water project, which was promised to the Native Americans 30 or 40 years ago. There is one critical fact out there: This is a Nation where the Eastern United States should understand the problems of the West and understand that the water situation here is different than our water situation back there in the West.

My whole point here tonight is to tell my colleagues that in the West, as they say, our life is written in water and water is so, so critical. It has all come together. It all comes together when we begin to understand the geographical conditions, the historical conditions, the political conditions. Then we begin to say, you know, there is another side to this story that is important for all of us to understand.

Mr. Speaker, let me wrap up this portion. The quickest way to drive people just simply reiterating one point, and that is that there is a difference between the Eastern United States and the Western United States when it comes to natural resources. There is a difference between the Eastern United States and the Western United States when it comes to public lands. There are very few public lands in the Eastern United States. There are vast quantities of public lands in the West.

The concept of multiple use, a land of many uses, is how I grew up. When you would enter the government lands, which we are completely surrounded in my district, I have over 100 communities, I have a district larger than the State of Florida, and every community except one is completely surrounded by public lands, and when we enter the national forest and so on, if any of my colleagues have ever been out to the national parks or public lands, it says something like, “you are now entering the White River National Forest” and there used to be a sign under that that said, “a land of many uses.” A land of many uses.

Now we are seeing groups like the national Sierra Club or Earth First or more radical environmental groups coming out and saying they want to take that sign, “the land of many uses,” they want to take it off and put on a sign that says “no trespassing.” And it is the same thing with our water. The quickest way to drive people out of the West is to cut off their water. And it is not complicated. In the Eastern United States it would be very complicated to shut off the water. You have a lot of it. It rains all the time. In the West, all we have to do is take down a couple of dams.

Go ahead, let the national Sierra Club take down Lake Powell. You take down Lake Powell, and you will shut off a large portion of the west. You would take down the human population, and, by the way, a great deal of vegetation and animal population out there because we have been able to utilize that water and store that water so we can use it beyond the spring runoff. So keep in mind in the west life is written in water.

Let me use my final concluding remarks on a topic that is obviously totally unrelated, but I want to go back to my remarks at the beginning of this and that is on this energy thing. By the way, I heard some comments earlier today that we have no free market in the energy, that we need to have the government run the energy business in this country. Nothing would be worse than inviting the government into our front doors to begin running our energy companies for us. Nothing would be worse than allowing the government to intercede in the private marketplace.

Now, I am not speaking about stopping antitrust, where intercession is necessary. What I am saying, Mr. Smith, and he is right, a monopoly is a dangerous tool to management. But to intercede and to actually become almost socialistic like, where we would have the government supply the power and the transmission, and we would have the government guarantee it will all come at a reasonable price, we should not buy into this concept that the government is going to be able to give us something for nothing.

Take a look, for example, at the government’s intercession in lots of other different programs. In almost every case, when the government takes over or begins to think that it can do better than the private marketplace, we end up with lots of regulation, we end up with subsidies, and we never get something for nothing. This energy is a problem that we all have to work through.

The way we work through it is we put several components together. One of those critical components is conservation. Now, not every citizen can go out and find natural gas, not every citizen is going to be able to build a transmission line out there, and not every citizen can build a generation plant, but one thing that every citizen in our Nation can do is to help conserve. And if we want to keep the government out of our lives, we only need to help conserve energy. Because the more energy that we waste, the more temptation there is to have the government come in as a quick fix, as some kind of waving of the magic wand that the government is going to be able to deliver to us any kind of product at a cheaper price. The private marketplace does pretty good if we can all help.

So to conclude this portion of my remarks, let me say that I think it is incumbent upon every citizen in this country, and I say to many colleagues, that we have to go out into our districts and encourage our constituents. Because if there is one thing that every citizen in this country can do to help alleviate the energy crisis, that exists primarily in California but is a warning shot to the rest of the Nation, it is to conserve.

And we can all do it by simply shutting off our lights, changing our car oil when the owner’s manual says it instead of when the lube market tells you to do it. I am optimistic about future energy of this country. Slowly but surely we are building an energy policy, and conservation is going to be an important part of it. You cannot conserve your way out of the situation that we are in.

Alternative energy is an important part, but do not overplay it. As I said earlier, if you took all of the alternative energy in the world and delivered it all to the United States, it would only supply 3 percent. Certainly this young generation behind us, their bright minds will be able to make that much, much larger because they will find ways to take energy out of water.

The first and most immediate thing we can do is come up with an energy policy as a government. We can urge our constituents to conserve. But the worst thing we can do is propose that the government put on price controls, that they take over industries, that they seize power plants and the government becomes your local utility. It would be the most inefficient operation in the history of our government. Do not let them do it. You cannot get something for nothing out of this government. If it is the government running it, you usually pay a higher price than if you as a community can have the private sector with checks and balances. I have spoken primarily about energy, about water.

Mr. Speaker, cut off water and then I am done. That is keep in mind in the East and West of this Nation, there are differences in water and differences in public lands. I would urge all of my colleagues in the East and all of their constituents in the East to please take the time before signing on a petition to take on Lake Powell or kick people off public lands, take a look at both sides of the story. If you take a look historically, politically, environmentally at both sides of the story, I think you will find a better understanding of what I have said tonight and a much deeper appreciation for our message from the West.

HIV/AIDS

The SPEAKER pro tem (Mr. REHBERG). Under the Speaker’s announced policy of January 3, 2001, the gentlewoman from North Carolina (Mrs. CLAYTON) is recognized for 60 minutes as the designee of the minority leader.

Mrs. CLAYTON. Mr. Speaker, often times we act on perceptions rather
than reality, and when we discuss HIV and AIDS, indeed that has been one baseless perception. Often times, what we have felt, who live in the rural South, have felt that AIDS was an issue of the North. Those of us who lived in small towns felt it was an issue of the big cities. Heterosexual persons thought this was only an issue for gays or that it was indeed white male gays. What we are finding is that those perceptions were ill-founded, and that the disease has affected all phases of the United States, particularly the South.

HIV/AIDS is becoming more prevalent in rural areas and in the South. AIDS cases in rural areas represent only about 5 percent of all reported HIV cases in 1995. Only 5 percent. However, the pattern of HIV infection suggests that the epidemic is spreading in rural areas throughout the United States. HIV in the rural South is growing at one of the fastest rates in the nation. The Southeast as a whole has the highest number of those infected. The southern region of the United States accounts for the largest proportion: that is, 34 percent, 34 percent of 641,886 AIDS cases. The latest figures we have is for 1997, and 54 percent of the 56,689 cases are among persons residing in rural areas.

However, according to a Boston Globe article, which I include for the Record, according to this article it references that in six Southern States, including my State, North Carolina, and South Carolina, Georgia, Alabama, and Mississippi as well as Louisiana, 70 percent of those with HIV are African American, and 25 percent are women, according to a Duke University study.

But more importantly, here is what it says. Both of these figures are higher than the national average, but few are saying anything about it, keeping the disease nearly invisible as it spreads. It is this silence that worries many AIDS activists, who are fearful that as the US government grapples with the out-of-control pandemic in parts of sub-Saharan Africa, it will neglect the increasingly costly programs to treat infected citizens. In at least a dozen states, there are waiting lists of people infected with HIV who want to get the drugs. One group, when asked about the nation’s initial position has been to put a lid on treatment funds. It has proposed no increase next year for the $1.8 billion Ryan White Care Act, which pays for AIDS cocktails for Americans not covered by Medicaid or other insurance programs. Broad, the administration has put $200 million in additional HIV money into a newly created Global AIDS and Health Fund, a sum belittled by many advocates as a trivial response to a problem that Secretary of State Colin L. Powell calls a war without an army. It’s a blindness as a world leader to fight AIDS at home and around the world,” said Ernest C. Hopkins, director of federal affairs for the San Francisco AIDS Foundation. “Furthermore, the crime of someone in rural North Carolina not getting treatment is far more egregious than the reality of that happening in sub-Saharan Africa, where countries spend a few dollars per capita on health care. This is an incredibly resource nation, and yet there are people here who are basically being written off.”

In the past 20 years, AIDS has killed 438,795 people in America, 23 million worldwide. In the city of Roanoke Rapids, North Carolina, 100 men and women are diagnosed with HIV, while others fail to adhere to the daily regimen of pills for a variety of reasons, including painful side effects. “I have friends—” and I don’t agree with them—who are sleeping around with it,” a man who asked to be identified only as J-Ray, a now-collaborate drag queen who adheres to the strict drug regimen. “They’re just spreading it. That’s what’s going on here. You have people who are either too scared to get tested, or find they have it and basically don’t care at all. They’re just angry.”

In interviews with several dozen AIDS caseworkers and patients in rural areas of North Carolina, many said that potentially thousands of people refuse to get tested for HIV, while others fail to adhere to the daily regimen of pills for a variety of reasons, including painful side effects. “I have friends—” and I don’t agree with them—who are sleeping around with it,” a man who asked to be identified only as J-Ray, a now-collaborate drag queen who adheres to the strict drug regimen. “They’re just spreading it. That’s what’s going on here. You have people who are either too scared to get tested, or find they have it and basically don’t care at all. They’re just angry.”

In interviews with several dozen AIDS caseworkers and patients in rural areas of North Carolina, many said that potentially thousands of people refuse to get tested for HIV, while others fail to adhere to the daily regimen of pills for a variety of reasons, including painful side effects. “I have friends—” and I don’t agree with them—who are sleeping around with it,” a man who asked to be identified only as J-Ray, a now-collaborate drag queen who adheres to the strict drug regimen. “They’re just spreading it. That’s what’s going on here. You have people who are either too scared to get tested, or find they have it and basically don’t care at all. They’re just angry.”

CONGRESSIONAL RECORD—HOUSE
12743

July 10, 2001

SHAM AND FEAR CONTRIBUTE TO RAPID SPREAD OF HIV IN RURAL AREAS
(By John Donnelly)

SCOTLAND NECK, NC.—In the short, grim history of AIDS, this rural town surrounded by cotton and tobacco fields would probably go unnoticed. The virus hasn’t killed people here in great numbers, as it has in Africa, nor has it devastated a whole sector of the population, as it did in gay men in the cities of America in the 1980s.

