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The cultural politics of HIV/AIDS and the Chinese State in late-twentieth century Yunnan

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The spread of HIV/AIDS in Yunnan China points to what Arjun Appadurai (1996) labels our late-twentieth century border crossings; the current great mass migrations of peoples, goods, services, and viruses that fill a large moving transnational canvas. Using this image of the moving transnational canvas, I argue that HIV disease in China gets mapped onto certain places and certain people more readily than others; and furthermore, that the identity of HIV disease gets spacialized through the discursive construction of the border. It is with the dual notions of discourse of the border and the fluidity of statistics that I locate my analysis of the Chinese state's distinctions of national and Han-ethnic boundaries and the representation of HIV/AIDS in China's southwest province of Yunnan and the areas bordering Burma and Laos[1]. I first provide a brief and condensed overview of the Chinese HIV/AIDS epidemic. Second, I give the reader a review of the social epidemiology of HIV in China, and finally, I present a discussion of the politics of statistics and the discourse of geography, borders and the ethnic other.

Background on HIV/AIDS in China

Sexually transmitted diseases (*xingbing* in Chinese and hereafter STDs) have now overtaken tuberculosis to become the third most common category of infectious disease in China after dysentery and hepatitis. Since the introduction of market reforms in the early 1980s, the Center for Disease Prevention in Beijing attributes this increase to changes in social mores, the rise in promiscuity and the low levels of risk-awareness among ordinary people (AFP Newsgroup May 6, 1999). In the summer of 2002, public health officials reported 30,736 HIV infected persons, 1,594 AIDS cases, and 684 deaths; howev-

[1] My fieldwork in China (1995-1996, 1997, 2000) was generously supported by Fulbright-Hays, Wenner-Gren, a CAPS Predoctoral AIDS Training grant, and from UC Berkeley a FLAS, a Regents Fellowship, and a Lowie grant. Writing time was made possible while I was an NIMH postdoctoral fellow at Harvard Medical School. This paper was first presented at the 1998 American Anthropological Association Meeting, and an earlier version was published in *Bad Subjects*. I sincerely thank Matthew Kohrman, Jing Jun, Byron and Mary-Jo DelVecchio Good, Corina Salis Gross, June Brady, and the anonymous reviewers from *Tsantsa* for their suggestions and critiques.

er, unofficial estimates are closer to 1.5 million people who are HIV positive (UNAIDS 2002: 12). The difference between the official and unofficial estimates are due to a number of factors including 1) limited reporting in rural and remote areas; 2) widespread fear of HIV/AIDS and the stigmatization often associated with an HIV diagnosis; 3) the relative expense of confirmation tests that can cost more than fifteen US dollars; and, 4) the relative inaccessibility of treatment and multiple drug therapies available in Europe and North America.

While these issues are critical in understanding a journalistic account of the Chinese AIDS epidemic, further exploration of the social epidemiology of AIDS is necessary before returning to my analysis of the Chinese state's distinctions of national and Han-ethnic boundaries and the representation of HIV/AIDS in China's southwest. To reiterate, the spread of HIV/AIDS in Yunnan points to our late-twentieth century border crossings and how the identity of a disease gets spacialized through the discursive construction of borders.

