2010 STD/HIV Program Report

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Department of Health and Hospitals
Office of Public Health

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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.

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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 and Hospitals (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 and Hospitals (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).

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.

SHP's main programmatic units include:

- Data Management/Analysis and Surveillance: This unit is responsible for monitoring the chlamydia, gonorrhea, syphilis and HIV epidemics throughout the state. Surveillance data are used for STD/HIV prevention planning and help guide the allocation of resources for STD/HIV treatment, care, and other supportive services.
- Regional Operations: This unit is responsible for educating providers, laboratories and other sites on reporting requirements for STD/HIV; conducting follow-up investigations on syphilis and HIV cases, including perinatal HIV exposures and congenital syphilis; and ensuring individuals diagnosed with syphilis and/or HIV are aware of their status and referred to care for treatment through the provision of partner services.
- Prevention: This unit is responsible for behavioral interventions and educational activities that are focused on reducing the spread of STDs and HIV in Louisiana. Prevention activities include partner services, HIV counseling, testing and referral, prevention with HIV-positive individuals, outreach, and behavioral interventions.
- HIV Care and Services: This unit provides a variety of patient care services to individuals living with HIV infection such as assistance with the payment of health insurance premiums, co-payments, and

deductibles; medications; dental services; assistance with transportation; rent and utility assistance; supplemental food items and other needed support services.

- Evaluation: This unit is responsible for examining the services provided to persons infected or affected by STDs and HIV and the prevention activities targeted at reducing the spread of STDs and HIV to ensure the quality, effectiveness, and efficiency of those activities.

About this Report

STD and HIV infection in Louisiana requires responsive interventions to decrease new infections, slow HIV disease progression, increase individual awareness of STD and HIV status, and help ensure access to medical care for persons who have HIV or need treatment for an STD. The *2010 STD/HIV Program Report* provides a thorough surveillance profile, as well as descriptions of the state's prevention, counseling and testing, care, services, housing, and evaluation programs. While many challenges remain, the report highlights several areas of progress

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 2010. Some of the most significant trends are highlighted below:

HIV Summary

At the end of 2010, 17,679 persons were living with HIV infection in Louisiana, of whom 9,572 (54%) 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. 22), Louisiana ranked 4th highest in estimated state AIDS case rates (20.0 per 100,000) and 11th in the number of estimated AIDS cases in 2010. In 2009, Louisiana ranked 5th highest in estimated state AIDS case rates (19.4 per 100,000) and 12th in the number of estimated AIDS cases.
- In the CDC *HIV Surveillance Report* (Vol. 22), the Baton Rouge metropolitan area ranked 1st in estimated AIDS case rates (33.7 per 100,000) and the New Orleans metropolitan area ranked 5th in estimated AIDS case rates (26.2 per 100,000) in 2010 among the large metropolitan areas in the nation.
- In 2010, 1,174 individuals were newly diagnosed with HIV infection in Louisiana, a 3% decrease from the 1,213 new diagnoses in 2009.
- The New Orleans region had the highest number of new HIV diagnoses and the 2nd highest rate of new diagnoses in 2010 out of all nine public health regions. The Baton Rouge region had the 2nd highest number of new diagnoses but the highest HIV rate in 2010.
- Women represented 28% of new HIV diagnoses in 2010. The HIV rate among men has increased since 2005, but among women has remained relatively stable over time.
- The HIV rate for blacks continues to be disproportionately high; the rate for blacks was almost seven times higher than among whites. Although blacks make up only 32% of the state's population, 74% of newly-diagnosed HIV cases and 78% of newly-diagnosed AIDS cases were among blacks in 2010.
- The number of diagnoses in youth aged 13-24 has been steadily increasing since 2006. In 2010, new diagnoses in youth aged 13-24 accounted for almost a quarter of all new diagnoses, and is the only age group where the number of new diagnoses increased from 2009 to 2010.
- The percentage of adult HIV diagnoses among MSM has increased from a low of 36% in 2001 to a high of 53% in 2010. An additional 4% of new diagnoses in 2010 were among MSM/IDU. The majority of the new diagnoses among MSM in Louisiana are black and under the age of 34.
- In 2010, 24% of persons newly diagnosed with HIV had AIDS at the time of their diagnosis, and an additional 9% of persons developed AIDS within six months of their diagnosis. Men, Hispanics, and persons aged 35 and older were most likely to be diagnosed late in the course of their disease.
- Perinatal transmission rates have dropped dramatically from 19% in 1994 to less than 2% in 2006 through 2009 due to increased screening of pregnant women and increased use of antiretroviral therapy by pregnant women with HIV and their infants.
- In 2010, there were a total of 99,465 HIV tests conducted through SHP's HIV Counseling Testing and Referral Program. Of these tests, 1,006 were positive, accounting for 1% of the total tests.
- Of the 99,465 tests conducted, 69% were among blacks and 50% were among females. Males had a higher positivity rate than females, and male-to-female transgender persons, men who have sex with men (MSM) and men who have sex with men and are injection drug users (MSM/IDU) had the highest positivity percents. Community-based organizations, emergency departments, and community health clinics had the highest positivity rates of all testing sites in 2010.

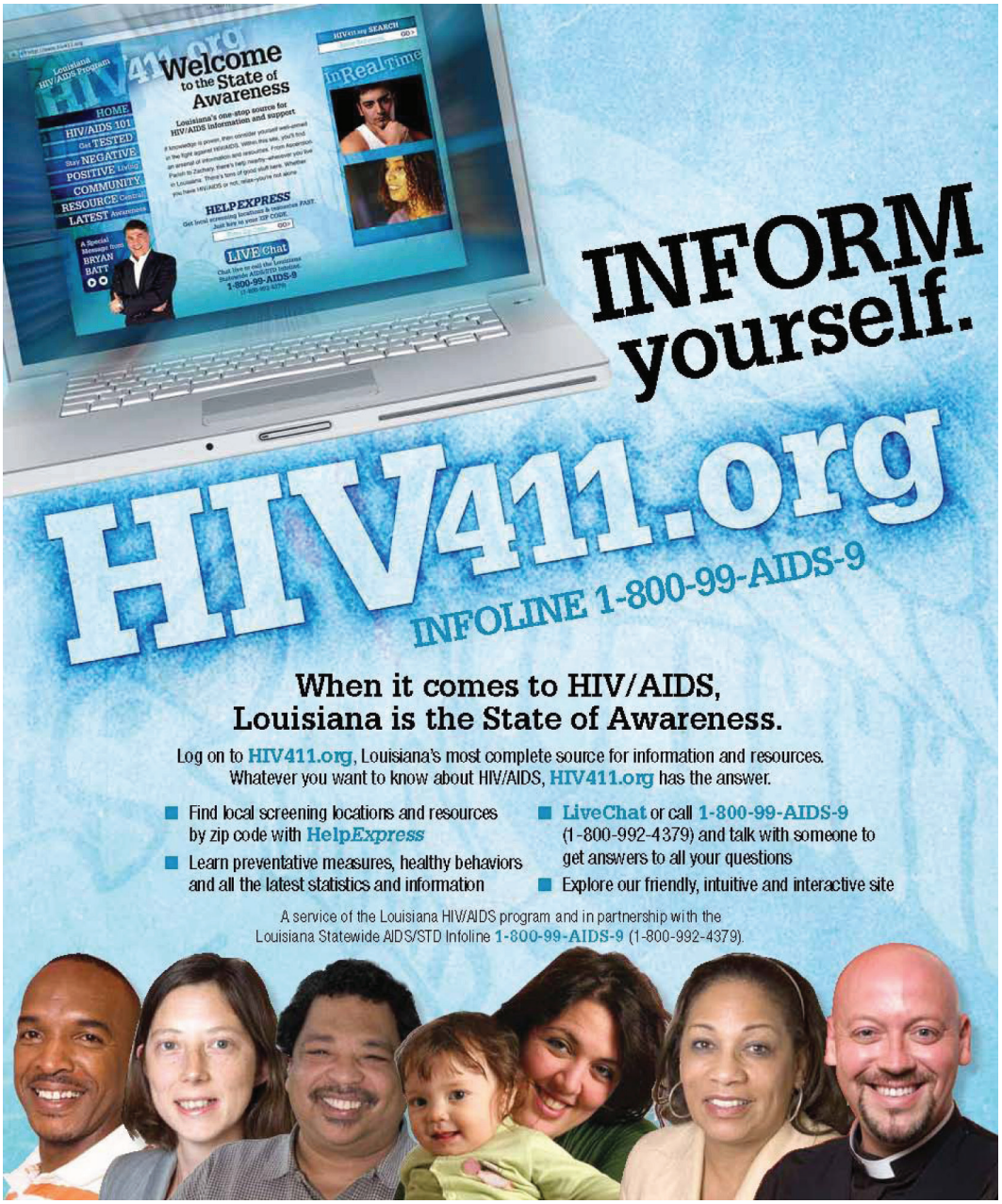
- In 2010, 1,530 persons were referred to the Disease Intervention Specialists (DIS) for HIV Partner Services. A total of 661 partners were contacted by the DIS, 52% of whom were tested for HIV. A total of 91 partners contacted by DIS were newly-diagnosed with HIV, a positivity rate of 25% among partners tested by DIS.
- In 2010, 36% of all persons living with HIV infection in Louisiana were not in care (did not have a CD4 or viral load test conducted in 2010). Males, Hispanic/Latinos, and persons living in the Lake Charles region had the highest percentage of people not in care.
- In 2010, SHP coordinated HIV-related care, treatment and support services for 5,848 people living with HIV infection in Louisiana. These services were supported through the Ryan White Part B and the state formula Housing Opportunities for Persons with AIDS (HOPWA) programs.