But as observers reflect on the two decades since the first public mention of a disease that was named Immunodeficiency Syndrome, the overarching reality is that the virus has stealthily managed to infect roughly 60 million people all over the world. For instance, in Roanoke Rapids, inside the four-room house of the Davis family, in the person of one Jeff Davis.

And that remains, largely, a secret here.

Keep it local. Davis, 26, his skinny 6-foot-3 frame sprawled out over a worn-out sofa as his mother hovered nearby. “I’m not sure people would like being around me if I said I was HIV-positive and their reaction was bad, I don’t think I could take it.” HIV in the rural South is growing at one of the fastest rates in the nation. The Southeast has the highest numbers of those infected. In six Southern states—North Carolina, South Carolina, Georgia, Alabama, Mississippi, and Louisiana—25 percent of those with HIV are African-American and 25 percent are women, a Duke University study found. Both figures are higher than the national averages.

But few say anything, keeping the disease nearly invisible as it spreads. It is this silence that worries many AIDS activists, who are fearful as the US government grapples with the out-of-control pandemic in parts of sub-Saharan Africa, it will neglect the increasingly costly programs to treat infected citizens. In at least a dozen states, there are waiting lists of people infected with HIV who want to get the drugs. One group, when asked about the nation’s initial position has been to put a lid on treatment funds. It has proposed no increase next year for the $1.8 billion Ryan White Care Act, which pays for AIDS cocktails for Americans not covered by Medicaid or other insurance programs. Broad, the administration has put $200 million in additional HIV money into a newly created Global AIDS and Health Fund, a sum belittled by many advocates as a trivial response to a problem that Secretary of State Colin L. Powell calls a war without an army. It’s a blindness as a world leader to fight AIDS at home and around the world,” said Ernest C. Hopkins, director of federal affairs for the San Francisco AIDS Foundation. “Furthermore, the crime of someone in rural North Carolina not getting treatment is far more egregious than the reality of that happening in sub-Saharan Africa, where countries spend a few dollars per capita on health care. This is an incredibly resource nation, and yet there are people here who are basically being written off.”

In the past 20 years, AIDS has killed 438,795 people in America, 23 million worldwide. In North Carolina, 100 men and women are diagnosed with HIV, while others fail to adhere to the daily regimen. “They’re just spreading it. That’s what’s going on here. You have people who are either too scared to get tested, or find they have it and basically don’t care at all. They’re just angry.”

In interviews with several dozen AIDS caseworkers and patients in rural areas of North Carolina, many said that potentially thousands of people refuse to get tested for HIV, while others fail to adhere to the daily regimen of pills for a variety of reasons, including painful side effects. “I have friends—” and I don’t agree with them—who are sleeping around with it,” a man who asked to be identified only as J-Ray, a now-collaborate drag queen who adheres to the strict drug regimen. “They’re just spreading it. That’s what’s going on here. You have people who are either too scared to get tested, or find they have it and basically don’t care at all. They’re just angry.”
Mr. Speaker, tomorrow we will be of-
fering an amendment to make sure that
the United States will get additional
funds. In fact, when we look at the budget,
the Ryan White Care Act, which pays for
AIDS cocktails, is maintained
about where it was.
The Globe article further says that in
the rural South, about 45 percent
of women with HIV/AIDS are infected by
having sex with infected men, again
breaking one of the perceptions we
have that heterosexual persons will not
be subject to it. But, indeed, the infec-
tion rate is 15 percent above what it is
nationally. The spread of AIDS in Afri-
can is being spread through heterosexual
transmission of the disease rather than
homosexual. In fact, women and chil-
dren are the ones who are most in-
ected.
Again, one doctor in this area, and
they are referencing North Carolina
and referencing Halifax County, which
is in my district, this doctor says, Dr.
Fiorilli, the only AIDS doctor in Halif-
ax County. "This is like a modern day
leprosy, no one wants to claim or talk
about it."
Mr. Speaker, the big difference be-
tween the United States and Africa are
that the medications we have are more
available here, but availability of
drugs does not guarantee access be-
cause there are people failing to take
the test to find out whether they are
eligible, and then there are people who
are failing to follow their prescription.
In interviews many said that poten-
tially thousands of people refuse to get
tested for HIV, and one person states
she travels 180 miles to get treated
twice a month when she could travel 40
miles and be treated, but everyone
knows her in her area. This person is
president of every active as
a leader, and so the culture of the area
does not allow her to seek out medical
care, and in some instances not even to
tell her own family members. We
have a problem in the Southeast and in
those six states.
The number of new AIDS cases in the
United States began to decline in the
mid-1990s, but actually the rate went
up in the South. While everybody else
was kind of dealing with the problem
and acknowledging that we had a prob-
lem, actually it went up. Particularly
we find this happening in the South
among black women as well as with
children. It is true there are still more
males than females, but the growth
rate for women is extremely high in
that area.
Mr. Speaker, from 1981 to 1999, 26,522
AIDS cases were reported--

In the First Congressional District as
well as in eastern North Carolina, in-
cluding the third district, African
Americans accounted for as much as 87
percent of HIV/AIDS cases that were
reported in this year alone, the new
cases that were reported.
The House of Representatives and the
General Assembly of North Carolina re-
cently passed under the leadership of
Representative Wright a resolution de-
claring HIV/AIDS as a public health
issue, that we need to acknowledge
and get our community involved,
good our faith-based community
and our education system in-
olved, because without the public rec-
ognition, we are not going to deal with
that.
While only 1 percent of AIDS cases are found among teenagers aged 13 through 19, an additional 18 percent are found among those who are in their early 20s, who may have acquired the infection while they were teens because many of them had the infection, but we are now just discovering it while they are in their early 20s. Likewise, we are finding infection of teenagers is increasing. Additionally, some 26 percent are found among those who are now in their 20s, assuming they might have been infected some years earlier.

As of December 31, 98 percent or 13,943 of all HIV disease reports in North Carolina were among those who were from 20 to 39, regardless of race. From 20 to 39. That is an astounding, large number of people. Let me repeat that: 13,943 were reported last year. Of those reported, 68 percent of those reported were between the ages of 20 and 39.

Now, earlier I had said that there was a correlation between STD, sexually transmitted disease, as a predictor of HIV.

I want to show you another chart as well. This is alarming because syphilis and gonorrhoea and other transmitted disease, we thought those had been eliminated. In fact, I have a map that I do not have with me; but if you look at this map, it is almost completely eliminated, other than in the South and in one or two places in the Midwest. Completely eliminated. In fact, there is no reason why sexually transmitted disease should be growing. There indeed is a bacterium treatment for it, but it is growing in the South; and it is growing in my State in alarming numbers.

Although it cannot be said that the STDs cause the AIDS, it can be said there is a correlation between them. Indeed, you can begin to see the large number of them growing in North Carolina. But also you see a high percentage of them being related to African Americans. Gonorrhoea percentage, almost a relationship between what you see in gonorrhoea and syphilis as the HIV chart. There is no reason for this. This is unexplainable why this is happening. One is a disease by a behavior pattern that we can correct, but also there is no public outcry in understanding this. One, we assign to the fact, well, this is their own doing and, therefore, we shouldn't be concerned.

There is a glaring racial disparity in North Carolina cases. Seventy-one percent of them are among African Americans. The infectious syphilis rate is almost 12 times greater for African Americans, 11 times greater for Native Americans, and eight times greater for Hispanics than the rate for non-Hispanic Whites.

In 1996, half of all syphilis cases were confined to 1 percent, 1 percent now, of all the counties in the United States. These cases of syphilis were found in 28 counties, primarily located in the South, and three independent cities: Washington, D.C.; Baltimore, the District of Columbia; North Carolina had five nationally significant high syphilis morbidity counties: Guilford, not in my district, but certainly a large county in my State; Forsyth, again not in my district, but a large county in my State; Mecklenburg, which is our largest city; Wake County, which is our capital; and Robeson County, growing at significant rates higher than all of the other southern states.

The National Alliance of State and Territorial AIDS Directors, something called NASTAD, did a report. I have that report. This report is entitled "HIV Services in Rural Areas." They studied New Mexico and South Carolina experienced.

Mr. Speaker, I include this study for the record.

NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS, NASTAD MONOGRAPH: EXPLORING HIV SERVICES IN RURAL AREAS

Introduction

AIDS cases in rural areas (less than 50,000 persons) represented approximately five percent of all reported AIDS cases in 1996. Patterns of HIV infection suggest that the epidemic is spreading in rural regions of the United States. Estimating the prevalence of HIV infection in AIDS cases is complicated by the tendency of rural residents to go to urban areas for diagnosis and treatment, if possible. Research findings indicated that the majority of HIV infections in rural areas tend to occur in young adults (15–29 years), primarily females. Rates of heterosexual transmission are more prevalent than homosexual transmission and appear to be compounded by the presence of other sexually transmitted diseases and the use of crack/cocaine. Areas with populations of 50,000 or fewer residents are considered rural. In 1997, over 54 million Americans lived in rural areas, composing 20 percent of the U.S. population (see Appendix A).

The HIV/AIDS Bureau (HAB) has set, as part of its policy agenda, an objective to document the experience of vulnerable populations that reflect the nature of the epidemic. One population that has been historically underserved is rural residents. In response, the National Alliance of State and Territorial AIDS Directors (NASTAD) developed this monograph on HIV Services in Rural Areas, as part of a cooperative agreement with the HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

HIV Services in Rural Areas describes approaches that states are using to address the health care and social service needs of rural residents living with HIV/AIDS. NASTAD identified two states, New Mexico and South Carolina, to highlight in this monograph because they are located in regions of the United States with reported rural AIDS. Additionally, these two states were selected because their populations include a disproportionately high number of rural communities. Native Americans—those from Native American—those very high risk populations for new HIV infections living in areas with limited resources to address their health care needs. NASTAD conducted interviews with the state AIDS directors and program staff and local providers in both New Mexico and South Carolina in fall 1999. These interviews, NASTAD identified barriers to access to HIV health care and key program components that support and link HIV health services in rural areas.