The social epidemiology of HIV/AIDS in China

A stunning and alarming statistic is that the Chinese epidemic has grown from an estimated two thousand people infected with HIV in 1995 to approximately 1.5 million by the end of 2001 (UNAIDS 2002). By April 2000, Liu reported in the *Renmin Ribao* that the incidence of HIV in China was increasing by twenty to thirty percent over each previous year. It is with these statistics in mind that I locate the rise of STDs within the opening of China's borders and the fact that no country has escaped the AIDS pandemic. Sexually transmitted diseases include all infectious diseases that are contracted through sexual contact. In China, these diseases are considered skin diseases (*pifubing*) and are often treated by skin specialists. The most common STDs in China are gonorrhea (*linbing*), syphilis (*meidu*), venereal warts (*jianreishiyou*), and increasingly herpes (*paozheng*) and HIV/AIDS, simply referred to in everyday speech as AIDS (*aizibing*). Because HIV infection is also referred to as AIDS, there is a certain slippage in the statistics, and in epidemiological information derived from popular health journals and the press. I have tried in this piece to be sensitive to these slippages and identify them when they are present. Also, a final note about statistics collected on HIV: in all countries statistics are problematic and that includes China. Reflecting the often dubious nature of statistics in general, Mark Twain, the American writer, said: «There are lies, damn lies, and statistics.» I wholeheartedly agree with his quip and feel it should be kept in mind while reading this piece.

According to Dr. Zhang Konglai (2001) of Peking Union Medical College's Epidemiology Department, China's AIDS epidemic has gone through three distinct phases. In 1985 the first case was identified in an American tourist who died in a Beijing hospital and from 1985-1989 there were only sporadic cases of HIV. The second phase, from 1989-1994, centered around four counties in Yunnan province. The third phase began in 1994 and continues into the present, marking the fact that every province, municipality, and autonomous region has both registered HIV positive persons and full-blown cases of AIDS. China first began its national HIV/AIDS surveillance program in 1984 and by the end of 1994, had selectively screened and tested more than five million people – reporting 1,173 HIV positives and sixty-five full-blown cases of AIDS[2]. At that time injection drug users from Yunnan Province made up seventy-eight percent of the total number of people with HIV (Zheng 1997)[3].

In the mid-1990s, Chinese public health officials in Kunming, the provincial capital of Yunnan Province, claimed that the heterosexual transmission of HIV was

[2] The definition of a diagnosis of full-blown AIDS continues to change. In China people who are HIV positive tend to have two to three symptoms of AIDS before receiving an AIDS diagnosis. In much of Europe and North America, an AIDS diagnosis is determined by helper T cell counts below 400.

[3] On December 8, 1996, the Hong Kong *South China Morning Post* ran an article by Fox Butterfield which stated the prediction that China would move from injection drug use to heterosexual transmission of HIV by the end of the century.

on the increase in China's southern minority border regions particularly the Dehong-Dai area in western Yunnan. Since the Dehong-Dai prefecture had high rates of HIV there was speculation that other regions with the presence of the Dai minority would also have high rates of HIV. Therefore both Xishuangbanna-Dai autonomous prefecture and Menglian Lahu-Dai-Wa autonomous county in Simao were targets for preliminary research on HIV / AIDS and for intervention programs[4].

In August 1999, the *China Daily* reported that injection drug users and prostitutes were the main routes of transmission for HIV in Yunnan. By global comparisons, even by September 2000, China was considered a low prevalence country with respect to HIV with only 20,711 documented people with HIV and 741 cases of full-blown AIDS. However, as Zhang warns, if HIV is not addressed in widespread prevention campaigns China could have upwards of 10 million cases by 2010 (Zhang Konglai 2001; Liu 2000; Butterfield 1996). I want to reiterate the problem of reported statistics here.

In Xishuangbanna the official counts of HIV are still not released to the press, to foreign researchers or to NGOs working on HIV / AIDS. And as for the number of HIV persons reaching 10 million, this appears to be a slight exaggeration. China's own admission is an increase of twenty-six to thirty percent a year, which brings the estimate closer to 6 million. Again, these figures must all be taken into careful consideration in terms of the problems associated with government reports that may both inflate and deflate statistics depending on who is reviewing them. In Jinghong the posters of popular fly-by-night STD clinic (commonly known as «black clinics» *hei zhensuo*) are only found off the beaten track and nowhere where tourists may tread.

