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Contested AIDS Stigmatization in Southwest China

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This article examines the emerging stigmatization of AIDS in a mountainous community of the Nuosu, a minority group in southwest China. The Nuosu did not discriminate against victims of the disease prior to state intervention, but stigma has been introduced by the Chinese state agents' mechanical transplantation of a global AIDS intervention program, which has generated fear of AIDS in the community. This situation developed from state agents' willful ignorance of the local moral world, an attitude cultivated since the beginning of China's socialist nation-building project in the 1950s. By unraveling Nuosu perceptions of AIDS and by delving into local particularities, this article points out the potential problems de-contextualized global disease-control projects may cause in diverse local contexts.

Key words: AIDS, stigma, policy transplantation, local morals, China

Introduction

My exploration of the emerging stigmatization of AIDS in the Nuosu community began during my 2002 visit to Limu (pseudonym) Township, which is located in a remote highland basin at an elevation of 1,900 m (6,200 ft) and under the jurisdiction of Zhaojue County, Liangshan Yi Autonomous Prefecture, Sichuan Province (see Figure 1). Liangshan is home to most of the Nuosu in southwest China, approximately 1,813,683 people, who mainly occupy the high hills (Sichuan Sheng Renkou Pucha Bangongshi 2002).

Over the years, I have spent 18 months in Limu, including the entire year of 2005 and intermittent visits between 2002 and 2007. My long-term fieldwork there has enabled me to both participate in township life and conduct in-depth interviews with local Nuosu and state agents involved in the AIDS intervention project. Both methods were essential for me to access intimate details of local daily life.

The Nuosu in Liangshan Prefecture, identified by the state as Yi nationality, have been reported to be engulfed in the HIV/AIDS epidemic since the state, in cooperation with a British aid agency, began seriously investigating the spread of the disease in the region in 2001. The extent of the epidemic startled the involved government agencies. The Nuosu, who constitute less than three percent of the Sichuan provincial population, had a stunning 59.56 percent of the HIV infection cases in the province (China-UK 2001).

Limu has been among the worst HIV-hit localities in Liangshan since the state's initial investigation. In 2002, the government reported 68 HIV infection cases, out of approximately 4,000 residents (or about 1.7%), among the three investigated villages in the Limu basin. Local officials and health workers believed that the real infection figure was much higher than reported numbers. In Limu and elsewhere across Liangshan, the spread of this disease resulted primarily from heroin injection among Nuosu young men who had since the mid-1980s moved from rural Liangshan to big towns or cities across the country where they encountered the drug in the early 1990s (Liu 2007a).

My initial impression of this minority township was shaped by the slogans ubiquitously painted along the roadside in huge red or white Chinese characters: *yuanli dupin* ("Stay Away from Drugs,") *yufang aizibing* ("Prevent AIDS,") or *jieshen zihao* ("Conduct Yourself Appropriately.") After passing these "greetings" at Limu's entrance, I noticed a sign down toward the township center made by the state AIDS project and hung above the township office compound that read: *aixin jiayuan* ("A Beloved Homestead.") Farther down the road, about 100 m beyond several paddy fields and a row of shabby houses, another prominent message ran across the walls of people's houses and the township clinic. It read, *shenchu ni de shou, gei aizibing bingren yifen guanhuai* ("Reach Out: Give AIDS Patients Care and Support.") It seemed to any casual visitor—including myself—that these awareness-raising slogans about AIDS, drugs, and care were

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Figure 1. Zhaojue County, Liangshan Yi Autonomous Prefecture, Sichuan Province, China

posted everywhere in this sleepy dusty town.

Such slogans suggested that the community must stigmatize people with HIV/AIDS, caring so little for their general well-being that the government had to intervene and preach compassion to remedy the situation. This assumption follows on a practice commonly seen across China: if slogans appear about some issue, they must correspond to a real and pressing problem.[1] But as my research on heroin use and AIDS in Limu progressed, I realized that my initial impression was at odds with reality. Limu was an exceptional locality where AIDS-related stigma was rare, if not nonexistent. So the issue became: why were these huge warning signs painted along the road, and why did they carry such a desperate pleading tone?

My ethnographic exploration of these questions revealed two layers of meaning. The first layer refers to the gap between the state agents' intended messages and the local social reality. To understand the discrepancy between these two, I must deal with how the Nuosu in Limu perceive AIDS through an analysis of their local moral world. In recent discussions on the formation of stigma, scholars have emphasized using local moral experience as a vantage point from which to understand its production and transformation in a culturally specific context (Yang et al. 2007). A local moral world, according to Kleinman (1999), is a circumscribed domain where daily life is seen as the expressive demonstration of moral tenets. The term "moral" here, following Kleinman, is defined as locally specific codes of reasoning and judgments about acceptable or unacceptable personal qualities or conduct in the social arena. In contrast to ethical discourse, which is conducted by elites and intellectuals, both global and local, a moral code is the ideational component of everyday experiences, which is "always about practical engagements in a particular local world" (Kleinman 1999:365).

