

Editorial

Corresponding author*Jill E. Rowe, PhD, MPH**

Assistant Professor
Western Michigan University
College of Health and Human
Services, School of Interdisciplinary
Health Programs, 1903 W. Michigan
Avenue, Kalamazoo, MI 49008, USA
E-mail: jill.rowe@wmich.edu

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Connecting PLWHA in Rural Virginia to Health and Mental Health Care-Perspectives from the Life Worlds of Frontline Health Workers and PLWHA

Jill E. Rowe*

Assistant Professor, Western Michigan University, College of Health and Human Services, School of Interdisciplinary Health Programs, 1903 W. Michigan Avenue, Kalamazoo, MI 49008, USA

ISSUE

Many areas in the rural south have historically been impoverished and medically underserved.¹⁻⁴ Virginia encompasses two geographically underserved regions: Appalachia and the Southeast. According to the Virginia HIV Epidemiology Profile (2011), at the end of 2009, approximately 18% of residents resided in rural locations. Virginia's Rural Health Plan (2008) utilizes the Isserman rural definition which combines all counties and county equivalents that are classified as rural or mixed rural as "rural" (see "defining rural" <http://www.va-srhp.org/docs/plan/11-appendix-d.pdf>). Among this population, nearly 53% had progressed to AIDS. Seventy-five percent of rural Persons Living with HIV/AIDS (PLWHA) were male, and 60% were African American. The majority of rural PLWHA without evidence of care were male (79%) and African American (47%). Forty-nine percent of rural PLWHA with unmet need reported a risk of MSM followed by high-risk heterosexual contact (19%). Cené and colleagues (2011) and the research teams of Akers et al.⁵ and Sutton et al.⁶ found that rural African American PLWHA are concentrated in areas lacking crucial resources necessary for self-sufficiency which may lead to engagement in high-risk behaviors as an escape mechanism. Other researchers concluded that there is a great need to assess the conditions of rural PLWHA regarding their susceptibility to new infections of HIV and to uncover the barriers to affective delivery of HIV testing, care, and treatment. Further, they contend that such efforts can serve a dual role by identifying unmet needs for a wide range of services (i.e. mental health, substance abuse, STI screening) for PLWHA in the rural south.^{7,8}

A number of studies⁹⁻¹³ reveal that African Americans who reside in rural southern areas face a number of health care challenges, including geographic isolation, poverty, limited employment opportunities, inadequate education, stigma directed toward those who engage in risky behaviors or have been diagnosed with HIV or AIDS, and close-knit social networks which make it difficult both to seek and to disclose confidential HIV testing and attain prevention services. Many of these barriers are unique to PLWHA in rural areas and can prohibit them from seeking HIV testing, counselling, and care, as well as related services such as drug and alcohol treatment and mental health counseling.^{14-16,3}

In rural Virginia, African American MSM accounted for nearly half of all HIV infections and AIDS cases. Many MSM, especially African Americans, do not self-identify as gay, have sexual intercourse with both men and women without disclosing their sexual behavior partners, and are inconsistent in their use of condoms.^{17,18} African American women in rural settings face a number of obstacles as well including higher exposure to drug and alcohol usage, unemployment, limited health care, gender inequality making it difficult to negotiate [for them] condom use with their male partners, socioeconomic disadvantages preventing access to medical care, and poor knowledge about HIV/AIDS.¹⁹⁻²¹

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To address the growing inequities in HIV/AIDS prevention and treatment among rural populations, the Centers for Diseases Control (CDC) recommends the following steps to reduce HIV infections: (1) intensifying HIV prevention efforts in communities with high prevalence, (2) increasing education efforts for all Americans, and (3) increasing the numbers of PLWHA in care and treatment.²² Further, the Division of AIDS Research (DAR) identifies the development of strategies to increase HIV-testing and improving linkages to care and timely treatment as an area of high priority. A PLWHA is considered to have an unmet need for care (or be out of care) when there is no evidence that he/she received any of the following four components of HIV primary medical care: (1) viral load testing; (2) CD4 count; (3) provision of anti-retroviral therapy; or (4) provision of HIV or AIDS related medical visit. Recent reports reveal inadequacies in the delivery of mental and physical health care services to PLWHA in rural southern areas.^{2,5,14,23,24}

SIGNIFICANCE

Despite substantial attention in the past decade to the co-morbidities of mental health and substance abuse problems among PLWHA these problems remain a significant barrier to maintaining the delivery of mental and physical health care.^{7,8} These inequities are even greater when applied to a rural setting, particularly in areas that are medically underserved.^{2,9,14,23,24} Further, researchers have found that PLWHA are more at risk of developing a mental health disorder than the general population.²⁵ Collins (2006) found that mental health providers were reluctant to talk to psychiatric patients about sexuality or HIV/AIDS prevention.²⁶ This is unfortunate as integrating psychosocial and psychiatric interventions into HIV care settings substantially improves the quality of life of PLWHA.^{25,27} Other researchers recommend the use of HIV-care settings to provide an important opportunity to assess substance and mental health needs among PLWHA and provide or make referrals for appropriate services.^{7,8} Coordination across agencies is required to ensure that psychosocial, psychiatric and health needs are met.^{2,6} To date, there is scarce research regarding the coordination of service provision to PLWHA across multiple agencies. More specifically, there is a relative lack of attention to the perspective of "frontline workers" (Defined as agency employees whose job description is HIV/AIDS counseling and subsequent referral to support agencies. In community-based organizations the position is a Community HIV Outreach Worker (CHOW); in public health clinics the position is a Disease Intervention Specialist (DIS); and in mental and behavioral health clinics the position is a HIV Prevention Specialist (HPS) and PLWHA themselves (both in and out of care). This gap widens when discussing frontline workers and PLWHA in rural settings.^{15,16}

More research is needed to examine the systemic and contextual issues that prohibit linkages to mental and physical health care and timely treatment in medically underserved rural areas. The perspectives and experiences of frontline workers in multiple agencies and rural PLWHA in and out of care would be an ideal focus for such a study. The overall goal is to gain an understanding of barriers to service delivery in one location

that can be broadened to multiple locations in a larger study. The larger study would provide systematic enhancers that will assist in improving linkages to care and timely treatment for rural African American PLWHA in and out of care in Southeastern Virginia.

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