Transcript
HIV in Rural America

Kristine Sande
I am Kristine Sande, program director of the Rural Assistance Center, and I'd like to welcome you to today's webinar, HIV in Rural America. We've worked collaboratively with the folks at HRSA to plan this webinar. However, due to the absence of either a fiscal year 2014 appropriation or a continuing resolution for the Department of Health and Human Services our colleagues at HRSA won't be able to join us today, including one of our featured speakers, Dr. Deborah Parham Hopson. However, this is really an issue that impacts the populations that HRSA serves, we thought it would be important to go ahead and hold the webinar as planned today.

At the end of 2009, an estimated 1.1 million Americans ages 13 and older were living with human immunodeficiency virus or HIV in the United States. Approximately 50,000 of them were living in rural areas. At the same time, 7.7% of new diagnoses of HIV and AIDS were in rural areas. While overall rates of people living with AIDS and HIV are lower in rural areas, people living with those conditions in rural areas face unique challenges due to barriers to diagnosis and service, including low rates of insurance in rural areas, transportation barriers, as well as stigma. Low population density and lower rates of prevalence can also make it difficult for rural communities to provide adequate services to people living with HIV and AIDS.

Before we begin, I'll go over some quick housekeeping items. We hope to have time for your questions at the end of the webinar. If you have questions for our presenters, please submit them towards the end of the webinar using the Q&A section of the screen which is directly beneath the slides. We've also provided a PDF copy of the presentation on the RAC webinar page, which is www.raconline.org/webinars. In addition to the slides that will be covered during the webinar today, you can find the slides that Dr. Deborah Parham Hopson, who is the HRSA senior advisor on HIV and AIDS policy, prepared for today. We thought it would be important that you have access to those slides about the Federal strategy and programs related to HIV, even though we won't have a speaker covering those today. If you do decide to go out and download the slides during the webinar, please don't close the webinar window as you'll have to log back in to the event. If you happen to have technical issues during the webinar today, you can contact our support area using the phone number listed on the information screen of the webinar. If you're not seeing that screen, the number is 701-777-6305. Once again, for technical issues the phone number is 701-777-6305.

We are delighted to have two real experts on HIV in rural America join us today. First, we will hear from Dr. Janice Probst regarding what the research tells us about HIV and AIDS in rural America. Dr. Probst is a professor in the department of health services policy and management at the Arnold School of Public Health, the University of South Carolina, where she leads the Federally-funded South Carolina Rural Health Research Center. Dr. Probst received her undergraduate training at Duke University and her graduate training at Purdue University and the University of South Carolina. Dr. Probst has extensive experience in heath services research with an emphasis on rural and vulnerable populations. She has more than 90 papers in the peer-reviewed literature. Dr. Probst received the 2008 National Rural Health Association Outstanding

Researcher Award for her work in rural minority health. In 2013, the University of South Carolina awarded her the Martin Luther King, Jr. Social Justice Award for faculty.

Our next presenter will be Dr. William Yarber who will discuss HIV and AIDS prevention in rural communications. Dr. Yarber is the senior director of the Rural Center for AIDS and STD prevention at Indiana University, Bloomington; and professor of applied health sciences at IU. He is also a senior research fellow at the Kinsey Institute in sex, gender, and reproduction. Dr. Yarber has authored or co-authored numerous scientific reports on sexual risk behavior and AIDS and STD prevention in professional journals, and has received several Federal and state grants to support his research in AIDS, STD prevention efforts. He is a member of the Kinsey Institute Condom Use Research Team, or CURT. For over a decade with Federal and institutional research support, CURT has investigated male condom use; particularly use errors and problems and has developed behavioral interventions designed to improve correct and consistent condom use.

At the request of the U.S. government, Dr. Yarber authored the country's first, secondary school AIDS prevention education curriculum called AIDS: What Young People Should Know. Dr. Yarber is the lead author of Human Sexuality, Diversity in Contemporary America, a college human sexuality textbook used in over 300 colleges and universities nationwide. Dr. Yarber chaired the National Guidelines Task Force, which developed the guidelines for comprehensive sexuality education, Kindergarten through 12th grade, published by the Sexuality Information and Education Council of the United States and adapted in six countries worldwide. Dr. Yarber is past president of the Society for the Scientific Study of Sexuality and a past chair of the Sexuality Information and Education Council of the United States board of directors. He has been a consultant to the World Health Organization Global Program on AIDS, as well as the sexuality related organizations in Jamaica, Portugal, and Brazil.

