Ending the HIV Epidemic: Addressing Challenges Specific to the Rural South

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Hotspot Cluster Map for HIV in Mississippi, 2008-2014

HIV rates per 100,000 population

HIV rates per 100,000 African Americans in Mississippi

Case counts among MSM in Mississippi

HIV Clustering in Mississippi: Spatial Epidemiological Study to Inform Implementation Science in the Deep South. Stopka T. et al. JMIR Public Health Surveill 2018

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CHALLENGES AND OPPORTUNITIES IN HIV PREVENTION AND CARE IN THE RURAL SOUTH

• **RURALITY:** large distances & shortage of health care providers
• **RACE:** Increased proportions of African Americans & racial disparities in health care
• **POVERTY**
• **POOR HEALTH INFRASTRUCTURE**
• **POOR IT INFRASTRUCTURE**
• **DISTRUST IN HEALTH CARE SYSTEM**
• **INADEQUATE FEDERAL FUNDING**
• **LACK OF EDUCATION**
• **UNDERESTIMATION OF PERSONAL RISK FACTORS**
• **ANTI-IMMIGRANT POLICIES & HEALTH-RELATED IMMIGRANT BILLS**
• **HIV STIGMA & “AGGRESSIVE HOMOPHOBIA”**

Adapted From Southern AIDS Coalition. Southern States Manifesto HIV/AIDS in the South: A call to action! (2016 Update)

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Mississippi Progress Towards National Prevention and Care Goals, 2016

Source: https://aidsvu.org/state/mississippi accessed September 16, 2018
Disparities between HIV Diagnosis and prep Users are largest in the South (Prep-to-need ratio)

PrEP Uptake Among YBMSM in Jackson

- Mean age 22.7 yr (18-29)
- High risk (100%)
- 66% non-exclusive sex partner
- Insurance (45%)

100% (108)
PrEP Education and Counseling

72% (78)
Willing to start PrEP

71% (77)
Scheduled Appointment

20% (22)
Made Appointment

15% (16)
Picked Up Rx

9% (10)
Attended 3 month FU

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Retention in care among AAMSM 18-24 years old at the OAHCC PrEP Program

AAMSM age 18-24 years who were prescribed PrEP through 8/31/16 and given up to 3/31/17 to follow-up (allows 7 month window to follow up for 6 months)
Summary and Recommendations

• Multiple factors beyond risk behavior are responsible for HIV disparities in the rural South
• HIV-related disparities can be reduced:
  • Facility based approaches
    • A different way of thinking about existing healthcare delivery systems
    • Mobile clinics visiting hotspots routinely
  • Community based approaches
    • Engagement with organizations and places where at-risk people live and trust
    • Leverage community efforts to strengthen the HIV continuum
    • Do you really need to start PrEP at a physician’s office?
• Quality improvement approaches that address SDH
• Strengthening of surveillance systems to support programmatic efforts
• Policy level changes to address the SDH
  • Medicaid expansion
  • Multisectorial engagement