2014 STD/HIV Surveillance Report

State of Louisiana
Department of Health
Office of Public Health

Louisiana Department of Health
Office of Public Health
STD/HIV Program
1450 Poydras Street, Suite 2136
New Orleans, LA 70112
(504) 568-7474
http://dhh.louisiana.gov/hiv
http://dhh.louisiana.gov/std
www.louisianahealthhub.org

Louisiana Office of Public Health

STD/HIV Program

DeAnn Gruber, PhD, LCSW
Director

Chaquetta Johnson, DNP, MPH
Deputy Director

Tsegaye Assefa, MBA
Financial Operations Manager

Sam Burgess, MA, MSHCM
Prevention Manager

Javone Davis, MPH
Field Operations Manager

Joy Ewell
CDC Lead Public Health Advisor

Jessica Fridge, MSPH
Surveillance Manager

Kira Radtke Friedrich, MPH
Care and Services Manager

Debbie Wendell, PhD, MPH
Data Management/Analysis Manager

Graphic Design
Jim McGowan, Complete Communications, Inc.

Editor/Production
Jessica Fridge, MSPH
Demerial Banks, MPH
Catherine Desmarais, DrPH
Antoine Brantley, MPH

Acknowledgements

Thank you to the STD/HIV Program staff who worked tirelessly to collect the data used within this report and ensured the quality and consistency of the data. Thank you for your input, editorial corrections, and time in creating this Annual Report to encompass all aspects of SHP's continued effort to prevent the transmission of STDs and HIV, to ensure the availability of quality medical and social services, and to track the impact of the STD and HIV epidemics in Louisiana.

In addition, we wish to acknowledge the contribution of persons with STD diagnoses, persons living with HIV Infection, STD and HIV health care providers, community groups, researchers, and members of the community. Publication of this report would not have been possible without their cooperation, dedication, and hard work.

Table of Contents

LIST OF FIGURES

CHAPTER 1 – PROFILE OF THE HIV EPIDEMIC IN LOUISIANA

LIST OF TABLES

CONTENTS

APPENDICES

Louisiana Office of Public Health STD/HIV Program Overview

The History of the STD and HIV Program Offices

The STD Control Program has been in existence for many years to screen and treat persons infected with a sexually transmitted disease, primarily syphilis, gonorrhea, and chlamydia in Louisiana. The STD Control Program staff who are located in the central office are responsible for collaborating with regional staff and community partners to ensure that STD screenings, treatment and partner services are provided, as well as for conducting surveillance and implementing outbreak response initiatives and other special projects.

The Louisiana State University Health Sciences Center (LSUHSC) HIV Program Office was established in 1992 under the LSU School of Medicine, Department of Preventive Medicine. Simultaneously, the Louisiana Department of Health (DHH) was also addressing HIV public health issues through the Office of Public Health (OPH) HIV/AIDS Services. Noting that there were two State agencies addressing the HIV epidemic, LSU and OPH came together as the Department of Health (DHH) Office of Public Health (OPH) HIV/AIDS Program (HAP) in 1998.

In December 2010, the STD Control Program and the HIV/AIDS Program merged to become the STD/HIV Program (SHP). In 2016, the Department of Health and Hospitals (DHH) became the Department of Health.

About the Current STD/HIV Program

The STD/HIV Program (SHP) administers statewide and regional programs designed to prevent the transmission of STDs and HIV, to ensure the availability of quality medical and social services for those diagnosed with an STD or HIV, and to track the impact of the STD and HIV epidemics in Louisiana.

VISION

Achieve a state of awareness that promotes sexual health, ensures universal access to care, and eliminates new STD and HIV infections.

MISSION

SHP's mission is to lead the effort to build a holistic, integrated and innovative system of STD and HIV prevention, care and education that eliminates health inequities. We will do this by utilizing quality data and technology to inform and direct policy and program around sexual health.

About this Report

The *2014 STD/HIV Surveillance Report* provides a thorough surveillance profile of the HIV and STD epidemics in Louisiana. The diagnoses included in this report include syphilis, congenital syphilis, gonorrhea, chlamydia, HIV and AIDS.

For More Information:

SHP maintains two websites http://dhh.louisiana.gov/hiv and www.louisianahealthhub.org.

Executive Summary

The following report provides detailed information regarding demographic and risk characteristics of individuals with HIV and STD infections and trends in the epidemics over time. This report includes cases diagnosed through 2014. Some of the most significant trends are highlighted below:

HIV Surveillance

- At the end of 2014, 19,612 persons were living with HIV infection in Louisiana, of whom 10,436 (53%) have been diagnosed with AIDS. There are persons living with HIV in every parish in Louisiana.

- In the most recent *CDC HIV Surveillance Report* (Vol. 25), Louisiana ranked 2nd in the nation for estimated HIV case rates (30.4 per 100,000 population) and 9th in the estimated number of HIV cases. The Baton Rouge MSA ranked 1st in the nation and the New Orleans MSA ranked 3rd in the nation for estimated HIV case rates (44.7 and 36.9 per 100,000, respectively), among the large metropolitan areas in the nation.

- According to the same report, Louisiana ranked 2nd highest in estimated state AIDS case rates (13.7 per 100,000) and 11th in the number of estimated AIDS cases in 2014. In 2013, Louisiana ranked 3rd highest in estimated state AIDS case rates (16.9 per 100,000) and 11th in the number of estimated AIDS cases. The Baton Rouge metropolitan area ranked 1st in estimated AIDS case rates (21.6 per 100,000) and the New Orleans metropolitan area ranked 4th in estimated AIDS case rates (17.0 per 100,000) in 2014 among the large metropolitan areas in the nation.

- In 2014, 1,235 individuals were newly diagnosed with HIV infection in Louisiana.

- The New Orleans region had the highest number and 2nd highest rate of new HIV diagnoses in 2014 out of all nine public health regions. The Baton Rouge region had the 2nd highest number and highest rate of new diagnoses.

- Women represented 27% of new HIV diagnoses in 2014. The HIV rate among men has increased over 43% since 2005, but the rate among women has remained relatively stable over time.

- Blacks continue to experience severe health inequalities; the HIV diagnosis rate for blacks was over six times higher than among whites in 2014. Although blacks make up only 32% of the state's population, 71% of newly diagnosed HIV cases and 74% of newly diagnosed AIDS cases were among blacks in 2014.

- In 2014, new HIV diagnoses in youth aged 13-24 accounted for 27% of all new diagnoses.

- The percentage of adult HIV diagnoses among MSM has increased from a low of 43% in 2005 to a high of 61% in 2014. An additional 4% of new diagnoses in 2014 were among MSM/IDU. The majority of the new diagnoses among MSM in Louisiana are black and under the age of 35.

- Of the 1,235 persons diagnosed with HIV in 2014, 20% had an AIDS diagnosis at the time of their initial HIV diagnosis, an additional 4% had an AIDS diagnosis within three months, and an additional 1% had an AIDS diagnosis between three and six months after diagnosis. Overall, 25% of all new HIV diagnoses in 2014 had an AIDS diagnosis within six months and are considered to be "late testers".

HIV Linkage and Retention in Medical Care

- In 2014, 81% of persons newly diagnosed with HIV were linked to HIV medical care within three months of their diagnosis.

- In 2014, 38% of all persons living with HIV infection in Louisiana were considered to have unmet need for HIV medical care. These persons did not have a single CD4 count or viral load test conducted in 2014.

- 70% of all persons living with HIV infection, who had at least one HIV medical care appointment in 2014, were virally suppressed.

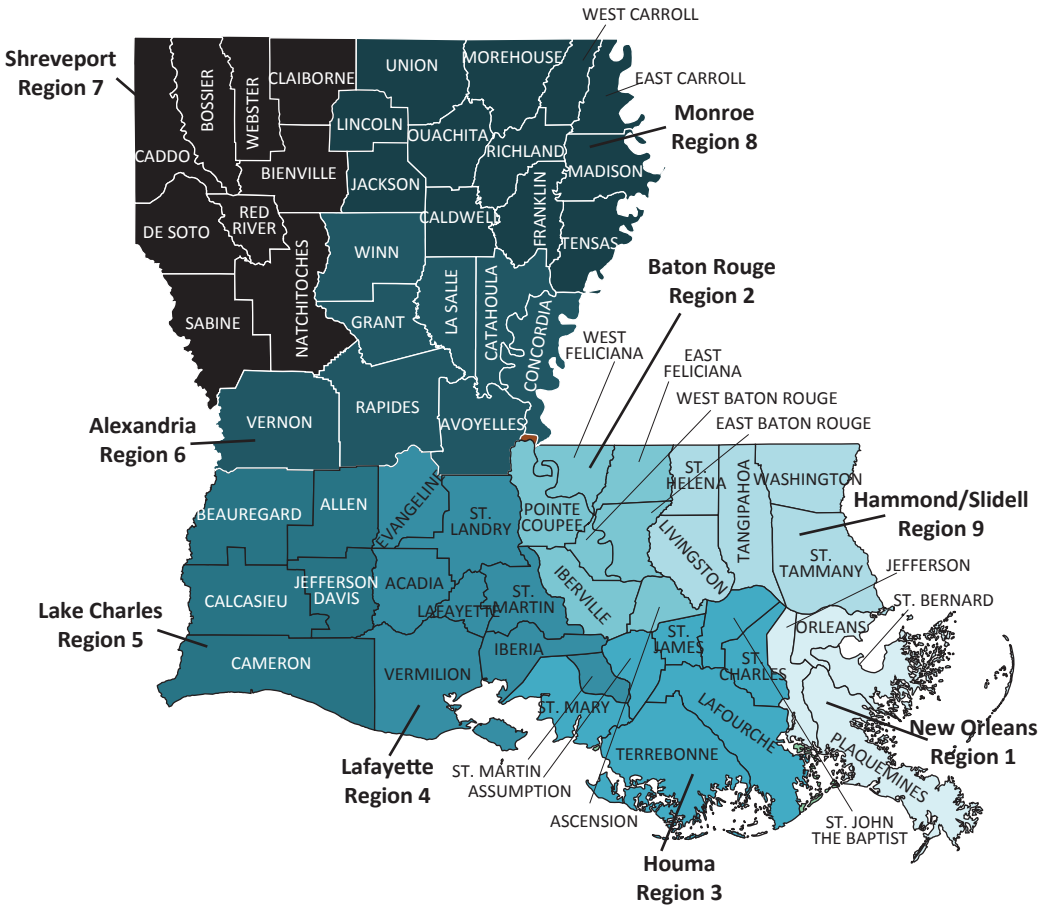
Perinatal HIV Exposure and Congenital Syphilis

- Perinatal HIV transmission rates have declined significantly from a high of nearly 16% in 1994 to zero transmissions in 2013. Preliminary data of infants born in 2014, reports two confirmed cases of perinatal transmission of HIV.
- In 2013, 89% of HIV positive women in Louisiana received ARV therapy during pregnancy; 93% received ARVs during labor/delivery; and almost 99% of newborns received prophylactic zidovudine shortly after birth. Overall, nearly 86% of mother-infant pairs received all three recommended components of the antiretroviral prophylaxis protocol.
- In 2014, Louisiana ranked 1st in the nation in congenital syphilis rates (73.4 per 100,000 live births). In 2014, there were 46 cases of congenital syphilis reported to the CDC. Only 30 states in the nation reported one or more cases of congenital syphilis in 2014.
- As of June 2014, it is now Louisiana state law that pregnant women are screened for HIV and syphilis at the beginning of their third trimester of pregnancy, in addition to screening at their first prenatal care visit. All pregnant women should receive this repeated testing and timely treatment for HIV and syphilis to reduce the number of perinatal transmission of HIV and syphilis.

STD Surveillance

- In 2014, Louisiana ranked 2nd in the nation in primary and secondary (P&S) syphilis rates (12.4 per 100,000), 1st in gonorrhea rates (193.1 per 100,000), and 3rd in chlamydia rates (621.5 per 100,000).
- There were 28,896 new cases of chlamydia, 8,978 cases of gonorrhea, and 575 cases of P&S syphilis diagnosed in Louisiana in 2014.
- The New Orleans region has the highest rates of P&S syphilis and the Monroe region has the highest rate of gonorrhea and chlamydia of all nine regions in Louisiana.
- Women account for almost 74% of chlamydia diagnoses, 56% of gonorrhea diagnoses, and 23% of P&S syphilis diagnoses in 2014.
- New STD diagnoses among blacks is a significant health disparity. Blacks account for 74% of chlamydia diagnoses, 83% of gonorrhea diagnoses and 75% of P&S syphilis diagnoses in 2014.
- Persons under the age of 25 account for the majority of STD diagnoses in Louisiana: 72% of chlamydia diagnoses; 65% of gonorrhea diagnoses; 39% of P&S syphilis diagnoses.

Geographic Guide to Louisiana's Public Health Regions and Metro Areas



Louisiana's Population

	Parishes in Public Health Region	Parishes in MSA
Region 1:New Orleans	Jefferson, Orleans, Plaquemines, St. Bernard	Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, St. Tammany
Region 2:Baton Rouge	Ascension, E. Baton Rouge, E. Feliciana, Iberville, Pointe Coupee, W. Baton Rouge, W. Feliciana	Ascension, E. Baton Rouge, E. Feliciana, Iberville, Livingston, Pointe Coupee, St. Helena, W. Baton Rouge, W. Feliciana
Region 3:Houma	Assumption, Lafourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne	Lafourche, Terrebonne
Region 4:Lafayette	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion	Lafayette, St. Martin
Region 5:Lake Charles	Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis	Calcasieu, Cameron
Region 6:Alexandria	Avoyelles, Catahoula, Concordia, Grant, La Salle, Rapides, Vernon, Winn	Grant, Rapides
Region 7:Shreveport	Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster	Bossier, Caddo, DeSoto
Region 8:Monroe	Caldwell, E. Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, W. Carroll	Ouachita, Union
Region 9:Hammond/Slidell	Livingston, St. Helena, St. Tammany, Tangipahoa, Washington	No MSA

Louisiana's Population and Healthcare Environment

Louisiana's Population

In the 2014 census, the total population of Louisiana was 4,649,676 persons. Louisiana is made up of 64 county-equivalent subdivisions called parishes. In 2014, parish populations ranged from a low of 5,008 persons (Tensas Parish) to a high of 443,598 persons (East Baton Rouge Parish). While the state is considered rural, 75% of the population resides in urban areas. The state has nine public health regions and eight metropolitan statistical areas (MSAs). The largest MSA is the New Orleans Metro Area (1,251,962) followed by the Baton Rouge Metro Area (825,499).[1]

Demographic Composition

According to the 2014 estimated census data, the racial and ethnic composition of the state was estimated to be 60.3% white, non-Hispanic, 32.5% black, non-Hispanic, 1.8% Asian, and <1% American Indian. Persons of Hispanic origin were estimated to make up 4.8% of the total population.[1]

Age and Sex

In 2014, the census estimates that persons under the age of 18 made up 23.9% of the population while persons 65 and older made up 13.6% of the population. The median age in Louisiana is 36 years. As in previous years, the estimated proportion of females in the overall population in 2014 was slightly higher than that of males (51% vs. 49%).[1]

Poverty, Income, and Education

In 2014, the average household size in Louisiana was 2.6 persons and the average family size was 3.2 persons. Of all Louisiana households, 65.9% are considered family households of which 16.9% have a female head of household with no husband present. An estimated 82.8% of Louisiana residents aged 25 years and older had attained a high school degree or higher, and 22.1% had a bachelor's degree or higher. The estimated median household income in Louisiana was $44,991 for 2014. Moreover, an estimated 19.8% of the population had an income below the federally defined poverty level, and 15.1% of families have an income below the poverty level. Louisiana has one of the highest proportions of children living in poverty, with an estimated 27.7% of all children 18 years or younger living in households with an income below the federally defined poverty level in 2014 compared to the national estimate of 21.9% of all US children.[1] The unemployment rate as of December 2014 in Louisiana was 6.9%.[2]

Incarceration/Crime

In 2014, the crime rate in Louisiana was 37% higher than the national average rate. Property crimes accounted for 87% of the crime rate and violent crimes accounted for 13% of the crime rate. Of the 50 states, the Louisiana incarceration rate ranked 1st with 816 per 100,000 adults incarcerated. A total of 38,030 inmates were managed by the Louisiana Department of Public Safety and Corrections in 2014.[3,4]

Health Indicators

In the 2014 United Health Foundation's America's Health Rankings report, Louisiana ranked 48th out of 50 in overall health. This national health survey compares multiple health outcomes and health determinants in all states. The low-place ranking is predominately due to high rates of obesity, low high school graduation rates, high infant mortality rates, high percentage of children in poverty and high infectious disease rates. In 2014, an estimated 13% of Louisiana residents lack health insurance, compared to a national average of 10%.[5]

Public Aid

In 2014, Medicaid covered 23% and Medicare covered 11% of all persons living in Louisiana. Medicaid expenditures in Louisiana totaled $7.4 billion in the 2014 fiscal year.[6] In 2014, 54% of children ages 0-18 were insured through Medicaid.[7]

2015 National HIV/AIDS Strategy

The National HIV/AIDS Strategy (NHAS) was released by the White House on July 13, 2010. This strategy is the first of its kind for the United States. The NHAS, outlines measurable targets to be achieved by 2015. The NHAS was constructed between Federal and community partners to create a common purpose and to determine what strategies and programs are working effectively to reach these common goals.

VISION

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination."

The NHAS divides 10 goals into three distinct categories.

Reducing New HIV Infections

- By 2015, lower the annual number of new infections by 25% (from 56,300 to 42,225).
- Reduce the HIV transmission rate, which is a measure of annual transmissions in relation to the number of people living with HIV, by 30% (from 5 persons infected per 100 people with HIV to 3.5 persons infection per 100 people with HIV).
- By 2015, increase from 79% to 90% the percentage of people living with HIV who know their serostatus (from 948,000 to 1,080,000 people).

Increasing Access to Care and Improving Health Outcome for People Living with HIV

- By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85% (from 26,824 to 35,078 people).
- By 2015, increase the proportion of Ryan White HIV/AIDS Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) from 73% to 80% (or 237,924 people in continuous care to 260,739 people in continuous care).
- By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86% (from 434,000 to 455,800 people). (This serves as a measurable proxy of our efforts to expand access to HUD and other housing supports to all needy people living with HIV.)

Reducing HIV-Related Health Disparities

- Improve access to prevention and care services for all Americans.
- By 2015, increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
- By 2015, increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.
- By 2015, increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

2015 National HIV/AIDS Strategy

The NHAS advocates for a more coordinated national response to the HIV epidemic. In coordination with the release of the NHAS, the White House also released a NHAS Federal Implementation Plan that outlines the activities and steps the Federal government will undertake to meet the goals set forth.

The implementation of NHAS, while spearheaded by the Federal government, will require the efforts of "all parts of society, including state, local and tribal governments, businesses, faith communities, philanthropy, the scientific and medical communities, educational institutions, people living with HIV, and others."

The NHAS outlines 11 Action Steps that the government, communities and agencies can use to help reach the strategy goals.

Reducing New HIV Infections

- Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.
- Expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches.
- Educate all Americans about the threat of HIV and how to prevent it.

Increasing Access to Care and Improving Health Outcomes for People Living with HIV

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.
- Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.
- Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

Reducing HIV-Related Disparities and Health Inequities

- Reduce HIV-related mortality in communities at high risk for HIV infection.
- Adopt community-level approaches to reduce HIV infection in high-risk communities.
- Reduce stigma and discrimination against people living with HIV.

Achieving a More Coordinated National Response to the HIV Epidemic

- Increase the coordination of HIV programs across the Federal government and between Federal agencies and state, territorial, tribal and local governments.
- Develop improved mechanisms to monitor and report on progress toward achieving national goals.

More information about the National HIV/AIDS Strategy can be found on the AIDS.gov website via the following link: http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/.

Breakout: Understanding HIV Disparities in Louisiana

Blacks; gay, bisexual, and other men who have sex with (MSM); and transgender persons in Louisiana are significantly more likely to become infected and die from HIV compared to other groups. Studies show that these disparities are largely the result of institutional and social inequities that block these populations from having the same unimpeded access to opportunities for positive health and life outcomes as others. These inequities act as a barrier to routine HIV screening and sustained engagement in HIV medical treatment, which are two critical methods of preventing new HIV infections and HIV/AIDS mortality. In recent years, Louisiana's STD/HIV Program (SHP) has increasingly focused on crafting policies and public health interventions to break down these barriers and achieve HIV equity among these groups. HIV equity is only achieved when HIV morbidity and mortality rates can no longer be predicted by race, gender, or sexual orientation.

Causes of HIV Disparities among Blacks

A common misconception is that Blacks have higher rates of engaging in individual risky behaviors than other populations (e.g., unprotected sex, high number of sexual partners, drug use) and consequently, are at greater risk of being infected with HIV. Data from numerous studies have debunked this myth and show that Blacks actually tend to have lower rates of individual risky behaviors compared to their White counterparts. Furthermore, Blacks have higher rates of HIV infection even when engaging in behaviors of similar risk as Whites.[1-16] Taken together, these data suggest that the causes of HIV/AIDS disparities among Blacks cannot be explained by differences in rates of individual risky behaviors.

Studies show the actual causes of HIV/AIDS disparities among Blacks are complex and involve interrelated social factors that are largely tied to the effects of historical and present-day institutionalized racism. A selection of these factors are discussed below.

Stigma and a Lack of Social Support. Studies have shown that stigma tied to race, HIV, same-sex sexuality and non-conforming gender identity has played a critical role in the development of HIV disparities.[17-20] Stigma generates psychological distress, internalized shame, loss of self-worth, fear of being ostracized by society, and discriminatory treatment by others among persons associated with a marginalized population.[21-23] Racial stigma against Blacks is fueled by an extensive history of institutional attitudes and policies that have systematically devalued, stereotyped, and excluded Blacks. Sources of racial stigma include the dehumanization of Blacks during slavery; denying Blacks equal rights; laws permitting and/or requiring racial segregation; unequal protection and treatment from police; housing discrimination and the isolation of Blacks in impoverished neighborhoods; inequitable access to education and employment; and inequities in incarceration rates. Furthermore, Blacks are often portrayed by the media and community leaders as being criminals, violent, promiscuous, lazy, and unintelligent. These institutional policies and practices reinforce the devaluation and stereotyping of Blacks in communities across the US.[24-30]

The effects of multiple stigmas have been shown to be additive; thus, Blacks are more sensitive to other stigmas that have been shown to be associated with HIV disparities such as HIV/AIDS stigma.[31-32] HIV/AIDS stigma also stems from the institutional marginalization and discrimination of persons with HIV infection that has existed in the US since the beginning of the epidemic. HIV infection is often involuntarily associated with other stigmatizing attributes (such as promiscuity, drug use, and same-sex sexuality) and myths regarding how it can be transmitted.33 Other related stigmas that are associated with HIV disparities include homosexuality stigma and gender-related stigma against effeminate men and transgender women (these stigmas are discussed below in *Causes of HIV Disparities among Men who have Sex with Men and Transgender Women: Stigma and a Lack of Support*).

Persons may forgo or delay HIV screening or HIV medical treatment due to the following stigma-related reasons:

- Avoiding healthcare providers that offer HIV-related services out of fear of being seen by community members

and subsequently being associated with HIV/AIDS, same-sex sexuality, or other stigmatizing attributes.

- Avoiding disclosure of HIV status, sexual orientation, or gender identity to providers, community members, sexual partners, or family because of internalized shame, fear of being shunned or discriminated against, or previous experiences of being shamed or treated unfairly.
- Avoiding HIV treatment adherence or sustained engagement in HIV medical treatment due to internalized shame or fear of HIV-status disclosure to community members, sexual partners, or family.

Poverty and Isolation in Underserved Neighborhoods. In Louisiana, 45% of Blacks are estimated to live in poverty compared to 17% of Whites.[34] This alarming socioeconomic gap is largely the result of institutional policies and practices that deny Blacks equal opportunities for housing, education, and employment.[35] Blacks have endured a history of discriminatory legislation and housing practices in the US that have limited them to living in underserved neighborhoods isolated from Whites. Throughout the majority of the 20th century, Blacks were banned from home ownership assistance programs (such as the GI bill), barred from White neighborhoods due to legislation (1934 Housing Act), and faced widespread discriminatory real estate and mortgage lending practices (such as redlining). Blacks also have a long history of being effectively barred from renting in White neighborhoods due to discriminatory renting practices.[36-45] Many Black neighborhoods suffer major disinvestment from local governments, the real estate market, and businesses leading to plummeting housing values, a dearth of livable wage employment opportunities, and a lack of high-quality public services such as education, healthcare, access to healthy foods, and public transportation. These structural inequities result in neighborhoods with little opportunity for overall economic growth and perpetually high rates of poverty.[36,46]

Poverty and isolation in underserved neighborhoods have a significant impact on the utilization of HIV screening and HIV medical treatment among Blacks. Some examples of this impact are described below.

- Lack of comprehensive, adequate healthcare coverage due to affordability, a lack of Medicaid expansion, and a lack of opportunities for jobs that include health insurance benefits. Consequently, Blacks may delay or forgo HIV screening and HIV medical treatment due to affordability concerns.
- Lack of transportation to attend healthcare appointments. Many Blacks lack adequate transportation options to attend healthcare appointments due to affordability and a lack of adequate public transportation options and nearby healthcare providers within Black communities.[36,46]
- Lack of job flexibility to attend healthcare appointments. Employees of low-wage jobs typically do not have paid sick leave or affordable child-care options in order to go to clinic appointments during business hours.
- Homelessness can lead to a lack of privacy to store and take HIV medications as well as a dearth of methods of contact for healthcare providers to reach patients.
- Healthcare providers may have policies that unintentionally or intentionally make healthcare access difficult for impoverished patients who have Medicaid, lack certain identification documents, are illiterate, have mental disabilities, or have drug abuse issues.

Inequitable Treatment in the Healthcare System. Blacks have endured a history of abuses and discriminatory treatment in the healthcare system that continues into the present-day. In response, many Blacks consider healthcare providers to be untrustworthy or unreliable. This sentiment can lead to delayed HIV screening and significant gaps in HIV medical treatment engagement. Some sources of this mistrust are listed below.[47]

- The Tuskegee syphilis experiment. A study conducted by the US Public Health Service for 40 years (between 1932 and 1972) where Blacks who were diagnosed with syphilis were purposely not told of their diagnosis and not treated in order to monitor the progression of the disease.[47,48]
- Blacks are more likely than Whites to report feeling belittled, stereotyped, or disrespected by healthcare

provider staff and doctors. Blacks have also been less likely than Whites to report feeling satisfied with the care and treatment they received.[48]

- Nationally, Blacks receive less aggressive or delayed treatment (including delayed prescribing of HIV treatment), on average, compared to Whites for the same medical conditions due to implicit racial biases and stereotyping among healthcare providers.[48]

- A lack of Black physicians in the healthcare system. Blacks make up only 4% of US physicians even though they make up 13% of the US population. Black patients report higher levels of confidence, trust, and satisfaction when seeing Black physicians compared to White physicians. In addition, Black physicians may be more likely to have a better understanding of the social and cultural factors that affect health behaviors and outcomes among Black patients.[48,49]

Incarceration Disparities. Louisiana has the highest incarceration rate and some of the longest incarceration sentences in the US. Blacks in Louisiana are four times more likely than Whites to be incarcerated while awaiting trial or after a conviction.[50] Reasons for this alarming disparity include over-policing in Black communities, racial profiling due to racial stigmas, differences in incarceration outcomes for similar crimes between Whites and Blacks, lack of adequate legal representation in court, bond policies that favor wealthy individuals, and a lack of social support and job opportunities upon reentry into the community.[51-56] Incarceration may have the following effects:

- Persons may experience substantial interruptions in routine HIV screening and HIV medical treatment during and after incarceration due to difficulty accessing HIV medical services in correctional facilities and significant difficulty obtaining employment, housing, and healthcare upon release.[51,56]
- Incarceration may disrupt stable, monogamous relationships and lead to a lower number of available sexual partners in a community. A smaller sexual network increases the risk of exposure to HIV and other STDs.[51,56]
- Incarceration generates additional stigma that may affect HIV screening and medical treatment utilization patterns.[51,56]

*Causes of HIV Disparities among Men who have Sex with Men and Transgender Women**

While transgender women and gay, bisexual, and other men who have sex with men (MSM) have the same concerns regarding their health as other groups, they continually have the highest rates of HIV infection in Louisiana and across the US.[64] Studies show that HIV disparities among MSM and transgender women are fueled by interrelated social factors associated with a history of institutional norms and policies in the US that are rooted in heterosexism, homophobia, and transphobia. Social factors related to the institutional oppression of Blacks (discussed in the previous section) also plays a role in the development and persistence of these disparities as Black MSM and transgender women bear the largest burden of HIV of any population in Louisiana. A selection of these social factors are discussed below.

Stigma and a Lack of Social Support. Studies have shown that stigma tied to same-sex sexuality and non-conforming gender identities has played a critical role in the development of HIV disparities.[17,21-24,32] Stigmas faced by MSM and transgender women are fueled and reinforced by an extensive history of institutional attitudes and policies that have perpetually devalued, stereotyped, and discriminated against same-sex sexuality and non-conforming gender identities. Laws and policies in the US have long allowed MSM and transgender women to be denied equal treatment, housing, employment, marriage benefits, entry into the armed forces, access to public accommodations (retail stores, banks, libraries, restaurants, etc.) , and other equal protections.[57-61] Likewise,

* Rates of HIV infection among transgender men in the US has not been sufficiently researched; however, transgender men in the US suffer from some of the same institutional oppressions as transgender women. SHP intends to include transgender men in all prevention and service efforts.

many important religious institutions strongly prohibit and/or vilify same-sex sexuality and non-conforming gender identities. Moreover, MSM and transgender women have often been negatively portrayed by community leaders and the media as being promiscuous, drug users, pedophiles, criminals, and/or sex workers.[62]

Due to widespread stigma, MSM and transgender women often face severe hostility, ostracism, and violence from family, friends, and community members upon revealing their sexuality and/or gender identity. Consequently, MSM and transgender women may feel tremendous internalized shame, fear of discrimination or mistreatment, and psychological distress. MSM and transgender women are also more sensitive to other stigmas such as HIV/AIDS stigma and racial stigma as the effects of multiple stigmas have been shown to be additive. Altogether, the psychological distress caused by this combination of stigma can result in delayed HIV screening and medical treatment (additional details on the effects of stigma on HIV infection risk are available in the above section, *Causes of HIV Disparities among Blacks: Stigma and a Lack of Support*).[17,21-24,32]

Poverty, Ostracism, and Discriminatory Treatment. Transgender persons, particularly transgender persons of color, are dramatically more likely to live in poverty and experience homelessness than the general US population due to the widespread prevalence of discriminatory policies and hostile attitudes against this population. A national study of transgender women in the US found that transgender persons were four times as likely to have a household income under $10,000 compared to the general US population (15% vs. 4%). Black transgender persons face worst financial outcomes then other transgender persons. One in three Black transgender persons (34%) reported an income below $10,000 and 41% of Black transgender persons have reported ever being homeless.[60]

Transgender women often first encounter poverty and homelessness as youths. Studies show that transgender women are significantly more likely to endure harsh bullying, ostracism, harassment and violence from schoolmates, families, and school administrators. Transgender students who face these experiences are more likely to have higher levels of psychological distress, lower academic achievement, miss class, and not plan on attending college. As a result, transgender persons may be less prepared to compete for livable-wage jobs. In addition, rejection from family members during childhood is a major cause of homelessness among transgender youth.[63,64] Currently, Louisiana has no laws protecting students from discrimination or bullying on the basis of gender identity.[59]

Transgender women also face significant employment and housing discrimination due to their gender identity. In a review of 11 surveys, 13-47% of transgender respondents reported being unfairly fired or denied a job. In another survey, 78% of transgender persons reported experiencing harassment or mistreatment at work.[60] In addition, 19% of transgender persons have reported discrimination in the housing and renting market and 29% have reported discrimination from shelters and public housing.[61] Currently, Louisiana has no laws banning employment or housing discrimination based on gender identity.[59]

Poverty and homelessness have a significant impact on the transmission of HIV and the utilization of HIV screening and HIV medical treatment among transgender women. Some examples of this impact are described below (additional examples can be found in the above section, *Causes of HIV Disparities among Blacks: Poverty and Isolation in Underserved Neighborhoods*).

- Transgender women face immense employment discrimination due to gender nonconformity and may turn to sex work in order to survive. In a national survey of transgender persons in the US, 40% of black transgender persons and 6.3% of white transgender persons reported ever engaging in sex work (10.8% for all races). Almost 70% of these individuals reported discrimination in the traditional workforce. Engaging in unregulated sex work for survival is a significant risk factor for HIV transmission as there are financial pressures to engage in unprotected sex and a risk of sexual assault.[61]
- Lack of comprehensive, adequate healthcare coverage due to affordability, a lack of Medicaid expansion, and a lack of opportunities for jobs that include health insurance benefits. In one study, 48% of transgender persons reported delaying or going without medical care because they could not afford it.[64]

Inequitable Treatment in the Healthcare System. MSM and transgender women face widespread discrimination and exclusionary policies within the US healthcare system. As a result, MSM and transgender women are less likely to have a regular place to go for medical care (such as a primary care physician) and they are more likely to delay or forgo preventative care and treatment (such as routine HIV screening and HIV medical treatment).[61,64]

- Many MSM and transgender individuals report being refused care by healthcare providers and/or facing harassment, ridicule, or disrespectful treatment by health provider staff and physicians. Staff and physicians may also blame a patient's sexual orientation or gender identity as the cause of an illness.[61,64]
- Many insurance policies have historically used or continue to use blanket exclusions to deny coverage for health concerns of transgender persons such as transition surgery, sex-specific preventative services (i.e., prostate exams for transgender women), and hormone medications. Louisiana lacks any laws prohibiting insurance companies from discriminating against transgender persons. As a result, transgender women may be discouraged from enrolling in healthcare insurance.[61,64]
- Transgender persons may experience delays or difficulties in accessing coverage because their gender identity or chosen name does not reflect the gender or name on their identification documents (such as a driver's license or social security card). Changing identification documents to reflect one's gender identity can be time-consuming and expensive.[61,64]
- Most doctors receive little or no instruction on the unique physical and mental health concerns of MSM and transgender women. Consequently, many MSM and transgender women go without receiving adequate, client-centered care.[61,64]

Incarceration and Survival. Transgender women, particularly low-income and Black transgender women, face high levels of over-policing, profiling, police harassment, and incarceration. Transgender women are often shunned from employment opportunities, family, and their surrounding community. To survive, some transgender women may turn to activities that carry a high risk of incarceration such as sex work or drug trafficking. Transgender women also report being the target of random searches by police and being incarcerated for carrying condoms due to suspicion of sex work engagement.[61,65] Incarceration may have the following effects for transgender women:

- Transgender women placed in men's prisons face a high risk of being sexually assaulted. One study found that 59% of transgender women in men's prisons reported ever being sexually assaulted while in prison.[61]
- Transgender women may experience substantial interruptions in routine HIV screening and HIV medical treatment during and after incarceration due to difficulty accessing HIV/AIDS services in correctional facilities and difficulty obtaining access to healthcare upon release. In addition, they may experience disruptions in transgender-specific health care such as hormone therapy and mental healthcare.
- Transgender women may be discouraged from carrying condoms due to the risk of profiling and subsequently being incarcerated.

Transgender persons who have been incarcerated are at higher risk of future incarceration because of the tremendous difficulty obtaining employment, housing, and healthcare they may face upon release.

Eliminating HIV Disparities among Blacks, MSM, and Transgender Women

SHP is committed to adopting policies and developing interventions that tackle the institutional and social inequities that are driving HIV disparities among Blacks, MSM, and transgender women. This commitment is aligned with the mission and goals of the National HIV/AIDS Strategy (described in the section titled *National HIV/AIDS Strategy*). Examples of SHP's efforts are presented below.

- **No-cost condom distribution.** Condoms and lubricant are made available in neighborhoods through 758 sites, 60 parish health units, and through various outreach activities. The use of condoms during sexual

activity is a highly effective method of preventing HIV transmission.

- **No-cost HIV testing and counseling.** SHP supports HIV testing and counseling through contracts with community-based organizations and through partnerships with parish health units, hospital emergency departments, correctional facilities, substance abuse treatment programs, Federally Qualified Health Centers, and school-based health clinics.
- **Case Management.** SHP contracts with community-based organizations to provide medical and non-medical case management and other critical supportive services to assist persons living with HIV with access to medical care and address potential medical and socioeconomic barriers to entering or staying connected to HIV care.
- **Trainings on Institutional Oppression.** SHP has partnered with capacity building organizations to provide trainings on institutional racism, transphobia, and homophobia to its staff, as well as staff at three community-based organizations in New Orleans and Baton Rouge. SHP is currently working on providing similar trainings to other community-based organizations and healthcare providers across the state.
- **Wellness Centers.** SHP has contracted with six community-based organizations to provide integrated prevention services to MSM and transgender women in New Orleans, Baton Rouge, Lafayette, Shreveport, Monroe, and Alexandria.
- **Louisiana Health Access Program (LA-HAP).** SHP provides access to HIV medications for uninsured persons living with HIV and assistance with health insurance premiums and other cost shares for insured persons living with HIV.
- **Louisiana Links.** A linkage/re-engagement and patient navigation intervention that utilizes HIV surveillance data to find persons living with HIV who may be in need of linkage/reengagement to HIV medical care or treatment adherence services. Enrollees in this program receive assistance overcoming socioeconomic barriers to HIV medical care that typically goes above and beyond what is provided through traditional case management.
- **Health Models.** A pay-for-performance treatment and prevention program that gives financial incentives to patients who attend regularly scheduled HIV medical appointments and reach and maintain viral suppression. Enrollees in this program also receive additional counseling and HIV education.

References: Understanding HIV Disparities in Louisiana

1. Millett GA, Flores SA, Peterson JL, Bakeman R. Explaining Disparities in HIV Infection Among Black and White Men Who Have Sex With Men: A Meta-analysis of HIV Risk Behaviors. AIDS. 2007;21(15):2083-2091.

2. Golub A, Johnson BD. Variation in youthful risks of progression from alcohol and tobacco to marijuana and to hard drugs across generations. Am J Public Health. 2001;91(2):225–32.

3. Fuller CM, Vlahov D, Ompad DC, et al. High-risk behaviors associated with transition from illicit non-injection to injection drug use among adolescent and young adult drug users: a case control study. Drug Alcohol Depend. 2002;66(2):189–98.

4. Fuller CM, Arria AM, Vlahov D, et al. Factors associated with adolescent imitation of injection drug use. Public Health Rep. 2001;116(Suppl 1):136–45.

5. Kral AH, Lorvick J, Edlin BR. Sex- and drug-related risk among populations of younger and older injection drug users in adjacent neighborhoods in San Francisco. J Acquir Immune Defic Syndr. 2000;24(2):162–7.

6. Ellickson PL, Morton SC. Identifying adolescents at risk for hard drug use: racial/ethnic variations. J Adolesc Health. 1999;25(6):382–95.

7. Substance Abuse and Mental Health Services Administration (SAMHSA).Results from the 2002 National Survey on Drug Use and Health. (Publication No. SMA 03-3836). Rockville, MD: SAMHSA, Office of Applied Studies.2003.

8. Neaigus A, Miller M, Friedman S, et al. Potential risk factors for the transition to injecting among non-injecting heroin users: a comparison of former injectors and never injectors. Addiction. 2001;96(6):847–60.

9. McClelland GM, Teplin LA, Abram KM, et al. HIV and AIDS risk behaviors among female jail detainees: implications for public health policy. Am J Public Health. 2002;92(5):818–25.

10. Smith DK, Gwinn M, Selik RM, et al. HIV/AIDS among African-Americans: Progress or progression? AIDS. 2000;14(9):1237–48.

11. Belzer M, Rogers AS, Camarca M, et al. Contraceptive choices in HIV infected and HIV at-risk adolescent females. J Adolesc Health. 2001;29(3 Suppl):93–100.

12. Anderson JE. Condom use and HIV risk among U.S. adults Am J Public Health. 2003;93(6):912–14.

13. Holtzman D, Bland SD, Lansky A, et al. HIV-related behaviors and perceptions among adults in 25 states: 1997 Behavioral Risk Factor Surveillance System. Am J Public Health. 2001;91(11):1882–8.

14. Soet JE, Dudley WN, Dilorio C. The effects of ethnicity and perceived power on women's sexual behavior. Psychol of Women Q. 1999;23(4):707–24.

15. Farley, TA. Sexually transmitted diseases in the Southeastern United States: Location, Race, and Social Context. Sexually Transmitted Diseases. 2006; 33(7 Suppl):s58-s64.

16. Hallfors DD et al. Sexual and drug behavior patterns and HIV and STD racial disparities: the need for new directions. American Journal of Public Health. 2007;97(1):125-132.

17. Fullilove MT, Fullilove RE. Stigma as an obstacle to AIDS action. American Behavioral Scientist. 1999;42(7):1117-1129.

18. Harawa NT, Williams JK, Ramamurthi HC, Bingham TA. Perceptions towards condom use, sexual activity, and HIV disclosure among HIV-positive African American men who have sex with men: Implications for heterosexual transmission. Journal of Urban Health. 2006;83(4),682-694.

19. Kraft JM, Beeker C, Stokes JP, Peterson JL. Finding the "community" in community-level HIV/AIDS interventions: Formative research with young African American men who have sex with men. Health Education & Behavior. 2000;27(4):430-441.

20. Wilson PA, Moore TE. Public health responses to the HIV epidemic among Black men who have sex with men: A qualitative study of health departments and communities in the US. American Journal of Public Health. 2009;99(6):1013-1022.

21. Lee RS, Kochman A, Sikkema KJ. Internalized stigma among people living with HIV-AIDS. AIDS Behav. 2002;6(4):309–319.

22. Rao D, Feldman BJ, Fredericksen RJ, et al. A structural equation model of HIV-related stigma, depressive symptoms, and medication adherence. AIDS Behav. 2012;16(3):711-716.

23. Rao D, Kekwaletswe TC, Hosek S, Martinez J, Rodriguez F. Stigma and social barriers to medication adherence with urban youth living with HIV. AIDS Care. 2007;19(1):28–33.

24. Stuber J, Meyer I, Link B. Stigma, prejudice, discrimination and health. Social Science & Medicine. 2008;67(3): 351-357.

25. Maulsby C, Millett G, Lindsey K, et al. HIV Among Black Men Who Have Sex with Men (MSM) in the United States: A Review of the Literature. AIDS and Behavior. 2013;18:10-25.

26. Gatrell AC, Popay J, Thomas C. Mapping the determinants of health inequalities in social space: can Bourdieu help us? Health Place. 2004;10(3):245–257.

27. Keene DE, Padilla MB. Race, class and the stigma of place: moving to "opportunity" in Eastern Iowa. Health Place. 2010;16(6):1216–223.

28. Wilton R. Diminished worlds: the geography of everyday life with HIV/AIDS. Health Place. 1996;2(2):69–83.

29. Popay J, Thomas C, et al. A proper place to live: health inequalities, agency and the normative dimensions of space. Soc Sci Med. 2003;57(1):55–66.

30. Cohen CJ. The boundaries of blackness: AIDS and the breakdown of black politics. Chicago: University of Chicago Press; 1999.

31. Berger MT. Workable sisterhood: the political journey of stigmatized women with HIV/AIDS. Princeton: Princeton University Press; 2006.

32. Reidpath DD, Chan KY. A method for the quantitative analysis of the layering of HIV-related stigma. AIDS Care. 2005;17(4):425–432.

33. Emlet CA, Fredriksen-Goldsen KI, Kim H, Hoy-Ellis C. The relationship between sexual minority stigma and sexual health risk behaviors among HIV-positive older gay and bisexual men. Journal of Applied Gerontology; June 2015:1-22.

34. DeNavas-Walt, Proctor BD. U.S. Census Bureau, Current Population Reports, P60-252, Income and Poverty in the United States: 2014. U.S. Government Printing Office, Washington, DC, 2015.

35. Sullivan L, Meschede T, Dietrich L, Shapiro T, et al. The Racial Wealth Gap: Why Policy Matters. Retrieved from: http://www.demos.org/sites/default/files/publications/RacialWealthGap_1.pdf.

36. Landrine H, Corral I. Separate and unequal: Residential segregation and black health disparities. Ethnicity & Disease. 2009;19:179-184

37. Iceland J, Weinberg DH, Steinmetz E. Racial and Ethnic Segregation in the United States, 1980–2000. Washington, DC: US Government Printing Office; 2002.

38. Johnston R, Poulsen M, Forrest J. Ethnic and racial segregation in US metropolitan areas, 1980–2000. Urban Aff Rev. 2007;42(4):479–504.

39. Wilks R, Iceland J. Hypersegregation in the 21st century. Demography. 2004;41:23–36.

40. Osypuk TL, Acevedo-Garcia D. Are racial disparities in preterm birth larger in hypersegregated areas? Am J Epidemiol. 2008;167(11):1295–1304.

41. Massey DS, Denton NA. American Apartheid. Cambridge, Mass: Harvard University Press; 1993.

42. Krysan M, Farley R. The residential preferences of Blacks: do they explain persistent segregation? Social Forces. 2002;80:937–980.

43. US Department of Housing and Urban Development. Housing Discrimination Study. Washington, DC: US Government Printing Office; 2002.

44. Ross SL, Turner MA. Housing discrimination in metropolitan America. Social Problems. 2005;52:148–151.

45. Adelman RM. Neighborhood opportunities, race, and class: the Black middle-class and residential segregation. City and Community. 2004;3:43–63.

46. Rankin BH, Quane JM. Neighborhood Poverty and the Social Isolation of Inner-City African American Families. Social Forces. 2000;79(1):139-164.

47. Graham JL, Giordano TP, Grimes RM, et al. Influence of trust on HIV diagnosis and care practices: a literature review. J Int Assoc Physicians AIDS Care (Chic). 2010;9(6):346-52.

48. Penner LA, Albrecht TL, Coleman DK, Norton WE. Interpersonal Perspectives on Black–White Health Disparities: Social Policy Implications. Social Issues and Policy Review. 2007;1(1):63-98.

49. Rao V, Flores G. Why aren't there more African-American physicians? A qualitative study and exploratory inquiry of African-American students' perspectives on careers in medicine. J Natl Med Assoc. 2007; 99(9): 986–993.

50. Prison rate: Sakala L. Breaking Down Mass Incarceration in the 2010 Census: State-by-State Incarceration Rates by Race/Ethnicity 2014. Retrieved from: http://www.prisonpolicy.org/reports/rates.html.

51. Harawa N, Adimora A. Incarceration, African Americans and HIV: advancing a research agenda. J Natl Med Assoc. 2008;100(1):57–62.

52. Binswanger IA, Redmond N, Steiner JF, Hicks LS. Health Disparities and the Criminal Justice System: An Agenda for Further Research and Action. J Urban Health. 2012 Feb; 89(1): 98–107.

53. United States Department of Justice: Civil Rights Division. Investigation of the New Orleans Police Department. 2011. Last accessed: April 11, 2016. Retrieved from: https://www.justice.gov/sites/default/files/crt/legacy/2011/03/17/nopd_report.pdf.

54. Doerner JK, Demuth S. The Independent and Joint Effects of Race/Ethnicity, Gender, and Age on Sentencing Outcomes in U.S. Federal Courts. Justice Quarterly. 2010;27(1):1-27.

55. Hartney C, Vuong L. Created Equal: Racial and Ethnic Disparities in the US Criminal Justice System. National Council on Crime and Delinquency 2009. Last accessed: April 11, 2016. Retrieved from: http://www.nccdglobal.org/sites/default/files/publication_pdf/created-equal.pdf.

