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CAPITOL RESEARCH

HEALTH

HIV and STD Prevention Policies: Focus on Rural Areas

Preventing disease in rural areas involves a set of challenges that go beyond the familiar issues in getting health care to rural residents. Health care providers must overcome issues of distance, resource scarcity and rural culture to reach and treat health problems in rural areas. Preventing HIV/AIDS and sexually transmitted diseases in rural areas requires addressing the additional barriers of overcoming stigma, a lack of awareness of disease prevalence and the need to assure confidentiality for testing and treatment.

Overcoming Unique Rural Challenges for HIV and STD Prevention

Residents of rural areas and particularly frontier areas, those with a population density of six or fewer people per square mile, face many obstacles in accessing health care. Isolation, poverty, limited income and a lack of health insurance combine with limited access to health, mental health and social services to create unique challenges.

Rural residents are more likely to stigmatize mental illness and receive inadequate treatment, which puts them at greater risk for HIV and other sexually transmitted diseases. Behaviors such as drug use, intravenous needle sharing, early initiation of sexual activity or unprotected sex with multiple partners also increase the likelihood of transmitting HIV and sexually transmitted infections.

Limited health care resources in rural areas mean that resources are often directed to mandated prevention services such as childhood immunizations or more acute health problems. As a result, services for early detection and treatment of sexually transmitted diseases and HIV/AIDS are more limited. In addition, prevention efforts are hampered by a lack of access to high speed Internet that allows residents to identify testing sites and obtain information, a scarcity of retail stores that make condoms available, and an absence of low-cost or free testing for HIV and STDs.

Increased stigma of HIV also is a barrier to education and prevention in rural areas. Many rural residents deny that HIV exists in their community.

Negative views toward homosexuality cause men who have sex with men to conceal their behavior and travel to urban areas for sex partners, where higher rates of infection exist. When they return to their rural homes, the lack of safe, confidential testing locations contributes to the spread of diseases. Increasing the awareness of HIV and STDs and encouraging prevention also is more difficult since residents of small towns can be reluctant to be seen buying condoms, seeking testing and treatment, or attending substance abuse treatment.[1,2] HIV/AIDS is more stigmatized in southern states, where the epidemic is more severe than in other U.S. regions.[3]

Providers of prevention programs face a number of challenges as well. Limited resources to address the cultural, racial or ethnic differences in various rural regions make it difficult to target those populations. Programs for men of color who have sex with men are especially lacking. Rural residents also may have a distrust of public health programs due to their general distrust of government-run programs, health care systems and directives for school-based sex education.

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Limited economic opportunity in rural areas makes it difficult to recruit a system of well-trained and stable health care providers. Lack of public transportation and geographically isolated communities can hinder residents' ability to get mental health and substance abuse treatment. The limited availability of local programs or community resources in rural areas reduces the opportunities for HIV and STD prevention efforts to be integrated with other services or activities.

Effective solutions in rural areas begin with identifying the local priority populations with the greatest risk of acquiring HIV or STDs, and then working with organizations in the community to reach those populations. Possibilities include:

- Partnering with schools, community services and faith-based organizations for prevention education and testing events.
- Providing testing at private doctors' offices, community and family planning clinics, hospital-based clinics, emergency departments, public health department clinics, correctional facilities, and mental health and substance abuse clinics.
- Offering special events where high-priority populations can be targeted for education and testing, including faith-based gatherings, health fairs, county fairs, rodeos, college fairs, AIDS walks, anti-meth events and Native American pow wows.

Prevention and testing events also must promote acceptance and provide support for those who test positive for infections. Confidentiality needs to be assured during all phases of the program, including parking, the site for services, testing, results and treatment. Testing and treating couples, and providing social support and transportation can increase participation. Medical providers in rural areas who offer testing and treatment also can work in conjunction with public health services to help detect and respond to local outbreaks.[4]

What State Policies Can Help Prevent HIV and STDs?

The Centers for Disease Control and Prevention recommends policies in six areas as valuable tools in the prevention of HIV/AIDS and sexually transmitted infections.