Although scholars have considered the importance of cultural meanings in analyzing stigma, there is no defined approach to studying what constitutes the local moral world in the origin of a specific stigma. My article explores this

problem and sheds light on its anthropological significance. Through my long-term stay in Limu and using what Geertz (1973) terms an "experience-near" process, I was able to determine the sociocultural factors crucial to understanding the rise of AIDS-related stigma among the local Nuosu people.

AIDS-related stigma, like other local moral codes, is complex, exhibiting a high degree of diversity in its conception and expression cross-culturally. However, the swift global spread of HIV has prompted people to mark this disease with alarm, and this sense of urgency has created a globalizing ethical discourse around the AIDS-related stigma which, in turn, may brush aside preexisting local moral particularities. As a consequence, people "tend to take as self-evident the claims of discrimination, related social losses, and resulting shrinking of the social networks of PHAs [people with HIV/AIDS]…. [That they] do not question these claims also may stem from the political incorrectness of stating that having AIDS is not necessarily as socially destructive as it is reputed to be" (Green and Sobo 2000:11).

Following this line of thought, the second layer of my exploration revolves around the state agents and their intervention practices. I argue that until the Chinese government implemented certain AIDS-awareness programs, AIDS-related stigma in Limu did not fit the general pattern in China—and, indeed, much of the world. Research in other parts of the world has illustrated that while globalization has brought an awareness of global risks such as HIV/AIDS and drug use, "it has not made people the same the world over" (Eves and Butt 2008:5). Interventionists, however, often employ ready-made and portable tools and discourses, known as "briefcase concepts," in dealing with such globalized problems in diverse cultural contexts (Ibid. 6). The problematic importation of "briefcase concepts" also took place in this remote corner of China. Without first understanding the local situation, Chinese state agents who implemented the official AIDS intervention project introduced a preexisting global anti-stigma agenda intended to enhance the local public's tolerance and acceptance of people with HIV/AIDS. Ironically, that intervention has actually promoted fear and stereotyping of AIDS patients, a phenomenon previously unknown in local Nuosu society that has now emerged in conjunction with Limu's changing political economy and social relationships within China's globalization drive.

My answer to the questions about those pleading slogans reveals the controversial nature of the intervention regime. Analytically, such regimes hinge on the planners' own conceptualization of AIDS-related stigma (Parker and Aggleton 2003). Preexisting structural power and social inequality also contribute to stigma's development (Castro and Farmer 2005; Link and Phelan 2001). In other words, the posted mottos around Limu in fact revealed the interventionists' attitudes toward drugs and AIDS. They also demonstrated the interventionists' habitual dismissal of local Nuosu culture which, in turn, led to their assumption that AIDS-related stigma must be present and would necessitate such countermeasures. The inadvertent creation of stigma by the very regime intended to offset it fits squarely with a warning that interventions "far too often are part of the problem; they become iatrogenic" (Kleinman and Kleinman 1997:9).

In what follows, I engage in a rigorous examination of the factors surrounding the stigmatization of AIDS in Limu, step by step. I will provide: (1) a brief review of research on AIDS-related stigma in hopes of drawing new insights; (2) an overview of AIDS interventions in China and in Limu in particular; (3) an analysis of Limu's local moral world to shed light on the particularities of the Nuosu perceptions of AIDS; and (4) a discussion of the problems caused by decontextualized disease intervention.

AIDS, Deviance, and Stigma

The term "stigma" derives from the Latin word that denotes bodily signs connoting unusual and especially bad moral characteristics of the person in question (Goffman 1963). Stigma is by definition a socially constructed label and can vary from place to place and over time: "The normal and the stigmatized are not persons but rather *perspectives*" (Goffman 1963:137-138; emphasis added). In other words, the stigmatization process represents the construction of "deviation" or "abnormality" from the socially acceptable and "normal" (Alonzo and Reynolds 1995).

Link and Phelan (2001) identify five sequential stages of stigmatization that are useful for our understanding of this social process. First, society identifies human differences and labels them accordingly. Second, society's dominant sociocultural beliefs associate labeled people with preexisting undesirable characteristics. Third, the label dispensers separate the "negatively" labeled people from "us," the normal ones. Fourth, people who carry negative labels experience status loss and discrimination. Fifth, dominant social, economic, and political powers in society formalize and legitimize this stigmatization. When these interrelated components converge, stigma exists.