In other instances the Chinese government has faced many obstacles in gaining accurate statistics for reasons including the causes noted in the introduction to this article. Currently injection drug users make up seventy-two percent of reported infections and prostitutes three percent of reported infections (UNAIDS 2002). While these categories appear both strange and problematic to western readers, they are important in terms about my argument of how AIDS is understood as a disease of political categories. In addition to the problematic category of *prostitute* for the transmission of HIV, Ronald Weitzer (2000) notes that in discussions of prostitution there is often a passive neglect about defining exactly what kind of work prostitutes perform in what location and what forms of compensation are provided. *Sex worker* is a compromise term that emerged out of the «sex war» battles in the United States and Europe in the late 1970s and early 1980s. In this essay, I use the Chinese term *jinu* (prostitute), commonly used on the street to cover many different levels of sex work.

In Jinghong all of the women I came in contact with performed a variety of services that ranged from providing sensual massages (*anmo*) to hand jobs (*tuiyou* or pushing-out oil, or the euphemism *dafeiji* or the big airplane), to performing intercourse with men back in their hotel rooms. In some social work circles in Yunnan, for example at the Women's and Children's Law Project in Singsong, the western term of sex workers (*xing gongzuozhe*) has been appropriated as a modern term of respect for the women that trade in sex. Other factors resulting in an increase in local epidemics include the large migration of people from the countryside into the cities, the increase of men who have sex with men (however, this is not well documented due to stigmatization association with homosexuality in China), the widespread use of blood and blood products for illness treatment, inadequate screening of blood in medical settings, and mother to child transmission (see Pan 2001). The inadequate screening for HIV / AIDS is just the tip of the iceberg in terms of accurate documentation of transmission rates.

The latest catastrophe for HIV / AIDS in China is the enormous numbers of people infected through lack of sterilization of medical equipment and the

[4] I want to point out that there may be some confusion over the use of the term Dai versus Tai. The term Tai refers to all speakers of Tai languages in southeast Asia and in present day China. It differs from the term Thai which refers to the citizens of Thailand. As Gehan Wijeyewardene (1990: 48) points out, «Dai is the pinyin spelling of the word and is used by Chinese speakers of the southwestern branch of languages living in China.» Here I use the term Dai when referring to Chinese representations of the Tai, and Tai Lü in all other cases.

pooling of blood by illegal blood banks. In Henan province there are whole villages that have upwards of an eighty percent infection rate due to nuclear families infected by blood pooling activities (UNAIDS 2002). The blood banks target poor peasants, the victims of China's economic reforms, by giving them money in exchange for their blood. With frequent extractions of blood, the banks were spinning down the plasma and putting the intermediary cells back into the donors' bloodstreams with the belief they were preventing anemia and fortifying the donors for repeated donations, thus securing their market. However, blood was not put back into the same person who had donated it, and it was distributed to several people with the same blood type. This meant that if one donor had HIV then all donors and later their wives and often children became HIV positive[5].

In August 2000 the *People's Daily*, the central government newspaper, reported that while it took five to six years for Yunnan Province to reach a rate of seventy percent HIV positives among injection drug users, in Xinjiang Province (another border minority autonomous region in the most northwestern part of China) it took only two to three years to reach a similar rate of infection. The current epicenters for the AIDS epidemic are concentrated in Yunnan Province, Xinjiang Province, Sichuan Province (just north of Yunnan), Henan Province (in south central China) and in coastal enclaves in Guangdong, Fujian, and Hebei Provinces. After compiling three years of surveillance data, researchers at the National HIV/AIDS Prevention and Control Center in Beijing identified eight sub-types of HIV-1 virus in China (A,B,B1,C,D,E,F, and G). In terms of my argument, I suggest this mean that the Chinese AIDS epidemic is truly an example of how globalization has penetrated China. Not only does China have distinct subtypes of HIV, it also has absorbed subtypes from neighboring countries from East and Southeast Asia. Specifically this means that seroprevalence surveys and blood sampling from six hundred people with HIV from thirty provinces revealed that 47,5 percent of the samples were of the sub-type 'B' or the same type found among injection drug users in Thailand. Over 34 percent of the blood samples were sub-type 'C', found among drug users in India, and 9,6 percent were sub-type 'E' which is common in southeast Asia. Sub-type 'B' was prevalent in all areas, while sub-type 'C' was concentrated in Xinjiang, Yunnan and Sichuan provinces. Sub-type 'E' commonly transmitted by sexual contact was concentrated in southeastern coastal areas and southwestern border regions[6].