Barriers to Providing HIV Services in Rural Areas

Long Distance Travel—Almost every service provider interviewed for this monograph found the distance to travel to overcome in the provision of services for persons living with HIV/AIDS in rural areas. Providers acknowledged that travel options are: (1) commercial transportation services; (2) volunteer drivers; (3) staff home visits, or (4) mileage reimbursement for the use of a personal vehicle. However, in cases of acute illness, the lack of an adequate transportation plan may make a critical difference.

Inadequate Supply of Health Care Providers with HIV/AIDS Expertise—Providers express frustration about the lack of physicians with expertise in HIV treatment, despite the wide availability of training and consultation opportunities. Providers also reported that it is difficult to monitor the quality of care that persons living with HIV/AIDS receive from local health care providers and that these providers, in many cases, may not be highly motivated to monitor care due to small client caseloads. In the absence of local medical expertise, a social service provider, such as a case manager, may become the local "HIV expert." In cases in which the provider has little or no medical training, serving as the local expert is a difficult and isolated job because clients living with HIV/AIDS and their families rely on this individual for a breadth of information that she or he may or may not be able to provide.

Linking HIV Counseling and Testing with Care—Many of the providers reported having either formal or informal relationships with local counseling and testing sites. Despite these linkages, providers also reported that a large number of persons living with HIV/AIDS, as high as 50% for some, are referred to sites either either formal or informal relationships with local medical expertise, a social service provider, such as a case manager, may become the local "HIV expert." In cases in which the provider has little or no medical training, serving as the local expert is a difficult and isolated job because clients living with HIV/AIDS and their families rely on this individual for a breadth of information that she or he may or may not be able to provide.

The Lack of Available Medical Facilities—Since the early 1980s, the number of rural hospitals and medical facilities has dwindled primarily due to financial cutbacks. Many facilities have closed or have been consolidated with other organizations or agencies, or the number of services has been drastically reduced due to managed care penetration, or the disappearance of an adequate supply of specialist, or the need to acquire new expensive equipment. Rural trends have exacerbated the limited supply of comprehensive health care services needed by rural residents living with HIV/AIDS.

Scattered HIV/AIDS Services—Rural areas, especially poor ones, may have few agencies to provide social or support services. The lack of available services reduces opportunities for community organization collaboration and prevents the formulation of service networks. Linkages to community-based social service agencies have become more critical now that an HIV/AIDS has become a chronic condition and clients’ needs have become more diverse.
The Stigma Attached to HIV/AIDS—The stigma attached to HIV/AIDS may be one of the community-wide denial that HIV is a problem that needs to be addressed. Medical providers may resist treating persons living with HIV/AIDS. In contrast, clients may be reluctant to seek services in rural areas because of the fear of being socially stigmatized.

In addition, there may be a sense of mistrust of health and related health care providers by individual clients and/or the community at large, especially if such services were unknown to the client or from outside their community.

Client Adherence to Treatment—With improved HIV/AIDS care and treatment, treatment adherence may become a more important concern. Promoting adherence to antiretroviral treatment regimens can be difficult when clients are isolated and face-to-face contact between case managers, physicians, treatment educators and persons living with HIV/AIDS is limited. It also is difficult to assure client adherence to treatment on a regular schedule if the ability to refill prescriptions is problematic, or if the client has issues of stigma to overcome.

Substance Abuse—Several providers noted that the provision of long-term substance abuse treatment remains a significant barrier in rural areas. Distance and limited client contact compound the challenge. Substance abuse treatment services may not be readily available outside of urban areas. There may be a sense of denial, both in the community and on the part of the clients who are using drugs and alcohol, because substance abuse treatment is not identified openly as a problem in rural areas, resulting in little effort to secure treatment services.

Additional Needs of Communities of Color in Rural Areas—Communities of color, including Africans, Hispanic, Native, and Asian Americans, are at high risk for HIV infection. Rural communities of color, like other rural residents, experience the same barriers—stigma, poverty, and the absence of accessible care, as well as cultural, social isolation and unemployment, and social-cultural differences and isolation.

State Components that Link HIV Services in Rural Areas

The providers interviewed for this monograph have developed and described various strategies for providing HIV services to clients living in rural areas based on client needs and available resources. State strategies include:

Addressing Clients’ Needs Beyond HIV—Service providers who address the entire range of client needs are more likely to maintain clients in care. Poverty, substance abuse, mental illness and other problems that are often associated with urban life also affect persons living in rural areas. For example, the Palmetto AIDS Life Support Services (PALS), in Columbia, SC, operates the Women’s Resource Center. Approximately 25 percent of the clients live in rural areas. The center provides a range of services that address the needs, both HIV-related and those not related to HIV, of their female clients. PALS also provides counseling and crisis intervention services specific to women and HIV, creating a link between service provider and client.

Client-Centered Approach—It is not always practical to design strategies for a specific population in a rural area. The caseload is often small and resources are extremely limited. These circumstances necessitate that staff be culturally sensitive and focus on the individual cases in the client population, though small, may be very diverse. For example, one of New Mexico AIDS Resource and Information Services (NMARS) of Native American and works with the organization’s Native American clients in Albuquerque. The case manager also understands the cultural importance of using Native American healing methods and administers NMARS’s complementary medicine program.

Flexibility—Service providers stressed the importance of designing and administering programs that are flexible enough to accommodate the unique needs of individuals living with HIV/AIDS. Many agencies allow clients to designate where they will meet with their case managers, whether at their home, a local health department or library, or even for lunch at a local restaurant. Such arrangements represent another challenge for providers. If a person living with HIV/AIDS cannot schedule an appointment during regular clinic hours and needs to see a physician in between weekly clinic visits, several service providers reported that the physicians will frequently allow office visits, even though they are contracted to do so.

Working with Available Resources—It is important to identify and to link collaborative partners in rural areas, even with limited resources. For example, the Edisto Health Department in central South Carolina works with the Cooperative Church Ministries of Orangeburg (CCMO), a coalition of churches in the area that has combined their resources to offer some services such as a small food and clothing bank to persons living with HIV/AIDS. CCMO also administers the Services for People With AIDS (SOPWA) fund for the health department.

Promoting Informal Relationships—Service providers in rural areas stressed the importance of informal relationships that repeatedly prove to be invaluable in identifying resources and service networks. These relationships may develop unexpectedly. The ACCESS Network in Hilton Head, SC, works closely with “Volunteers in Medicine,” a medical staffed clinic serving HIV/AIDS health care professionals, who moved next door to ACCESS several years ago. Some ACCESS clients now receive services at the clinic because they are assigned to the clinic’s staff to coordinate clients’ care. They also provide clinic staff with information on HIV/AIDS treatment developments.

Providers recognize informal relationships between their own physicians and infectious disease (ID) specialists outside their service area who are available for consultation. Clinicians also cited the importance of working with local media to raise awareness about HIV/AIDS and the agency’s services by running public service announcements (PSAs) or providing coverage of agency activities and events.

Conclusion

Both New Mexico and South Carolina have implemented strategies that seem to be working well for their specific residents who are living with HIV/AIDS. Both states also have found it necessary to remain flexible in implementing these strategies to meet the needs of specific groups of residents who have unique challenges from one geographic area to another within each state. The selection of these two states in no way suggests that other states are not exemplary in their efforts to assure positive outcomes for their respective residents. The inclusion of these states simply presents an opportunity to learn from new HIV/AIDS health services in rural areas with other jurisdictions and stimulate national discussion among states on how best to meet the needs of persons living with HIV/AIDS.

HIV Services in Rural Areas: The New Mexico and South Carolina Experiences

Introduction

AIDS cases in rural areas represent approximately five percent of the all AIDS cases in the United States. Long distances between residents and accessible health care services, social isolation as a result of social stigma related to HIV/AIDS, lack of adequate, if any, health insurance coverage, insufficient medical facilities, few medical specialists, and limited support services like transportation and child care are among the efforts of rural communities (see Appendix A) to serve residents living with HIV/AIDS.

State health departments, in collaboration with state AIDS directors and local health agencies and organizations, are focusing on preventing new infections in rural areas, getting persons living with HIV into care (see Appendix B), and improving access to HIV health care services in rural areas. State health departments offer experienced insight, methodological research and analysis, and documented evidence of the successes and failures of the various strategies that collectively are designed to improve the quality of life for persons living with HIV/AIDS. State health departments also have the expertise to provide technical assistance and support for capacity building to local health care agencies and organizations that serve persons living with HIV/AIDS and to develop linkages between HIV/AIDS health care and related services in urban as well as rural areas.

Rural Areas is a monograph developed by the National Alliance of State and Territorial AIDS Directors (NASTAD), under a cooperative agreement with the HIV/AIDS Bureau, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. NASTAD conducted interviews with state AIDS directors and local service providers receiving Ryan White CARE Act funds in fall 1999. This monograph highlights activities in New Mexico and South Carolina, two states that have developed strategies to address the primary care and support service needs of people living with HIV/AIDS in rural areas. These two states were selected because they are located in regions of the United States that are sparsely populated and are characterized as rural with remote populations. Additionally, these two states exhibit significant differences in their populations include a disproportionately high number of rural communities of color—African, Hispanic, and Native Americans—who are at high risk for new HIV infections.

New Mexico

Total Population: 1,737,000.

Area: 121,595 sq. miles.

Population Density: 14 persons per sq. mile.

HIV/AIDS Cases (cumulative reported through June 1999) (HIV reporting was initiated January 1986). People living with HIV/AIDS (reported): 1,334.

CONGRESSIONAL RECORD—HOUSE

July 10, 2001
HIV cases reported in New Mexico are attributed to male to male sexual contact (MSM). Women reported that while there were physicians adequate services. Many in the task forces were concerned that people available to see persons living with HIV/AIDS, their knowledge about the disease was insufficient and resulted in misdiagnoses of other serious conditions. Physicians HIV/AIDS compet-ency is a serious area in rural areas (Finney, 1999).