In dissecting the stigma-construction process, we may further ask: what constitutes "deviance" in a society where diverse groups live in variegated local cultures, as do the different ethnic groups in China? We may assume that these groups possess distinct criteria for identifying what is deviance as opposed to one monolithic concept of normality. "Stigma arises and stigmatization takes shape in specific contexts of culture and power" (Parker and Aggleton 2003:17), and in China, unfortunately, the social sector that has the most power in identifying what constitutes "deviance" is usually the hegemonic state government and its bureaucratic elite. This has been equally true under socialist governance (circa 1949-1978) and the market capitalism (post-1978), in which the relentless modernization drive has engendered a hierarchical ranking based on political and economic status.

So AIDS-related stigma does not occur autogenously. From the disease's outset, people with HIV/AIDS have constantly been labeled "deviants" or associated with socially unacceptable forms of behavior such as drug use, prostitution,

and male homosexuality (Alonzo and Reynolds 1995; Green and Sobo 2000; Herek 1999). The production or reproduction of difference through AIDS labeling of "high-risk" groups has contributed to social effects that go beyond the sheer epidemiological purpose of calling attention to the high incidence of infection among certain populations. Stigma arose when the public linked "high-risk groups" to preexisting negative stereotypes. When the general public considers a group of people "culturally" predisposed to a particular type of problem, they may also consider them unworthy of investment in resources (Lock and Nichter 2002). Under these circumstances, the "at-risk" label may actually place individuals or groups at further risk, owing to a fatalism that commonly arises after the withdrawal of external support (Hahn 1999).

Many scholars have criticized the inappropriate labeling of high-risk groups (e.g., Dworkin 2005; Frankenberg 1993; Glick Schiller 1992; Hyde 2007; Schoepf 2001), and have even proposed the concept of "structural violence" to analyze AIDS stigmatization caused by, or contributed to, the "at-risk" label (e.g., Castro and Farmer 2005; Farmer, Connors, and Simmons 1996; Parker and Aggleton 2003). Possible forms of structural violence include racism, sexism, poverty, and other inequalities that are rooted in the historical and socioeconomic processes that also shape discrimination against people with the disease.

Ever since its emergence, the stigma of AIDS has become a human rights concern. The United Nations and other international organizations often stress the urgent need to counteract stigma as part of the worldwide fight against the disease (Castro and Farmer 2005). International, or more precisely, Western-derived organizations are crucial in formulating the ways in which AIDS is conceptualized and combated. When they impose Western discourses on AIDS worldwide, human rights has become a major issue (Altman 1998). Despite the differences in motivation and practice among international agencies, they have acted in concert to establish a universal anti-stigma agenda and coping strategies that help combat the disease. This international campaign shaped even the planning and practices of state intervention in remote southwest China.

The Importation of a Global Anti-stigma Agenda

Beginning in 2001, China-UK HIV/AIDS Prevention and Care Project (hereafter, the China-UK Project or the Project) was set up in Limu and other localities across Sichuan and Yunnan provinces; the duration of the first phase of the Project was five years. The Project was sponsored by the Department for International Development (DFID), an official British aid agency, in cooperation with the Chinese government. According to the bilateral memorandum, the China-UK Project would experiment with successful international AIDS intervention practices in the recipient communities. A guiding premise was that the Project's practices would be consistent with Chinese conditions (China-UK 2000). Those so-called "Chinese conditions" in practice meant that implementation would be in conformity primarily with bureaucratic rather than local sociocultural conditions.

In China, any foreign aid, especially in rural areas, including the Limu project, must be funneled through state agencies, from the top to the local, for approval and distribution. Considering the country's general bureaucratic inertia, how local state agents execute a project may not be in accordance with national or international planning. Implementation is, thus, a process fraught with intersecting cultural, social, political, and economic tensions and accommodations in both the national and local contexts.

In the Chinese national context, the label "high-risk groups" in relation to AIDS is not only a medical designation but also a legal, political, and moral one (Hyde 2007). As in many countries, the label connotes personal misconduct or characteristics that can be classified as "deviant," but in China, the state also considers deviance a threat to public security and a challenge to government authority. For example, among high-risk groups, drug users are specially targeted because China's HIV/AIDS epidemic began among needle-sharing heroin users among whom it spread along drug trafficking routes from Central Asia and Myanmar; these run through the largely minority regions of south and southwest China (Beyrer et al. 2000; Kaufman and Meyers 2006). Targeting drug users is additionally part and parcel of China's war on drugs, an important component of its modern nation-building project (Zhou 1999).

The label of "at-risk groups" also carries preexisting moral connotations the state has associated with certain populations since the founding of socialist China. In the Nuosu context, for instance, the state adopted Marxian-Morganian evolutionary theory (from primitive society to slave, feudal, capitalist, and, lastly, socialist society) to categorize its ethnic minorities, and it relegated the Nuosu to a low rung on the societal development ladder, calling the Nuosu the only surviving "slave society" in China in the 1950s.[2] In the eyes of the state, the Nuosu and their cultures stood as "deviant" to its science-based and Han-centered governance. In recent years, the prevalence of heroin use and HIV/AIDS among the Nuosu has only earned them more negative stereotypes.