HIV/AIDS and barbarians

While the Chinese AIDS epidemic may be transmitted and experienced by local people, many Chinese view AIDS as not only a foreign disease but as a barbarian one as well. Specifically this refers to the notion that barbarian diseases come from historically barbarian areas of China, including the minority prefectures along China's Burma and Lao borders. The term «barbarian» has specific historical semantics in China and these reverberate throughout the discussions of HIV/AIDS along the borders. Among public health officials in Yunnan, AIDS was first identified as a problem of injection drug use in the Dehong-Dai minority prefecture in Yunnan Province and later framed as a potential problem of sexual transmission in the Xishuangbanna-Dai and Menglian Lahu-Wa autonomous minority border prefectures.

The Xishuangbanna-Dai prefectural capital of Jinghong, the capital of the Tai Lü kingdom of *Sip Song Panna* for over 800 years, is a tourist destination for those mainland Chinese who can afford vacations. Jinghong's ethnic tourism market involves a journey into a place that is famous as a tropical paradise and is linked to sexual pathology and an urban ethnic

[6] I have not listed all my sources for the information conveyed in this paragraph because they are various: a French News agency press release dated August 5, 1999; Liu Baoying 2000; Cheng Hehe 1996; and Chris Beyer 1998.

[5] Based on personal accounts by Dr. Gao Yaojie, an activist and recipient of last year's Jonathan Mann award for her work in Henan at the Social Science for STI and HIV/AIDS Prevention and Care Symposium in Beijing in January 2001.

erotic subculture. By this I mean that the dominant Chinese ethnic group, the Han, often believes that one of the fundamental cultural characteristics of the Tai Lü is their high level of sexual promiscuity, leading to the assumption that they are particularly susceptible to the transmission of HIV. However, as a Han Chinese tourist destination, Jinghong does have a cosmopolitan sex industry that has brought the city fame and fortune, as well as STDs including HIV / AIDS.

Based on my fieldwork interviews, this sexual pathology is linked to the notion that the beautiful sex workers in Jinghong are local Tai Lü women. In order to increase their allure, sex workers wear a tourist version of the local Tai clothing, based on a closely cropped long sleeve top and a sarong. In interviews with these sex workers I discovered that almost ninety percent were Han Chinese from the adjacent provinces of Guizhou and Sichuan; they were migrants who came to Jinghong in search of work in the tourist industry[7]. In these Chinese border minority prefectures, HIV / AIDS challenges fundamental cultural systems of sexuality, gender, and ethnic relations, presenting problems for representatives of the Chinese state in handling the prefecture's anti-epidemic clinics, public security bureaus, and international non-governmental health organizations (NGOs). Fieldwork in 1996, 1997 and 2000 in Jinghong, Menglian (the capital of Menglian Lahu-Wa autonomous region) and in Kunming (the capital of Yunnan province) reveals the often shifting and contradictory positions of the state in response to AIDS prevention in this area (see Hyde 2001, 1999). Since AIDS prevention and control in contemporary China are addressed primarily by the state health bureaucracy, it is crucial to understand how agents in the county and provincial governments limit and define work around HIV / AIDS.