HMAs Respond to Local Needs

The findings of the review process identified needs in rural areas of the state. The final report states:

Access to adequate services diminishes the further away from Santa Fe or Albuquerque

The University of New Mexico’s Health Science Center (University Hospital), a Ryan White CARE Act (RWCA) Title III grantee, administers the “Partners in Care Program.” Medical services are provided at the hospital in Albuquerque and the grantee also recruits physicians across the state to provide services to persons living with HIV/AIDS. To be eligible for the program, physici-

Successful Cost Containment

The New Mexico DOH reports significant cost savings as a result of implementing the HMA model. The cost of providing HIV-related care and support services, including medications, to New Mexico’s caseload of persons living with HIV/AIDS, decreased from $5.2 million in 1995 to $3.2 million in 1996, a 37 percent increase. The increase was primarily due to the expense of antiretroviral medications. The cost of HIV care jumped significantly between 1995 and 1996, rose slightly in 1997, then in 1998 fell to the

CONGRESSIONAL RECORD—HOUSE

FUNDING FISCAL YEAR 1999

<table>
<thead>
<tr>
<th>District</th>
<th>State funds</th>
<th>CARE funds</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1</td>
<td>$730,000</td>
<td>$115,000</td>
<td>$845,000</td>
</tr>
<tr>
<td>University Hosp.*</td>
<td>$730,000</td>
<td>$115,000</td>
<td>$845,000</td>
</tr>
<tr>
<td>District 2</td>
<td>$509,000</td>
<td>$115,000</td>
<td>$624,000</td>
</tr>
<tr>
<td>District 3</td>
<td>$170,000</td>
<td>$115,000</td>
<td>$285,000</td>
</tr>
<tr>
<td>District 4</td>
<td>$70,000</td>
<td>$115,000</td>
<td>$185,000</td>
</tr>
</tbody>
</table>

*University Hospital has separate contract to provide primary care in District 1

The HMA system allows HIV case management to be specialized within an agency and specific to the needs of persons living with HIV/AIDS. Before the HMAs, the state sub-contracted with approximately 100 providers. Most of the providers did not specialize in HIV services and there was great variation in the case management services provided. The formation of the HMAs resulted in state-wide availability of comprehensive case management and support services for persons living with HIV/AIDS. Consolidation has been an important part of the HMAs. With the establishment of the HMAs, person living with HIV/AIDS enroll in and receive services from only one organization. Referral to services is facilitated because there is only one access point in each district and HMAs have publicized their services throughout their service area. Clients receive all necessary services from one provider, not various providers scattered through the case management services. The program also reimburses the patient’s premiums for the continuation program. The program pays up to $100 per month for the premiums of a participating client’s existing health insurance. The program reimburses the patient’s share (co-pays) for HIV medications under the New Mexico Medication Assistance Pro-

Two Years Later * * *

Since their establishment, HMAs have become identified as the source of HIV care in New Mexico. Of the approximately 1,300 persons living with HIV/AIDS, 1,100 persons liv-

Two Years Later * * *

Since their establishment, HMAs have become identified as the source of HIV care in New Mexico. Of the approximately 1,300 persons living with HIV/AIDS, 1,100 persons living with HIV/AIDS access case management services throughout the HMAs. In New Mexico, anyone who tests positive for HIV is eligible for care through the HMAs. To be eligible for services through the HMA a person must: 1) have a documented diagnosis of HIV disease from a qualified licensed medical provider; 2) be a resident of the service area (district); and 3) have a documented income at or below 300% of the federal poverty level (FPL). Members may elect to enroll in a HMA other than the one they reside in the service area. People living with HIV/AIDS must be members of the HMA at the same time. Clients also were generally in favor of the HMA system. As with any major change, the move toward Medicaid managed care in the state created an environment where people expected change in the health care delivery system. As with any major change, the move toward HMAs created some concerns. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies necessitated an examination of the case and treatment shifts. The introduction of antiretroviral combination therapies neces-
assure the quality of services delivered by HMAs have toll-free telephone numbers. In rural areas, all the HMAs reimburse clients residing, surrounded by rural areas. The larger HMAs, Al- districts 2) contain urban areas, where most clients are provided. Twice a year, the HMA surveys services available at the main office and in the field office in Farmington. For example, clients in rural areas requested that the food bank services be made more accessible to them with distances (and getting reimbursed for the mileage) for a relatively small amount of food. Now, the HMA purchases gift certificates from the major supermarkets in the rural areas of the district and sends them to clients twice a month. Any client living more than 50 miles from the main office is eligible for the food voucher program.

Obtaining Client Feedback—Providing opportunities for clients to give feedback on their needs and the services they receive can be done through Focus Group discussions. In the process, the District 4 HMA holds their Community Advisory Committee meetings at six different sites throughout the service area. The meetings are open to all clients. Local physicians who treat clients also are invited. At the meetings, clients can raise concerns about specific issues. To encourage attendance, dinner is served and incentives, such as grocery store vouchers, are provided. Twice a year, the HMA surveys clients and non-clients of the program. The findings of the survey, the HMA will tailor information provided at the meetings to client needs and depending on the topics, the agency will invite appropriate staff to attend. Treatment issues are always a popular topic at the meetings.

Addressing Needs in Rural Areas

Each of the HMAs has developed a unique service delivery system based on available resources, the number of clients living in rural areas. All four districts serve clients who reside in rural areas. Albuquerque (District 1), Las Cruces (District 3) and Santa Fe (District 2) contain urban areas, where most clients reside, surrounded by rural areas. Roswell (District 4) is predominantly rural.

The New Mexico DOH has established different capitation rates for the HMAs based on the greater per client expense of serving clients in rural areas. The larger HMAs, Albuquerque and Santa Fe, are able to achieve some economies of scale because they serve a larger number of clients. Additionally, they have access to more resources, including more fundraising opportunities. In rural areas, it is more difficult to facilitate the process that clients and staff are required to travel also can escalate costs for mileage reimbursement and staff driving time. To facilitate access for clients in rural areas, HMAs reimburse clients for travel expenses (mileage) and all the HMAs have toll-free telephone numbers.

Quality Assurance Activities

DOH has adopted a variety of measures to assure the quality of services delivered by the HMAs with the HMA system had not been implemented, the cost of HIV care in New Mexico would have increased between five percent and 20 percent in 1996. HMA implementation saved the state between $400,000 and $3.7 million. These savings are a result of the treatment of people being served increased. The net number of clients served increased by an average of six percent each year.

In the coming year, DOH plans to more thoroughly integrate the Title III grant with the HMA program. Even though training is available for physicians in outlying areas, the HMAs report that care is still problematic and that some physicians lack the required expertise to provide quality HIV care. By integrating the Title III funds into the HMA system, HMAs will be able to select physicians in their districts who are motivated to treat persons living with HIV/AIDS and to develop their HIV-related expertise.

Additionally, these physicians are more likely to work with case managers and persons living with HIV/AIDS in the development of care plans. The state's early intervention nurses also play a key role in linking persons living with HIV/AIDS with services. Five nurses are employed by the state. The post-test counselor, persons living with HIV/AIDS are linked with early intervention nurses who conduct an initial assessment, refer clients to the appropriate agencies, and provide services to clients who do not access care. The nurses also conduct partner notification services.

As of the end of 1999, DOH plans to expand the Rio Grande Valley, state guidelines will be added that will serve Native American persons living with HIV/AIDS. It will be based in Albuquerque. The state also plans to contract with an agency to provide benefits advocacy services. The new contractor will help persons living with HIV/AIDS obtain benefits and also address emerging needs such as education and re-employment. Additionally, the contractor will provide advocacy services, including mediating grievances with HMAs. The contract will be awarded through a Request for Proposal (RFP) process.

Lack of Medical Providers with HIV Experi- ence—Addressing the need for HIV service providers interviewed, local doctors do not take advantage of the availability of training opportunities to increase their knowledge of HIV treatment. In District 4, two physicians receive direct training. Approximately 12 other physicians see one or two clients. With a large number of physicians working together, the informal nature of the relationship between the HMA and these physicians, it is difficult to monitor the quality of care clients receive.

Challenges

Accessing Services Based at the Main Office—The HMA has developed alternative approaches for clients living in rural areas because it is not possible to provide all the services that are available in Albuquerque or Santa Fe. The smaller HMAs in rural areas have developed services to meet the needs of the clients. The DOH, Guidelines also have been developed to address case management in rural areas.

HIV/AIDS Cases: (cumulative reported through June 1999) (HIV reporting was initiated in February 1984)

People living with HIV/AIDS (reported): 10,108.

AIDS cases reported in 1999: 984 (annual rate per 100,000 population: 25.7).

HIV cases reported in 1999: 877.

Cases of AIDS reported (Cumulative): 8,332.

FY 1999: $4,968,208.


Total Title II Funds, FY 1999: $10,934,388.

The HIV Epidemic in South Carolina—In rural areas of the southeastern United States, the HIV epidemic is increasingly concentrated in the heterosexual population and is associated with sexually trans- mitted diseases (STDs), especially syphilis, alcohol abuse and crack cocaine use. In South Carolina, 71 percent of HIV/AIDS cases reported in 1998 were among women, 29 percent among men, African Americans made up 75 percent of reported HIV/AIDS cases. Twenty-seven percent of HIV/AIDS cases are attributed to male sexual contact (MSM), in- cluding MSM and injection drug use, 27 percent are attributed to heterosexual contact and nine percent to injection drug use (36 percent have no reported risk). One third (33 percent) of the people reported with HIV/ AIDS in 1998 reside in rural areas.