With that, we are now ready to hear from our first presenter, Jan Probst. Jan?

Jan Probst:
Thank you so much. I now have the ability to advance the slides? Thank you so much. I would like to thank you first for giving me the opportunity to talk about some of the prevalent work that we've done in finding out where HIV/AIDS is in the rural U.S., and of course, acknowledge that nothing that any of us does, especially me, is a single-handed project. These are co-investigators who helped us with this data collection – Deesha Leonard who has now completed her Ph.D. and is now Dr. Leonard, Dr. Metaar who is Ph.D., M.D.; and Dr. Sarah Glover. All of these have helped us with the reports and the information that I'm going to provide next.

Since our first speaker, who could not be here, but still said I should tackle the topic of what is HIV, I will attempt as a non-clinician, non-biologist, to lead us off by, just in case we have any new folks to this conference, just briefly describing what HIV and AIDS are. HIV is the human immunodeficiency virus which actually was discovered second, AIDS was discovered first. It reduces something called CD4 lymphocyte cells. Do not ask me what they are, but they're very important because you need them to combat infection. Normal adults have between 500 and 1,000 of those cells in each cubic millimeter of their blood. When the HIV virus begins, it slowly drops those levels and treatment is recommended somewhere in the 500 to 350mm range. At any level, the person who has HIV is contagious, but in general, the contagion is greater the lower

their CD count level, which, how do you keep the CD4 count low? You keep people in treatment. We'll go on to that.

If the CD4 count gets very, very low, below 200, various immune deficiency diseases that once were rare can show up. As a very, very old researcher, I can remember in the '80's people discussing the unusual occurrence of a disease that used to be rare, called Karposi's saracoma, a particular type of skin cancer. There are certain diagnoses, like Karposi's sarcoma, or a CD4 count below 200, is what we consider to be acquired immune deficiency syndrome. We have these two names as a heritage of the past. The acquired immune deficiency syndrome was labeled, there's a syndrome where you don't know what's causing it, and only after it had been studied for a number of years was the contributing virus, HIV, finally identified, which is why there are still two confusing names for one basic condition. The person is HIV positive and they are living with HIV or AIDS.

As was noted, there's approximately, I think, my number is a tad higher they have Kristine's, about 1.2 million people, and estimates are not precise, living with HIV/AIDS in the U.S. What I'd like to talk about today, is to point out that this disease disproportionately affects certain populations. Those populations include minorities, non-white Americans, women, persons living in the south, and that last category, rural. I'm going to raise that controversial point that, could AIDS/HIV positivity evolve into a rural disease? Maybe not based on numbers, but based on the percent of the population that has it. What I'm going to talk about today is research from the South Carolina Rural Health Research Center on the prevalence of HIV positivity in rural America, and service availability in rural America. It's in the potential mismatch between those two that I think we have the possibility for a very undesirable growth in prevalence.

Prevalence, I'm a scientist so I have to say where I got my data. Part of what I will talk about today was retrieved by us from websites all across the U.S. We went to every department of health, tried to ascertain if they'd published HIV prevalence data. What percent of the population has prevalence, has HIV at the county level. At that time, we were able to identify 28 states and 2,000 counties that had that data. The first information I'll present is from our study, which if you're interested in the full report, is available at our website which is shown there (http://rhr.sph.sc.edu/). Since that time, two additional sources of data have become available. The 2013 Robert Wood Johnson County Rankings Project's database has 2009 data that was provided to that project by CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. The CDC also provided this organization, using 2010 data, provided this information to a group called AIDSVu, so if you're interested in this data you can go there. I give all this detail about where we get the data, in case there's anyone listening at the state or county level who wants to access one of these data sources for helping in their own planning.

Limitations to the data, as noted on our report, we could only fine 28 states. CDC suppresses data for any county with fewer than 20 cases. Since counties with small numbers of persons are more likely to be rural counties, data suppression affects rural more than it affects urban counties in the U.S. With that, big introduction and details where you can look for further information, what did we find out about what are the prevalence rates for HIV positivity in rural?

