

RAP* Time



RURAL CENTER *for* AIDS/STD PREVENTION

A JOINT PROJECT OF
INDIANA UNIVERSITY, PURDUE UNIVERSITY,
and TEXAS A&M UNIVERSITY

*Rural AIDS/STD prevention. rap (rap) v. *Slang*. To talk freely and openly.

Vol. 7, No. 7, July 2, 2003

Rural physicians diagnose bacterial STD less often than non-rural physicians

STDs are an emerging problem in many rural communities. An important component of controlling STD and HIV infection is the timely and accurate diagnosis of newly acquired cases. In the context of rural versus non-rural differences, an important research question is whether the diagnostic practices of physicians in rural areas differ from those of non-rural physicians. Published studies have not investigated possible differences in these practices.

The current exploratory study compared selected STD/HIV-diagnostic practices between rural and non-rural physicians.

Methodology

Data were drawn from an extensive survey designed to assess U. S. physicians' practices with respect to STD screening, testing, case reporting, partner notification, and clinical behaviors related to four STDs. Survey questionnaires were mailed to a randomly selected sample of 7,300 physicians from the American Medical Association's Physician Master File representing five medical specialties that provide the most STD diagnosis in the U.S. The response rate was 70.2%, and the completed surveys (N=4,226)

were received from all 50 states and the District of Columbia.

Mean age was 46.2 years and 72% were male. Most were white (81%), 13% were Asian, 5% were Hispanic/Latino, 4% were African-American, and less than 1% were Native American or Hawaiian/Pacific Islander. The physicians spent about 43 hours per week in direct patient care, seeing an average of 98 patients each week.

Outcomes of the Study

Major findings include:

- Rural physicians were less likely than non-rural physicians to diagnose syphilis, gonorrhea, and chlamydia.
- Rural and non-rural physicians did not differ in their screening for asymptomatic males and asymptomatic females.
- Rural physicians were more likely to report not screening any patients for STD, not screening females for bacterial STDs and HIV, and not screening males for syphilis.
- Rural physicians were less likely to report they treated gonorrhea and chlamydia presumptively.
- Only minor differences between rural and non-rural physicians' use of STD diagnosis procedures

were observed.

- Rural physicians diagnosed bacterial STDs less often than non-rural physicians, but their screening and diagnostic practices were very similar..
- Rural physicians were less likely to screen asymptomatic non-pregnant females for bacterial STDs and HIV infection.

Implications for Prevention

This study found that rural physicians diagnosed bacterial, but not viral or parasitic, STDs less often than non-rural physicians. Rural physicians were less likely to report recent HIV or syphilis diagnosis.

Remarkable similarities were found between rural and non-rural physicians' screening practices for males and pregnant females and their relatively infrequent use of gonorrhea and chlamydia testing. Hence, rural physicians may be as prepared as their non-rural counterparts to meet the diagnostic challenges of STD.

SOURCE: Crosby, R. A., et al. (2003). Sexually transmitted disease diagnosis by rural and non-rural physicians: A national comparison of practices. *The Health Education Monograph*, 20, 26-32.

Substance use highest among HIV-infected MSM

Substance use is related to increased risk for transmitting HIV by HIV-positive people to uninfected partners during sex. Little is known about substance use post-HIV diagnosis. The prevalence of substance use was compared among men who have sex with men, injecting drug users, and heterosexual men and women. Participants were from the HIV Cost and Services Utilization Study of 2,864 persons at least 18 years old with known HIV infection.

Substance use was most prevalent among MSM. Substance use and current dependence were associated with being sexual active among MSM, but not IDUs. Marijuana, alcohol, and hard drug use were most strongly associated with being sexually active among MSM. Although substance use predicted high-risk sex, there were few differences among exposure groups in these associations.

The study concluded that substance use is a special health problem for HIV-positive MSM.

SOURCE: Beckett, M., et al., (2003). Substance use and high-risk sex among people with HIV: A comparison across exposure groups. *AIDS and Behavior*, 7, 209-219.

Failure to reduce new HIV infections by 50% could cost \$18 billion

The potential net economic implications of a failure to meet the national HIV prevention goal of reducing new HIV infections by 50% by 2005 were calculated. Standard methods of cost-effectiveness analysis were used to determine (1) the excess number of HIV infections incurred if the goal is not achieved and (2) the excess net medical-associated costs (without the cost of an expanded HIV prevention program in the United States) incurred if the goal is not achieved.

Base case results indicated that if the goal is not met, 130,000 excess HIV infections will occur between the present and 2010, and that the excess net medical costs incurred will total over \$18 billion during the same time frame.

The human and fiscal outcomes of meeting the national HIV prevention goal of reducing new infections by 50% by 2005 are sufficiently large to make the achievement of this goal an urgent public health policy.

SOURCE: Holtgrave, D. R., & Pinkerton, S. D (2003). Economic implications of failure to reduce incident HIV infections by 50% by 2005 in the United States. *Journal of Acquired Immune Deficiency Syndromes*, 33, 171-174.

Half of U. S adults have been tested for HIV infection

Nearly 50% of all U.S. adults under age 65 have been tested for HIV infection at least once. Only 38% of U.S. adults in 1994 indicated HIV testing. Women were more likely to report having been HIV tested, probably attributed to pregnancy testing. Hence, variability in HIV testing by gender should be monitored and has implications for HIV prevention and education programs.

SOURCE: CDC. (2003). HIV testing -- United States, 2001. *MMWR*, 52, 540-545.

Only 50% took HAART prior death

Analysis of HIV-infected patients in one Texas hospital found that 48% of patients who died in 1999-2000 were not taking HAART at the time of death. Mains reasons for not taking HAART were inability to adhere to the treatment regimen and HIV diagnosis less than six months prior death.

SOURCE: Jain, M. T. (2003). Changes in mortality related to human immunodeficiency virus infection: Comparative analysis of inpatient deaths in 1995 and in 1999-2000. *Clinical Infectious Diseases*, 36, 1030-1038.

RAP Time is a monthly AIDS/STD prevention bulletin published by the Rural Center for AIDS/STD Prevention (RCAP) at Indiana University, Bloomington. RCAP is a joint project of Indiana University, Purdue University and Texas A&M University. The major focus of RCAP is the promotion of HIV/STD prevention in rural America, with the goal of reducing HIV/STD incidence.

The opinions expressed here do not necessarily represent those of the cooperating universities.

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