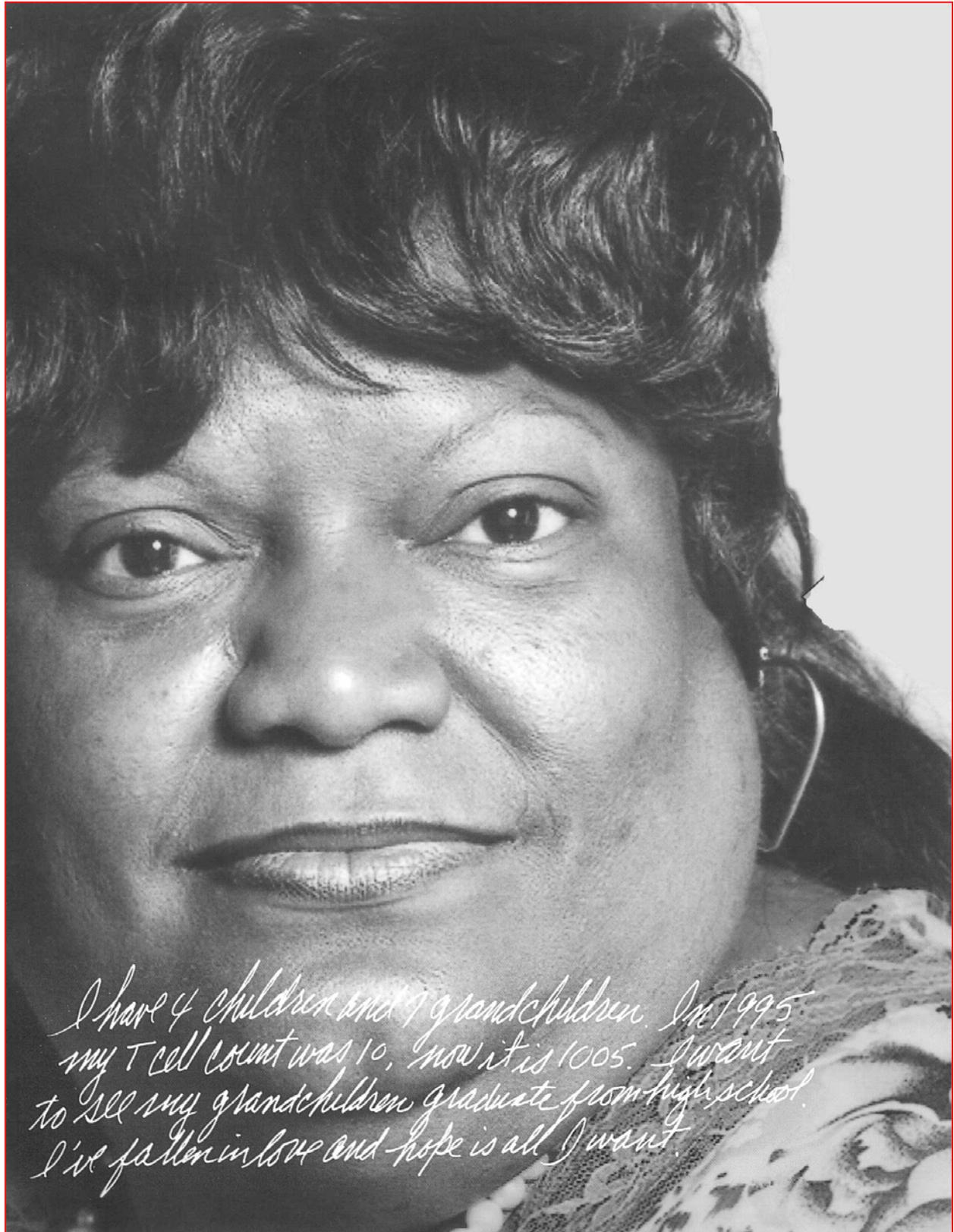
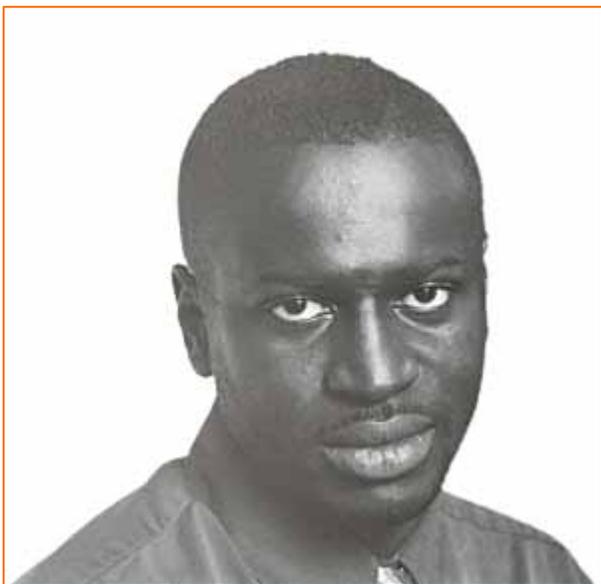