Knowledge of preexisting stereotypes is crucial to our understanding of the state's AIDS interventions in China. As both a fatal infectious disease and "an epidemic of signification," AIDS has shown a "continuum… not a dichotomy, between popular and biomedical discourses," as Treichler (1999:15) puts it. Under such circumstances, it is no surprise that AIDS-related stigma and discrimination have become a major problem across China (He and Detels 2005). Some provinces or cities have even instituted explicit discriminatory practices against people with HIV/AIDS (Davis 2003). In 1999, Chengdu, the capital city of Sichuan Province, enacted a law that prohibited HIV-infected people from applying for marriage licenses (Hyde 2007). Policy researchers have frequently pointed out the

stigma of AIDS among Chinese health workers and officials, seen in their reluctance to work with HIV-infected people (Wu, Rou, and Cui 2004; Yang et al. 2005).

Researchers and international organizations working with the Chinese government have all emphasized the importance of preventing the formation of stigma against people with HIV/AIDS and have proposed various plans to minimize such a development (e.g., China-UK 2001; Kaufman and Jing 2002; UNAIDS 2001). It is in this context that the state AIDS intervention in Limu followed the international regime and prioritized an anti-stigma agenda. Unfortunately, the counter-productiveness of its efforts underscores the failure of a top-down, de-contextualized intervention program. The case of Limu demonstrates that the government-sponsored scheme was a self-fulfilling prophecy: it first created and then opposed a stigma that was much more limited by local factors than imagined. In the process, it engendered a local public discourse at odds with its initial intervention goal.

In the next section, I explain the earlier absence of AIDS-related stigma in Limu. My construction of an ideal-typical explanatory model for the Nuosu moral world aims at filling the conceptual gaps between the Limu peasants' and state agents' ideas about AIDS. My description and discussion of the local moral world are not chronological but topical; the aim is to highlight the co-existence of contradictory phenomena and demonstrate the dynamic process of changing moral codes in Nuosu people's everyday lives.

The Nuosu Moral World

Driven by their anti-stigma concerns, health workers and government officials involved in the China-UK Project were endlessly puzzled at the general absence of AIDS stigma in Limu in the early stages of program implementation. The state agents came to believe that the peasants did not hold adverse feelings toward the disease because they knew little about its fatality. This speculation, however, is contrary to other reports that indicate simple misunderstanding or little awareness about the emerging epidemic has often caused hyper-vigilance among the public and creates hostility toward HIV/AIDS patients (Green and Sobo 2000).

To fully explore the complicated factors underlying Limu's situation, I examine four facets of the Nuosu culture: kinship relationships, disease etiology, the Nuosu theory of death causality and liability, and the taxonomy of death. A discussion of indigenous Nuosu reasoning may help explain why local people have only a vague perception of AIDS as a disease and do not harbor prejudice toward its victims.

Stigma in a Kinship-Based Society

In rural Nuosu society, individuals can barely survive emotionally without their lineage's support, and the most dreadful punishment for an ordinary Nuosu is to be expelled from one's lineage (Bamo 1994). Prior research has reported that HIV-infected Nuosu in Limu and elsewhere in Liangshan continued to participate in lineage meetings and share food and drinks with healthy kinsmen who seemingly had no apprehension about their participation (Hou et al. 2003). This inclusive kinship principle, with its central concern for the general well-being of all kinsmen, undermines the centrifugal forces of stigmatization.

The kinship principle dominates the Nuosu social milieu in which AIDS is situated, but kinship alone cannot account for the general absence of stigma in Limu; locals do not stigmatize people with HIV/AIDS outside their kinship networks either. Turning this reasoning the other way around, we find that they do not automatically accept *all* kin members unconditionally. In other words, the Nuosu *do* have their own cultural criteria—or discriminatory conditions—that facilitate their identification of difference and labeling of deviance, in opposition to normality.

In Nuosu society, deviance and major social stigma are often associated with the breaching of established norms and precepts that originate from within the kinship universe. Most non-disease-related stigma arise from socially unacceptable conduct judged to violate preexisting social relationships. For instance, anyone who steals from other lineage members or engages in sex that violates the incest taboo code (among lineage members as remote as up to 20 or more generations) can anticipate facing strong stigma, possibly the death penalty, or at least ostracism from kinship networks that extend beyond the local community.