STD Summary

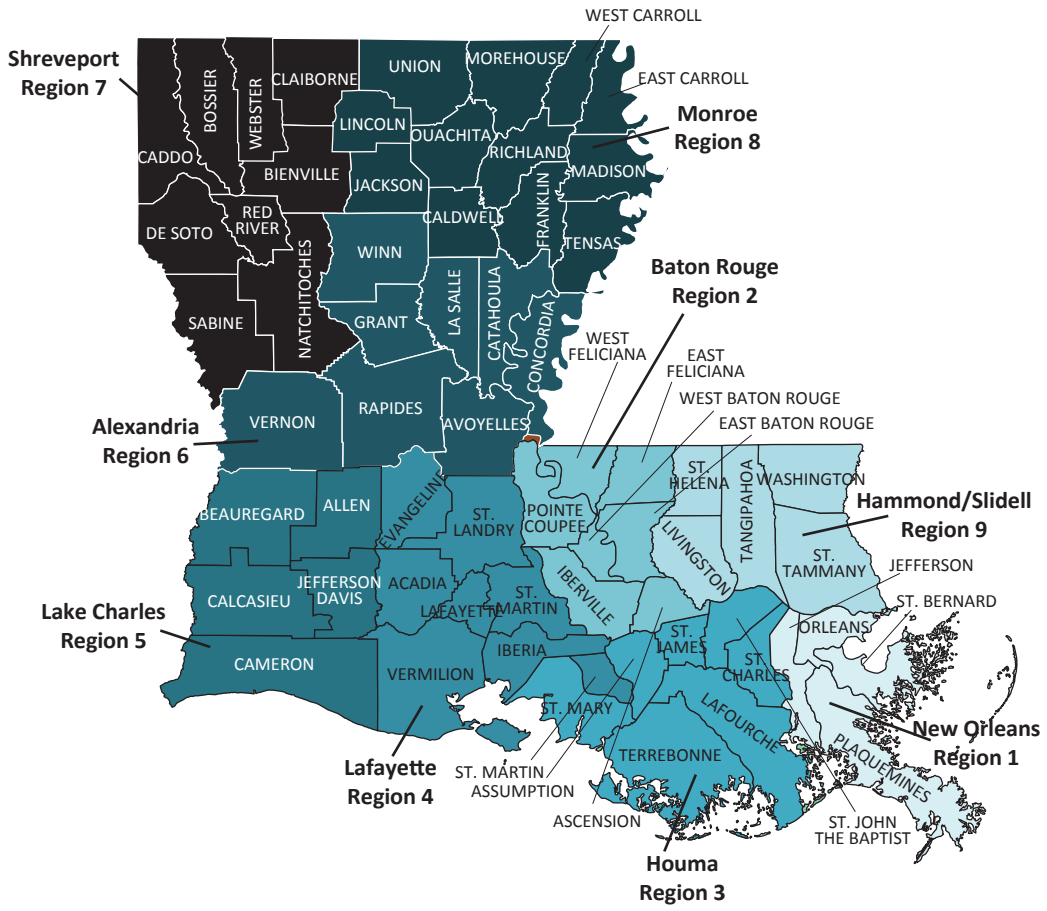
- Louisiana continues to have very high rates of STDs. In 2010, Louisiana ranked 1st in the nation in primary and secondary (P&S) syphilis rates (12.1 per 100,000), 1st in congenital syphilis rates (52.3 per 100,000 live births); 2nd in gonorrhea rates (196.6 per 100,000); and 3rd in chlamydia rates (643.0 per 100,000).
- There were 29,151 new cases of chlamydia, 8,912 cases of gonorrhea, and 547 cases of P&S syphilis diagnosed in Louisiana in 2010.
- The Shreveport region has the highest rates of gonorrhea, chlamydia, and P&S syphilis of all nine regions in Louisiana.
- Louisiana has the highest rate of congenital syphilis in the nation. In 2010, there were 33 cases of congenital syphilis reported to the CDC. Only 26 states in the nation reported one or more cases of congenital syphilis in 2010.
- In 2010, 547 persons were referred to the Disease Intervention Specialists (DIS) for syphilis Partner Services. A total of 404 partners were contacted by the DIS, 93% of whom were tested for syphilis. A total of 146 partners contacted by DIS were newly-diagnosed with syphilis, a positivity rate of 39% among partners tested by DIS.
- Throughout Louisiana, women under the age of 30 are targeted for chlamydia and gonorrhea screenings at parish health units and STD and family planning clinics. These facilities had an overall chlamydia positivity rate of 14% and a 5% gonorrhea positivity rate in 2010.

Staying Connected with SHP

In August, 2009, the SHP office launched www.HIV411.org, to serve as a comprehensive resource of HIV and AIDS and support services for Louisiana residents living with HIV infection. This website now incorporates STD resources and data. Housed on the HIV411 website is a search engine to locate HIV testing locations and HIV-related resources by zip code. Publications, including this Annual Report, can be found under the "Resource Central" tab. An archive of all Annual Reports, quarterly reports, and fact sheets can be found at SHP's Office of Public Health website, http://dhh.louisiana.gov/hiv.



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



	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 2010 census, the total population of Louisiana was 4,533,372 persons. Louisiana is made up of 64 county-equivalent subdivisions called parishes. In 2010, parish populations ranged from a low of 5,252 persons (Tensas Parish) to a high of 440,171 persons (East Baton Rouge Parish). The New Orleans region (composed of the Orleans, Jefferson, Plaquemines, and St. Bernard Parishes) represented 18% of the state's population. While the state is considered rural, 75% of the population resides in urban areas.[1] The state has nine public health regions and eight metropolitan statistical areas (MSAs).

Distribution of the General Population by Region
Louisiana, 2001, 2006 & 2010

Public Health Region	2001 Total Population[a]	2006 Total Population[b]	% Change from 2001-2006	2010 Total Population[b]	% Change from 2006-2010	% Change from 2001-2010
1 - New Orleans	1,034,126	665,017	-36.0%	835,320	25.6%	-19.2%
2 - Baton Rouge	603,634	640,611	6.1%	663,255	3.5%	9.9%
3 - Houma	383,697	396,152	3.2%	407,055	2.8%	6.1%
4 - Lafayette	548,154	570,615	4.1%	584,118	2.4%	6.6%
5 - Lake Charles	283,429	281,764	-0.6%	292,619	3.9%	3.2%
6 - Alexandria	301,390	302,252	0.3%	309,761	2.5%	2.8%
7 - Shreveport	522,560	531,005	1.6%	544,249	2.5%	4.2%
8 - Monroe	353,865	348,525	-1.5%	355,761	2.1%	0.5%
9 - Hammond/Slidell	438,121	504,386	15.1%	541,243	7.3%	23.5%
Louisiana	**4,468,976**	**4,240,327**	**-5.1%**	**4,533,372**	**6.9%**	**1.4%**

Source: aCensus 2001, US Bureau of the Census; bCensus 2010 Population Estimates, US Bureau of the Census

- In 2010, the New Orleans region (Region 1) had the largest population in the state and the Lake Charles region (Region 5) had the smallest.
- From 2001 to 2006, the population of the New Orleans region decreased 36%, largely due to the impact of Hurricane Katrina. The hurricane devastated the New Orleans metropolitan area in August 2005 and caused a massive displacement of the population. Between 2006 and 2010, the population of the New Orleans region increased 26%, but is still 19% below the population reported in 2001. Each year since the hurricane, the population of the New Orleans region continues to increase.
- The Hammond/Slidell region (Region 9) had the largest population increase, 103,122 persons, (23.5%) from 2001 to 2010.

