Published in final edited form as:

Health Place. 2016 July ; 40: 169–177. doi:10.1016/j.healthplace.2016.06.005.

NAVIGATING IDENTITY, TERRITORIAL STIGMA, & HIV CARE SERVICES IN VANCOUVER, CANADA: A QUALITATIVE STUDY

Alexandra B. Collins¹, Surita Parashar¹, Kalysha Closson^{1,2}, Rosalind Baltzer Turje³, Carol Strike⁴, and Ryan McNeil^{1,2}

¹ BC Centre for Excellence in HIV/AIDS, Vancouver, BC, Canada

² Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, Canada

³ Dr. Peter AIDS Foundation, Vancouver, BC, Canada

⁴ Dalla Lana School of Public Health, University of Toronto, Toronto, ON, Canada

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.

Keywords

territorial stigma; HIV; neighbourhoods; qualitative research; place; Canada

INTRODUCTION

As assemblages of people, objects, and practices (Cummins, Curtis, Diez Roux, & Macintyre, 2007; Gieryn, 2000), places hold specific meanings bound up with lived experiences (Chiotti & Joseph, 1995) and significantly impact people's practices, interactions, and identities (Butler, 1990; Dovey, Fitzgerald, & Choi, 2001; Duff, 2011,

Send correspondence to: Ryan McNeil, PhD, Postdoctoral Fellow, BC Centre for Excellence in HIV/AIDS, 608 - 1081 Burrard Street, Vancouver, B.C. V6T 1Z1, rmcneil@cfe.net.ubc.ca.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Conflicts of Interest: None

2012; Fast, Shoveller, Small, & Kerr, 2013). This shaping of identities and practices typically results in the clustering of individuals with a shared sense of 'place' or 'community' (Chiotti & Joseph, 1995; Eyles, 1985; Thompson, Pearce, & Barnett, 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 & Smith, 1999; Nations & Monte, 1996), and contribute to adverse health outcomes (Keene & Padilla, 2010, 2014; Latkin, German, Vlahov, & Galea, 2013; Wutich, Ruth, Brewis, & Boone, 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 & 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 & Padilla, 2014; Author 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 & Smith, 1999; Chiotti & Joseph, 1995; Nations & 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 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 & Millington, 2012; Kallin & Slater, 2014). Here, it has been associated with state-sponsored gentrification (Kallin & 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 & Padilla, 2014; McCormick, Joseph, & Chaskin, 2012; Author 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 (Author et al., 2015) or entirely new cities (Keene & Padilla, 2014), and engage in other spaces. In doing so, it limits individuals' access from 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). Author and colleagues (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 and colleagues (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 & Wolch, 1987; Wolch, 1980), there has been a more recent movement towards dispersing facilities, and thus stigmatized populations, outside of urban cores (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, Singer, Bourgois, Friedman, & Strathdee, 2005). As Wilton (1996) demonstrates, spatial barriers to accessing HIV care are also impacted by physical, psychological, and social challenges (e.g. fear of 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, Shoveller, Shannon, & Kerr, 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, Strathdee, Wood, & Kerr, 2012; Wood, Milloy, & Montaner, 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 & 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 Figure 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; Author 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.

METHODS

We draw upon semi-structured, qualitative interviews conducted with PLHIV who use drugs and are clients of the DPC. The interviews are a component of the DPC study, a mixed-methods, community-based research initiative exploring social- and structural-level barriers to accessing HIV-related care, and the impact of risk environments (i.e. social, structural, and spatial contexts that shape risk) on health outcomes of marginalized PLHIV. In brief, the

DPC study includes: (1) a virtual cohort (n=145) consisting of current DPC clients who consent to an confidential linkage between their DPC client file and clinical data housed at the BC Centre for Excellence in HIV/AIDS Drug Treatment Program; (2) a longitudinal cohort (n=121) of recent DPC clients meeting specific eligibility criteria (i.e. joined the DPC after February 27, 2011) who participate in an interview eliciting socio-behavioural data; and (3) qualitative interviews (n=30) (see Table 1).

Participants interviewed for the qualitative component of the DPC study were recruited from among individuals completing baseline surveys as part of the longitudinal cohort. Of the 98 participants in the baseline cohort at recruitment, 85 consented to be contacted regarding potential participation in qualitative interviews. A database query was conducted of the 85 consenting participants to identify their demographic characteristics and thus facilitate purposeful sampling. All DPC clients who reported recent illicit drug use (in the six months prior to the survey interview) during their baseline surveys were eligible to participate in the qualitative component of this study. We sought to oversample women because of their underrepresentation among DPC clients, as well as people of Indigenous ancestry due to their disproportionate representation among PLHIV in Vancouver (BCCDC, 2015). At baseline, all participants recruited for the qualitative interviews were registered clients of the DPC Day Health program, a low-barrier community-based basic support program offering clinical and therapeutic services (e.g. counselling). Recruitment letters were sent in waves to eligible participants to allow for purposeful sampling. The first wave of recruitment prioritized women and people of Indigenous ancestry, while the subsequent waves sought to recruit participants of varying sexual orientations and levels of antiretroviral adherence, respectively. The recruitment letter instructed eligible participants to contact the study research coordinator to schedule an interview, if interested in participating.