56. Sykes B, Piquero A. Structuring and Re-Creating Inequality: Health Testing Policies, Race, and the Criminal Justice System. The Annals of the American Academy of Political and Social Science.

57. Reisner SL, White JM, Dunham EE, *et al*. Discrimination and Health in Massachusetts: A Statewide Survey of Transgender and Gender Nonconforming Adults. Fenway Health July 2014. Last Accessed: June 3, 2016. Retrieved from: http://fenwayhealth.org/documents/the-fenway-institute/policy-briefs/The-Fenway-Institute-MTPC-Project-VOICE-Report-July-2014.pdf.

58. Reisner SL, White JM, Dunham EE, et al. Discrimination and Health in Massachusetts: A Statewide Survey of Transgender and Gender Nonconforming Adults. Fenway Health 2014. Last Accessed: April 11, 2016. Retrieved from: http://fenwayfocus.org/wp-content/uploads/2014/07/The-Fenway-Institute-MTPC-Project-VOICE-Report-July-2014.pdf.

59. Mapping LGBT Equality in America. Movement Advancement Project 2015. Last accessed: April 11, 2016. Retrieved from: http://www.lgbtmap.org/file/Mapping%20Equality%20for%20LGBT%20Americans%20Post%20SCOTUS.pdf.

60. Badgett MV, Lau H, Sears B, Ho D. Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination. The Williams Institute June 2007. Last accessed: April 11, 2016. http://williamsinstitute.law.ucla.edu/wp-content/uploads/Badgett-Sears-Lau-Ho-Bias-in-the-Workplace-Jun-2007.pdf.

61. Grant JM, Mottet LA, Tanis J. Injustice at Every Turn: A report of the national transgender discrimination survey. National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011. Last Accessed: April 11, 2016. Retrieved from: http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

62. Herek GM. Stigma, Prejudice, and Violence Against Lesbians and Gay Men. Homosexuality: Research implications for public policy. 1991:60-80.

63. Baum J, Brill S, Brown J, et al. Supporting and Caring for our Gender Expansive Youth. Human Rights Campaign Foundation and Gender Spectrum 2014. Last accessed: April 11, 2016. Retrieved from: http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/Gender-expansive-youth-report-final.pdf.

64. Kates J, Ranji U, Beamesderfer A, et al. Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S. The Henry J. Kaiser Family Foundation. July 2015. Last accesed: April 11, 2016. Retrieved from: http://files.kff.org/attachment/issue-brief-health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s-2.

65. Movement Advancement Project, National Center for Transgender Equality, and Transgender Law Center. Understanding Issues Facing Transgender Americans. 2015. Last accessed: April 11, 2016. Retrieved from: http://www.lgbtmap.org/file/understanding-issues-facing-transgender-americans.pdf.

Chapter 1

Profile Of The HIV Epidemic In Louisiana

Introduction to HIV Surveillance

The Louisiana Department of Health, Office of Public Health STD/HIV Program's (SHP) HIV Surveillance Program conducts general case ascertainment through the receipt of reports of potential cases of HIV infection from clinical providers, laboratories and other public health providers throughout the state with funding from the Centers for Disease Control and Prevention (CDC) and in accordance with the Louisiana Sanitary Code. Basic demographic and risk information are also collected. Additionally, the program monitors perinatal exposure to and transmission of HIV, HIV incidence, medication resistant strains of HIV, clinical manifestations of HIV disease, mortality, the utilization and impact of care and treatment, and measures of high risk behavior.

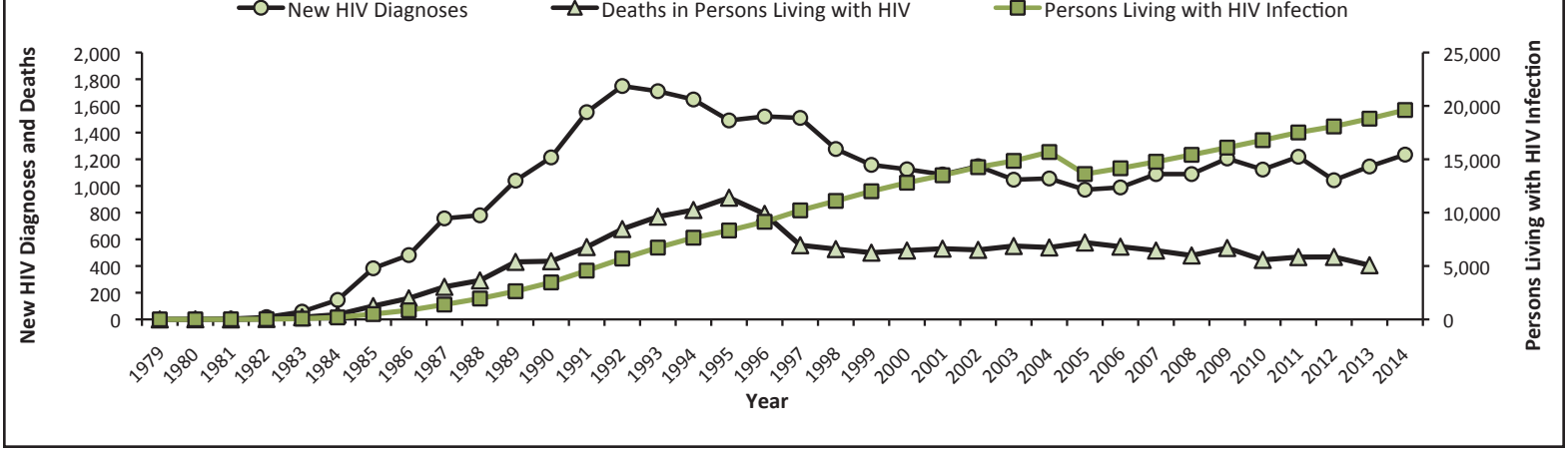
Louisiana began confidential name-based reporting of AIDS diagnoses in 1984 and confidential name-based reporting of HIV (non-AIDS) diagnoses in 1993. In 1999, the Louisiana Sanitary Code was revised to mandate the reporting of all HIV-related laboratory results (e.g., CD4 counts, viral loads, Western blots). In 2010, the Sanitary Code was revised to explicitly require the reporting of HIV in pregnancy as well as prenatal exposure to HIV. The maternal and pediatric medical records are reviewed to assess testing and treatment received. Follow-up occurs until the infant's infection status can be determined.

Data from the above surveillance activities are analyzed and non-identifying summary information is provided to public health programs, community based organizations, researchers, and the general public through reports, presentations, data requests, and regional profiles. The information is provided for the purposes of program planning and education, such as to assess the risks for HIV infection and develop effective HIV prevention programs; to help identify where services for people living with HIV infection are needed; and to assist with the allocation of federal and state funding.

This report includes data for persons diagnosed with HIV or AIDS through December 31, 2014 and reported to SHP before December 23, 2015. The report presents both numbers and rates of HIV and AIDS diagnoses. New HIV diagnoses are the number of people diagnosed with HIV at any stage of the disease within a given year. Rates take into account differing population sizes among demographic groups or areas, and comparing rates between two or more groups or areas can identify important differences.

.

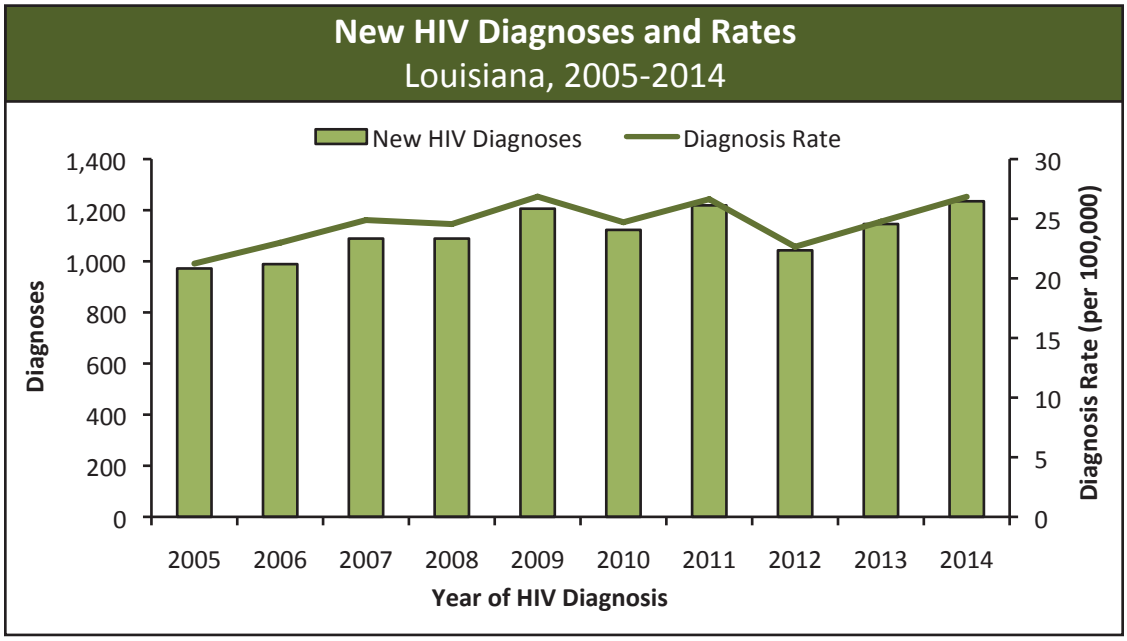
Number of HIV Diagnoses, Deaths, and Persons Living with HIV Infection
Louisiana, 1979-2014



The first reported Louisiana resident with AIDS was diagnosed in 1979. In the thirty-five years since then, the number of persons living with HIV infection in the state has continued to increase. New HIV diagnoses peaked in 1992 and deaths among persons with HIV infection peaked in 1995. Deaths have decreased since 1995 due to the availability of more effective treatments. The decreases seen in 2005 in both persons living with HIV infection and new HIV diagnoses were due to the impact of Hurricane Katrina which resulted in the dislocation of a large number of persons from the New Orleans metropolitan area and disruptions in HIV testing.

10-Year Trends in New HIV Diagnoses (2005-2014)

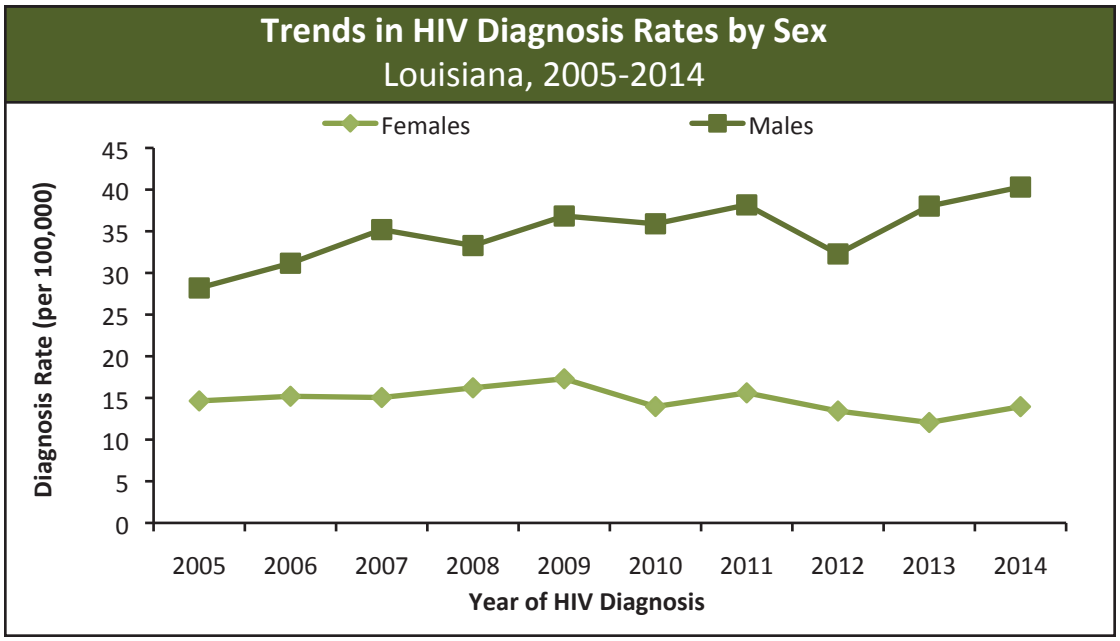
The number of new HIV diagnoses in a given year has historically served as a measure of new infections (incidence). However, since individuals can be infected with HIV for varying periods of time before they are diagnosed, counting new HIV diagnoses is not an accurate representation of new infections in a given year. Louisiana is one of 25 selected states and jurisdictions that have been participating in a CDC initiative to develop a national system to measure recent HIV infections (HIV incidence) as described in the Louisiana *2011 STD/HIV Program Report*.



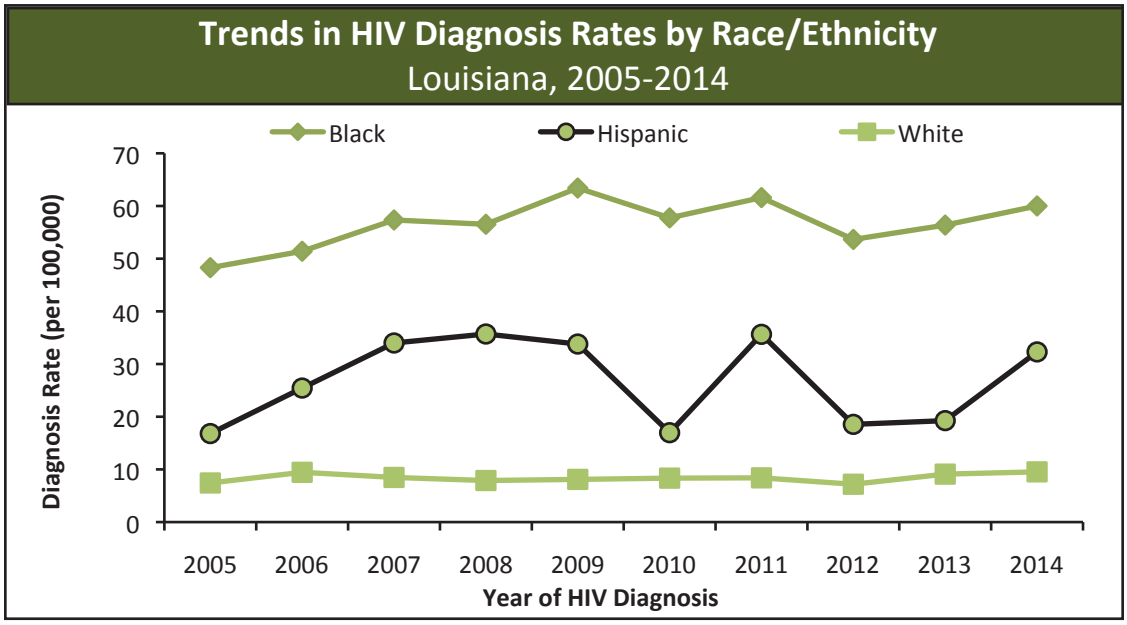
- In 2014, 1,235 individuals were newly diagnosed with HIV infection in Louisiana. Over the past 10 years, the number of new HIV diagnoses has fluctuated from a low of 972 diagnoses in 2005 to a high of 1,235 diagnoses in 2014. In 2005 and 2006, there was a large disruption to HIV testing services due to Hurricane Katrina.
- Over the past 10 years, the HIV diagnosis rate ranged from a low of 21.2 per 100,000 in 2005 to a high of 26.9 per 100,000 in 2009, followed closely by 26.8 per 100,000 in 2014.

HIV Diagnoses by Sex, Race/Ethnicity, and Age

Although the HIV epidemic affects persons of all genders, ages and race/ethnicities in Louisiana, the impact is not the same across all populations. Identifying the populations most at risk for HIV infection helps in planning HIV prevention activities and services, and in determining the most effective use of limited resources. To get a better understanding as to how some groups are more severely impacted by the HIV epidemic, please read the introductory chapter of this surveillance report.

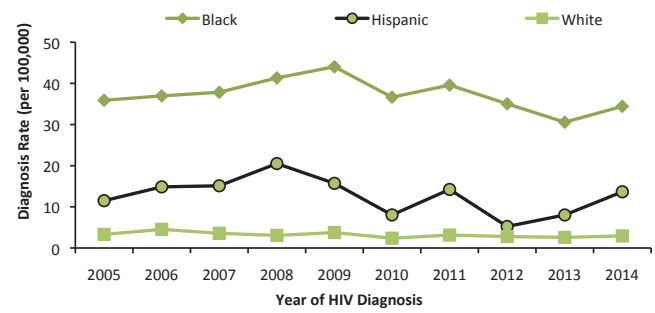


- The HIV diagnosis rate for females in Louisiana has remained relatively stable over the past 10 years. In 2014, the female HIV diagnosis rate increased slightly from 2013 to 13.9 per 100,000 females.
- The rate for men has been more variable (between 28.2 and 40.1 per 100,000 males). The male HIV rate in 2014 was 40.1 per 100,000 males which was a sharp increase from previous years. The HIV diagnosis rate for males was almost three times greater than females in 2014. Cumulatively, males have accounted for 69% of all new HIV diagnoses in Louisiana over the past 10 years.

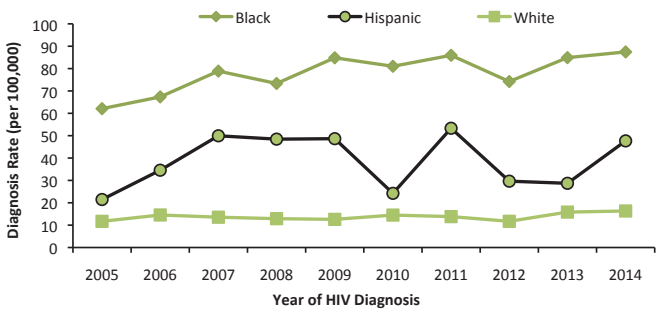


- The HIV diagnosis rate among whites has remained stable over the past 10 years, with a diagnosis rate of 9.5 per 100,000 whites in 2014. The rate for blacks has been more variable and has increased from a low of 48.3 per 100,000 blacks in 2005 to a high of 63.4 per 100,000 blacks in 2009. The 2014 diagnosis rate was 60.0 per 100,000 blacks.
- In 2014, the HIV diagnosis rate for blacks was over six times greater than the rate for whites and almost two times the rate for Hispanic/Latinos (32.3 per 100,000 Hispanic/Latinos). The HIV diagnosis rate for Hispanic/Latinos was more than three times greater than for whites; among the 1,235 newly diagnosed persons in 2014, 68 were Hispanic/Latino.

Trends in HIV Diagnosis Rates Among Females by Race/Ethnicity
Louisiana, 2005-2014

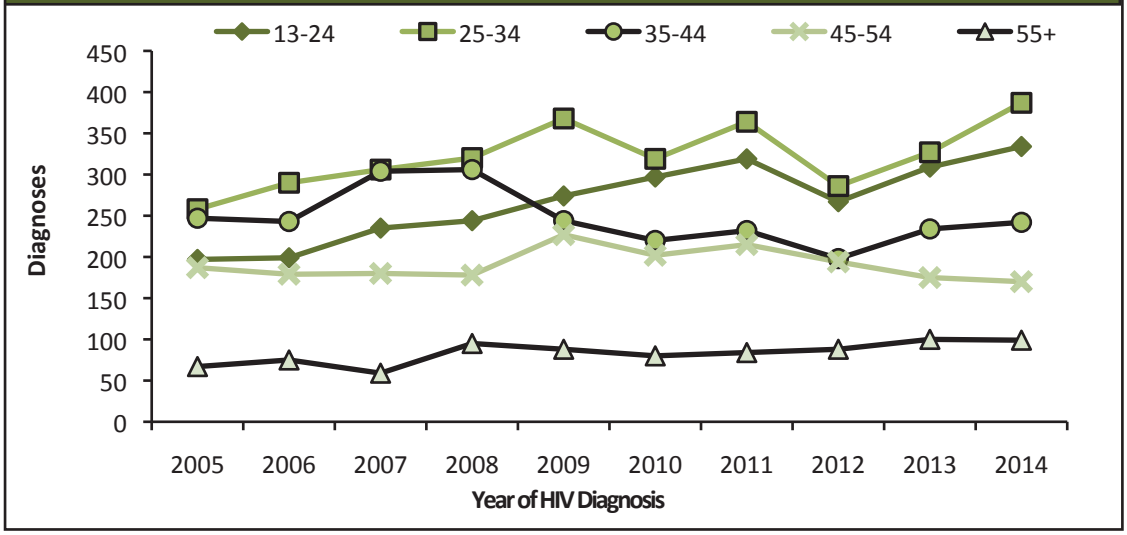


Trends in HIV Diagnosis Rates Among Males by Race/Ethnicity
Louisiana, 2005-2014



- Black females and males in Louisiana account for the overwhelming majority of new HIV diagnoses each year. Blacks make up only 32% of Louisiana's population which when taken into account creates exceptionally high diagnosis rates. The HIV diagnosis rates for Hispanic/Latino females and males are higher than for white females and males, although the diagnosis counts are higher among whites.
- In 2014, the HIV diagnosis rate in black females was almost 12 times greater than the rate for white females and was more than two times the rate for Hispanic/Latina females.
- In 2014, the HIV diagnosis rate among black males reached a peak of 87.5 per 100,000 black males. In 2014, the HIV diagnosis rate in black males was more than five times greater than the rate for white males, and was almost double the rate for Hispanic/Latino males.

Trends in New HIV Diagnoses by Age Group
Louisiana, 2005-2014

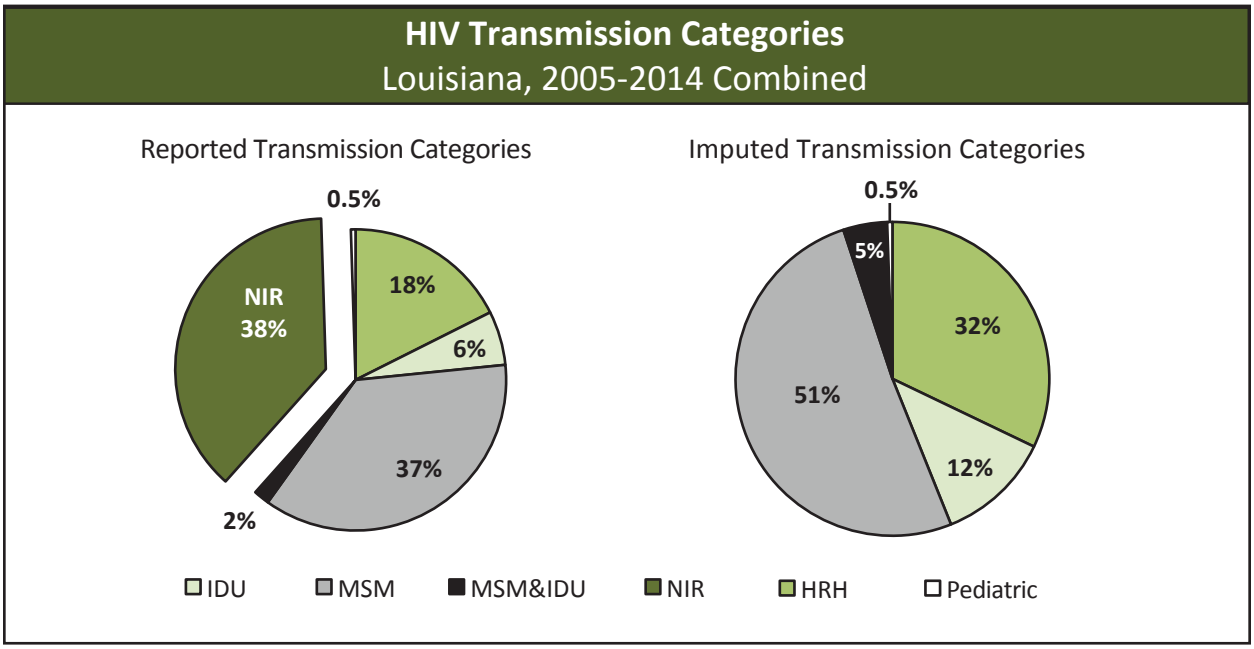


- The number of new diagnoses among youth, age 13-24 years, is of special interest in Louisiana and across the nation. In 2009, the number of new diagnoses among 13-24 year olds surpassed the number of new diagnoses among 35-44 year olds to become the second largest age group for new diagnoses. In 2014, new diagnoses in youth accounted for 27% of new diagnoses, compared to 20% of new diagnoses in 2005 and 2006.
- The 25-34 year age group has the highest number of new diagnoses (31% of all new HIV diagnoses in 2014). The number of new diagnoses in persons aged 35-44 accounted for an additional 20% of all new diagnoses in 2014.

HIV Diagnoses by Transmission Category

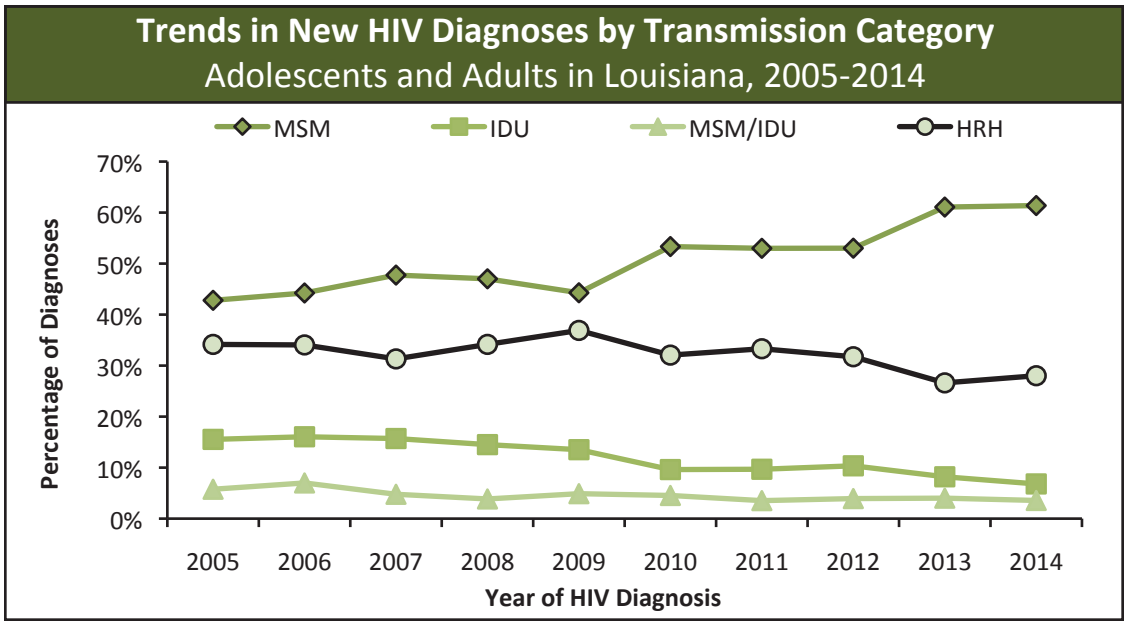
In accordance with the transmission categories used by the CDC, SHP classifies cases into six transmission categories: men who have sex with men (MSM), high risk heterosexual contact (HRH), injection drug use (IDU), men who have sex with men and inject drugs (MSM/IDU), mother-to-child transmission (Pediatric), and cases who received a transfusion or hemophiliac products (Transfusion/Hemophilia). As illustrated in the graph below, many cases do not have risk information reported or do not meet the transmission category criteria and are labeled as no identified risk (NIR). For all persons diagnosed between 2005 and 2014, 38% still do not have a reported risk.

Risk information is difficult to ascertain because individuals may not know how they acquired the infection, their healthcare provider may not feel comfortable collecting the information, or the person may not be willing to share that information possibly due to stigma or fear of discrimination. A person who reports only heterosexual contact is not classified with a transmission category because according to the CDC "persons whose transmission category is classified as high risk heterosexual contact are persons who report specific heterosexual contact with a person known to have, or to be at high risk for, HIV infection (e.g., an injection drug user)." Due to the large number of NIR cases, SHP uses a statistical method to assign a mode of transmission for NIR cases called "imputation" (described in the Technical Notes located in the Appendix of this report).

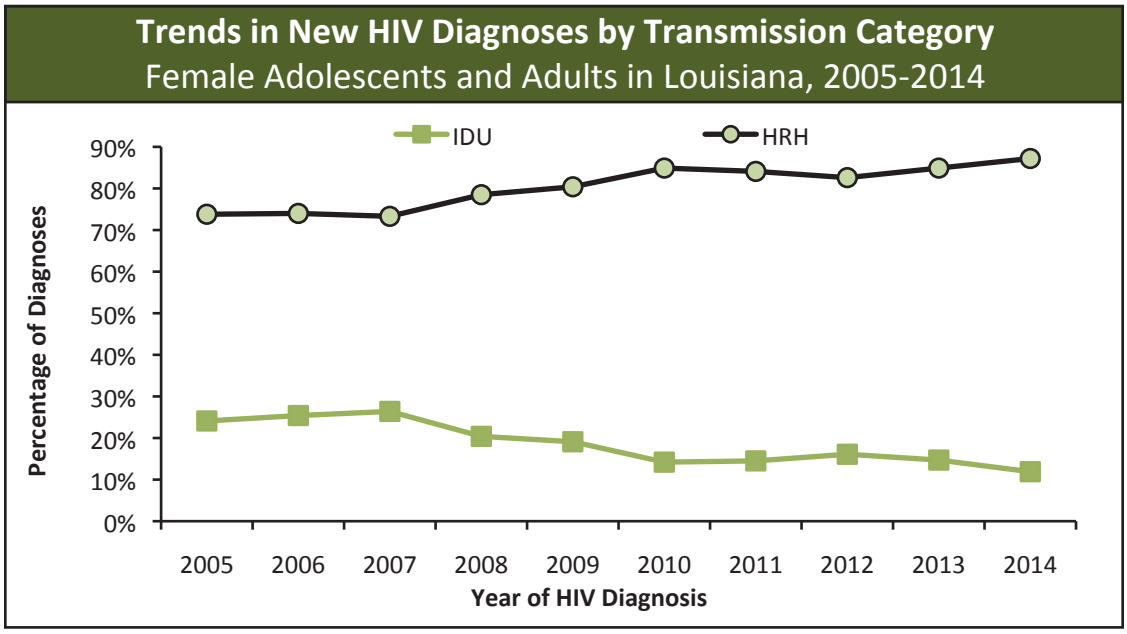


- Of the new diagnoses from 2005 to 2014, 38% do not have a recorded transmission category.
- A risk category is imputed for all cases without a recorded risk; 51% of all cases over the past 10 years were MSM, 32% were HRH, 12% were IDU, 5% were MSM/IDU and 0.5% were perinatally infected.

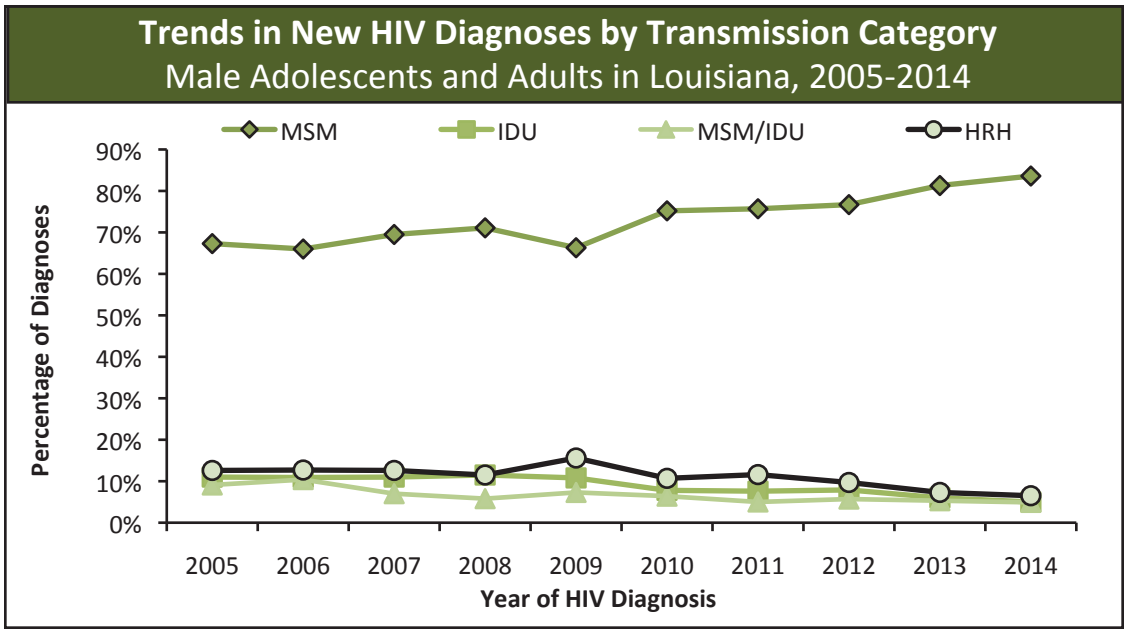
After assigning a transmission category for all NIR cases through imputation, trends in the percentage of cases for each transmission category can be analyzed. The following graphs use imputed transmission categories unless otherwise noted.



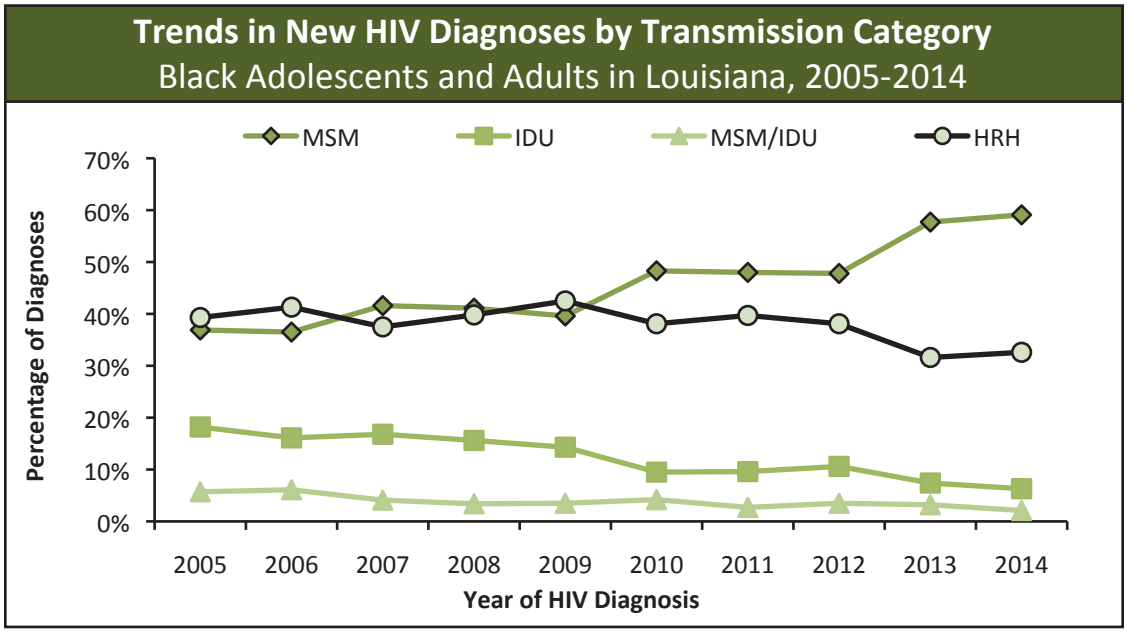
- The percentage of adult HIV diagnoses attributed to MSM has increased significantly from a low of 43% in 2005 to a high of 61% in 2014. The percentage of HRH diagnoses has decreased slightly, from a high of 37% in 2009 to a low of 28% in 2014. The percentage of diagnoses attributed to IDU and MSM/IDU has declined over the past 10 years from 16% IDU and 6% MSM/IDU in 2005 to 7% and 4% respectively in 2014.



- The primary mode of transmission for women is HRH contact.
- Although there has always been a significant difference in the percentage of female diagnoses attributed to HRH and IDU, the difference was greatest in 2014 when 88% of females were high risk heterosexuals and 12% of females were injection drug users.

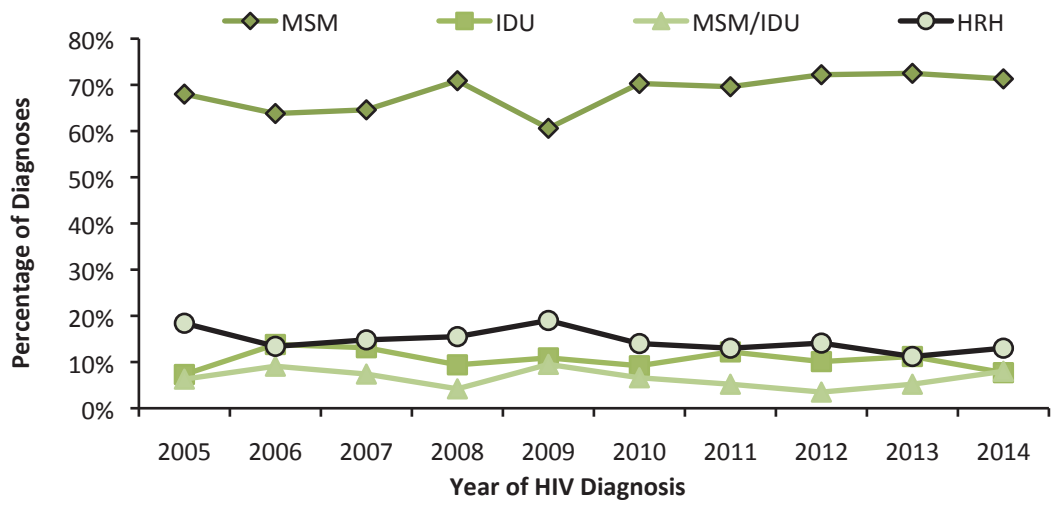


- The primary mode of transmission for males in Louisiana continues to be MSM, with far fewer reports of IDU, MSM/IDU and HRH. In 2014, the percentage of male diagnoses that were MSM was 84%, compared to ten years ago when MSM accounted for only 67% of all newly diagnosed males. The percentage of HRH diagnoses among men has remained low with the lowest proportion of 7% in 2014.
- The percentage of new male diagnoses with a transmission category of IDU and MSM/IDU has declined since 2005. In 2014, IDU accounted for 5% and MSM/IDU accounted for an additional 5% of new diagnoses, compared to 11% and 9% in 2005.



- Historically, the primary mode of transmission for blacks was HRH contact followed closely by MSM. In 2008, the percentage of new diagnoses of MSM in blacks surpassed the percentage of diagnoses attributable to HRH.
- In 2014, 59% of all new HIV diagnoses among blacks were MSM and 33% were HRH; 2013 marked a large increase among MSM which continued in 2014.
- From 2005 to 2014, the percentage of HIV diagnoses resulting from IDU and MSM/IDU among blacks has declined significantly from 18% to 6% for IDU and 6% to 2% for MSM/IDU.

Trends in New HIV Diagnoses by Transmission Category
White Adolescents and Adults in Louisiana, 2005-2014



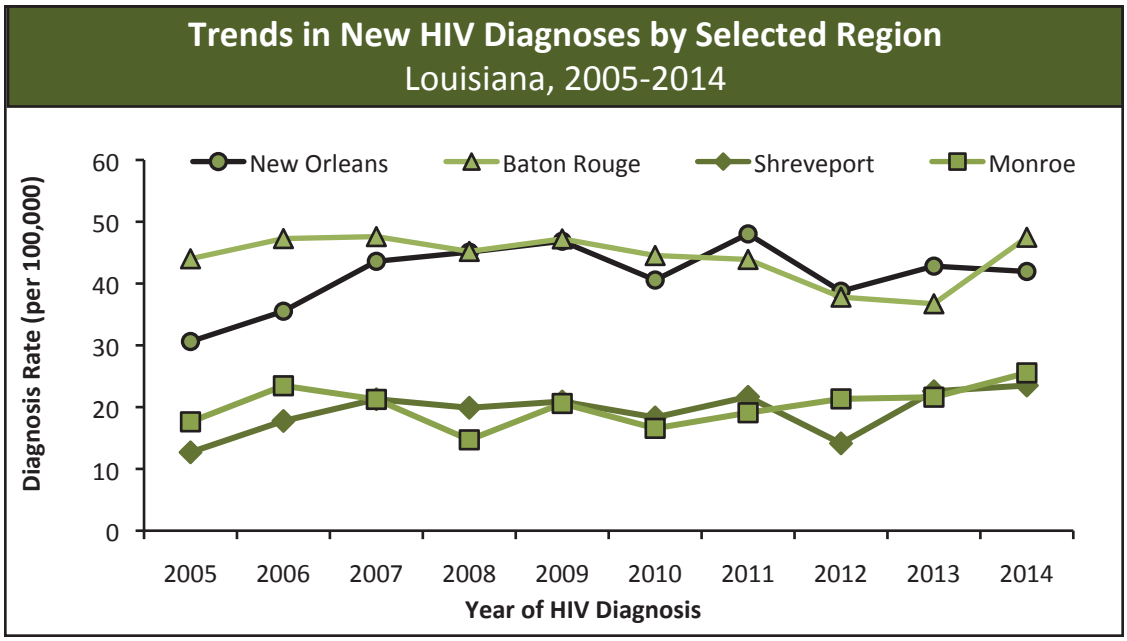
- The predominant mode of transmission among whites has historically been and continues to be MSM. In 2014, 71% of newly diagnosed cases among whites were attributed to MSM.
- In 2014, 13% of diagnoses were attributed to HRH, 8% to IDU and 8% to MSM/IDU.

HIV Diagnoses by Public Health Region

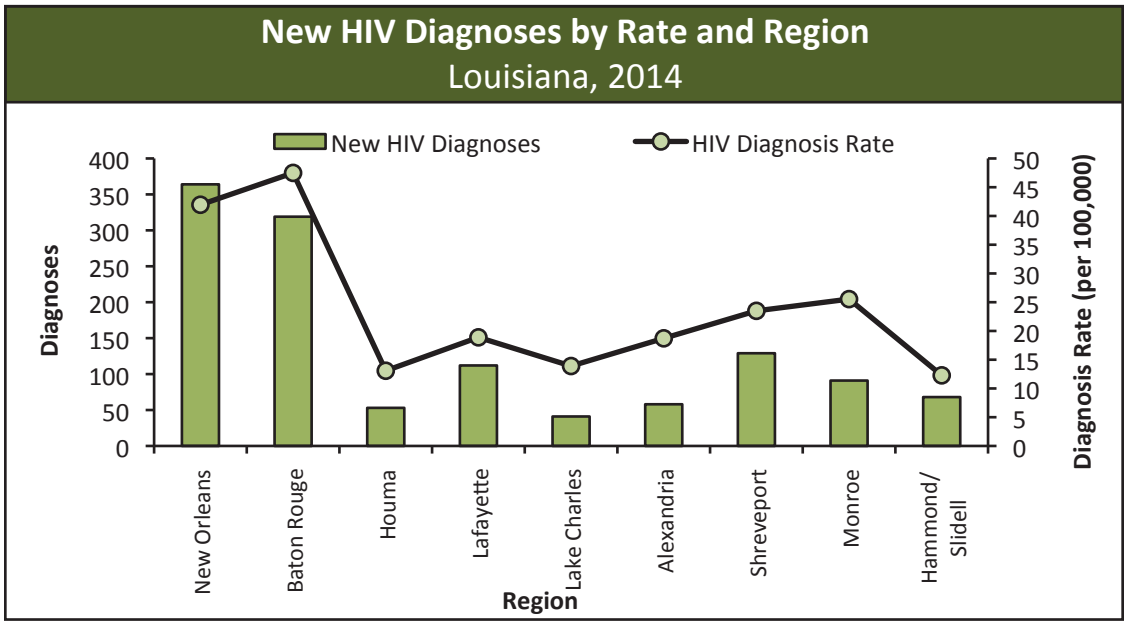
New HIV Diagnoses by Region and Year
Louisiana, 2010-2014

	2010		2011		2012		2013		2014	
Louisiana	**1,123**	**%**	**1,219**	**%**	**1,043**	**%**	**1,146**	**%**	**1,235**	**%**
1-New Orleans	341	30%	412	34%	337	32%	377	33%	364	29%
2-Baton Rouge	296	26%	293	24%	254	24%	248	22%	319	26%
3-Houma	57	5%	56	5%	53	5%	58	5%	53	4%
4-Lafayette	89	8%	89	7%	81	8%	94	8%	112	9%
5-Lake Charles	48	4%	50	4%	38	4%	37	3%	41	3%
6-Alexandria	61	5%	64	5%	57	5%	65	6%	58	5%
7-Shreveport	100	9%	119	10%	78	7%	124	11%	129	10%
8-Monroe	59	5%	68	6%	76	7%	77	7%	91	7%
9-Hammond/Slidell	72	6%	68	6%	69	7%	66	6%	68	6%

- The majority of new HIV diagnoses occur in the New Orleans and Baton Rouge regions each year. In 2014, the Shreveport region has the third highest number of new diagnoses followed by Lafayette and Monroe. From 2013 to 2014, the proportion in Baton Rouge increased from 22% to 26%, and the proportion in New Orleans decreased from 33% to 29%.



- The four public health regions in Louisiana with the highest HIV diagnosis rates in 2014 were New Orleans, Baton Rouge, Shreveport, and Monroe (regions 1, 2, 7, and 8 respectively).
- Over the past 10 years, the New Orleans and Baton Rouge regions have had the highest rates in the state. From 2005-2010, the HIV diagnosis rate in Baton Rouge was greater than the rate in New Orleans, largely due to the impact of Hurricane Katrina in August 2005. From 2011 to 2013, the New Orleans region had the highest HIV diagnosis rate in the state but in 2014, the diagnosis rate of 47.5 per 100,000 in Baton Rouge surpassed the rate of 42.0 per 100,000 in New Orleans. The Shreveport region had the third highest rate from 2008 to 2011, but in 2014, it had the fourth highest rate (23.5 per 100,000). In 2014, the Monroe region regained the third highest diagnosis rate (25.5 per 100,000). *A table with the number of HIV diagnoses for each region, 2005-2014, is located in the Appendix.*



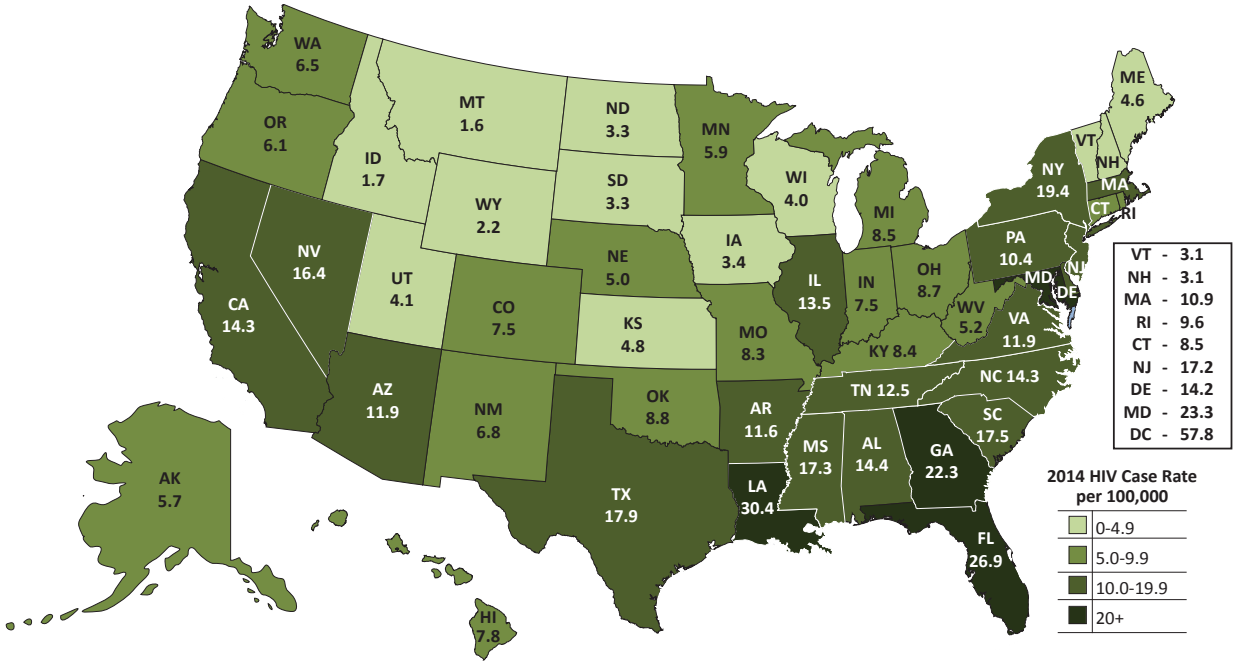
- In 2014, New Orleans had the highest number of new HIV diagnoses and the second highest HIV diagnosis rate. The Baton Rouge region had the second highest number of new diagnoses and the highest diagnosis rate.
- The Lake Charles region had the lowest number of new HIV diagnoses, and the Hammond/Slidell region had the lowest HIV diagnosis rate.