Big picture: that was giving you the ending before we get to the beginning. Yes, HIV is present in rural America. It tracks closely with poverty and with rural minority race/ethnicity, and these

rates are growing. This is from our first report, and hopefully, people can see my little mouse as it wanders across this. When we first did this, but using 2008 data, we were able to get information down to the county level on the 28 states you'll see here. If you look at your own state you'll notice that this Q4, the dark color, is not limited to urban counties. It's in rural counties, in northern California, rural counties as well as urban counties in Washington, rural counties throughout the southwest, throughout the southeast. One of the things that we picked up on very quickly was that HIV, if you look at what quartile does the county fit in, is not limited to the cities. Cities may have the big numbers because more people live there, but when you look at the rate, the proportion of the population affected, rural America is sadly keeping up.

Specifically for this presentation, we did two additional analyses with the newer data that we were able to find. This is HIV prevalence in 2009, and at this point we were able to look at 43 states. You'll see that we've done our colors a little differently. We have rural high, which is a really dark red; rural low, which is a pink; and then urban high, which is dark green; and urban low which is light green. And, gosh darn, those same counties are lighting up. But we're also able to see something interesting, which is that we have rural counties, and much clearer when you have them in two different colors, that have high prevalence that are located in really, really rural areas. This little one that I'm circling right now is in Oklahoma which I don't think most people consider terribly urban and certainly not that part of it. So, yes, we have rates above the national median in the big cities in California, in the big urban areas of New York and New Jersey, but we also have them in rural areas. Notice I'm circling upstate New York here, because if anybody is from that area, some of those counties are frontier in their population density, but they are keeping up the bigs when it comes to HIV. Here we have pockets in Appalachia. Here we have the southern rural counties of the entire southeast. All of these dark red counties are rural, but they have HIV positivity rates above the national average.

Anecdotally, since we did not do a subsequent detailed analysis for this, I can say things like, this pattern of counties, which continues into 2010, when you find an isolated rural county, like this one up in Washington State, American Indian Reservation. When you look at these guys in the rural south, high minority populations here are principally African-American. When you look at some of the rural counties here, you have a mixture of African-American and Hispanic populations. Where you have the combination of poverty plus minority status, plus rural, you have these high rates. To me, that creates a perfect storm. This is where we need to intervene. Our next speaker is going to tell us how to do that.

One of the things that I find a little bit alarming is that, when I was preparing these maps I asked my graduate student to cut me down some specific states. She had them in two colors. I looked at gray states so I could see them. All of a sudden, when I looked at the state level, pop, look at that. Here's one that was below the median in 2009, but it's a rural county and jumped above the median. It isn't the only rural county changing. Here's a little rural county. This is Kansas. This is Oklahoma. Here's a little rural county down in Oklahoma. It didn't used to show up and now it does show up. Here's another little rural county. It didn't used to show up and now it does.

I realize that I'm extrapolating and I should do this for the whole U.S. and a big scientific analysis, but look at what's happening. To me, I see rural areas becoming darker that used to be below the reporting level that would get shown. Here's another white one going to a pink one, and another pink one going to a red one. These are rural counties becoming more acute. In only

one case do we have a rural county that used to be above the median for prevalence that's going the other way. These are tiny harbingers, but this is something I worry about. Is the rate of HIV prevalence in rural America growing faster than in urban America? Is it, by any chance, related to the absence of services in these areas? This is what leads me to worry that we are going to go in a direction of rural pockets of contagion that we never eliminate.

This is from our 2008 study. We looked at the rural prevalence and urban prevalence of HIV and we compared rural prevalence, which is these garnet lines, to the prevalence across the whole state, which is the gray line. In 2008, with the data that we had we found one state, unfortunately, South Carolina, my home state, in which the rural prevalence, the rate at which people have HIV is higher than in our cities or therefore in the rest of our state. We went and redid that analysis. We only studied, this is in a 2010 data, we only studied the states for which we had a report for every single county on the AIDSVu data. Another one of those "ping". It used to be just in South Carolina was rural greater than urban. Now we have Florida which has HIV prevalence in rural counties that is greater than the HIV prevalence in urban counties.

Remember, this is not the absolute number of people. If you go to a big place like Miami, you're going to get a bigger number of people. The proportion of the population that has this disease in Florida is greater in the rural counties than in urban. One of my concerns is that this will continue. In North Carolina, the rates are close. In Massachusetts, they're close. In New York, maybe not so close. These differences that we are seeing between rural and urban, I do not believe our as great as they might once have been. I think that we are evening-out, that's the kind of rural parity that I don't want, the HIV prevalence rates. I'm very concerned that the trend if we come back and do this with 2013 data, there's going to be five states in which rural is greater than urban.

