

# HIV Risk Reduction

A quarterly of The Office of Addictive Disease, for professionals in the fields of HIV & SA/P  
Volume 6, Issue 2

## HIV in Rural Georgia

An interview with Claire Hicks, MD



Dr. Claire Hicks,  
Clinical Coordinator  
Public Health District 9-2  
Jesup, Georgia

An encounter with a single AIDS patient early in the career of Dr. Claire Hicks has helped improve the lives of thousands of HIV positive patients in rural Georgia. As she was completing her residency in the early years of the AIDS epidemic, Dr. Hicks treated a woman afflicted with an HIV complication. The patient was admitted to the hospital and died without ever returning home.

The episode made an indelible impression on this family practitioner. The patient had none of the identified risk factors, yet she quickly succumbed to the disease and left children behind. “I was a young mother myself,” Dr. Hicks explains, who was unsettled by the reality of a disease that could so swiftly sweep away a vital being. She was also concerned that this patient’s experience might not be an anomaly; it might be a bellwether. HIV had not yet had a significant impact on rural populations. That was about to change.

Nearly two decades have passed. Dr. Hicks now works as a public health physician in the Southeast Georgia District, serving a 16-county area the size of Massachusetts. She credits the aforementioned patient – as well as inspirational peers who were leaders in establishing systems of care and acquiring treatment funding -- for igniting her desire to treat HIV patients. Based at the Wayne Wellness

Center in Jesup, she supervises the medical treatment of nearly 600 patients. She was there when the program was first conceived.

Life in a town of about 10,000 people revolves around church and family. A drive-in theater is the source of much entertainment and a pulp mill employs a large percentage of the citizens. Living here presents “lots of wonderful things” – as well as many challenges for those diagnosed with HIV.

With Interstate 95 bisecting the district, drug trafficking is an enormous issue. In the late 80s, as the incidence of syphilis skyrocketed, District Health Director Dr. Ted Holloway saw what that would mean in terms of HIV and worked to secure early

*(Continued on page 2)*

*(Continued from page 1)*

federal funding for HIV care. He invited Dr. Hicks to oversee medical care and she was grateful for the opportunity.

One of the biggest barriers to care in a large rural territory is transportation. Many patients don't own vehicles and there are no public transportation systems. When determining the best way to deliver services to the community, public health organizers decided closer is better thus establishing five smaller clinics, rather than one large center.

*"...rural programs excel in one significant area. Staff members can develop close, one-to-one relationships with patients."*

As with most facilities providing HIV services, the patient population encompasses a mélange of demographics. The youngest patient is 10. The oldest is nearly 80. Some 80 percent are African-American and 50 percent are women. Half have substance abuse problems and a quarter of those also suffer from mental illness. There is also a contingent of homosexual males as well as a small, but growing, Hispanic population.

Even more than their big city compatriots, Dr. Hicks feels her patients are affected by the lingering stigma associated with the disease. People living in urban settings have access to more support resources and a greater network of HIV-positive people. In a small town, "people feel they have to keep their diagnosis a secret," she explains.

Maintaining confidentiality used to be more difficult. Services were once provided at the county health department, where staff members were often acquainted with or related to patients. Simply having to walk into the HIV portion of the building stopped some from seeking testing or treatment, and the building was not designed to protect privacy. Dr. Hicks recalls one encounter in her first year of seeing patients—with a gay man who

was explaining about his extensive sexual practices. When she exited the room, she found eight obstetrical patients parked outside the door. From the looks on their faces, she knew they had overheard the entire conversation. She began seeing the HIV patients at her private practice, and when she later became a fulltime public health physician, treatment moved into a separate building.

Her biggest frustration today is the number of patients with late diagnoses accompanied by high viral loads and low CD4 counts. The reason? Reduced funding for prevention and early diagnosis. "There is not money for rural areas to implement the CDC's recommended plan," she says. Educating professionals and financing universal testing is impossible. At one Wellness Center, 50% of newly diagnosed patients had spent some time in jail, but the staff and resources do not exist to test jail inmates on a consistent basis.

In addition, budget cuts will force her department to consolidate care and institute hiring freezes. She predicts a decline in the level of service because there will be fewer personnel to provide case management and to support medication compliance. Another challenge facing rural areas: a paucity of medical specialists to treat opportunistic infections. In addition, she worries about continuity of care when she is out of town.

Despite the challenges, Dr. Hicks feels rural programs excel -- at least for now -- in one significant area. Staff members can develop close, one-to-one relationships with patients. "Studies have shown that a strong relationship to a healthcare provider influences people's adherence to a treatment regimen," she says. This extends to continual reinforcement of safer sex messages -- which are discussed at every visit. "We are able to offer something that is incredibly important to individual patients, to their families, and to the broader community in terms of prevention," she says. "We can't lose sight of that."

## Rural Meth Use and HIV

During the early 1990s, methamphetamine use intensified in the rural West and Midwest, gradually moving eastward and into the rural South. Nationwide, meth use continues highest in sparsely populated areas. Lab seizures are one indicator of increasing rural methamphetamine use. Another is the rate of treatment for meth addiction. Between 1993 and 2003, national rates of admission for treatment of meth abuse increased more than 300%. In 2005, meth was considered the leading drug problem for rural counties in the Southeast.