Characteristics of Persons Newly Diagnosed with HIV

Characteristics of Persons Newly Diagnosed with HIV Louisiana, 2013-2014				
	Persons First Diagnosed with HIV in 2013		Persons First Diagnosed with HIV in 2014	
	Diagnoses	Percent	Diagnoses	Percent
TOTAL	**1,146**	**100.0%**	**1,235**	**100.0%**
Sex				
Female	285	24.9%	328	26.6%
Male	861	75.1%	907	73.4%
Race/Ethnicity				
Black/African American	836	72.9%	881	71.3%
Hispanic/Latino	42	3.7%	68	5.5%
White	251	21.9%	262	21.2%
Other/Unknown/Multi-race	17	1.5%	24	1.9%
Age Group	**Age at HIV Diagnosis**		**Age at HIV Diagnosis**	
0-12	1	0.1%	3	0.2%
13-19	65	5.7%	76	6.2%
20-24	244	21.3%	258	20.9%
25-34	327	28.5%	387	31.3%
35-44	234	20.4%	242	19.6%
45-54	175	15.3%	170	13.8%
55-64	87	7.6%	84	6.8%
65+	13	1.1%	15	1.2%
Transmission Category				
Men who have sex with men (MSM)	700	61.1%	758	61.4%
Injection Drug User (IDU)	94	8.2%	84	6.8%
MSM/IDU	46	4.0%	44	3.6%
High Risk Heterosexual (HRH)	305	26.6%	346	28.0%
Transfusion/Hemophilia/Other	0	0.0%	0	0.0%
Perinatal/Pediatric	1	0.1%	3	0.2%
Rural/Urban				
Rural	180	15.7%	194	16.1%
Urban	966	84.3%	1,041	83.9%

- In 2014, 1,235 persons were newly diagnosed with HIV, an 8% increase from 2013.
- In 2014, 27% of all HIV diagnoses were female and 73% were male.
- Approximately 71% of all HIV diagnoses in 2014 were among blacks even though blacks make up only 32% of Louisiana's population, representing a large racial disparity among new HIV diagnoses.
- In 2013 and 2014, the greatest number and proportion of diagnoses were among persons age 25-34 years.
- From 2013 to 2014, the proportion of diagnoses among the different transmission categories remained relatively unchanged.
- In Louisiana, most new diagnoses in 2014 (84%) were among persons residing in an urban area. An urban area is defined as a parish that belongs to a metropolitan statistical area (MSA).

HIV Rates in the United States (2014)[8]



- In November 2015, the CDC released their *HIV Surveillance Report, 2014; vol. 26,* which provides national and statewide HIV and AIDS data.[8]
- In the US, there were an estimated 44,073 new HIV diagnoses in 2014, for a national HIV diagnosis rate of 13.8 diagnoses per 100,000 population. In 2013, the national HIV diagnosis rate was 15.0 per 100,000 population.[8]
- In 2014, Louisiana ranked 2nd highest in state estimated HIV diagnosis rates (30.4 per 100,000 population) in the US, behind the District of Columbia (57.8 per 100,000). In 2013, Louisiana ranked 3rd highest in state estimated HIV diagnosis rates (30.3 per 100,000 population).[8]
- In 2014, Louisiana ranked 9th in the nation for the number of new HIV diagnoses.[8]

HIV Among Men Who Have Sex with Men (MSM)

Nationally, MSM account for almost half of the one million people living with HIV and two-thirds of all new HIV infections in the US each year. In 2014, MSM accounted for 67% of all new HIV diagnoses across the nation.[8]

SHP has made a concerted effort to analyze the epidemic among MSM to adequately target prevention efforts. The following table shows the demographics of all new HIV diagnoses in 2014 among MSM who may or may not be injection drug users.

- In 2014, there were 1,235 new HIV diagnoses in Louisiana; 65% (802) were among all MSM (IDU and non-IDU).
- The majority of the new diagnoses among MSM in Louisiana are black and under the age of 35.
- 57% of all new diagnoses among MSM occurred in the New Orleans and Baton Rouge regions.
- Persons who identify as MSM/IDU tend to be older than persons who identify as MSM/non-IDU.
- The percentage of late testers who are MSM is similar to that of the overall population of new diagnoses.

* For more information about the HIV/AIDS disparities in Louisiana in relation to the MSM population, please refer to the introduction of this surveillance report.

Demographics of New HIV Diagnoses Among MSM
Louisiana, 2014

	MSM/Non-IDU		MSM/IDU		All MSM*	
	Cases	Percent	Cases	Percent	Cases	Percent
TOTAL	**758**	**100%**	**44**	**100%**	**802**	**100%**
Race/Ethnicity						
Black/African American	519	68.5%	18	40.9%	537	67.0%
Hispanic/Latino	42	5.5%	3	6.8%	45	5.6%
White	186	24.5%	21	47.7%	207	25.8%
Other/Unknown/Multi-race	11	1.5%	2	4.5%	13	1.6%
Age at HIV Diagnosis						
13-24	277	36.5%	2	4.5%	279	34.8%
25-34	236	31.1%	20	45.5%	256	31.9%
35-44	124	16.4%	15	34.1%	139	17.3%
45-54	79	10.4%	3	6.8%	82	10.2%
55-64	33	4.4%	3	6.8%	36	4.5%
65+	9	1.2%	1	2.3%	10	1.2%
Region						
1-New Orleans	252	33.2%	12	27.3%	264	32.9%
2-Baton Rouge	174	23.0%	15	34.1%	189	23.6%
3-Houma	33	4.4%	0	0.0%	33	4.1%
4-Lafayette	70	9.2%	3	6.8%	73	9.1%
5-Lake Charles	21	2.8%	3	6.8%	24	3.0%
6-Alexandria	35	4.6%	1	2.3%	36	4.5%
7-Shreveport	78	10.3%	6	13.6%	84	10.5%
8-Monroe	51	6.7%	2	4.5%	53	6.6%
9-Hammond/Slidell	44	5.8%	2	4.5%	46	5.7%
Late Testers						
AIDS at Time of HIV Diagnosis	148	19.5%	5	11.4%	153	19.1%
AIDS Within 3 Months of HIV Diagnosis	164	21.6%	5	11.4%	169	21.1%
AIDS Within 6 Months of HIV Diagnosis	177	23.4%	6	13.6%	183	22.8%
AIDS Within 12 Months of HIV Diagnosis	185	24.4%	7	15.9%	192	23.9%

*All MSM is a cumulative total of MSM/Non-IDU (758) and MSM/IDU (44). Male is defined by birth sex of male.

HIV Among Youth in Louisiana

In 2014, persons age 13-24 made up 22% of all new HIV diagnoses in the United States.[8]
In 2015, the CDC released a supplemental report with 2013 data that focused on metropolitan areas across the nation. In 2013, the Baton Rouge MSA ranked 1st in the nation for HIV case rates among 13-24 year old females and 7th among 13-24 year old males. The New Orleans MSA ranked 3rd in the nation among 13-24 year old females and 1st in the nation for 13-24 year old males.*

- In 2014, there were 1,235 new HIV diagnoses in Louisiana; 27% (334) were among youth 13-24 years old.
  - 258 (77%) of the youth diagnoses were among persons age 20-24 years.
- Among all youth, 84% of the new diagnoses were male. This percentage was slightly lower for 13-19 year olds where 82% of the diagnoses were male.
- The majority (81%) of the new diagnoses among youth were black. The proportion was higher among 13-19 year olds (86%) than it was among 20-24 year olds (80%).
- The majority (83%) of new diagnoses among youth were MSM.
- Among all youth diagnosed in Louisiana, 55% of all new diagnoses occurred in the New Orleans and Baton Rouge regions.
- The percentage of late testers among youth is much lower than the overall population of new diagnoses.

Demographics of New HIV Diagnoses Among Youth
Louisiana, 2014

	13-19 Years		20-24 Years		All Youth: 13-24 Years	
	Cases	Percent	Cases	Percent	Cases	Percent
TOTAL	**76**	**100%**	**258**	**100%**	**334**	**100%**
Sex at Birth						
Female	14	18%	38	15%	52	16%
Male	62	82%	220	85%	282	84%
Race/Ethnicity						
Black/African American	65	86%	206	80%	271	81%
Hispanic/Latino	2	3%	9	3%	11	3%
White	8	11%	40	16%	48	14%
Other/Unknown/Multi-race	1	1%	3	1%	4	1%
Imputed Transmission Category						
Men Who Have Sex With Men (MSM)	62	82%	215	83%	277	83%
Injection Drug User (IDU)	1	1%	7	3%	8	2%
MSM/IDU	0	0%	2	1%	2	1%
High Risk Heterosexual (HRH)	13	17%	34	13%	47	14%
Region						
1-New Orleans	18	24%	84	33%	102	31%
2-Baton Rouge	17	22%	62	24%	79	24%
3-Houma	6	8%	13	5%	19	6%
4-Lafayette	8	11%	24	9%	32	10%
5-Lake Charles	0	0%	7	3%	7	2%
6-Alexandria	3	4%	8	3%	11	3%
7-Shreveport	10	13%	32	12%	42	13%
8-Monroe	8	11%	19	7%	27	8%
9-Hammond/Slidell	6	8%	9	3%	15	4%
Late Testers						
AIDS at Time of HIV Diagnosis	3	4%	16	6%	19	6%
AIDS Within 3 Months of HIV Diagnosis	3	4%	22	9%	25	7%
AIDS Within 6 Months of HIV Diagnosis	3	4%	26	10%	29	9%
AIDS Within 12 Months of HIV Diagnosis	4	5%	27	10%	31	9%

* Centers for Disease Control and Prevention. Diagnosed HIV infection among adults and adolescents in metropolitan statistical areas—United States and Puerto Rico, 2013. *HIV Surveillance Supplemental Report* 2015;20 (No. 4).

HIV Among African Americans in Louisiana

In 2014, African Americans made up 44% of all new HIV diagnoses across the United States.[8]

- In 2014, there were 1,235 new HIV diagnoses in Louisiana; 71% (881) were among African Americans.
- In 2014, 70% of the new diagnoses among blacks were male.
- Youth, age 13-24, made up 31% of all diagnoses among African Americans. This age group had the greatest proportion of new diagnoses. An additional 30% of all diagnoses among blacks were 25-34 years old.
- The majority (59%) of new diagnoses among African Americans were MSM.
- More than half (59%) of all new diagnoses among African Americans occurred in the New Orleans and Baton Rouge regions.
- The percentage of late testers among African Americans is the same as the overall population of new diagnoses.

* For more information about the HIV/AIDS disparities in Louisiana in relation to the black population, please refer to the introduction of this surveillance report.

Demographics of New HIV Diagnoses Among African Americans
Louisiana, 2014

	All African Americans	
	Cases	Percent
TOTAL	**881**	**100.0%**
Sex at Birth		
Female	267	30.3%
Male	614	69.7%
Age at HIV Diagnosis		
0-12	2	0.2%
13-24	271	30.8%
25-34	268	30.4%
35-44	160	18.2%
45-54	104	11.8%
55-64	64	7.3%
65+	12	1.4%
Imputed Transmission Category		
Men Who Have Sex With Men (MSM)	519	58.9%
Injection Drug User (IDU)	55	6.2%
MSM/IDU	18	2.0%
High Risk Heterosexual (HRH)	287	32.6%
Perinatal*	2	0.2%
Region		
1-New Orleans	242	27.5%
2-Baton Rouge	274	31.1%
3-Houma	27	3.1%
4-Lafayette	76	8.6%
5-Lake Charles	15	1.7%
6-Alexandria	28	3.2%
7-Shreveport	102	11.6%
8-Monroe	74	8.4%
9-Hammond/Slidell	43	4.9%
Late Testers		
AIDS at Time of HIV Diagnosis	175	19.9%
AIDS Within 3 Months of HIV Diagnosis	202	22.9%
AIDS Within 6 Months of HIV Diagnosis	221	25.1%
AIDS Within 12 Months of HIV Diagnosis	231	26.2%

*Perinatal transmission is not imputed.

HIV Among Transgender Persons in Louisiana

Since data for transgender people is not collected uniformly, overall new infections in the United States is not available. According to the Center of Excellence for Transgender Health, there are numerous social and contextual issues that impact the ascertainment of risk behaviors reported among transgender people, including stigma, discrimination, alienation, poverty, and victimization. (http://transhealth.ucsf.edu/)

- In 2014, there were 1,235 new HIV diagnoses in Louisiana; 11 diagnoses were reported as transgender women.
- As of December 31, 2014, there were 19,612 persons living with HIV infection, 163 persons were transgender. Of the 163 transgender people living with HIV infection in Louisiana, 99% (162) were transgender women.
- 100% of the new 2014 diagnoses among transgender people and 80% of transgender persons living with HIV infection at the end of 2014, were African American.
- In 2014, almost 100% of the diagnoses among transgender people were among persons age 20-34 years.
- Of the transgender persons living with HIV in Louisiana, almost half (47%) were 25-34 year olds.
- The majority (73%) of new diagnoses among transgender individuals' reported engaging in sex with men; 9% of transgender people reported engaging in sex with men and injection drug use, and 18% did not report a risk.
- In 2014, 83% of transgender persons living with HIV infection reported having sex with men and 12% reported having sex with men and also injection drug use; 5% did not report risk.
- The majority of new diagnoses among transgender people occurred in Baton Rouge region (46%), while the New Orleans region had 27%.
- More than half (53%) of transgender persons living with HIV infection reside in New Orleans and 23% reside in Baton Rouge.

* For more information about the HIV/AIDS disparities in Louisiana in relation to the transgender population, please refer to the introduction of this surveillance report.

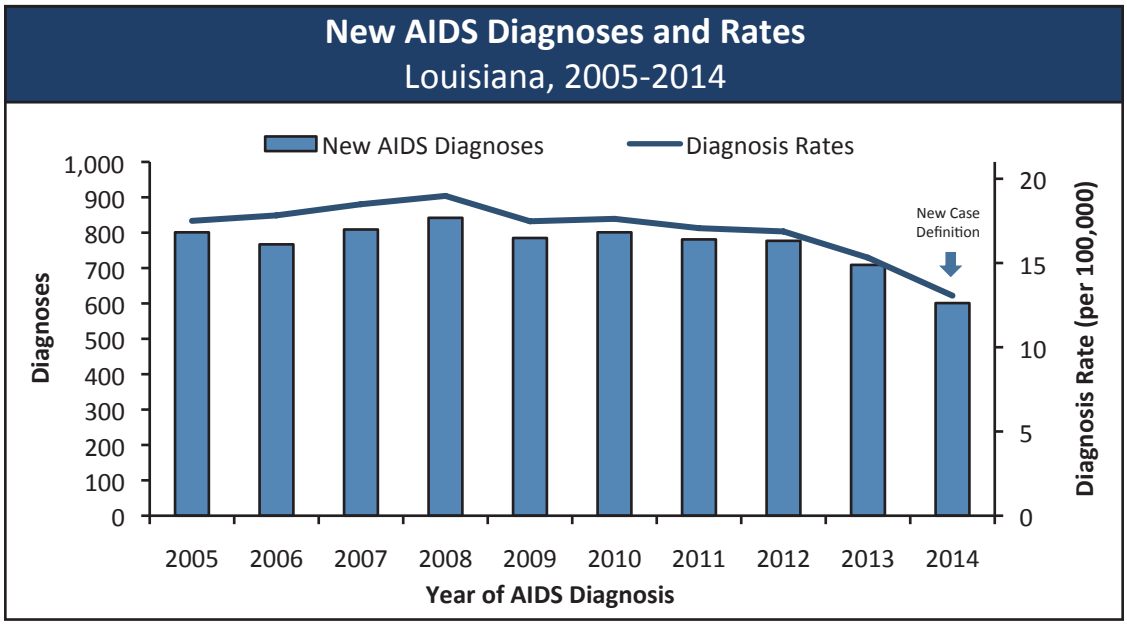
Demographics of New HIV Diagnoses and Persons Living with HIV Infection Among Transgender Persons
Louisiana, 2014

	Number of New Diagnoses	Percent	Persons Living with HIV Infection	Percent
TOTAL	**11***	**100.0%**	**163***	**100.0%**
Transgender Women	11	100.0%	162	99.4%
Transgender Men	0	0.0%	1	0.6%
Race/Ethnicity				
Black/African American	11	100.0%	131	80.4%
Hispanic/Latino	0	0.0%	9	5.5%
White	0	0.0%	21	12.9%
Multi/Unknown/Other	0	0.0%	2	1.2%
Age at HIV Diagnosis				
20-24	5	45.5%	18	11.0%
25-34	5	45.5%	76	46.6%
35-44	1	9.1%	40	24.5%
45-54	0	0.0%	21	12.9%
55-64	0	0.0%	8	4.9%
Transmission Category				
Sex with Men	8	72.7%	136	83.4%
Sex with Men & Injection Drug User	1	9.1%	19	11.7%
No Risk Indicated	2	18.2%	8	4.9%
Late Testers				
1 - New Orleans	3	27.3%	86	52.8%
2 - Baton Rouge	5	45.5%	37	22.7%
3 - Houma	0	0.0%	6	3.7%
4 - Lafayette	0	0.0%	6	3.7%
5 - Lake Charles	0	0.0%	5	3.1%
6 - Alexandria	0	0.0%	4	2.5%
7 - Shreveport	2	18.2%	8	4.9%
8 - Monroe	1	9.1%	4	2.5%
9 - Hammond/Slidell	0	0.0%	7	4.3%

*These individuals are included by their birth sex throughout the report. Please review the technical notes at the conclusion of this report for a full explanation of transmission risk categorization.

10-Year Trends in New AIDS Diagnoses (2005-2014)

AIDS diagnoses are the number of individuals diagnosed with AIDS within a given time period. The surveillance case definition for an AIDS diagnosis is a CD4 cell count <200 or the diagnosis of an opportunistic infection (OI) such as Kaposi Sarcoma or wasting syndrome. Once a person is diagnosed with AIDS, they remain categorized as AIDS even if their CD4 count rises above 200 or they are cured of their OI. The number of AIDS diagnoses has been collected since the beginning of the epidemic, both nationally and in Louisiana. AIDS diagnoses are useful for highlighting issues regarding access to testing, medical care, medication and treatment adherence. *In 2014, the AIDS surveillance case definition was altered to no longer define an AIDS case based on CD4 percentage. This change in case definition only impacts AIDS cases diagnosed after 2013 and makes 2014 data difficult to compare to prior years*.

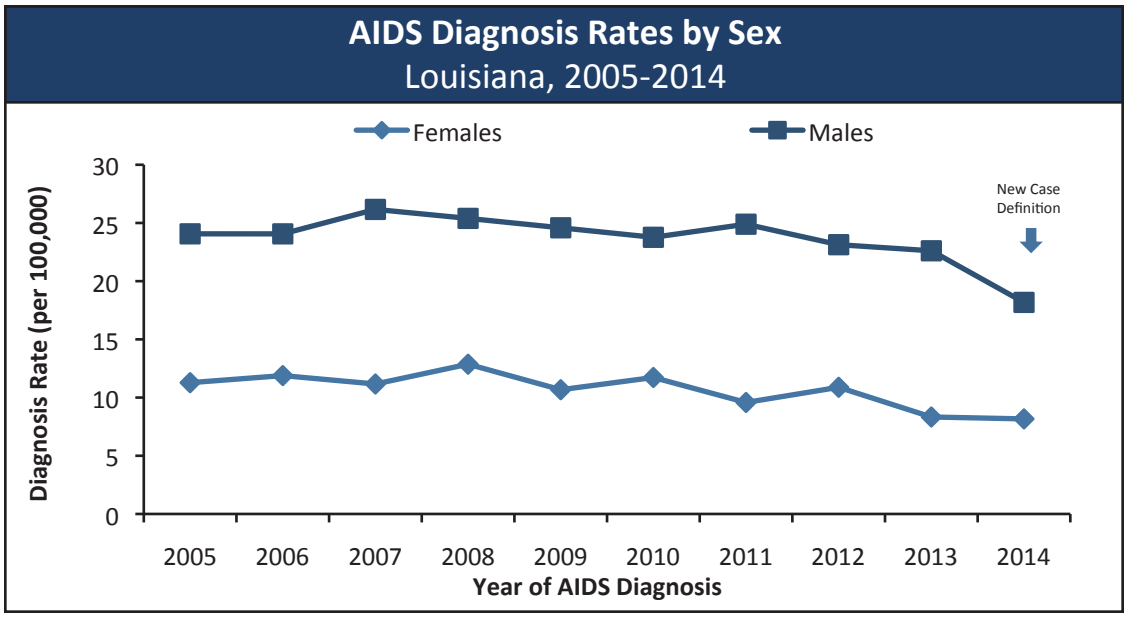


- Since 1997, the number of new AIDS diagnoses each year in Louisiana has remained below 1,000. Over the past 10 years, the number of new AIDS diagnoses has fluctuated from a high of 842 diagnoses in 2008 to a low of 601 AIDS diagnoses in 2014. The steep decrease between 2013 and 2014 was due to the new AIDS surveillance case definition.
- The AIDS diagnosis rate fluctuates slightly each year in accordance with the change in the number of AIDS diagnoses. In 2014, the AIDS diagnosis rate for Louisiana was 13.1 per 100,000 population which was twice as high as the national AIDS diagnosis rate of 6.6 per 100,000.[8]

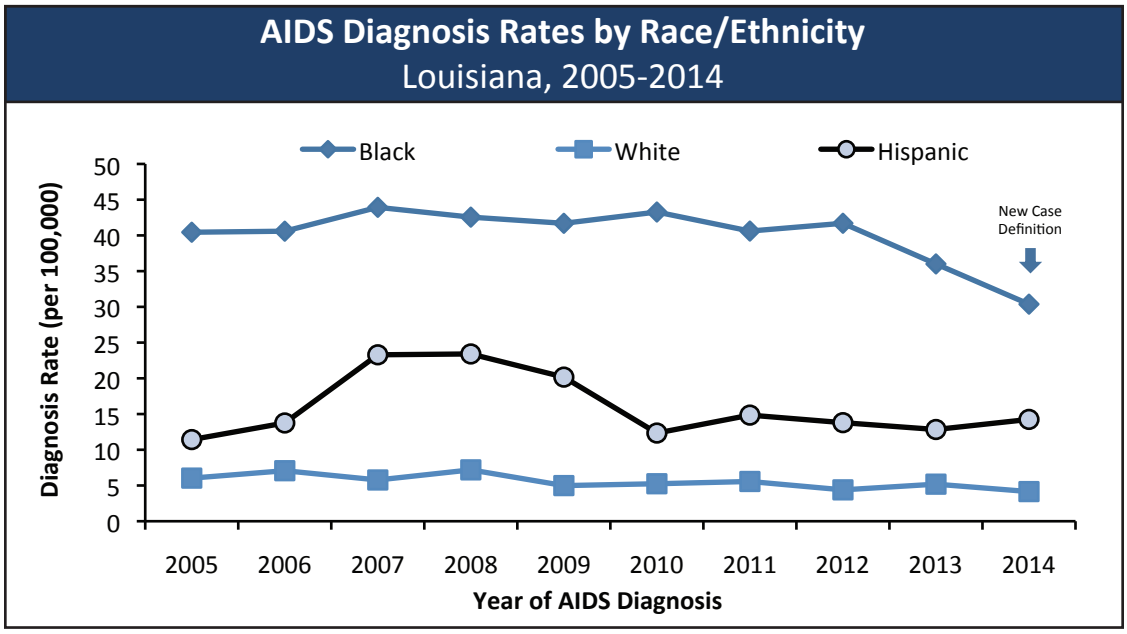
AIDS diagnoses and deaths in the United States

In June 1981, the first cases of what would later be diagnosed as AIDS were reported in the US. During the 1980s, there was a rapid increase in the number of AIDS diagnoses and deaths in persons with AIDS. Cases peaked in 1993 with the expansion of the AIDS case definition. The most dramatic drop in both new diagnoses and deaths began in 1996, with the widespread use of combination antiretroviral therapy. Since 2000, the annual numbers of AIDS diagnoses have been relatively constant, with an estimated 20,896 new AIDS diagnoses in 2014. The CDC estimates that since the beginning of the epidemic through the end of 2014, approximately 1,210,835 people have been diagnosed with AIDS in the US. By region, the South has the greatest number of people living with AIDS, AIDS deaths, and new AIDS diagnoses.

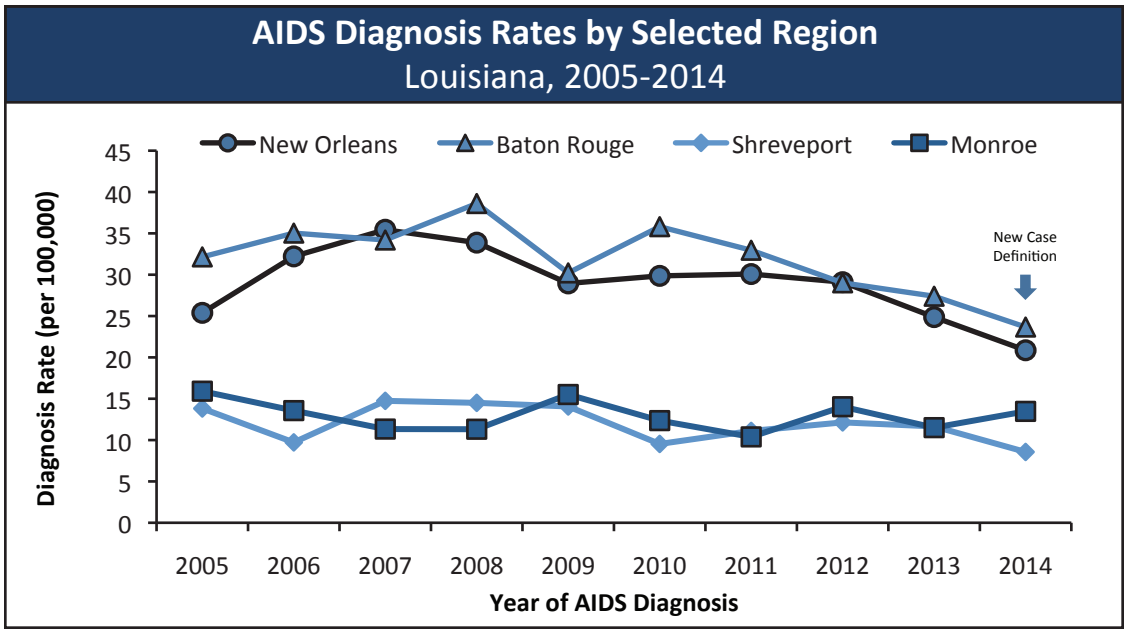
Centers for Disease Control and Prevention. *HIV Surveillance Report*, 2014. Vol. 26



- The AIDS diagnosis rate for females has remained relatively stable over the past 10 years. In 2014, the AIDS diagnosis rate was 8.2 per 100,000 females.
- The AIDS diagnosis rate for males has fluctuated within a relatively small range (low of 18.2 per 100,000 males in 2014 and a high of 26.2 per 100,000 males in 2007).
- In 2014, the AIDS diagnosis rate in males was over two times greater than the rate in females.

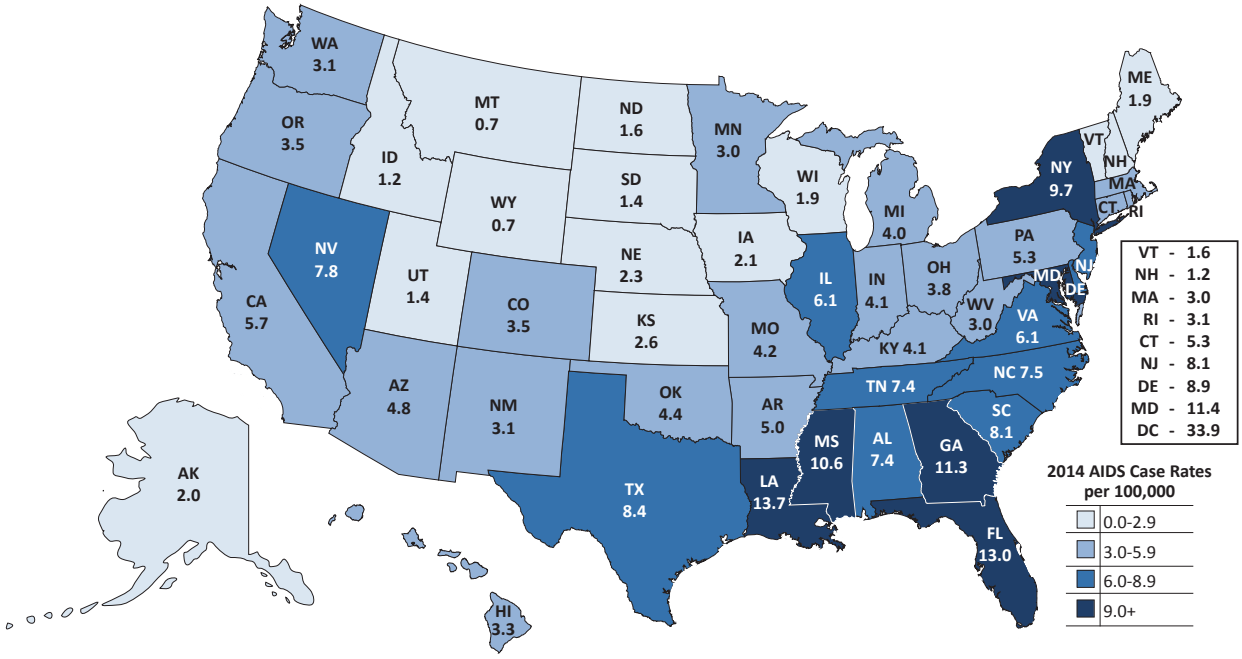


- In 2014, the AIDS diagnosis rate for blacks (30.4 per 100,000 blacks) was over two times greater than for Hispanic/Latinos (14.3 per 100,000 Hispanic/Latinos) and over seven times greater than for whites (4.2 per 100,000 whites).
- From 2005 to 2014, the AIDS diagnosis rate among Hispanic/Latinos has fluctuated significantly, but remained fairly stable since 2010.
- The AIDS diagnosis rate for whites has remained stable over the past 10 years.



- For the majority of the past 10 years, the Baton Rouge region has had the highest AIDS diagnosis rate among all nine public health regions. In 2014, the Baton Rouge and New Orleans regions had the highest AIDS diagnosis rates (23.7 per 100,000 population and 20.9 per 100,000 population respectively). Since 2010 the rate in Baton Rouge has been decreasing.
- The AIDS diagnosis rates for the Monroe and Shreveport regions are very similar each year. In 2014, the AIDS rates in Monroe and Shreveport were 13.5 per 100,000 and 8.6 per 100,000 respectively.

AIDS Rates in the United States (2014)[8]



- In the US, there were an estimated 20,886 new AIDS cases in 2014, for a national diagnosis rate of 6.6 AIDS diagnoses per 100,000 population. In 2013, the national AIDS diagnosis rate was 8.0 per 100,000 population.[8]
- In 2014, Louisiana ranked 2nd highest in state estimated AIDS diagnosis rates (13.7 per 100,000 population) and 11th in the number of estimated AIDS diagnoses in the US, according to the most recent CDC *HIV Surveillance Report, 2014; vol. 26*. Louisiana's AIDS rate was twice as high as the national rate.[8]

Characteristics of Persons Newly Diagnosed with AIDS

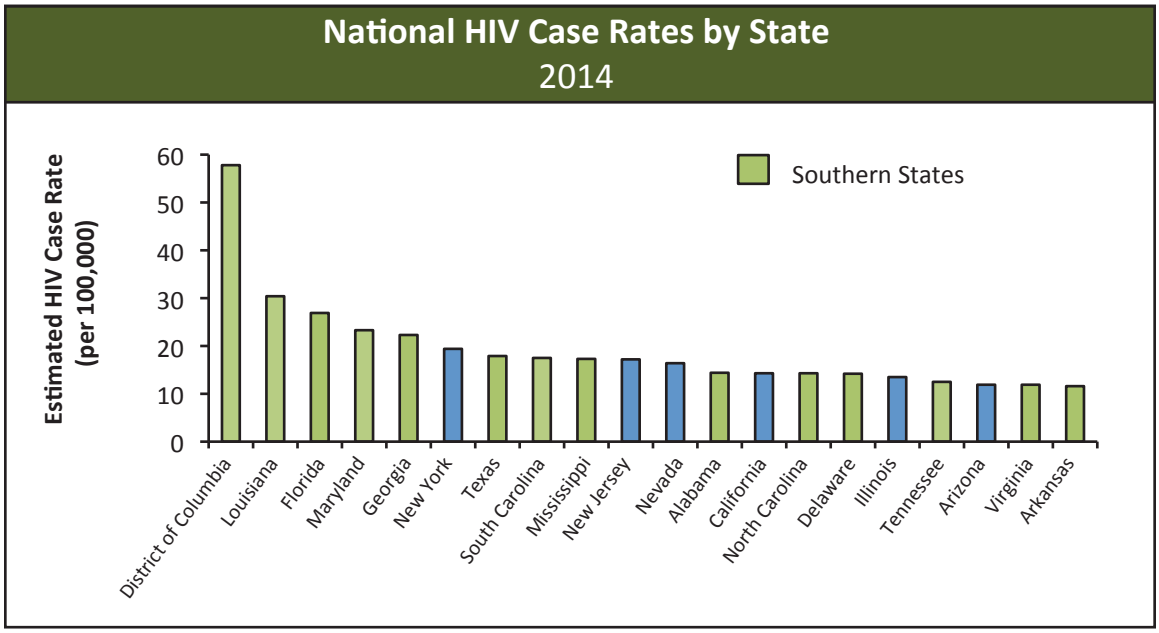
Characteristics of Persons Newly Diagnosed with AIDS Louisiana, 2014		
	Persons First Diagnosed with AIDS in 2014	
	Diagnoses	Percent
TOTAL	**601**	**100.0%**
Sex at Birth		
Female	192	31.9%
Male	409	68.1%
Race/Ethnicity		
Black/African American	446	74.2%
Hispanic/Latino	30	5.0%
White	114	19.0%
Other/Unknown/Multi-race	11	1.8%
Age Group	**Age at AIDS diagnosis**	
0-12	2	0.3%
13-19	5	0.8%
20-24	34	5.7%
25-34	171	28.5%
35-44	163	27.1%
45-54	149	24.8%
55-64	58	9.7%
65+	19	3.2%
Imputed Transmission Category		
Men who have sex with men (MSM)	296	49.3%
Injecting Drug User (IDU)	71	11.8%
MSM/IDU	16	2.7%
High Risk Heterosexual (HRH)	214	35.6%
Transfusion/Hemophilia/Other*	1	0.2%
Perinatal/Pediatric*	3	0.5%
Rural/Urban		
Rural	102	17.0%
Urban	499	83.0%

* These transmission categories are not imputed.

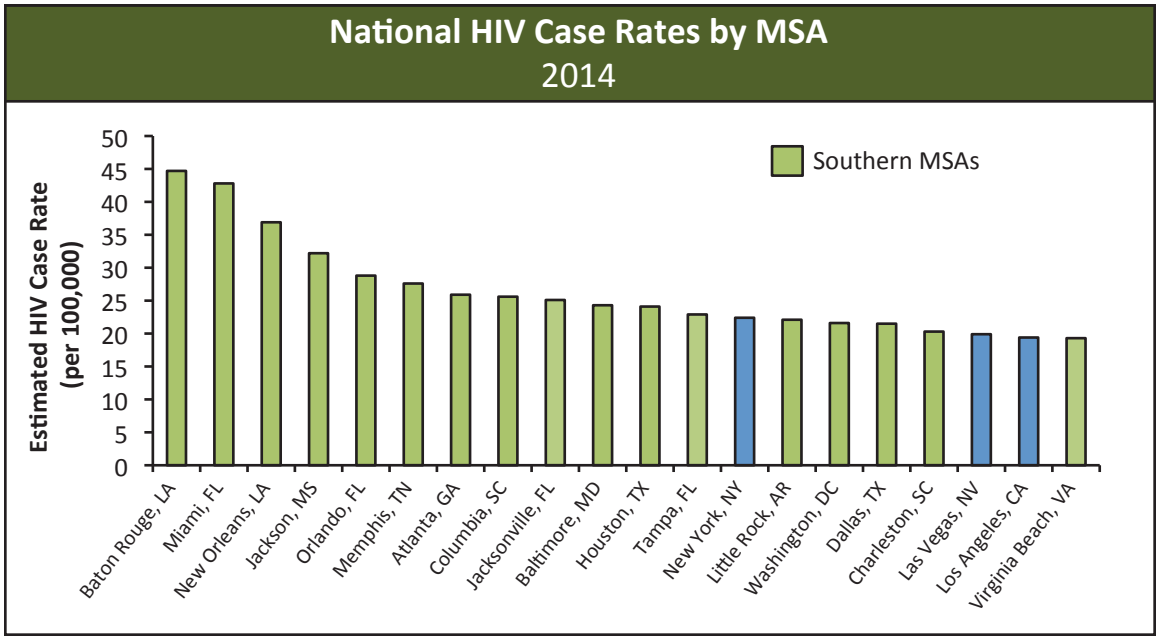
- In 2014, there were 601 new AIDS diagnoses in Louisiana.
- In 2014, males accounted for 68% of all new AIDS diagnoses.
- In 2014, 74% of all AIDS diagnoses were among blacks.
- In 2014, the greatest number of new AIDS diagnoses were among persons age 25-34, followed by persons age 35-44.
- In 2014, the greatest number and percentage of new AIDS diagnoses were among men who have sex with men (MSM), followed by high risk heterosexuals (HRH).
- The majority of AIDS diagnoses occurred in urban areas in 2014 (83%).

HIV and AIDS in the South, 2014

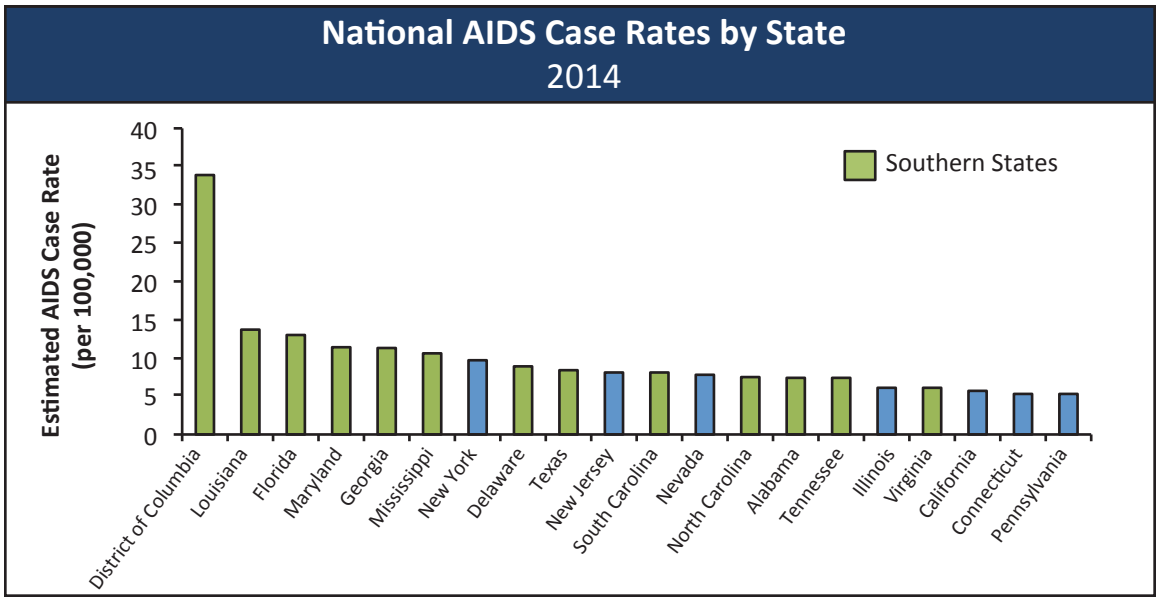
Southern states are disproportionately impacted by HIV infection and AIDS, as shown below. Seventeen states are included in the southern region of the United States: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia. Southern states are represented in green below.[8]



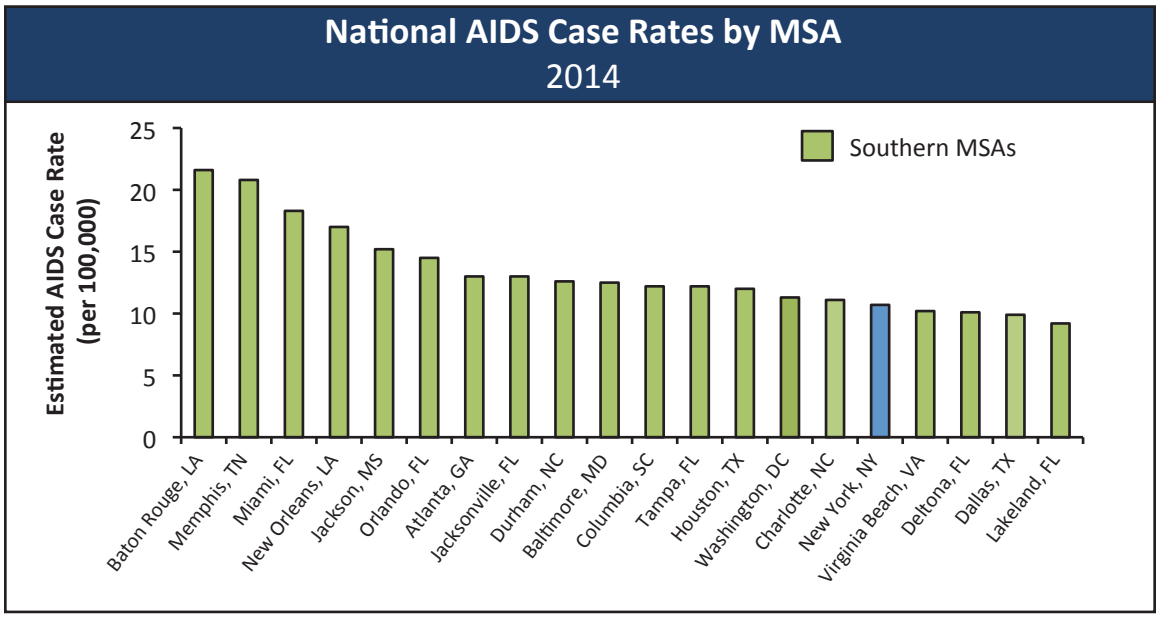
- In 2014, southern states represented 37% of the US population but over 50% of new HIV diagnoses. The District of Columbia, when included as a state, is restricted to its borders.[8]
- Of the 20 states that had the highest HIV diagnosis rates in 2014, 14 (70%) were in the South.[8]



- Of the 20 metropolitan areas that had the highest HIV diagnosis rates in 2014, 17 (85%) were in the South. According to the CDC, the Baton Rouge metro area ranked 1st in estimated HIV diagnosis rates and the New Orleans metro area ranked 3rd in estimated HIV diagnosis rates in 2014 among metropolitan areas in the US with more than 500,000 people. Washington, DC when included as a MSA, includes parts of neighboring states and has a much higher population.[8]



- In 2014, southern states represented 37% of the US population but over 52% of new AIDS diagnoses.
- Of the 20 states that had the highest AIDS diagnosis rates in 2014, 13 (65%) were in the South.[8]



- Of the 20 metropolitan statistical areas that had the highest AIDS diagnosis rates in 2014, 19 (95%) were in the South. According to the CDC, the Baton Rouge metro area ranked 1st and the New Orleans metro area ranked 4th in estimated AIDS diagnosis rates in 2014 among metropolitan areas in the US with more than 500,000 persons.[8]

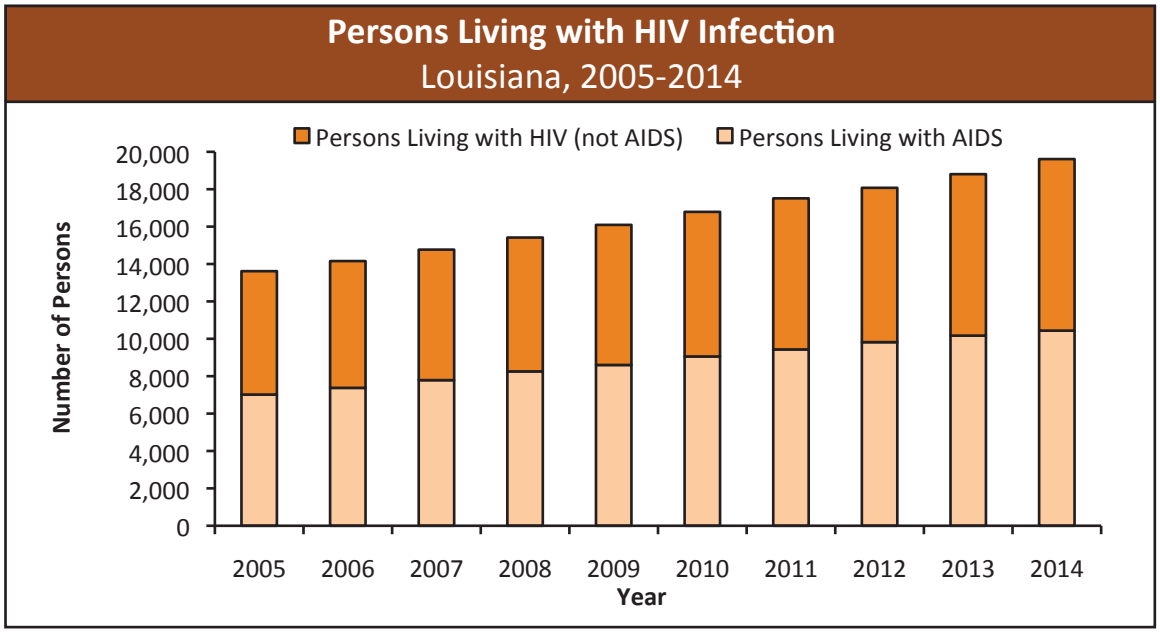
Comparison of 2013 and 2014 AIDS and HIV National Rankings

	LOUISIANA				NEW ORLEANS MSA				BATON ROUGE MSA			
	2013		2014		2013		2014		2013		2014	
	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
Estimated AIDS Case Rate*	16.9	3rd	13.7	2nd	23	5th	17	4th	25.4	3rd	21.6	1st
Estimated AIDS Case Count	783	11th	637	11th	286	19th	213	20th	208	25th	178	23rd
Estimated HIV Case Rate*	30.3	3rd	30.4	2nd	43.4	2nd	36.9	3rd	36.2	4th	44.7	1st
Estimated HIV Case Count	1,399	11th	1,411	9th	538	19th	462	19th	297	31st	369	24th

* Rates are per 100,000

Persons Living in Louisiana with HIV Infection (Prevalence)

Prevalence is a measure describing the number of persons living with HIV infection at a certain point in time and includes people living with all stages of HIV or AIDS. Prevalence is the accumulation of diagnoses for people who are still living with the disease. Prevalence numbers and rates are important for ascertaining the burden of HIV on health care systems, allocating resources and monitoring trends over time. Reported HIV diagnosis data provide only the minimum estimate of the number of people living with HIV, since persons who have not been tested and those who test anonymously are not included. The CDC now estimates that 12.8% of persons living with HIV are unaware of their infection status.[9]



- The number of persons living with HIV infection increased each year in Louisiana from the beginning of the epidemic. There was a decrease from 2004 to 2005 due to the dislocation of a large number of persons from the New Orleans metropolitan area who left Louisiana following Hurricane Katrina in August 2005. Since then, the number of persons living with HIV infection has far surpassed pre-Katrina numbers.
- At the end of 2014, 19,612 persons were known to be living with HIV infection in Louisiana, 10,436 (53%) of whom had progressed from HIV to AIDS.