Characteristics of Newly-Diagnosed People with HIV/AIDS: Urban vs Rural—From January 1991—December 1998, the Department of Health and Environmental Control (DHEC) conducted the Supplement to HIV/AIDS Survelliance (SHAS) Project (supported by CDC). The project initially included Charleston County and the Edisto Health District (a three county area). A third county, Rich- land, was added in July 1995. Project staff conducted interviews with newly reported/diagnosed people with HIV/AIDS, 18 years of age or older, who were residents in the study area. A total of 1,146 eligible persons were interviewed. Of these, 78 percent were from urban communities and 22 percent were from rural communities. The project was implemented in Edisto Health District between January 1995 and December 1996. Seventy interviews

July 10, 2001

July 10, 2001

July 10, 2001

July 10, 2001
were completed as part of this study. The majorities were male (93 percent) and African American (77 percent). Approximately 47 percent of the Rural SHAS participants had never lived outside of the county. The study had the following findings:

At the time of diagnosis, 28 percent of rural participants had AIDS, as compared to 34 percent in the urban counties.

Sixty-nine percent of rural participants had 12 years of education or less, as compared to 69 percent in the urban counties.

Sixty-nine percent of rural participants were unemployed at the time of diagnosis, as compared to 57 percent in the rural counties.

Sixty-nine percent of rural participants had household incomes of $10,000 a year or less, as compared to 39 percent in the urban counties.

The study also revealed that participants in rural areas were more likely to have used crack cocaine than those in urban areas (33 percent rural, 28 percent urban) but were less likely to have used alcohol (9 percent rural, 16 percent urban). Rural participants were more likely to have used methamphetamine with their steady sexual partner (46 percent rural, 34 percent urban) and were more likely to have received money or drugs for sex (12 percent rural, 18 percent urban).

The CARETEAM of South Carolina relies primarily on eleven Title II-funded regional consortia to provide primary care and support services to persons living with HIV/AIDS. CARE Act-funded services are provided by two Title III grantees and one Title IV grante. The DHEC administers the Title IV grant on a statewide basis that provides primary care and specialty care and assures that primary care is easily accessible for infants, children, youth, and women infected and affected by HIV. The two Title III grantees that focus on outpatient early intervention and primary care services are based in Columbia, the state’s capital, and in Ridgeeland, in the southern section of the state. The Ridgeeland Title III provider was first funded in late 1996, so it is still a relatively new component to the service network in this area (note: two new Title III grants were made in 1999). The Grady Health System Community Health Center in Greenville and Low Country Health Care Systems in Fairfax. The addition of these two primary care providers is the result of additional federal resources to two rural consortia.

The state opted for the consortia system due to a lack of support service and medical providers, especially in rural areas. The state-wide plan developed in 1990 identified primary medical care as the greatest need in the state. The formation of consortia was seen as a way to stimulate the development of local service networks.

Initially, the state funded consortia in four areas. By 1994, state-wide coverage was achieved through the formation of seven more consortia. The consortia basically mirror the geographic boundaries of the state’s public health districts to each consortia region also includes a local health department.

The consortia, which vary in size from three to six counties, are charged with assessing needs and resources in their regions and developing and maintaining a service delivery network. Each consortium has developed a unique system of care based on existing resources and programs in the local area. The following variables influenced the development service networks in the consortia:

- Existence of AIDS service organizations (ASOs) prior to the formation of the consortia.
- Ability of the lead organization to identify and recruit other providers into the services network.
- Availability of primary care providers in the service area and their willingness to work with persons living with HIV/AIDS.
- Availability of informal information sources on HIV treatment for primary care providers, and access to specialty providers.
- Several providers stressed the role personability plays in developing service networks in rural areas. Many relationships between service providers and rural areas were forged between staff members in various agencies. Service delivery systems must be flexible enough to allow staff to take advantage of these informal linkages that can provide access to necessary expertise or resources.

Currently, 39 percent of the state’s Title II funds (including ADAP) go to the consortia. Funds received by each consortium are based on the estimated number of persons living with HIV/AIDS in the region, with some variance in the formula due to demonstrated need. Consortia submit a request for proposal (RFP) process and awarded funds on a five-year cycle. While the process is designed to be competitive, only a single application has been made in other regions. Service and reporting requirements are outlined in the RFP and any necessary changes can be made in the annual contracts. DHEC meets quarterly with consortia representatives.

The consortia developed into one of three basic structures:

- Lead agency and subcontractors.
- Single lead agency providing both primary care and support services, and single lead agency providing case management with informal linkages to primary care.

The structure that evolved depended greatly on the resources available in the communities. For example, the Midlands AIDS Consortium, based in Columbia, SC serves both urban and rural areas. The consortium focused on establishing linkages through a system of subcontracts because there were already existing HIV-related services. In other consortia regions, a single agency was identified and funded to provide HIV-related services that may or may not already have been region.

- Quality Assurance—The Ryan White CARE Act Peer Review Committee oversees the activities of Title II consortia in the state. It is made up of eleven members, one for each consortium, and DHEC representatives. When the committee was formed in 1996, each consortium completed a self-assessment. The committee established a mission statement based on the findings of this process. For the last two years the committee was developing standards and guidelines that each state could use as tools to assess services. The committee has developed guidelines for case management services and is also developing outcome measures for primary care.

- The committee has developed a guideline for case management services, the committee surveyed all case managers in the state and held a series of meetings for additional input. Based on the input and recommendations, the committee has developed standards for intake, assessment, and discharge.

- State Efforts to Link HIV Services in Rural Areas—The state relies primarily on the consortia to meet needs in their own regions, the state does conduct activities that assist in the provision of services in rural areas. In fact, the state has consolidated the ADAP program in a centralized pharmacy operated by DHEC which allows the state to administer the program in a more effective and cost-saving manner. Dispersing medications. Medications are mailed to clients at their homes. Initially, medications were distributed through local health departments. In the near future, the number of persons living with HIV/AIDS soon exceeded the capacity of the regional pharmacies to carry out the necessary services.

A major advantage of the centralized pharmacy approach is that it allows DHEC to assess adherence to U.S. Public Health Service guidelines, through monitoring prescriptions for persons living with HIV/AIDS in rural areas. DHEC pharmacists review prescriptions for any deviation from the standard protocol. If an irregularity is identified, the physician is contacted to find out why the medications were prescribed and to discuss treatment decisions before the prescription is filled. This provides a training opportunity for physicians in rural areas who may not have treated a large number of persons living with HIV/AIDS and may lack expertise in HIV treatment.

Local providers frequently report the shortage of physicians with expertise in HIV care in rural areas. The CARETEAM of Title II-funded medical consultant who is available to consult with physicians. All physicians treating HIV are encouraged to develop an informal relationship with the medical consultant. For the Title III providers, the state plans to move toward a primary provider model, in which persons living with HIV/AIDS access medical services through a physician in their community who has access to specialty providers who can be contacted for consultation or referral.

Challenges

Serving a Large Region—Initially, most of the services provided by the CARETEAM, the lead agency of the Waccamaw Care Consortium and based in Myrtle Beach, were concentrated in Horry County, near Myrtle Beach, and all staff members resided in this area. To meet with clients in the southern counties, the state had to make a round trip from the agency’s office in the northern part of the service area. To alleviate some of this geographic distance, the state contracted with providers in the outlying counties. On days when case managers see clients in the southern part of the service area, these case managers go into the field the day before or after they have been to the office. Staff also may see clients at either the beginning or the end of the day, before or after they have been to the office. Within a large service area, outlying areas may have access to fewer services and feel less connected to a service provider. In addition to improving services for clients, hiring staff from that area help to facilitate linkages with the community. CARETEAM found that as they increased their presence in the two southern counties, it was much easier for work with communities in terms of raising awareness of HIV and of CARETEAM services.

Jeff Kimbro, Executive Director of CARETEAM, “We have worked hard to make sure that Georgetown and Williamsburg Counties feel they have a stake in the program and know who to call to seek help or to serve them. Even though these counties will never have the same level of resources as Horry County, as we’ve expanded our efforts to the outlying counties we have seen that the community gradually become more involved in the response to the epidemic.”

Knowledge Level of Primary Care Providers—Because they do not have physicians on staff or have contracts with medical providers, the ACCESS Network has had to...
work hard to assure that physicians in the service areas to information on the treatment of HIV. Located in Hilton Head and Hampton, ACCESS Network is the lead agency for the Low Country Care Consortium. Jerry Binns, President of ACCESS Network, physicians have become much more knowledgeable about HIV in the past few years but it is still necessary to provide educational opportunities.

ACCESS Network has used a variety of approaches. They regularly provide written materials on treatment developments to local practitioners. They also hold informal meetings between ACCESS Network staff and local practitioners, organize educational presentations by experts (sometimes done with the potential costs of treating people with HIV (low reimbursement rates), scheduling time to attend training activities and the distance providers must travel for training. For more information about each of South Carolina’s consortia, please refer to Appendix E.

CONCLUSION

State Efforts to Support HIV Services in Rural Areas

Local providers in both states identified several ways that the state HIV/AIDS Program (Title II grantees) can support the delivery of HIV services in rural areas. These program components that are often difficult to resolve.

Assistance in Diversifying Funding Sources—Although sources of financial support can be limited in rural areas, service providers expressed concern about being overly dependent on the state and the Ryan White CARE Act for funding. Rarely do rural areas have access to a fundraising base or grant opportunities from foundations and corporate donors as do service providers in urban areas. States also acknowledged that many do not possess the organizational capacity to conduct fundraising activities or prepare grant proposals and/or contracts. Providers suggested that states provide technical assistance on fundraising, grant writing, and financial and organizational capacity building. States may have the resources to hire a fundraiser who can focus on identifying new sources of funding for HIV services for rural areas. States can assist in identifying funding sources in the private sector and pass information about such sources to providers at the local level.

Identification of Outcome Measures—States can play a role in initiating and maintaining a process to develop outcome measures for rural medical and support services. While conducting this type of program evaluation, additions or additions to the potential clients living with HIV/AIDS in rural areas in which they provide services.

Provision of Ryan White CARE Act Cross-Title Collaboration—Especially in rural areas, service providers can be separated by significant distances making the establishment of linkages more difficult. The absence of established linkages in areas in which other CARE Act providers (Title III, IV, and SPNs) are present, but are not participating in the state’s Title II-funded activities, can lead to duplication of and/or significant gaps in care. States can play a role in facilitating cross-title collaboration within service areas to assure more coordinated service delivery.

