UCSF Center for AIDS Prevention Studies
AIDS Research Institute

what are rural HIV prevention needs?

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are rural populations at risk?

Over the years, rural areas, which represent roughly 20% of the US population, have consistently reported 5-8% of all US HIV cases.[1] Yet certain rural areas and populations are disproportionately affected—the South and African Americans in particular. There may not be an epidemic of rural HIV/AIDS cases but there are troubling hot spots.

The South comprises 68% of all AIDS cases among rural populations.[2] In 2000, the rate of new AIDS diagnoses was three times higher for the South than for other rural areas in the US.[3] In certain areas of the South, the rate of HIV/AIDS diagnoses is almost as high in rural areas as in urban areas.[3]

African American men and women represent 50% of rural AIDS cases, Whites 37%, Latinos 9% and American Indian/Alaska Natives 2%.[2] African Americans and Latinos are disproportionately affected by HIV in rural areas: In the Northeast, African Americans and Latinos each represent 1% of the rural population, but 25% and 20% of the AIDS cases, respectively.[3]

Most rural AIDS cases (75%) occur among men.[2] However, rates among rural women are increasing, particularly among African American women. Heterosexual transmission accounts for most cases among rural women, whereas injection drug use is the most common transmission category for urban women.[2]

Among rural men, men who have sex with men (MSM) comprise approximately 60% of rural AIDS cases and injecting drug users (IDUs) about 20%.[2] In 2000, in the rural South, 28.5% of men were infected through heterosexual contact.[3]

what are rural challenges?

In rural areas, HIV prevention and intervention programs have lagged behind urban programs, due to stigmatization of HIV and high risk groups, geographic factors and low overall HIV rates. These three factors combine to make it difficult, financially and practically, to implement rural HIV prevention programs.[4]

Geographic isolation can hinder access to preventive services for rural residents who have limited access to transportation. Rugged topography and long distances between towns can mean traveling several hours for medical care or social services. This can result in services that are not tailored to specific population needs and delays in delivery of services.[5]

In addition, isolation can lead to difficulty finding sexual partners and might lead to riskier behaviors when sexual encounters do occur. One study found that rural men are more likely to have sex on their first date than urban men, possibly due to long travel distances and concern that the next chance may be a long time away.[6]

A powerful stigma remains associated with both HIV/AIDS and homosexuality. Rural MSM may avoid stigma, social hostility and expected violence by hiding their sexuality and assimilating into the heterosexual culture. Rural venues where MSM openly socialize are scarce, resulting in some men seeking sex partners in public sex environments, through the Internet and by regularly traveling to higher seroprevalence areas.[4]

Rural residents are more likely to live in poverty and less likely to have health insurance than urban residents.[7] Without insurance, rural residents are less likely to seek medical care or social services. Rural areas have fewer healthcare providers with HIV expertise and rural HIV+ patients are less likely than urban patients to be on antiretroviral therapy.[8] There is limited funding for and access to substance abuse treatment services.

Poverty can also increase individual risk such as exchanging sex for money, shelter or drugs. In one study, Black women reported the most common reason for engaging in high risk behaviors was financial dependence on male partners.[9]

Says who?

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what puts rural populations at risk?

As with all populations, HIV risk depends not on where you live, but on whether you have unprotected sex or share needles with an HIV+ partner, and whether you have access to care, education and prevention services.

Rates of sexual partner change and concurrent relationships (having more than one sexual partner at a time) increase the risk of transmission of HIV. A study of rural African Americans with heterosexually transmitted HIV found that more than half had multiple partners, 40% had concurrent partners and 87% believed that their partner had sex with others during their relationship. Concurrency was associated with smoking crack cocaine and incarceration of a sex partner.[10]

Drug abuse is often seen as an urban problem, but it poses a significant problem in rural areas, methamphetamine in particular.[11] One report showed that rural youth are more likely to become substance abusers than urban youth: eighth graders in rural towns are 59% more likely than urban eighth graders to use methamphetamines.[12] Substance abuse contributes to risky behaviors such as engaging in unprotected sex, having multiple partners, sharing needles or exchanging sex for drugs.

what's being done?

The Strong African American Families (SAAF) program is a 7-week prevention intervention designed for African American mothers and their 11-year-old children in rural Georgia. SAAF sought to strengthen parenting skills that would in turn promote positive self-pride and positive sexual body image in their children to help lower their sexual risk behaviors. Mothers reported an increase in targeted parenting behaviors, which increase self pride in their children. Youth reported less intention and willingness to engage in risky behaviors, and a reduction in risky sexual behavior.[13]

The Wyoming Rural AIDS Prevention Project (WRAPP) piloted an Internet-based intervention for rural MSM that used conversations between an "expert" HIV+ gay man and an "inexperienced" HIV- gay man to deliver basic HIV education and behavior change strategies. The 2 modules lasted 20 minutes and featured dialogues, interactive activities and graphics. Men who participated in the intervention reported increases in knowledge, safer sex outcome expectancies and self-efficacy.[14]

In rural Arkansas, collaboration between a CBO, the Department of Corrections, the Health Department and Addiction Treatment and Recovery Centers, helped to identify and recruit HIV+ clients engaging in risky sexual and drug-using behaviors. These clients enrolled in the Healthy Relationships Intervention and reported decreased unprotected sex and increased disclosure to family, friends and partners.[15]

In Mississippi, the Mobile Medical Clinic van travels to rural areas where people are at highest risk for HIV and syphilis, specifically focusing on African Americans. So that they are not seen as the "VD van," they offer glucose, blood pressure and cholesterol screening. Before the clinic enters a community, they arrange for a local sponsoring organization, like a church or community representative, to ensure that there is support in the community for their presence. They have partnered with local agencies to perform clinical breast exams, PAP smears and dental sealant applications in youth.[16]

what needs to be done?

Because resources are limited in rural areas, prevention activities need to be targeted to populations at highest risk, including women and men who have sex with men, African Americans and Latinos, young persons, and alcohol and drug users. Recent immigrants and migrant workers may also be at high risk, especially along the US/Mexico border.[4]

It is critical to expand and improve care for HIV+ persons in rural areas and provide prevention education in medical settings. Rural healthcare providers need better training and support on HIV clinical care, delivering prevention messages, assessing risk behavior and cultural sensitivity and confidentiality issues.

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