R A P* Time

RURAL CENTER *for*
AIDS/STD PREVENTION

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***Rural AIDS/STD prevention. rap (rap) v.** *Slang.* To talk freely and openly. *Vol. 9, No. 9, September 2, 2005*

HIV and AIDS rates are higher for Mississippi Delta and Southeast Region

While the proportion of persons living with HIV and AIDS is higher for metropolitan areas (>500,000 population), the rates of HIV/AIDS has increased in nonmetropolitan or rural areas (<50,000 population). The demographic traits of people with HIV disease in rural areas may differ from those in urban areas. Further, compared to their urban counterparts, persons with HIV disease in rural areas may face additional barriers to HIV care.

HIV/AIDS data from CDC were analyzed to determine the burden of disease in predominantly rural areas of the U.S.

Methodology

Data were analyzed from 29 states with confidential name-based HIV reporting of people who received an HIV diagnosis in 2000. People with HIV were those who had received a diagnosis of HIV with or without a concurrent diagnosis of AIDS. Data on people with AIDS reported from 50 states and District of Columbia were also analyzed; these people had progressed to AIDS when they received their initial HIV diagnosis.

Regions of interest were Appalachia, the Mississippi Delta, the Southeast Region, and the US-Mexico Border. The burden of HIV was determined for each geographic area by demographic traits, mode of exposure, population density, and economic level of county.

Outcomes of the Study

An estimated 25,538 new cases of HIV in the 29 states with name-based reporting were diagnosed in 2000. Of these cases, 1823 were living in rural counties at time of diagnosis. An estimated 39,832 new AIDS cases were diagnosed in 2000 with 1856 cases in rural areas. Major findings include:

- The rate of HIV diagnosis was lower in rural areas (7.3 per 100,000) than in suburban (8.6/100,000) or urban areas (22.7/100,000).
- The highest rate of HIV diagnoses was observed for the US-Mexico Border (21.1/100,000) followed by Mississippi Delta (17.3/100,000), Southeast Region (14.7/100,000), and Appalachia (10.4/100,000)
- Heterosexually acquired HIV was most common in the Southeast Region and the Mississippi Delta.
- The Mississippi Delta has the highest proportion of HIV diagnoses among people aged 13-24 years (18.4%).
- Three-quarters of people diagnosed with HIV in the Mississippi and Southeast Region were black.
- HIV diagnosis rates were higher among blacks and Hispanics than white in all regions.
- The demographic and residence characteristics among people with AIDS was similar to that of people diagnosed with HIV.
- The rate of HIV/AIDS was almost as high in rural areas as urban areas in the Southeast Region.

Implications for Prevention

This analysis confirmed that rates of HIV and AIDS were higher for the Mississippi Delta and Southeast Region. Higher HIV/AIDS rates were found among young adults, blacks and Hispanics. These areas have been historically identified as rural, poor, and lacking in health infrastructure. Strategies are needed to reach populations of these areas to reduce HIV transmission.

SOURCE:
Hall, H. I., et al. (2005). HIV in predominantly rural areas of the United States. *The Journal of Rural Health, 21,* 245-253.

Recent Hispanic migrants have higher HIV risk behavior

Labor migration from Mexico and Central America to California may increase risk to STDs and HIV. This study compared HIV/STD risk between recent (< 5 years in U.S.) and established (>5 years in U.S.) Hispanic immigrant men, ages 18-35 years residing in low income counties in California (N=410).

Recent immigrants were less likely to have a main sexual partner (45% vs. 67%) and more likely to have used commercial sex workers (40% vs. 28%). Recent immigrants were less likely to have received medical care in the previous six months (21% vs. 31%) or to ever have been tested for HIV (26% vs 43%). Established immigrants were more likely to report having engaged in unprotected sex and having used hallucinogenic drugs or ecstasy.

Prevention and testing programs should consider the risk spectrum when targeting recent migrating Hispanic men.

SOURCE: Levy, V., et al. (2005). HIV-related risk behavior among Hispanic immigrant men in a population based household survey in low income neighborhoods in Northern California. *Sexually Transmitted Diseases, 32,* 487-490.

Women of all sexual orientations engage in STD/HIV risk behavior

The sexual behavior of women of diverse sexual orientations has been understudied. The goal of this study was to determine whether and how STD/HIV risk patterns differed across sexual orientation among women in primary care settings.

Of 1304 women, 49%, 11%, and 40% self-identified as heterosexual, bisexual and lesbian, respectively.

Among women who had recently had sex with men (n=600), 51% reported using condoms. Heterosexual women had the highest risk of acquiring HIV as a result of a lack of condom use. Bisexual women had the highest rate of substance use during sex compared lesbian and heterosexual women. Lesbians had the highest rate of sex with bisexual men and injection drug users, but reported the highest rate of condom use compared to the other groups.

Women of all sexual orientations, and particularly heterosexual women, engaged in behaviors that placed them at risk for STD/HIV. Prevention programs are needed for women of all sexual orientations.

SOURCE: Koh, A. S., et al. (2005). Sexual risk factors among self-identified lesbians, bisexual women, and heterosexual women accessing primary care settings. *Sexually Transmitted Diseases, 32,* 563-569.

Female condoms protect against STI like male condoms

A review of research shows that randomized control trials provide evidence that female condoms confer as much protection from STIs as male condoms. Studies suggest that female condoms can be re-used for at least five years if properly disinfected. Observational studies suggest that the diaphragm protects against STI pathogens.

SOURCE: Minnis, A. M., & Padim, N. S. (2005). Effectiveness of female controlled barrier methods in preventing sexually transmitted infections and HIV: Current evidence and future research directions. *Sexually Transmitted Infections, 81*, 193-200.

Starting HAART earlier has several benefits

A Markov model was used to track HIV-infected persons over 6 disease stages. Starting HAART earlier increases total lifetime costs by $19,074, increases years of life by 1.21 years, and has an incremental cost-effectiveness ratio of $31,266 per quality-adjusted life-year.

SOURCE: Mauskopf, J., et al. (2005). HIV antiretroviral treatment: Early vs later. *Journal of Acquired Immune Deficiency Syndromes, 39*, 562-569.

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 the University of Colorado. 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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