FACT SHEET

RURAL CENTER for AIDS/STD PREVENTION

A Joint Project of

INDIANA UNIVERSITY, UNIVERSITY OF COLORADO, AND UNIVERSITY OF KENTUCKY

HIV/AIDS in Rural America: Challenges and Promising Strategies

Life in rural America is as varied as the men, women, and children who live there. For some, rural life comes with the freedom to enjoy a slower-paced life style, a small supportive community, and wide-open spaces. For others, rural life traps them in a web of inadequate education, limited job opportunities, limited access to health care and social services, and isolation due to social stigma and a lack of public transportation.

Challenges like these make HIV/AIDS prevention and care difficult in rural settings. Wide-open spaces create long distances to travel for HIV/AIDS care. Close-knit social networks may make it hard to get an HIV/STD test or even buy condoms without friends, relatives, or acquaintances noticing. Freedom from big-city congestion may also mean living with fewer local resources for health care, mental health care, substance abuse treatment, housing, and jobs. And traditional values embraced by many rural communities may contribute to stigma toward those who engage in risky behaviors or have been diagnosed with HIV or AIDS. Traditional values and stigma account for some obstacles that keep people from talking about sexuality and learning how to prevent HIV/AIDS. Fear of stigma also stops people from getting tested, learning their results, and disclosing their HIV status.

Despite these challenges, many rural communities have created innovative and promising strategies to HIV prevention and care that take advantage of the diverse people and strengths of their communities. Promising strategies that address HIV in rural areas are not one-size-fits-all solutions, but are strategies that rural communities can adopt and adapt to meet their own unique needs and build on their own unique strengths.

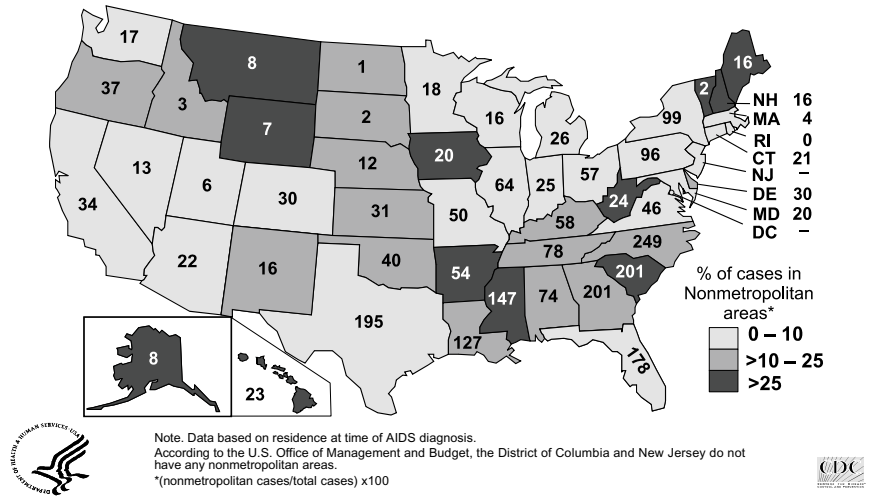
The Incidence of Rural HIV/AIDS

The U.S. Centers for Disease Control and Prevention (CDC) reports that since the early 1990s, 5% to 8% of the new AIDS cases each year have been diagnosed among those who live in non-metropolitan areas (counties with fewer than 50,000 residents). By the end of 2007, 56,209 rural people had been diagnosed with AIDS.[1] This number does not include those whose HIV infection has not progressed to AIDS, who are unaware of being infected with HIV, who have migrated to rural areas after diagnosis [2] or those who are diagnosed in urban areas and do not provide their rural home address to avoid hometown stigma.