Strengthening Prevention Efforts—Rural areas can be more conservative than urban areas and more resistant to HIV prevention efforts. State efforts can result in less public awareness which, in turn, may reinforce the perception that HIV is not a problem in rural areas. This lack of awareness on the part of the public, especially in rural areas, may lead to increased spread of HIV and delays in accessing services. Since states administer HIV prevention funds as well, they can provide leadership in recommending or mandating HIV prevention programs at the local level and providing technical assistance in implementing such programs. States can work to strengthen linkages between HIV counseling and testing services and HIV-related primary care and support services to facilitate access to care.

State Responses to the Challenges of Serving Persons Living with HIV/AIDS—Both New Mexico and South Carolina have implemented strategies to meet the needs of specific groups of residents who have unique challenges from one geographic area to another within each state. The selection of these two states in no way suggests that other states are not conducting exemplary work to assure positive outcomes for their respective residents. The selection of these states simply presents an opportunity to share information with other jurisdictions and stimulate national discussion among states on how best to meet the needs of persons living with HIV/AIDS in rural areas.

INTERVIEWS

NEW MEXICO

David Barrett, HMA Director, District 2, Southwest C.A.R.E. Center, Santa Fe, 505/986-1084.

Kathleen Kelly, HMA Director, District 1, New Mexico AIDS Services, Albuquerque, 505/266-0911.

Kari Maier, HMA Director, District 3, Camino De Vida Center for HIV Services, Las Cruces, 505/332-0202.

Jane Peranteau, HMA Director, District 4, Pecos Valley HIV/AIDS Resource Center, Roswell, 800/957-1995.

Donald Torres, Section Head, HIV/AIDS Program, Infectious Disease Bureau, Public Health Division, New Mexico Department of Health, 505/476-3629.

SOUTH CAROLINA

Department of Health and Environmental Control

Lynda Kettering, Director, STD/HIV Branch, Division of Preventive and Personal Health, 803/898-0749.

JoAnn LaForest, RWCA Coordinator, STD/HIV Branch, Division of Preventive and Personal Health, 803/898-0752.

Low Country Care Consortium

Jerry Binns, President, ACCESS Network, 843/681-2437.

Ann Driessen, Case Manager, Beaufort-Jasper Comprehensive Health Services, Ridgeland, 843/987-7438.

Midlands Care Consortium

Pat Derajtys, Nurse Practitioner, Department of Internal Medicine, University of South Carolina School of Medicine, 803/340-1000.

Carmen Julus, Executive Director, Palmetto AIDS Life Support Services (PALS), 803/779-7257.

Nancy Raley, Executive Director, Midlands Care Consortium, 803/340-1000.

Michelle Rojas, Title III Project Coordinator, Richland Community Health Care Association, 803/799-8407.

Pine Belt Care Consortium

Karen Beckford, Executive Director, Help for the Pee Dee, 843/697-9414.

Tri-County Interagency AIDS Coalition

Carl Humphries, Communicable Disease Supervisor, Edisto Health Department, 803/938-3526.

Waccamaw Care Consortium

Jeff Kimbro, Executive Director, CAREST, 843/236-9000.

REFERENCES


APPENDIX A: FEDERAL DEFINITION OF A RURAL AREA

One of the challenges of addressing needs in rural areas from a policymaker’s perspective is the term “rural” is not clearly defined. Of the various definitions, two of the most commonly used by federal programs were developed by the Office of Management and Budget (OMB) and the Bureau of the Census. Both of these definitions establish a quantitative measure to define rural.

The Bureau of the Census defines an urbanized area (UA) by population density. Each UA includes a central city and the surrounding densely settled territory that together have a population of 50,000 or more and a population density exceeding 1,000 people per square mile. A UA may cover parts of several counties. Additionally, places (cities, towns, villages, etc) with a population of 2,500 or more outside of a UA are considered to be urban.

OMB defines Metropolitan Statistical Areas (MSAs) as one city with 50,000 or more inhabitants and a total urbanized area (defined by the Bureau of Census) with at least 50,000 inhabitants and a total MSA population of at least 100,000 (75,000 in New England). Each MSA includes the county in which the central city is located and additional contiguous counties that are economically and socially integrated with the central county. A county that is included in an MSA is considered to be non-metropolitan. Periodically, OMB reclassifies counties on the
basis of Census data and population estimates. It is generally agreed that in rural areas, unless additional encouragement or support is provided, easy geographical access to health and social services is lacking. However, the rural population grew faster than urban populations. The population and the rural population grew faster than urban populations.

Race/Ethnicity—Nineteen (19) percent of rural residents are white, as compared to 69 percent of urban residents. African Americans make up nine percent of the rural population. Hispanics account for five percent of the rural and 11 percent of the urban population.

Income Level—In 1996, real per capita income in rural areas was $18,927 as compared to $23,941 in urban areas. Sixteen percent of rural residents live in poverty as compared to 15 percent of urban residents. Poverty is especially high among rural minorities with 33 percent of African Americans, 33 percent of Hispanics, and 34 percent of Native Americans living below the poverty level. In comparison, 27 percent of African Americans, 27 percent of Hispanics, and 29 percent of Native Americans living in urban areas live in poverty.

Unemployment—In 1997, unemployment in rural areas was 5.2 percent as compared to 4.9 percent in urban areas.

Health Care—In 1996, 46 percent of rural residents lacked private health insurance as compared to 38 percent of urban residents.

Access to Health Care Providers—Over 22 million rural Americans live in areas that are designated Primary Care Health Professional Shortage Areas (HPSAs). The cause of this shortage is the rural population of the United States. Rural Information Center Health Service, August 1998.

Although African Americans account for approximately 13 percent of the U.S. population, they represent 36 of all AIDS cases and 45 percent of all new HIV infections. Similarly, Hispanic Americans constitute approximately 8 percent of the U.S. population, but account for 18 percent of all AIDS cases and 22 percent of new HIV infections. Risk for HIV infection may be compounded by diversity in nationalities and cultural practices, language and poverty.

Native Americans often live in geographically isolated areas of the United States. Native Americans represent less than one percent of the total United States population and comprise at least 557 federally recognized tribes having their own historical traditions, beliefs, and cultural practices. Approximately 1,800 cases of AIDS have been reported among Native Americans through 1997. Asian Americans have come to the United States from more than forty countries and territories and speak more than one hundred languages and dialects. Generally, Asian Americans live in more urban areas, as opposed to remote rural locations. As HIV/AIDS infections increase throughout South and Southeast Asia, the likelihood of a rise in Asian American cases can be expected. An increase in migration and improved surveillance in that region increases the likelihood of an increase among the Asian American population. The prominence of Asian Americans in the business community means that they may provide early warning signs of future increase.

APPENDIX B: CHARACTERISTICS OF U.S. RURAL POPULATION

In 1997, over 54 million Americans lived in rural areas, making up 20 percent of the U.S. population. During much of the 1990s, the rural population grew faster than urban populations. Similarly, Hispanic Americans constitute approximately 8 percent of the U.S. population, while African Americans make up nine percent of the U.S. population. Hispanics account for five percent of the rural and 11 percent of the urban population.

APPENDIX C: CHARACTERISTICS OF COMMUNITIES AT RISK FOR HIV/AIDS

Although African Americans account for approximately 13 percent of the U.S. population, they represent 36 of all AIDS cases and 45 percent of all new HIV infections. Similarly, Hispanic Americans constitute approximately 8 percent of the U.S. population, but account for 18 percent of all AIDS cases and 22 percent of new HIV infections. Risk for HIV infection may be compounded by diversity in nationalities and cultural practices, language and poverty.

Native Americans often live in geographically isolated areas of the United States. Native Americans represent less than one percent of the total United States population and comprise at least 557 federally recognized tribes having their own historical traditions, beliefs, and cultural practices. Approximately 1,800 cases of AIDS have been reported among Native Americans through 1997. Asian Americans have come to the United States from more than forty countries and territories and speak more than one hundred languages and dialects. Generally, Asian Americans live in more urban areas, as opposed to remote rural locations. As HIV/AIDS infections increase throughout South and Southeast Asia, the likelihood of a rise in Asian American cases can be expected. An increase in migration and improved surveillance in that region increases the likelihood of an increase among the Asian American population. The prominence of Asian Americans in the business community means that they may provide early warning signs of future increase.

APPENDIX D: NEW MEXICO AIDS SERVICES: DESCRIPTIONS OF FOUR HMA DISTRICTS

APPENDIX E: NEW MEXICO AIDS SERVICES: DESCRIPTIONS OF FOUR HMA DISTRICTS

APPENDIX F: NEW MEXICO AIDS SERVICES: DESCRIPTIONS OF FOUR HMA DISTRICTS

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751

July 10, 2001

CONGRESSIONAL RECORD—HOUSE 12751
assistance and referral of clients. For example, the nurse will see a client three times more intensive management. Case managers contact clients by phone at least once a month and meet with clients on a face-to-face basis at least once every three months (when applicable). Case managers will drive clients to the office, clients’ homes, or at a designated location.

The agency contracts with five physicians that have been recruited (either paid per month or per patient). Two of the doctors reside in the region. The other three are ID physicians that contract on an hourly basis. The clinical clinics are operated all day Monday and half day on Tuesday and Wednesday. Limited clinic hours have not been a problem since clients can see a physician during off-hours if necessary. All clinics are held off-site at three physicians’ offices located throughout the service area. A key component in the provision of primary care is the medical case manager, who is a medical technician. The medical case manager does all the administrative work, including scheduling appointments, making prescription refills, and arranging access to prescriptions in addition to assuring that the other needs of clients are addressed.