Let's circle back. Why might this happening? I will be talking just about one particular program and I think our next speaker will be talking in much greater detail. HIV back in the '80's, and I was in public health in the '80's, was a death sentence. Part of the stigma associated with the disease, was both the populations in which it took a foothold, and also that you were going to die, and it was contagious and you were going to kill everybody. Now it has become, with the introduction of anti-retroviral therapy, a chronic disorder. Those anti-retroviral meds are not inexpensive. You have to have good health care just to pay for the meds, not to mention the cost of your doctor visits and so on. If you are not sufficiently wealthy, and a lot persons living with HIV or AIDS are not, you can get care through the Ryan White program. Unfortunately, our speaker on the Ryan White program was not here, and I have one slide but we'll talk about it.

Nearly half of people get care through Ryan White. For our purposes, in terms of ascertaining who's in treatment and who isn't, we are looking at the location of Ryan White programs. It covers nearly half of the people. The funding that it provides for care is significant, $2.1 billion. One of my concerns is where that funding goes, especially since, even where the epidemic started, 30% of Ryan White funding is legislatively directed to urban, it's automatically directed to urban areas. I do not know whether that is legislation or regulation.

This is the limitation: we do not have information on people who may be getting their HIV care from private providers. I know that here in South Carolina there are clinics that actually have developed an infectious disease specialty in HIV for insured population. These may be present in

other places. I have no information on the VA. We're just looking at where, if you go and ask, "I have HIV. I'm moving into this community. Where is my provider?" That's what we did. We mapped all of the Ryan White providers that were present on the Health Resources and Services Administration's HIV/AIDS Bureau website. This is where they are.

There we go. As you can see, they're spread all over the place. Here we have, just to go through the categories, the darkest category is an urban county with a Ryan White provider. The reddish one is a rural county with a Ryan white provider. As you can see, they're fairly densely concentrated. There are a lot of them in the really high need areas. Actually, in the southeast you'll notice that there are a fair number of red rural counties that light up. Certainly, the remarkable HIV prevalence in the rural south has not gone totally unnoticed by local providers. But, you know what? We still have a lot of rural counties that have nothing. You might say, "There's not a lot of people in Nevada." There aren't, but they can still get sick.

One thing I should've mentioned about treatment. Treatment keeps your viral loads down, which makes you less contagious. Here in South Carolina, we have found that 40% to 50% of people do not stay in care, meaning they do not show up at their provider and get their viral load test once a year. The fact that people drift in and out of care is a significant problem for controlling the infection and for educating those people about what they should do. As we all know, we're all bad at taking our doctors' orders, but it is at least helpful if we've heard them now and then. If you don't go visit your provider at all, you won't.

This map is available in our report which is available on our website. Why am I concerned? Across the U.S. 14% of persons in 28 states live in a county no provider. Only 11% of people who live in an urban county don't have a provider in their own county. In other words, virtually all urban counties have an HIV provider, have a Ryan White provider who can help low income people with HIV get care. Seventy-eight percent of the rural counties we studied in 28 states did not have a provider. In other words, not having a provider is the mode. It's what you expect. If you're rural, you're going to have to leave your county most of the time.

Of course, more urban people are traveling than rural people because more people live in urban. I think if I were asked to guess, how many people in rural America, if went from 28 states to all 50, have to leave their county to get care? I'd say that's about 50,000 people - like extrapolating out to the whole U.S. I can hear what everybody saying. "So, big deal, they have to drive a little bit."

Well, maybe they have to drive a little bit. One of the concerns that I have is that in some cases it's not a small distance. This is that little red zone from 2010 data in Kansas. I went and found a town in that tiny county from Norton, Kansas, to Wichita is 268 miles, ka-ching. Then, in this little county I found a tiny city here, Guymon, I guess that's how they say it, Oklahoma. To go from Guymon to the nearest HIV/AIDS provider is 263 miles. The distances that you have to drive to get from places, if you're HIV positive and live in these great stretches with no provider in them, can be significant enough that they may be a deterrent. Even though we say rural people drive further. They don't do your basic 500, 600 mile roundtrips every day. That may, in fact, be a deterrent to care.

What do I conclude from all of this? One is that we know that HIV is present in rural. We are concerned that it may be growing in rural at an inappropriate rate. There simply aren't the providers there. If you just look at Ryan White, there's not the providers there that possibly should be. We need a little bit more detailed research to find out what is it. Does the distance that you live from your provider effect the all-important remaining in care status and thus your health outcomes?