Increasing AIDS Cases in the Rural South

Hidden within the seemingly consistent rate of new rural AIDS cases is a soaring incidence of new cases and deaths from AIDS in the South [1,3] (i.e., Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia). In 2006, 67% of all new rural AIDS cases were located in the rural South and there were more deaths from AIDS there than in any other area of the country.[3] In 2007, the rate of AIDS cases in the rural South was substantially higher than in other geographic areas at 9.2 per 100,000 compared to rates of 5.6 per 100,000 in the Northeast, 3.9 per 100,000 in the West, and 2.5 per 100,000 in the Midwest.[1]

Reported AIDS Cases among Adults and Adolescents Nonmetropolitan Areas, 2007 – 50 States and DC



Note. Data based on residence at time of AIDS diagnosis.
According to the U.S. Office of Management and Budget, the District of Columbia and New Jersey do not have any nonmetropolitan areas.
*(nonmetropolitan cases/total cases) x100

Source: Centers for Disease Control and Prevention. HIV/AIDS surveillance in urban and non-urban areas (through 2007). Slide set.

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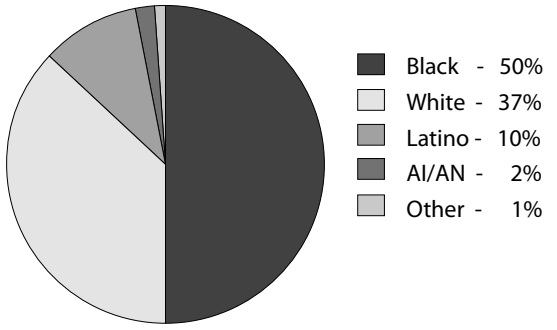
Disparities

In rural America, African-American men and women account for 50% of AIDS cases, Whites 38%, Latinos 10%, and American Indians and Alaska Natives (AI/AN) 2%.[1] The disparity is greatest for African-Americans and Latinos living in the rural South and rural Northeast, with young African-American women being the fastest growing group infected with HIV through heterosexual exposure.[4] Race and ethnicity themselves are not risk factors for HIV. However, minority status is related to social determinants associated with higher rates of HIV/AIDS such as a lack of economic and educational opportunities, poor access to health care, high rates of other STDs, and living in a neighborhood where crack cocaine use and prostitution occur.[5] There is evidence that the cocaine-fueled "war on drugs" has disproportionately increased incarceration of African American men which, in turn, has impacted patterns of sexual behavior. High rates of incarceration have been associated with high rates of STDs, men and women having more concurrent sexual partners, and an increase in sexual partnerships between lower-risk African-American women and men at higher risk for HIV – all factors linked to HIV transmission.[6-8]

Racial/Ethnic Disparities in Rural AIDS Cases, US-2007

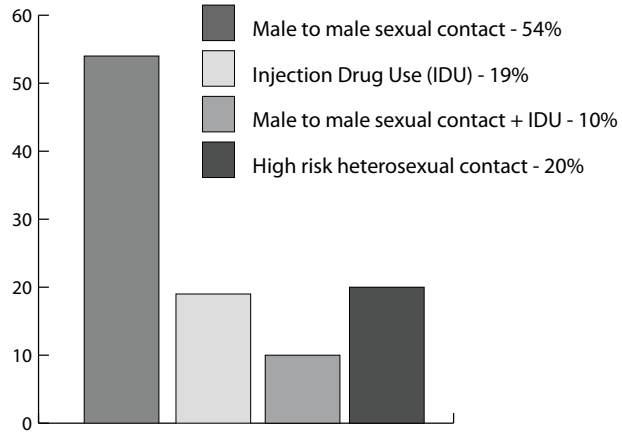


Source: Centers for Disease Control and Prevention. HIV/AIDS surveillance in urban and non-urban areas (through 2007). Slide set.