Despite our efforts to ensure a representative sample to facilitate analyses of gendered and racialized experiences in relation to the DPC and HIV care services, we encountered several challenges. Notably, in recruiting participants in connection with the larger study, our pool of potential participants for the qualitative component of this study included only 7 women (trans inclusive) and 13 Indigenous persons. Although we were able to recruit greater than half of these individuals for participation in qualitative interviews, we were unable to reach others through approved recruitment mechanisms (e.g. recruitment letters, phone).

Interviews were conducted by three trained interviewers in a private meeting room at the DPC between December 2014 and April 2015. Prior to the interviews, the interviewers explained the study, answered any questions, and obtained written informed consent. The interviewer then collected demographic information on screening forms. Substance use was recorded as 30 days prior to interview. An interview guide was used to facilitate discussion regarding participants' perspectives on a range of topics, including the DPC environment (e.g. relationships with other clients), current and previous housing circumstances, and barriers to accessing the DPC. Each interview lasted approximately 60 minutes and was audio recorded. Participants received \$30 CAD honoraria as compensation for their time. A professional transcription service was used to transcribe interviews, which were later reviewed for accuracy by the interviewers. Ethical approval for the study was obtained from

the Providence Healthcare/University of British Columbia and Simon Fraser University research ethics boards.

Analysis began during data collection and employed an inductive approach (Corbin & Strauss, 2008), with emerging themes informing subsequent interviews. Interviewers regularly met with senior team members to discuss data collection and preliminary observations, as well as identify directions for subsequent interviews. Interview transcripts were imported into NVivo qualitative analysis software to facilitate coding and thematic extraction. The research team met regularly to discuss emerging themes during the preliminary analysis to determine ways in which theory could be applied to deepen the interpretation of findings. Based on emerging findings relating to experiences of stigma within the DPC and elsewhere, we drew upon the concept of territorial stigma to lend greater focus to efforts to delineate how participants experienced stigma when moving between neighbourhoods and visiting the DPC (Keene & Padilla, 2010, 2014; Wacquant, 2007, 2008). As part of this analysis, the lead author mapped out participants' residential trajectories and movements between neighbourhoods based on interview data, and characterized how participants operationalized territorial stigma through comparison to narrative data. Of particular interest was how territorial stigma shaped access to and engagement with care and support services within the landscape of HIV care in Vancouver.

FINDINGS

Downtown Eastside, HIV, and Residential Trajectories

All participants described having lived in or been immersed in the Downtown Eastside at some point during their lifetime. Many of these participants identified the Downtown Eastside as their 'place of origin' — that is, the neighbourhood where they had grown up or spent the majority of their lives. In mirroring popular stereotypes of the neighbourhood, participant narratives underscored how the Downtown Eastside was associated with health risks, in particular HIV transmission and suboptimal HIV treatment outcomes. For example, "Sarah," a 44 year-old Indigenous woman, described how her health was "poor and declining rapidly" when she lived in a decrepit single room occupancy hotel in the Downtown Eastside and was not yet taking antiretroviral medication:

My numbers were so low [when diagnosed] that they put me on medication right away and I saw an improvement right away, but I was living in a place where I couldn't manage. I couldn't take care of myself.

Like most participants, "Sarah" explained how HIV-related risks were compounded by the poor quality of housing in her neighbourhood and led her to move from the Downtown Eastside to Vancouver's West End to "get healthier." Similarly, "Melanie," a 57 year-old Indigenous transgender woman, described being "weak" and underweight while living in the Downtown Eastside where various social pressures resulted in frequent illicit drug use and thus affected her ability to adhere to antiretroviral therapy. "Melanie" thus moved close to the West End "cause it was close to this place [the DPC]" where she could access HIV medications and food daily. For these participants, West End neighbourhoods were perceived as places where they could obtain better housing and receive "genuine" HIV care,

while beginning a “new life” by getting “healthy” or “clean.” As such, the social and material characteristics of the West End neighbourhood provided many participants with the resources and environment needed to re-shape their daily practices (e.g. decrease drug usage, adhere to HIV medication) and improve their health.

When participants moved from the Downtown Eastside to Vancouver’s West End or Downtown South, they employed stigmatizing, medicalized language to distance themselves from their previous neighbourhood. Participant narratives functioned to essentialize the Downtown Eastside by focusing only on its perceived negative characteristics, notably high rates of injection drug use, and overlooking positive characteristics of the neighbourhood. In doing so, participants sought to reposition their identities as they negotiated their positions within new neighbourhoods (e.g. the West End). According to many participants, the street-based drug scene was the defining characteristic of the Downtown Eastside, and its inhabitants were “drug addicts” with “bad mental health issues.” Additionally, one third of participants emphasized the ways in which social and physical-environmental characteristics of the Downtown Eastside, such as poor quality of housing (e.g. run-down single room occupancy hotels) and the entrenched street-based drug scene, negatively impacted their health and served as ‘triggers’ that risked returning them to past drug use patterns. For example, “Martin,” a 44 year-old Latino man who had previously been entrenched within the neighbourhood’s drug scene, explained:

[I don’t like going to the Downtown Eastside anymore] because there, almost everybody [is] sick. You know, people from Hastings [Street]. And, when I was there, I was thinking, I don’t wanna see [this] anymore...because they get angry. [...] They say, ‘I don’t want food, I want drugs’. ...And they demand for this. They need clothes, ‘we need shoes, we need this, we need that, we need a house.’