Persons living with HIV Infection in the United States

At the end of 2012, an estimated 1,218,400 persons were living with HIV infection in the United States, including 155,955 (12.8%) persons whose infections had not been diagnosed.* Of these over one million people, gay and bisexual men of all races, blacks, and Hispanics/Latinos were most heavily affected. There has been a steady increase in the US in the number of persons living with HIV infection, which is expected, due to the widespread use of antiretroviral treatment and the continued development of new antiretroviral regimens. In the US, more people become infected with HIV than die from the disease each year.

Historically, it was estimated that 25% of HIV-positive persons were undiagnosed or are unaware of their status. Since 2008 when the CDC released a new undiagnosed estimate of 21%, the estimate has continued to decrease to a low of 12.8% as reported by the CDC in 2013.

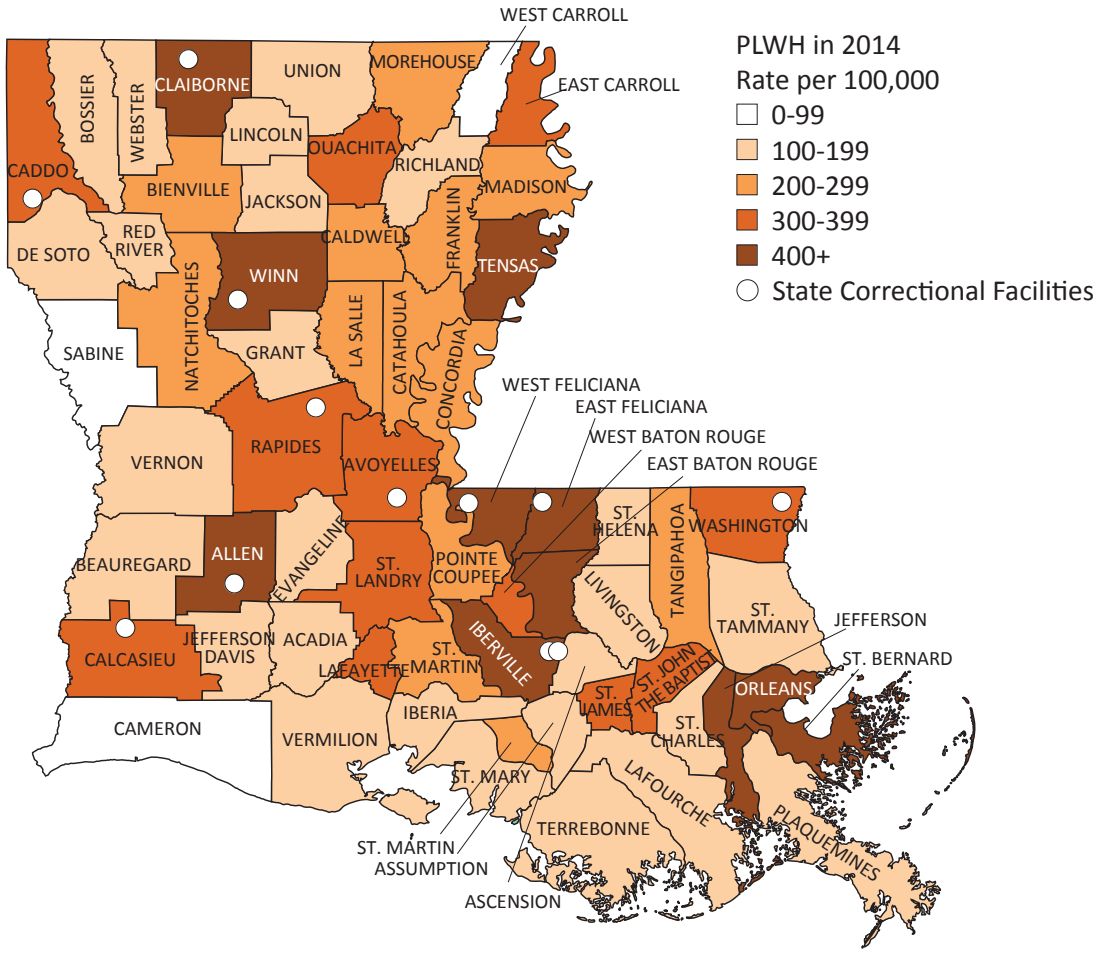
* CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 U.S. dependent areas—2012. HIV Surveillance Supplemental Report 2013;20(No. 2).

Characteristics of Persons Living with HIV Infection and Cumulative Cases Louisiana, 2014				
	Persons Living with HIV Infection as of 12/31/2014		Cumulative Persons with HIV Infection as of 12/31/2014*	
	Number	Percent	Number	Percent
TOTAL	19,612	100%	35,284	100%
Sex at Birth				
Female	5,793	29.5%	9,218	26.1%
Male	13,819	70.5%	26,066	73.9%
Race/Ethnicity				
Black/African American	13,454	68.6%	23,168	65.7%
Hispanic/Latino	765	3.9%	1,083	3.1%
White	5,148	26.2%	10,647	30.2%
Other/Unknown/Multi-race	245	1.2%	386	1.1%
Age Group	**Age in 2014**		**Age at Diagnosis**	
0-12	64	0.3%	351	1.0%
13-19	180	0.9%	1,767	5.0%
20-24	997	5.1%	4,846	13.7%
25-34	3,833	19.5%	12,176	34.5%
35-44	4,729	24.1%	9,536	27.0%
45-54	5,723	29.2%	4,660	13.2%
55-64	3,234	16.5%	1,502	4.3%
65+	852	4.3%	446	1.3%
Transmission Category				
Men who have sex with men (MSM)	9,567	48.8%	16,471	46.7%
Injection Drug User (IDU)	2,584	13.2%	6,467	18.3%
MSM/IDU	1,318	6.7%	2,992	8.5%
High Risk Heterosexual (HRH)	5,861	29.9%	8,517	24.1%
Transfusion/Hemophilia/Other**	75	0.4%	498	1.4%
Perinatal/Pediatric**	207	1.1%	339	1.0%
Rural/Urban				
Rural	2,911	14.8%	4,491	12.7%
Urban	16,701	85.2%	30,793	87.3%

*Cumulative persons reflects the total number of HIV-infected persons diagnosed in Louisiana, including those who have died, regardless of cause of death.
**These transmission categories are not imputed.

- In 2014, males made up 71% of all people living with HIV infection in Louisiana.
- Although blacks only made up 32% of Louisiana's population in 2014, they accounted for 69% of all people living with HIV infection.
- More than a quarter of all persons living with HIV are under the age of 35, 24% are between 35-44 years of age, and 50% are 45 and older.
- Over 49% of all people living with HIV infection are MSM, 30% are HRH, 13% are IDU, and 7% are MSM/IDU. Less than 0.5% of people living with HIV in Louisiana were infected via transfusion or from the use of hemophiliac products and just over 1% were perinatally infected.
- The majority of people living with HIV infection live in urban areas of the state.

Persons Living with HIV Infection by Parish
Louisiana, 2014



- The above map illustrates the geographic distribution of persons living with HIV infection in the state. There are persons living with HIV in every parish in Louisiana. All persons living with HIV infection in Louisiana are included in the analyses, regardless of their type of residence (correctional facility, nursing home, homeless shelter, etc.).
- At the end of 2014, 12 parishes had a prevalence rate greater than or equal to 400 per 100,000 and an additional 11 parishes had a rate between 300 and 399 per 100,000.
- Many of the parishes with disproportionate prevalence rates have state correctional facilities that have reported persons who are incarcerated and living with HIV.
- Although the majority of persons living with HIV reside in urban areas, 13% live in rural parishes.

Late HIV Testing in Louisiana

Since improved antiretroviral medications and preventive therapies are now available for people living with HIV, it is important that people are tested for HIV and if positive, are referred into care early so that they can benefit from these treatment advances. However, a significant number of people are not tested for HIV until they are symptomatic. In 2006, the CDC released new recommendations for HIV testing of adults, adolescents and pregnant women in health-care settings. HIV screening is recommended for all patients age 13 and older, unless the patient declines testing ("opts out"). Persons at high risk of HIV should be tested annually. HIV screening is required for all pregnant women as part of their routine prenatal screening tests.

Late HIV Testing
Louisiana, 2014

	Persons Diagnosed with HIV, 2014								
	New HIV Diagnoses	AIDS at Time of Diagnosis*		AIDS Within 3 Months of Diagnosis		AIDS Within 6 Months of Diagnosis		AIDS Within 12 Months of Diagnosis	
		Count	Percent	Count	Percent	Count	Percent	Count	Percent
Total	**1,235**	**253**	**20%**	**291**	**24%**	**314**	**25%**	**328**	**27%**
Sex at Birth									
Female	328	71	22%	85	26%	88	27%	91	28%
Male	907	182	20%	206	23%	226	25%	237	26%
Race/Ethnicity									
Black/African American	881	175	20%	202	23%	221	25%	231	26%
Hispanic/Latino	68	19	28%	21	31%	22	32%	23	34%
White	262	52	20%	60	23%	63	24%	66	25%
Other/Unknown/Multi-race	24	7	29%	8	33%	8	33%	8	33%
Age Group									
0-12	3	1	33%	1	33%	1	33%	1	33%
13-19	76	3	4%	3	4%	3	4%	4	5%
20-24	258	16	6%	22	9%	26	10%	27	10%
25-34	387	68	18%	80	21%	86	22%	92	24%
35-44	242	67	28%	75	31%	82	34%	85	35%
45-54	170	69	41%	76	45%	80	47%	83	49%
55-64	84	24	29%	29	35%	31	37%	31	37%
65+	15	5	33%	5	33%	5	33%	5	33%
Transmission Category									
Men who have sex with men (MSM)	758	148	20%	164	22%	177	23%	185	24%
Injection Drug User (IDU)	84	17	20%	23	27%	26	31%	28	33%
MSM/IDU	44	5	11%	5	11%	6	14%	7	16%
High Risk Heterosexual (HRH)	346	82	24%	98	28%	104	30%	107	31%
Perinatal/Pediatric**	3	1	33%	1	33%	1	33%	1	33%
Region									
1-New Orleans	364	64	18%	76	21%	80	22%	82	23%
2-Baton Rouge	319	69	22%	75	24%	82	26%	84	26%
3-Houma	53	10	19%	14	26%	15	28%	15	28%
4-Lafayette	112	22	20%	27	24%	30	27%	33	29%
5-Lake Charles	41	11	27%	13	32%	13	32%	14	34%
6-Alexandria	58	12	21%	12	21%	14	24%	14	24%
7-Shreveport	129	18	14%	23	18%	26	20%	28	22%
8-Monroe	91	25	27%	27	30%	29	32%	31	34%
9-Hammond/Slidell	68	22	32%	24	35%	25	37%	27	40%

*If AIDS diagnosis was within 1 month of HIV diagnosis.

**This transmission category is not imputed.

- Of the 1,235 persons diagnosed with HIV in 2014, 20% had an AIDS diagnosis at the time of their initial HIV diagnosis, an additional 4% had an AIDS diagnosis within three months, an additional 1% had an AIDS diagnosis between three and six months after diagnosis, and an additional 2% had and AIDS diagnosis between six and twelve months after diagnosis. Overall, 27% of persons with a new HIV diagnosis in 2014 had an AIDS diagnosis within twelve months.

- The proportion of late testers was not significantly different by sex.

- Persons not identifying as white (non-Hispanic) or black (non-Hispanic) did have higher proportions of AIDS at twelve months after diagnosis then whites and blacks.

- Persons diagnosed with HIV after the age of 34 were more likely to be diagnosed with AIDS at the time of their HIV diagnosis, and in the subsequent twelve months.

- Injection drug users were more likely to have AIDS within the following twelve months after their diagnosis, compared to persons with other risk factors.

- The proportion of late testers varies by region throughout the state. The Shreveport, New Orleans, and Alexandria regions had the lowest proportion of persons with an AIDS diagnosis within twelve months, and the Hammond/Slidell, Lake Charles, and Monroe regions had the highest proportion.

National HIV Behavioral Surveillance Survey 2012-2014

Initiated in 2003, the National HIV Behavioral Surveillance (NHBS) system collects behavioral data among people at high risk for HIV infection in the United States. The rationale for this surveillance system is to "provide ongoing, systematic collection of data on behaviors related to HIV acquisition". New Orleans was among 20 US metropolitan areas conducting NHBS in 2014. This study collects data from three target populations: men who have sex with men (MSM), injection drug use (IDU), and heterosexuals living in areas at high risk for HIV/AIDS (HET), each in discrete annual cycles. The NHBS survey instrument contains items regarding sexual behavior, substance use, and HIV testing behaviors. In 2007, NHBS added anonymous HIV testing of participants, followed by hepatitis C testing in 2012 study cycle. During each annual cycle, NHBS staff conduct ethnographic research and in-depth surveys, which include locally developed questions concerning key issues for each target population.

Because many of the behaviors surveyed are highly stigmatized or illegal, the populations are considered hard to reach using traditional probability-based sampling methods. Each cycle utilizes specialized sampling methods for recruitment of participants in order to yield the most valid population estimates.

Injection drug users (2012 Study Cycle)

Persons who inject drugs are recruited during the IDU cycle using a modified chain referral strategy known as respondent-driven sampling (RDS) wherein a small number of known injectors are recruited and interviewed by staff and asked to recruit other injectors from within their own social network. These respondents are then subsequently interviewed and offered a similar opportunity to recruit their peers. Recruitment continues until a desired sample size of 500 is reached.

- The majority of the IDU sample (87%) had been tested for HIV in their lifetime. Of those, 30% received their last HIV test in a correctional facility, followed by a public health clinic (21%) or hospital (15%).

- Only 21% of the IDU sample had been tested for gonorrhea, chlamydia, or syphilis in the past 12 months. Of those who had been tested for gonorrhea 22% were positive. Of those who had been tested for chlamydia 16% were positive. Of those who had been tested for syphilis 16% were positive.

- When asked what drug they primarily injected, 69% of participants reported heroin by itself or a combination of heroin and cocaine (speedball), 21% reported cocaine by itself, 5% crystal meth, and 3% crack. Heroin was the most commonly used injection drug (72%).

- Additional hepatitis C testing was provided to the IDU sample participants in 2012; 55% screened positive for hepatitis C antibodies. Among those, 55% were unaware of their HCV status before NHBS screening.

Heterosexuals living in high risk areas (2013 Study Cycle)

Heterosexual (HET) recruitment is conducted using a similar RDS procedure; however, the initial recruits or "seeds" are individuals who reside in areas with high rates of HIV infection and poverty. Key qualitative and quantitative findings from the New Orleans NHBS surveillance during 2013 are presented below:

- The majority of participants during the HET cycle (84%) had been tested for HIV in their lifetime. Of those, 25% reportedly received their last HIV test at public health clinic followed by the hospital (15%), or correctional facility (12%).

- Only 29% (152) of the HET sample had been tested for gonorrhea, chlamydia, or syphilis in the past 12 months. Of those who had been tested for gonorrhea 10% were positive. Of those who had been tested for chlamydia 18% were positive. Of those who had been tested for syphilis 8% were positive.

Men who have sex with men (2014 Study Cycle)

Men who have sex with men (MSM) are recruited using a venue-based time-space sampling procedure, where individuals are approached within venues that are attended by MSM.

- HIV testing is high within the MSM community with 96% having been tested for HIV in their lifetime. Of those, 41% reportedly received their last HIV test at an HIV counseling and testing site nearly half of which were during an outreach event or mobile testing unit, followed by a public health clinic (19%), or private health clinic (17%).

- Only 46% of the MSM interviewed had been tested for other STDs in the past 12 months. Of those who had been tested for gonorrhea 17% were positive. Of those who had been tested for chlamydia 7% were positive. Of those who had been tested for syphilis 9% were positive.

Additional topics

In each cycle additional topics of interest and/or importance to the population are asked.

- Beliefs about stigma and discrimination surrounding HIV are asked during all cycles. Across all cycles many participants agreed that "most people in New Orleans would discriminate against someone with HIV" (45% of MSM, 66% IDU, 62% HRH). However, the majority of participants (52%-67%) agreed that most people in New Orleans would support the rights of a person with HIV to live and work wherever they wanted and about two thirds (62%-65%) think that people would be friends with someone with HIV. From 17%-24% agreed that most people in the city think that individuals who got HIV through sex or drug use have gotten what they deserve.
- When asked about personal negative experiences due to being attracted to men during the past 12 months, 15% of MSM participants reported receiving poorer services than other people in restaurants, stores, other businesses or agencies and 38% had been called names or insulted.
- Compared to the general population of Louisiana, MSM are much more likely to be current smokers. More than half of the MSM participants were current tobacco smokers. In addition, 84% reportedly had friends who are MSM that smoke and 58% of those who currently smoke reported being interested in quitting.
- Twenty nine percent of IDU surveyed experienced an overdose in their lifetime and 64% of IDU had been around someone else while they were overdosing. Only in about half of those instances did they or someone else call for medical assistance.

National HIV Behavioral Surveillance (NHBS) Louisiana, 2012-2014						
	Injection Drug Users (2012)		Heterosexuals at Increased Risk for HIV (2013)		Men Who Have Sex With Men (2014)	
Category	**Number**	**%**	**Number**	**%**	**Number**	**%**
Race/Ethnicity						
Black/African American	268	56%	475	91%	201	35%
White	182	38%	31	6%	306	53%
Other	25	5%	17	3%	69	12%
Gender						
Male	397	80%	280	53%	579	100%
Female	96	19%	244	47%	N/A	0%
Transgender	2	<1%	0	0%	N/A	0%
Age						
18-24	25	5%	56	11%	104	18%
25-29	47	9%	45	9%	113	20%
30-34	53	11%	71	14%	93	16%
35-39	48	10%	55	10%	51	9%
40-44	56	11%	47	9%	47	7%
45-50	104	21%	102	19%	62	11%
51+	162	33%	148	28%	114	20%
Sexual Identity						
Heterosexual or “Straight”	420	85%	469	90%	20	3%
Homosexual, Gay, or Lesbian	16	3%	52	10%	459	80%
Bisexual	57	12%	2	<1	97	17%
Substance Use						
Ever Injected Drugs	495	100%	103	20%	58	10%
Injected Any Drug (past 12 months)	495	100%	35	7%	16	3%
Shared Needle (past 12 months)	218	56%	15	3%	5	1%
Shared Works/Equipment (past 12 months)	311	63%	22	4%	4	1%
Used Non-Injection Drugs (past 12 months)	427	86%	268	51%	332	57%
HIV Testing History and Positivity						
Self-Reported Previous Known Positive	36	8%	22	5%	115	22%
Newly Detected Positive	13	3%	10	2%	22	3%
Never Tested Previously	62	13%	84	16%	18	4%

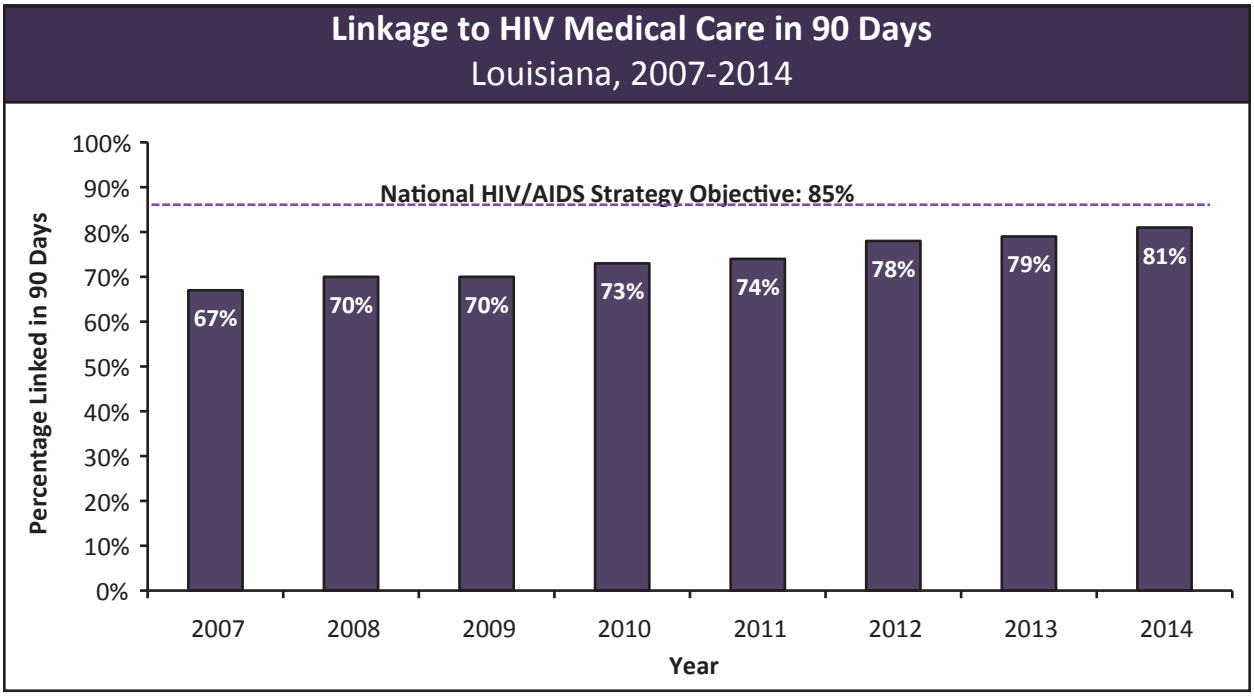
Chapter 2

Linkage and Retention in HIV Medical Care

Linkage to HIV Medical Care

Following a person's HIV diagnosis, patients should be immediately linked into HIV medical care. Linkage into HIV medical care allows for proper monitoring of a person's health and well-being. Linkage to care also provides opportunities for intervention to prevent transmissions. Early initiation of HIV treatment and long-term adherence leads to better health outcomes and reduces transmission of infection. Initiation of HIV treatment is dependent on linkage to medical care.

Louisiana's surveillance system is able to monitor linkage to care rates for newly diagnosed persons, using HIV laboratory and surveillance data. Linkage to care within 90 days is defined as having a CD4 count or VL test conducted within 90 days of HIV diagnosis. If the diagnosis and the CD4 count or viral load test are conducted on the same day, those persons are considered to be linked to care.

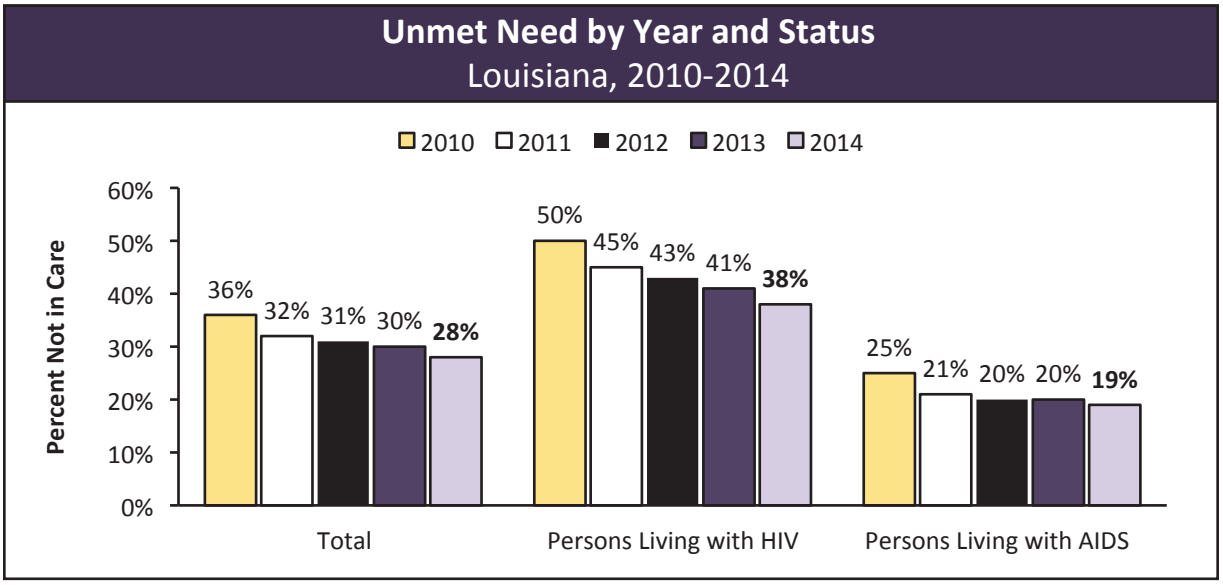


- Louisiana's linkage to care within 90 days rate has increased substantially over the past eight years. In 2007, only two-thirds of newly diagnosed persons were linked to care within 90 days. The linkage to care rate in 2014 reached 81%.
- In the National HIV/AIDS Strategy (NHAS), a national goal of 85% was selected to be attained by 2015. In 2014, Louisiana fell short of that NHAS goal but linkage to care rates continue to improve.

Unmet Need: Percentage of Persons out of HIV Medical Care

The primary focus of the Ryan White HIV/AIDS Program is to help ensure that individuals living with HIV routinely access primary medical care and medications in order to maintain their health and delay progression to an AIDS diagnosis or death. There are, however, many people who are living with HIV infection who do not regularly access medical care. Unmet need is defined as the number of individuals in a set geographic area who know their HIV status but have not accessed HIV-related primary medical care in a 12-month period, as measured by lack of evidence of a CD4 or viral load (VL) test result in the last 12 months.

In Louisiana, SHP's Surveillance Unit manages and calculates the data needed to estimate unmet need for the state's Ryan White grantees. Persons who had at least one CD4 or VL test within a 12-month period are considered to have been "in care" during that year. Persons who did not are considered "out of care," and are deemed as having an "unmet need" for care and treatment. Louisiana's Public Health Sanitary Code requires that laboratories report all test results indicative of HIV infection for persons residing in Louisiana. As a result, laboratory data received by SHP's Surveillance Unit can be used to assess whether a person is in care or not in care during a specified time period.



- The overall percentage of persons with unmet need has been steadily decreasing and in 2014 reached a low of 28%.
- Persons living with AIDS continue to have lower percentages of unmet need than persons living with HIV. People living with AIDS may require more medications and may have more symptoms, leading them to more frequent medical visits.

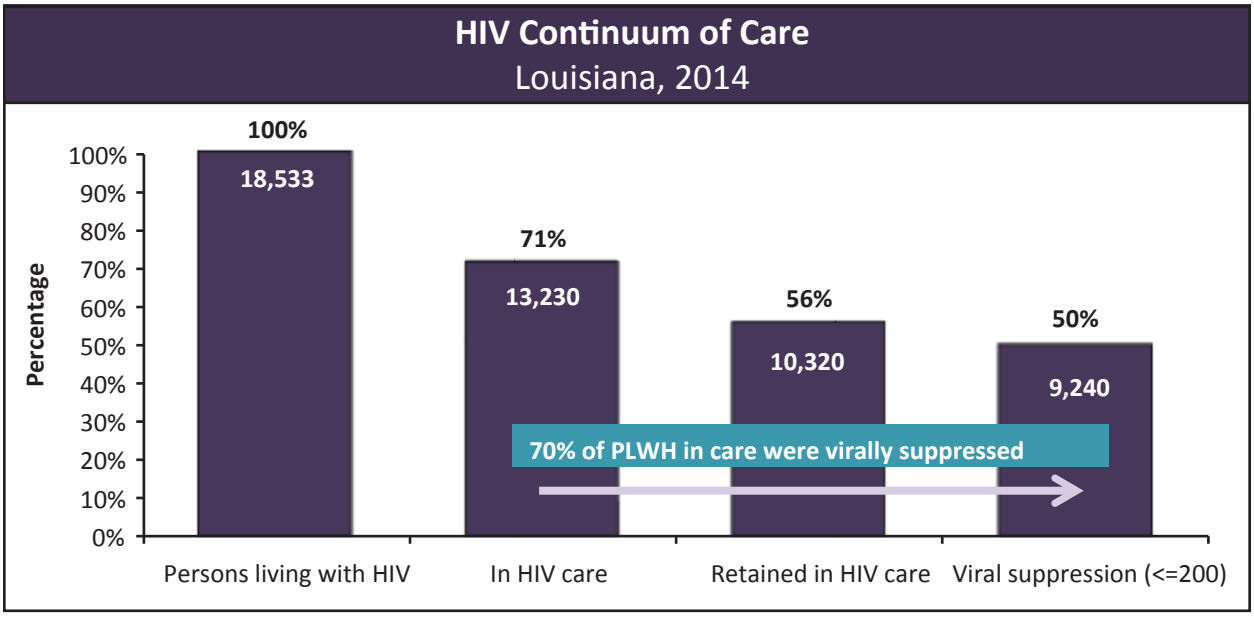
Unmet Need for Primary HIV Medical Care Louisiana, 2013 and 2014				
	2013		2014	
	Percent in Care	Percent Not in Care (Unmet Need)	Percent in Care	Percent Not in Care (Unmet Need)
Overall	**70%**	**30%**	**72%**	**28%**
Persons living with HIV	59%	41%	62%	38%
Persons living with AIDS	80%	20%	81%	19%
Sex at Birth				
Female	75%	25%	76%	24%
Male	68%	32%	70%	30%
Race/Ethnicity				
Black/African American	70%	30%	73%	27%
Hispanic/Latino	49%	51%	53%	47%
White	72%	28%	73%	27%
Other	64%	36%	68%	32%
Age Group				
0-12	90%	10%	81%	19%
13-24	71%	29%	72%	28%
25-44	69%	31%	72%	28%
45-64	71%	29%	73%	27%
65+	65%	35%	67%	33%
Region				
1-New Orleans	70%	30%	72%	28%
2-Baton Rouge	75%	25%	77%	23%
3-Houma	74%	26%	76%	24%
4-Lafayette	68%	32%	69%	31%
5-Lake Charles	60%	40%	61%	39%
6-Alexandria	67%	33%	69%	31%
7-Shreveport	63%	37%	67%	33%
8-Monroe	66%	34%	69%	31%
9-Hammond/Slidell	72%	28%	74%	26%

- Of persons living with HIV infection in 2014, only 72% had at least one primary medical care visit during the year. Persons living with AIDS were more likely to have a medical visit (81%) compared to persons living with HIV (non-AIDS) (62%).
- Females and non-Hispanics were more likely to be receiving medical care.
- Persons residing in the New Orleans, Baton Rouge, Houma, and Hammond/Slidell regions were most likely to be in care, while persons in the Lake Charles and Shreveport regions were least likely to be in care.

Louisiana's Continuum of Care

The HIV continuum of care is a way to show, in visual form, the numbers of individuals living with HIV who are actually receiving the full benefits of the medical care and treatment they need. This model was first described by Dr. Edward Gardner and colleagues, who reviewed current HIV research and developed estimates of how many individuals with HIV in the US are engaged at various steps in the continuum of care from diagnosis through viral suppression. The following graph shows the Louisiana-specific continuum created by the STD/HIV program using data from surveillance and laboratory reporting.

- Column 1: The number of persons living with HIV infection (PLWH) at the end of 2014 included in the continuum is limited to people living with HIV infection as of 12/31/2014, but who were diagnosed before 01/01/2014 and whose current address is in Louisiana. This number is smaller than the overall number of persons living with HIV infection presented in Chapter 1 because it removes anyone newly diagnosed in 2014. In 2014, there were 18,533 persons in Louisiana who met these criteria.
- Column 2: The number of people in HIV care includes all PLWH who had at least one CD4 count or VL test conducted in 2014. In 2014, 71% of Louisiana's PLWH had at least one medical care visit.
- Column 3: The number of people retained in HIV care includes the number of PLWH who had two or more CD4 counts or VL tests conducted in 2014 at least 90 days apart. In 2014, 56% of Louisiana's PLWH were retained in HIV medical care.
- Column 4: The number of people who are virally suppressed are the number of PLWH whose most recent VL test in 2014 was less than or equal to 200 copies/ml. In 2014, 50% of Louisiana's PLWH were virally suppressed at their most recent VL.
- An additional feature that Louisiana has added is the connection between Column 2 and Column 4. If viral suppression is assessed for people who had at least one medical care visit in 2014, 70% of the persons living with HIV infection in care are virally suppressed.



Chapter 3

Perinatal HIV Exposure and Congenital Syphilis

Active surveillance of perinatal HIV exposure and congenital syphilis is an important aspect in preventing disease transmission of HIV or syphilis to a newborn. Through proper care and treatment, both perinatal transmission of HIV and congenital syphilis can be prevented. The rate of HIV transmission from mother to child can be reduced from 25% to less than 1% with adherence to antiretroviral prophylaxis. Adequate treatment for syphilis during pregnancy is 98% effective in reducing congenital syphilis.[10] Early and repeat testing for HIV and syphilis during pregnancy is important in the timely treatment and reduction of transmission. In a move to reinforce these recommendations, Louisiana passed legislation in 2014 requiring physicians to repeat HIV and syphilis testing for pregnant women during their third trimester, in addition to testing already mandated during their first prenatal care visit.

Perinatal exposure to HIV and congenital syphilis are not equal in Louisiana. Black mothers under the age of 30 are affected more than any other race/ethnicity and age group in Louisiana. Barriers to care can include lack of transportation to and from healthcare appointments, low income, stigma, and gaps in other supportive services for pregnant women with these particular health concerns. While Louisiana's rates for perinatal HIV exposure/transmission and congenital syphilis have been historically higher than the US rate, Louisiana is committed to improving health and birth outcomes for women that have been affected by HIV and syphilis.

Perinatal HIV Exposure

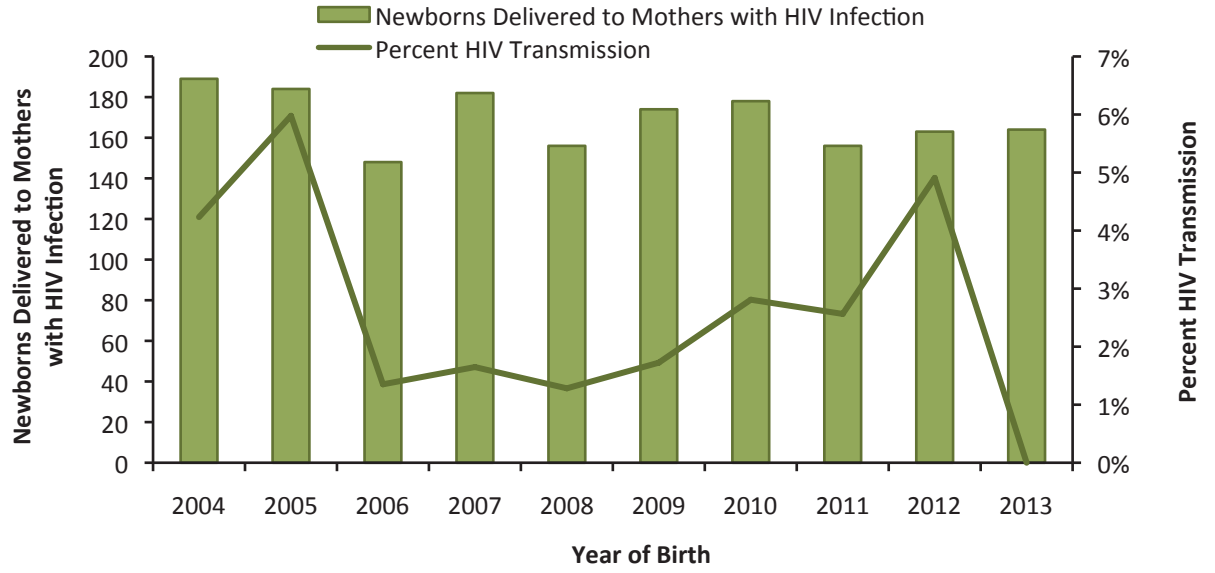
Background and Overview

In 1994, the Pediatric AIDS Clinical Trials Group demonstrated that zidovudine (ZDV) administered to HIV-infected pregnant women could reduce the risk of perinatal transmission of HIV. As a result, the United States Public Health Service (USPHS) issued recommendations for the use of ZDV during pregnancy to reduce perinatal transmission. Subsequent clinical trials and observational studies demonstrated that combination antiretroviral (ARV) medication given to a mother was associated with further declines in transmission. The recommendations for prevention of perinatal transmission are continuously updated and are available from the NIH's AIDS Info website (http://aidsinfo.nih.gov/).[11]

The CDC has published recommendations to include HIV testing as part of the routine screening panel for all pregnant women, as well as repeat testing during the third trimester in areas with high HIV incidence, which includes Louisiana. The CDC also recommends a rapid test at delivery for women without documented HIV test results.[12] Louisiana law (Louisiana RS 40:1091) requires any physician providing medical care to a pregnant woman to offer an HIV test as a component of her routine laboratory panel at her first prenatal care visit and at the first prenatal care visit of the third trimester unless she specifically declines ("opts out"). In addition, the law allows physicians to test a child born to a woman whose HIV status is unknown at the time of delivery, without parental consent. Title 51 of the Administrative Code (Public Health -- Sanitary Code, available at: http://doa.louisiana.gov/osr/lac/books.htm) also requires the explicit reporting of pregnancy in an HIV-infected woman, as well as all HIV tests performed on children aged 0-6 years regardless of test result (positive or negative).

Perinatal HIV exposure surveillance requires several rounds of testing to determine whether an infant is definitively HIV positive or HIV negative. Reporting of this information ensures effective monitoring of all perinatal HIV exposures. Infants born to HIV-infected women need a recorded negative result on HIV tests conducted at one month and four months of age to be confirmed as HIV negative. Until an infant receives adequate HIV testing, that infant is considered to have an indeterminate HIV status.

Perinatal HIV Exposure and Transmission
Louisiana, 2004-2013

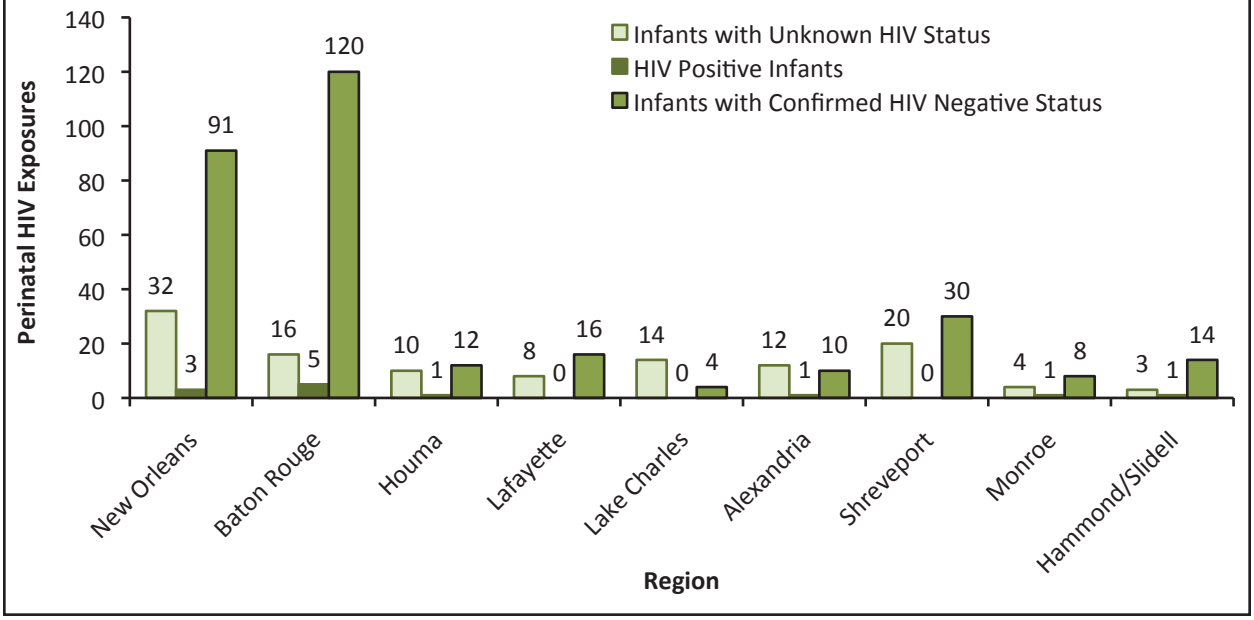


- There were zero cases of perinatal HIV transmission in 2013.
- Over the past ten years, the highest percentage of perinatal transmission was in 2005 (6%), while 2013 was the lowest (0%).
- Preliminary data of infants born in 2014 reports two confirmed cases of perinatal transmission of HIV.

Perinatal HIV in the United States

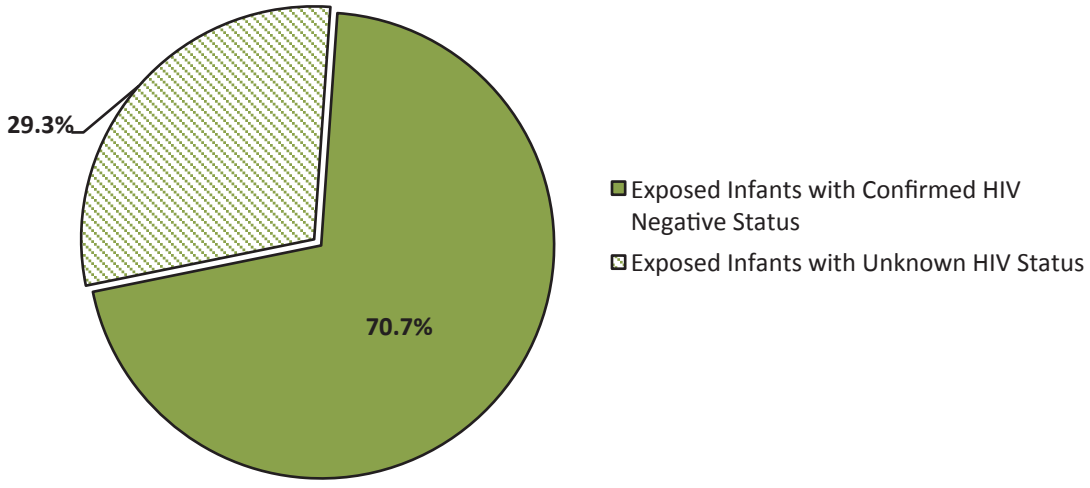
In 2013, an estimated 107 children under the age of 13 were infected with HIV as a result of perinatal transmission.[13] While the United States has a low rate of mother-to-child transmission (MTCT) of HIV, the CDC has proposed a framework to end MTCT in the United States, which is defined as a transmission rate of less than 1% of infants born to HIV-infected mothers. The framework includes universal testing (i.e. opt-out testing), data reporting and long-term monitoring, as well as reproductive health and family planning services for women. These efforts, individually managed by each state, sets a foundation for the elimination of MTCT through identifying HIV positive women before they are pregnant, providing care for them while they are pregnant, and monitoring of women out of care or in need of other services related to their infection.[14]

Perinatal HIV Exposure Status by Region
Louisiana, 2011-2013



- Between 2011 and 2013, HIV positive mothers delivered newborns in every region of Louisiana. The Baton Rouge region had the highest number of perinatal exposures (141 exposures) and the highest number of perinatal transmissions with five transmissions. The New Orleans region had 126 exposures and three perinatal transmissions during this period.
- Approximately 27% of HIV exposed infants born during 2011-2013 have an indeterminate HIV status. More work must be done to improve reporting of negative test results, create better access to testing, and conduct better follow-up on infants to decrease the number of perinatal exposure cases with an indeterminate status.

Perinatal HIV Exposure Status
Louisiana, 2013



- Nearly one-third of infants born in 2013 have an unknown HIV status due to an insufficient number of labs to confirm if they are definitely negative.

The following table shows demographic information for mothers infected with HIV who delivered a newborn in 2013. There were four sets of twins. A total of 160 mothers are included below who gave birth to 164 infants.

Demographics of Mothers with HIV Infection
Louisiana, 2013

	Mothers with HIV Infection	Percent
Total	**160**	**100.0%**
Race/Ethnicity		
Black/African American	140	87.5%
White	13	8.1%
Hispanic	3	1.9%
Asian	1	0.6%
Multiple Races	3	1.9%
Age at Delivery		
13-19	10	6.3%
20-24	53	33.1%
25-34	80	50.0%
35-44	17	10.6%
Transmission Category		
Injection Drug User (IDU)	11	6.9%
High Risk Heterosexual (HRH)	149	93.1%
Region		
1-New Orleans	53	33.1%
2-Baton Rouge	44	27.5%
3-Houma	10	6.3%
4-Lafayette	10	6.3%
5-Lake Charles	5	3.1%
6-Alexandria	10	6.3%
7-Shreveport	20	12.5%
8-Monroe	3	1.9%
9-Hammond/Slidell	5	3.1%

- Mothers with HIV infection were predominately black (87%) and between 20-34 years old (83%).
- Nearly 7% of the mothers with HIV infection were infected through injection drug use, while the majority were infected by high risk heterosexual activity (93%).
- In 2013, 33% of HIV-infected women who delivered a newborn lived in the New Orleans region, and almost 28% lived in the Baton Rouge region.