1. **Screening for HIV/AIDS and chlamydia infections:** Routine screening for chlamydia is recommended for all sexually active adolescents and young women ages 25 and younger. Chlamydia screening is among the high value clinical preventive services ranked by the National Commission on Prevention Priorities and is one of the few evidence-based recommendations for adolescent preventive care.[5] To date, health insurance coverage for annual chlamydia screening is mandated in just four states—Georgia, Maryland, Rhode Island and Tennessee.[6]

CDC recommends routine HIV screening for all patients ages 13 to 64 in all health care settings to help all people understand their HIV infection status. Patients are to be notified testing will be done, and offered the opportunity to decline testing (opt-out screening). General consent for medical care should encompass consent for HIV testing, and HIV prevention counseling prior to screening and testing should not be required in health care settings. Those at high risk for HIV infection should receive testing at least annually, and all pregnant women should receive HIV screening as part of the routine panel of prenatal screening tests.

2. **Medicaid coverage for routine HIV screening tests:** CDC supports state Medicaid reimbursement for routine HIV screening in all populations and settings.

3. **State laboratory reporting on the HIV epidemic:** The National HIV/AIDS strategy and the CDC recommend that all state laboratories collect and report information on CD4 and viral load statistics for people infected with HIV. These reports are used to monitor the strength of the HIV/AIDS epidemic, particularly in populations at greatest risk for HIV infection.[7]

4. **Syringe exchange programs:** Syringe exchange programs can prevent transmission of HIV among intravenous drug users[8] and have been found to be cost-effective.[9]

5. **Partner therapy:** Expedited partner therapy is a clinical approach to treat the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to give to his or her partner without the health care provider first examining the partner.[10] This practice is an alternative public health approach which can be used when other partner follow-up activities are not practicable, and has been found to be cost-effective.[11]

6. **Health education for adolescents:** Comprehensive sex education can cause youth to delay their first sexual encounters and reduce the number of partners, especially when it is delivered by trained instructors, is age-appropriate and includes accurate information about reducing the risk of HIV infection or getting pregnant, forming strong relationships and making good decisions.[12,13]

Do Rural States Have the Policies to Prevent HIV and STDs?

There is no standard designation for rural states, instead the U.S. Census defines areas of states as rural based on population centers of 50,000 and their proximity to those centers. Rural or non-urban areas are those areas that do not meet the standards to be designated as urban. The higher the proportion of the state's population outside of urban areas, the more likely the state is commonly referred to as rural. Another measure of rurality is very low density of the population of an area. Frontier areas are those with fewer than 6 persons per square mile. States containing large frontier areas, both designated by population or land area, are also commonly referred to as rural.

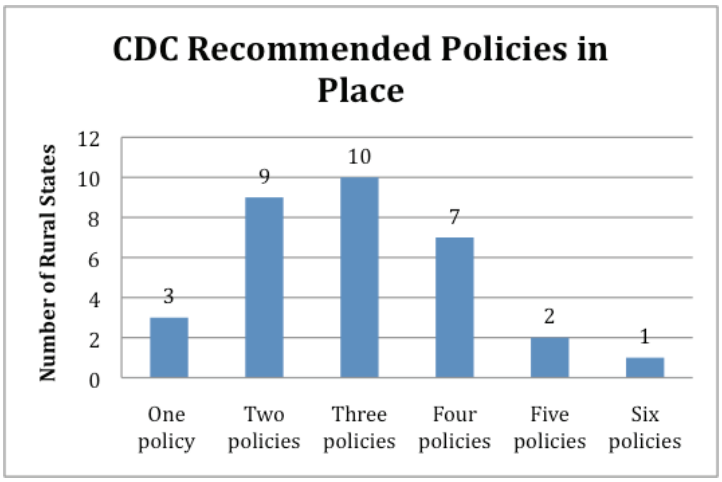
The top 10 states for each of these five rural and frontier definitions were identified:

- Rural population: Highest percent of population in rural areas, largest rural population[14]
- Frontier population: Highest percent of population in frontier areas, largest frontier population, largest frontier land area[15]

Thirty-two states ranked in the top 10 for one or more of these criteria (see chart on following page). Less than one-third of the 32 rural states have at least four of the recommended policies in place. Maine is the only state with all six policies in effect.

Among the 32 rural states, only one of the six recommended policies is implemented in nearly all the rural states and progress on the other five policies includes:

- Most rural states (29) have HIV screening provisions consistent with CDC recommendations. Two rural states also mandate private insurance coverage for annual chlamydia screening.
- Half the states (19) allow expedited partner therapy, and 18 have syringe exchange programs in place.
- One-third of the states (12) mandate school-based education on both sexual health and HIV, and 11 of their state laboratories monitor CD4 and viral load for HIV patients.
- Less than one-fifth of the states (6) provide Medicaid reimbursement for routine HIV screening.