Everyday AIDS and the creation of the *Other*

State agents of the county and provincial Yunnan governments have a particular way of defining those at risk for AIDS. The construction of a disenfranchised «other» – comprised of prostitutes, transients, foreigners and drug addicts – creates a test population that fits into international epidemiological risk categories for HIV / AIDS. Furthermore, as stated previously, certain agents of the Chinese state's provincial anti-epidemic clinics conflate HIV / AIDS in Yunnan with China's Dai minority. The conflation of certain groups of people and HIV / AIDS is not new. Paul Farmer (1990) in his eloquent book on AIDS in Haiti points out that the American government in the 1980s also stigmatized certain minorities as being carriers of HIV: heroin addicts, hemophiliacs, homosexuals and Haitians. Similarly, the incongruous mapping of the Tai Lü people to disease leads to a whole series of regulatory practices which social philosopher Michel Foucault (1991) terms governmentalities. These governmentalities include mandatory HIV testing, and videotaping the presentation of HIV test results to a HIV-positive Tai Lü woman without her knowledge. The videotape was for what one informant called «research». In other cases, Tai Lü women who have crossed the border to work in Thailand are forced into taking HIV tests. These testing procedures are based on the assumption that crossing the border has two key complementary meanings: one, that all women who cross the border are working in Thailand's infamous sex industry; and two, that all women working in the Thai sex industry get HIV based on the high incidence of HIV among Thai sex workers.

In this context, prevention strategies are never easy. Since China has focused on social categories such as drug users and prostitutes in identifying HIV risk as opposed to the contemporary western

[7] During a brief trip in summer 2002, I discovered that the tourist industry is in decline and some sex workers' status is as well. The well-placed beauty salon where I once did extensive fieldwork is now a dingy run-down salon owned by two rather seedy men from Beijing (see Hyde 2001). The young women that work there were still from outlying provinces but now wear *modern* clothing.

identification of HIV with risky behavior, an edifice of state controlling practices and regulations accompany persons placed in these categories. HIV/AIDS epidemiological surveillance has been carried out since 1995, with twice a year screening among the following politically targeted groups: STD patients, drug users, truck drivers and pregnant women (UNAIDS 2002: 12). This process of testing politically sensitive groups suggests the problem of fighting an imagined disease with imaginary figures precisely because the question of who gets tested for HIV, and who is marked as an AIDS carrier, has everything to do with how someone is politically labeled or where they come from, rather than how that person behaves. In addition to this notion of political categories of risky persons, I want to return to my earlier point about borders and border persons carrying HIV. To illustrate this I discuss the 1995 Yunnan public health project to erect an epidemic fence around Yunnan province.

HIV/AIDS and the geography of the border

Shortly after the first case of AIDS in Kunming was reported in 1985, the Ministry of Health in Beijing set up a working group for the prevention of AIDS. By 1995 the State Council established a Coordinating Conference for the Prevention and Treatment of Sexually Transmitted Diseases and AIDS, and provided special funding for three regional centers in Guangdong, Jiangsu, and Yunnan. Dr. Li[8] was the appointed head of this government AIDS center in Yunnan and was instrumental in establishing the third regional center. I met Dr. Li at a Red Cross meeting that had been called to discuss the Yunnan provincial disease control plan. In 1996, the Yunnan provincial government was to invest close to 500 million yuan (roughly 60 million dollars) to build a disease-prevention zone along its border, and in the next four years to set up an elaborate border AIDS control surveillance network. This notion of the border is complicated. For Chinese provincial level government officials stationed in Kunming, the border patrols would prove adequate to determine who came into China and who did not. However, the local notions of a border are much more porous because in the densely forested subtropical climate of southern Yunnan, migrants from several countries, particularly Burma, come in and out of China without visas on a daily basis for work and for economic trade.