Another area in which our research may be deficient, and maybe we're missing something, is that maybe there are other providers who are giving care. If there are, the one point that we would like to note is that this is a complex condition. HIV is not like treating the common cold. It's not even like treating diabetes where providers are likely to encounter enough of it that they will realize that they need to get their continuing ed credits in. We may need to expand the resources that we have available, as the VA does to use telemedicine and tele-education to see how we can improve HIV care and this HIV retentioning care in rural areas. My concern is that if we do not do something to improve the availability of care and resources, we may have a rural HIV epidemic that we don't control and that will really come back to bite us in 10 years. At this point, I'd like to thank the Rural Assistance Center for giving me this opportunity and turn it over to our next speaker who I'm sure will be far more knowledge about the details of HIV.

Kristine Sande
Jan, this is Kristine. Before we get to Dr. Yarber, I would just note that a couple of people have written in and wanting to clarify that the new national treatment guideline for treating HIV patients recommends that anti-retroviral treatment occur for every patient with HIV regardless of CD4 count.

Jan Probst
I apologize. I did get that from the CDC, but what with the shutdown, I suspect they're not updating websites.

Kristine Sande
Two different people wrote I with that.

Jan Probst
Thank you. Thank you, everyone, for sharing that because that makes the availability of a Ryan White provider even more important

Kristine Sande
Right. There's also someone who's interested in the Alaska data and saying that it doesn't look accurate. Could that person contact you directly, Jan?

Jan Probst
I would be delighted. I'll share what we have and they can tell us what's wrong. My email address is just jprobst@sc.edu. Just Google our website or my name, you'll find me.

Kristine Sande
We'll hold all other questions until Dr. Yarber's presentation. With that, we'll turn it over to Dr. Bill Yarber.

Bill Yarber
This Bill Yarber. I'm the senior director of the Rural Center for AIDS,/STD Prevention, at Indiana University. We will be celebrating actually our 20th anniversary of existence this coming spring.

You can see on this website that if you need to contact me the email is aids@indiana.edu. The RCAP is the acronym that we use is listed there on the webpage or also in the screen also. Those are the ways that you can contact me.

This happens to be our logo we have individuals say oh yeah you're the organization that has the candle so we thought was the kind of a logo that would represent rural areas, but shining a light on things that we need to do for prevention.

I'm going to talk about four different things briefly today. It's hard to, obviously, cover every aspect of prevention programming relative to education and resources just in this brief time. I'm going to talk some about the challenges of HIV/STD prevention and management in rural America. Briefly, about places for prevention programming, some ideas about adapting intervention, and then some of the opportunities that we have for the future.

One trait of rural America is that there's all this disparities among populations in rural America. Certainly, oftentimes rural America is much different than urban. Therefore, the challenges I would say for HIV prevention in rural communities are quite unique. As you can see on this quote here, this illustrates one of the most significant barriers and challenges in the rural America relative to sexually transmitted infections, HIV included, as well as the information about sexuality. You can read that quote as I am talking here. What I think is really significant, of course, is the power of the first sentence, a fear of stigma leads to silence and when it comes to fighting AIDS, silence is death.

We look in rural America, the statement I would say goes hand in hand with this problem of anonymity. That maybe a little bit different than it would be in urban areas. In rural communities, the threat of being noticed, the threat of being identified relative to maybe, for example, buying condoms or treatment for substance abuse or even treatment for HIV and diagnosis is so powerful in many communities that it hinders individuals from protecting themselves from HIV. As you go along with stigma other aspects of a rural environment that they make it difficult that they're challenges for our efforts to minimize the risk of HIV and STD in rural communities and that would be racism and other forms of discrimination that I think increase pressure on individuals in rural communities that increase pressure for them to engage in risky behaviors underground. There are other types of factors that do contribute. I'm just going to talk a little bit about some of those.

One aspect of rural America is the fact that it's not homogeneous, that there are many cultural differences, there's many different populations. This presents I think additional HIV prevention treatment, educational challenges that I'll talk about pretty soon. This idea, and I guess this is a common phrase that we've all heard, one size fits all for HIV and STD prevention efforts is clearly not realistic in a multicultural rural America. Despite that there are some commonalities, and I just want to name a couple of those commonalities in rural America, one would be a

distrust of government and the health care system. The other one is the fact that there's a lot of value placed on rural control.