Among these participants, spatial separation and denigration of others accessing the area through stigmatizing discourses (Wacquant, 2007) reified the territorial stigma of the Downtown Eastside and allowed participants to further ‘distance’ themselves from popular stereotypes and the practices (e.g. injection drug use) associated with the neighbourhood.

Mobilities, Concentration of Resources, and Unmet needs

Our analysis of participant accounts highlights how participants’ mobilization of territorial stigma as a way to distinguish themselves from people in the Downtown Eastside functioned as a barrier to the health and social supports in that neighbourhood. The majority of HIV-related care and other relevant services, with the exception of HIV/AIDS social housing, are concentrated in the Downtown Eastside. In order to minimize their involvement with people living in the Downtown Eastside and the physical neighbourhood, some participants often avoided much needed services concentrated in the area (e.g. food services). “Leon,” a 41 year-old Indigenous man who had recently moved to Vancouver’s Downtown South neighbourhood after being released from prison, described how “a lot of people like going to hang out on Hastings for [meal] line-ups” but he avoids the neighbourhood due to his concern that it will trigger drug use and instead “eats nothing” many nights. Continuing, “Leon” explained:

[They put all of the services in the Downtown Eastside because] they think that lot[s] of people are going to go down there now. ...People up here...are trying to stay clean. ...They don't want to go down there because [they are tempted to use]. [...] I don't want nothing from down there.

“Leon’s” reiterations of physical space – “up here [West End]” versus “down there [Downtown Eastside]” – in connection to drug use patterns and services highlights his efforts to spatially distance himself from the stigmatizing discourses and social practices (e.g. injection drug use, street involvement) of the Downtown Eastside and rebuild his identity in a new place.

Some participants expressed fear of HIV-related stigma if they were to access HIV care services in the Downtown Eastside. “Rebecca,” a 44 year-old Indigenous woman who had moved from the Downtown Eastside to the West End, explained:

I wouldn't want to have to pass by all these people that I've known for a long time and...walk in the doors [of an HIV service organization]...off a popular street where there's tens, you know, a hundred people that I know...[They might] label me...and judge me...when it's absolutely none of their damn business.

For “Rebecca,” previous experiences of stigma due to her HIV status and history of injection drug use in the Downtown Eastside, along with her fears and uncertainty regarding HIV disclosure, led her to avoid accessing potentially helpful HIV care services located in the Downtown Eastside. Here, territorial stigma intersected with HIV-related stigma to constrain access to needed resources concentrated in the Downtown Eastside. Conversely, because she did not know anyone in the West End neighbourhood, “Rebecca” perceived it as providing her with the anonymity needed to access HIV care, although there remained shortcomings in access to other resources. “Rebecca” and “Leon’s” narratives illustrate the potential of territorial stigmatization to shape health-related outcomes, including health-enabling practices (e.g. HIV medication adherence), and access to health and social resources, due to the measures that participants take to disassociate themselves from the ‘tainted space’ of the Downtown Eastside and perceived HIV-related stigma in that neighbourhood.

While many went to great lengths to distance themselves from the Downtown Eastside, a minority of participants nonetheless accessed critical support services (e.g. healthcare services, emergency shelters) concentrated within this neighbourhood. Among these participants, accessing these services was viewed as necessary to negotiate survival within the context of extreme poverty. Rather than essentializing the Downtown Eastside, participants regularly accessing services in the neighbourhood described a sense of “community” and “belonging” that they seldom experienced elsewhere in the city. These participants refrained from utilizing stigmatizing language when describing the Downtown Eastside and its inhabitants. For these participants, the wider stigma associated with the Downtown Eastside created a type of connection to others in the neighbourhood whose practices and identities they identified with. This sharing of a ‘sense of place’ allowed the Downtown Eastside to be “more home than anything [else].”

Moving away from the Downtown Eastside and towards a West End ‘sanctuary’

Whereas participants had at some point lived or been immersed in the Downtown Eastside, most had since moved into social housing for PLHIV in the West End area and begun regularly accessing HIV care at the DPC. Participant accounts illustrated how they viewed their claims to being West End neighbourhood residents as tenuous. This tenuousness was particularly salient for participants living in the West End who used injection drugs and felt that “people on the West End don’t do drugs like that.” Only one participant fully identified as a resident of the West End. As a gay man, “Daren” considered the West End to be a neighbourhood where he could finally be comfortable with his sexuality:

I wanted to get into the West End because I’ve never lived the life of a gay man in the open. It’s always like running around sneaky...I got to normalize myself and feel comfortable and the only place I would feel comfortable would be in the West End. I waited to get that housing and it’s perfect, it’s right in the best part. I couldn’t get a better place. [47 year-old, White man]

Conversely, nearly all participants occupied a tenuous position in which they rejected the Downtown Eastside while simultaneously feeling alienated from the West End due to their socio-economic status. For example, “Nina,” a 39 year-old Indigenous woman who had been living in the West End for three years, explained,

[The West End is] a nice area—quiet, mellow, a lot of nice classy people. The working people, they don’t bother you. They don’t bum money off you or they don’t panhandle like me.

Later, she distanced herself from other individuals who had also moved from the Downtown Eastside to her apartment building in the West End stating she “live[s] nice...[and] upper class,” and others “feel bad cause they’re not doing quite as well [i.e. financially].” Such internal contradictions were common among participants who had relocated from the Downtown Eastside to less stigmatized neighbourhoods (i.e. West End, Downtown South), and illustrate how territorial stigma can function to complicate identity construction and renegotiation, particularly when intensified by classism and anti-drug stigma.