As for disease-related stigma, the most serious attaches to people who live with leprosy, tuberculosis, or nauseating body odor. On the basis of their worldview and disease etiology, the Nuosu consider these three conditions "hereditary." Consequently, intermarriage with people bearing them is taboo because the Nuosu fear that these marriages—through reproduction—will spread the illnesses or symptoms among the lineage. People even express strong aversion to the kin of a person with such symptoms, a sort of "courtesy stigma" attached to "normal" people related to the stigmatized person (Goffman 1963). To protect lineage members from contagion and to preserve the lineage reputation, kinsmen would in the past kill any member with these conditions, lepers in particular. At the very least, they would be sent into exile to live in the wilderness. AIDS as a disease has not been identified or categorized as a "hereditary" disease, and, hence, it has yet to jeopardize kinship relationships the way other stigmatized diseases do.

Nuosu Popular Knowledge of Diseases and Illnesses

In all societies, diseases demand explanation, and this is a culturally informed process (Logan 1996). Kleinman (1980) proposes an explanatory model to distinguish the objective and subjective natures of sickness; namely disease vs. illness. A disease is the physiological malfunctioning of the organic body that incapacitates the patient. An illness, on the other hand, is a disease symptom that is defined by the native point of view as "sick," according to established norms. Following

this explanatory model, we may argue that the biomedical fact of AIDS as a new disease has yet to be incorporated into culturally established illness categories of the Nuosu.

According to traditional Nuosu culture, most illnesses are caused by ghosts or the loss of the patient's soul (Azi 1993; Liu 2001). This etiology still dominates Nuosu peasants' daily life to a considerable degree. Although in some cases they may agree that science-based biomedicine has the most potency to treat certain physiological problems, especially those concerning acute diseases, they may still reckon the "actual" or "original" cause of illness through their cultural lens. Even today, Nuosu peasants still spend a considerable amount of money on ritual healings, as much as they do on biomedicine (Zhongguo 1999).

Bimo (traditional Nuosu priests or ritual healers) have a body of knowledge about illnesses and treatments that derives from their predecessors and ritual texts. AIDS has yet to be classified as a distinctive disease category in this tradition. A bimo who once held exorcism rituals to treat two HIV-infected patients in Limu explained to me how he conceptualized AIDS:

> I don't know anything about AIDS. I just treat their illness symptoms and identify what the problems are in their body and in their relationships with specific ghosts, with the help of our bimo ritual texts and instruments. All disease symptoms are recorded in the texts. *There is no AIDS ghost*.

Indeed, many AIDS symptoms are quite similar to what local Nuosu have already experienced in their rural environment where inadequate hygiene, nutrition, and medical services are chronic problems and common diseases prevail. People are familiar with symptoms such as fever, fatigue, diarrhea, coughing, rash, and external infections. They also can recognize symptoms to diagnose diseases such as tuberculosis, liver disease, and skin disease. In short, local people may link many AID-related symptoms to their established knowledge of illness and, therefore, do not need to identify and explain AIDS as a "new" disease.

During my casual conversations with Limu people, they often asked me what AIDS "really" is or whether there is an AIDS disease. Many did not believe the disease existed at all. Some patients might have accepted their biomedical status of HIV infection, but their knowledge of AIDS remained vague. For example, one day at the Limu clinic, I saw an HIV-positive couple coming in for the wife's treatment. Upon seeing me, they invited me to visit them that evening when they would be holding a bimo ritual. I asked them the reasons for the event and the husband replied, "We Nuosu believe that there must be ghosts for our unknown illnesses." I was curious and kept asking, "But you know you are HIV-infected and why you are sick. So why do you need the bimo?" The man explained:

> I know my AIDS comes from my drug injection. And my wife's AIDS [virus] was transmitted from me. So we don't rely on bimo for treating our AIDS. But my wife coughs endlessly and has had bad diarrhea lately. We think that these are caused by ghosts, and we want the bimo to find out which ghosts.

These remarks suggest the extent to which local Nuosu consider AIDS to be an amorphous disease. It has yet to carve out a niche in their traditional universe of illness.

The Nuosu Theory of Causality

The Nuosu have a general theory of causality that provides a rational scheme of culpability in life events, which can further help explain how their moral convictions resist the formation of AIDS-related stigma. When deliberating about a person's bodily injury or death, Nuosu people typically attribute cause to the latest and most immediate event. This reasoning is comparable to that of the Jalé in New Guinea: "Jalé's reasoning deduces jural liability from a doctrine of effective action that does not distinguish between intent, negligence, inadvertence, and accident as aggravating or extenuating circumstances" (Koch 1974:87).[3]

A Nuosu proverb best reveals this doctrine of direct and immediate causation: *Gene torruo masuwe, syne orruo masuwe* (In wrestling, the one on top wins; in death, the one at the bottom wins). This means that the dead person always merits compensation regardless of his or her previous conduct, and the person who "causes" the death is liable regardless of his or her intentions or circumstances. For instance, if person A exposes person B to be a thief, and subsequently B commits suicide out of shame, person A will be held responsible for B's death, regardless of whether B has actually stolen. When a death is involved, *ndeggu* (traditional Nuosu judges or mediators) frequently quote the proverb above when dispensing justice. This sort of death is called *nga sy ne bby*, literally meaning "I give my death to you," signifying B's most effective method of protest against A. As a rule, the Nuosu are reluctant to express their negative feelings toward someone directly to his or her face. In light of this Nuosu judiciary doctrine, should someone humiliate an HIV-infected person and "cause" him or her to commit suicide, the discriminating person will have to compensate dearly.