Demographic Composition

According to the 2010 estimated census data, the racial and ethnic composition of the state was estimated to be 61% white, 32% African American, 2% Asian, and <1% American Indian. Persons of Hispanic origin were estimated to make up 4% of the total population. Almost 79% of persons living in Louisiana in 2010 were born in Louisiana and 3.8% are foreign born. Of the foreign-born population, 61% are non-US citizens.[2]

Age and Sex

In 2010, persons under the age of 18 made up 25% of the population while persons 65 and older made up 12% of the population. As in previous years, the proportion of females in the overall population in 2010 was slightly higher than the proportion of males (51% vs. 49%).[3]

Poverty, Income, and Education

In 2010, the average household size in Louisiana was 2.6 persons and the average family size was 3.2 persons. Of all Louisiana households, 67% are considered family households of which 16% have a female head of household with no husband present. In the 2010 estimated census, 81.1% of Louisiana residents aged 25 years and older had attained a high school degree or higher, and 20.8% had a bachelor's degree or higher. In 2010, the median household income in Louisiana was $42,438. According to the 2010 estimates, approximately 17.9% of the population has an income below the federally defined poverty level, and 13.8% of families have an income below the poverty level. Louisiana has one of the highest proportions of children living in poverty with 25.4% of all children 18 years or younger in 2010 compared to the national estimate of 18.9% of all US children.[4] The unemployment rate as of December 2010 in Louisiana was 8.0%.[5]

Incarceration/Crime

In 2009, the crime rate in Louisiana was 18% higher than the national average rate, property crimes account for 85% of the crime rate and violent crimes account for 18% of the crime rate. Louisiana's incarceration rate is 48% higher than the national average of incarcerated adults per 100,000. Of the 50 states, Louisiana ranked 50th in incarceration rates with 866 per 100,000 adults incarcerated in 2010 and a total of 36,083 inmates managed by the Louisiana Department of Public Safety and Corrections.[6]

Health Indicators

In the 2010 United Health Foundation's *America's Health Rankings* report, Louisiana ranked 47th out of 50 in overall health. This national health survey compares multiple health outcomes and health determinates in all states. The low-place ranking is predominately due to increases in obesity, low high school graduation rates, high infant mortality rates, and high infectious disease rate. An estimated 19.3% of Louisiana residents lack health insurance, compared to a national average of 15.3%.[7]

Public Aid

In 2010, Medicaid covered 16% and Medicare covered 13% of all persons living in Louisiana.[8] Medicaid expenditures in Louisiana totaled $6 billion in the 2009 fiscal year. In 2010, 36% of children ages 0-18 were insured through Medicaid, and 10% of children were uninsured.

Publicly Available Healthcare in Louisiana

The Office of Public Health (OPH) provides free and low-cost basic health services through parish health units in the regions. Services include family planning, HIV testing, STD screening and treatment, nutrition programs, and immunizations. Regional activities also include sanitation, environmental monitoring, and epidemiologic investigations. (See the Office of Public Health website for additional information about OPH programs www.dhh.louisiana.gov/oph). Comprehensive inpatient and outpatient medical services are also available in each region of the state through regional public medical centers. The three medical centers in the central and northern parts of the state operate under the auspices of the Louisiana State University (LSU) – Shreveport system, and the seven medical centers in the southern part of the state operate under the LSU Health Care Services Division. Individuals may access care at these facilities regardless of insurance status or ability to pay.

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 measureable 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. These goals are further outlined in the Surveillance, Services and Prevention sections of this 2010 STD/HIV Program Report with Louisiana specific data.

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%.

National HIV/AIDS Strategy

The NAHS 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/.

Chapter 1

Profile of the HIV Epidemic in Louisiana

Introduction to HIV Surveillance

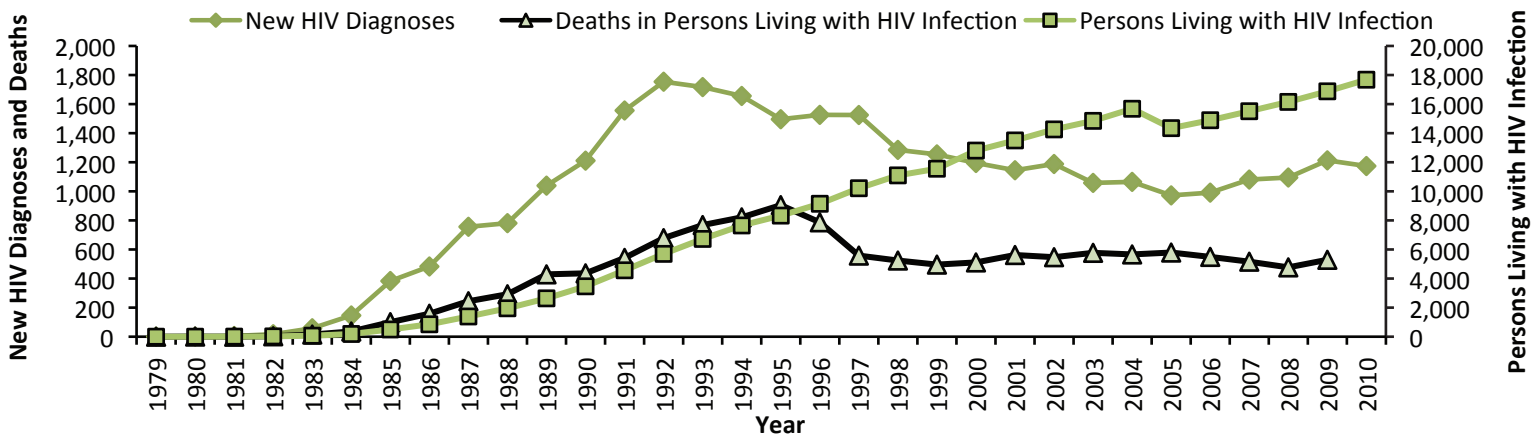
The Louisiana Office of Public Health STD/HIV Program's (SHP) HIV Surveillance Program conducts general case ascertainment through the receipt of reports of potential cases of HIV infection from clinical providers, laboratories and other public health providers throughout the state with funding from 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, 2010 and reported to SHP before August 14, 2011. 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, 1979-2010



- The first reported Louisiana resident with AIDS was diagnosed in 1979. In the three decades 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.

National HIV/AIDS Strategy
Reducing HIV-Related Health Disparities

The national goal is to improve access to prevention and care services for all Americans.

2015 Objectives:

- Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
- Increase the proportion of HIV diagnosed blacks with undetectable viral load by 20%.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

Reducing HIV-Related Disparities and Health Inequities
Louisiana, 2009 and 2010

	Persons Living with HIV		Percent with a Viral Load		Percent with Undetectable Viral Load*	
	As of 12/31/2009	As of 12/31/2010	2009	2010	2009	2010
Total	**17,155**	**17,679**	**58%**	**59%**	**54%**	**59%**
MSM**	7,592	7,961	60%	57%	59%	62%
Black/African American	11,450	11,855	58%	60%	49%	54%
Hispanic/Latino	624	641	44%	40%	66%	73%

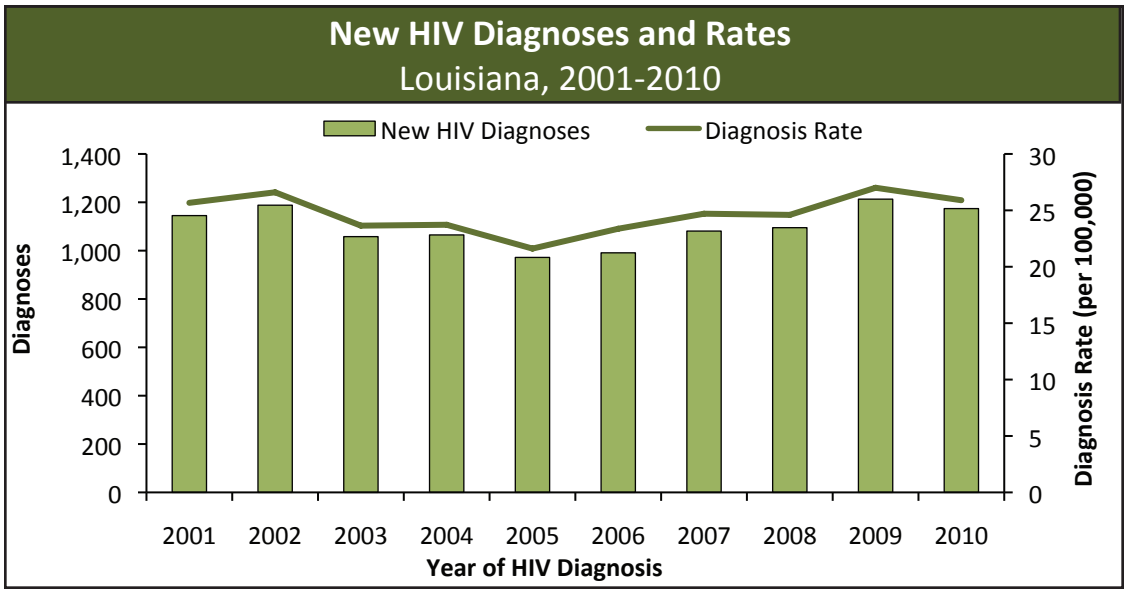
* Of those who had a viral load.
** Imputed Risk

- In 2010 in Louisiana, 62% of gay/bisexual men, 54% of blacks and 73% of Latinos living with HIV who had a viral load test conducted in 2010, had an undetectable viral load. An increase in the percentage of persons with an undetectable viral load occurred for all three groups from 2009 to 2010.
- The proportion of persons with an undetectable viral load will be monitored yearly to determine if there is an annual increase and to see if disparities among subgroups are reduced.

