HIV in Rural America

Presentation

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Presenters

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HIV/AIDS in the Rural US
Prevalence and Service Availability

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At the Heart of Public Health Policy
HIV/AIDS Basics

- Human Immunodeficiency Virus (HIV) reduces CD4 lymphocyte cells, needed to combat infection
  - Normal range is 500 – 1,000 cells per cubic milliliter of blood
  - Treatment recommended when CD4 count drops to 350/mm$^3$
  - At any level, person is contagious and should be educated re precautions

- CD4 count < 200, or selected diagnoses, considered to be Acquired Immune Deficiency Syndrome (AIDS)

HIV/AIDS importance

- Estimated 1.2 million persons living with HIV/AIDS (PLWHA)
- Disproportionately affects minorities, women, persons living in the South
- Could it become a rural disease?
  - Prevalence in rural America
  - Service availability in rural America
Prevalence: Data sources

- County data retrieved from state department of health web sites, 2008 data
  - 28 states, 2,012 counties
  - SCRHRC Study, available at rhr.sph.sc.edu
- County data from 2013 RWJ County Rankings data base, 2009
  - Data provided by CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- County-level data from AIDSVu, 2010 data, also from CDC
- Limitations: non-reporting and data suppression

Big picture

- HIV is present in rural as well as urban counties
  - “High” is in relation to the national median rate.
- HIV tracks closely with poverty and with minority race/ethnicity
- HIV rates in rural are growing
HIV/AIDS prevalence, 28 states, 2008

Source: HIV/AIDS in Rural America, rhr.sph.sc.edu

HIV prevalence, 2009, 43 states, by rurality

HIV Prevalence, 2010, by rurality

Tiny changes may be harbingers

- Kansas, Oklahoma 2009
- Kansas, Oklahoma 2010
Rural/urban HIV prevalence, 28 states, 2008


- HIV/AIDS Cases per 100,000 population

Rural/urban HIV prevalence, 16 states, 2010

(Data from AidsVu.org)


- HIV+ per 100,000

Source: AIDSVu. Restricted to 16 states with complete county data
HIV treatment

- Chronic treatment with antiretroviral medications costs about $10,000 - $12,000 per year
- Nearly half of PLWHA receive care through the Ryan White program
  - Current funding ~ $2.1 billion
  - 30% of Ryan White funding specifically directed to urban areas (Part A)
- Ryan White providers a reasonable proxy for care availability
- Limitation: no information VA, other providers

Ryan White providers, 50 states, 2008
### PLWHA with no county provider, 28 states, 2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Total</th>
<th>All urban</th>
<th>All rural</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>U.S</td>
<td>94,616</td>
<td>14.4%</td>
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<td>Northeast</td>
<td>17,894</td>
<td>11.0%</td>
<td>14,767</td>
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<td>South</td>
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<td>14.1%</td>
<td>21,868</td>
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<tr>
<td>Midwest</td>
<td>24,582</td>
<td>26.7%</td>
<td>18,409</td>
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<tr>
<td>West</td>
<td>15,138</td>
<td>10.8%</td>
<td>13,231</td>
</tr>
</tbody>
</table>

### Why worry? Distance may matter

- Norton KS to Wichita KS:
  - 268 miles
- Guymon OK to Oklahoma City:
  - 263 miles
Conclusions

- Few Ryan White providers in rural counties
  - Research is needed to assess effects of local service availability on remaining in care, health outcomes
- Research is needed to assess use of other providers in rural areas
  - HIV is a complex condition requiring specialized knowledge
  - VA addresses non-specialist quality of care through telemedicine and tele-education

HIV/AIDS Prevention in Rural America

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“The fear of stigma leads to silence, and when it comes to fighting AIDS, silence is death. It suppresses public discussion about AIDS, and detours people from finding out whether they are infected. It can cause people – whether a mother breastfeeding her child or a sexual partner reluctant to disclose their HIV status – to risk transmitting HIV rather than attract suspicion that they might be infected.”

Factors that contribute to challenges of rural HIV/STD prevention

| Lack of infrastructure to support MSM |
| Rural to urban travel for sex |
| Denial that HIV exists in rural areas |
| Stigma toward HIV and those at risk |
| Traditional values |
| “Hidden” at-risk populations |
| Isolation – social and geographic |
| Limited access to healthcare resources |
| Methamphetamine use |
“Ignorance breeds passivity, pessimism, resignation, or a sense that AIDS is someone else’s problem.”

Paul Farmer, MD in Global AIDS: Myths and Facts – Tools for Fighting the AIDS Pandemic.

Rural HIV/AIDS Prevention

• Schools
• Communities
• The Faith Community
• Healthcare Providers
Adapting an HIV/STD Behavioral Intervention

• Changing elements of the program to better fit rural culture and social contexts
• Changing language to terms and phrases used by the target audience
• Using examples that reflect the experience of the target audience
• Changing the days or times when the program meets to fit the target audience’s needs
• Changing location to meet the target audience where they congregate or feel safe

Opportunities

• Challenge rural HIV/AIDS complacency
• Reduce stigma toward HIV and those at heightened risk
• Develop effective rural HIV/AIDS prevention interventions
• Collaborate to take advantage of what you’ve got
“The evidence demonstrates that we are not powerless against the epidemic, but our response is still a fraction of what it needs to be. The real task now is to increase, massively, the political will, resources, systems, and social commitment to turn the tide.”

*Peter Piot,*
`Joint United Nations Programme on AIDS.*`

“Their needs are immense and all encompassing – yet rural areas do not have this capacity.”

*Rural Health Care Provider*
Q & A

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Thank you!

• Contact us at www.raonline.org with any questions
• Please complete webinar survey
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