The Taxonomy of Death

By and large, local Nuosu do not avoid preparing and attending funerals for the HIV-infected dead. I saw female kin and relatives stay beside or touch the face of a newly deceased victim to express their affection. Male kin prepared the cremation of the dead the same way they do for those who have died of "ordinary" causes. Kin, relatives, friends, and neighbors came from near and far to mourn the dead as common courtesy. Upon my questioning how they thought of HIV-related deaths, local Nuosu usually responded, "They died of AIDS, just as other people die from normal sickness."

The Nuosu have their unique way of distinguishing between normal and abnormal deaths and performing different

commemorating rituals. Normal deaths include those from *nas* (illness) and *mojji* (senility). *Bby* (abnormal deaths) are caused by murder, suicide, or accidents. Each category has its distinct mortuary treatment. For example, the bodies of the abnormally dead cannot be burned on hillsides or in the woods as can those of the normally dead. The abnormally dead must be burned next to a stream and, immediately after cremation, the ashes are to be washed away in the running water. I observed that the Nuosu cremator burned HIV-infected bodies the same way as other normally dead as a group of kinsmen waited on-site for the completion of the cremation.

The Nuosu taxonomy of death is directly related to their general theory of causality. People point to the latest and most direct factor as the "real" killer when deaths are associated with multiple causes. For example, when someone's death involves drugs, people count the death as normal if the person falls ill for a few days after injection. In contrast, the death is reckoned as abnormal—an accident—if it occurs immediately after the injection. In line with this reasoning, people who injected heroin using contaminated needles, contracted HIV, and eventually died of AIDS symptoms were viewed to have had a normal death.

For these reasons above, in early days, local Nuosu did not assign negative labels to AIDS or its victims. In recent years, however, I have begun to notice changes. During my initial visit to Limu in 2002, I never observed or heard of any AIDS stigma. I interviewed a young man who married that year. No one from his or the wife's family objected to him because of his HIV status. Later in 2004, when the sister-in-law of a young male drug user with HIV was transferred (married) to him following the Nuosu levirate rule, she made no objection. But by 2005, most young people I spoke to clearly rejected the possibility that they would marry anyone with HIV/AIDS. Although local Nuosu retained their old perceptions about AIDS and generally did not stigmatize its victims, the fear of AIDS seemed to be creeping in, and it has continued to grow in people's daily lives.

State Practices vs. Folk Responses

International public health protocols have intersected with the Nuosu moral codes as state AIDS interventions have inculcated a new sense of stigma among the locals. The China-UK Project identified the Nuosu as the most volatile and epidemic-prone population in Sichuan Province (China-UK 2001), and state agents link people in Limu and other HIV-hit localities in Liangshan to old stereotypes of the Nuosu, treating them with a certain condescension. Unsurprisingly, the Project's promise to consult local knowledge and practices remained an empty one.

The China-UK Project, like other international AIDS interventions, called for anti-stigma efforts to protect the human rights of people with HIV/AIDS. The project team working in Limu received directives from above and proceeded on the assumption commonly seen elsewhere that ordinary people would respond negatively to people with HIV/AIDS (Parker and Aggleton 2003). Naturally, the project team adopted the state's habit of using public slogans as key instruments of policy dissemination.

The eye-catching slogans in Limu, put up right after the Project was launched, revealed the state agents' fear and unease toward AIDS and its victims. They served as more of a declaration of the agents' authority and altruistic efforts than as messages for public education. But the Nuosu peasants remained indifferent to the slogans, in large part because of the region's high illiteracy rate.[4] Moreover, since local people tended not to stigmatize people with HIV/AIDS, they needed no "correction" for non-existent prejudices. Even years after the Project's intervention, most Limu people still cannot make sense of what the state agents told them about AIDS. As one local health worker concluded in 2005, "There is no AIDS in the minds of our Nuosu peasants. It's hard for us doctors to teach them about it."