Transportation is provided to medical visits by either volunteers or through contracts with individual drivers who are paid by the hour. CARETEAM has used taxis in the past but these proved to be too expensive. While some providers in rural areas have been reluctant to use volunteers to provide transportation, fear of riding with volunteers due to confidentiality concerns, this has not been the experience of CARETEAM. In the future, CARETEAM would like to acquire a van driver on a part-time basis to provide transportation to clients. Transportation is provided to medical visits by either volunteers or through contracts with individual drivers who are paid by the hour. CARETEAM has used taxis in the past but these proved to be too expensive. While some providers in rural areas have been reluctant to use volunteers to provide transportation, fear of riding with volunteers due to confidentiality concerns, this has not been the experience of CARETEAM. In the future, CARETEAM would like to acquire a van driver on a part-time basis to provide transportation to clients. Transportation is provided to medical visits by either volunteers or through contracts with individual drivers who are paid by the hour. CARETEAM has used taxis in the past but these proved to be too expensive. While some providers in rural areas have been reluctant to use volunteers to provide transportation, fear of riding with volunteers due to confidentiality concerns, this has not been the experience of CARETEAM. In the future, CARETEAM would like to acquire a van driver on a part-time basis to provide transportation to clients.
the region, if it had to close, even tempo-
aturally, it would have been difficult to ar-
range an alternative source of food for the 
agency's clients.
Most clients can find some way to get to 
the clinic, even if the Rural Transit System, 
but this travel can be time consuming and 
inconvenient. The agency will help arrange 
local transportation and will pay when nec-
essary. The agency would like to either es-

dablish a mobile clinic or find physicians in 
the region who would donate office space in 
which the agency could hold off-site clinics.
Low Country Care Consortium, Hilton Head—
(Counties served: Beaufort, Colleton, Hampton, 
and Jasper)
Caseload—190 clients.
Client Characteristics:
Male: 68%, Female: 32%.
African American: 65%, Asian/Pacific Is-
länder: 1%, Hispanic: 5%, White: 29%.
Uninsured: 85%
Rural: 100%
ACCESS Network, located in Hilton Head 
and Hampton, is the lead agency for the Low 
Country Care Consortium, which serves a 
four-county area in the southeastern section 
of the state. The service area is about the 
size of Delaware and Rhode Island combined 
and has a population of about 200,000. The 
consortium covers the entire service area 
to be rural in nature.
ACCESS Network is an ASO providing a 
full range of support services. In the service 
area, primary care is provided by various 
clinics, including Beaufort/Jasper Com-
prehensive Health Services, a Title III-fund-
ed provider, and private physicians. The 
Title III provider was first funded in 1996 and 
operates five local clinics serving Beaufort, 
Hampton and Jasper Counties. This addi-
tional primary care for every case service 
allowed the consortium to expand support 
services with Title II funds that had been 
previously used for primary care.
ACCESS Network employs two case man-
agers, each serving a specific geographic 
area. One serves approximately 110 clients, 
the other 65-85. The case managers focus on 
the above-mentioned needs through a face-
to-face interaction. Most meetings with cli-
ents take place off-site, requiring significant 
travel on the part of case managers. The 
agency has found that the most important 
way to ensure the success of the management 
process and complete paper work in order to provide suf-
cient time for the case managers to meet with 
clients. Contact with case managers de-
pends on the severity of the client’s needs.
Approximately 20 percent of the caseload re-
quires intensive contact either daily or once 
a week. Other clients see their case manager 
every 6-9 months.
Case managers link clients with primary 
care providers in the service region. There 
are no formal linkages between ACCESS 
Network and these providers. Primary care 
is available from clinics operated by rural 
health services, private physicians and non-
profit organizations. Since ACCESS is not 
formally linked to primary health care 
providers, case managers play an important 
role in ensuring that clients access care. At 
time of intake, if they are not already 
have a physician that they would like to continue 
to see and whether they have a source of 
payment. If the client does not have a physi-
cian, a search is based on geography and 
availability to pay. Low-income clients are 
treated in various local clinics that provide 
services on a free or sliding-scale basis to 
eligible patients.
Because the physicians in these clinics see 
more HIV-infected clients, they often have 
greater expertise in the treatment of HIV 
than primary physicians in the community. Cli-

"I said, 'Get out of here, that can't be so,' " Ms. Roney recalled. "I just broke down 
and cried. I just couldn't explain it. I don't want to go on being 

It is a scene that has become all too famil-

CONGRESSIONAL RECORD—HOUSE
July 10, 2001
12753

G
nize that AIDS is an issue that is affec-
ting the South and is going unno-
ticed. It is a silent disease killing peo-
ple that cannot be detected. AIDS is an 
issue that is not something that we have had. We need to un-
derstand the fact. We really need to 
look and to see what we can do to curb 
certainly the whole issue of sexu-
ally transmitted disease and it being a 
predictor for the likelihood of getting 
HIV, that ought to be addressed. Only 
28 counties in more than 3,000 counties 
in the country really have any signifi-
cant cases of sexually transmitted dis-
case, and in North Carolina we cer-
tainly have it. There is a relationship. 
We can fight that. We can fight that 
only by education and awareness.

The final article I wanted to ref-

terence is indeed the impact it is having 
on women. Again, one of the major 
problems for women is the disease of 
white gay men. That could not be 

:

"I said, 'Get out of here, that can't be so,' "

"I just broke down and cried. I just 
couldn't explain it. I don't want to go on being 

It is a scene that has become all too famil-

lar for poor black women here in the Mis-
delta and across the rural south. Even as the AIDS epidemic has subsided else-
where in the United States, it has taken firm 
root among women in places like Greenwood.

Ms. Roney, the local article for the 
New York Times, again, Mr. 
Speaker, I include the article for the 
RECORD.

[From the New York Times, July 3, 2001]
AIDS EPIDEMIC TAKES TOLL ON BLACK WOMEN

Greenwood, Miss.—Here is the rural 
South, the image of AIDS today looks 
very much like Tysete W. Roney.

Not a gay white man. Not a crack-addicted 
prisoner. But a 20-year-old black woman 
with a gold stud in her nose, an orange ban-
danna covering her braids, and her nick-
name, Easha, tattooed on one leg.

Ms. Roney had known for years she could contract 
H.I.V. by having unprotected sex. Her moth-
er had been telling her since Ms. Roney 
was 13, when she lost her virginity. But ei-
ther the lesson did not stick, or Ms. Roney 
did not have the power to negotiate safer sex 
with older lovers. She says that many of the 
men she can count as partners did not use 
condoms.

In February, after enduring 10 days of 
bleeding, Ms. Roney went to a health clinic.

First a nurse surprised her by telling her 
that she had been pregnant and had miscarried. 
Then the nurse asked Ms. Roney if 
she knew she was carrying the virus that 
causes AIDS.

"I said, 'Get out of here, that can't be so,'" 

"I just broke down and cried. I just 
couldn't explain it. I don't want to go on being 

It is a scene that has become all too famil-

lar for poor black women here in the Mis-
ndelta and across the rural south. Even as the AIDS epidemic has subsided else-
where in the United States, it has taken firm 
root among women in places like Greenwood.
Researchers say that in many ways the epidemic in the south, particularly in the Delta, re-
creates the situation of the developing world
than that of the rest of the country. Joblessness, sub-
stance abuse, teenage pregnancy, sexu-
ally transmitted diseases, and inadequate
health care exist side by side in the Delta. UnEMPLOY-
MENT jeopardizes the health of affected
women and children. In the rural South, life
can become intensely monotonous, from the
boredom and despondency of life here, and cer-
tainly little that provides pleasure, other than
sexual activity.

“There’s a sense that you don’t control
your life that much, and if God wants me
to have H.I.V. I’ll get it,” said Kathryn Whet-
stein, an assistant in public policy at Duke who has been studying AIDS in Southern
states. “All of their life experiences teach them that they have very little control over the
ir lives.”

Some girls start having sex at extremely
young ages, almost always with older men,
and find they have little ability to persuade
their parents to use contraception.

“Most times I asked them to use one,”
said Ms. Roney, a ninth-grade dropout, “but
you know how guys are. They do their little
sweet talk. ‘It won’t feel the same. Let’s use
one next time.’ I just went along with it.
I fell into that trap.”

POVERTY, DRUGS AND RISK

Often, though not always, drugs and money
play a vital role as well. Indeed, Dr. Brimah
said the desperate need for money had be-
come an H.I.V. risk factor in the Delta in the
same way that needle-sharing was in the cit-
ties.

The Mississippi Delta, where the young
cotton crop shares the summer land-
scape with immense catfish farming ponds,
has for years been among the poorest regions
in America.

The median income here in LeFlore Coun-
ty was $21,027 in 1997, more than $7,000 below
the state median, which is itself the second
lowest in the country. Three of every 10
LeFlore residents live below the poverty
line. The unemployment rate in April was 7.1
percent. In neighboring counties, which are
broken well into double digits) and the recent clos-
ing of several large plants has made work
ever harder to find than usual.

The poverty is apparent on the rough
streets and unpaved alleys of black
neighborhoods like Baptisttown and Mc-
Claurin, where men and women sweat out steamy nights on the porches of dilapidated shotgun
shacks. Just across the Yazoo River lies another
world of brick mansions and lovingly tended
lawns, a microcosm of the American Dream in
which nothing is negotiated up front. Rather,
several women and health workers explained,
there is an unspoken assumption that a woman
who engages in casual sex with a man will be re-
warded with a little financial help, perhaps
in paying the rent, perhaps in buying

groceries. As one woman explained it to Dr.
Brimah: “You know how it is with men, doc.
No honey, no money.

Gina M. Wingood, assistant professor of
public health at Emory University who has
studied AIDS in rural Alabama, said, “It’s just
trying to make ends meet, day-to-day
survival. We sort of see it in terms of pres-
tation, but they see it as how they have to
frame their lives, especially if they have
children or elderly parents to care for.”

Jean, the 44-year-old AIDS patient, said
she regularly operated that way. “Some of the
peopple in the community, if I was out on the
street, she said, “The guy would just give me a little something some-
times. I had an apartment and had bills and
I needed some money.”

Jerome E. Winston, a health department
worker who tracks the sexual networks of
infected people in the Delta, said he had
heard similar complaints about other
women who accepted insufficient compen-
sation for their companionship.
Sex is also sometimes exchanged for drugs, particularly crack cocaine, though this seems more common in larger towns in the southern part of the state.