The DPC provided participants with a ‘legitimate’ reason for being in the West End neighbourhood, and thereby allowed them to challenge the tenuousness of their claim to the West End neighbourhood. While the ‘legitimacy’ of their claims to the West End was conditional upon their HIV status, participants actively took up this often stigmatized identity because it was viewed as more favourable than being from the Downtown Eastside, which was often synonymous with injecting drugs and living in extreme poverty. In doing so, participants sought to attenuate the territorial stigma associated with the Downtown Eastside by locating themselves among PLHIV in this new neighbourhood. For “Christopher,” a 48 year-old White man, this new ‘sense of place’ was achieved through regularly visiting the DPC:

It’s [the medication] there [at the DPC] and it doesn’t – it’s not a big deal. They will help you get it worked into your usual, daily routine and it doesn’t seem like it’s such a... You know, I don’t feel so dirty or gross like because or whatever kind

of things they might conjure up...I'm not alone either. I know other people are in the same boat.

In repositioning themselves in relation to the DPC and West End, the majority of participants enacted strategies such as 'defensive othering' or 'identity talk' (Keene & Padilla, 2010) in which they emphasized differences between themselves and others to contrast current situations and reinforce their right to be in this neighbourhood. These rhetorical strategies functioned to perpetuate popular stereotypes of the Downtown Eastside (e.g. "war zone," "unhealthy") that actively reinforced territorial stigma. While the Downtown Eastside was constructed primarily in relation to individual 'failings' and the street-based drug scene, participants framed the West End by focusing on its physical landscape (e.g. parks) and comparatively wealthy neighbourhood residents. Many participants variously described the West End as "safe," "nice," and "quiet," with several emphasizing how they could see the natural landscape from their apartment.

Territorial stigma, identity and tensions within the DPC

Participant accounts underscore how territorial stigma followed participants when they relocated to the West End and began accessing HIV care at the DPC. Despite the considerable overlap between client groups, with many who identified as MSM reporting histories of injection drug use and others identifying as PWID reporting prior same-sex relationships, our analysis revealed that tensions emerged between groups of clients based on how they defined the 'normative' DPC client. Whereas MSM-identified participants considered the 'normative' client to be a gay, non-injection drug-using person living with HIV, participants identifying as PWID considered the 'normative' client to be a straight person living with HIV who injected drugs. These conflicting views of who constituted the 'normative' DPC client, which were often grounded in drug-related stigma and homophobia, led to conflict as these groups asserted ownership over the facility. Importantly, while the DPC is located in the heart of Vancouver's historic 'gay neighbourhood' (i.e. the West End), the facility has included comprehensive harm reduction strategies (including supervised injection services) within its model since the early 2000s when the organization's clients began to increasingly include both MSM and PWID. Participant accounts illustrated how the facility's location in the West End and service delivery model served to legitimize competing claims to the DPC.

Among participants who identified primarily as MSM, there was a tendency to 'defensively other' (Keene & Padilla, 2010) clients who injected drugs by asserting that those were the people that "needed help" (i.e. counselling and support services). In many cases, these participants employed stigmatizing popular stereotypes of the Downtown Eastside's street-based drug scene (e.g. "chaos," "addicts") when discussing clients whom they considered to be from that neighbourhood, primarily those using the facility's supervised injecting services. These participants rejected the notion that injection drug use should be permitted to occur onsite, with one participant expressing that the DPC "is not an Insite place [i.e. local supervised injection facility in the Downtown Eastside]." Continuing, "Rob," a 50 year-old gay White man, stated:

We have a lot of drug addicts here who do the stuff [i.e. inject] and then are just dozing off in their food...It's a trigger. [...] Over 30 people I've spoken to myself have brought this point up to me...We're sick of seeing this. You guys are turning this into an East Hastings [Downtown Eastside] type of environment.

These participants commonly expressed that injection drug use should remain contained within the Downtown Eastside so as to not 'contaminate' the West End neighbourhood. "Charlie," a gay 41 year-old Indigenous man, explained:

I don't [think] they should have one [supervised injection site] here. [...] They should have their own injection site like down on Hastings...keep that down there. Like, why bring it up here? [...] That should be something that happens in that part of town.

Consistent with the views expressed in these interview excerpts, several other participants identifying as MSM emphasized how injection drug-using clients were 'irresponsible' and 'disrespectful' when using drugs at the DPC because they access common areas immediately after usage and are 'disruptive' (e.g. "dozing off," "singing in the lunch room").

Conversely, participants who injected drugs believed that they had a 'right' to the DPC because of the organization's harm reduction strategies. These strategies, as well as the physical room where supervised injections take place, created a 'sense of place' for these participants who, at various times, felt disconnected from the DPC due to their method of drug consumption, and often, their sexual orientation. However, their 'othering' of MSM clients – at times due to homophobia – served to distance themselves from their discomfort in the space. For example, "Frank," a 50 year-old Indigenous man, indicated that he was worried when he started going to the DPC because, in his words, "[there's] homosexual activities, and I don't swing that way." "Richard," a 55 year-old Indigenous man, indicated that he would more comfortable if the DPC were relocated from the West End to the Downtown Eastside because, as he explained, "I'd be more comfortable there...[because] I'd be with straight people." Participants who grouped themselves with straight DPC clients expressed discomfort and judgement based on differing sexual preferences.