FACES OF AIDS



*I have 4 children and 9 grandchildren. In 1995
my T cell count was 10, now it is 1005. I went
to see my grandchildren graduate from high school.
I've fallen in love and hope is all I want.*

My name is Essence. I am 4 years old and was born with a disease called HIV. I don't know what that is, but sometimes my Daddy is sad so I sing him my favorite song, this little light o' mine.



I am here and not going anywhere. Hear me now. I am Robert, age 35 and HIV positive for 6 years. Let me give to the world all my skills, my love and my determination to rid this planet of AIDS.

I am Susan and have been infected with HIV since 1987. I am married to a wonderful man. I teach, counsel and lecture about this epidemic. The more you learn the longer you live.



THE CHANGING FACES OF AIDS

The HIV/AIDS epidemic is changing; the faces of HIV/AIDS are becoming increasingly rural, female, black and heterosexual (*Rural Health in the United States*, Ricketts, 1999). Seven of the states with the ten highest AIDS case rates in the nation are located in the South (CDC, 2002). While the South represents a little more than one-third of the U.S. population (38%), it now accounts for 40% of people estimated to be living with AIDS and 46% of the estimated number of new AIDS cases (Kaiser, 2002).

Among the 25 metropolitan areas (with a population of 500,000 or more) with AIDS case rates in 2001 above the national average for areas of this size, 18 were in the South. In addition, 6 of the metropolitan areas with the 10 highest AIDS case rates were in the South (Kaiser, 2002).

STDs In 1998, half of all syphilis cases were confined to 1 percent of United States counties. These cases of syphilis were found in 28 counties, primarily located in the South and in three independent cities – Baltimore, St. Louis and the District of Columbia (CDC, 1999). In 2000, the South had the highest case rates for chlamydia, gonorrhea and primary and secondary syphilis in the nation. Rates of gonorrhea and primary/secondary syphilis have been higher in the South when compared to other regions throughout the last two decades. Chlamydia rates have been higher in the South since 1997 (CDC, 2001).

PEOPLE OF COLOR African-Americans are disproportionately affected by the HIV/AIDS epidemic in the U.S. (Smith & Friday, 2001), and are infected with HIV at a greater rate than any other racial/ethnic group. HIV continues to be the leading cause of death for African-Americans 25-44 years of age.

African-Americans are at increased risk for HIV infection and other sexually transmitted diseases largely due to socio-economic and cultural factors affecting access to and utilization of health care, education and prevention services. African-Americans are less likely to seek care and treatment for a number of reasons including: lack of health insurance, lack of trust in care and limited positive experiences with care providers. Untreated STDs increase the risk of HIV transmission from infected persons not in care for substantially greater periods of time than for person engaged in care.

PARITY IN FUNDING The rise of HIV/AIDS in the South creates new challenges for an already overburdened public health care system. It is essential that people living with HIV/AIDS and STDs have basic access to primary medical care and life sustaining drugs. There must be expanded eligibility under Medicaid to ensure that Ryan White CARE Act funding is the payer of last resort. Increased resources must be directed to the South in order to meet the ever-increasing need. Individuals in rural areas of the South, especially African-Americans, do not have the safety net available in most urban areas. The rise of HIV/AIDS in rural areas creates new challenges for an already overburdened rural health care system. Historically, funding has been directed to the needs of large urban areas primarily outside the South. With the growing epidemic in rural areas, this now leaves HIV prevention and health care in the South under funded.