Unfortunately, the warnings and painted signs *did* convey the message of a fearsome new disease to one local demographic group, the mostly educated state agents—government officials, health workers, and primary school teachers. In their conversations with me, they often expressed moral condemnation of AIDS and its victims. Some health workers suggested that all HIV-infected people be quarantined in a separate locality so there would be no further transmissions. Other health workers questioned why HIV-infected people should be entitled to the Project's free treatment of symptomatic illnesses and considered them just "troublesome." One commented, "*zizuo zishou*" ("They reap what they sow!") Some officials complained that their work exposed them to the risk of HIV transmission, even though they had no direct bodily contact with HIV-infected people. One said to me, "We [the project team] are under a lot of stress. Think about the risks we run *facing* these HIV-positive people everyday! I don't want to do this work. It's too risky!" In reality, his main project-related duties were delivering charity materials and presenting lectures to registered HIV-positive people—hardly risky activities by any biomedical standard. This sense of repulsion stood in ironic contrast to the idealistic China-UK Project proclamation of "A Beloved Homestead" hung at the entrance to the township government building.

Fear of AIDS can be contagious. The driver for the China-UK Project did not want to get out of his vehicle any time he drove officials over to Limu for inspections because, as he argued, "Here [in Limu], it is horrifying. I don't want to contract AIDS!" A Limu primary school teacher who lived in the township clinic screamed in fear when she realized that she had just touched an embroidery made by a local HIV-infected woman. She cried out, "What can I do [to remedy my exposure to the disease]? I haven't gotten married yet!"

By exploring these negative reactions, we may trace the steps of Limu's developing stigmatization of AIDS. The China-UK Project provided local peasants with many forms of AIDS education, from propaganda posters in the township

clinics to mass lectures delivered at the local school and during township and village meetings. Failing to convey correct AIDS knowledge to local Nuosu, not least because of their own vague understanding of the disease, state agents resorted to lecturing peasants on the dreadful characteristics of AIDS in hopes of promoting awareness. Once I heard a township official at a village meeting give the following warning: "Han people are not afraid of leprosy but of AIDS. But you are scared of leprosy, not of AIDS. It's no good. *You should be afraid of AIDS.* It's fatal and incurable!" On another occasion, a village cadre put it this way: "We are all afraid of AIDS. The AIDS education has taught us that. Being infected means you have at most 15 more years to live, just like probation from a death sentence!" This sort of warning kept circulating out to and among Limu peasants.

By continually lecturing on AIDS and, in particular, by conveying the horrifying effects of the disease, state agents overcame the initial obstacle of general illiteracy and instilled in Nuosu peasants a vague idea of AIDS as a fearsome disease—a mixture of biomedical assertions, half-truths, and a degree of guesswork. Acceptance of this problematic conception was more pronounced among people who interacted more with state agents or who lived adjacent to the clinic, the school, or the township government office. This local demographic difference in conceptualizing AIDS reveals how its stigmatization has taken shape along power lines, from international and national levels through state agents to local educated people and gradually to the entire community.

One day in September 2005, my informant Quti was squatting in front of his house; he had bruises and scratches on his face. Quti, a slender and mild man said to be HIV-infected, lived by the township office. He had had a big fight with his robust wife the night before. His wife had learned from others that AIDS was a frightening disease. She scolded Quti about his disease. The previous year a health worker informed Quti about his HIV-positive status, but he did not ask him to attend the Project's monthly AIDS sessions. So Quti thought his "AIDS" had already been cured. Unbeknownst to Quti, his name did not appear on the Project's roster of HIV cases, even though he already acquired the official "AIDS" label in 2004. When his wife blamed him for having the disease, he replied, "I am cured. I don't have AIDS now." But she refused to believe him and beat him out of fear and anger. A few days later, Quti's wife asked me privately, "Is there *really* AIDS?" I told her that there is indeed an AIDS disease but it is often preventable if people follow simple and appropriate protection procedures, such as condom use. But she abruptly ended our conversation by asserting, "I don't believe in AIDS. People say it doesn't exist." The disparity between the professional and the vernacular perceptions of AIDS underscores an eloquent characterization of AIDS as "an epidemic of clarity, a disease of confusion" (Setel 1999:183). Moreover, such ambivalence about AIDS shows how messages emanating from the state run their course in the local people's minds.

The Emerging Stigmatization of AIDS

Over the course of my stay in Limu, I observed that local people's negative perception toward AIDS and its victims has grown in frequency and intensity. In this township, there is no secret as to who is HIV-positive because of the Project's broad-based blood tests and the charity goods distributed to registered patients. Often, when people introduced or described someone who was HIV-positive to me, they would mention the person's "AIDS" along with the lineage name. Once I attended the funeral of a woman who had died the day before. One of her elder kinsmen led me into her one-room house. Inside, I found her body beneath the television set that was mounted up high on the wall. There were 20 to 30 women, young and old, sitting by her side or against the wall watching the flickering screen. Knowing that I carried a camera, the elder man glanced at the dead woman and said to me, "AIDS. Take a picture?" Several women in the room laughed and gazed at me expectantly. My local knowledge told me that Nuosu people do not readily disclose a shameful or stigmatized death case, particularly to an outsider like me. In brief, numerous AIDS-related episodes suggest to me that while the locals still entertained the idea that AIDS does not fall into the category of abnormal disease, they have gradually come to identify the disease as something special, whose exact nature has yet to be defined.