National HIV/AIDS Strategy (www.thewhitehouse.gov)

10-Year Trends in New HIV Diagnoses (2001-2010)

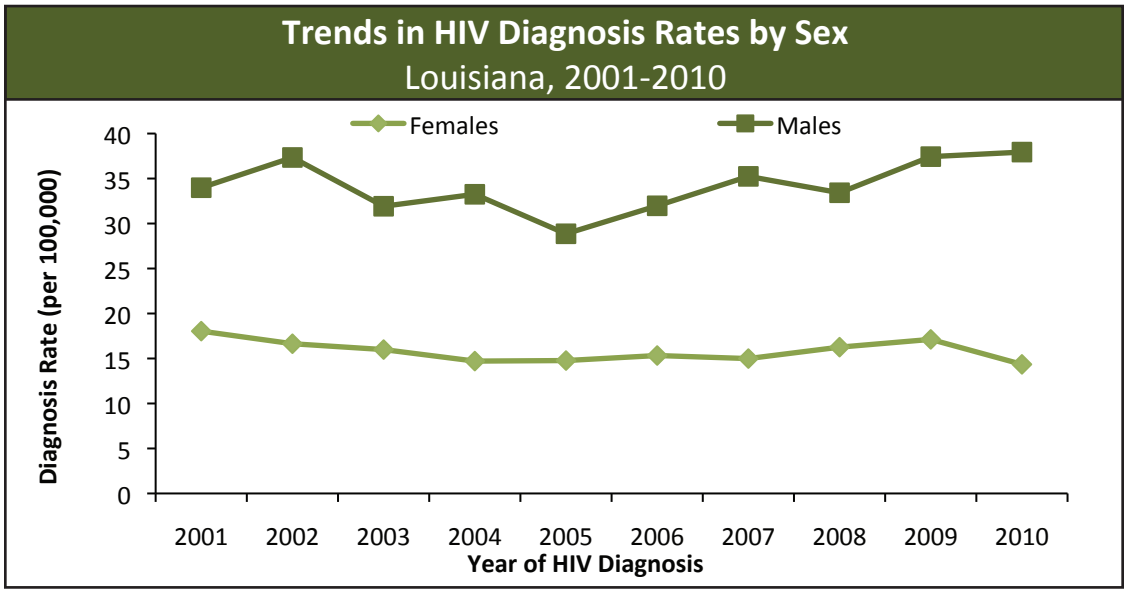
The number of new HIV diagnoses in a given year has historically served as a measure of new infections (incidence). However, since individuals can be infected with HIV for a long time before they are diagnosed, counting new HIV diagnoses is not an accurate representation of new infections in a given year. Louisiana is one of 25 selected states and jurisdictions that has been participating in a CDC initiative to develop a new national system to measure recent HIV infections (HIV incidence). In 2011, the CDC published data from the incidence estimation methodology.[9] Louisiana specific data and national incidence data can be found in the HIV Incidence Surveillance section on page 48.



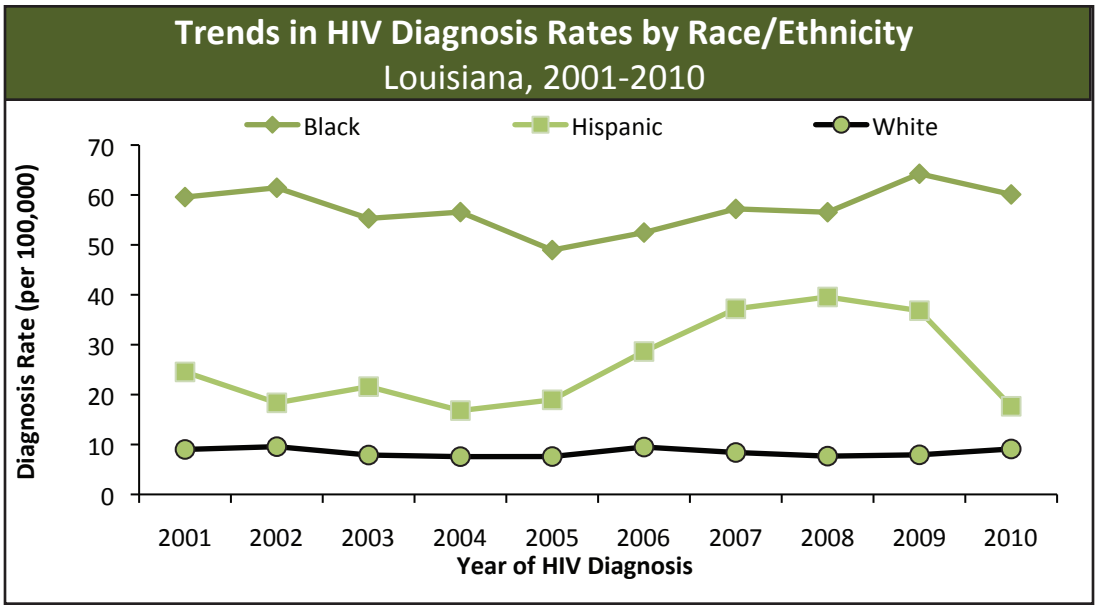
- In 2010, 1,174 individuals were newly diagnosed with HIV infection in Louisiana, a 3% decrease from 2009. Although the number of new HIV diagnoses decreased from 1999 to 2005, it has increased by 21% since 2005. The lower number of new diagnoses in 2005 and 2006 was due to the impact of Hurricane Katrina in August 2005, which caused a significant dislocation of the population and a disruption of HIV testing services.
- The rate of new HIV diagnoses follows a similar pattern. From 2005 to 2010, the rate (per 100,000 population) has increased in Louisiana from 22 to 26.

HIV Diagnoses by Sex, Race/Ethnicity, and Age

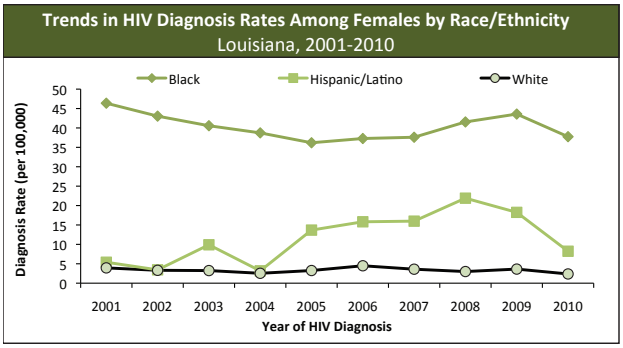
Although the HIV epidemic affects persons of all genders, ages and race/ethnicities in Louisiana, the impact is not the same across all populations. Identifying the populations most at risk for HIV infection helps in planning HIV prevention activities and services, and in determining the most effective use of limited resources.

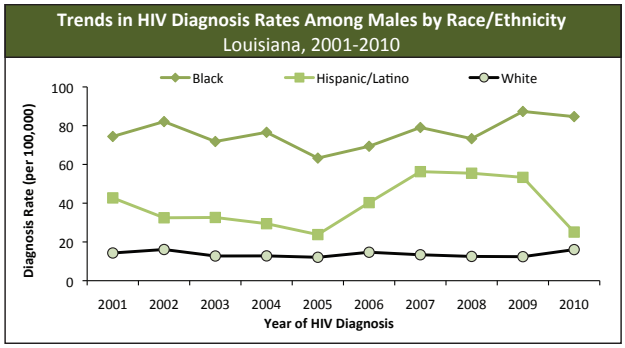


- While the HIV diagnosis rate for females in Louisiana has remained relatively stable over the past 10 years (between 14.4 and 18.0 per 100,000 females), the rate for men has been more variable (between 28.9 and 37.9 per 100,000 males). From 2002 to 2005, the diagnosis rate for males declined significantly, but since then has risen to its highest level in the past 10 years. The HIV diagnosis rate for males is over two and a half times the rate for females in Louisiana.