Characteristics of People Living with HIV/AIDS in Rural America

Men continue to comprise the majority of rural AIDS cases (9.1 per 100,000) at nearly three times the rate for women (3.1 per 100,000). Over half of all males diagnosed with AIDS in rural areas are exposed to HIV through male-to-male sexual contact. An additional 20% of male cases are attributed to exposure from injection drug use and a similar proportion are attributed to heterosexual contact with a person known to have, or to be at high risk for, HIV infection. These patterns of exposure for men are similar in rural and non-rural settings.[1]

Transmission Categories of Rural Male Adult and Adolescent Estimated AIDS Cases, US, 2003-2007



Source: Centers for Disease Control and Prevention. HIV/AIDS surveillance in urban and non-urban areas (through 2007). Slide set.

Although men account for the majority of rural AIDS cases, the rural epidemic may be shifting to women, particularly African-American women in the rural South.[4,9,10] In contrast to HIV-infected men, the majority of HIV-infected rural women report being exposed through heterosexual sex with an HIV infected partner. Often, these women are not aware of the behaviors that put their partner at risk.[4] The shift of infection to African-American women is partly an extension of the legacy of high rates of STDs in the southern U.S., [3,11] especially since many STDs make women more vulnerable to HIV infection. It is also related to the sexual partnering patterns in which lower-risk women partner with men at heightened risk of HIV/AIDS.[6]

The largest proportion of new AIDS cases (approximately 35%) are diagnosed among adults ages 35-44, although 21% of new cases are diagnosed among young adults ages 25-34.[1] The age distribution of those diagnosed with AIDS is nearly identical in rural and non-rural areas. However, evidence that nearly half of rural HIV infections are diagnosed "late" within 12 months of advancing to AIDS suggests that HIV infection may occur at younger ages in rural settings compared to non-rural settings.[12,13]

Behavioral Risk Factors for HIV in Rural America

Only a handful of studies exist that explore sexual risk-taking behaviors among rural Americans in comparison to individuals from more metropolitan areas. A recent analysis of data from a national probability sample found that individuals living in rural areas were less likely to use condoms than those living in large metropolitan areas.[14] Another study found that rural women were less likely than their metropolitan counterparts to report ever using condoms for HIV prevention.[15] A related study among

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low-income African-American women found that those living in rural areas were more likely than their metropolitan counterparts to report:

- not using condoms
- not having HIV prevention counseling during pregnancy
- not having a preferred method of protection because they did not worry about HIV/STD
- having a sex partner who had not been tested for HIV, and
- a belief that their current partner was HIV negative, even without an HIV test.[16]

In-depth interviews conducted in rural South Carolina counties revealed that rural women infected with HIV were less likely than men to have completed high school, less likely to be employed, and more likely to have a history of an STD. The same study showed that 98% of HIV-infected rural women and 69% of men reported having unprotected heterosexual intercourse and that 24% of women and 36% of men engaged in unprotected sex after learning they were infected with HIV.[4] This is consistent with findings that rural Americans were less likely than their non-rural counterparts to report changing sexual behavior, including condom use, in response to the AIDS epidemic.[17]

In a recent analysis of data from the National Survey of Family Growth,[18] investigators found remarkable similarities between metropolitan and rural Americans relative to their reported behavioral risks risks for HIV/STD acquisition. There were no significant differences between metropolitan and non-metropolitan men and women in terms of lifetime number of sexual partners, rates of unprotected sex (in the previous four weeks), condom use at last sexual encounter, ever having had an HIV test, and discussing correct condom use with a health professional during the last HIV test. One difference, however, was that rural men were significantly less likely to report discussing STDs other than HIV with a health professional after their last HIV test.

Promising Strategies

Rural HIV prevention and care must fit the attitudes, needs, and culture of the community and those being served. As such, identifying community disease burden, educational needs, medical needs, and available resources is the first step. Once needs and resources are identified, there are many strategies that communities can adapt and use to educate the community, reduce stigma, detect new cases, reach out to at-risk groups, link those who are infected to care, and reduce individual risk behaviors.

