The Rural Disadvantages in Accessing HIV Care

Advocates are addressing a shortage of health sites and skilled providers, transportation challenges and stigma.

June 15, 2026 By Tim Murphy

When Tammy Kinney, 66, of Winder, Georgia, (population: 21,000) needs to see her HIV providers once every three months, she must set aside at least half a day. That's because Kinney, who was diagnosed with HIV in 1987, has to drive round trip to Atlanta (an hour each way) to see her providers. It was even worse before she got a car in 2017. Prior to that, she had to take a bus, which was nearly two hours each way.

"And even now," she says, "I'm sitting in traffic the whole way. It's a beast!"

Yes, she could go to HIV specialists in Athens, Georgia, a college town about 20 miles from her home. "But I prefer to go to Atlanta because I've been with those doctors for quite some time"—she used to live in Atlanta—"and I'm not really a fan of the services that they provide in Athens." Also, she still works 3 p.m. to 11 p.m. Sunday through Thursday as a forensics case manager, further limiting when she can drive to Atlanta for appointments.

"I sure wish we had a specialized HIV care site right here in Winder," she says.

Kinney isn't alone when it comes to Americans living with HIV in rural or medically underserved areas. Much more so than people with HIV living in urban areas, folks in rural or underserved areas are more likely to have to travel farther to get to medical and other support appointments, to rely on use of a car to get there, to have fewer HIV and other care options and to feel impacted by the stigma of possibly being seen going into an HIV care facility.

These disparities are especially true in the South, the site of more than half of new HIV diagnoses in the United States in recent years.

A 2019 study published in the Journal of the International AIDS Society found that of 671 U.S. HIV care sites, 95% were located in urban counties. What's more, median drive time to HIV care sites for residents of rural counties was 90 minutes, more than twice the commute time for folks in urban counties. The study also found that geographic access to HIV care was suboptimal for more than 170,000 people with HIV, with more than half of them from the South—and,

disproportionately, from the rural South.

Additionally, a 2020 study in 14 Southern states found that providers with HIV experience disproportionately practiced in urban areas, with more than 80% of counties across those states lacking an HIV-experienced provider. The study found that more than 20,000 people with HIV in those states lived in rural counties with no experienced HIV providers, and 7,000 lived in rural counties with no HIV providers at all.

Studies in recent years have also found that Black Americans living in rural areas were more likely than Black folks in urban areas to be diagnosed with HIV late into the disease's advancement and also, became virally suppressed later upon starting treatment,.

As of 2024, after Washington, DC, Southern states had the highest death rates of people with HIV per 100,000 people.

Kathie Hiers, the longtime CEO of the nonprofit group AIDS Alabama, which provides medical care, housing and other services to low-income people with HIV in the state, knows the real-life repercussions behind these stats all too well. "Clearly, the biggest disparity here is access to healthcare," she says. "We're talking about a very poor state with a horrible Medicaid program that has the second-lowest income level for eligibility in the country after Texas."

Another disparity, she says, is around housing. "People in rural areas might not meet the federal definition of homelessness in terms of acquiring benefits, such as they might be living with relatives or couch surfing," she says. "And cities in general have way more housing stock than in rural areas as well as emergency shelters that aren't available at all in rural areas. And this impacts healthcare. I don't know how many times someone has had to pay their relatives to drive them to their appointments. There's almost no bus system in rural Alabama."

However, AIDS Alabama has somewhat mitigated the rural HIV care challenge by creating a hub-and-spoke model in which the nonprofit, based in Birmingham, is the hub that helps fund seven other HIV service agencies throughout the state.

"So no matter where you live in Alabama, we have an agency in all 67 counties," says Hiers. "We also fund things like transportation and case managers for our rural clients. We try very hard to make sure that whether you live in Birmingham or Pine Apple"—a tiny town with just over 100 residents—"you should be able to get services."

Sadly, now is not the best time to be looking for help from the federal government in terms of reducing geographic disparities in HIV care. Yes, the current Trump administration has preserved the Ending the HIV Epidemic initiative it started in 2019. The initiative overlays additional funding onto existing anti-HIV funds in hard-hit localities nationwide, including many rural ones.

But massive restrictions to Medicaid passed by a Trump-allied GOP Congress last year will go into effect next year, likely pushing many people living with HIV off Medicaid and onto the Ryan White CARE Act, the federal care payer of last resort for people with HIV. With RWCA funded at the same

level for more than a decade despite the ever-rising costs of the underlying medications and health plans it covers, it's likely that many states, especially in the South, will be cutting back their RWCA services.

Also, the steep Medicaid cuts may well lead to further closures of already scarce rural hospitals nationwide. A 2022 analysis found that the most rural U.S. counties also have the fewest health resources.

According to Hiers, the best chance to narrow HIV disparities in rural areas, at least in the immediate future, likely will come from nonprofits like AIDS Alabama that find creative ways of leveraging federal, state and private funding into care networks that operate outward from cities into rural areas through a combination of on-site visits and telehealth. (See "Solutions in Three States" to learn more.)

Aside from such efforts, it often falls to individual folks living with HIV in underserved areas to advocate for themselves to get the best care they can among options that are few and far between. (See the sidebar "Navigating Rural Living With HIV" for more.) That's partly why Kinney cofounded Rural Woman in Action, a group where women in her region meet twice monthly to talk about any and all health issues—not just HIV-related—such as how to have productive and proactive conversations with one's care provider.

At least, she says, her supermarket and pharmacy are not far from where she lives. "I could walk there," she says. "In fact, I probably need to!"

© 2026 Smart + Strong All Rights Reserved.

http://beta.docker.poz.com/article/rural-disadvantages-accessing-hiv-care