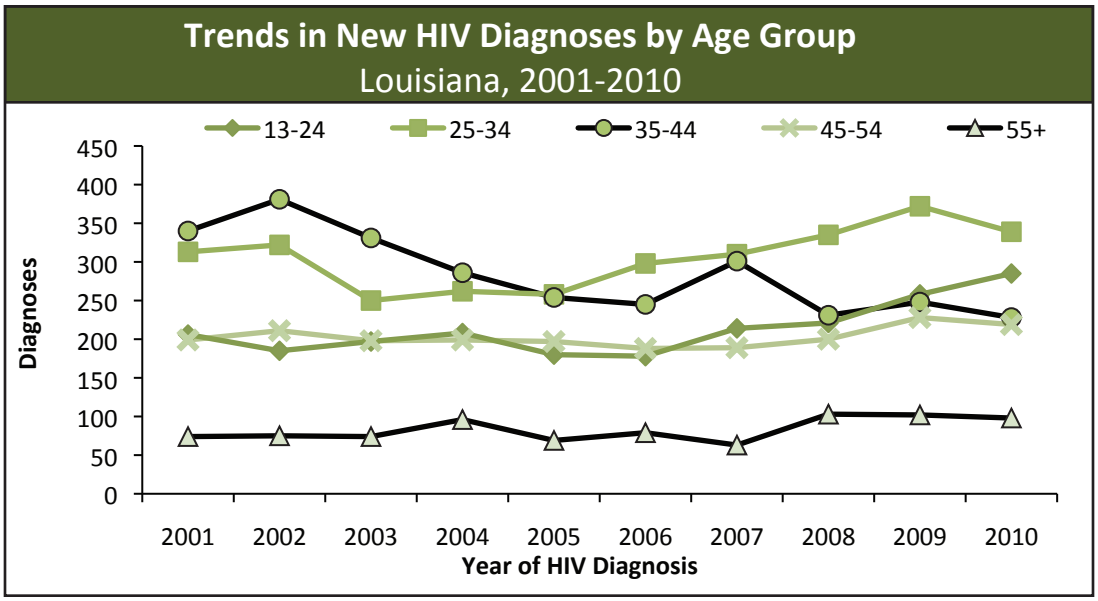


- The HIV diagnosis rate among whites has remained stable over the past 10 years. The rate for blacks has been more variable over the past 10 years and has increased from a low of 49.0 per 100,000 blacks in 2005 to its current rate of 60.1 per 100,000 blacks in 2010.
- In 2010, the HIV diagnosis rate for blacks was nearly seven times greater than the rate for whites and more than three times the rate for Hispanic/Latinos. Although the HIV diagnosis rate for Hispanic/Latinos is two times greater than for whites, the total HIV case count for Hispanic/Latinos was only 34 cases in 2010. This is a significant decrease from the 60 diagnoses among Hispanic/Latinos in 2009.





- For both females and males in Louisiana, the majority of new HIV diagnoses are in blacks. 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 2010, the HIV diagnosis rate in black females was almost 16 times greater than the rate for white females, and was over four and a half times the rate for Hispanic/Latino females.
- In 2010, the HIV diagnosis rate in black males was over five times greater than the rate for white males, and was over three times greater than the rate for Hispanic/Latino males.
- In 2010, the HIV diagnosis rates for Hispanic/Latino males decreased for the first time since 2005.



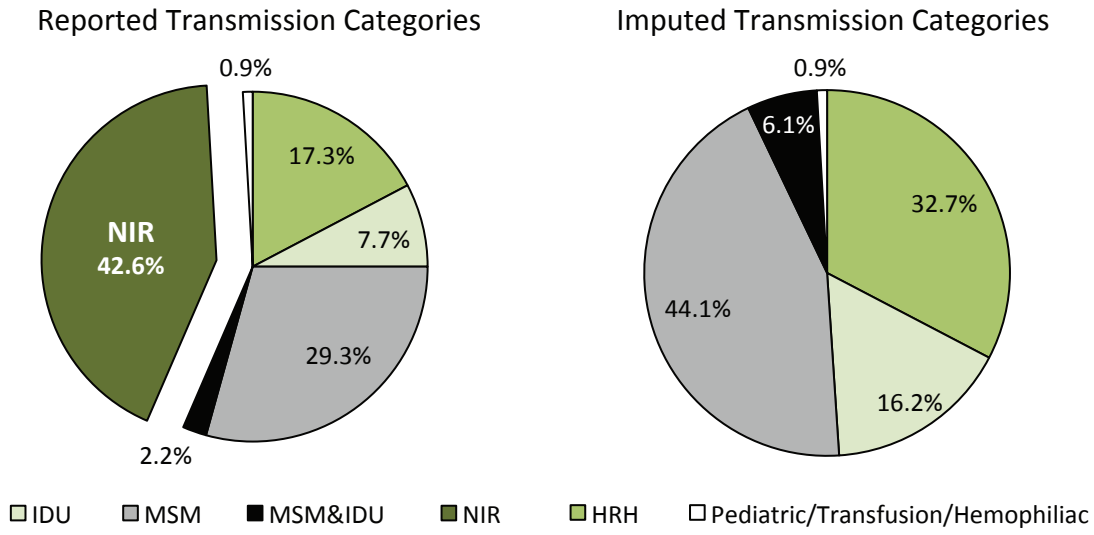
- The majority of all new infections have historically occurred in persons aged 25-44; 48% of all new diagnoses in 2010 were in this age group. While the number of new diagnoses in persons aged 25-34 decreased from 2001 to 2003, it has steadily increased since then to become the age group with the highest number of new diagnoses (29% of all new HIV diagnoses in 2010). The number of new diagnoses in persons aged 35-44 has decreased in the past few years and in 2010 accounted for 19% of all new diagnoses.
- The number of diagnoses in youth aged 13-24 has been steadily increasing since 2006. In 2010, new diagnoses in youth aged 13-24 accounted for almost a quarter of all new diagnoses, and is the only age group where the number of new diagnoses increased from 2009 to 2010.

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 on the following page, 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 2001 and 2010, 42.6% still do not have a reported risk.

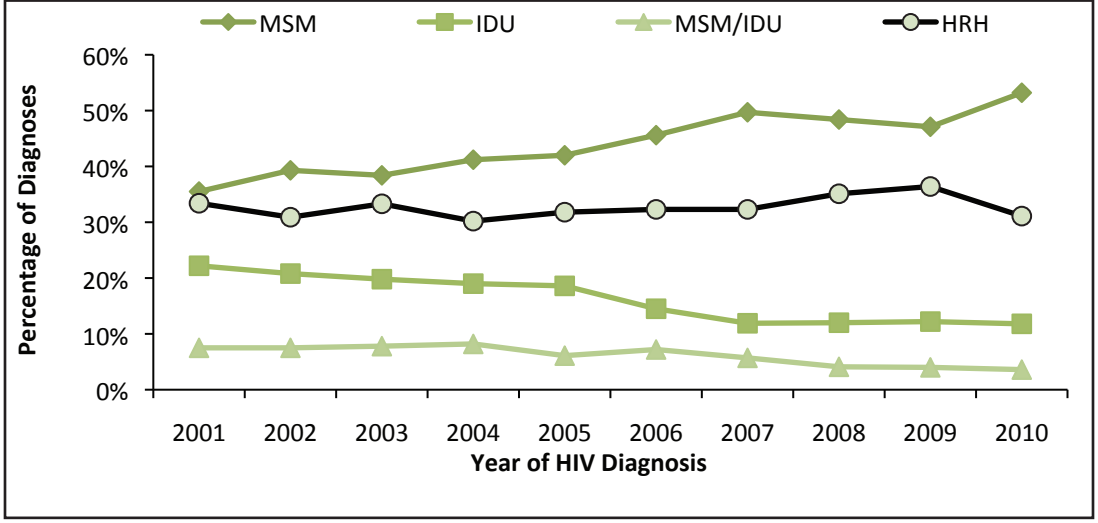
Risk information is difficult to ascertain because individuals may not know how they acquired the infection, their healthcare provider may not feel comfortable collecting the information, or the person may not be willing to share that information possibly due to stigma or fear of discrimination. A person 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).

HIV Transmission Categories
Louisiana, Cases Diagnosed in 2001-2010 Combined

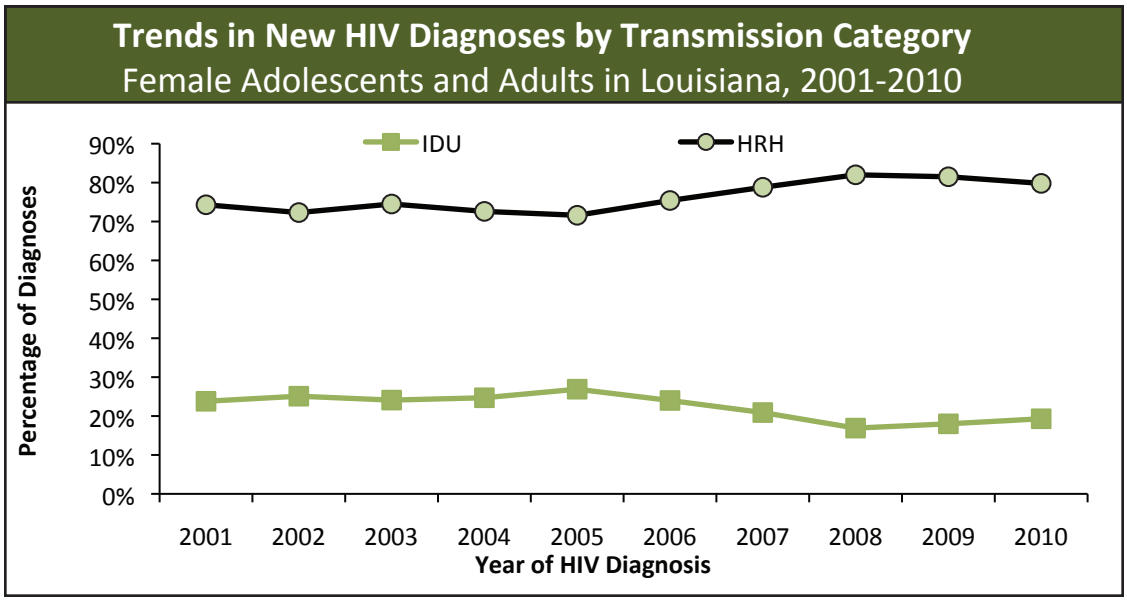


After assigning a transmission category for all NIR cases through imputation, trends in the percentage of cases for each transmission category can be analyzed. The following graphs use imputed transmission categories unless otherwise noted.