The long-term negative consequence of labeling is stigmatization, which develops incrementally rather than all at once (Link and Phelan 2001). Moreover, the distribution of stigma may not be uniform or even: young people may be more receptive to new ideas than the old. As local Nuosu learned that AIDS is to be feared and categorized differently, some have begun to translate these ideas into their interaction with AIDS-labeled people. One day, I invited several local young men to lunch. One of them did not make it because, as he privately confessed to me later, he did not want to eat with another guest who was HIV-positive.

The growing stigmatization of AIDS is also finding expression among infected people themselves. One young HIV-infected man made me especially aware of this "stigma consciousness" (Pinel 1999). During my fieldwork, men liked to shake hands with me as a way of expressing their welcome or friendliness. This man did not offer his hand upon my arrival. I assumed he was just shy, so I extended my right hand toward him. He hesitated and said, "I have AIDS…." At that moment, it dawned on me that he had internalized others' fear of his disease and himself.

In its initial stages, stigma development may appear vague and amorphous. For this reason, we should not be surprised that the stigmatization of AIDS in Limu has so far seemed indeterminate. Coexistent with the emerging stigma toward AIDS came other observations: HIV-infected men still joined lineage meetings, participated in social activities, drank together with kinsmen on these occasions, and enjoyed leisure time with friends and neighbors; they also continued to labor with others in the fields, in the local cement factory, and on construction projects beyond Liangshan.

However, the abovementioned episodes, one involving the fear of eating with an HIV-positive man and the other the hesitation of an infected man to shake hands, made me aware of an additional factor that should be taken into account. In these two cases, the HIV-infected persons were extremely poor. I know many better-off people with HIV/AIDS who have not encountered comparable social isolation or discrimination. Stigmatization as a social process surely takes shape along the fault lines of inequality and power disparity (Castro and Farmer 2005; Link and Phelan 2001; Parker and Aggleton 2003; Yang et al. 2007). As Limu takes strides toward a market economy in China's post-reform era, its traditional moral economy is changing in sync with its capitalist development (Heberer 2005; Liu 2007b).

The social process of stigmatizing AIDS in Limu has revealed itself to be a complicated and delicate issue entwined with the local moral world, the overarching political economy, and the state's AIDS-intervention practices. Both state agents and local peasants participate in this process. As a village cadre stated, "We knew nothing about AIDS until the China-UK Project came here. Now everybody is afraid of AIDS. But we don't stigmatize AIDS patients…. It's hard to say whether there will be discrimination in the future."

Preventing and removing stigma is truly important in any AIDS-intervention project. Yet such projects should be based on a prior understanding of local moral codes. International intervention protocols underscore that all local values and meanings are cultural constructs and all services and interventions should be locally appropriate (e.g., UNAIDS 2000). In many situations, however, the notion of "culturally appropriate AIDS intervention" is an empty promise because of policymakers' or practitioners' ignorance of cultural difference and the structures of power inequality (Pigg 2002). Limu's case offers a critique of the "AIDS industry" in which AIDS is a cause of one form of globalization, "namely the dissemination of western-derived discourses to other societies" (Altman 1998:233). The state's mechanical application of the global anti-stigma agenda to the Nuosu community ignored the local situation. State agents, through their problematic practices, have projected themselves into a local quagmire in which they "are experience-distant, [and] are at risk of delegitimizing their subject matter's human conditions" (Kleinman 1995:96). Their anti-stigma practice has contributed to, rather than prevented or alleviated, stigmatization of AIDS in Limu.

Notes

[1]The Chinese Communist Party considers propaganda to be of great political importance in conveying messages from the top to the masses; it considers *kouhao* (slogans) the principal vehicle by which to attain social-engineering goals. For a detailed discussion about rhetoric and the effect of political slogans on transforming Chinese official ideology, see, for example, Lu's (1999) analysis about political slogans between the 1960s and the late 1980s.

[2]Whether Nuosu society is a "slave society" is hotly debated, especially between Chinese ethnologists and Western anthropologists (Harrell 2001; Hill 2001). Hill (2001), in particular, argues that slave labor was not essential to the structures of production in Nuosu society and that, therefore, the Nuosu society was a society with slaves but not a slave society.

[3]Occasionally, the Nuosu may consider a culprit's motivation in an accidental or unpremeditated killing, and the factor of motivation may lead to other forms of compensation. However, in a murder case, a culprit's shirking of the death penalty (namely, collectively demanded suicide) will generally lead to disrespect in the community (Qubi and Ma 2001).

[4]According to the 2000 population census, in Zhaojue County where Limu is located, 37 percent of the population above the age of six had had no schooling at all (Sichuan Sheng Renkou Pucha Bangongshi 2002).

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