There's a lot of difference in structural disparity that I think influences HIV and STD prevention in rural communities. The structural disparity may be a reflection of poverty. It may be a reflection of limited economic opportunities. We know in many rural communities there are fewer job opportunities. There's smaller tax base. There's lack of adequately trained health care providers. Public transportation that's already been mentioned is a major issue. A lot of rural communities, actually most, have inadequate infrastructures for mobilizing and leveraging resources. This economic context of the rural community prevents enormous challenge, and as those who are in rural areas understand and know that there's extremely limited Federal funding specifically for HIV/STD prevention in rural America.

What I'm going to be talking about, the material I'm going to be presenting briefly in these next few minutes actually are based from a prevention guide that the RCAP developed called Tearing Down the Fences: HIV/STD Prevention Rural America. It was developed by a network of individuals, rural individuals, and national organizations. There's a PDF of that on our website, so you can get the entire copy on our website.

One of the major challenge, I think, in rural communities is to get adequate information to the individuals, particularly those at risk. Certainly, we know that medical advances are significant. We've seen that, certainly, in HIV and AIDS treatment. As an educator, I think one of the ultimate solution to HIV beyond medical advances is providing adequate information and prevention services. Not only preventing new infection depends on medicine, but as we know, it depends on individuals practicing safe sexual and drug use behaviors. As the epidemic has evolved, we have found that strategies for HIV prevention, educational programs, most of those have been developed in research for urban area. There're some issues that I'll be talking about in a few minutes. Overall, if you look at one of the HIV education in rural communities, most often, they're poorly planned, inadequately implemented, rarely is an evaluation of these programs. I think that education can be a particularly strong prevention strategy for rural areas, particularly because of the fact of limited or even no resources designated for medical treatment and prevention.

One thing about rural communities is that many of them have really very more a of homogeneous and strong value system, and also a lot of health needs that may compete with health concerns in that community. Therefore, we would believe that these educational efforts have to be tailored to a specific type of audience and that these tailored interventions can be based on urban areas but they need to be based on programs from urban but they need to be adapted to, tailored particularly, in the rural America.

As you can see, this one particular slide, the quote here, that really, I think, emphasizes the value of a knowledgeable population in the rural community. I want to briefly talk about four venues here that could be really important in HIV and prevention in rural communities. Of course, the thing about schools is that schools reach nearly, not all, maybe 95% of all youth, and so it's a great opportunity, but also it's an obligation that many people think to provide young people with knowledge and skills to avoid STIs and HIV. Most states in the United States mandate schools teaching about HIV. Over 90% of the adults in the United States believe that schools

should provide sexuality education. Anyone who's been in involved in this area and tried to schools, of course, realizes that there are constant controversies about the content. Typically, the controversy is should we educate about abstinence only until marriage or should we provide a more comprehensive approach. That kind of challenges continues in our culture and it continues in rural communities and one that is a challenge to provide young people adequate information that they can protect themselves. They even go onto a philosophical perspective about this. Do young people have a right to have the knowledge to protect their health. The type of knowledge, of course, is debated in our country.

There are a lot of programs that have been researched on to effectively decrease sexual risk behavior. Many of those are age appropriate. They're medically accurate. They're presented by the instructor who's not judgemental, and there are organizations that can give information about that. You can check the website or Advocates for Youth and The National Campaign to Prevent Teen and Unplanned Pregnancy, compendiums from the CDC, ETR Associates and SIECUS. Doug Kirby has reviewed and developed the curricula and has presented information about which are the traits effective in preventing HIV through school curriculum. He's found that those curricula that are most effective or those that emphasize that are theory based, that provide social skills training, provide practice of new skills, use formative research, target and tailor messages to specific audiences, and have multiple sessions, among other kinds of traits. The research of this has found that soundly developed educational programs in school settings have been effective in delaying the initiation of sex, have improved refusal skills, and increased condom use. Those are the ones that have been found effective.

Another venue, of course, is the community. We know that many rural communities lack funding resources, but yet, guess what? They may be rich in human resources. Many of those are volunteers and volunteers can do a lot, but rarely can they be held responsible as the sole responsibility for prevention. As we know, state and local health departments can certainly be valuable and need to be the anchor for this. If we look from community to community, the needs may be different. Some communities may have a particular problem of those imprisoned in correctional facilities. Some may have particular problems with men who have sex with men particularly African American men in the Deep South, night workers, victims of partner violence and those who use methamphetamine drugs. The challenge in rural communicates is the fact that there are different populations. A particular challenge, of course, is adapting any particular urban intervention to the rural communities. Unfortunately, we know that many local health departments are understaffed and many are underfunded.