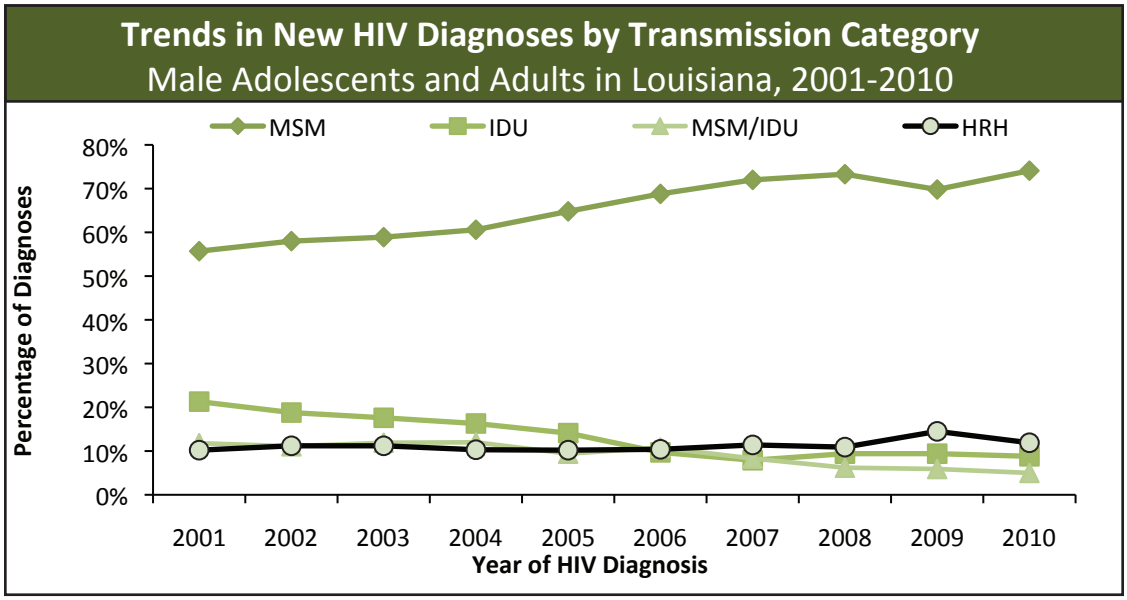
Trends in New HIV Diagnoses by Transmission Category
Adolescents and Adults in Louisiana, 2001-2010



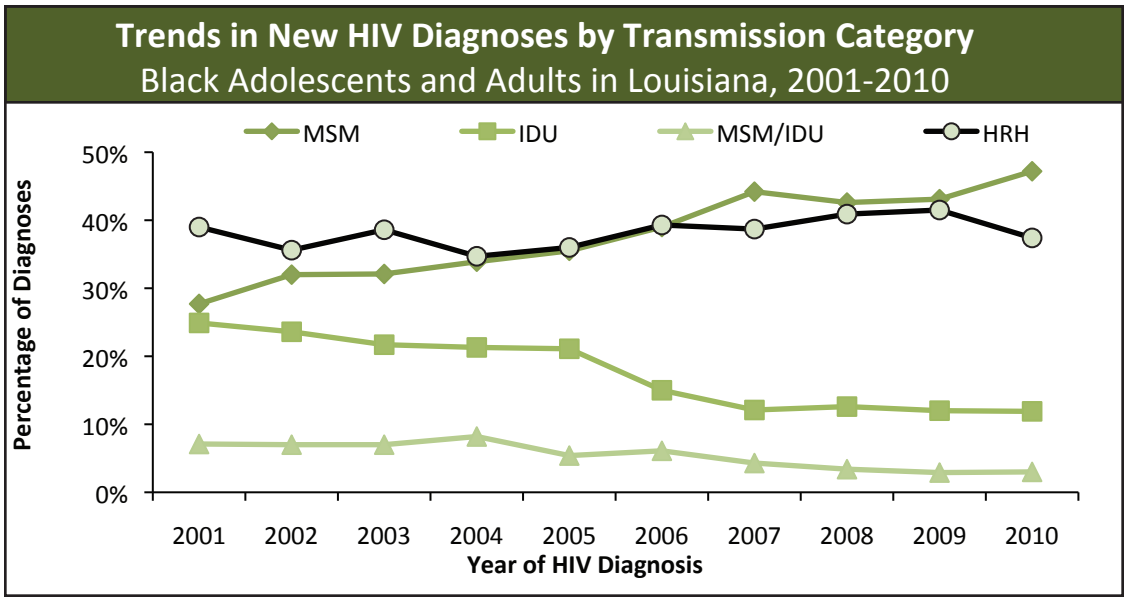
- The percentage of adult HIV diagnoses attributed to MSM has increased from a low of 36% in 2001 to a high of 53% in 2010. The percentage of HRH diagnoses has increased slightly, from 33% in 2001 to 36% in 2009. In 2010, the percentage of HRH diagnoses was 31%. The percentage of diagnoses attributed to IDU and MSM/IDU has declined dramatically over the past 10 years to 12% and 4% respectively in 2010.



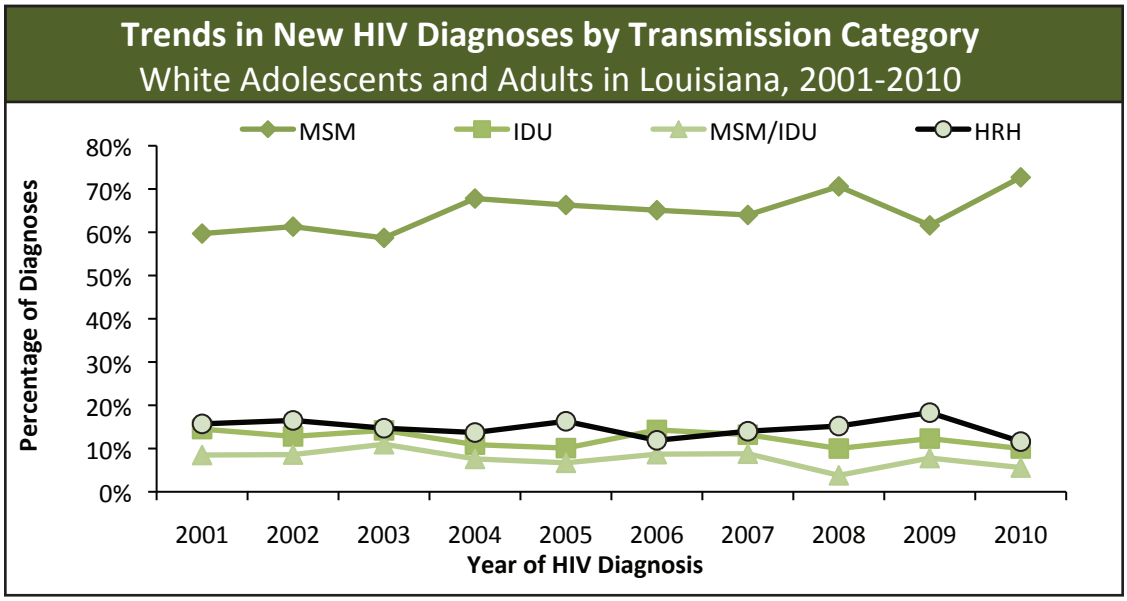
- The primary mode of transmission for women is HRH contact.
- Although there has always been a significant difference in the percentage of female diagnoses attributed to HRH and IDU, the difference was greatest in 2008 when 82% of females were high risk heterosexuals. In 2010, 80% of the female diagnoses were high risk heterosexuals and 19% 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 2010, the percentage of male diagnoses that were MSM was 74%, compared to ten years ago when MSM accounted for only 56% of all diagnosed males. The percentage of HRH diagnoses among men has increased slightly in the past five years from 10% in 2006 to 12% in 2010.
- The percentage of new diagnoses with a transmission category of IDU and MSM/IDU has declined since 2001 to one of the lowest percentages since the beginning of the epidemic. In 2010, IDU accounted for 9% and MSM/IDU accounted for 5% compared to 21% and 12% in 2001, respectively.