Finding common ground despite differences

While mobilizing territorial stigma to stigmatize certain groups of DPC clients, the majority of participants nonetheless sought to develop a group identity with the same clients they were excluding. Participants often referred to sharing a common ground with other DPC clients despite differences exacerbated by territorial stigma. One participant stated, "You know, at the end of the day, we're all the same. And that's what I see" [47 year-old, White-Indigenous man]. Others expressed how they are "all [living] with HIV" so other factors are irrelevant:

It was a little intimidating [here at first] just like I said there wasn't too many women but once I...shook it off and I realized we were all just here for the same reason and it was our place right then I wasn't intruding on somebody else's place or something then I immediately just tried to make friends and I was comfortable,

comfortable enough to come back you know more often enough and make it my place. ["Rebecca," 44 year-old, Indigenous woman]

Although many participants expressed initial discomfort due to differences across DPC client groups, this changed overtime as participants began to actively focus on, and seek out, similarities with other members.

[The first time I came to the DPC] I wasn't comfortable due to my sexual orientation. I found that a lot of homosexual people came here and I was not in that category. [...] [It made me uncomfortable] till I got to know people. [...] Then we found out that we all had the same disease and sexual orientation was not important. [...] I thought the homosexual avenue was a preference [here], but I found out...it was not a preference and that we were all welcome here. [50 year-old, Indigenous man]

As a consequence, the impact of overlapping forms of stigma, including territorial stigma, lessened and they were able to access HIV care and other onsite services through the DPC.

In recognizing their similarities, most participants emphasized how reorienting their identity around their HIV status enabled them to resist other stigmatized identities (e.g. homeless, injection drug user) and access exclusive resources through engaging with the DPC. This in-group alignment (Goffman, 1963)—identifying with others who share a stigmatized identity—is a collective effort for participants to manage the socio-spatial stigmatization they face. While the majority of participants' narratives illustrated an evolving sense of community within the DPC, positive HIV statuses created a sense of ownership over DPC facilities and services for various participants. For example, several participants frequently referred to the DPC as "our place" because they were not judged due to their HIV status, reiterating that the DPC was about those living with HIV. This served as a way to distance themselves from HIV-negative persons with similar demographic characteristics (e.g. sexual or gender nonconformity, occupation) who could not access a "state-of-the-art" facility such as the DPC that offered health and supportive services. Additionally, several participants indicated that they were 'deserving' of the DPC by emphasizing their respect for service providers – that is, that they were truly in need rather than "scamming" them for resources. Participants reported that this was in contrast to the motivations of people accessing non-HIV related services in the Downtown Eastside. Such narratives served to defensively other their HIV-negative counterparts, while solidifying their 'right' to the DPC and the West End neighbourhood.

DISCUSSION

In summary, our findings underscore how territorial stigma can exacerbate challenges spatially stigmatized populations can face when accessing HIV care services. These findings demonstrate how many participants use negative, hegemonic discourses regarding the Downtown Eastside to distance themselves from the neighbourhood as they renegotiated their identities within the DPC. Moreover, the geographic placement of the DPC, as well as services offered, generated varying ideas of a 'normative' client, spurring conflict between MSM and PWID populations who both made claims to the physical space. While there was

an evolving sense of community in the DPC, common HIV statuses simultaneously facilitated a sense of ownership and group identity among clients, which was used to further distance themselves from HIV-negative persons.

Consistent with previous research (Chambers et al., 2015; Chesney & Smith, 1999; Fast, Small, Wood, & Kerr, 2009; Keene & Padilla, 2010; Macintyre, Ellaway, & Cummins, 2002; Vasarhelyi et al., 2011), our findings demonstrate how territorial stigma can disrupt access to health resources. However, whereas previous literature has detailed how neighbourhoods and socio-spatial stigma impact community-based interventions and services (Chiotti & Joseph, 1995; Latkin et al., 2013; Author et al., 2015; Thompson et al., 2007), this study elucidates how stigma remains despite moving out of the stigmatized neighbourhood. For example, once participants moved out of the Downtown Eastside, many avoided the neighbourhood rather than utilizing needed support services concentrated there for fear of re-associating themselves with the area and engaging in past practices (e.g. injection drug use). This underscores how the siting of HIV care service organizations can have pronounced implications on the utilization of services, even when these services are concentrated in neighbourhoods in close proximity to one another. While this finding underscores the continuing need for interventions to address stigma at the societal level (e.g. public awareness campaigns rooted in anti-oppression principles), it also suggests the need for targeted programmatic interventions and inter-organization collaboration (e.g. satellite sites, service partnership agreements) that facilitate mobility while minimizing stigma.

