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Navigating identity, territorial stigma, and HIV care services in Vancouver, Canada: A qualitative study

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ABSTRACT

This study examines the influence of territorial stigma on access to HIV care and other support services. Qualitative interviews were conducted with thirty people living with HIV (PLHIV) who use drugs recruited from the Dr. Peter Centre (DPC), an HIV care facility located in Vancouver, Canada's West End neighbourhood that operates under a harm reduction approach. Findings demonstrated that territorial stigma can undermine access to critical support services and resources in spatially stigmatized neighbourhoods among PLHIV who use drugs who have relocated elsewhere. Furthermore, PLHIV moving from spatially stigmatized neighbourhoods – in this case, Vancouver's Downtown Eastside – to access HIV care services experienced tension with different groups at the DPC (e.g., men who have sex with me, people who use drugs), as these groups sought to define who constituted a'normative' client. Collectively, these findings demonstrate the urgent need to consider the siting of HIV care services as the epidemic evolves.

1. Introduction

As assemblages of people, objects, and practices (Cummins et al., 2007; Gieryn, 2000), places hold specific meanings bound up with lived experiences (Chiotti and Joseph, 1995) and significantly impact people's practices, interactions, and identities (Butler, 1990; Dovey et al., 2001; Duff, 2011, 2012; Fast et al., 2013). This shaping of identities and practices typically results in the clustering of individuals with a shared sense of 'place' or 'community' (Chiotti and Joseph, 1995; Eyles, 1985; Thompson et al., 2007). However, places, people, and experiences are co-constructed and produce an intricate agglomeration, in which each element is actively shaped and reshaped by the others. For stigmatized populations, such as people living with HIV (PLHIV) and people who use drugs (PWUD), experiences of place can influence their access to health care services (Chesney and Smith, 1999; Nations and Monte, 1996), and contribute to adverse health outcomes (Keene and Padilla, 2010, 2014; Latkin et al., 2013; Wutich et al., 2014).

An emerging body of literature suggests that the spaces – or neighbourhoods – in which marginalized, urban populations reside can be marked by stigma and 'discourses of vilification,' especially when socially constructed as dangerous by outsiders (Takahashi, 1997; Wacquant, 1999, 2007). Such territorial stigmatization is often reinforced by popular media discourses (Liu and Blomley, 2013; Wutich et al., 2014) and functions to affirm the existing stigmas experienced by these populations due to socio-structural inequities (e.g. classism, racism). The resulting 'blemish of place' (Wacquant, 2007) denigrates neighbourhood occupants who often embody stigmatizing discourses, disrupting their sense of identity and social interactions, while also constraining their access to other neighbourhoods (Keene and Padilla, 2014; McNeil et al., 2015; Wutich et al., 2014). As such, territorial stigmatization exacerbates inequality for these populations, often leading to considerable consequences for their well-being.

The role of this socio-spatial stigmatization and exclusion in producing vulnerability to adverse health outcomes and undermining access to resources (e.g. education, employment) has been documented since the 1990s (Chesney and Smith, 1999; Chiotti and Joseph, 1995; Nations and Monte, 1996; Takahashi, 1997). This body of literature has provided an understanding of the exclusionary function of stigma associated with space, and the impacts this has on individuals' negotiation of place and identity. Although

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the concept of territorial stigma has only begun to be applied in health research, it has been employed in studies focusing on housing inequities and community development (August, 2014; Garbin and Millington, 2012; Kallin and Slater, 2014). Here, it has been associated with state-sponsored gentrification (Kallin and Slater, 2014), particularly around mixed public housing. For example, August (2014) highlights residents' connection to a stigmatized neighbourhood and sense of community despite discourses of danger and isolation. Additionally, Garbin and Millington (2012) describe ways in which residents manage or disassociate themselves from territorial stigmatization and urban marginalization, highlighting ways stigma is inflicted upon residents and reproduced.

However, the concept of territorial stigma has more recently been employed to advance understandings of how these processes further vilify stigmatized populations as they move – or attempt to move – from stigmatized places or neighbourhoods into other areas (Keene and Padilla, 2014; McCormick et al., 2012; McNeil et al., 2015; Rhodes, 2012; Thompson et al., 2007; Wacquant, 2007; Wutich et al., 2014). While rooted in geographic areas, territorial stigma is mobile and follows people as they move from stigmatized areas to other spaces, whether other neighbourhoods (McNeil et al., 2015) or entirely new cities (Keene and Padilla, 2014), and engage in other spaces. In doing so, it limits individuals' access to specific spaces. Keene and Padilla (2010, 2014) argue that territorial stigma can negatively impact health by limiting individuals' access to resources (e.g. employment, housing, health care), creating stress and negative coping mechanisms (e.g. discrimination), and facilitating unfavourable methods of identity construction (e.g. isolation). McNeil et al. (2015) have also outlined how territorial stigma can function to undermine access to critical resources (e.g. harm reduction services, HIV care) in outside neighbourhoods even when individuals face legal restrictions that prohibit them from entering resource-rich stigmatized neighbourhoods. Additionally, Graham et al. (2016) have explored spatial stigma as a social determinant of health, highlighting how residents' sense of identity and community interactions may restrict access to health promoting supports and services.