In general, rural meth users are white, working class young adults. Nearly even numbers of males and females are in treatment for primary meth abuse, and in contrast to urban areas, rural users are more likely to be heterosexual. Rural males are more likely than females to report enhanced sexual libido and endurance as a reason for meth use. Rural females, on the other hand, are more likely to report using meth for weight control and to combat fatigue. Meth also provides a social network for those who feel like “outsiders” in a closed, stratified rural social system with limited social outlets. As one rural user explained, meth is “something we see as ours – like country music.”

While rural communities are keenly aware of many of the problems associated with meth production and use, the potential risk for HIV and other STDs is less obvious. A sample of rural meth users pinpointed factors that increase the risk of HIV/STD, including a belief that HIV is not present in rural areas, prolonged unprotected sex while high, deciding to inject meth, mental confusion resulting from chronic use or bingeing, and HIV stigma.

Geographic isolation, poverty, closed social net-

*(Continued on page 4)*

## AIDS Rises Sharply in Rural South

People living in rural areas of the United States are at growing risk for HIV, particularly in the southeast. Georgia, along with Florida, Louisiana, Mississippi, and South Carolina have some of the highest rates of HIV infection and AIDS in the nation.

In a study published in the *Journal of HIV/AIDS & Social Services*, HIV workers from over 500 Southern AIDS service organizations were surveyed. Participants reported that health education and risk re-

*“Rural HIV workers may do the most to break down stigma around HIV by actively participating in the community...”*

duction, condom distribution, and one-to-one client education or outreach were their most successful programs. Listing the elements of a successful program, respondents

most often cited free services, non-judgmental delivery of services, confidentiality, and trust. The number one lesson learned in providing successful programs was to take a non-threatening approach.

Study authors noted that as members of the community, HIV workers in rural areas may do the most to break down social barriers and stigma around HIV by actively participating in community groups like parent-teacher associations and faith organizations.

They have an opportunity to keep HIV prevention education on local “radar screen” and to serve as resource persons. In the role of resource person, an HIV worker may be able to connect with hard to reach populations. For example, an HIV prevention education program for rural non-gay identified men who have sex with men, that reaches out to men in parks or parking lots where sexual activities are known to take place. The authors concluded that although the work is challenging, it is possible for rural HIV workers to “adapt, advocate for, and advance HIV prevention in their communities.”

*Source: HIV Education, Prevention, and Outreach Programs in Rural Areas of the Southeastern US*

## Stigma & HIV/STDs in Rural South

In the South, stigma related to sexually transmitted disease (STD) affects people's willingness to be treated for STDs, including HIV. In a recent survey in Alabama, over 50 percent of respondents said they would delay seeking medical care for STDs because of stigma, and one third would not seek treatment at all. Rural residents, especially if they were African-American and church-going, were even more likely than others to say that they would avoid screening or treatment for STDs because of stigma. Regarding disclosing the names of sexual partners, nearly half feared what disclosure would do to the relationship and almost all said they would feel angry and betrayed if they were infected. Some would seek revenge by outing the infecting partner to family and friends, which can be particularly damaging in rural communities where people know one another and where stigma can be long-lasting. HIV positive men in the rural South fear being labeled homosexual; this fear is more pronounced for African-Americans.

STD clinics are often avoided because of stigma. A qualitative study found that residents living adjacent to a county STD clinic engaged in "patient spotting" and gossiped about their sightings to neighbors. Non-clients have been reported to take snapshots of clients at rural STD clinics with their camera phones. Free public health care can also carry stigma for some. Further, clinic employees can mirror the moral attitudes of the community and have been known to discriminate against clients deemed promiscuous or immoral.

The topic of HIV prevention in the rural South is so stigmatized that according to *The Tuscaloosa News*, several church leaders have stated publicly that HIV-positive persons deserve their fate and state and local politicians have refused to fund HIV prevention and life-saving medications for infected persons on the basis of their "ungodly lifestyle."

*Source: Rural Center for AIDS/STD Prevention*

## Resource for Rural HIV Workers

The Rural Center for AIDS/STD Prevention offers free membership and free fact sheets on HIV/STD prevention in rural areas. Topics include HIV and stigma, methamphetamine and HIV, and older adults and HIV/AIDS. For more information, visit [www.indiana.edu/~aids](http://www.indiana.edu/~aids) or call 800.566.8644.

*(Continued from page 3)*

works, social stratification, stigma, and a lack of anonymity in small rural communities may unwittingly contribute both to the appeal of meth and the challenges of eradicating it. Remote settings and limited law enforcement resources decrease the risk of arrest while inadequate mental health services and the distances required to access them can be barriers to treatment, especially for those without transportation. Social outlets are often limited to church-sponsored functions or mainstream bars, making the meth scene attractive to those who feel like outsiders.

Promising approaches to the challenge of curbing HIV and other STDs among meth users include traveling health educators or nurses who offer free testing, HIV and hepatitis prevention, and counseling services to high risk individuals like people in court-ordered diversion programs, those charged with driving while under the influence, and those arrested for domestic violence.

*Source: Rural Center for AIDS/STD Prevention*

## *HIV Risk Reduction*

is a newsletter of  
HIV Early Intervention Services (EIS)  
Georgia Department of Human Resources  
Office of Addictive Disease

For more information, visit our website at  
[www.hiveis.com](http://www.hiveis.com)

Manager, Marie Sutton at 404.874.4040  
Editor, Winona Holloway at 678.752.9571