

# What Are Rural HIV Prevention Needs?



## Are rural populations at risk for HIV?

Yes. From 1988 to 1990, the 25 counties in the US with the highest rates of increase in AIDS cases were mostly rural counties with an average population of 73,000. [\(1\)](#) In 1996, AIDS cases in rural areas (population of less than 50,000) represented 6.7% of all AIDS cases in the US. [\(2\)](#)

Newly reported AIDS cases in rural areas of the US are increasing in the South, among young people, among African-Americans and Hispanics, and among people infected through heterosexual contact. In rural eastern North Carolina, people with HIV are more likely to be female, heterosexual, non-white, and younger. [\(3\)](#)

## What puts rural people at risk?

In many rural areas, heterosexual contact accounts for the most HIV transmission. In addition, having a sexually transmitted disease (STD) such as syphilis and gonorrhea may increase the likelihood of HIV transmission. In Monroe County, LA, women accounted for 33.3% of all new HIV infections and adolescents 9.7%. Monroe also has one of the highest syphilis rates in the nation. [\(4\)](#)

Injection drug use and non-injection drug use, especially crack cocaine use, puts many rural residents at risk for HIV. Drug use is closely linked to prostitution, especially among women and teens. The combination of crack cocaine use and a flourishing sex industry have caused Belle Glade, FL, an agricultural community near West Palm Beach, to have the highest cumulative per capita incidence of AIDS in the US. [\(5\)](#)

Many men who have sex with men in rural areas remain "in the closet" and their sexual lives remain secretive. [\(6\)](#) These men may engage in unprotected sex in anonymous sexual encounters in public places like rest stops and adult book stores, or may travel to large cities where they encounter a large pool of HIV-infected men.

## What are rural challenges?

Rural communities can provide their members both strong support and strong condemnation at times. In rural areas, traditional moral values, conformity to community norms and intolerance of diversity can be strong. [\(7\)](#) In some cases, homophobia, racism, sexism, and stigmatization of people with AIDS, homosexuals, minorities and drug users makes effective HIV prevention nearly impossible. [\(8\)](#)

Confidentiality can be hard to maintain in rural areas, yet is crucial for many residents due to fear of

stigmatization. (9) Testing for HIV, discussing sexual practices with clinicians, obtaining drug treatment, or buying condoms in local stores-all important preventive activities-can be difficult to do confidentially in rural areas.

Health care providers are the primary source for health education and prevention counseling in many rural areas. However, rural clinicians may believe that HIV is not a problem in their area and may not conduct proper risk assessments of patients and may not properly diagnose cases. Rural physicians may also be reluctant to become known as "the AIDS doctor" for fear of scaring off other patients. (9)

In addition to addressing prevention issues in their own areas, rural service providers must also address issues surrounding residents who travel to urban areas and may engage in high risk sexual or drug using behavior while there. Rural health care providers are also burdened by the migration of HIV+ patients who may have become infected in urban centers and returned home to rural areas for care. (3)

Geographic and climactic conditions can hinder access to preventive services, especially in rural western US. (10) Many rural residents do not have access to transportation, and for those who do, rugged topography, severe winters and long distances between towns can mean traveling several hours for medical care or social services.

## What are legal barriers?

Schools are one of the few venues available to educate adolescents about HIV/STD prevention in rural areas. However, in recent years many states have passed laws that restrict sex education in schools and limit what teachers can say to students, including discussing condom use, drug use and homosexuality. (11)

For many seasonal migrant farm workers, poverty, lack of access to health care services and isolation have hampered HIV prevention efforts. Recent anti-immigrant laws, including mandatory HIV testing, have driven many at-risk migrant workers into an underground way of life and have made it hard to offer services to non-legal workers. (12)

## What's being done?

Prevention efforts that are incorporated into already existing services can be effective in rural areas. Settings that might attract those at greatest risk for HIV include truck stops, rest areas, gay bars, recreation centers, adult book shops and movie theaters. (6)

In rural British Columbia, Canada, local AIDS services, resources, populations and transmission statistics were inventoried in a computer database and mapping program. The program created easy-to-read colored maps that broke down literacy and cultural barriers. The program increased resource sharing and networking among communities and harnessed non-traditional resources. After six months, community partnerships and job satisfaction increased and rural populations served increased tenfold with no increase in program costs. (13)

In rural North Carolina, health care providers are identifying most of the HIV+ pregnant women and treating them with AZT to prevent transmission to their infants. Over half (56%) of HIV+ mothers lived

in rural counties or small metropolitan statistical areas. Rural infants were more likely to be identified and tested for HIV than urban infants (96% vs. 73% in 1994). Overall, for urban and rural areas in North Carolina, HIV transmission in infants decreased from 21% in 1993 to 8.5% in 1994. [\(14\)](#)

Rural health care providers were trained in HIV/AIDS information, how to conduct risk assessments, advances in treatments, and sensitivity to diverse populations in one program in the Mountain Plains region of the West. The most effective training was achieved with a self-study booklet which helped increase prevention, early intervention and health promotion among rural health care providers. Interactive teleconference training and personal training from visiting educators were also effective. [\(15\)](#)

## What still needs to be done?

HIV prevention efforts are urgently needed to address the rising HIV infection rates in rural areas. Accurate needs assessments can help target populations at greatest risk for HIV. Programs for adolescents, heterosexual women and gay men are needed. Outreach to at-risk rural drug users is key to reaching this often hidden population.

As HIV and related illnesses begin to strain existing health care services in rural areas, access to quality treatment is critical. Aggressive diagnosis and treatment of STDs will help prevent HIV transmission. Also, migrant farm workers need basic preventive health care while they are working in rural areas. [\(16\)](#)

Rural communities need to foster acceptance of prevention messages for safer sex and drug use. Rural residents, especially teens, should have easier and more confidential access to low priced or free condoms. A comprehensive HIV prevention strategy uses many elements to protect as many people at risk for HIV as possible. Dealing with HIV in an open manner can help strengthen rural programs and protect rural populations.

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## Says who?

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