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Resources:
Policy profiles for each state are available at *http://knowledgecenter.csg.org/drupal/content/state-policies-std-hiv-and-teen-pregnancy-prevention*. Updated state profiles are planned for release in summer 2011.

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Availability of HIV and STD Prevention Policies in Rural States

State	Ranked Top 10 in Rural Definitions	Highest Top Ten Rank[1,2,3]	HIV Screening Consistent with CDC Recommendation[4,5,6]	Medicaid Covers Routine HIV Testing[4]	Laboratory Reports for HIV/AIDS include CD4, Viral Load[4]	Syringe Exchange Programs Exist[7]	Expedited Partner Therapy Permitted[8]	Sex and HIV Education Mandated[9]
Alabama	Twice	Percent Population in Rural Area (8th)	Yes	Partial	No	No	Partial	Partial
Alaska	Twice	Frontier Land Area (1st)	Yes	Partial	Partial	Yes	Yes	No
Arizona	3 times	Frontier Population (2nd)	Yes	No	No	Yes	Yes	No
Arkansas	Once	Percent Population in Rural Area (6th)	Yes	Partial	Partial	No	No	No
California	Once	Frontier Population (5th)	Yes	No	Yes	Yes	Yes	Partial
Colorado	Twice	Frontier Population (7th)	Yes	No	Partial	Yes	Yes	No
Georgia	Once	Rural Population (7th)	Yes*	No	Partial	Yes	Partial	Yes
Idaho	Once	Percent Population in Frontier Area (8th)	Yes	Yes	No	No	Partial	No
Kentucky	Once	Percent Population in Rural Area (9th)	Yes	No	Partial	No	No	Yes
Maine	Twice	Percent Population in Rural Area (2nd)	Yes	Yes	Yes	Yes	Yes	Yes
Michigan	Once	Rural Population (5th)	Yes	No	Yes	Yes	No	Partial
Minnesota	Once	Frontier Population (4th)	Yes	Yes	No	Yes	Yes	Yes
Mississippi	Once	Percent Population in Rural Area (4th)	Yes	Partial	Partial	No	Yes	No
Montana	4 times	Percent Population in Frontier Area (2nd)	Yes	No	No	Yes	Partial	Yes
Nebraska	Once	Percent Population in Frontier Area (9th)	Partial	Partial	Yes	No	Partial	No
Nevada	Once	Frontier Land Area (6th)	Yes	Partial	No	No	Yes	No
New Mexico	3 times	Frontier Population (3rd)	Yes	Partial	Partial	Yes	Yes	Yes
New York	Once	Rural Population (6th)	Partial	Yes	Yes	Yes	Yes	Partial
North Carolina	Once	Rural Population (2nd)	Yes	Partial	No	Yes	Yes	Yes
North Dakota	Twice	Percent Population in Frontier Area (4th)	Yes	No	Yes	No	Yes	No
Ohio	Once	Rural Population (4th)	Yes	No	No	Yes	No	Yes
Oklahoma	Once	Frontier Population (8th)	Yes	Partial	Partial	Yes	No	Partial
Pennsylvania	Once	Rural Population (3rd)	Partial	Partial	No	Yes	Yes	Partial
South Dakota	3 times	5th in both Population in Rural Area and Frontier Area	Yes	Yes	No	No	Partial	No
Tennessee	Once	Rural Population (8th)	Yes*	Partial	No	No	Yes	Yes
Texas	3 times	1st in both Population in Rural Area and Frontier Area	Yes	No	Yes	Yes	Yes	No
Utah	Once	Frontier Land Area (8th)	Yes	No	Yes	No	Yes	Yes
Vermont	Once	Percent Population in Rural Area (1st)	Yes	Yes	Partial	Yes	Yes	Yes
Virginia	Once	Rural Population (10th)	Yes	No	Yes	No	Partial	No
Washington	Once	Frontier Population (9th)	Yes	Partial	Yes	Yes	Yes	Partial
West Virginia	Once	Percent Population in Rural Area (3rd)	Yes	No	Yes	No	No	Yes
Wyoming	3 times	Percent Population in Frontier Area (1st)	Yes	No	Partial	No	Yes	No

* Also mandates insurance coverage for chlamydia screening.

Sources for table:

[1]Rural Assistance Center. "What is Rural? Frequently Asked Questions." Available from *http://www.raconline.org/info_guides/ruraldef/ruraldeffaq.php#current*

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