Increasing community awareness of how HIV is transmitted and decreasing stigma often requires small steps and patience. Finding the right person to break the silence can be challenging. Sometimes a local champion such as the football coach or radio announcer can start the conversation about sexuality and HIV prevention. Increasingly, faith-based organizations are broaching topics of sexuality and HIV/AIDS either directly from the pulpit or indirectly through women's groups, health and wellness groups, or service projects that address the needs of those infected with and affected by HIV/AIDS such as a lack of housing. Often it is the women in the congregation, rather than the pastor, who are willing to bring these topics to the forefront. Data describing local rates of teen pregnancy or common STDs such as chlamydia may provide a more comfortable starting point for community discussion. This can lead to prevention education of youth in school or in after-school programs, which ideally includes education about abstinence, condoms, other forms of contraception, and negotiation skills. After-school service learning youth programs may be more appealing to communities with traditional values and have been shown to delay sexual initiation and decrease adolescents' sexual risk behaviors.

Making sure people have the opportunity to know their HIV status would ideally be a routine part of health care for those who are sexually active. But not all rural residents have a health care provider and not all health care providers have the skills and willingness to address sexual health. Rural communities have shown incredible innovation in providing testing in places that decrease stigma by making testing seem routine or by increasing confidentiality. Examples include offering free HIV and STD tests at regional high-school basketball games with an incentive of a chance to win an iPod; offering regularly scheduled free testing in a "neutral" community space such as a college campus, church, or a health center without an STD or HIV label; going door to door in high-risk or high-prevalence areas; or taking free testing to places where those at heightened risk gather such as an outdoor venue, bar, or gay bookstore.

Linking those who are diagnosed with HIV/AIDS to confidential care requires matching community needs and resources as well. Some states offer comprehensive care clinics that recruit rural primary care providers to provide treatment on an ongoing basis with phone support and/or quarterly visits from urban HIV specialists. Covering transportation costs is another approach for getting people to care who prefer or require care outside their local community, although recent Ryan White CARE Act regulations make this more difficult. Sending medications by mail decreases unintentional disclosure through visits to the local pharmacy. And having resources earmarked for case management and prevention with positives can help link rural PLWHA to care and reduce disease transmission while protecting their privacy.

Although many county jails test incoming inmates for HIV and other STDs, there is a need to provide education about prevention to this at-risk group while

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incarcerated, to provide condoms in jail, to test for HIV/STD upon release, and to develop a plan for those who are living with HIV or another STD to be connected to care upon release. Disease intervention specialists plan for care after release in some states. California now provides condoms in some prisons. And some jails, detention centers, and prisons implement evidence-based interventions such as VOICES/VOCES to teach and encourage correct and consistent condom use.

For more examples of how rural communities have addressed HIV prevention and care, see the recent publication from the Rural Center for AIDS/STD Prevention, ***Tearing Down Fences: HIV/STD Prevention in Rural America*** at www.indiana.edu/~aids.

Conclusions

Rural residents are not immune to HIV/AIDS and account for an increasing proportion of new AIDS cases in the rural South and Northeast. Rural men and women engage in behaviors that put them at risk for HIV infection like their more metropolitan counterparts and in some cases they have attitudes, beliefs, and behaviors that put them at heightened risk for HIV. Although White men who have sex with men account for more current cases of AIDS than any other risk group, the alarming increase in rates of AIDS among racial and ethnic minority men and women in rural areas highlights the need for additional attention focusing on the disparities in the rural HIV/AIDS epidemic. To address these inequities, it will be essential to increase our understanding of how rural context such as conservative values, limited educational and economic opportunities, geographic isolation, limited health care accessibility, drug use, and incarceration contributes to HIV transmission ■

This Fact Sheet was prepared for the Rural Center for AIDS/STD Prevention by RCAP Co-Direcor Susan Dreisbach, Ph.D., Assistant Research Professor, Department of Health and Behavioral Sciences, University of Colorado Denver.

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