In addition, our findings generate unique insights into how territorial stigma, intensified by additional stigma (e.g. classism, homophobia), can function within service environments to foster tension between groups of clients making claims to services. By focusing their service delivery models on an 'assumed community' (Fast et al., 2013), public health programs (inclusive of HIV service organizations) can assume social cohesion among their clients and, in doing so, overlook larger social tensions occurring between sub-groups of clients. As such, public health programs can be at risk of facilitating conflict among those who access services. For example, despite overlapping experiences, MSM and PWID populations may see themselves as distinct communities, which our findings suggest can foster tension within HIV service environments designed to engage both populations. This tension has been reported in relation to hospital settings where the organization of space, bodies, and practices creates and re-creates tensions between PLHIV who do and do not use drugs (Author et al., 2014). Moreover, stigma does not work in a vacuum, but is interconnected with other forms of marginalization (Chambers et al., 2015). The mobility and renegotiation of territorial stigmatization further illustrates how the socio-spatial positions occupied by marginalized populations living with HIV may intensify health inequalities and impede access to care as particular neighbourhoods, such as service-dependent areas (e.g. Vancouver's Downtown Eastside) (Dear & Wolch, 1987; Wolch, 1980), are avoided or restricted.

Importantly, our findings underscores the role that HIV care organizations can play in promoting solidarity among their clients by shifting focus away from differences by instead emphasizing similarities. Certainly, promoting solidarity may be problematic because, as Author and colleagues (2014) note, shared spaces can become highly politicized and

contested, creating new dangers for those who use these spaces. For example, our findings demonstrate that, despite efforts for an inclusive service model, larger social forces frame interactions among clients and create challenges in the shared space. Moreover, our findings demonstrate the urgency for territorial stigma, as well as the processes and mechanisms through which it works, to be taken into account when health programs and services are developed and reformed in the context of an evolving epidemic, particularly as territorial stigma exacerbates existing stigma for vulnerable populations. However, inclusive programming and efforts to encourage group cohesion around living with HIV may be useful in creating a more prominent focus towards client similarities. For example, integrating social interventions into HIV care settings for the purposes of promoting solidarity between various groups of PLHIV, including those whose identities are shaped by place, will likely prove important in accomplishing this goal and achieving other benefits. Notably, social bonding and cohesion can improve the impacts of territorial stigma on individuals' health (Wutich et al., 2014). To this end, territorial stigma deserves further attention in the siting and design of new HIV-related care services and implementation of current programs to ensure accessibility and engagement, particularly when facilities are sited outside of, but intended to serve PLHIV from, 'service-dependent' neighbourhoods. Including vulnerable and affected PLHIV in dialogue informing programming and service organization placement may minimize the impacts of territorial stigma and increase program utilization and effectiveness.

This study has several limitations that should be noted. First, our study was undertaken within a specific HIV service environment and findings, therefore, are not representative of MSM and PWID communities. Second, our findings are based on the experiences of a particular subset of the DPC client base, and thus might not be representative of the larger DPC client population. Third, women, transgender persons were underrepresented in our study as only a small number access the DPC, and additional research is needed to further understand the gendered dynamics of territorial stigmatization, particularly in relation to access and engagement with HIV care services. Similarly, additional research into the specific experiences of Indigenous peoples in relation to HIV services, generally, and the DPC, specifically, is needed to identify racialized dimensions of territorial stigma. Fourth, our findings lack diversity based in socio-economic class, and thus are not generalizable. Fifth, because our study focused on PLHIV who use drugs and are actively engaged with care, we have possibly underestimated the negative impact of territorial and other forms of stigma on access to health services. Finally, our study was undertaken in a community with HIV care and support services provided under harm reduction strategies and might not reflect experiences with HIV care in settings operating under service delivery models that exclude drug-using populations (e.g. abstinence-based approaches).

Despite these limitations, our findings elucidate the critical role of territorial stigma in shaping vulnerable populations' access to services, identity negotiation, and 'sense of place' as they move from the Downtown Eastside to the West End for HIV-related care services. Our study also demonstrates how territorial stigma not only created barriers to accessing services in stigmatized neighbourhoods, but also created conflict between different populations within a care setting. The tensions stemming from territorial stigma within a

health care setting highlight the need to explore the ways in which solidarity and social cohesion can be achieved across sub-groups of PLHIV as the epidemic continues to evolve.

ACKNOWLEDGEMENTS

The authors would like to thank the participants in the Dr. Peter Study; the physicians, nurses, social workers and volunteers who support them; and current and past researchers and staff. We are also grateful to the contributions of the Peer Research Associates; the DPC Community Advisory Committee; and study Co-Investigators: Robert Hogg, Rolando Barrios, Stuart Skinner, Silvia Guillemi, Susan Kirkland, M-J Milloy, Bernadette Pauly, Hasina Samji, Cathy Worthington, Earl Nowgesic, Kate Salters, and Ciro Panessa. The Dr. Peter Study is funded by the Canadian Institutes of Health Research (CIHR R-PHE-122186). The DTP receives funding from the provincial government of British Columbia (PharmaCare). Ryan McNeil is supported by the Michael Smith Foundation for Health Research and National Institutes of Health (R01DA033147).