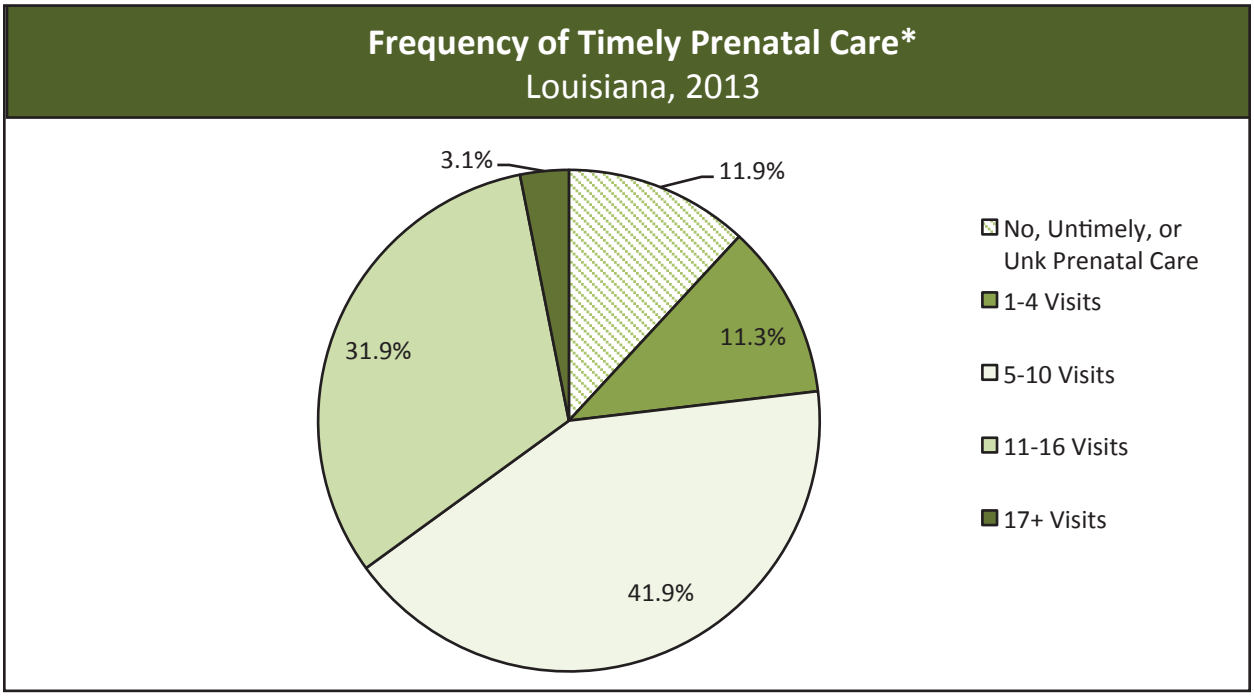
Birth Outcomes of HIV Exposed Newborns, Louisiana, 2013		
	HIV Exposed Newborns	**Percent**
Total	**164**	**100.0%**
Birth Weight		
Very Low (<1500g)	8	4.8%
Low (≥1500g and <2500g)	37	22.6%
Normal (≥2500g)	119	72.6%
Gestational Age		
Very Preterm (<32 weeks)	8	4.9%
Preterm (32-36 weeks)	33	20.1%
Early Term (37-38 weeks)	79	48.2%
Full Term (≥39 weeks)	44	26.8%
Delivery Type		
Vaginal	62	38.8%
Elective Cesarean	79	49.4%
Non-elective Cesarean	19	11.9%

- Among HIV exposed newborns in Louisiana in 2013, nearly 28% were low or very low birth weight (<2500g), and 25% were born either preterm (before 37 weeks gestational age) or very preterm (before 32 weeks). This is compared to all newborns born in Louisiana in 2013, where just 13% were low or very low birthweight and 15% were born preterm.[15]

Prenatal Care and Perinatal Transmission Risk Reduction

The American Congress of Obstetricians and Gynecologists (ACOG) recommends a total of 14 prenatal care visits during pregnancy.[16] Lack of prenatal care is one of the factors that most significantly impacts perinatal transmission since women who are not in prenatal care are less likely to get tested for HIV and receive ARVs during their pregnancy.

Frequency of Timely Prenatal Care*
Louisiana, 2013



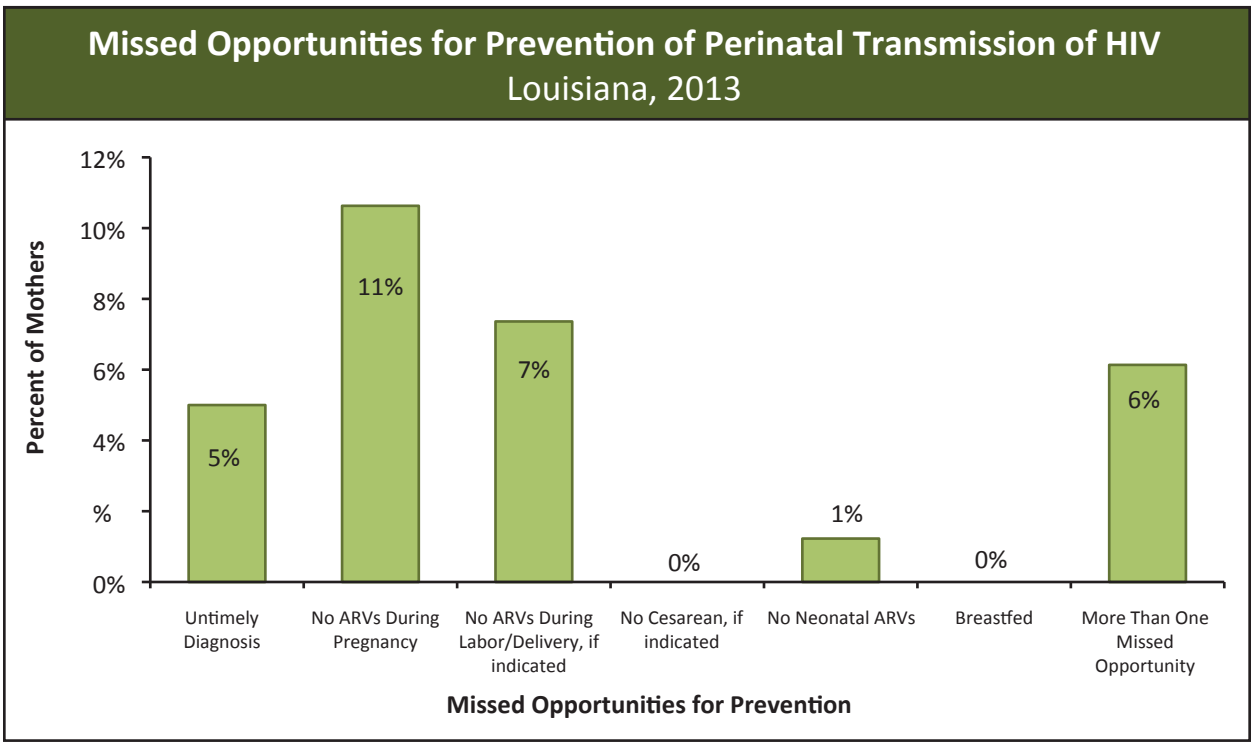
- In 2013, 12% of mothers with HIV infection had no, untimely, or unknown status of prenatal care. Most mothers had between 5 and 10 visits (42%).
- Three percent of mothers had 17 or more visits.

Perinatal HIV Exposure Risk and Missed Opportunities

Risk of perinatal transmission of HIV depends on fetal/infant exposure to maternal virus. This exposure can be reduced by adhering to the following recommendations:

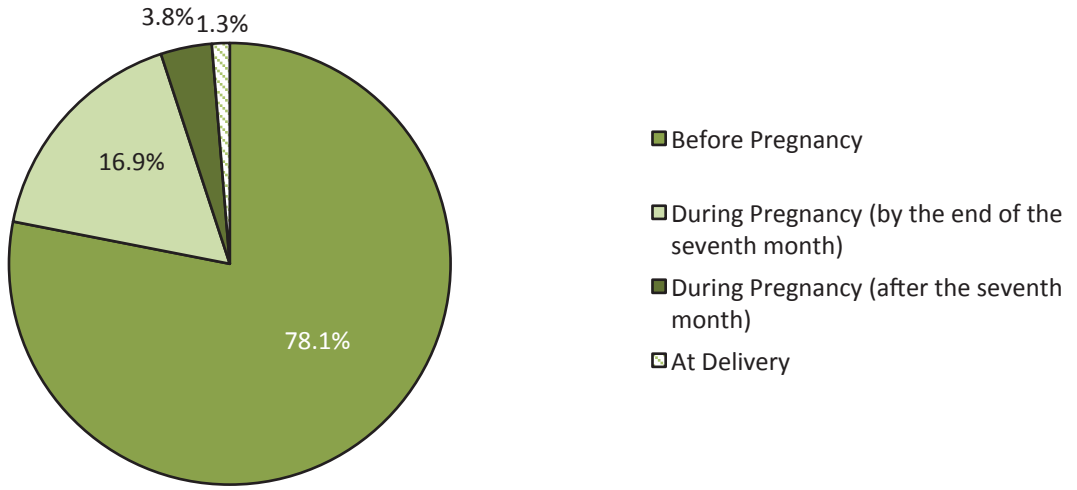
- The mother's infection is diagnosed early (by the end of the seventh month of pregnancy) so that maternal viral load can be reduced
- The mother receives ARVs during pregnancy
- The mother receives ARVs during labor/delivery (recommended if the maternal viral load is over 1,000 copies/mL)
- The newborn is delivered by cesarean section (recommended if the maternal viral load is over 1,000 copies/mL)
- The newborn receives ARVs after delivery
- The newborn/infant is not breastfed

Following all of these recommendations can reduce the rate of perinatal transmission to less than 1%. Although prenatal care is not listed among these missed opportunities because it does not directly increase fetal exposure to maternal virus, it is a crucial component of the prevention of perinatal transmission and facilitates testing and treatment for pregnant women.



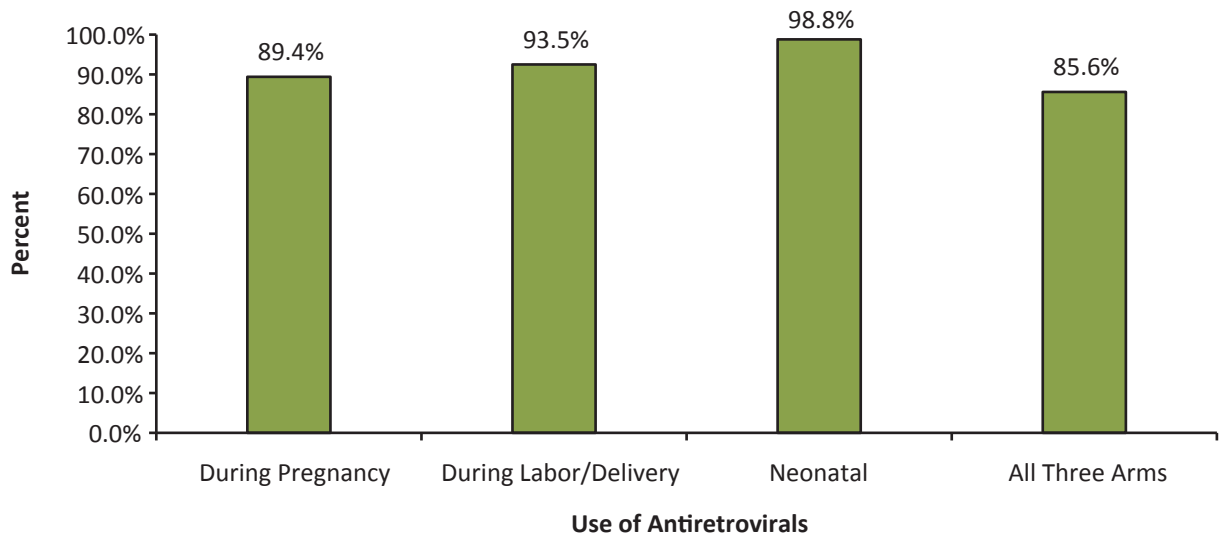
- In 2013, the most prevalent missed opportunity was no ARVs during pregnancy. Eleven percent of mothers did not receive ARVs during pregnancy. The use of ARV medication during pregnancy depends on several factors including timing of diagnosis, prenatal care, and mother's access to ARVs. Overall, 6% of mother-infant pairs had more than one missed opportunity for prevention of perinatal transmission.

Timing of Mother's Diagnosis
Louisiana, 2013



- Seventy-eight percent of mothers were diagnosed with HIV before pregnancy, while 17% were diagnosed before their seventh month of pregnancy, 4% after the seventh month, and 1% at delivery.

Three-Part Antiretroviral Therapy
Louisiana, 2013



- Antiretroviral therapy administered to women with HIV during pregnancy, labor/delivery and to newborns can greatly reduce perinatal transmission to less than 1%.
- In 2013, 89% of HIV positive women in Louisiana received ARV therapy during pregnancy; 93% received ARVs during labor/delivery; and almost 99% of newborns received prophylactic zidovudine shortly after birth. Overall, nearly 86% of mother-infant pairs received all three recommended components of the antiretroviral prophylaxis protocol.

Highlight

Fetal Infant Mortality Review/HIV (FIMR/HIV)

In 2009, the Louisiana STD/HIV Program and the Louisiana Bureau of Family Health partnered and were funded to carry out a perinatal HIV prevention methodology, based upon the Fetal Infant Mortality Review (FIMR), in the New Orleans region. The FIMR/HIV Prevention Methodology is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. The goal of the FIMR/HIV Prevention Methodology is to improve perinatal HIV prevention systems by using the FIMR case review and community action process. The FIMR/HIV Methodology follows a five-step process for data collection, review, and community action:

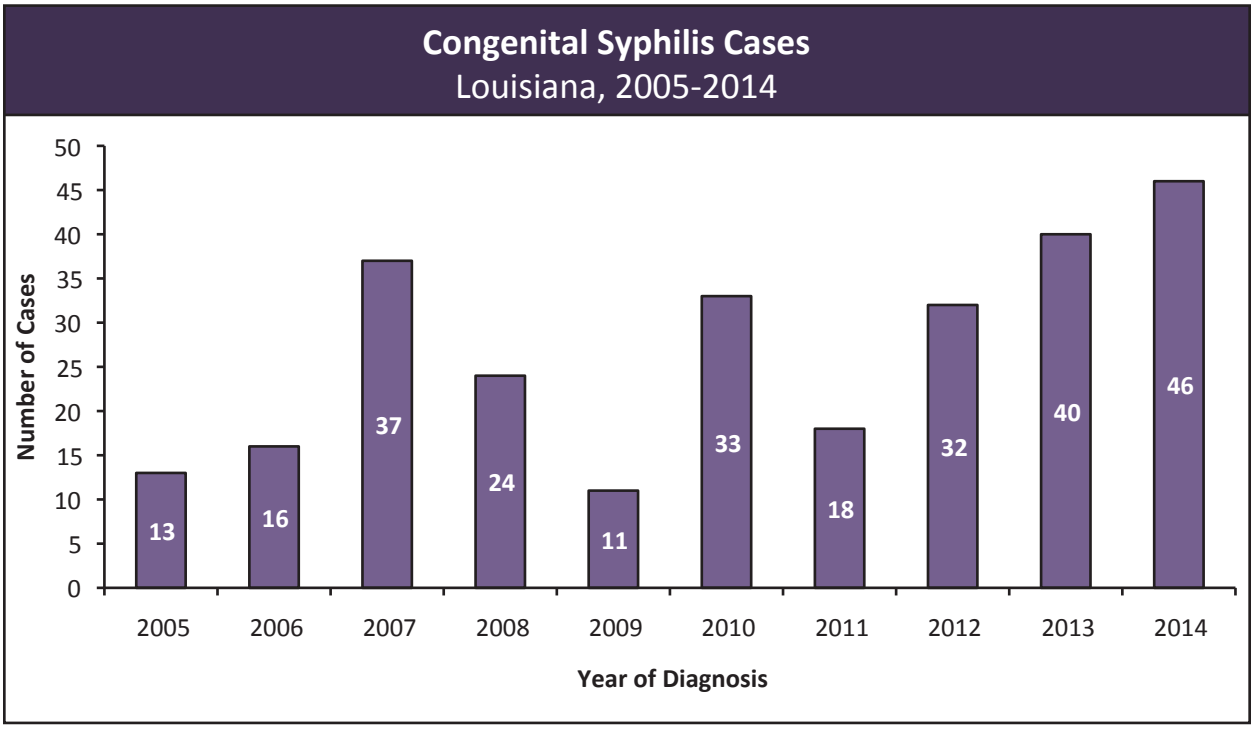
Cases reviewed to date include all cases of perinatal transmission of HIV from 2009 onward, as well as other cases with noted gaps in HIV or prenatal care. Louisiana is no longer funded specifically for FIMR/HIV, but continues to implement this methodology in the New Orleans and Baton Rouge regions with resources from the STD/HIV Program. Below are several recent recommendations from the FIMR/HIV Case Review Team.

FIMR/HIV Recommendations

- HIV Testing and Care for Emergency Departments: If a mother does not have prenatal care during her pregnancy, a visit to the Emergency Department may be the only contact she has with the health care system. HIV testing for women, especially pregnant women, during Emergency Department visits would provide a testing opportunity as well as care for women who do not otherwise utilize the healthcare system.
- Hospital Social Workers and Mental Health Services: Hospital Social workers can be a crucial asset for women with HIV giving birth in a hospital, especially for women in greatest need of other social support services, including mental health and referrals to housing services, food/nutrition assistance and other services.

Congenital Syphilis

Syphilis is both curable and easily treated. Subject to the stage of infection, treatment of syphilis during pregnancy ranges from one to three shots of benzathine penicillin at least 30 days prior to delivery. A case of congenital syphilis occurs when a pregnant woman with a syphilis infection passes the infection on to her infant in utero or during delivery, most often due to inadequate and/or incomplete treatment, reinfection during pregnancy, or no treatment during pregnancy. Congenital syphilis may result in stillbirth, infant death and/or other significant negative clinical outcomes.[17]



- Congenital syphilis cases have fluctuated over the past ten years, though there has been a consistent increase in cases since 2011.
- The number of congenital syphilis cases in Louisiana increased by 15%, from 40 cases in 2013 to 46 in 2014.

The following table shows demographic information for mothers of congenital syphilis cases in 2014. A total of 46 mothers are included below who gave birth to 46 infants.

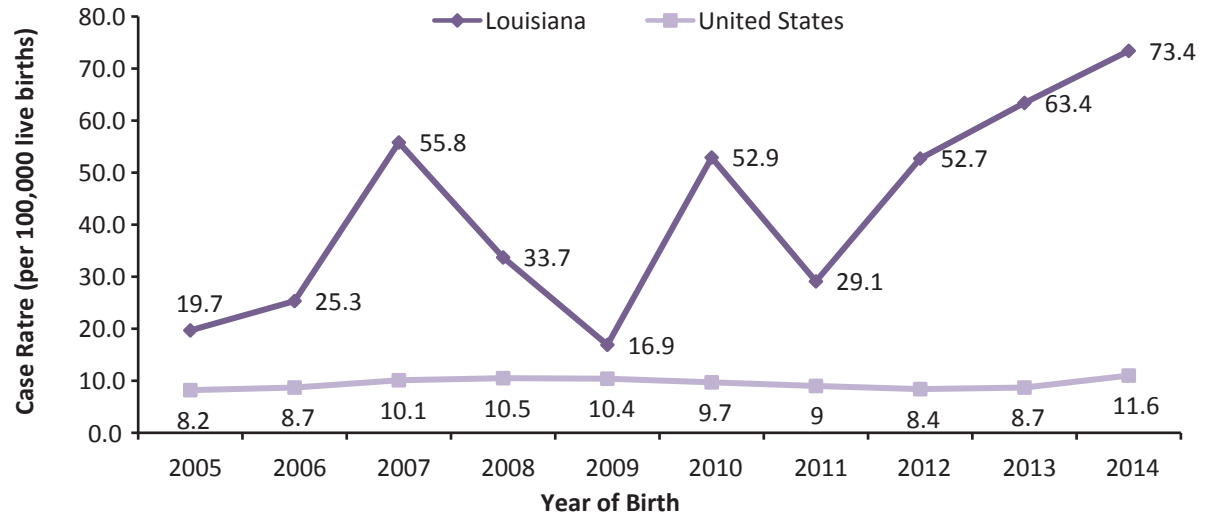
Congenital Syphilis
Louisiana, 2014

	Number	Percent
Total Cases	**46**	**100.0%**
Case Definition		
Presumed Case*	45	97.8%
Syphilitic Stillbirth	1	2.2%
Maternal Race/Ethnicity		
Black/African American	39	84.8%
Hispanic/Latino	1	2.2%
White	6	13.0%
Maternal Age Group		
15-19	10	21.7%
20-24	14	30.4%
25-29	15	32.6%
30-34	5	10.9%
35+	2	4.3%
Region		
1-New Orleans	7	15.2%
2-Baton Rouge	3	6.5%
3-Houma	6	13.0%
4-Lafayette	5	10.9%
5-Lake Charles	0	0.0%
6-Alexandria	0	0.0%
7-Shreveport	16	34.8%
8-Monroe	7	15.2%
9-Hammond/Slidell	2	4.3%
Frequency of Prenatal Care		
No Prenatal Care	7	15.2%
1-4 Prenatal Visits	16	34.8%
5-10 Prenatal Visits	10	21.7%
11+ Prenatal Visits	13	28.3%

**A presumed case of congenital syphilis is defined as an infant whose mother had untreated or inadequately treated syphilis at delivery or an infant who had a reactive test for syphilis and possible signs of syphilis at birth. The case is only considered to be confirmed through laboratory confirmed identification.*

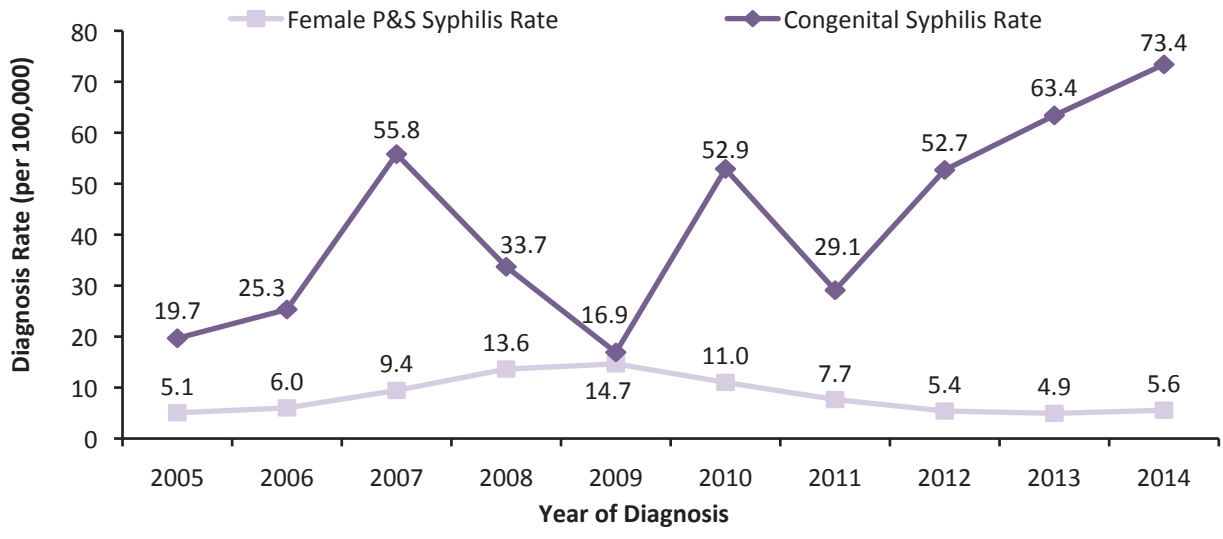
- In 2014, 85% of mothers of the 46 congenital syphilis cases were black and 15% were white.
- Nearly 85% of mothers were under 30 years of age when they delivered.
- Seven of Louisiana's nine public health regions had at least one case of congenital syphilis. The Shreveport region had the highest proportion of cases (35%), followed by New Orleans and Monroe (15%).

Congenital Syphilis Rates
Louisiana and the United States, 2005-2014



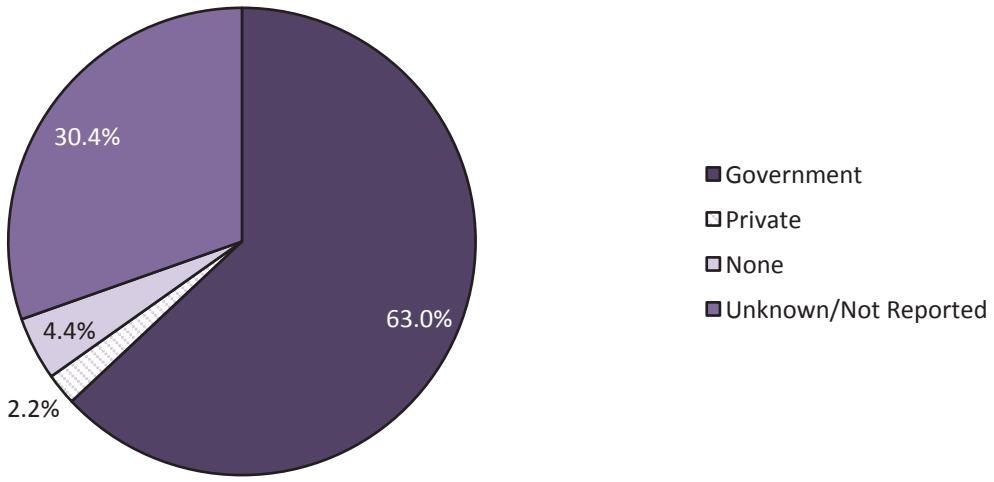
- In 2014, Louisiana ranked 1st in the nation for congenital syphilis diagnosis rates.[18]
- Only 30 states in the nation reported one or more cases of congenital syphilis in 2014. Until 2014, the US congenital syphilis rate remained below 11 cases per 100,000 live births.[18]
- In 2014, the congenital syphilis rate in Louisiana was 73.4 cases per 100,000 live births (46 cases). Though the US rate increased from 2013 to 2014, Louisiana's rate was still over six times the national rate of 11.6 per 100,000 live births.[18]

Trends in Female P&S Syphilis and Congenital Syphilis
Louisiana, 2005-2014



- National trends in congenital syphilis tend to follow trends for early syphilis in women with a one to two year lag. However, in Louisiana, the congenital syphilis rate has increased despite a significant decrease of syphilis among women since 2009.

Congenital Syphilis Cases and Type of Insurance During Pregnancy/Delivery
Louisiana, 2014



- While insurance is not a direct measure of income, it can help identify where the greatest need in prevention is.
- Though one third of women had unknown/no reported insurance, over half of the mothers (63%) utilized government or publicly funded insurance.

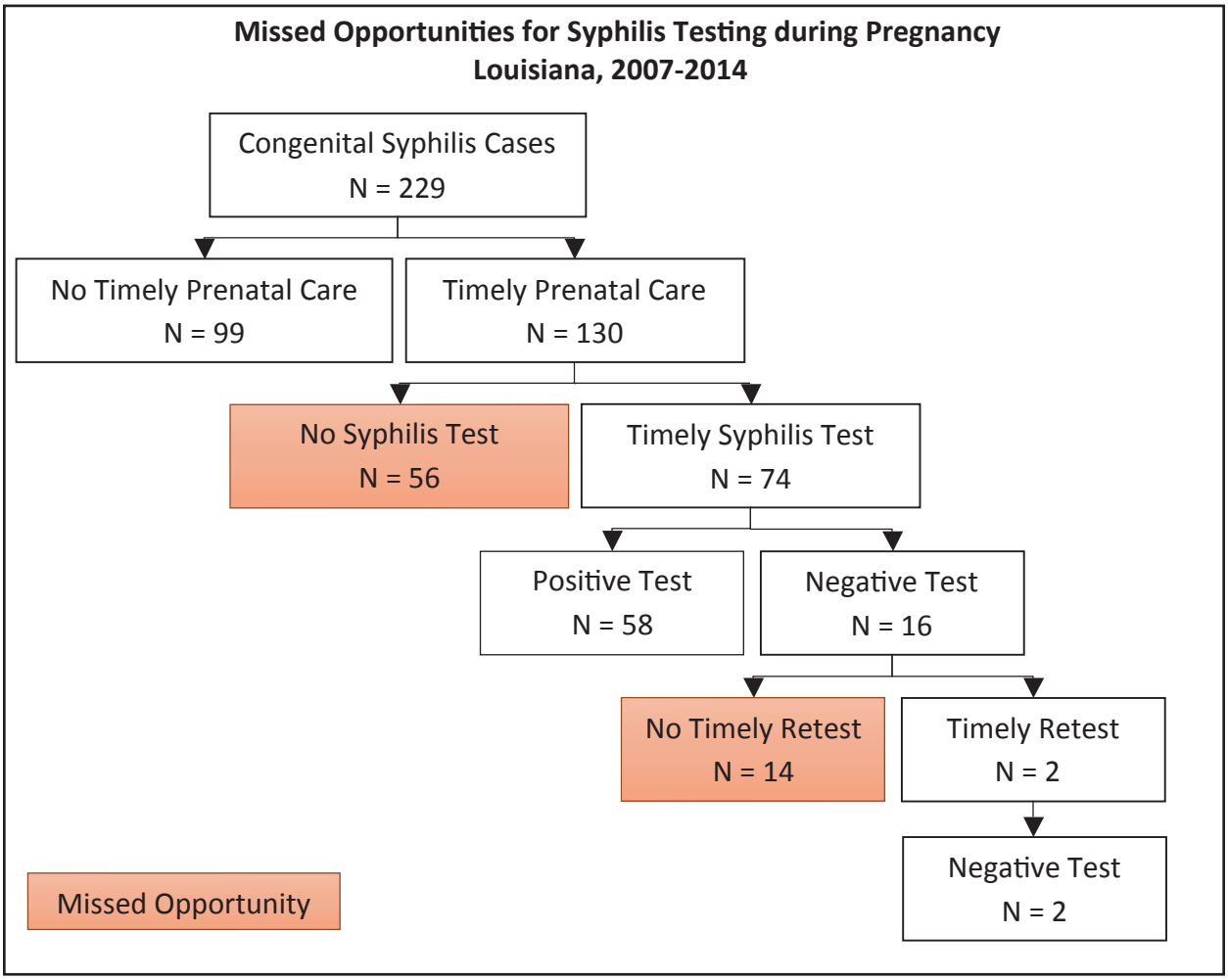
Prenatal Care and Birth Outcomes of Congenital Syphilis Cases
Louisiana, 2014

	Number	Percent
Total Cases	**46**	**100.0%**
Frequency of Prenatal Care		
No Prenatal Care	7	15.2%
1-4 Prenatal Visits	16	34.8%
5-10 Prenatal Visits	10	21.7%
11+ Prenatal Visits	13	28.3%
Birth Weight		
Low Birth Weight (<2500g)	9	20.0%
Normal Birthweight (≥2500g)	36	80.0%
Gestational Age		
Preterm (<37 weeks)	11	24.40%
Term (≥37 weeks)	34	75.60%

- Little to no prenatal care is evident within this group of mothers. Of the 46 mothers, 15% had no prenatal care and 35% attended between one and four prenatal visits.
- Infants born prematurely or underweight have greater health risks during their first year of life, as well as later in life. Twenty-four percent of infants in 2014 were born prematurely and 20% had a low birth weight.

Missed Opportunities for Syphilis Testing

Syphilis testing during pregnancy is a crucial aspect of preventing cases of congenital syphilis. In 2007, Louisiana enacted a law requiring that physicians offer opt-out syphilis testing during a woman's first prenatal care visit. In 2014, Louisiana extended the law to require that physicians also offer opt-out syphilis testing at the first prenatal care visit of the third trimester. In the chart below, 'Timely Prenatal Care' is prenatal care that starts at least 60 days before delivery and a 'Timely Syphilis Test' is a syphilis test conducted at least 45 days before delivery. This timing allows ample time for a woman to be treated for syphilis before delivery.



Approximately 43% of the women who delivered a newborn with congenital syphilis and who had timely prenatal care were never tested for syphilis during pregnancy. Physicians are required to offer a syphilis test at the first prenatal care visit, which could have prevented these cases of congenital syphilis.

Several women received timely, negative syphilis tests but were not retested later in pregnancy. Third trimester syphilis testing is essential for preventing cases in which syphilis infection or seroconversion occurs late in pregnancy.

Chapter 4

Profile of STDs in Louisiana

Introduction to STD Surveillance

The Louisiana Department of Health Office of Public Health STD/HIV Program's (SHP) Sexually Transmitted Disease (STD) Surveillance Program collects and analyzes data on diagnoses of syphilis (all stages), congenital syphilis, gonorrhea, and chlamydia. Louisiana's Sanitary Code mandates that all medical providers and laboratories report these STDs to SHP along with basic demographic and residence information. Funding for STD Surveillance comes from the Centers for Disease Control and Prevention (CDC).

Reports of positive syphilis tests are sent to the field staff in each region for evaluation and follow-up investigations, when needed. Positive chlamydia and gonorrhea tests are reviewed in the state central office and presently do not receive additional follow-up by regional staff.

Data from STD surveillance activities are analyzed and non-identifying summary information is provided to public health programs, medical providers, researchers, and the general public through reports, presentations, data requests, and fact sheets. The information is provided for the purposes of program planning, education, and evaluation.

Louisiana consistently experiences some of the highest rates of STDs in the United States. Syphilis, chlamydia, and gonorrhea are three commonly reported STDs. In 2014, Louisiana had the highest rate in the nation for gonorrhea, the 2nd highest primary and secondary (P&S) syphilis rate, and the 3rd highest chlamydia rate according to the CDC's 2014 *STD Surveillance Report*.[19]

The data presented below represent all new diagnoses of chlamydia, gonorrhea, and P&S syphilis diagnosed from 2005 to 2014 and reported to SHP before May 2, 2015. This report presents both counts of STD diagnoses and STD diagnosis rates. Rates take into account differing population sizes among demographic groups or areas, and comparing rates between two or more groups or areas can identify important differences.

Trends in Louisiana STD Cases
Louisiana, 2005-2014

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Chlamydia	17,227	17,885	19,362	23,536	28,148	29,151	31,614	27,353	28,739	28,896
Gonorrhea	9,572	10,883	11,137	9,766	9,150	8,912	9,169	8,873	9,002	8,978
P&S Syphilis	278	342	533	721	742	547	447	339	423	575

In 2014, 28,896 chlamydia diagnoses, 8,978 gonorrhea diagnoses, and 575 P&S syphilis diagnoses were reported in Louisiana.

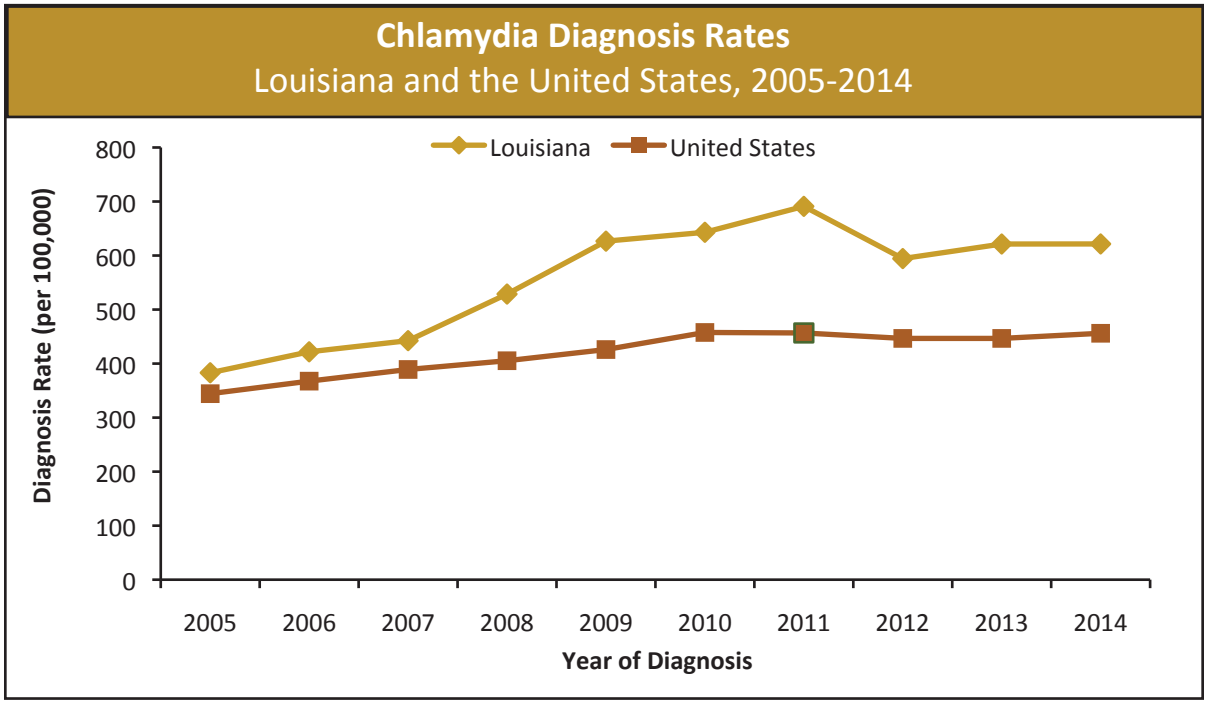
Chlamydia

Caused by the bacterium *Chlamydia trachomatis*, chlamydia is the most commonly diagnosed STD in the United States. 2013 was the first time that chlamydia diagnosis rates decreased nationally since reporting began. National rates once again rose in 2014. Though chlamydial infections are often asymptomatic, symptoms can range from urethritis or vaginitis to severe pelvic inflammatory disease (PID) in women. PID can cause infertility, ectopic pregnancy, and chronic pelvic pain. Pregnant women with chlamydia can pass the infection to their infants during delivery, potentially causing health issues such as ophthalmia neonatorum or pneumonia. The CDC recommends annual screening of all sexually active women under 25 years.[20]

10 Year Trends in Chlamydia Diagnoses

There were 28,896 diagnoses of chlamydia reported in Louisiana in 2014. This represents a 0.5% increase in the number of diagnoses from 2013, when 28,739 diagnoses were reported. Over the past 10 years, the number of new chlamydia diagnoses has fluctuated from a low of 17,864 in 2005 to a high of 31,642 in 2011. In 2005 there was a large disruption in STD testing services due to Hurricane Katrina.

Some of the rise in diagnoses may be due to improved chlamydia screening practices. Louisiana's public health units have replaced genetic probe testing with the Amplified Nucleic Acid Test as recommended by the CDC, which has increased sensitivity, capturing more infections.[20] In addition, screening for chlamydia is performed for all sexually active female patients age 30 and younger in Louisiana's parish health units.



- In 2014, the chlamydia diagnosis rate in Louisiana was 621.5 per 100,000 population, remaining nearly the same as the 2013 rate of 621.3 diagnoses per 100,000. This represents the first time Louisiana's diagnosis rates have remained stable in the past 10 years. The 2014 Louisiana rate was 36% higher than the 2014 national rate of 456.1 per 100,000 population. It should be noted than in 2012, intensive deduplication efforts were begun in Louisiana which may be responsible for the reduction in diagnosis counts and rates from previous years.[19]
- Chlamydia diagnosis rates in Louisiana increased significantly from a low of 397.2 per 100,000 in 2005 to a high of 691.7 per 100,000 in 2011. A steady increase has been seen across the nation since 2005.[19]

Chlamydia Diagnoses by Sex at Birth, Race/Ethnicity, and Age

Although STDs affect persons of all sexes, ages, and race/ethnicities in Louisiana, the impact is not the same across all populations. Identifying the populations most at risk of contracting an STD helps in planning STD prevention activities and services, and in determining the most effective use of limited resources.

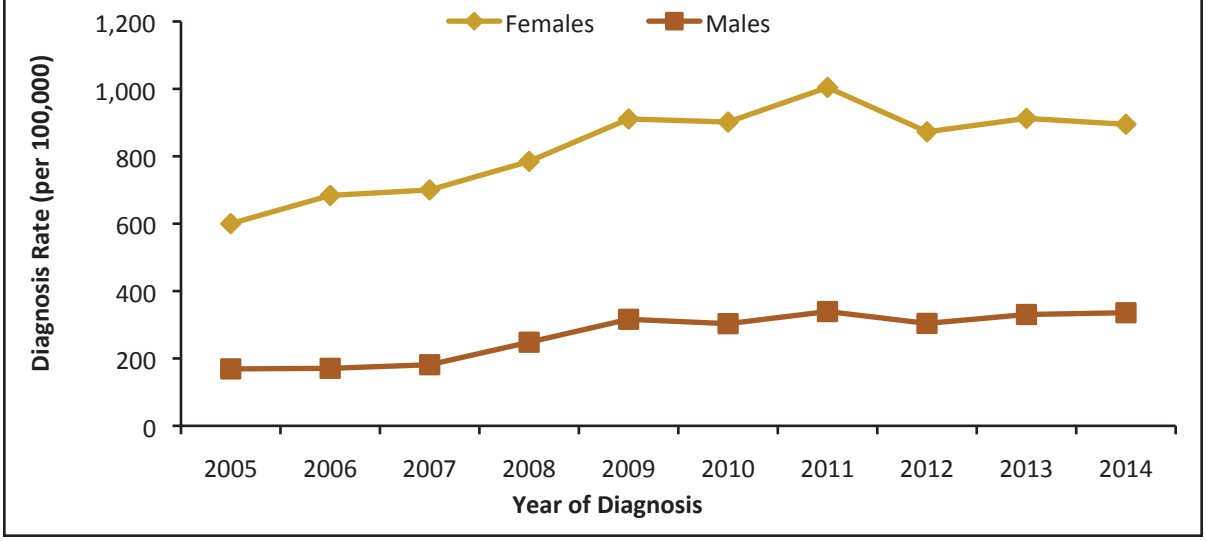
Characteristics of Persons Diagnosed with Chlamydia
Louisiana, 2014

	Cases	Percent	Rate
Total	**28,896**	**100%**	**621.5**
Sex at Birth*			
Female	21,259	73.6%	894.8
Male	7,634	26.4%	335.7
Unknown	*3*	*0.0%*	-
Race/Ethnicity*			
Black/African American	21,192	73.9%	1,421.6
Hispanic/Latino	834	2.9%	370.9
White	6,202	21.6%	224.8
Other/Multi-race	434	1.5%	-
Unknown	*234*	*0.8%*	-
Age Group*	**Age at Diagnosis**		
0-9	9	0.0%	1.4
10-14	404	1.4%	131.4
15-19	9,344	32.3%	3,112.0
20-24	11,108	38.4%	3,175.5
25-29	4,634	16.0%	1,365.9
30-34	1,919	6.6%	580.9
35-39	770	2.7%	268.8
40-44	352	1.2%	125.9
45+	351	1.2%	19.1
Unknown	*5*	*0.0%*	-

*Demographic and address information not available through all reporting mediums

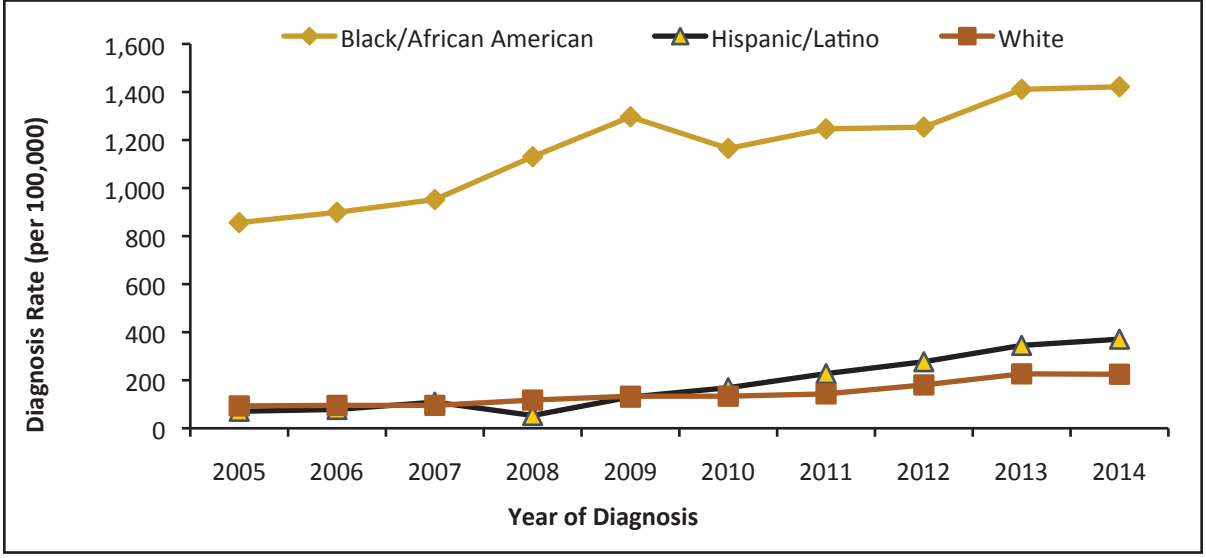
- In 2014, 21,259 females were diagnosed with chlamydia, remaining equivalent to 2013. The number of males diagnosed with chlamydia in Louisiana increased 2%, from 7,481 in 2013 to 7,634 in 2014.
- There is a significant racial disparity for chlamydia diagnoses in Louisiana. The rate of chlamydia in blacks in Louisiana was over six times higher than the rate in whites, and nearly four times higher than among Hispanics/Latinos.
- Almost 74% of all chlamydia diagnoses with reported race were among blacks and 22% were among whites. Only 32% of Louisiana's population was black in 2014.
- In 2014, nearly 71% of new chlamydia diagnoses were among 15-24 year olds. The number of new diagnoses in persons aged 20-24 decreased 2% from 2013. The number of new diagnoses among all other age groups increased.

Trends in Chlamydia Diagnosis Rates by Sex at Birth
Louisiana, 2005-2014



- The 2014 female chlamydia rate of 894.8 per 100,000 females was almost three times the male rate of 335.7 per 100,000 males.
- The chlamydia diagnosis rate for males in Louisiana has slowly risen over the past 10 years.
- The rate for females has been more variable (between 600.1 and 1,004.3 per 100,000 females). Cumulatively, females accounted for 77% of all chlamydia diagnoses in Louisiana over the past 10 years.

Trends in Chlamydia Diagnosis Rates by Race/Ethnicity
Louisiana, 2005-2014



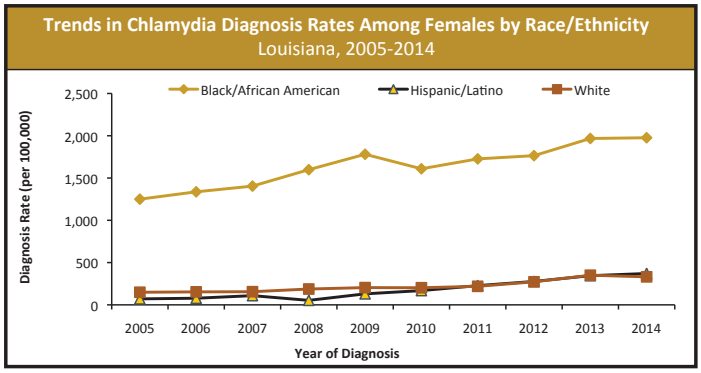
- The chlamydia diagnosis rate for whites and Hispanic/Latinos in Louisiana has slowly risen over the past 10 years. The rate for whites increased from a low of 169.1 per 100,000 in 2005 to a high of 335.7 per 100,000 in 2014. The rate for Hispanics/Latinos increased from a low of 53.2 per 100,000 in 2008 to a high of 370.9 per 100,000 in 2014.
- The diagnosis rate for blacks has consistently been higher than the rate for other race/ethnicities. Since 2008, the rate of chlamydia among blacks has been over 1,000 per 100,000 blacks.

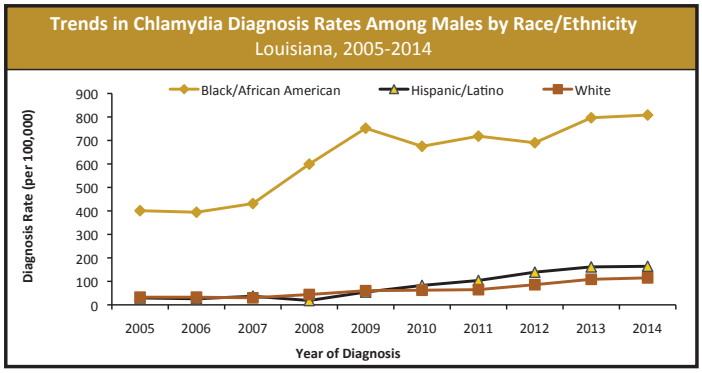
Race/Ethnicity of Persons Diagnosed with Chlamydia by Sex at Birth
Louisiana, 2014

	Cases	Percent	Rate
Total*	**28,896**	**100%**	**621.5**
Female	**21,259**	**73.6%**	**894.8**
American Indian/Alaskan Native	57	0.3%	382.7
Asian/Pacific Islander	136	0.6%	321.5
Black/African American	15,470	73.3%	1976.4
Hispanic/Latino	634	3.0%	615.3
White	4,641	22.0%	331.4
Other/ Multirace	155	0.7%	-
Unknown	*166*	*0.8%*	-
Male	**7,634**	**26.4%**	**335.7**
American Indian/Alaskan Native	13	0.2%	89.8
Asian/Pacific Islander	41	0.5%	100.8
Black/African American	5,722	75.6%	808.2
Hispanic/Latino	200	2.6%	164.2
White	1,561	20.6%	114.9
Other/ Multirace	32	0.4%	-
Unknown	*65*	*0.9%*	-

*Total includes 3 persons of unknown birth sex.