Understanding how territorial stigma operates and impacts the well-being of vulnerable populations is integral to understanding socio-structural and spatial inequalities that render particular populations disproportionately vulnerable to poor health. This is particularly relevant in the context of HIV care and ancillary services, which are often located in neighbourhoods with high concentrations of men who have sex with men (MSM) and PWUD (Cain, 2002; Carter et al., 2015). While health and social service facilities have often been spatially concentrated in urban cores, often termed 'service-dependent ghettos' (Dear and Wolch, 1987; Wolch, 1980), there has been a more recent movement towards dispersing facilities, and thus stigmatized populations, outside of these areas (Evans, 2012; Yanos, 2007). For vulnerable populations living with HIV, territorial stigma can possibly exacerbate the obstacles that they encounter in seeking care and accessing supportive service facilities (e.g. classism, drug-related stigma), impeding their willingness to seek treatment. The physical location of HIV services can create impediments for vulnerable individuals due to travel barriers (e.g. cost and distance of travel) (Rhodes et al., 2005). As Wilton (1996) demonstrates, spatial barriers to accessing HIV care are also impacted by physical, psychological, and social challenges (e.g. fear of HIV disclosure), constraining individuals to a particular space.

Moreover, services targeted at "assumed communities," such as PLHIV or people who inject drugs (PWID) (Fast et al., 2013), can hinder access to specific care services as individuals' experiences and 'sense of place' can be at odds with the targeted 'community' (Carter et al., 2015). Additionally, particular spaces can guide the construction and reconstruction of individuals' identities (Robinson, 2000). As such, moving between spaces can disrupt socio-spatial networks, which presents challenges for individuals whose identities are constructed through specific 'group' and space associations and disassociations (Fast et al., 2010; Robinson, 2000).

Examining the impacts of territorial stigma on access to HIV care services is of particular importance in Vancouver, British Columbia (BC), which has experienced co-occurring and spatially concentrated HIV epidemics among MSM and PWUD. Vancouver's MSM community was first impacted by the HIV epidemic in BC in the 1980s, and remains the most impacted group in the province (BCCDC, 2015; McInnes et al., 2009), making up 59% of new HIV diagnoses in 2013 (BCCDC, 2015). Meanwhile, the city's injection drug-using population experienced an explosive HIV outbreak throughout the 1990s and an estimated 23% were living with HIV by the mid-1990s (Strathdee et al., 1997). While transmission rates have steadily declined among both populations due to advances in HIV treatment and prevention (e.g. increased availability of harm reduction services, universal access to HIV treatment) (Hogg et al., 2012; Hyshka et al., 2012; Wood et al., 2012), they remain at an elevated risk of HIV transmission (Antiretroviral Therapy Cohort, 2008; BCCDC, 2015).

The HIV epidemics among MSM and PWID populations are concentrated in the West End and Downtown Eastside, respectively (McInnes et al., 2009). Vancouver's West End is a primarily middle class neighbourhood and the historical centre of the province's largest MSM community (Wood et al., 2000; Woolford, 2001). The Downtown Eastside, an approximately ten-block area, was the historic centre of Vancouver and the city's oldest residential neighbourhood. This neighbourhood is the site of the city's primary street-based drug scene and serves as a metonym for urban disorder in popular discourse (Liu and Blomley, 2013; Woolford, 2001). Both the Downtown Eastside and the West End have a high concentration of HIV care services, specifically targeting PWID and MSM populations (see Fig. 1), respectively. Although popular stereotypes that characterize neighbourhoods, such as the Downtown Eastside and West End as drug scenes and 'gayborhoods' (Ghaziani, 2014), respectively, are of further relevance to co-occurring HIV epidemics, these constructions likely overlook how their physical and demographic characteristics change as cities evolve. Nonetheless, popular stereotypes linked to such neighbourhoods are important markers of place-based identity politics. However, little is known about how stigma is experienced and mobilized by individuals as they move from one neighbourhood to another to access HIV care services.

In this paper, we explore how stigma shapes particularities of place and creates exclusivity within the Dr. Peter Centre (DPC)—a community-based HIV care service organization located in Vancouver's West End. Due to the large client base who use illicit drugs, the DPC integrated harm reduction strategies into its programming in 2002 to minimize drug-related harm and address the diverse needs of clients (Hyshka et al., 2012; McNeil et al., 2014). As a result of its location, the DPC is positioned in a way where emerging experiences of place can be examined as individuals move between neighbourhoods. We explored how territorial stigmatization shapes access to services, identity negotiation, and 'sense of place,' intensifying stigmatizations as people move from Vancouver's Downtown Eastside to the West End to access the DPC. We also sought to generate insights into how territorial stigma operates within the DPC so as to inform the development and siting of community-based HIV care services as co-occurring epidemics continue to evolve in urban settings.

2. Methods

We draw upon semi-structured, qualitative interviews