Another venue for HIV/STD prevention is the faith community. David Satcher, M.D., the 16th U.S. Surgeon General, said the church has been silent too long about sexuality. There are several faith based organizations that have good programs in HIV and STD prevention. Health care providers, even though they may be medically to diagnosis and treatment HIV, although that's the challenge in rural communities, to have specialists. We need, I think, further emphasis and further training on the commitment ability to ask patients about their risk behaviors. Physicians and medical personnel in rural communities may be hesitant to do that because these individuals may be their neighbors, they may be their friends and it's very difficult and sensitive topic to approach.

In this textbook that I mentioned, the guide Tearing Down Fences, there's one particular chapter that I think can be very valuable to people. In this particular chapter called behavioral interventions that may work, again, that they may work has been shown that have evidence in urban areas but maybe not in rural areas. It does give examples of current programs that decrease unprotected sex including male-and-male sex, unprotected injecting drug users, programs tailored to women, programs tailored to youth, programs tailored to ethnic and racial minorities.

Here are some of the important tenets in adapting behavioral intervention that most of those show empirical evidence in the urban area, but don't have it in rural areas. That doesn't mean that we can't adapt those, and it does not mean that they may not be affective, but there are principles that you can see here listed that I think are actually necessary for adapting of these intervention to rural communities.

There are opportunities. I think if we look ahead here, and one of the traits of rural America is that sometimes there's a false sense of security. There's a low annual HIV incident in many rural communities. As I've already said there's denial. There could be stigma. There can be homophobia. A lot of this denial and complacency I think it makes it really difficult for them to have adequate prevention programs. Not only do we mean in the educational programs but ongoing surveillance, increased public awareness, attention to other STDs. That may be a way of educating about HIV.

One challenge is this rural HIV complacency. That calls attention, I think, to a focus on HIV risk and you could do that by talking about other STDs like chlamydia, syphilis, hepatitis B, and other STDs. Another opportunity is to reduce stigma. Some people in the rural communities through our work have said, "We need to destigmatize HIV in rural America." Without that, the testing, the risk reduction, and the prevention programs are going to be really difficult because of the fear of discrimination and the fear of violence. Removing stigma can also open the door to greater social support and that's very, very important, particularly in the rural community. That means we have to change attitudes toward people who are often marginalized in our culture. It's very, very difficult to do that, but it's a very important goal.

Another challenge is develop effective rural HIV/STD prevention intervention. We need to identify real specific strategies. Tearing Down the Fences actually identifies some of those. We can at least four or five populations need to be the focus of this. Men who have sex with men, men and women residing particularly in the deep rural south, marginalized lower economic communities, injecting drug users, migrant workers, and your immigrants. We need to take advantage of broad social and scientific advances. This is technology. Tele-medicine, Internet, mobile phones, text messaging, long distance services, chat room, all these can provide a way to reach rural communities. Of course, the fact that rural communities do have limited resources, minimal funding options, and a difficult time initiating rapid change. We need to take advantage of what we have and that's volunteers and that's partnerships. These things, I think, collaborations can be really valuable with rural communities.

So it's been said of course that evidence does demonstrate that we're not powerless, and of course, that we can do more, the challenges of increased massively the political will, resources, systems, and social commitment. Unfortunately, as a rural health provider has told us, is that the needs are immense and all encompassing, and yet rural areas oftentimes don't have the solution,

the magic capacity to do that. Indeed, I don't think that there are any simple solutions that will magically end rural HIV. There are opportunities that make a difference, but there are unique challenges and limited resources in rural America. That means that we need to know the community. We need to assess what the risk is. We need to understand the context. Now, I think, is the time to come together and put all that together.

Going back to the document from our RCAP, Tearing Down the Fences, I think now is the time to come together to tear down the fences that divide communities, tear down the fences that isolate individuals, tear down the fences that prevent collaboration that allow HIV funding to be increased to rural communities. As these fences collapse, hopefully, new ideas and partnerships will arise to strengthen HIV prevention in rural America.