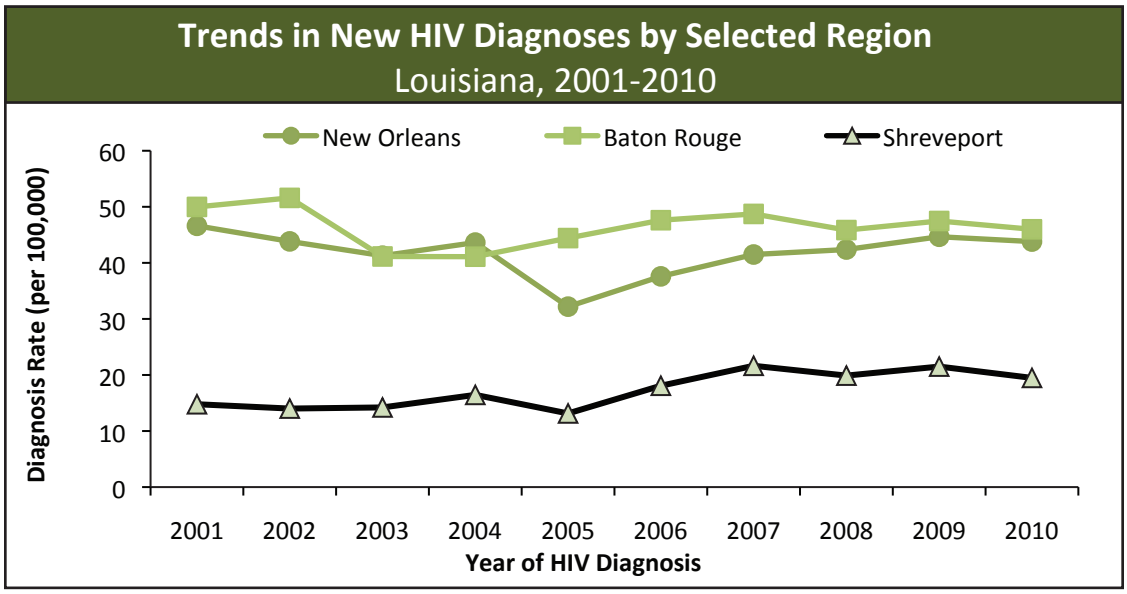


- Historically, the primary mode of transmission for blacks was HRH contact followed closely by MSM. In 2005, the percentage of new diagnoses of MSM in blacks reached and has since surpassed the percentage of diagnoses attributable to HRH.
- In 2010, 47% of all new HIV diagnoses among blacks were MSM and 37% were HRH.
- From 2001 to 2010, the percentage of HIV diagnoses resulting from IDU and MSM/IDU among blacks has declined significantly from 25% to 12% for IDU and 7% to 3% for MSM/IDU.

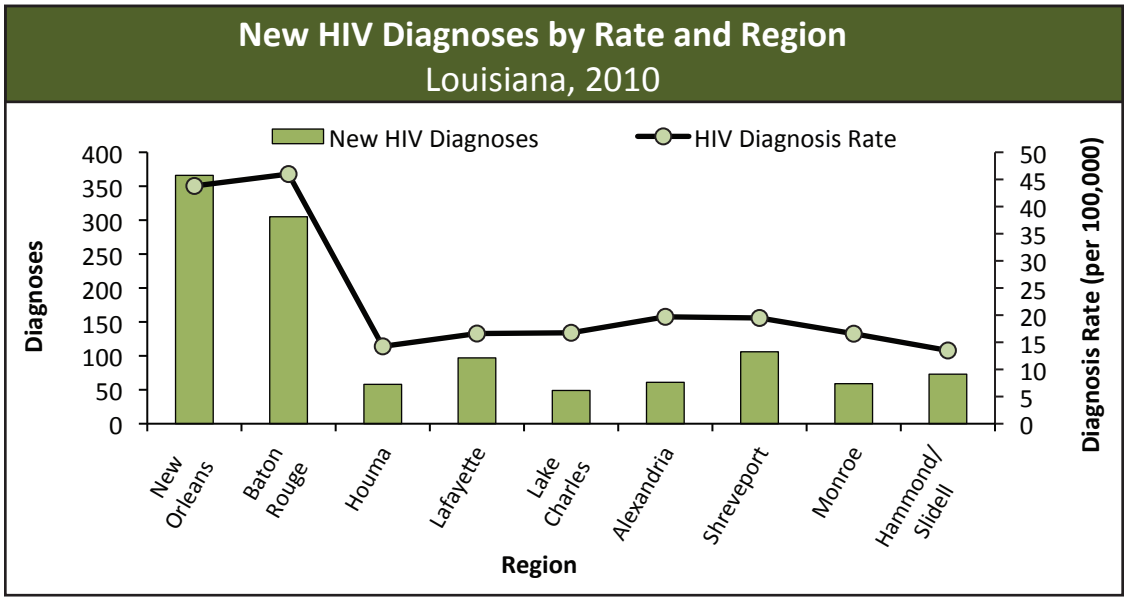


- The predominant mode of transmission among whites has historically been and continues to be MSM. From 2001 to 2010, the percentage of diagnoses attributed to MSM has fluctuated from a low of 59% in 2003 to a high of 73% in 2010.
- In 2010, 12% of diagnoses were attributed to HRH, 10% to IDU and 6% to MSM/IDU.

HIV Diagnoses by Public Health Region



- The three public health regions in Louisiana with the largest number of new HIV diagnoses in 2010 are New Orleans, Baton Rouge and Shreveport (regions 1, 2, and 7 respectively). The ten year trends for these three regions are shown above.
- Since 2005, the HIV diagnosis rate in Baton Rouge has been higher than the rate in New Orleans, largely due to the impact of Hurricane Katrina in August 2005. In 2010, the diagnosis rate in Baton Rouge was 46.0 per 100,000 population and the rate in New Orleans was 43.8 per 100,000 population. The diagnosis rate in Shreveport was 19.5 per 100,000 population in 2010, which was a significant increase from 2005 when it was 13 per 100,000. A table with the number of HIV diagnoses for each region, 2001-2010, is located in the Appendix.



- In 2010, New Orleans had the highest number of new HIV diagnoses, but Baton Rouge had the highest HIV 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, 2009-2010				
	Persons First Diagnosed with HIV in 2009		Persons First Diagnosed with HIV in 2010	
	Number	Percent	Number	Percent
TOTAL	**1,213**	**100.0%**	**1,174**	**100.0%**
Sex				
Female	395	32.6%	332	28.3%
Male	818	67.4%	842	71.7%
Race/Ethnicity				
Black/African American	919	75.8%	867	73.9%
Hispanic/Latino	60	4.9%	34	2.9%
White	219	18.1%	249	21.2%
Other/Unknown/Multi-race	15	1.2%	24	2.0%
Age Group	**Age at HIV Diagnosis**		**Age at HIV Diagnosis**	
0-12	5	0.4%	5	0.4%
13-19	43	3.5%	65	5.5%
20-24	215	17.7%	220	18.7%
25-34	372	30.7%	339	28.9%
35-44	248	20.4%	228	19.4%
45-54	228	18.8%	219	18.7%
55-64	84	6.9%	84	7.2%
65+	18	1.5%	14	1.2%
Imputed Transmission Category				
Men who have sex with men (MSM)	571	47.1%	624	53.2%
Injecting Drug User (IDU)	148	12.2%	138	11.8%
MSM/IDU	48	4.0%	42	3.6%
High Risk Heterosexual (HRH)	441	36.4%	365	31.1%
Transfusion/Hemophilia/Other	0	0.0%	0	0.0%
Perinatal/Pediatric	5	0.4%	5	0.4%
Rural/Urban				
Rural	206	17.0%	187	15.9%
Urban	1,007	83.0%	987	84.1%

- In 2010, 1,174 persons were newly diagnosed with HIV, a 3% decrease from 2009.
- From 2009 to 2010, the number of female HIV diagnoses decreased 16% while the number of male diagnoses increased 3%.
- From 2009 to 2010, the number of white diagnoses increased while the number of black and Hispanic diagnoses decreased.
- In 2009 and 2010, the greatest number and percentage of diagnoses were in persons age 25-34.
- From 2009 to 2010, the number of MSM diagnoses increased by 9%.
- In Louisiana, most new diagnoses (84% in 2010) were among persons residing in urban areas.

HIV Among Men Who Have Sex with Men (MSM)

Nationally, MSM account for almost half of the one million people living with HIV and more than half of all new HIV infections in the US each year. Louisiana is experiencing a similar epidemic among MSM as is being seen nationally.

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 2010 among MSM who may or may not be injection drug users.