Sharyn Janes, a professor of nursing at the University of Southern Mississippi, said she heard stories while conducting interviews with people considered at high risk of infection. One man, she said, told her that he once drove a woman out of town when she refused his demand for sex after he gave her crack. He told her that “nobody gets a free ride” and left her to walk home, Ms. Janes said.

TRACING SEXUAL NETWORKS

Because of the breadth and casualness of sexual networks here, an infection can be virtually impossible to track and control.

In the first half of 1999, for instance, health officials examined the sexual histories of 339 infected positive men in Greenwood who had had sex with 18 women over a three-year period. Two of the women had sex with both men. Five were infected with the virus, and they in turn had had sex with 24 other men.

A study of the cluster by the C.D.C. found that half of those interviewed had a history of other sexually transmitted diseases, that some of the H.I.V.-infected women were as young as 13, and that the median age of the infected women was 16, compared with 25 for the infected men.

“The teenager’s concept is that this guy is older so he’s going to know what he’s doing and he will take care of me,” said Dr. Shannon L. Hader, a Centers for Disease Control researcher who studied the Greenwood cluster. “The reality is that older men have had explicit discussions about sex.

Dr. Hader also found a lack of knowledge about H.I.V. treatment. Five of the seven infected members of the Greenwood cluster had no idea that those with H.I.V. could now live for long periods with the help of antiretroviral drugs. That misconception has made it difficult to get patients into care, where they could also receive information about not spreading the virus.

Those who do seek care have few options. Before Dr. Brimah opened his clinic here, AIDS patients had to travel more than two hours to Jackson or Memphis, a trip that many could not make. Sandra Moore, a 32-year-old Greenwood woman who first learned that she was infected with the virus in 1996, would sometimes drive as far as New Orleans for treatment. Ms. Moore had w thered to 60 pounds when she first visited Dr. Brimah, and was seemingly weeks away from death. Now, with medication, she has increased her weight to 105 pounds and talks of living to see her four young children graduate from high school.

The clinic is also provocative for many here. The pills typically prescribed by Dr. Brimah can cost up to $1,200 a month. Medicaid covers many of the poorest patients, and thus prevention, are denial and stigma. Many infected women here received a disproportionately small share of the funds appropriated to states by a formula based on the number of people living with AIDS in that state. But the growth of the epidemic in the South has been relatively recent, and many of those infected have not progressed from H.I.V. to AIDS. Congress changed the formula last year so that money will eventually be based on H.I.V. cases, but the new system might not take effect for years.

The other factors obstructing treatment, and thus prevention, are denial and stigma. Many infected women like to tell family members and close friends for fear of being shunned and abandoned.

“One of the problems is that our women don’t understand about it,” said Jane Smith, who has only told her pastor and her mother-in-law since learning two years ago that she has AIDS. “I guess they’re scared they can catch it from being around people with it, if they cough on them or shake their hands.”

One married couple, both infected, said they were open about their status when they lived in New York but had told no one since moving to Mississippi, not even their friends at Narcotics Anonymous meetings. “Everybody would scatter if they knew,” said the wife.

Jean has lied to her family members, telling them that she has cancer, and has batted away their questions. Her joy, she said, is “just not thinking about getting sick.”

“I want to tell my family,” she said, “but I know they’re not going to accept it, and I’m just not strong enough right now for them to reject me. It would just send me over the edge.”

This article is entitled “AIDS Epidemic Takes Toll on Black Women.” Let me just cite a couple of things from it.

It says: “While AIDS rates in the United States remain lower among women than men, women now account for a fourth of all newly diagnosed cases, double the percentage from 10 years ago. That growth has largely been driven by the disproportionate spread of the disease among heterosexual black women, particularly in the South.” Again, the South.

“Black women, who make up 7 percent of the Nation’s population, accounted for 16 percent of all new AIDS diagnoses last year, a percentage that has grown steadily since the syndrome was first identified 20 years ago. By comparison, black men made up 35 percent, white men 27 percent, Latino men 14 percent, and white and Latino women each 4 percent.” Again, in women.

One of the things that I was asked at this says that he hears repeatedly by his patients in New York, and this is a doctor in New York who treats HIV patients, says that his women patients understand clearly, or they say they understand clearly, that they are infected or could be infected with HIV transmitted heterosexually, but nevertheless they go ahead and do it. It is almost like smoking. They say it is like smokers knowing indeed that the cigarette is killing them, but they go ahead and do it. It is almost like a death wish. The issue is, is it drugs or is it the need for money? What is driving this kind of reckless behavior?

He says that women often struggle to explain this recklessness. They look down at the floor and they say, I know that what has happened to me is that I was not sure, I didn’t protect myself, but yet I knew I should have. I trusted this person. I knew this person. And I just wasn’t thinking about getting HIV. These are older women.

Health workers and researchers are struggling to know, How do you make these women understand early on that the relationship between poverty and drugs were risk often a part of this? We just have to find how we address those issues and make sure that as the life and the quality of life in these communities, that people are not walking into their own death trap. Poverty is apparently on rough streets and in the cities, and the exchange of sex for money or the exchange of drug needles that cause that has a strong part to play in it.

Clearly,” Dr. Hader said, “messages about prevention are not getting through.” We need to find a way to get those messages through. The rural South is politically conservative, and prevention programs in the schools tend to be episodic and focused on abstinence. Many infected women here have had sex with both men. Five were infected with the virus, and they in turn had had sex with 24 other men.

A study of the cluster by the C.D.C. found that half of those interviewed had a history of other sexually transmitted diseases, that some of the H.I.V.-infected women were as young as 13, and that the median age of the infected women was 16, compared with 25 for the infected men.

“The teenager’s concept is that this guy is older so he’s going to know what he’s doing and he will take care of me,” said Dr. Shannon L. Hader, a Centers for Disease Control researcher who studied the Greenwood cluster. “The reality is that older men have had explicit discussions about sex.

Dr. Hader also found a lack of knowledge about H.I.V. treatment. Five of the seven infected members of the Greenwood cluster had no idea that those with H.I.V. could now live for long periods with the help of antiretroviral drugs. That misconception has made it difficult to get patients into care, where they could also receive information about not spreading the virus.

 Those who do seek care have few options. Before Dr. Brimah opened his clinic here, AIDS patients had to travel more than two hours to Jackson or Memphis, a trip that many could not make. Sandra Moore, a 32-year-old Greenwood woman who first learned that she was infected with the virus in 1996, would sometimes drive as far as New Orleans for treatment. Ms. Moore had w thered to 60 pounds when she first visited Dr. Brimah, and was seemingly weeks away from death. Now, with medication, she has increased her weight to 105 pounds and talks of living to see her four young children graduate from high school.

The clinic is also provocative for many here. The pills typically prescribed by Dr. Brimah can cost up to $1,200 a month. Medicaid covers many of the poorest patients, and thus prevention programs in the schools tend to be episodic and focused on abstinence. Many infected women here have had sex with both men. Five were infected with the virus, and they in turn had had sex with 24 other men.

A study of the cluster by the C.D.C. found that half of those interviewed had a history of other sexually transmitted diseases, that some of the H.I.V.-infected women were as young as 13, and that the median age of the infected women was 16, compared with 25 for the infected men.

“The teenager’s concept is that this guy is older so he’s going to know what he’s doing and he will take care of me,” said Dr. Shannon L. Hader, a Centers for Disease Control researcher who studied the Greenwood cluster. “The reality is that older men have had explicit discussions about sex.

Dr. Hader also found a lack of knowledge about H.I.V. treatment. Five of the seven infected members of the Greenwood cluster had no idea that those with H.I.V. could now live for long periods with the help of antiretroviral drugs. That misconception has made it difficult to get patients into care, where they could also receive information about not spreading the virus.

Those who do seek care have few options. Before Dr. Brimah opened his clinic here, AIDS patients had to travel more than two hours to Jackson or Memphis, a trip that many could not make. Sandra Moore, a 32-year-old Greenwood woman who first learned that she was infected with the virus in 1996, would sometimes drive as far as New Orleans for treatment. Ms. Moore had w thered to 60 pounds when she first visited Dr. Brimah, and was seemingly weeks away from death. Now, with medication, she has increased her weight to 105 pounds and talks of living to see her four young children graduate from high school.

The clinic is also provocative for many here. The pills typically prescribed by Dr. Brimah can cost up to $1,200 a month. Medicaid covers many of the poorest patients, and thus prevention programs in the schools tend to be episodic and focused on abstinence. Many infected women here have had sex with both men. Five were infected with the virus, and they in turn had had sex with 24 other men.

A study of the cluster by the C.D.C. found that half of those interviewed had a history of other sexually transmitted diseases, that some of the H.I.V.-infected women were as young as 13, and that the median age of the infected women was 16, compared with 25 for the infected men.

“The teenager’s concept is that this guy is older so he’s going to know what he’s doing and he will take care of me,” said Dr. Shannon L. Hader, a Centers for Disease Control researcher who studied the Greenwood cluster. “The reality is that older men have had explicit discussions about sex.

Dr. Hader also found a lack of knowledge about H.I.V. treatment. Five of the seven infected members of the Greenwood cluster had no idea that those with H.I.V. could now live for long periods with the help of antiretroviral drugs. That misconception has made it difficult to get patients into care, where they could also receive information about not spreading the virus.

Those who do seek care have few options. Before Dr. Brimah opened his clinic here, AIDS patients had to travel more than two hours to Jackson or Memphis, a trip that many could not make. Sandra Moore, a 32-year-old Greenwood woman who first learned that she was infected with the virus in 1996, would sometimes drive as far as New Orleans for treatment. Ms. Moore had w thered to 60 pounds when she first visited Dr. Brimah, and was seemingly weeks away from death. Now, with medication, she has increased her weight to 105 pounds and talks of living to see her four young children graduate from high school.

The clinic is also provocative for many here. The pills typically prescribed by Dr. Brimah can cost up to $1,200 a month.