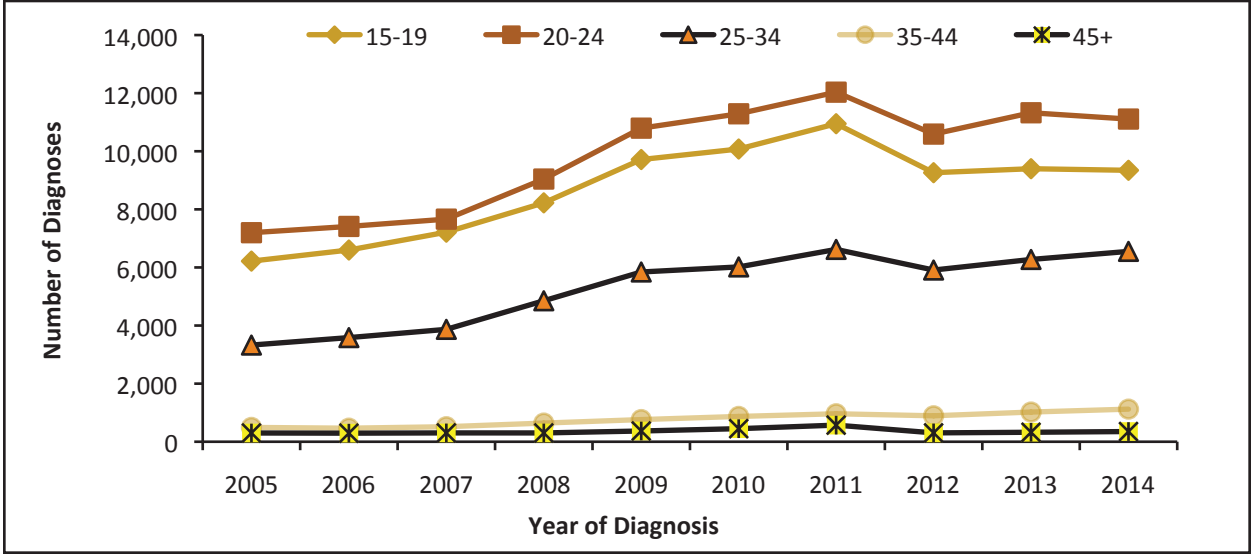
- Among the chlamydia diagnoses in females with a reported race, 73% were black and 22% were white. Of the diagnoses in males with a reported race, 76% were black and 21% were white.
- Although the numbers were small, there were over three times as many chlamydia diagnoses in females of Asian/Pacific Islander and American Indian/Alaskan Native backgrounds combined as in males of the same race/ethnicities. There were also over three times as many diagnoses among Hispanic/Latina females as there were among Hispanic/Latino males.
- The rate of chlamydia in black females was nearly two and a half times the rate in black males, and the chlamydia rate in white females was nearly three times that seen in white males. The rate in Hispanic/Latina females was nearly four times that of Hispanic/Latino males.





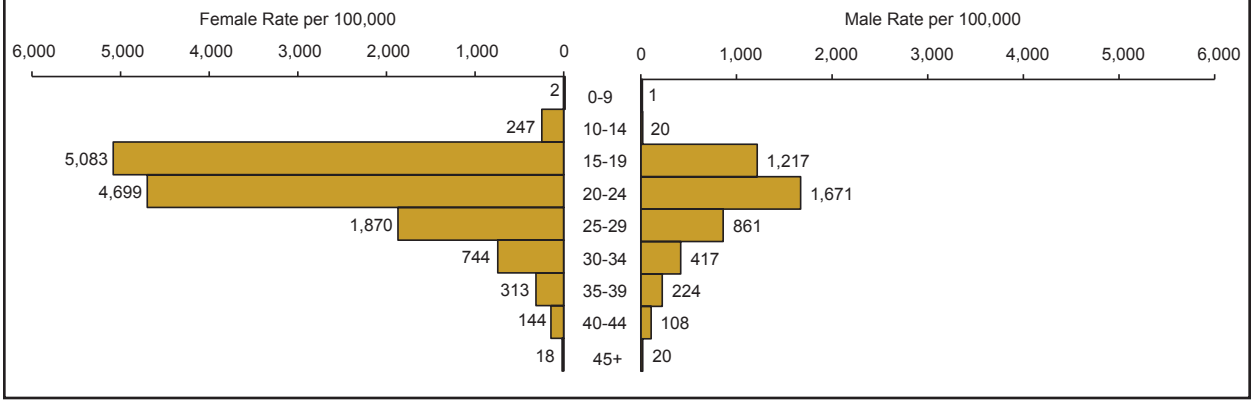
- The rate of chlamydia in black females was nearly six times the rate in white females and three times the rate in Hispanic/Latina females.
- The rate of chlamydia in black males was seven times the rate in white males and nearly five times the rate in Hispanic/Latino males.

Trends in Chlamydia Diagnoses by Age Group
Louisiana, 2005-2014



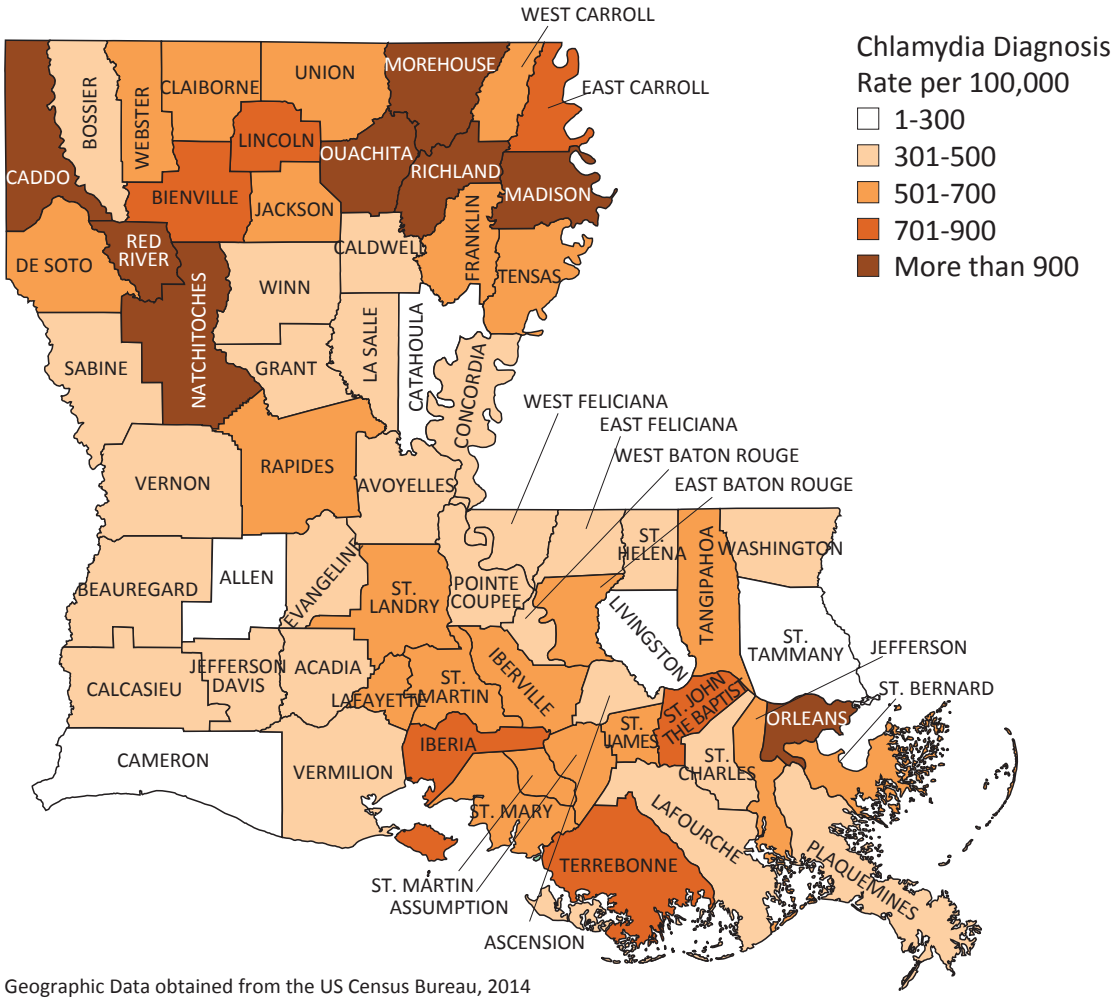
- The highest number of chlamydia diagnoses occur in persons aged 20-24 and 15-19, making up 71% of Louisiana diagnoses since 2005. Persons aged 25-34 have made up an additional 23% of diagnoses over the last 10 years.

Chlamydia Diagnosis Rates by Age and Sex at Birth
Louisiana, 2014



- In 2014, the highest age-specific rate was among 15-19 year old females, followed closely by females age 20-24.
- Among males in 2014, the highest age-specific rate was among 20-24 year olds, followed by males aged 15-19. It is only in the 45+ age group that the male diagnosis rate is higher than the female rate.

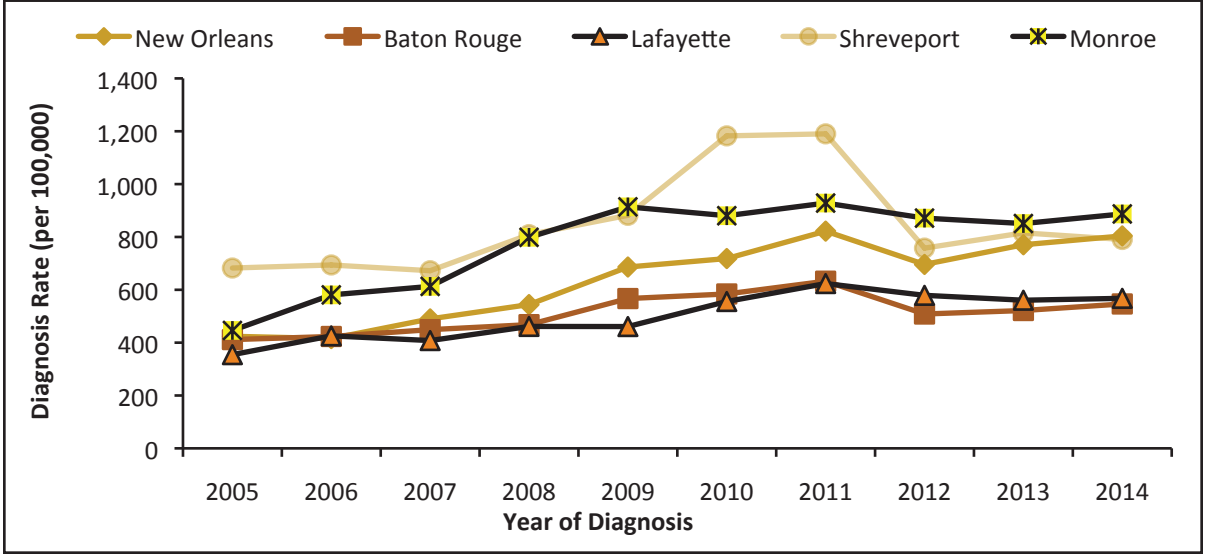
Chlamydia Diagnosis Rates by Parish, 2014



Geographic Data obtained from the US Census Bureau, 2014

- Chlamydia diagnosis rates vary by parish in Louisiana. There were persons diagnosed with chlamydia in all 64 parishes in 2014.
- A total of eight parishes had a chlamydia diagnoses rate greater than 900 per 100,000 (Caddo, Madison, Natchitoches, Morehouse, Ouachita, Orleans, Red River, and Richland), the same as in 2013.
- Additional breakdowns by race/ethnicity and sex at birth by parish can be found in the Appendix.

Trends in Chlamydia Diagnosis Rates by Selected Region
Louisiana, 2005-2014



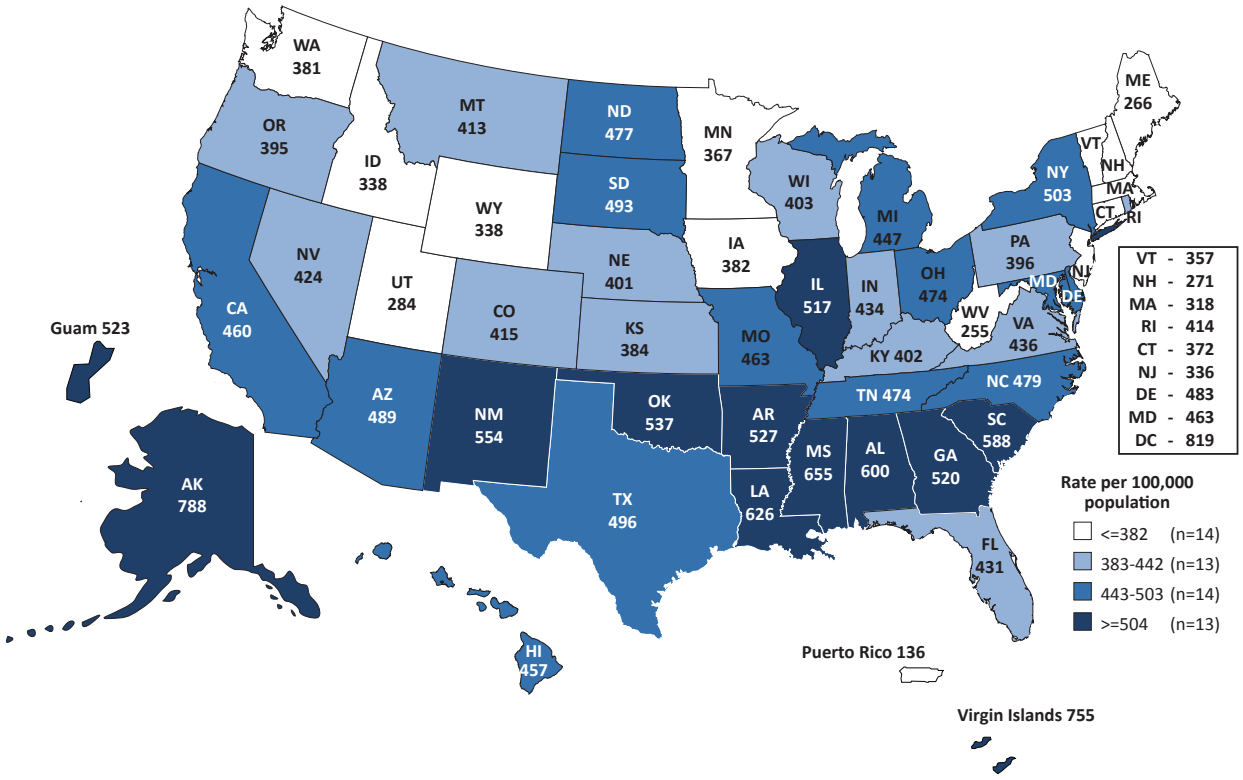
- Since 2012, the Monroe region has had the highest chlamydia diagnosis rate in the state.
- In 2014, the New Orleans region ranked 2nd for chlamydia diagnosis rates. This is the first time in over a decade that the rate for the New Orleans region has been higher than the Shreveport region.

New Chlamydia Diagnoses by Region and Year
Louisiana, 2010-2014

	2010		2011		2012		2013		2014	
Louisiana	**29,151**	**%**	**31,614**	**%**	**27,353**	**%**	**28,739**	**%**	**28,896**	**%**
1-New Orleans	6,000	21%	6,884	22%	6,045	22%	6,784	24%	7,138	25%
2-Baton Rouge	3,875	13%	4,165	13%	3,418	13%	3,522	12%	3,711	13%
3-Houma	1,906	7%	2,400	8%	2,118	8%	2,304	8%	2,441	8%
4-Lafayette	3,246	11%	3,649	12%	3,427	13%	3,342	12%	3,420	12%
5-Lake Charles	1,459	5%	1,595	5%	1,394	5%	1,364	5%	1,111	4%
6-Alexandria	1,784	6%	1,828	6%	1,744	6%	1,678	6%	1,499	5%
7-Shreveport	5,662	19%	5,668	18%	4,174	15%	4,480	16%	4,328	15%
8-Monroe	3,132	11%	3,293	10%	3,103	11%	3,032	11%	3,158	11%
9-Hammond/Slidell	1,989	7%	2,133	7%	1,908	7%	2,081	7%	2,024	7%
Unknown	*98*	*0%*	*0*	*0%*	*22*	*0%*	*152*	*1%*	*66*	*0%*

- The New Orleans region had the highest number of new chlamydia diagnoses in 2014, followed by Shreveport and Baton Rouge.

Chlamydia Diagnosis Rates in the United States (2014)[19]



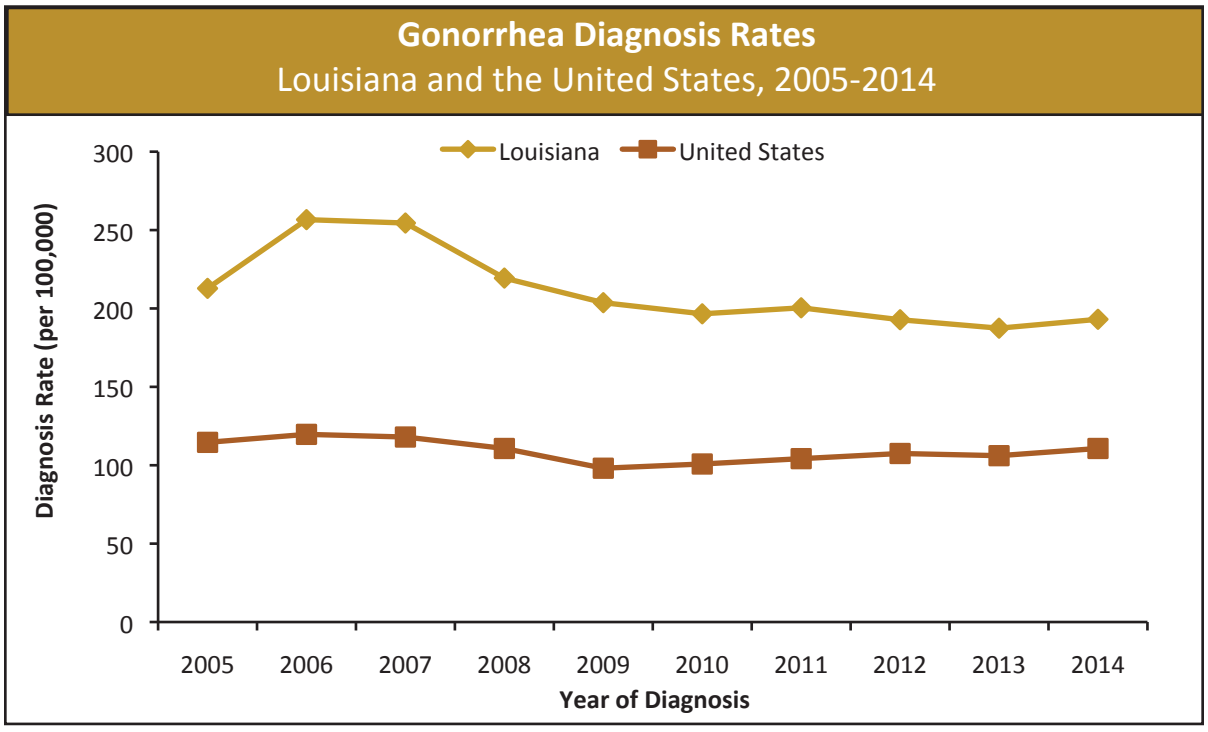
- In November 2015, the CDC released the *STD Surveillance Report, 2014*, which provides national and state-specific STD data. The CDC report uses estimated 2013 Census Data while the Louisiana report uses estimated 2014 Census data, resulting in slightly different rate estimates between their report and ours.
- In the US, there were 1,441,789 new chlamydia diagnoses reported in 2014, for a national chlamydia rate of 456.1 diagnoses per 100,000 population. In 2013, the national chlamydia diagnosis rate was 446.6 per 100,000 population.[19]
- Chlamydia rates increased 2% across the nation from 2013 to 2014.[19]
- In 2014, Louisiana ranked 3rd in the nation for chlamydia diagnosis rates. Alaska (787.5 per 100,000), and Mississippi (655.4 per 100,000) ranked 1st and 2nd respectively in 2014.[19]
- Louisiana's 2014 rate was 36% greater than the national rate.[19]
- Nationally, the rate of females diagnosed with chlamydia rose 1% from 2013, while the rate in males increased 7%. Potential reasons for the increase in males include increased disease transmission, changes in testing technology, more sensitive tests, and changes in reporting practices.[19]

Gonorrhea

Gonorrhea is caused by the bacterium *Neisseria gonorrhea*. It is the second most commonly reported STD in the United States. If left untreated, gonorrhea can affect fertility in males and females, increase the risk of HIV infection and transmission, and cause other serious health problems. Gonorrhea is a common cause of epididymitis in men and PID in women, and both of these conditions can lead to infertility. Pregnant women with a gonorrhea infection may infect their infants during delivery which can potentially cause blindness, joint infection, or a blood infection.[20] Resistance to antimicrobials is important in considering the treatment of gonorrhea infections. Increasing resistance to flouroquinolones and a decline in susceptibility to cefixime has been noted. Therefore, only dual therapy with ceftriaxome and azithromycin or doxycycline is now recommended by the CDC.[20]

10 Year Trends in Gonorrhea Diagnoses

There were 8,978 gonorrhea diagnoses in Louisiana in 2014. This represents nearly a 4% increase in the number of diagnoses from 2013, when 8,669 diagnoses were reported. Over the past 10 years, the number of new gonorrhea diagnoses has fluctuated from a low of 8,669 in 2013 to a high of 11,357 in 2007. In 2005 there was a large disruption in STD testing services due to Hurricane Katrina.



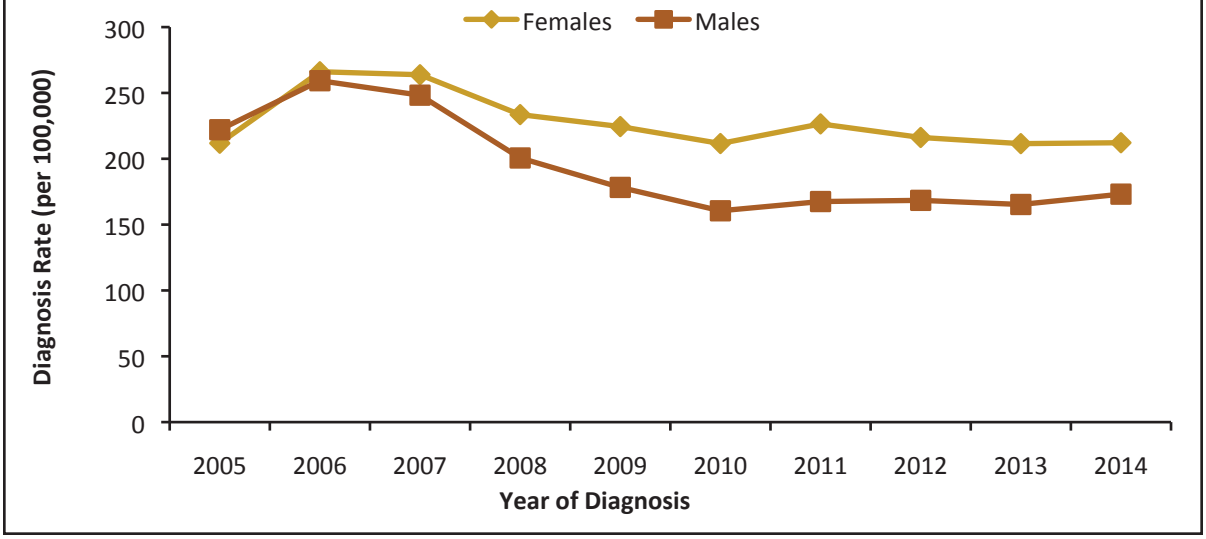
- In 2014, the gonorrhea diagnosis rate in Louisiana was 193.1 per 100,000 population, a 3% increase from 187.4 diagnoses per 100,000 in 2013. The 2014 Louisiana rate was 74% greater than the national rate of 110.7 per 100,000 population. It should be noted than in 2012, intensive deduplication efforts were begun in Louisiana which may be responsible for the reduction in diagnosis counts and rates from previous years.[19]
- From 2006 to 2013, the gonorrhea diagnosis rate in Louisiana decreased by almost 30%.

Characteristics of Persons Diagnosed with Gonorrhea Louisiana, 2014			
	Cases	Percent	Rate
Total	**8,978**	**100%**	**193.1**
Sex at Birth*			
Female	5,041	56.1%	212.2
Male	3,937	43.9%	173.1
Race/Ethnicity*			
Black/African American	7,444	83.4%	499.3
Hispanic/Latino	125	1.4%	55.6
White	1,272	14.2%	46.1
Other/Multi-race	87	1.0%	-
Unknown	*50*	*0.6%*	-
Age Group*	**Age at Diagnosis**		
0-9	6	0.1%	1.0
10-14	113	1.3%	36.7
15-19	2,484	27.7%	827.3
20-24	3,244	36.1%	927.4
25-29	1,605	17.9%	473.1
30-34	738	8.2%	223.4
35-39	368	4.1%	128.5
40-44	165	1.8%	59.0
45+	252	2.8%	13.7
Unknown	*3*	*0.0%*	-

*Demographic and address information not available through all reporting mediums.

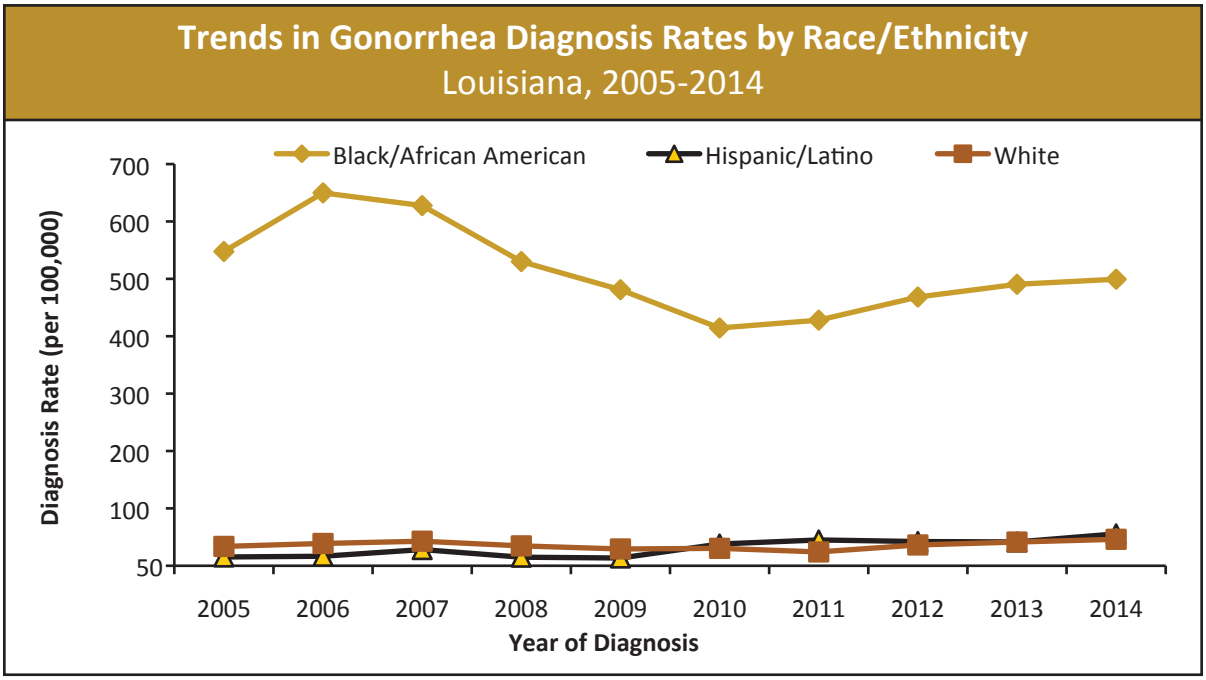
- In 2014, 5,041 females were diagnosed with gonorrhea, a 2% increase from the 4,927 diagnoses in 2013. The number of males diagnosed with gonorrhea in Louisiana increased 5% to 3,937 diagnoses in 2014 from 3,742 diagnoses in 2013.
- There is a significant racial disparity for gonorrhea diagnoses in Louisiana. In 2014, the rate of new gonorrhea diagnoses among blacks was 499.3 per 100,000, nearly 11 times higher than among whites and nine times higher than among Hispanics/Latinos.
- Over 83% of all gonorrhea diagnoses with reported race were among blacks and 14% were diagnosed among whites. Only 32% of Louisiana's population is black.
- In 2014, nearly 64% of new gonorrhea diagnoses were among 15-24 year olds. The number of new diagnoses in persons aged 20-24 decreased 3% from 2013. The number of new diagnoses among all other age groups increased.

Trends in Gonorrhea Diagnosis Rates by Sex at Birth
Louisiana, 2005-2014



- The 2014 female gonorrhea diagnosis rate of 212.2 per 100,000 females was 23% greater than the male rate of 173.1 per 100,000 males.
- The gonorrhea rates for males and females were nearly the same in 2005 and 2006, after which time diagnosis rates began to diverge. The greatest gap in rates between males and females was observed in 2011 when the rates were 226.5 per 100,000 females and 167.5 per 100,000 males.
- Cumulatively, females have accounted for 55% of all gonorrhea diagnoses in Louisiana over the past 10 years.

Trends in Gonorrhea Diagnosis Rates by Race/Ethnicity
Louisiana, 2005-2014

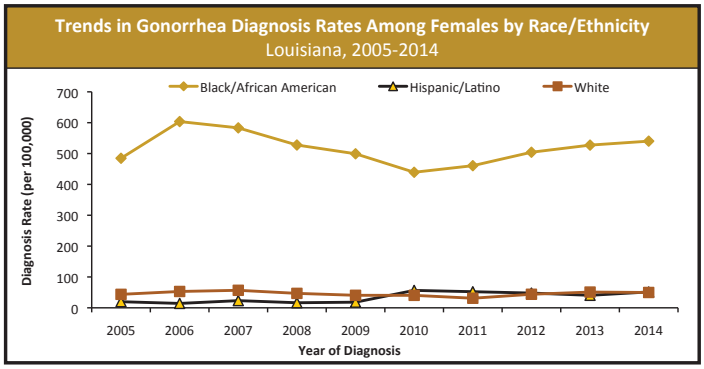


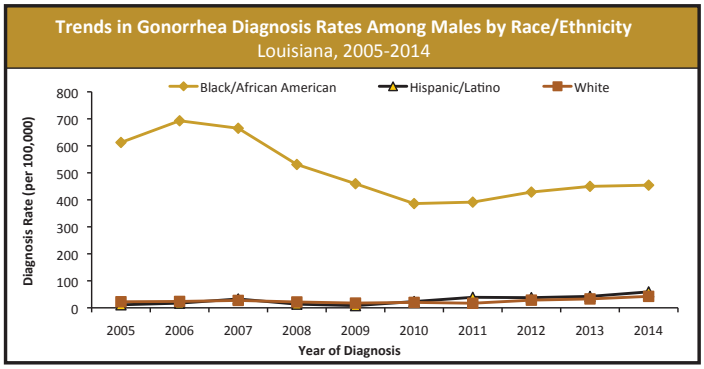
- The gonorrhea rate for blacks has increased steadily over the past five years, from a low of 414.4 per 100,000 in 2010 to a high of 499.3 per 100,000 in 2014. The rate has also risen in Hispanics/Latinos, from a low of 13.5 per 100,000 in 2009 to a high of 55.6 per 100,000 in 2014.
- The diagnosis rate for blacks has consistently been higher than the rate for other races and ethnicities. The rate of gonorrhea has consistently exceeded 400 per 100,000 blacks, while the rate for whites has remained under 50 per 100,000 whites.

Race/Ethnicity of Persons Diagnosed with Gonorrhea by Sex at Birth
Louisiana, 2014

	Cases	Percent	Rate
Total	**8,978**	**100%**	**193.1**
Female	**5,041**	**56.1%**	**212.2**
American Indian/Alaskan Native	7	0.1%	47.0
Asian/Pacific Islander	14	0.3%	33.1
Black/African American	4,228	84.1%	540.1
Hispanic/Latino	53	1.1%	51.4
White	696	13.9%	49.7
Other/ Multirace	27	0.5%	-
Unknown	*16*	*0.3%*	-
Male	**3,937**	**43.9%**	**173.1**
American Indian/Alaskan Native	8	0.2%	55.2
Asian/Pacific Islander	21	0.5%	51.6
Black/African American	3,216	82.4%	454.2
Hispanic/Latino	72	1.8%	59.1
White	576	14.8%	42.4
Other/ Multirace	10	0.3%	-
Unknown	*34*	*0.9%*	-

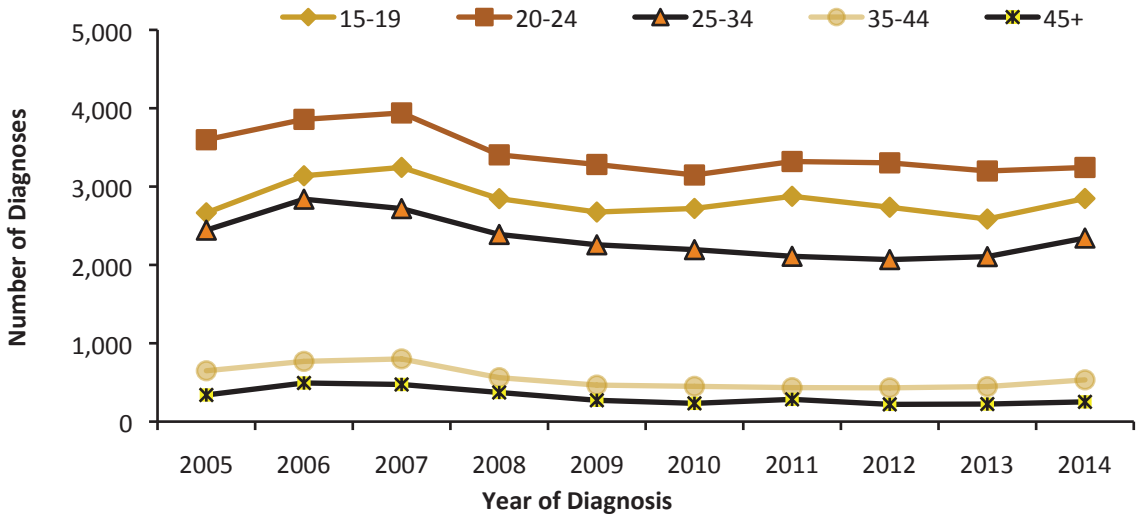
- Among gonorrhea diagnoses in females with reported race, 84% were black and 14% were white. Of diagnoses in males with reported race, 82% were black and 15% were white.
- The number of diagnoses in males of Hispanic/Latino, Asian/Pacific Islander, and American Indian/Alaskan Native background was 36% higher than the number of diagnoses in females of the same race/ethnicities. These three groups accounted for 2% of all gonorrhea diagnoses with reported race in 2014.
- The rate of gonorrhea in black females was 19% higher than the rate in black males, and the gonorrhea rate in white females was 17% greater than in white males.





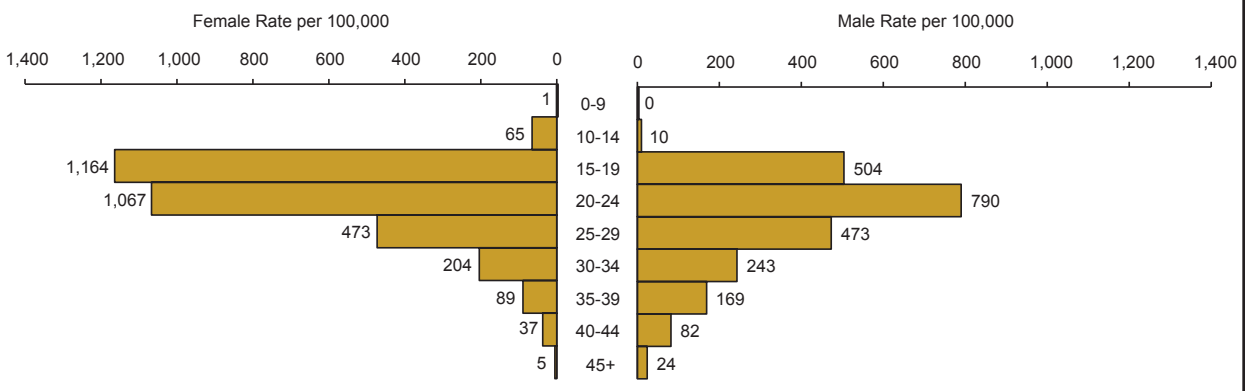
- The rate of gonorrhea in black females was nearly 10 times the gonorrhea rate in white and in Hispanic/Latina females.
- The rate of gonorrhea in black males was nearly 11 times the rate in white males and over seven times the rate in Hispanic/Latino males.

Trends in Gonorrhea Diagnoses by Age Group
Louisiana, 2005-2014



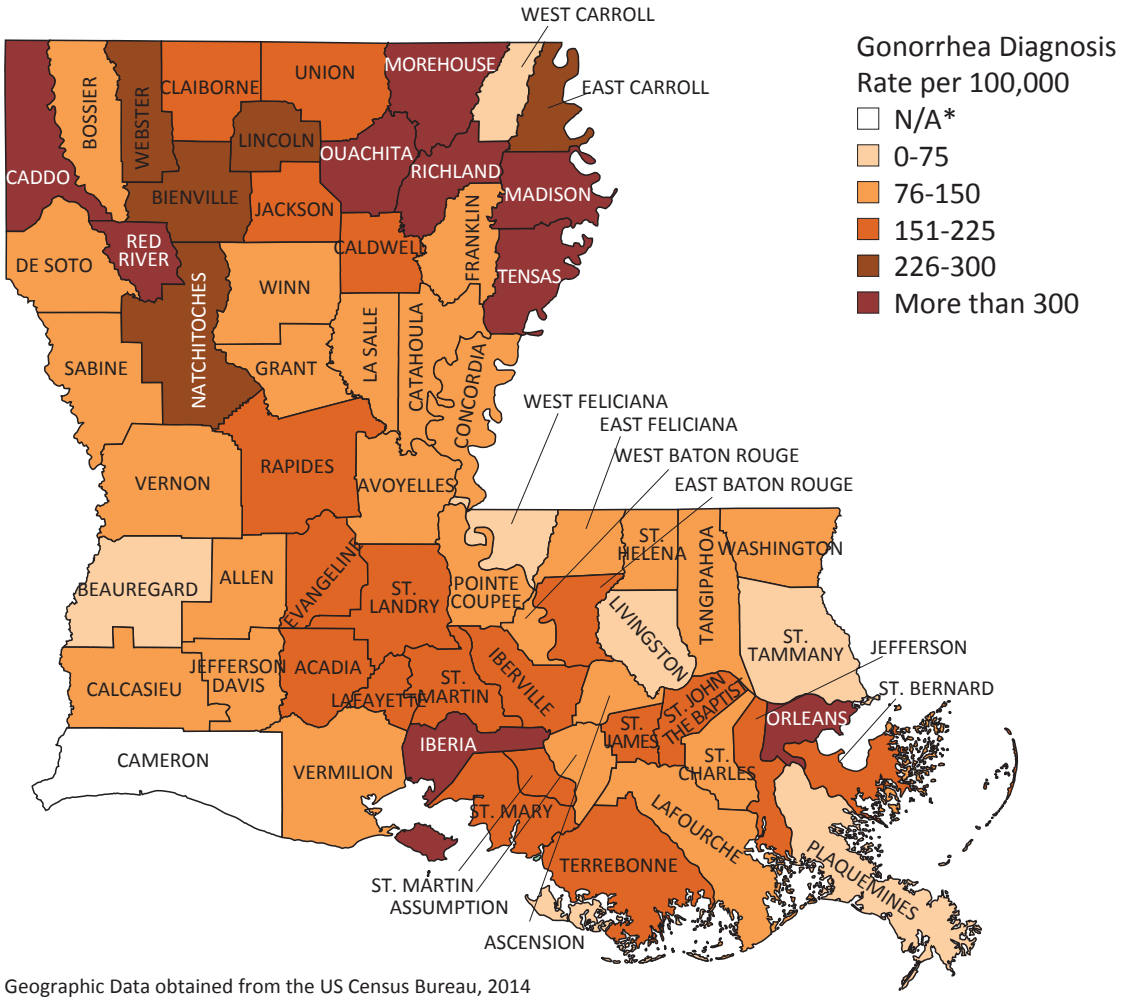
- The highest number of gonorrhea diagnoses occur in persons aged 15-24, accounting for 66% of Louisiana's gonorrhea diagnoses since 2005. Persons aged 25-34 made up an additional 25% of diagnoses over the past 10 years.
- The number of new diagnoses among persons 35 years old and higher has remained steady since 2011.

Gonorrhea Diagnosis Rates by Age and Sex at Birth
Louisiana, 2014



- In 2014, the highest age specific rate was among 15-19 year old females, followed by 20-24 year old females.
- Among males in 2014, the highest age-specific rate was among 20-24 year olds, followed by males age 15-19. Among persons 30 and older, the diagnosis rates seen in males were higher than those in females.

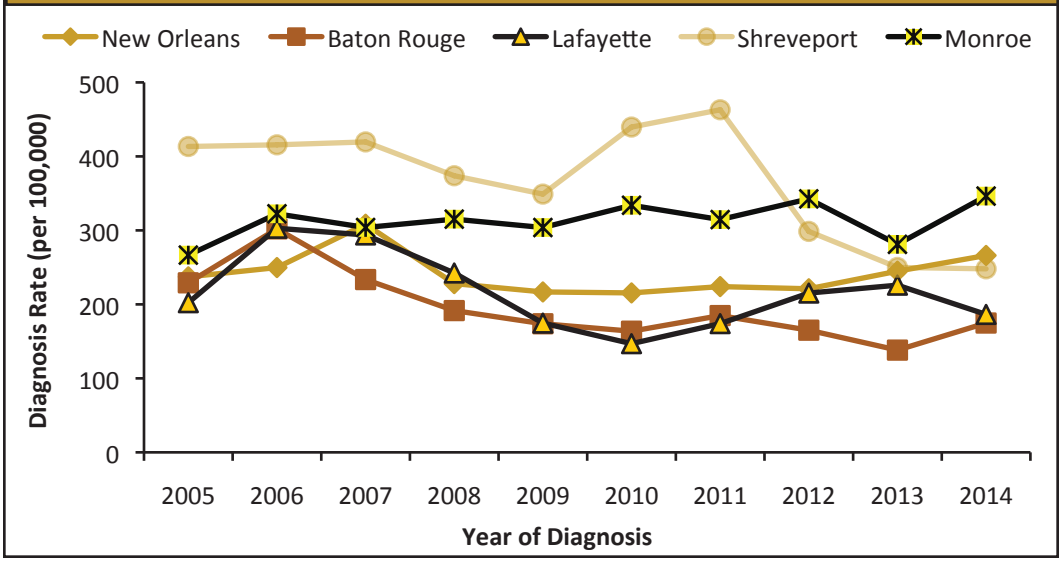
Gonorrhea Diagnosis Rates by Parish, 2014



Geographic Data obtained from the US Census Bureau, 2014
*Rates derived from numerators less than 5 are not available.

- Gonorrhea diagnosis rates vary by parish in Louisiana. In 2014, there were persons diagnosed with gonorrhea in all 64 parishes.
- A total of nine parishes had a gonorrhea diagnoses rate greater than 300 per 100,000 (Orleans, Iberia, Caddo, Red River, Madison, Morehouse, Ouachita, Richland, and Tensas), up from seven parishes in 2013.
- Additional breakdowns by race/ethnicity and sex at birth by parish can be found in the Appendix.

Trends in Gonorrhea Diagnosis Rates by Selected Region
Louisiana, 2005-2014



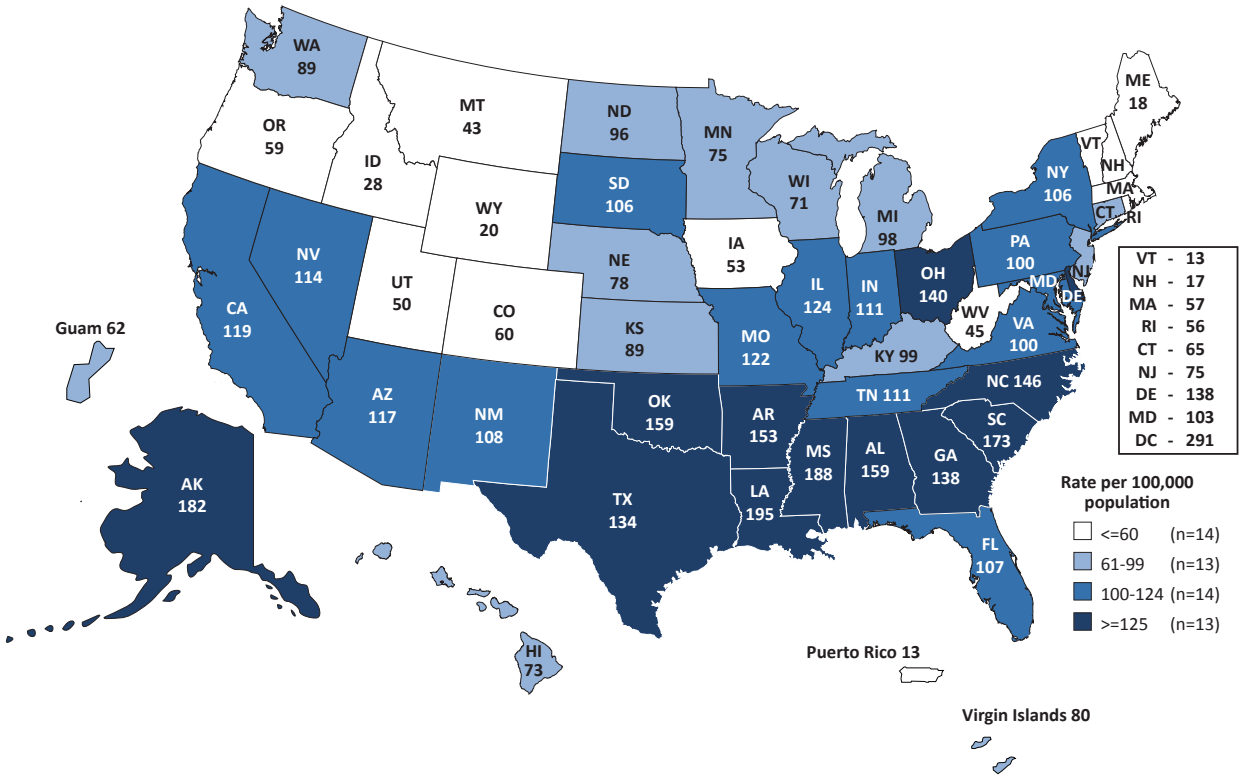
- Until 2012, the gonorrhea diagnosis rate was highest in the Shreveport region. In 2012 and 2013, the gonorrhea rate in Shreveport was 2nd overall, and was 3rd in 2014. From 2012 to 2014, the Monroe region had the highest gonorrhea rate. From 2013 to 2014, the Monroe diagnosis rate increased 23%.
- In 2014 the New Orleans region ranked 2nd for the gonorrhea diagnosis rate. This is the first time in over a decade that the rate for the New Orleans region has been higher than the rate for the Shreveport region.

