Do HIV/AIDS positive women with children face more or less stigma than single HIV/AIDS positive women?

- h. Are support groups/systems provided especially for female HIV/AIDS patients? Are they effective, and if not what kind of implementation gaps need to be addressed?