REFERENCES

- Antiretroviral Therapy Cohort, C. Life expectancy of individuals on combination antiretroviral therapy in high-income countries: a collaborative analysis of 14 cohort studies. *Lancet*. 2008; 372(9635): 293–299.
- August M. Challenging the rhetoric of stigmatization: the benefits of concentrated poverty in Toronto's Regent Park. *Environment and Planning A*. 2014; 46:1317–1333.
- BCCDC. HIV in British Columbia: an annual surveillance report 2013. 2015. Retrieved from <http://www.bccdec.ca/util/about/annreport/default.htm>
- Butler, J. *Gender trouble: feminism and the subversion of identity*. Routledge; New York: 1990.
- Cain R. Devoting ourselves, devouring each other. *Journal of Progressive Human Services*. 2002; 31(1):93–113.
- Carter A, Greene S, Nicholson V, O'Brien N, Dahlby J, de Pokomandy A, team, C. r. 'It's a very isolating world': the journey to HIV care for women living with HIV in British Columbia, Canada. *Gender, Place & Culture*. 2015:1–14.
- Chambers LA, Rueda S, Baker DN, Wilson MG, Deutsch R, Raeifar E, Stigma Review, T. Stigma, HIV and health: a qualitative synthesis. *BMC Public Health*. 2015; 15:848.
- Chesney M, Smith A. Critical delays in HIV testing and care: the potential role of stigma. *American Behavioral Scientist*. 1999; 42(7):1162–1174.
- Chiotti Q, Joseph A. Casey house: interpreting the location of a Toronto AIDS hospice. *Social Science and Medicine*. 1995; 41(1):131–140. [PubMed: 7667667]
- Corbin, J.; Strauss, A. *Basics of qualitative research: techniques and procedures for developing grounded theory*. 3. Sage Publications; Los Angeles: 2008.
- Cummins S, Curtis S, Diez Roux A, Macintyre S. Understanding and representing 'place' in health research: a relational approach. *Social Science and Medicine*. 2007; 65(9):1825–1838. [PubMed: 17706331]
- Dear, M.; Wolch, JR. *Lanscapes of despair-from deinstitutionalization to homelessness*. Polity Press; Cambridge: 1987.
- Dovey K, Fitzgerald J, Choi Y. Safety becomes danger: dilemmas of drug-use in public space. *Health and Place*. 2001; 7(4):319–331. [PubMed: 11682331]
- Duff C. Networks, resources and agencies: on the character and production of enabling places. *Health Place*. 2011; 17(1):149–156. [PubMed: 20926330]
- Duff C. Exploring the role of 'enabling places' in promoting recovery from mental illness: a qualitative test of a relational model. *Health Place*. 2012; 18(6):1388–1395. [PubMed: 22853876]
- Evans J. Supportive measures, enabling restraint: governing homeless 'street drinkers' in Hamilton, Canada. *Social & Cultural Geography*. 2012; 13(2):185–200.
- Eyles, J. *Senses of place*. Silverbrook Press; Warrington: 1985.
- Fast D, Shoveller J, Shannon K, Kerr T. Safety and danger in downtown Vancouver: understandings of place among young people entrenched in an urban drug scene. *Health Place*. 2010; 16(1):51–60. [PubMed: 19733496]

- Fast D, Shoveller J, Small W, Kerr T. Did somebody say community? Young people's critiques of conventional community narratives in the context of a local drug scene. *Human Organization*. 2013; 72(2):98–110. [PubMed: 24634540]
- Fast D, Small W, Wood E, Kerr T. Coming 'down here': young people's reflections on becoming entrenched in a local drug scene. *Social Science and Medicine*. 2009; 69(8):1204–1210. [PubMed: 19700232]
- Garbin D, Millington G. Territorial stigma and the politics of resistance in a Parisian banlieue: La Courneuve and beyond. *Urban Studies*. 2012; 49(10):2067–2083.
- Ghaziani, A. *There goes the gayborhood?*. Princeton University Press; Princeton: 2014.
- Gieryn T. A space for place in sociology. *Annual Review of Sociology*. 2000; 26(1):463–496.
- Goffman, E. *Stigma: notes on the management of spoiled identity*. Englewood Cliffs; Prentice-Hall: 1963.
- Graham LF, Padilla MB, Lopez WD, Stern AM, Peterson J, Keene DE. Spatial Stigma and Health in Postindustrial Detroit. *International Quarterly of Community Health Education*. 2016; 36(2):105–113. [PubMed: 26833796]
- Hogg R, Heath K, Lima V, Nosyk B, Kanter S, Wood E, Montaner J. Disparities in the burden of HIV/AIDS in Canada. *PLoS One*. 2012; 7(11):e47260. [PubMed: 23209549]
- Hyshka E, Strathdee S, Wood E, Kerr T. Needle exchange and the HIV epidemic in Vancouver: lessons learned from 15 years of research. *International Journal of Drug Policy*. 2012; 23(4):261–270. [PubMed: 22579215]
- Kallin H, Slater T. Activating territorial stigma: gentrifying marginality on Edinburgh's periphery. *Environment and Planning A*. 2014; 46:1351–1368.
- Keene D, Padilla M. Race, class and the stigma of place: moving to 'opportunity' in eastern Iowa. *Health and Place*. 2010; 16(6):1216–1223. [PubMed: 20800532]
- Keene D, Padilla M. Spatial stigma and health inequality. *Critical Public Health*. 2014; 24(4):392–404.
- Latkin C, German D, Vlahov D, Galea S. Neighborhoods and HIV: a social ecological approach to prevention and care. *American Psychologist*. 2013; 68(4):210–224. [PubMed: 23688089]
- Liu S, Blomley N. Making news and making space: framing Vancouver's Downtown Eastside. *The Canadian Geographer*. 2013; 52(2):119–132.
- Macintyre S, Ellaway A, Cummins S. Place effects on health: how can we conceptualise, operationalise and measure them? *Social Science and Medicine*. 2002; 55(1):125–139. [PubMed: 12137182]
- McCormick N, Joseph M, Chaskin R. The new stigma of relocated public housing residents: challenges to social identity in mixed-income developments. *City and Community*. 2012; 11(3):285–308.
- McInnes C, Druyts E, Harvard S, Gilbert M, Tyndall M. HIV/AIDS in Vancouver, British Columbia: a growing epidemic. *Harm Reduction Journal*. 2009; 6(5) al., e.
- Author. Details removed for peer review. 2015
- Author. Details removed for peer review. 2014
- Nations M, Monte C. "I'm not dog, no!": cries of resistance against cholera control campaigns. *Social Science and Medicine*. 1996; 43(6):1007–1024. [PubMed: 8888470]
- Rhodes J. Stigmatization, space, and boundaries in de-industrial Burnley. *Ethnic and Racial Studies*. 2012; 35(4):684–703.
- Rhodes T, Singer M, Bourgois P, Friedman S, Strathdee S. The social structural production of HIV risk among injecting drug users. *Social Science and Medicine*. 2005; 61(5):1026–1044. [PubMed: 15955404]
- Robinson C. Creating space, creating self: street-frequenting youth in the city and suburbs. *Journal of Youth Studies*. 2000; 3(4):429–443.
- Strathdee S, Patrick D, Currie S, Cornelisse P, Rekart M, Montaner J, O'Shaughnessy M. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS*. 1997; 11(8):F59–65. [PubMed: 9223727]
- Author. Details removed for peer review. 2014