New Gonorrhea Diagnoses by Region and Year
Louisiana, 2010-2014

	2010		2011		2012		2013		2014	
Louisiana	**29,151**	**%**	**31,614**	**%**	**27,353**	**%**	**28,739**	**%**	**28,896**	**%**
1-New Orleans	1,800	20%	1,876	20%	1,920	22%	2,156	25%	2,363	26%
2-Baton Rouge	1,086	12%	1,217	13%	1,110	13%	933	11%	1,187	13%
3-Houma	481	5%	456	5%	476	5%	623	7%	553	6%
4-Lafayette	858	10%	1,018	11%	1,274	14%	1,347	16%	1,123	13%
5-Lake Charles	372	4%	335	4%	343	4%	324	4%	310	3%
6-Alexandria	533	6%	519	6%	444	5%	483	6%	428	5%
7-Shreveport	2,105	24%	2,205	24%	1,645	19%	1,373	16%	1,358	15%
8-Monroe	1,188	13%	1,116	12%	1,220	14%	1,002	12%	1,233	14%
9-Hammond/Slidell	449	5%	422	5%	429	5%	388	4%	408	5%
Unknown	*40*	*0%*	*5*	*0%*	*12*	*0%*	*40*	*0%*	*15*	*0%*

- In 2014, the New Orleans region had the highest number of gonorrhea diagnoses, followed by the Shreveport and Monroe regions.

Gonorrhea Diagnosis Rates in the United States (2014)[19]



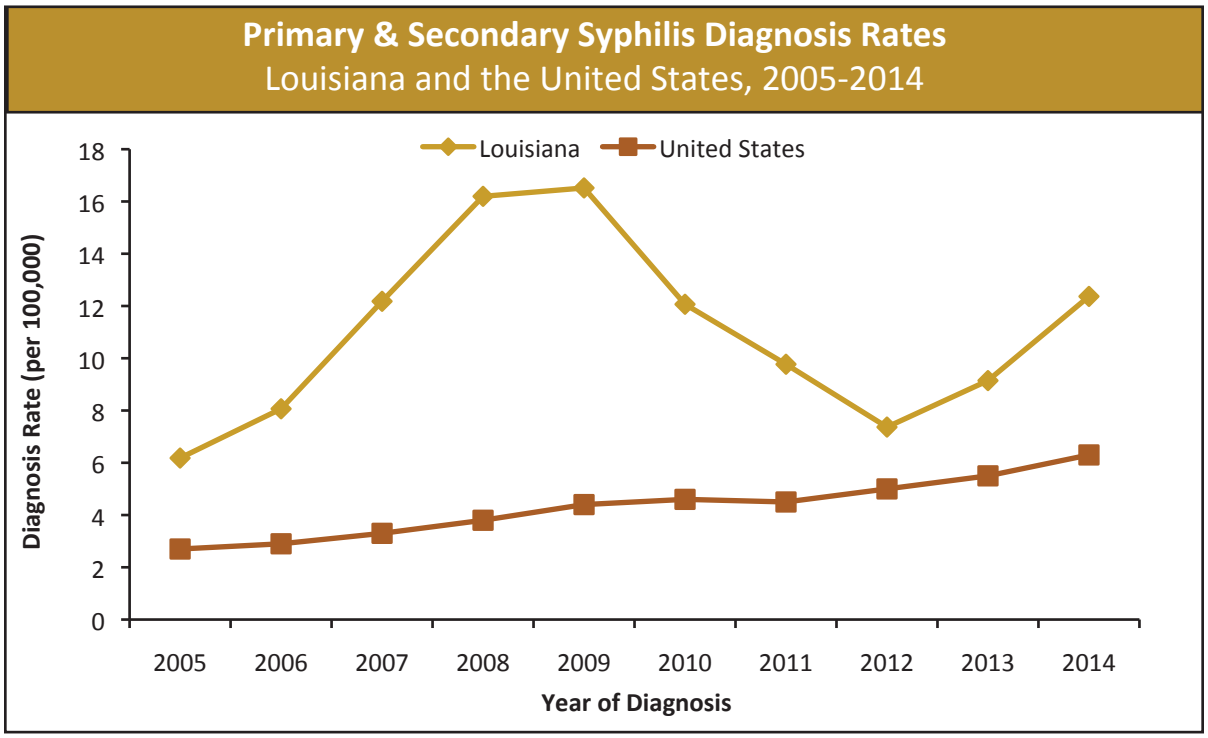
- According to the most recent CDC report, there were 350,062 new gonorrhea diagnoses reported in the United States in 2014, for a national gonorrhea rate of 110.7 diagnoses per 100,000 population. In 2013, the national gonorrhea diagnosis rate was 105.3 per 100,000 population.[19]
- The national gonorrhea rate increased 4% from 2013 to 2014.[19]
- In 2014, Louisiana ranked 1st in the nation for gonorrhea diagnosis rates. Mississippi (188.1 per 100,000), and Alaska (182.4 per 100,000), ranked 2nd and 3rd respectively in 2014.[19]
- Louisiana's 2014 rate was 74% greater than the national rate.[19]
- Nationally, the rate of males diagnosed with gonorrhea surpassed the rate in females, rising 11% from 2013, while the rate in females decreased 0.4%. Potential reasons for the increase in males include increased disease transmission, changes in testing technology, more sensitive tests, and changes in reporting practices.[19]

Primary & Secondary Syphilis

Syphilis is one of the three most commonly diagnosed STDs. It is caused by the bacterium *Treponema pallidum* and is typically transmitted through contact with an infected genital ulcer. These ulcers also facilitate the sexual transmission and contraction of HIV. The primary and secondary stages are the most infectious stages of syphilis.[20] If left untreated, syphilis can cause other serious health problems and may include neurologic involvement. Pregnant women with an untreated syphilis infection may experience stillbirth or give birth to a child with congenital defects. Penicillin G is the preferred drug for treating all stages of syphilis. The preparation, dosage, and length of treatment depend on the stage and clinical manifestation of the disease.[20]

10 Year Trends in P&S Syphilis Diagnoses

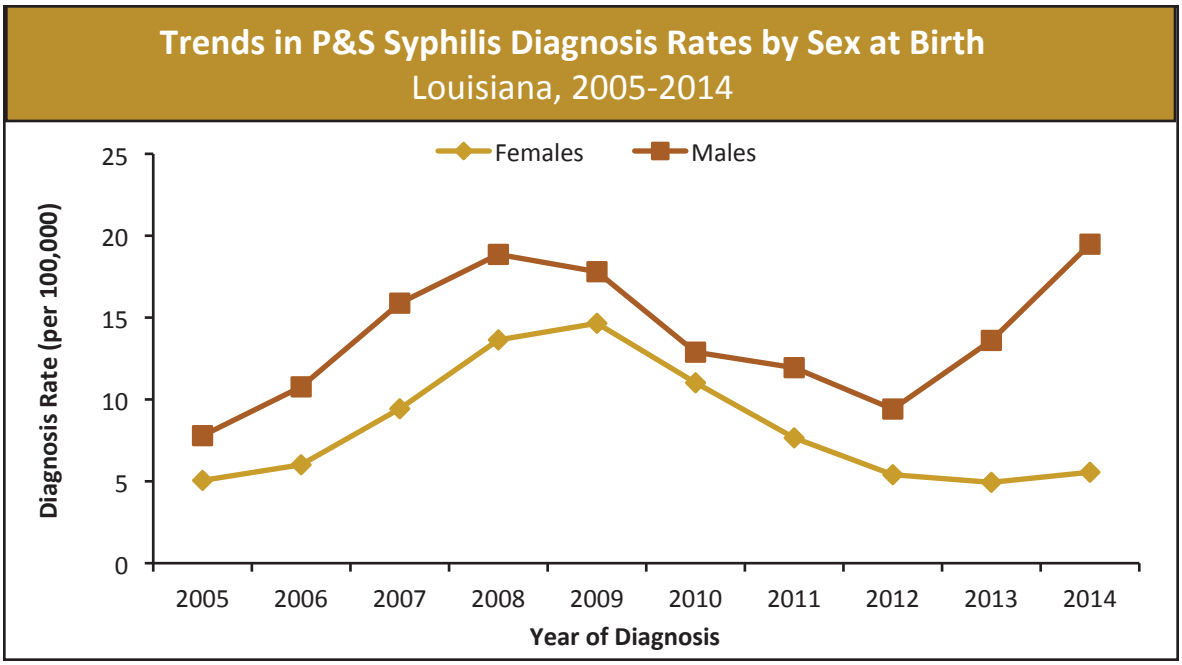
There were 575 diagnoses of P&S syphilis in Louisiana in 2014, a 36% increase compared to 423 diagnoses in 2013. This was the second year the rate increased since 2012. Over the past 10 years, the syphilis rate in Louisiana has consistently exceeded the national rate. From 2006-2011, Louisiana had the highest P&S syphilis rate in the nation even though Louisiana's rate had been decreasing since 2009. Between 2011 and 2012, the Louisiana syphilis rate decreased by 25% from 9.9 to 7.4 per 100,000 and Louisiana's ranking dropped to 3rd in the nation. However, in 2014 the Louisiana syphilis rate rose nearly 36% from 9.1 per 100,000 in 2013 to 12.4 per 100,000 in 2014, and Louisiana's ranking rose to 2nd.[19]



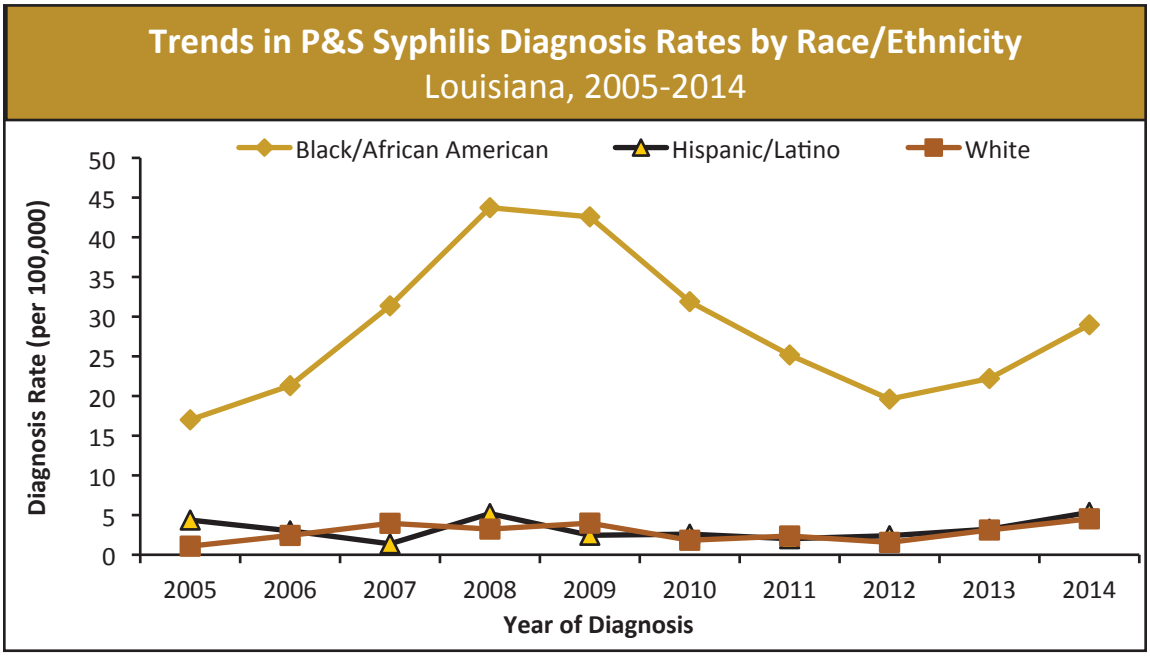
- In 2014, the P&S syphilis diagnosis rate in Louisiana was 12.4 per 100,000 population, which was nearly two times the national rate of 6.3 per 100,000 population.[19]
- From 2009 to 2012, the P&S syphilis diagnosis rate decreased by 54%.

Characteristics of Persons Diagnosed with P&S Syphilis Louisiana, 2014			
	Cases	Percent	Rate
Total	**575**	**100%**	**12.4**
Sex at Birth			
Female	132	23.0%	5.6
Male	443	77.0%	19.5
Race/Ethnicity			
Black/African American	432	75.1%	29.0
Hispanic/Latino	12	2.1%	5.3
White	125	21.7%	4.5
Other/Multi-race	6	1.0%	-
Age Group	**Age at Diagnosis**		
0-9	0	0.0%	0.0
10-14	2	0.3%	0.7
15-19	66	11.5%	22.0
20-24	159	27.7%	45.5
25-29	115	20.0%	33.9
30-34	77	13.4%	23.3
35-39	44	7.7%	15.4
40-44	37	6.4%	13.2
45+	75	13.0%	4.1

- In 2014, 132 females were diagnosed with P&S syphilis, a 15% increase from the 115 diagnoses in 2013. The number of males diagnosed with P&S syphilis in Louisiana increased 42% to 443 diagnoses in 2014, from 308 diagnoses in 2013.
- There is a significant racial disparity for syphilis diagnoses in Louisiana. In 2014, the rate of new P&S syphilis diagnoses among blacks was 29.0 per 100,000 blacks, nearly six and a half times higher than among whites and five and a half times higher than among Hispanics/Latinos.
- Nearly 75% of all P&S syphilis diagnoses with reported race were among blacks and 22% were among whites. Only 32% of Louisiana's population is black.
- In 2014, 39% of new P&S syphilis diagnoses were among 15-24 year olds. The number of new diagnoses in persons aged 10-14 decreased 33% from 2013. The number of new diagnoses among all other age groups increased.



- The 2014 male P&S syphilis diagnosis rate of 19.5 per 100,000 males was three and a half times greater than the female rate of 5.6 per 100,000 females.
- From 2013 to 2014, the diagnosis rate increased slightly for females but continued to increase sharply for males. The greatest gap in rates between males and females was observed in 2014.
- In 2014, 77% of P&S syphilis diagnoses were male. Cumulatively, males made up 62% of all P&S syphilis diagnoses in Louisiana over the past 10 years.

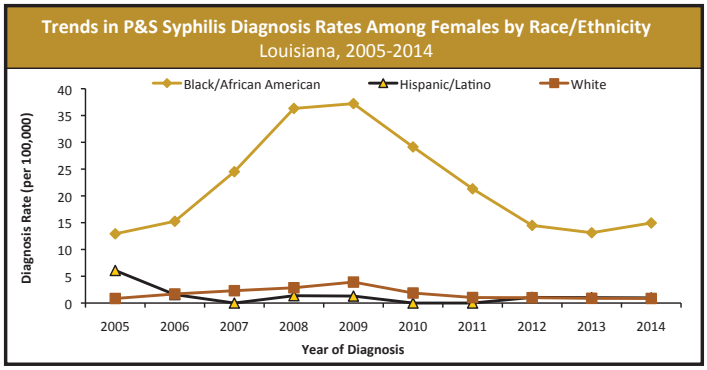


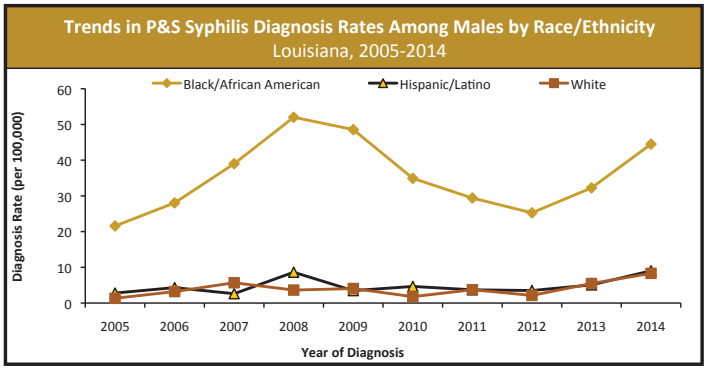
- The P&S syphilis rate for blacks has varied greatly over the past 10 years, from a low of 17.0 per 100,000 in 2005 to a rate of 43.7 per 100,000 in 2008. The rate has also fluctuated in whites, from a low of 1.1 per 100,000 in 2005 to a high of 4.5 per 100,000 in 2014.
- The rate for blacks has consistently been higher than the rate for other races and ethnicities. The rate of P&S syphilis has averaged 28.4 per 100,000 black persons over the last 10 years, while the white rate has averaged 2.8 per 100,000.
- The P&S syphilis rate for blacks increased 48% from 2012 to 2014.

Race/Ethnicity of Persons Diagnosed with P&S Syphilis by Sex at Birth
Louisiana, 2014

	Cases	Percent	Rate
Total	**575**	**100%**	**12.4**
Female	**132**	**23.0%**	**5.6**
American Indian/Alaskan Native	2	1.5%	13.4
Asian/Pacific Islander	0	0.0%	0.0
Black/African American	117	88.6%	14.9
Hispanic/Latino	1	0.8%	1.0
White	12	9.1%	0.9
Other/Multi-race	0	0.0%	-
Male	**443**	**77.0%**	**13.0**
American Indian/Alaskan Native	1	0.2%	6.9
Asian/Pacific Islander	1	0.2%	2.5
Black/African American	315	71.1%	44.5
Hispanic/Latino	11	2.5%	9.0
White	113	25.5%	8.3
Other/Multi-race	2	0.5%	-

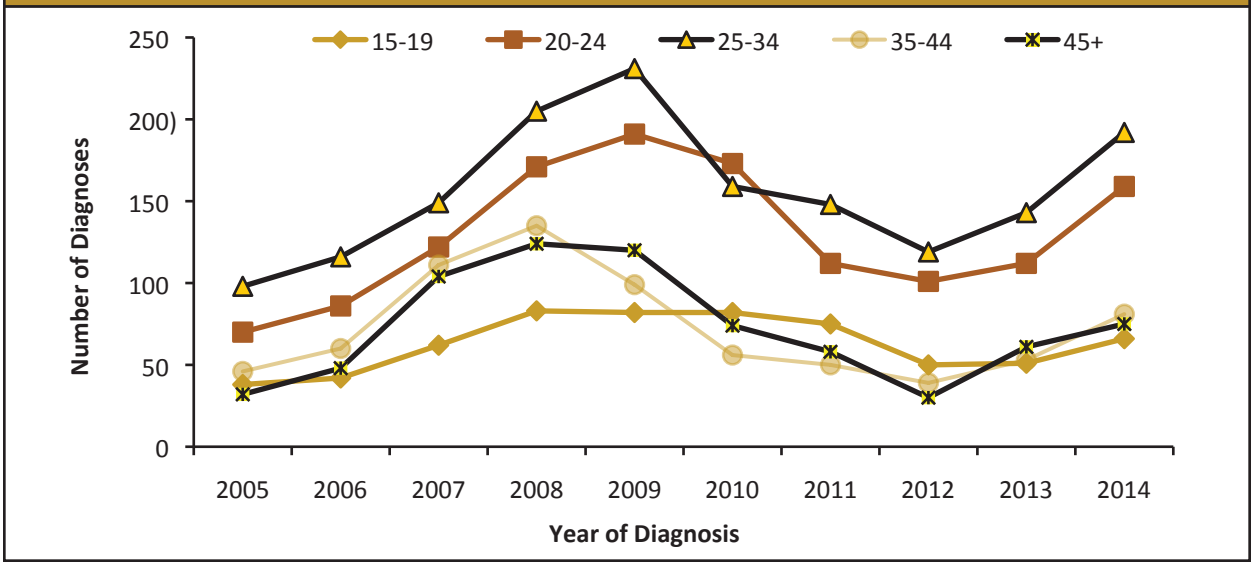
- Among the P&S syphilis diagnoses in females, 89% were black and 9% were white. Of the P&S syphilis diagnoses in males, approximately 71% were black and 26% were white.
- The rate of P&S syphilis in black males was nearly three times higher than the rate in black females, and the P&S syphilis rate in white males was more than eight times higher than the rate in white females.





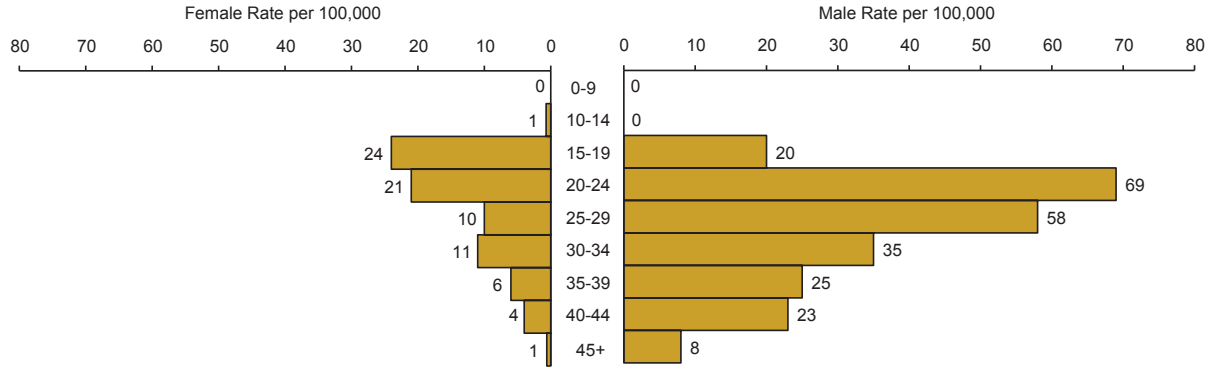
- The rate of P&S syphilis in black males was over five times the rate in white males and five times the rate in Hispanic/Latino males.
- From 2012 to 2014, the syphilis diagnosis rate among white males has quadrupled, and the syphilis rate among black males has increased 76%.
- The rate of P&S syphilis in black females was over 17 times the rate in white females and over 15 times the rate in Hispanic/Latina females.

Trends in P&S Syphilis Diagnoses by Age Group
Louisiana, 2005-2014



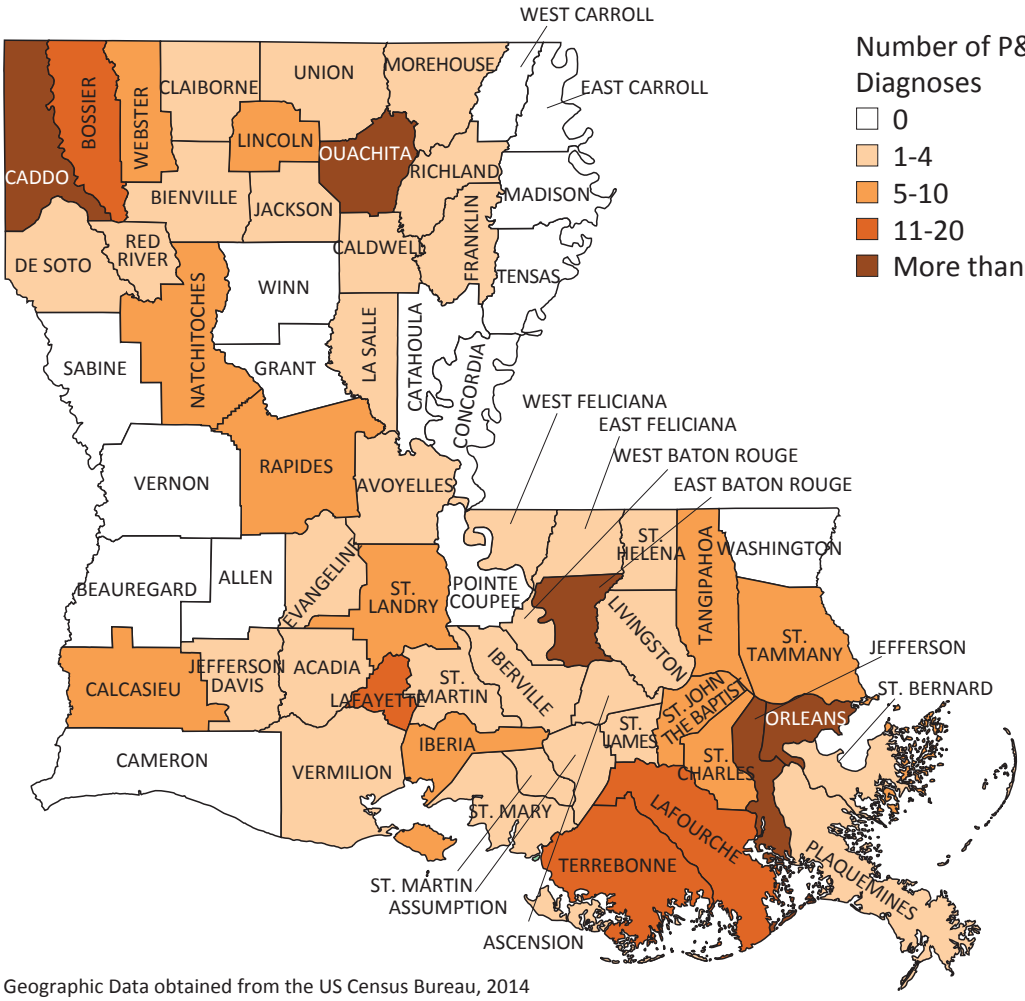
- The highest number of P&S syphilis diagnoses occur in persons aged 25-29, making up 32% of Louisiana diagnoses since 2005. Persons aged 20-24 have made up an additional 26% of diagnoses over the last 10 years.
- The number of new diagnoses have increased among all age groups since 2012.

Primary & Secondary Syphilis Diagnosis Rates by Age and Sex at Birth
Louisiana, 2014



- In 2014, the highest age specific rate was among 20-24 year old males, followed by 25-29 year old males.
- Among females in 2014, the highest age-specific rate was among 15-19 year olds, followed by females age 20-24. Only in persons age 10-14 was the age specific P&S syphilis rate higher for females than for males.

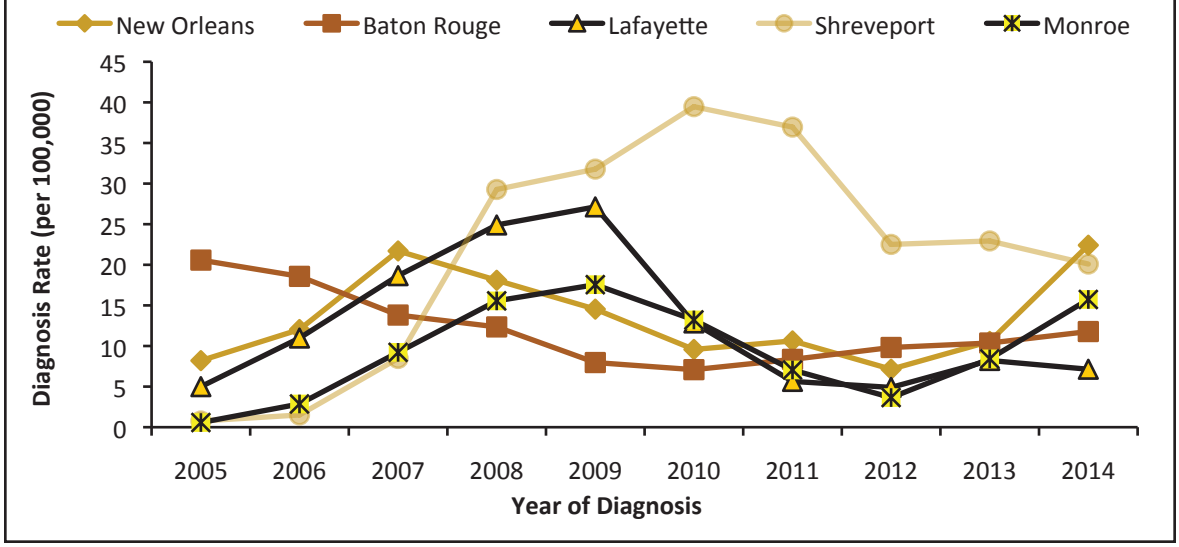
Number of P&S Syphilis Diagnoses by Parish, 2014



Geographic Data obtained from the US Census Bureau, 2014

- The number of P&S syphilis diagnoses varies by parish in Louisiana. In 2014, there were persons diagnosed with P&S syphilis in 50 of Louisiana's 64 parishes.
- A total of five parishes had P&S diagnosis counts greater than 20 (Orleans, Caddo, East Baton Rouge, Jefferson, and Ouachita). These five parishes contained 65% of all P&S syphilis diagnoses in 2014.
- Additional breakdowns by race/ethnicity and sex at birth by parish can be found in the Appendix.

Trends in P&S Syphilis Diagnosis Rates by Selected Region
Louisiana, 2005-2014



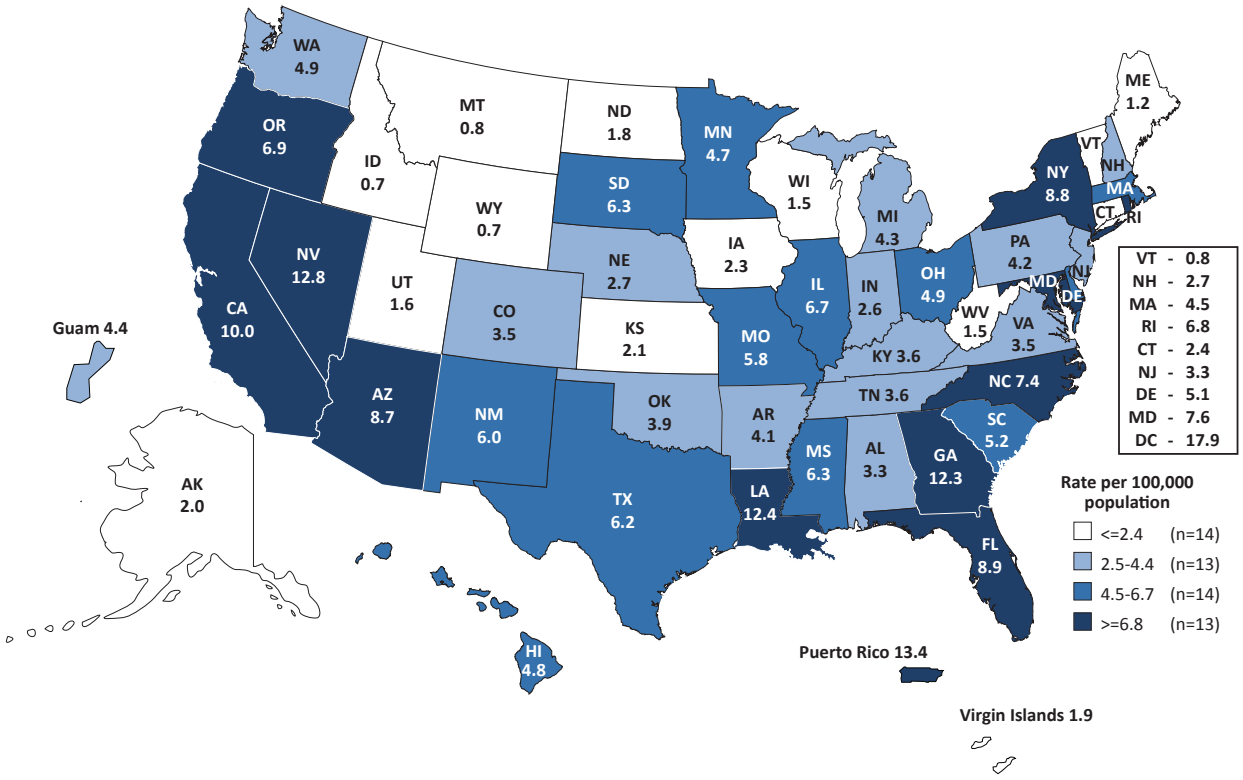
- From 2008 to 2013, the P&S syphilis diagnosis rate was highest in the Shreveport region. In 2014 the P&S syphilis rate in Shreveport was 2nd overall while the highest P&S syphilis rate was in the New Orleans region. In 2014, the Shreveport region had a 12% decrease in the diagnosis rate from 2013 and the rate in the New Orleans region more than doubled.

New P&S Syphilis Diagnoses by Region and Year
Louisiana, 2010-2014

	2010		2011		2012		2013		2014	
Louisiana	**546**	**%**	**446**	**%**	**338**	**%**	**423**	**%**	**575**	**%**
1-New Orleans	80	15%	89	20%	62	18%	93	22%	199	35%
2-Baton Rouge	47	9%	55	12%	66	20%	70	17%	80	14%
3-Houma	35	6%	14	3%	14	4%	21	5%	54	9%
4-Lafayette	75	14%	33	7%	29	9%	49	12%	43	7%
5-Lake Charles	35	6%	21	5%	12	4%	7	2%	6	1%
6-Alexandria	13	2%	17	4%	17	5%	13	3%	10	2%
7-Shreveport	189	35%	176	39%	124	37%	126	30%	110	19%
8-Monroe	47	9%	25	6%	13	4%	30	7%	56	10%
9-Hammond/Slidell	25	5%	16	4%	1	0%	14	3%	17	3%

- In 2014, the number of new diagnoses was highest in the New Orleans region. From 2012 to 2014, the number of diagnoses more than tripled in this region.
- Since 2010, the number of P&S syphilis diagnoses in the Shreveport region has decreased by 42%.

P&S Syphilis Diagnosis Rates in the United States (2014)[19]



- According to the most recent CDC report, there were 19,999 new P&S syphilis diagnoses reported in the United States in 2014, for a national P&S syphilis rate of 6.3 diagnoses per 100,000 population. In 2013, the national P&S syphilis diagnosis rate was 5.5 per 100,000 population.[19]
- The national P&S syphilis rate increased 15% from 2013 to 2014.[19]
- In 2014, Louisiana ranked 2nd in the nation for P&S syphilis diagnosis rates. Nevada (12.8 per 100,000), and Georgia (12.3 per 100,000), ranked 1st and 3rd respectively in 2014.[19]
- Louisiana's 2014 rate was 96% greater than the national rate.[19]
- Nationally, the diagnosis rate in females increased more than the rate in males, rising 23% from 2013 to 2014 in females, and 14% in males. However, the rate of P&S syphilis in males still far exceeds that seen in females. Black MSM aged 20-29 accounted for the majority of P&S syphilis diagnoses seen nationally.[19]

Appendices

The appendix contains additional tables relevant to the HIV Surveillance chapter of this report, Chapter 1 and the STD Surveillance Chapter, Chapter 4. Immediately following the tables are the Technical Notes and Works Cited.

CHAPTER 1: PROFILE OF THE HIV EPIDEMIC IN LOUISIANA

Trends in HIV Infection, Louisiana, 1979-2014

- This table includes the number of HIV Diagnoses, AIDS Diagnoses, Persons Living with HIV Infection, and Deaths in Persons with HIV Infection from 1979 to 2014. The number of deaths in 2014 are not finalized and are therefore not available.

New HIV Diagnoses by Region and Year, Louisiana, 2005-2014

- This table includes the number of New HIV Diagnoses from 2005 to 2014, for each of the nine public health regions in Louisiana.

New AIDS Diagnoses by Region and Year, Louisiana, 2005-2014

- This table includes the number of New AIDS Diagnoses from 2005 to 2014, for each of the nine public health regions in Louisiana.

Geographic Distribution of HIV in Louisiana, 2014

- This two-page table includes new AIDS Diagnoses in 2014, HIV Diagnoses in 2014, HIV Diagnosis Rate in 2014, Persons Living with HIV Infection in 2014 and Deaths in Persons Living with HIV Infection in 2013 for each of the nine public health regions and the 64 parishes of Louisiana.

Deaths among Persons with HIV Infection, Louisiana, 2013

- This table contains the demographic breakdown of Persons with HIV Infection who died in 2013 in Louisiana, regardless of cause of death.

CHAPTER 4: PROFILE OF STDS IN LOUISIANA

Geographic Distribution of Chlamydia by Race/Ethnicity, Louisiana, 2014

- This two-page table includes Chlamydia diagnoses in 2014, for each of the nine public health regions and the 64 parishes of Louisiana.

Geographic Distribution of Chlamydia in Females by Race/Ethnicity, Louisiana, 2014

- This two-page table includes Chlamydia female diagnoses in 2014, for the 64 parishes of Louisiana.

Geographic Distribution of Chlamydia in Males by Race/Ethnicity, Louisiana, 2014

- This two-page table includes Chlamydia male diagnoses in 2014, for the 64 parishes of Louisiana.

Geographic Distribution of Gonorrhea by Race/Ethnicity, Louisiana, 2014

- This two-page table includes Gonorrhea diagnoses in 2014, for each of the nine public health regions and the 64 parishes of Louisiana.

Geographic Distribution of Gonorrhea in Females by Race/Ethnicity, Louisiana, 2014

- This two-page table includes female Gonorrhea diagnoses in 2014, for the 64 parishes of Louisiana.

Geographic Distribution of Gonorrhea in Males by Race/Ethnicity, Louisiana, 2014

- This two-page table includes Gonorrhea male diagnoses in 2014, for the 64 parishes of Louisiana.

Geographic Distribution of Primary & Secondary Syphilis by Race/Ethnicity, Louisiana, 2014

- This two-page table includes P&S syphilis diagnoses in 2014, for each of the nine public health regions and the 64 parishes of Louisiana.

Geographic Distribution of Primary & Secondary Syphilis in Females by Race/Ethnicity, Louisiana, 2014

- This two-page table includes P&S syphilis female diagnoses in 2014, for the 64 parishes of Louisiana.

Geographic Distribution of Primary & Secondary Syphilis in Males by Race/Ethnicity, Louisiana, 2014

- This two-page table includes P&S syphilis male diagnoses in 2014, for the 64 parishes of Louisiana.

Trends in HIV Infection Louisiana, 1979-2014				
Year	**New HIV Diagnoses**	**New AIDS Diagnoses**	**Persons Living with HIV Infection**	**Deaths**
1979	1	1	1	0
1980	1	1	1	1
1981	5	0	7	0
1982	17	10	22	3
1983	58	27	70	16
1984	146	84	187	36
1985	383	151	498	100
1986	482	242	852	158
1987	757	417	1,391	244
1988	780	450	1,954	292
1989	1,040	613	2,638	431
1990	1,214	708	3,466	436
1991	1,553	937	4,568	542
1992	1,749	1,065	5,698	677
1993	1,710	1,133	6,726	770
1994	1,648	1,104	7,653	820
1995	1,491	1,040	8,330	912
1996	1,521	1,120	9,144	791
1997	1,510	940	10,213	556
1998	1,277	841	11,097	527
1999	1,158	788	12,005	500
2000	1,125	822	12,805	516
2001	1,086	887	13,502	530
2002	1,148	970	14,260	521
2003	1,047	890	14,848	550
2004	1,056	864	15,680	539
2005	972	801	13,617	576
2006	989	767	14,157	545
2007	1,089	809	14,769	516
2008	1,089	842	15,415	479
2009	1,206	785	16,093	535
2010	1,123	801	16,789	446
2011	1,219	781	17,512	467
2012	1,043	777	18,075	468
2013	1,146	709	18,805	406
2014	1,235	601	19,612	n/a*

*Data are not complete

New HIV Diagnoses by Region and Year Louisiana, 2005-2014										
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Louisiana	**972**	**989**	**1,089**	**1,089**	**1,206**	**1,123**	**1,219**	**1,043**	**1,146**	**1,235**
1-New Orleans	322	247	326	354	382	341	412	337	377	364
2-Baton Rouge	271	305	309	295	311	296	293	254	248	319
3-Houma	35	38	45	42	40	57	56	53	58	53
4-Lafayette	77	72	71	75	85	89	89	81	94	112
5-Lake Charles	43	39	55	56	51	48	50	38	37	41
6-Alexandria	39	51	44	47	62	61	64	57	65	58
7-Shreveport	67	95	114	107	113	100	119	78	124	129
8-Monroe	62	83	75	52	73	59	68	76	77	91
9-Hammond/Slidell	56	59	50	61	89	72	68	69	66	68

New AIDS Diagnoses by Region and Year Louisiana, 2005-2014										
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Louisiana	**801**	**767**	**809**	**842**	**785**	**801**	**781**	**777**	**709**	**601**
1-New Orleans	267	224	265	266	236	251	258	253	219	181
2-Baton Rouge	198	226	222	252	199	238	220	195	185	159
3-Houma	29	42	31	32	34	49	30	37	40	29
4-Lafayette	66	65	56	63	50	60	55	59	65	48
5-Lake Charles	38	34	39	37	42	29	38	33	26	20
6-Alexandria	31	31	35	34	41	36	40	35	27	24
7-Shreveport	73	52	79	78	76	52	61	67	64	47
8-Monroe	56	48	40	40	55	44	37	50	41	48
9-Hammond/Slidell	43	45	42	40	52	42	42	48	42	45

Geographic Distribution of HIV Louisiana, 2014						
Region	**Parish**	**AIDS Diagnoses in 2014***	**HIV Diagnoses in 2014**	**HIV Diagnosis Rate 2014****	**Persons Living with HIV Infection 2014**	**Deaths 2013**
Statewide		**601**	**1,235**	**27**	**19,612**	**406**
Region 1		**181**	**364**	**42**	**6,869**	**118**
	Jefferson	53	108	25	1,831	30
	Orleans	121	250	68	4,822	87
	Plaquemines	2	1	4	46	0
	St. Bernard	5	5	12	170	1
Region 2		**159**	**319**	**48**	**4,766**	**111**
	Ascension	10	22	20	225	8
	East Baton Rouge	123	256	58	3,810	88
	East Feliciana	5	6	30	135	1
	Iberville	16	18	54	294	5
	Pointe Coupee	3	4	18	50	2
	West Baton Rouge	1	7	29	96	4
	West Feliciana	1	6	39	156	3
Region 3		**29**	**53**	**13**	**783**	**25**
	Assumption	n/a	0	n/a	32	2
	Lafourche	8	17	17	145	1
	St. Charles	3	9	17	103	0
	St. James	2	5	23	74	5
	St. John the Baptist	3	5	11	154	4
	St. Mary	6	4	7	84	6
	Terrebonne	7	13	12	191	7
Region 4		**48**	**112**	**19**	**1,466**	**28**
	Acadia	4	7	11	105	1
	Evangeline	4	8	24	66	2
	Iberia	3	11	15	112	3
	Lafayette	15	47	21	702	9
	St. Landry	17	31	37	276	12
	St. Martin	2	0	n/a	109	1
	Vermilion	3	8	14	96	0
Region 5		**20**	**41**	**14**	**1,002**	**21**
	Allen	2	7	27	245	0
	Beauregard	0	1	3	43	1
	Calcasieu	15	31	16	650	19
	Cameron	1	1	15	4	0
	Jefferson Davis	2	1	3	60	1

Geographic Distribution of HIV Louisiana, 2014						
Region	**Parish**	**AIDS Diagnoses in 2014***	**HIV Diagnoses in 2014**	**HIV Diagnosis Rate 2014****	**Persons Living with HIV Infection 2014**	**Deaths 2013**
Statewide		**601**	**1,235**	**27**	**19,612**	**406**
Region 6		**24**	**58**	**19**	**881**	**18**
	Avoyelles	3	1	2	156	1
	Catahoula	1	1	10	24	0
	Concordia	0	0	n/a	42	1
	Grant	1	4	18	42	0
	La Salle	5	15	101	30	1
	Rapides	13	28	21	456	13
	Vernon	1	7	13	66	1
	Winn	0	2	13	65	1
Region 7		**47**	**129**	**24**	**1,626**	**31**
	Bienville	2	1	7	33	2
	Bossier	5	18	15	194	2
	Caddo	33	89	35	1,067	16
	Claiborne	1	1	6	74	1
	De Soto	3	6	22	47	3
	Natchitoches	3	8	20	109	2
	Red River	0	1	11	15	2
	Sabine	0	1	4	16	1
	Webster	0	4	10	71	2
Region 8		**48**	**91**	**26**	**1,012**	**27**
	Caldwell	2	2	20	22	0
	East Carroll	2	4	53	25	2
	Franklin	2	8	39	49	0
	Jackson	0	1	6	17	0
	Lincoln	5	11	23	94	2
	Madison	1	2	17	34	1
	Morehouse	4	4	15	61	0
	Ouachita	29	55	35	589	17
	Richland	2	2	10	41	3
	Tensas	0	0	n/a	37	0
	Union	1	2	9	32	0
	West Carroll	0	0	n/a	11	2
Region 9		**45**	**68**	**12**	**1,207**	**27**
	Livingston	11	14	11	210	5
	St. Helena	0	1	9	16	0
	St. Tammany	10	18	8	435	10
	Tangipahoa	19	25	20	365	9
	Washington	5	10	21	181	3

*AIDS diagnoses will be included in counts of HIV diagnosis (3rd Column) for persons first diagnosed with HIV at an AIDS diagnosis or within the same year; therefore numbers from the two columns should not be added.
**Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.