The rationale behind this new AIDS prevention directive was to tighten security and health controls along the Yunnan border, to erect multiple new guard posts, and to test people coming back and forth across the border for a variety of infectious diseases including HIV/AIDS. Another local health official told me: «The biggest problem in Xishuangbanna is its freedom, its openness. What we need to do is secure our borders.» I questioned him: «If AIDS knows no borders, and the locals know where to cross in the jungle, trying to place an iron-clad AIDS prevention belt around Yunnan just doesn't make sense epidemiologically.» Again he repeated, «As a public health measure, we need this disease prevention belt around the province.» I continued: «What about the sex industry in places like Jinghong, what about putting AIDS prevention announcements on all the flights, and free condoms in hotel rooms?» He laughed, and said: «In China, especially in a tourist town, that would be impossible.» Perhaps it was not so much a case of impossibility but unfeasibility: the issue was too sensitive for a growing tourism market. What emerged from the interview is that a physician/epidemiologist would treat AIDS as a problem for the border police rather than one of behavioral practice.

Ultimately in Yunnan representatives of the state maintain a discourse of the *border*. This discourse of the border, and a discussion of what constitutes the center and the periphery, is tangled up because

[8] My informant's name is a pseudonym.

the definition of a border does not serve the same ideological, social and political purposes for different ethnic groups and different levels of the government. China's borders are defined by military and political strategists in Beijing: Yunnan's border while reflecting the political boundaries set by Beijing also reflect a more sociological understanding of who uses these borders and for what purposes. Furthermore, the borders may become porous for those actually living on them as people from Burma, Laos and Thailand come over the border without proper documentation. While I was conducting fieldwork in Jinghong, on several occasions boat owners offered me a ride into Thailand down the Lancang (the local name for the Mekong) hidden in the hull of their boats.

Conclusion

Personal mobility within China can be used as a tool to exercise power over and resistance to different layers of the socialist state. In the case of HIV/AIDS, the state reacts to the exercise of this individual power by trying to recreate new sets of boundaries and borders. When geography and politics are wedded in this way, AIDS ceases to be a disease without borders and becomes a disease with distinct borders, as if it only seeps though at certain points on a map. This idea of border-building mirrors Dr. Li's notion of how to keep AIDS out of the general population, erecting the Great Wall of China once again, this time to keep not only barbarians out but barbarian diseases as well. Even on the eve of liberation in 1953, Xishuangbanna was perceived as a desolate wasteland of malaria and leprosy-infested jungles, full of barbarians (Dodd 1923). These conceptions of barbarians and barbarian diseases live on in the perceptions of Kunming physicians and public health bureaucrats working in these autonomous regions. When epidemiologists in Kunming try to map cultural prejudices onto risk variables, the results reflect what Cindy Patton (1996) calls their own prejudices rather than situations on the ground.

In such a cultural context, AIDS prevention policy becomes cloaked in the language of hyper-mobility, transgression and resistance to a previous Communist state regime that did not permit people from the countryside to move into the cities (see Zhang Li 2001). For these minority prefectures, the regulatory practices of the state express not only the contradictory positions of officials, but the contradictory locations of these places, places not entirely controlled by the Ministry of Health in Beijing, the provincial bureau in Kunming, or even the county health departments in Jinghong and Simao. People and places become mired in relationships that navigate between the different levels of the state government, illustrating the Chinese idiom «the mountains are high and the emperor is far away.» In AIDS policy the question still remains: how high and how far?

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Abstract

The cultural politics of HIV/AIDS and the Chinese State in late-twentieth century Yunnan

Sexually transmitted diseases have now overtaken tuberculosis to become the third most common category of infectious disease in China after dysentery and hepatitis. By the end of 2001, Chinese public health officials reported estimates of close to 1.5 million people infected with HIV. In this paper, I discuss the Chinese state's distinctions of national and Han-ethnic boundaries and the representation of HIV/AIDS in the southwest province of Yunnan and in particular, the areas bordering Burma and Laos. The spread of HIV/AIDS in Yunnan points to what Appadurai labels as our late-twentieth century border crossings: the mass migrations of peoples, goods, services, and viruses that paint a moving transnational canvas. Using this image of the moving transnational canvas, I turn my attention to how diseases get mapped onto certain places and certain people more readily than others; how the identity of a disease gets spacialized through the discursive construction of borders.

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