- Takahashi L. The socio-spatial stigmatization of homelessness and HIV/AIDS: toward an explanation of the NIMBY syndrome. *Social Science and Medicine*. 1997; 45(6):903–914.
- Thompson L, Pearce J, Barnett R. Moralising geographies: stigma, smoking islands and responsible subjects. *Area*. 2007; 39(4):508–517.
- Vasarhelyi K, Brandon E, Palmer A, Fernandes K, Zhang W. Home is where the HAART is: an examination of factors affecting neighbourhood perceptions among people with HIV/AIDS on antiretroviral therapy. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*. 2011; 23(2):245–251. al., e.
- Wacquant L. Urban marginality in the coming millennium. *Urban Studies*. 1999; 36(10):1639–1647.
- Wacquant L. Territorial stigmatization in the age of advance marginality. 2007; 99:66–77. Thesis Eleven.
- Wacquant, L. *Urban outcasts*. Polity Press; Cambridge: 2008.
- Wilton R. Diminished worlds? The geography of everyday life with HIV/AIDS. *Health and Place*. 1996; 2(2):69–83.
- Wolch JR. Residential location of the service-dependent poor. *Annals of the Association of American Geographers*. 1980; 70:330–341.
- Wood E, Low-Beer S, Bartholomew K, Landolt M, Oram D, O'Shaughnessy M, Hogg R. Modern antiretroviral therapy improves life expectancy of gay and bisexual males in Vancouver's West End. *Canadian Journal of Public Health*. 2000; 91(2):125–128. [PubMed: 10832178]
- Wood E, Milloy MJ, Montaner J. HIV treatment as prevention among injection drug users. *Current Opinion in HIV AIDS*. 2012; 7(2):151–156. [PubMed: 22227587]
- Woolford A. Tainted space: representations of injection drug-use and HIV/AIDS in Vancouver's Downtown Eastside. *BC Studies*. 2001; 129:27–50.
- Wutich A, Ruth A, Brewis A, Boone C. Stigmatized neighborhoods, social bonding, and health. *Medical Anthropology Quarterly*. 2014; 28(4):556–577.
- Yanos PT. Beyond "landscapes of despair": the need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness. *Health Place*. 2007; 13(3):672–676. [PubMed: 17178251]

HIGHLIGHTS

- Spaces where vulnerable populations reside can be marked by territorial stigma.
- Territorial stigma can create challenges to accessing HIV services.
- Explores impact of stigma on PLHIV who use drugs and access an HIV care facility.
- Using territorial stigma, participants generated ideas of a ‘normative’ client.
- HIV care facilities can play a role in mitigating the effects of stigma.

FIGURE 1.
Selected relevant services located in Vancouver's Downtown Eastside and West End

TABLE 1

PARTICIPANT CHARACTERISTICS

Participant characteristic	n (%) N=30
Age	
Mean	46.6
Range	26 – 77 years
Gender	
Men	24 (80.0%)
Women	4 (13.3%)
Transgender	2 (6.66%)
Race	
White	19 (63.3%)
Indigenous ancestry	8 (26.7%)
Other	3 (10.0%)
Sexual Orientation	
Straight	14 (46.7%)
Gay	13 (43.3%)
Bisexual	3 (10.0%)
Current housing	
SRO hotel	6 (19.3%)
Apartment	15 (51.6%)
Unsheltered	0 (0.00%)
Other	9 (29.0%)
Substance Use ^a	
(Thirty days prior to interview)	
Other Opiates (including methadone)	20 (31.7%)
Crystal methamphetamine	18 (28.6%)
Heroin	10 (15.9%)
Crack cocaine	9 (14.3%)
Powdered Cocaine	6 (9.52%)
HAART adherence ^b	
(Twelve months prior to qualitative interview)	
HAART <50	12 (40.0%)
HAART >50	18 (60.0%)

^aDrug categories are not mutually exclusive

^bAccording to validated pharmacy refill measure obtained through external data linkage (HAART %=(haart_days/365)*100)