Deaths Among Persons with HIV Infection Louisiana, 2013		
	2013 Deaths	**Percent**
Total Deaths	**406**	**100.0%**
Diagnosis at Death		
AIDS	343	84.5%
HIV	63	15.5%
Sex		
Female	117	28.8%
Male	289	71.2%
Race/Ethnicity		
Black/African American	315	77.6%
Hispanic/Latino	7	1.7%
White	81	20.0%
Other	3	0.7%
Age at Death		
0-12	0	0.0%
13-19	3	0.7%
20-24	2	0.7%
25-34	49	11.5%
35-44	80	21.4%
45-54	142	32.2%
55-64	90	26.6%
65+	40	12.4%
Imputed Transmission Category		
Men who have sex with men (MSM)	148	36.5%
Injection Drug User (IDU)	109	26.8%
MSM/IDU	36	8.9%
High Risk Heterosexual (HRH)	107	26.4%
Transfusion/Hemophilia/Other	2	0.5%
Pediatric	4	1.0%
Region		
1-New Orleans	118	29.1%
2-Baton Rouge	111	27.3%
3-Houma	25	6.2%
4-Lafayette	28	6.9%
5-Lake Charles	21	5.2%
6-Alexandria	18	4.4%
7-Shreveport	31	7.6%
8-Monroe	27	6.7%
9-Hammond/Slidell	27	6.7%
Rural/Urban		
Rural	69	17.0%
Urban	337	83.0%

Geographic Distribution of Chlamydia by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**6,202**	**225**	**21,192**	**1,422**	**834**	**371**	**28,896**	**621**
Region 1: New Orleans	**1,066**	**267**	**5,452**	**1,537**	**377**	**433**	**7,138**	**804**
Jefferson	532	226	1,712	1,498	267	445	2,616	600
Orleans	431	360	3,565	1,577	98	460	4,220	1,098
Plaquemines	27	174	43	919	3	n/a	78	333
St. Bernard	76	267	132	1,370	9	212	224	504
Region 2: East Baton Rouge	**573**	**165**	**2,983**	**1,065**	**79**	**305**	**3,711**	**546**
Ascension	151	186	272	1,027	10	165	439	375
East Baton Rouge	331	163	2,307	1,129	62	360	2,759	619
East Feliciana	17	163	69	795	2	n/a	90	454
Iberville	26	164	140	868	1	n/a	170	510
Pointe Coupee	16	118	70	883	1	n/a	88	393
West Baton Rouge	20	139	86	896	3	n/a	112	446
West Feliciana	12	151	39	556	0	0	53	344
Region 3: Houma	**748**	**289**	**1,540**	**1,445**	**83**	**417**	**2,441**	**602**
Assumption	32	210	85	1,245	2	n/a	120	521
Lafourche	166	221	273	2,069	13	288	465	474
St. Charles	70	202	156	1,136	10	323	240	455
St. James	11	106	108	1,020	1	n/a	121	559
St. John the Baptist	36	219	291	1,217	9	380	343	784
St. Mary	95	316	206	1,207	15	439	321	604
Terrebonne	338	441	421	1,982	33	597	831	733
Region 4: Lafayette	**858**	**215**	**2,415**	**1,472**	**85**	**415**	**3,420**	**568**
Acadia	118	243	166	1,467	0	0	287	459
Evangeline	52	228	92	977	0	0	163	484
Iberia	114	259	468	1,994	18	629	605	819
Lafayette	321	205	952	1,566	52	495	1,348	572
St. Landry	95	206	405	1,178	4	n/a	512	612
St. Martin	50	145	218	1,356	6	443	276	518
Vermilion	108	231	114	1,319	5	262	229	384
Region 5: Lake Charles	**428**	**201**	**627**	**957**	**21**	**237**	**1,111**	**374**
Allen	29	161	25	424	0	0	59	229
Beauregard	68	237	34	716	3	n/a	109	301
Calcasieu	268	198	511	1,037	16	264	816	414
Cameron	5	83	0	0	0	0	5	75
Jefferson Davis	58	236	57	1,069	2	n/a	122	388

Geographic Distribution of Chlamydia by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**6,202**	**225**	**21,192**	**1,422**	**834**	**371**	**28,896**	**621**
Region 6: Alexandria	**480**	**237**	**964**	**1,165**	**30**	**259**	**1,499**	**486**
Avoyelles	51	189	144	1,199	2	n/a	198	481
Catahoula	7	106	23	707	0	0	30	296
Concordia	19	163	56	675	1	n/a	76	371
Grant	63	368	33	942	1	n/a	99	442
La Salle	33	268	15	820	3	n/a	55	371
Rapides	175	215	572	1,359	13	345	769	580
Vernon	107	294	84	1,156	10	200	210	403
Winn	25	260	37	821	0	0	62	421
Region 7: Shreveport	**626**	**209**	**3,588**	**1,716**	**51**	**270**	**4,328**	**791**
Bienville	20	262	88	1,527	0	0	109	785
Bossier	185	218	356	1,334	18	224	576	461
Caddo	202	172	2,187	1,809	21	300	2,446	968
Claiborne	10	134	92	1,106	3	n/a	107	652
De Soto	21	135	151	1,473	2	n/a	175	645
Natchitoches	63	302	357	2,216	3	n/a	424	1,083
Red River	14	280	81	2,374	0	0	96	1,107
Sabine	49	297	63	1,555	1	n/a	113	467
Webster	62	246	213	1,564	3	n/a	282	699
Region 8: Monroe	**489**	**236**	**2,611**	**1,964**	**33**	**410**	**3,158**	**887**
Caldwell	25	321	18	1,092	0	0	43	435
East Carroll	6	277	47	937	0	0	53	708
Franklin	27	202	87	1,343	0	0	114	558
Jackson	13	120	73	1,580	0	0	88	550
Lincoln	32	127	336	1,713	5	390	379	796
Madison	8	193	132	1,804	4	n/a	144	1,216
Morehouse	45	339	222	1,744	0	0	271	1,013
Ouachita	220	241	1,400	2,418	14	416	1,647	1,054
Richland	48	379	159	2,172	2	n/a	209	1,008
Tensas	2	n/a	25	953	0	0	27	559
Union	22	142	91	1,565	7	707	120	532
West Carroll	41	449	21	1,134	1	n/a	63	547
Region 9: Hammond/Slidell	**932**	**216**	**1,005**	**1,058**	**53**	**220**	**2,024**	**358**
Livingston	265	221	81	961	8	169	357	263
St. Helena	4	n/a	39	697	0	0	43	405
St. Tammany	408	209	277	956	26	196	732	298
Tangipahoa	169	208	472	1,241	13	260	664	523
Washington	86	282	136	972	6	621	228	493

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of Chlamydia in Females by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**4,641**	**331**	**15,470**	**1,976**	**634**	**615**	**21,259**	**895**
Acadia	92	368	123	2,065	0	0	218	678
Allen	26	314	17	832	0	0	48	431
Ascension	102	249	203	1,447	7	255	316	533
Assumption	22	285	70	1,957	1	n/a	94	799
Avoyelles	42	304	111	1,974	2	n/a	156	760
Beauregard	54	382	23	1,100	1	n/a	79	448
Bienville	17	437	67	2,155	0	0	85	1,172
Bossier	149	350	272	1,942	14	381	447	709
Caddo	159	264	1,652	2,534	17	513	1,858	1,399
Calcasieu	200	289	373	1,462	13	444	603	597
Caldwell	18	463	11	1,501	0	0	29	601
Cameron	5	164	0	0	0	0	5	150
Catahoula	5	154	15	1,084	0	0	20	420
Claiborne	6	174	74	2,174	2	n/a	84	1,178
Concordia	15	261	42	1,034	1	n/a	58	576
De Soto	15	191	118	2,166	2	n/a	136	970
East Baton Rouge	200	192	1,577	1,433	42	539	1,858	800
East Carroll	3	n/a	41	1,786	0	0	44	1,282
East Feliciana	12	240	53	1,370	2	n/a	69	751
Evangeline	41	357	68	1,479	0	0	128	771
Franklin	25	364	58	1,723	0	0	83	790
Grant	44	530	29	2,783	0	0	74	752
Iberia	95	425	355	2,889	13	1,033	467	1,238
Iberville	22	282	109	1,386	1	n/a	133	818
Jackson	12	225	49	2,207	0	0	62	792
Jefferson	405	332	1,231	2,010	224	67,267	1,951	869
Jefferson Davis	52	413	43	1,583	2	n/a	101	628
La Salle	23	373	12	1,685	2	n/a	40	560
Lafayette	215	271	671	2,095	40	828	941	782
Lafourche	142	370	197	2,811	9	510	360	724
Lincoln	20	159	238	2,244	4	n/a	267	1,094
Livingston	184	302	52	1,205	6	286	243	354
Madison	7	334	106	2,893	2	n/a	115	1,925
Morehouse	42	616	175	2,623	0	0	221	1,594
Natchitoches	48	448	276	3,196	0	0	324	1,582
Orleans	250	421	2,577	2,098	70	730	2,988	1,489
Ouachita	168	356	1,020	3,304	10	676	1,208	1,483

Geographic Distribution of Chlamydia in Females by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**4,641**	**331**	**15,470**	**1,976**	**634**	**615**	**21,259**	**895**
Plaquemines	19	244	34	1,452	1	n/a	57	486
Pointe Coupee	12	174	52	1,220	0	0	64	550
Rapides	143	340	441	1,998	10	576	601	877
Red River	9	356	65	3,583	0	0	75	1,677
Richland	38	587	118	3,063	2	n/a	158	1,473
Sabine	40	481	47	2,235	1	n/a	88	720
St. Bernard	60	420	100	1,919	6	313	173	771
St. Charles	58	333	108	1,513	7	455	176	657
St. Helena	3	n/a	22	749	0	0	25	457
St. James	8	153	71	1,265	1	n/a	80	717
St. John the Baptist	34	411	227	1,807	7	651	275	1,226
St. Landry	79	333	280	1,552	3	n/a	366	843
St. Martin	33	191	172	2,060	5	803	212	785
St. Mary	76	496	153	1,711	11	797	242	899
St. Tammany	331	330	215	1,412	22	341	589	466
Tangipahoa	120	289	332	1,646	10	447	470	718
Tensas	1	n/a	14	1,023	0	0	15	603
Terrebonne	278	717	313	2,827	24	1,035	650	1,134
Union	13	167	69	2,274	6	1,268	88	772
Vermilion	88	366	81	1,798	4	n/a	175	571
Vernon	69	400	46	1,346	7	320	128	520
Washington	69	445	110	1,553	5	1,149	184	786
Webster	50	392	159	2,229	1	n/a	214	1,037
West Baton Rouge	12	164	58	1,162	2	n/a	75	586
West Carroll	35	750	15	1,771	1	n/a	51	889
West Feliciana	7	205	25	1,521	0	0	34	648
Winn	19	404	30	1,571	0	0	49	712

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of Chlamydia in Males by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**1,561**	**115**	**5,722**	**808**	**200**	**164**	**7,634**	**336**
Acadia	26	110	43	802	0	0	69	228
Allen	3	n/a	8	208	0	0	11	75
Ascension	49	121	69	554	3	n/a	123	213
Assumption	10	134	15	461	1	n/a	26	231
Avoyelles	9	68	33	516	0	0	42	204
Beauregard	14	96	11	414	2	n/a	30	162
Bienville	3	n/a	21	792	0	0	24	362
Bossier	36	85	84	662	4	n/a	129	208
Caddo	43	76	535	961	4	n/a	588	491
Calcasieu	68	103	138	581	3	n/a	213	221
Caldwell	7	179	7	764	0	0	14	276
Cameron	0	0	0	0	0	0	0	0
Catahoula	2	n/a	8	428	0	0	10	185
Claiborne	4	n/a	18	366	1	n/a	23	248
Concordia	4	n/a	14	331	0	0	18	173
De Soto	6	79	33	687	0	0	39	297
East Baton Rouge	131	131	730	774	20	212	900	421
East Carroll	3	n/a	6	221	0	0	9	222
East Feliciana	5	92	16	333	0	0	21	198
Evangeline	11	97	24	498	0	0	35	205
Franklin	2	n/a	29	932	0	0	31	312
Grant	19	215	4	n/a	1	n/a	25	199
Iberia	19	88	113	1,010	5	312	138	381
Iberville	4	n/a	31	375	0	0	37	217
Jackson	1	n/a	24	1,000	0	0	26	318
Jefferson	127	112	481	907	43	135	665	315
Jefferson Davis	6	50	14	535	0	0	21	136
La Salle	10	163	3	n/a	1	n/a	15	195
Lafayette	106	138	281	977	12	212	406	352
Lafourche	24	65	76	1,228	4	n/a	105	217
Lincoln	12	95	98	1,088	1	n/a	112	483
Livingston	81	137	29	705	2	n/a	114	170
Madison	1	n/a	26	711	2	n/a	29	494
Morehouse	3	n/a	47	776	0	0	50	388
Natchitoches	15	147	81	1,084	3	n/a	100	535
Orleans	181	299	988	957	28	239	1,232	671
Ouachita	52	118	380	1,406	4	n/a	439	586

Geographic Distribution of Chlamydia in Males by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**1,561**	**115**	**5,722**	**808**	**200**	**164**	**7,634**	**336**
Plaquemines	8	104	9	385	2	n/a	21	179
Pointe Coupee	4	n/a	18	491	1	n/a	24	223
Rapides	32	81	131	655	3	n/a	167	261
Red River	5	203	16	1,001	0	0	21	500
Richland	10	162	41	1,182	0	0	51	509
Sabine	9	110	16	821	0	0	25	209
St. Bernard	16	113	32	724	3	n/a	51	232
St. Charles	12	70	48	728	3	n/a	64	247
St. Helena	1	n/a	17	640	0	0	18	350
St. James	3	n/a	37	744	0	0	41	391
St. John the Baptist	2	n/a	64	564	2	n/a	68	319
St. Landry	16	71	125	766	1	n/a	146	362
St. Martin	17	99	46	595	1	n/a	64	243
St. Mary	19	129	53	653	4	n/a	79	301
St. Tammany	77	81	62	451	4	n/a	143	120
Tangipahoa	49	124	140	784	3	n/a	194	315
Tensas	1	n/a	11	876	0	0	12	512
Terrebonne	60	159	108	1,062	9	280	181	323
Union	9	117	22	791	1	n/a	32	287
Vermilion	20	88	33	797	1	n/a	54	186
Vernon	38	198	38	987	3	n/a	82	298
Washington	17	113	26	376	1	n/a	44	192
Webster	12	97	54	832	2	n/a	68	345
West Baton Rouge	8	113	28	608	1	n/a	37	301
West Carroll	6	134	6	597	0	0	12	207
West Feliciana	5	110	14	261	0	0	19	187
Winn	6	122	7	270	0	0	13	165

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of Gonorrhea by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**1,272**	**46**	**7,444**	**499**	**125**	**56**	**8,978**	**193**
Region 1: New Orleans	**314**	**79**	**1,952**	**550**	**50**	**57**	**2,363**	**266**
Jefferson	95	40	571	500	23	38	697	160
Orleans	197	164	1,327	587	24	113	1,585	412
Plaquemines	4	n/a	8	171	1	n/a	13	55
St. Bernard	18	63	46	478	2	n/a	68	153
Region 2: East Baton Rouge	**120**	**35**	**1,035**	**369**	**15**	**58**	**1,187**	**175**
Ascension	25	31	60	227	1	n/a	88	75
East Baton Rouge	76	37	846	414	14	81	949	213
East Feliciana	3	n/a	24	277	0	0	28	141
Iberville	11	69	41	254	0	0	52	156
Pointe Coupee	2	n/a	21	265	0	0	23	103
West Baton Rouge	2	n/a	34	354	0	0	37	147
West Feliciana	1	n/a	9	128	0	0	10	65
Region 3: Houma	**118**	**46**	**415**	**389**	**9**	**45**	**553**	**136**
Assumption	9	59	15	220	0	0	24	104
Lafourche	24	32	80	606	1	n/a	107	109
St. Charles	7	20	38	277	1	n/a	47	89
St. James	3	n/a	38	359	0	0	41	189
St. John the Baptist	5	30	67	280	0	0	72	165
St. Mary	23	77	57	334	5	146	86	162
Terrebonne	47	61	120	565	2	n/a	176	155
Region 4: Lafayette	**221**	**55**	**876**	**534**	**15**	**73**	**1,123**	**186**
Acadia	29	60	77	680	1	n/a	107	171
Evangeline	11	48	41	436	2	n/a	56	166
Iberia	33	75	186	792	3	n/a	227	307
Lafayette	88	56	339	558	8	76	437	185
St. Landry	24	52	118	343	0	0	144	172
St. Martin	15	43	79	491	0	0	94	176
Vermilion	21	45	36	416	1	n/a	58	97
Region 5: Lake Charles	**87**	**41**	**211**	**322**	**6**	**68**	**310**	**104**
Allen	7	39	17	288	0	0	26	101
Beauregard	6	21	5	105	0	0	12	33
Calcasieu	53	39	167	339	4	n/a	227	115
Cameron	1	n/a	0	0	0	0	1	n/a
Jefferson Davis	20	82	22	413	2	n/a	44	140

Geographic Distribution of Gonorrhea by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**1,272**	**46**	**7,444**	**499**	**125**	**56**	**8,978**	**193**
Region 6: Alexandria	**75**	**37**	**338**	**408**	**9**	**78**	**428**	**139**
Avoyelles	6	22	53	441	0	0	59	143
Catahoula	0	0	9	276	0	0	9	89
Concordia	2	n/a	17	205	0	0	19	93
Grant	14	82	3	n/a	0	0	17	76
La Salle	10	81	3	n/a	0	0	13	88
Rapides	25	31	216	513	7	186	250	189
Vernon	14	38	26	358	2	n/a	45	86
Winn	4	n/a	11	244	0	0	16	109
Region 7: Shreveport	**99**	**33**	**1,235**	**591**	**11**	**58**	**1,358**	**248**
Bienville	4	n/a	29	503	0	0	33	238
Bossier	24	28	125	468	5	62	156	125
Caddo	37	32	810	670	3	n/a	861	341
Claiborne	1	n/a	27	325	0	0	28	171
De Soto	3	n/a	33	322	0	0	36	133
Natchitoches	6	29	86	534	2	n/a	94	240
Red River	5	100	24	703	0	0	29	335
Sabine	9	55	14	346	0	0	23	95
Webster	10	40	87	639	1	n/a	98	243
Region 8: Monroe	**122**	**59**	**1,098**	**826**	**6**	**75**	**1,233**	**346**
Caldwell	5	64	11	667	0	0	16	162
East Carroll	1	n/a	17	339	0	0	18	240
Franklin	3	n/a	19	293	0	0	22	108
Jackson	11	102	23	498	1	n/a	35	219
Lincoln	13	52	108	551	0	0	123	258
Madison	1	n/a	44	601	0	0	45	380
Morehouse	10	75	115	904	0	0	126	471
Ouachita	57	62	636	1,099	2	n/a	699	447
Richland	8	63	75	1,024	0	0	83	400
Tensas	3	n/a	15	572	1	n/a	19	393
Union	7	45	31	533	2	n/a	40	177
West Carroll	3	n/a	4	n/a	0	0	7	61
Region 9: Hammond/Slidell	**114**	**26**	**280**	**295**	**3**	**n/a**	**408**	**72**
Livingston	34	28	16	190	2	n/a	53	39
St. Helena	2	n/a	8	143	0	0	10	94
St. Tammany	41	21	84	290	1	n/a	132	54
Tangipahoa	21	26	135	355	0	0	159	125
Washington	16	52	37	264	0	0	54	117

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of Gonorrhea in Females by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**696**	**50**	**4,228**	**540**	**53**	**51**	**5,041**	**212**
Acadia	18	72	48	806	0	0	66	205
Allen	7	84	9	441	0	0	18	162
Ascension	13	32	34	242	1	n/a	49	83
Assumption	5	65	10	280	0	0	15	127
Avoyelles	3	n/a	32	569	0	0	35	171
Beauregard	4	n/a	4	n/a	0	0	8	45
Bienville	3	n/a	17	547	0	0	20	276
Bossier	17	40	78	557	4	n/a	100	159
Caddo	25	41	499	765	2	n/a	531	400
Calcasieu	32	46	107	419	2	n/a	144	143
Caldwell	4	n/a	7	955	0	0	11	228
Cameron	1	n/a	0	0	0	0	1	n/a
Catahoula	0	0	5	361	0	0	5	105
Claiborne	0	0	20	588	0	0	20	281
Concordia	0	0	11	271	0	0	11	109
De Soto	3	n/a	17	312	0	0	20	143
East Baton Rouge	27	26	434	394	6	77	471	203
East Carroll	1	n/a	14	610	0	0	15	437
East Feliciana	1	n/a	15	388	0	0	17	185
Evangeline	8	70	18	392	2	n/a	30	181
Franklin	3	n/a	11	327	0	0	14	133
Grant	7	84	2	n/a	0	0	9	92
Iberia	23	103	107	871	1	n/a	134	355
Iberville	9	115	25	318	0	0	34	209
Jackson	5	94	13	586	1	n/a	19	243
Jefferson	53	43	295	482	9	2,703	361	161
Jefferson Davis	18	143	9	331	2	n/a	29	180
La Salle	8	130	2	n/a	0	0	10	140
Lafayette	45	57	177	553	5	104	227	189
Lafourche	15	39	48	685	1	n/a	64	129
Lincoln	10	80	66	622	0	0	78	320
Livingston	16	26	11	255	0	0	28	41
Madison	1	n/a	35	955	0	0	36	603
Morehouse	7	103	71	1,064	0	0	78	562
Natchitoches	5	47	56	648	1	n/a	62	303
Orleans	44	74	705	574	5	52	768	383
Ouachita	28	59	400	1,296	1	n/a	433	532

Geographic Distribution of Gonorrhea in Females by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**696**	**50**	**4,228**	**540**	**53**	**51**	**5,041**	**212**
Plaquemines	4	n/a	2	n/a	0	0	6	51
Pointe Coupee	2	n/a	13	305	0	0	15	129
Rapides	19	45	119	539	4	n/a	143	209
Red River	3	n/a	17	937	0	0	20	447
Richland	6	93	48	1,246	0	0	54	504
Sabine	6	72	7	333	0	0	13	106
St. Bernard	12	84	22	422	1	n/a	37	165
St. Charles	5	29	24	336	0	0	30	112
St. Helena	1	n/a	4	n/a	0	0	5	91
St. James	0	0	20	356	0	0	20	179
St. John the Baptist	4	n/a	42	334	0	0	46	205
St. Landry	20	84	70	388	0	0	91	210
St. Martin	10	58	49	587	0	0	59	219
St. Mary	15	98	32	358	1	n/a	48	178
St. Tammany	19	19	48	315	1	n/a	70	55
Tangipahoa	12	29	67	332	0	0	80	122
Tensas	3	n/a	5	365	1	n/a	9	362
Terrebonne	31	80	80	722	1	n/a	117	204
Union	4	n/a	17	560	1	n/a	22	193
Vermilion	15	62	18	400	0	0	33	108
Vernon	7	41	8	234	0	0	15	61
Washington	11	71	20	282	0	0	31	132
Webster	10	78	55	771	0	0	65	315
West Baton Rouge	0	0	10	200	0	0	11	86
West Carroll	3	n/a	4	n/a	0	0	7	122
West Feliciana	1	n/a	3	n/a	0	0	4	n/a
Winn	4	n/a	9	471	0	0	13	189

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of Gonorrhea in Males by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**576**	**42**	**3,216**	**454**	**72**	**59**	**3,937**	**173**
Acadia	11	47	29	541	1	n/a	41	135
Allen	0	0	8	208	0	0	8	55
Ascension	12	30	26	209	0	0	39	68
Assumption	4	n/a	5	154	0	0	9	80
Avoyelles	3	n/a	21	329	0	0	24	116
Beauregard	2	n/a	1	n/a	0	0	4	n/a
Bienville	1	n/a	12	452	0	0	13	196
Bossier	7	17	47	370	1	n/a	56	90
Caddo	12	21	311	559	1	n/a	330	275
Calcasieu	21	32	60	253	2	n/a	83	86
Caldwell	1	n/a	4	n/a	0	0	5	99
Cameron	0	0	0	0	0	0	0	0
Catahoula	0	0	4	n/a	0	0	4	n/a
Claiborne	1	n/a	7	142	0	0	8	86
Concordia	2	n/a	6	142	0	0	8	77
De Soto	0	0	16	333	0	0	16	122
East Baton Rouge	49	49	412	437	8	85	478	224
East Carroll	0	0	3	n/a	0	0	3	n/a
East Feliciana	2	n/a	9	187	0	0	11	103
Evangeline	3	n/a	23	478	0	0	26	152
Franklin	0	0	8	257	0	0	8	81
Grant	7	79	1	n/a	0	0	8	64
Iberia	10	46	79	706	2	n/a	93	257
Iberville	2	n/a	16	193	0	0	18	105
Jackson	6	109	10	417	0	0	16	196
Jefferson	42	37	276	520	14	44	336	159
Jefferson Davis	2	n/a	13	497	0	0	15	97
La Salle	2	n/a	1	n/a	0	0	3	n/a
Lafayette	43	56	162	563	3	n/a	210	182
Lafourche	9	24	32	517	0	0	43	89
Lincoln	3	n/a	42	466	0	0	45	194
Livingston	18	30	5	122	2	n/a	25	37
Madison	0	0	9	246	0	0	9	153
Morehouse	3	n/a	44	727	0	0	48	372
Natchitoches	1	n/a	30	402	1	n/a	32	171
Orleans	153	253	622	603	19	162	817	445
Ouachita	29	66	236	873	1	n/a	266	355

Geographic Distribution of Gonorrhea in Males by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**576**	**42**	**3,216**	**454**	**72**	**59**	**3,937**	**173**
Plaquemines	0	0	6	257	1	n/a	7	60
Pointe Coupee	0	0	8	218	0	0	8	74
Rapides	6	15	97	485	3	n/a	107	167
Red River	2	n/a	7	438	0	0	9	214
Richland	2	n/a	27	779	0	0	29	290
Sabine	3	n/a	7	359	0	0	10	83
St. Bernard	6	42	24	543	1	n/a	31	141
St. Charles	2	n/a	14	212	1	n/a	17	65
St. Helena	1	n/a	4	n/a	0	0	5	97
St. James	3	n/a	18	362	0	0	21	200
St. John the Baptist	1	n/a	25	220	0	0	26	122
St. Landry	4	n/a	48	294	0	0	53	132
St. Martin	5	29	30	388	0	0	35	133
St. Mary	8	54	25	308	4	n/a	38	145
St. Tammany	22	23	36	262	0	0	62	52
Tangipahoa	9	23	68	381	0	0	79	128
Tensas	0	0	10	797	0	0	10	427
Terrebonne	16	42	40	393	1	n/a	59	105
Union	3	n/a	14	503	1	n/a	18	162
Vermilion	6	26	18	435	1	n/a	25	86
Vernon	7	37	18	468	2	n/a	30	109
Washington	5	33	17	246	0	0	23	101
Webster	0	0	32	493	1	n/a	33	168
West Baton Rouge	2	n/a	24	522	0	0	26	212
West Carroll	0	0	0	0	0	0	0	0
West Feliciana	0	0	6	112	0	0	6	59
Winn	0	0	2	n/a	0	0	3	n/a

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of Primary & Secondary Syphilis by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**125**	**5**	**432**	**29**	**12**	**5**	**575**	**12.4**
Region 1: New Orleans	**58**	**15**	**130**	**37**	**9**	**10**	**199**	**22.4**
Jefferson	13	6	27	24	4	n/a	44	10.1
Orleans	43	36	100	44	4	n/a	149	38.8
Plaquemines	1	n/a	0	0	1	n/a	2	n/a
St. Bernard	1	n/a	3	n/a	0	0	4	n/a
Region 2: East Baton Rouge	**7**	**2**	**72**	**26**	**1**	**n/a**	**80**	**11.8**
Ascension	0	0	2	n/a	0	0	2	n/a
East Baton Rouge	7	3	64	31	1	n/a	72	16.1
East Feliciana	0	0	3	n/a	0	0	3	n/a
Iberville	0	0	1	n/a	0	0	1	n/a
Pointe Coupee	0	0	0	0	0	0	0	0.0
West Baton Rouge	0	0	1	n/a	0	0	1	n/a
West Feliciana	0	0	1	n/a	0	0	1	n/a
Region 3: Houma	**17**	**7**	**35**	**33**	**1**	**n/a**	**54**	**13.3**
Assumption	0	0	2	n/a	0	0	2	n/a
Lafourche	4	n/a	10	76	0	0	14	14.3
St. Charles	2	n/a	4	n/a	0	0	6	11.4
St. James	0	0	3	n/a	0	0	3	n/a
St. John the Baptist	3	n/a	3	n/a	0	0	6	13.7
St. Mary	3	n/a	1	n/a	0	0	4	n/a
Terrebonne	5	7	12	56	1	n/a	19	16.8
Region 4: Lafayette	**21**	**5**	**22**	**13**	**0**	**0**	**43**	**7.1**
Acadia	2	n/a	0	0	0	0	2	n/a
Evangeline	1	n/a	2	n/a	0	0	3	n/a
Iberia	3	n/a	7	30	0	0	10	13.5
Lafayette	9	6	8	13	0	0	17	7.2
St. Landry	2	n/a	3	n/a	0	0	5	6.0
St. Martin	1	n/a	2	n/a	0	0	3	n/a
Vermilion	3	n/a	0	0	0	0	3	n/a
Region 5: Lake Charles	**2**	**n/a**	**3**	**n/a**	**0**	**0**	**6**	**2.0**
Allen	0	0	0	0	0	0	0	0.0
Beauregard	0	0	0	0	0	0	0	0.0
Calcasieu	1	n/a	3	n/a	0	0	5	2.5
Cameron	0	0	0	0	0	0	0	0.0
Jefferson Davis	1	n/a	0	0	0	0	1	n/a

Geographic Distribution of Primary & Secondary Syphilis by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**125**	**5**	**432**	**29**	**12**	**5**	**575**	**12.4**
Region 6: Alexandria	**2**	**n/a**	**6**	**7**	**1**	**n/a**	**10**	**3.2**
Avoyelles	0	0	1	n/a	0	0	1	n/a
Catahoula	0	0	0	0	0	0	0	0.0
Concordia	0	0	0	0	0	0	0	0.0
Grant	0	0	0	0	0	0	0	0.0
La Salle	0	0	0	0	1	n/a	1	n/a
Rapides	2	n/a	5	12	0	0	8	6.0
Vernon	0	0	0	0	0	0	0	0.0
Winn	0	0	0	0	0	0	0	0.0
Region 7: Shreveport	**11**	**4**	**98**	**47**	**0**	**0**	**110**	**20.1**
Bienville	0	0	1	n/a	0	0	1	n/a
Bossier	3	n/a	12	45	0	0	15	12.0
Caddo	6	5	66	55	0	0	72	28.5
Claiborne	0	0	1	n/a	0	0	1	n/a
De Soto	0	0	4	n/a	0	0	4	n/a
Natchitoches	1	n/a	6	37	0	0	7	17.9
Red River	0	0	2	n/a	0	0	3	n/a
Sabine	0	0	0	0	0	0	0	0.0
Webster	1	n/a	6	44	0	0	7	17.4
Region 8: Monroe	**5**	**2**	**51**	**38**	**0**	**0**	**56**	**15.7**
Caldwell	1	n/a	0	0	0	0	1	n/a
East Carroll	0	0	0	0	0	0	0	0.0
Franklin	1	n/a	1	n/a	0	0	2	n/a
Jackson	0	0	1	n/a	0	0	1	n/a
Lincoln	0	0	8	41	0	0	8	16.8
Madison	0	0	0	0	0	0	0	0.0
Morehouse	0	0	2	n/a	0	0	2	n/a
Ouachita	3	n/a	34	59	0	0	37	23.7
Richland	0	0	4	n/a	0	0	4	n/a
Tensas	0	0	0	0	0	0	0	0.0
Union	0	0	1	n/a	0	0	1	n/a
West Carroll	0	0	0	0	0	0	0	0.0
Region 9: Hammond/Slidell	**2**	**n/a**	**15**	**16**	**0**	**0**	**17**	**3.0**
Livingston	0	0	3	n/a	0	0	3	n/a
St. Helena	0	0	2	n/a	0	0	2	n/a
St. Tammany	1	n/a	4	n/a	0	0	5	2.0
Tangipahoa	1	n/a	6	16	0	0	7	5.5
Washington	0	0	0	0	0	0	0	0.0

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of P&S Syphilis in Females by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**12**	**1**	**117**	**15**	**1**	**n/a**	**132**	**6**
Acadia	0	0	0	0	0	0	0	0
Allen	0	0	0	0	0	0	0	0
Ascension	0	0	0	0	0	0	0	0
Assumption	0	0	0	0	0	0	0	0
Avoyelles	0	0	0	0	0	0	0	0
Beauregard	0	0	0	0	0	0	0	0
Bienville	0	0	1	n/a	0	0	1	n/a
Bossier	2	n/a	3	n/a	0	0	5	8
Caddo	3	n/a	34	52	0	0	37	28
Calcasieu	0	0	0	0	0	0	0	0
Caldwell	0	0	0	0	0	0	0	0
Cameron	0	0	0	0	0	0	0	0
Catahoula	0	0	0	0	0	0	0	0
Claiborne	0	0	1	n/a	0	0	1	n/a
Concordia	0	0	0	0	0	0	0	0
De Soto	0	0	1	n/a	0	0	1	n/a
East Baton Rouge	0	0	9	8	0	0	9	4
East Carroll	0	0	0	0	0	0	0	0
East Feliciana	0	0	0	0	0	0	0	0
Evangeline	0	0	0	0	0	0	0	0
Franklin	0	0	0	0	0	0	0	0
Grant	0	0	0	0	0	0	0	0
Iberia	0	0	2	n/a	0	0	2	n/a
Iberville	0	0	0	0	0	0	0	0
Jackson	0	0	1	n/a	0	0	1	n/a
Jefferson	0	0	2	n/a	0	0	2	n/a
Jefferson Davis	0	0	0	0	0	0	0	0
La Salle	0	0	0	0	1	n/a	1	n/a
Lafayette	0	0	0	0	0	0	0	0
Lafourche	1	n/a	6	86	0	0	7	14
Lincoln	0	0	0	0	0	0	0	0
Livingston	0	0	0	0	0	0	0	0
Madison	0	0	0	0	0	0	0	0
Morehouse	0	0	2	n/a	0	0	2	n/a
Natchitoches	1	n/a	4	n/a	0	0	5	24
Orleans	0	0	12	10	0	0	12	6
Ouachita	0	0	16	52	0	0	16	20

Geographic Distribution of P&S Syphilis in Females by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**12**	**1**	**117**	**15**	**1**	**n/a**	**132**	**6**
Plaquemines	0	0	0	0	0	0	0	0
Pointe Coupee	0	0	0	0	0	0	0	0
Rapides	1	n/a	2	n/a	0	0	3	n/a
Red River	0	0	0	0	0	0	1	n/a
Richland	0	0	2	n/a	0	0	2	n/a
Sabine	0	0	0	0	0	0	0	0
St. Bernard	0	0	1	n/a	0	0	1	n/a
St. Charles	0	0	0	0	0	0	0	0
St. Helena	0	0	0	0	0	0	0	0
St. James	0	0	2	n/a	0	0	2	n/a
St. John the Baptist	0	0	1	n/a	0	0	1	n/a
St. Landry	0	0	2	n/a	0	0	2	n/a
St. Martin	0	0	0	0	0	0	0	0
St. Mary	1	n/a	0	0	0	0	1	n/a
St. Tammany	0	0	0	0	0	0	0	0
Tangipahoa	0	0	4	n/a	0	0	4	n/a
Tensas	0	0	0	0	0	0	0	0
Terrebonne	2	n/a	7	63	0	0	10	17
Union	0	0	1	n/a	0	0	1	n/a
Vermilion	0	0	0	0	0	0	0	0
Vernon	0	0	0	0	0	0	0	0
Washington	0	0	0	0	0	0	0	0
Webster	1	n/a	1	n/a	0	0	2	n/a
West Baton Rouge	0	0	0	0	0	0	0	0
West Carroll	0	0	0	0	0	0	0	0
West Feliciana	0	0	0	0	0	0	0	0
Winn	0	0	0	0	0	0	0	0

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Geographic Distribution of P&S Syphilis in Males by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**113**	**8**	**315**	**44**	**11**	**9**	**443**	**19**
Acadia	2	n/a	0	0	0	0	2	n/a
Allen	0	0	0	0	0	0	0	0
Ascension	0	0	2	n/a	0	0	2	n/a
Assumption	0	0	2	n/a	0	0	2	n/a
Avoyelles	0	0	1	n/a	0	0	1	n/a
Beauregard	0	0	0	0	0	0	0	0
Bienville	0	0	0	0	0	0	0	0
Bossier	1	n/a	9	71	0	0	10	16
Caddo	3	n/a	32	57	0	0	35	29
Calcasieu	1	n/a	3	n/a	0	0	5	5
Caldwell	1	n/a	0	0	0	0	1	n/a
Cameron	0	0	0	0	0	0	0	0
Catahoula	0	0	0	0	0	0	0	0
Claiborne	0	0	0	0	0	0	0	0
Concordia	0	0	0	0	0	0	0	0
De Soto	0	0	3	n/a	0	0	3	n/a
East Baton Rouge	7	7	55	58	1	n/a	63	29
East Carroll	0	0	0	0	0	0	0	0
East Feliciana	0	0	3	n/a	0	0	3	n/a
Evangeline	1	n/a	2	n/a	0	0	3	n/a
Franklin	1	n/a	1	n/a	0	0	2	n/a
Grant	0	0	0	0	0	0	0	0
Iberia	3	n/a	5	45	0	0	8	22
Iberville	0	0	1	n/a	0	0	1	n/a
Jackson	0	0	0	0	0	0	0	0
Jefferson	13	11	25	47	4	n/a	42	20
Jefferson Davis	1	n/a	0	0	0	0	1	n/a
La Salle	0	0	0	0	0	0	0	0
Lafayette	9	12	8	28	0	0	17	15
Lafourche	3	n/a	4	n/a	0	0	7	14
Lincoln	0	0	8	89	0	0	8	34
Livingston	0	0	3	n/a	0	0	3	n/a
Madison	0	0	0	0	0	0	0	0
Morehouse	0	0	0	0	0	0	0	0
Natchitoches	0	0	2	n/a	0	0	2	n/a
Orleans	43	71	88	85	4	n/a	137	75
Ouachita	3	n/a	18	67	0	0	21	28

Geographic Distribution of P&S Syphilis in Males by Race/Ethnicity
Louisiana, 2014

	White		Black/African American		Hispanic/Latino		Total†	
	Cases	Rate*	Cases	Rate*	Cases	Rate*	Cases	Rate*
Louisiana**	**113**	**8**	**315**	**44**	**11**	**9**	**443**	**19**
Plaquemines	1	n/a	0	0	1	n/a	2	n/a
Pointe Coupee	0	0	0	0	0	0	0	0
Rapides	1	n/a	3	n/a	0	0	5	8
Red River	0	0	2	n/a	0	0	2	n/a
Richland	0	0	2	n/a	0	0	2	n/a
Sabine	0	0	0	0	0	0	0	0
St. Bernard	1	n/a	2	n/a	0	0	3	n/a
St. Charles	2	n/a	4	n/a	0	0	6	23
St. Helena	0	0	2	n/a	0	0	2	n/a
St. James	0	0	1	n/a	0	0	1	n/a
St. John the Baptist	3	n/a	2	n/a	0	0	5	23
St. Landry	2	n/a	1	n/a	0	0	3	n/a
St. Martin	1	n/a	2	n/a	0	0	3	n/a
St. Mary	2	n/a	1	n/a	0	0	3	n/a
St. Tammany	1	n/a	4	n/a	0	0	5	4
Tangipahoa	1	n/a	2	n/a	0	0	3	n/a
Tensas	0	0	0	0	0	0	0	0
Terrebonne	3	n/a	5	49	1	n/a	9	16
Union	0	0	0	0	0	0	0	0
Vermilion	3	n/a	0	0	0	0	3	n/a
Vernon	0	0	0	0	0	0	0	0
Washington	0	0	0	0	0	0	0	0
Webster	0	0	5	77	0	0	5	25
West Baton Rouge	0	0	1	n/a	0	0	1	n/a
West Carroll	0	0	0	0	0	0	0	0
West Feliciana	0	0	1	n/a	0	0	1	n/a
Winn	0	0	0	0	0	0	0	0

*Rates per 100,000 persons in parish. Rates derived from numerators less than 20 may be unreliable and are not available (n/a) for numerators less than 5.
** Louisiana total includes cases with unknown parish.
† The totals include cases with other and unknown race.

Program Report Technical Notes

Report Format

The *2014 HIV/STD Surveillance Report* includes only HIV and STD surveillance data and does not include HIV/STD prevention and services data. This STD/HIV Program Report is divided into the follow sections: Introduction, Chapter 1: Profile of the HIV Epidemic in Louisiana, Chapter 2: Linkage and Retention in HIV Care, Chapter 3: Perinatal HIV Exposure and Congenital Syphilis, Chapter 4: Profile of STDs in Louisiana, and an Appendix which includes additional HIV and STD tables.

Tabulation of Data

This report includes all STD information entered at the STD/HIV Program office as of May 2, 2015 and all HIV information entered as of December 22, 2015. Chlamydia, gonorrhea, syphilis, congenital syphilis, HIV and AIDS cases diagnosed through 2014 are included in this report. The 2014 data are very complete and are not adjusted for a potential reporting delay. Due to reporting and collection delays for deaths among person with an HIV diagnosis and pediatric HIV exposures, those data are reported only through 2013 to ensure complete data.

Census Data and Rate Calculation

For all rates calculated for years 2005-2014, mid-year estimates for populations were obtained from the U.S. Census Bureau. The census estimates for 2010 are from the census data completed in 2010. These populations are used to calculate changes in the population, and incidence and prevalence rates. All rates are calculated per 100,000 persons except for death rates, which are calculated per 1,000 persons, and congenital syphilis rates which are calculated per 100,000 live births. An example of how rates are calculated is as follows. For the HIV diagnosis rate in 2014 for the New Orleans Public Health Region 1, the 2014 Census populations for the four parishes within Region 1 are added together equaling a regional population of 867,658 persons. Then the number of new HIV diagnoses in Region 1 in 2014, 364 new diagnoses, is divided by the totaled population, 867,658 persons to get 0.0004195. This number is multiplied by 100,000 to result in an HIV case rate of 41.95 per 100,000 population for Region 1 in 2014.

Interpretation of HIV Data

HIV data are not without limitations. Although an HIV diagnosis is usually closer in time to HIV infection than is an AIDS diagnosis, data represented by the time of HIV diagnosis must be interpreted with caution. HIV data may not accurately depict trends in HIV transmission because HIV data represent persons who were reported with a positive confidential HIV test, which may first occur several years after HIV infection. In addition, the data are underreported because only persons with HIV who choose to be tested confidentially are counted. HIV diagnoses do not include persons who have not been tested for HIV.

Therefore, HIV diagnosis data do not necessarily represent characteristics of persons who have been recently-infected with HIV nor do they provide a true measure of HIV incidence. Demographic and geographic subpopulations are disproportionately sensitive to differences and changes in access to health care, HIV testing patterns, and targeted prevention programs and services. All of these issues must be considered when interpreting HIV data.

Interpretation of STD Data

Similar to the limitations of the HIV data, STD data in this report represent only persons who have been tested for an STD. For many people, symptoms of an STD may not be obvious or may be ignored and a person does not seek STD testing.

HIV and AIDS Case Definition Changes

Most recently, the HIV surveillance case definitions were revised in 2008 for adults and adolescents (age ≥13 years).[21] A single case definition was created that incorporates AIDS and an HIV classification system. HIV infection is now categorized into four stages based on severity. Stage 1 is HIV infection with no AIDS-defining conditions

and either the CD4+ T-lymphocyte count is >500 cells/µl or the lymphocyte percentage is ≥29%. Stage 2 is HIV infection with no AIDS-defining conditions and either the CD4+ T-lymphocyte count is between 200-499 cells/µl or the lymphocyte percentage is between 14-28%. Stage 3 is AIDS where one of the following three conditions is met: CD4+ T-lymphocyte count is <200 cells/µl, or the lymphocyte percentage <14%, or there is documentation of an AIDS-defining condition. An AIDS-defining condition supersedes the CD4 count or percentage. Stage 4 is an unknown stage where no information has been collected on AIDS-defining conditions, CD4 count, or percentage. Once a person is classified as Stage 2 or 3, they cannot be reclassified at a lower stage.

The case definition for children less than 18 months of age has also been revised. The only category that was revised was "presumptively uninfected" with HIV. Additional laboratory criteria were added. In children age 18 months to <13 years, the surveillance case definition requires laboratory-confirmed evidence of HIV infection.

The definition of Stage 3 (AIDS) was further modified for all HIV-positive persons with laboratory results in 2014 and going forward. The new case definition relies only on the diagnosis of an OI or a CD4 count below 200. If the CD4 lymphocyte count is above 200 and the lymphocyte percentage is below 14%, this no longer meets the surveillance definition for Stage 3 (AIDS). If no CD4 lymphocyte count is available then a CD4 lymphocyte percent below 14% does meet the surveillance definition for AIDS.[22]

Definitions of the HIV Transmission Categories

For the purposes of this report, HIV and AIDS cases were classified into one of several hierarchical transmission (risk) categories, based on information collected. Persons with more than one reported mode of exposure to HIV were assigned to the category listed first in the hierarchy. Definitions are as follows:

Men who have Sex with Men (MSM): Cases include persons whose birth sex is male who report sexual contact with other men, i.e. homosexual contact or bisexual contact. The CDC does calculate a risk of MSM for transgender women who report male sex partners, because the birth sex is collected as male.

Injection Drug User (IDU): Cases who report using drugs that require injection - no other route of administration of illicit drugs at any time since 1978.

High-Risk Heterosexual Contact (HRH): Cases who report specific heterosexual contact with a person who has HIV or is at increased risk for HIV infection, e.g., heterosexual contact with a homosexual or bisexual man, heterosexual contact with an injection drug user, and/or heterosexual contact with a person known to be HIV-infected.

Hemophilia/Transfusion/Transplant (Hemo/Transf): Cases who report receiving a transfusion of blood or blood products prior to 1985.

Perinatal: HIV infection in children that results from transmission from an HIV-infected mother to her child.

Unspecified/NIR: Cases who, at the time of this publication, have no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. These cases are traditionally marked as No Identified Risk factor (NIR). NIR cases include: persons for whom risk behavior information has not yet been reported and are still under investigation; persons whose exposure history is incomplete because they have died, declined risk disclosure, or were lost to follow-up; persons who deny any risk behavior; and persons who do not know the HIV infection status or risk behaviors of their sexual partners. For this report, all cases with an unspecified transmission category were assigned an imputed transmission category. Imputation procedures are described below.

HIV Imputed Transmission Category

Newly reported cases, especially HIV (non-AIDS) cases, are often reported without a specified risk exposure, thereby causing a distortion of trends in exposure categories. Thus, statistical procedures to provide or

impute predicted values of transmission category were used. All data in the graphs and tables throughout the surveillance section of the report represent imputed transmission categories. Values for transmission category for cases with no known risk were estimated using a statistical procedure known as hotdeck imputation, similar to methods used by the U.S. Census on the American Community Survey (www.census.gov/acs/www/Downloads/tp67.pdf). The Louisiana hotdeck imputation method was locally developed and validated against the CDC methodology. Logistic regression models were developed to identify those variables that are highly correlated with either a) missingness or b) one of the three chief risk factors for HIV infection (MSM, IDU, HRH). Next, a profile for each case was constructed using information from these variables, including age, race, sex, parish of residence, incarceration history, substance use, and year of infection. Finally, a predicted value for risk was then obtained by matching cases with no known risk to cases with a known risk along this profile and substituting the missing risk value. Transmission categories are not imputed for STD data.

Works Cited

Introduction Chapter

1 U.S. Census Bureau, 2014 Population Estimates

2 U.S. Bureau of Labor Statistics, site accessed June 1, 2016. http://www.bls.gov/eag/eag.la.htm

3 National Institute of Corrections, site accessed June 1, 2016. http://nicic.gov/statestats/?st=la

4 Department of Public Safety and Corrections, site accessed June 1, 2016. http://www.doc.la.gov/media/1/Briefing%20Book/APR%202016/1a-f.-.pop.trends.4.charts.dpsc.inmates.-.apr.16.pdf

5 Kaiser Family Foundation State Health Facts, site accessed June 1, 2016. http://kff.org/other/state-indicator/total-population/?state=LA

6 Kaiser Family Foundation State Health Facts, site accessed June 1, 2016. http://kff.org/medicaid/state-indicator/total-medicaid-spending/?state=LA

7 Kaiser Family Foundation State Health Facts, site accessed June 1, 2016. http://kff.org/other/state-indicator/children-0-18/?state=LA

Chapter 1

8 Centers for Disease Control and Prevention. *HIV Surveillance Report, 2014*; vol. 26. http://www.cdc.gov/hiv/library/reports/surveillance/. Published November 2015. Accessed [January 8,2016].

9 CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 U.S. dependent areas—2012. HIV Surveillance Supplemental Report 2013;20(No. 2).

Chapter 3

10 Alexander JM, Sheffield JS, Sanchez PJ, Mayfield J, Wendel GD Jr. Efficacy of treatment for syphilis in pregnancy. Obstetrics and Gynecology 1999;93:5–8.

11 Panel on Treatment of HIV-Infected Women and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. Department of Health and Human Services. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/perinatalgl.pdf. Accessed [January 11, 2016]

12 CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings. MMWR 2006:55(RR-14):1-17.

13 CDC. HIV Surveillance Report, 2013; vol. 25. http://www.cdc.gov/hiv/library.reports/surveillance/. Published February 2015. Accessed [January 22, 2016].

14 CDC. Pregnant Women, Infants and Children: Elimination of Mother-to-Child Transmission. http://www.cdc.gov/hiv/group/gender/pregnantwomen/emct.html#ref6. Accessed [January 25, 2016]

15 Kids Count Data Center. http://www.datacenter.kidscount.org. Accessed [February 5, 2016]

16 American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care. Sixth Edition. October 2007.

17 Gomez G, et al. Untreated maternal syphilis and adverse outcomes of pregnancy: a systematic review and meta-analysis. World Health Organization. Available at http://www.who.int/bulletin/volumes/91/3/12-107623.pdf. Accessed [January 11, 2016]

18 Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2014*. Atlanta, GA: U.S. Department of Health and Human Services, 2014.

Chapter 4

19 Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance, 2014*. Atlanta, GA: U.S. Department of Health and Human Services, 2014.

20 Centers for Disease Control and Prevention. *Update to CDC's Sexually Transmitted Diseases Treatment Guidelines, 2010. Oral cephalosporins no longer a recommended treatment for gonococcal infection.* MMWR 2012; 61(31).

Appendices

21 MMWR 2008; 57 [RR-10]: 1-12

22 MMWR 2014; 63 [RR-03]: 1-10