In the textbook, I'd like to read in concluding this quote: "Much like rural America itself, the road to effective HIV/STD prevention and control maybe unpaved and winding, yet the moral obligation to develop and smooth this road is clearly evident. The challenges are inherently difficult and the available research and financial support are modest at best. Innovative, collaborative responses and solutions are required to contain and reduce HIV and other STDs in rural communities." That concludes my presentation.

Kristine Sande
Thank you Dr. Yarber. That concludes the presentations for today's webinar. Now we can go into the question and answer period. We have just a few minutes left. If people listening in have questions they can enter those in the Q&A section of the screen. I'll just start and ask a few and we'll see how many we get through.

The question is, in Wisconsin there simply are not enough HIV providers to have one in each of our 72 counties. We seem to be succeeding with rural clients with our primary care support network where specialists in HIV care interact frequently as expert consultants and intensive medical case managers with clients and their primary care providers by phone, by visits at clinic, home, or community, and with local education efforts related to specific patients and their circumstances such as training local obstetric staff on the special needs of a birthing mother with HIV and by case studies via conference sessions. Have either of the speakers know of other circumstances like that or have direct knowledge of those sorts of programs?

Jan Probst
I do not and I want to encourage the Wisconsin folks to present their stuff at the next rural health association meeting because I think we need to get more rural examples out there.

Bill Yarber
I concur about that recommendation. That's one of the most important things, I think, is for us to share programs that work or programs that bring people together that fill the void of lack of resources and so on. I hope it can be presented. Clearly, if you have information we'd be glad to post that on our website.

Jan Probst
Just noticing, Wisconsin's actually better at having wide awake providers than other counties and other states in the Midwest. Keep up the good work. On Wisconsin!

Kristine Sande
On that note, another question was asking you to define again what is a Ryan White medical provider?

Jan Probst
The way we define it was basically going to the HIV/AIDS Bureau's website. The HIV/AIDS Bureau within HRSA, and it has a thing find HIV/AIDS medical care. Basically, you can go there. You can search by address and search by state or county, and we went and basically there's also a backdoor you can use to get the list of all HIV, Ryan White HIV providers. If there's someone listening who wants to find that out for their own area you can search by state or by county. It's findhivcare.hrsa.gov, and there's like a little back slash so that you're actually into the search window. If you go to the HIV/AIDS Bureau within HRSA, they make it real easy to find these. I'm going to go to Wisconsin, but you can't see my screen because it's not your screen. If I click Wisconsin and search, let's see what happens. Please be good, please be good to me. It's saying loading content, please wait. I was hoping it was going display a nice little map of Wisconsin because it says that's one of the options. Oh never mind, it didn't find anything because I didn't have my … never mind, but I recommend that people can go to this live, go find something.

Kristine Sande
Great, thanks. Another question is, "is the definition of men who have sex with men and interplay with new HIV epidemics a problematic issue? In other words, indigenous and African-American populations do not subscribe to MSM, nor queer or gay labels, this is more of an issue with youths and adults. Is that a problem for data collection and evidence based practices, and if so what can we do?"

Jan Probst
I'm going to defer that one to Dr. Yarber who's much better.

Bill Yarber
An epidemiologist, but I think that's an important question and intriguing question. Throughout the epidemic there's been some evolution of the Federal government of various groups from homosexual to men who have sex with men, but yet that's a broad sweeping term. You're exactly right that there are populations that don't fit. They're cultural.

Jan Probst
Certainly here in the black community in the south, I'm not even going to try to repeat this slang because I'm sure I'll screw it up and become a total object of ridicule, but yes, they do not define themselves as homosexuality. They are keywords for the behavior which may occur in addition to regular heterosexual sex, so they do not define themselves by that one behavior as being homosexual. That is an issue. I think we don't have anyone here who is, unless one of our listeners is a member of a health department where this information is actually taken down, we don't know if we're recording it accurately. Therefore, we don't know if the conclusions we draw are right and there you go.

Kristine Sande
It looks like we're about at the end of our time. I think we'll wrap it up for today. On behalf of

the Rural Assistance Center, I'd like to sincerely thank our speakers for the great information and insights that you've shared with us today. I'd also like to thank our participants for joining us as well. Please note that a survey will be emailed to you following today's webinar and we strongly encourage you to complete the survey and provide us with feedback that we can use in hosting future webinars. Once again, the slides used in today's webinar are currently available on the webinar page on raconline.org. In addition, a recording and a transcript of today's webinar will be made available on the RAC website and sent to you by email in the near future. Thank you again for participating and have a great day.