

The Impact of Marginalization on the Continuum of Care Treatment Model on African American Communities in the Southern United States

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Recently, I was asked to speak at the *National Academy of Public Administration (NAPA) Conference* about my experiences serving as an ethnographic consultant on the *National HIV Behavioral Surveillance System (NHBS¹) Study*. My role on the project involved shadowing the field team and providing an analysis of the data as reported by three sources, specifically focus groups, key informant interviews, and street intercept interviews. Additionally, I was asked to write an ethnographic report and submit it along with the Norfolk Program's summaries of project activities. This was an interesting assignment for a medical anthropologist, as ethnographic methodologies were a relatively new tactic for this study. In the past, the NHBS solely relied on quantitative analysis of the at-risk behaviors under surveillance.

¹The NHBS is a CDC-sponsored longitudinal study centered on HIV behavior in 25 cities throughout the nation. These cities include: Seattle, San Francisco, Los Angeles, San Diego, Las Vegas, Denver, St. Louis, Dallas, Houston, New Orleans, San Juan, Miami, Fort Lauderdale, Atlanta, Washington DC, Baltimore, Chicago, Philadelphia, Baltimore, Detroit, New York City, Boston, New Haven, Suffolk/Nassau, Newark and Norfolk—the city where the data reported in this article is focused on. Three populations are monitored regarding their degree of risk. These populations include: men who have sex with men (MSM); injecting drug users (IDU); and high-risk heterosexuals (HRH). Surveillance activities at these sites focused on these high-risk populations are conducted in 12-month cycles—one group per cycle (MSM, IDU, HRH). These activities include different sampling methods each cycle; formative research is done for each cycle; the same populations and metropolitan statistical areas (MSAs) over time. The consistent eligibility criteria is that the participant must be over 18 years of age, resident of the MSA, and specific criteria related to the high-risk activity of the targeted group. The sample size at each location is 500-to-1000 persons living in the MSA interviewed each cycle. The NHBS operated in these locations from 2002 to 2012.

During the participation observation phase, a few structural trends that may impact the concentration of HIV among African Americans in the targeted Norfolk MSA were noted. There is a current trend in Norfolk of imploding public housing projects and replacing them with low-quality single-family housing that is aesthetically pleasing. This activity is reminiscent of the 1960's when the trend was the opposite—inner city African Americans were moved from their single-family housing into public housing projects. Federal government authorities called these projects “Urban Renewal” while community folks referred to the practice as “Negro Removal.” In the 1990s and 2000s, inner city neighborhood redevelopment occurred throughout the United States as billions in public and private investments entered impoverished African American communities [1].

In the 21st century the trend focuses on in the formation of new mixed-income communities. The neighborhoods are still predominantly African American and concentrate poverty in central locations throughout the city. The increasing economic diversity and widening cleavages among blacks living in these contexts generate complex interracial social dynamics where relocated public housing residents and other low-income black renters experience marginalization from both black and nonblack neighbors [2].

Understanding the impact of marginalization is crucial as new HIV/AIDS prevention strategies are put in place. Once diagnosed, a person with HIV needs life-long, regularly scheduled medical care. This allows the

patient and care provider to monitoring disease status, make decisions about when to start or adjust complex antiretroviral treatment, and managing other health conditions that may be affected by HIV infection. Continuous medical visits, lab screens, and medication adherence are associated with decreases in deaths and a slower onset of AIDS [3]. In fact, average life expectancy after HIV diagnosis increased from 10.5 years in 1996 to 22.5 years in 2005, and much of the improvements in survival among HIV patients in industrialized countries can be attributed to the introduction of effective treatment in 1996 [4].

Despite these improvements, the number of new diagnoses of HIV has not decreased in the Southern United States. While there are many complex reasons for this, two issues stand out: there are too many people with HIV in these areas with undiagnosed or late diagnosed infections, and there are too many people with HIV who are not receiving treatment for their infections. Persons with undiagnosed or untreated infections have higher viral loads, and these higher viral loads increase the chances of further transmission. While primary preventive actions are important (that is, preventing

someone from getting HIV), improvements in diagnosis and participation in care provide the “breathing space” for primary prevention to work at a population level.

References

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