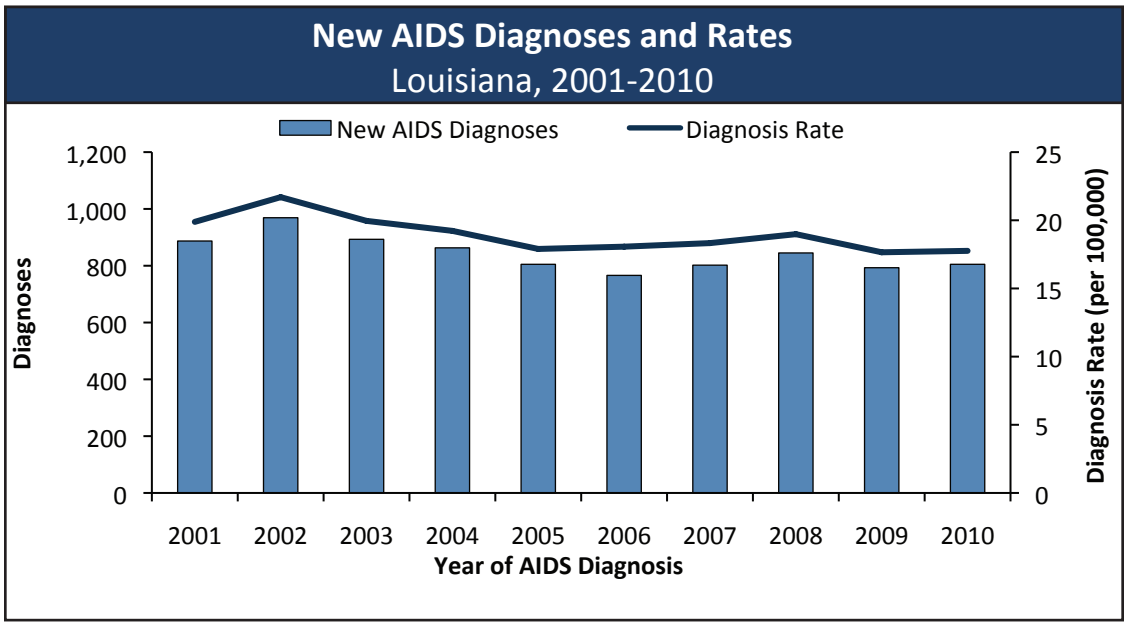
Demographics of New HIV Diagnoses Among MSM
Louisiana, 2010

	MSM/Non-IDU		MSM/IDU		All MSM	
	Number	Percent	Number	Percent	Number	Percent
TOTAL	**624**	**100%**	**42**	**100%**	**666**	**100%**
Race/Ethnicity						
Black/African American	409	66%	26	62%	435	65%
Hispanic/Latino	21	3%	1	2%	22	3%
White	181	29%	14	33%	195	29%
Other/Unknown/Multi-race	13	2%	1	2%	14	2%
Age at HIV Diagnosis						
13-24	207	33%	4	10%	211	32%
25-34	182	29%	12	29%	194	29%
35-44	107	17%	13	31%	120	18%
45-54	100	16%	10	24%	110	17%
55-64	22	4%	3	7%	25	4%
65+	6	1%	0	0%	6	1%
Region						
1-New Orleans	212	34%	12	29%	224	34%
2-Baton Rouge	134	21%	11	26%	145	22%
3-Houma	30	5%	2	5%	32	5%
4-Lafayette	63	10%	2	5%	65	10%
5-Lake Charles	20	3%	5	12%	25	4%
6-Alexandria	36	6%	2	5%	38	6%
7-Shreveport	56	9%	6	14%	62	9%
8-Monroe	31	5%	2	5%	33	5%
9-Hammond/Slidell	42	7%	0	0%	42	6%
Late Testers						
AIDS at Time of HIV Diagnosis	141	23%	10	24%	151	23%
AIDS Within 6 Months of HIV Diagnosis	195	31%	15	36%	210	32%

- In 2010, there were 1,174 new HIV diagnoses in Louisiana; 57% (666) were among all MSM.
- The majority of the new diagnoses among MSM in Louisiana are black and under the age of 34.
- 56% of all new diagnoses among MSM occurred in the New Orleans and Baton Rouge regions.
- Whites account for a greater percentage of MSM/IDU than MSM/non-IDU.
- 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.

10-Year Trends in New AIDS Diagnoses (2001-2010)

AIDS diagnoses are the number of individuals diagnosed with AIDS within a given time period. An AIDS diagnosis is made when a person has a CD4 cell count <200, a CD4 percentage <14%, or develops an opportunistic infection (OI) such as Pneumocystis carinii pneumonia (PCP) or wasting syndrome. Once a person is diagnosed with AIDS, they remain categorized as AIDS even if their CD4 count rises above 200, their CD4 percentage is above 14% 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.

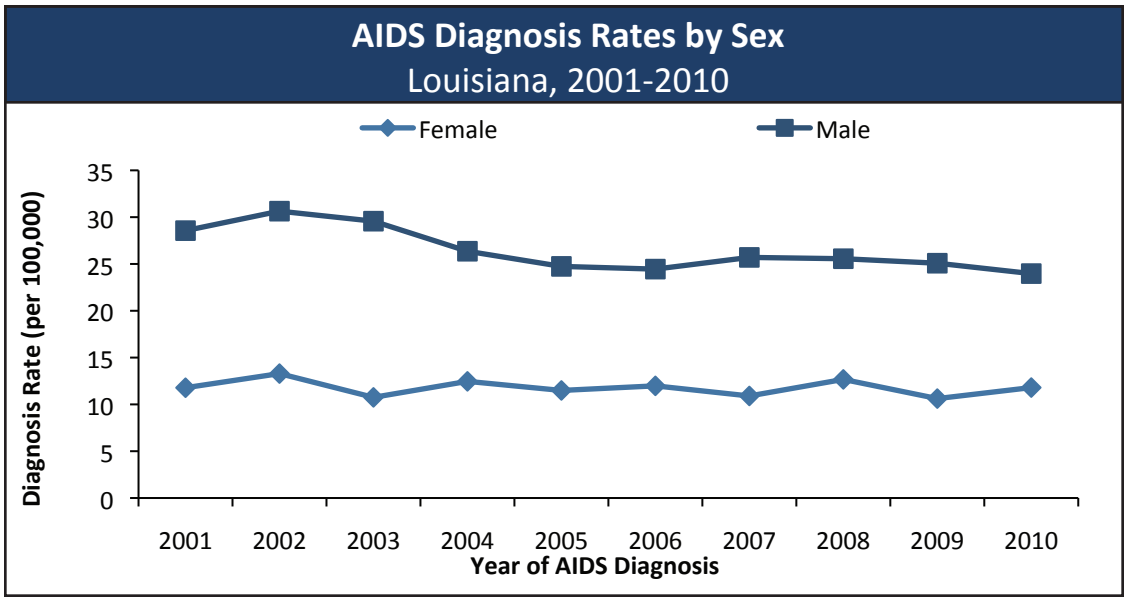


- The number of new AIDS diagnoses in 2010 remains below its highest level in 2002 as a result of the availability of more effective treatments.
- The AIDS diagnosis rate fluctuates slightly each year in accordance with the change in the number of AIDS diagnoses. In 2010, the AIDS diagnosis rate for Louisiana was 17.8 per 100,000 population.

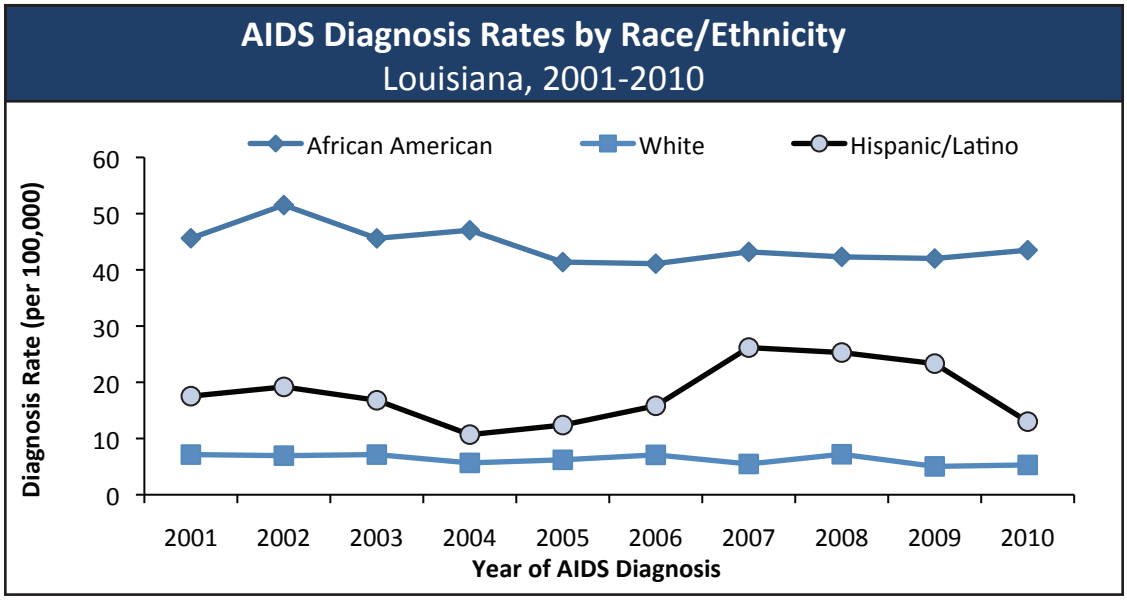
AIDS diagnoses and deaths in the United States

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 33,015 new AIDS diagnoses in 2010. The CDC estimates that since the beginning of the epidemic through the end of 2010, approximately 1,129,127 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.

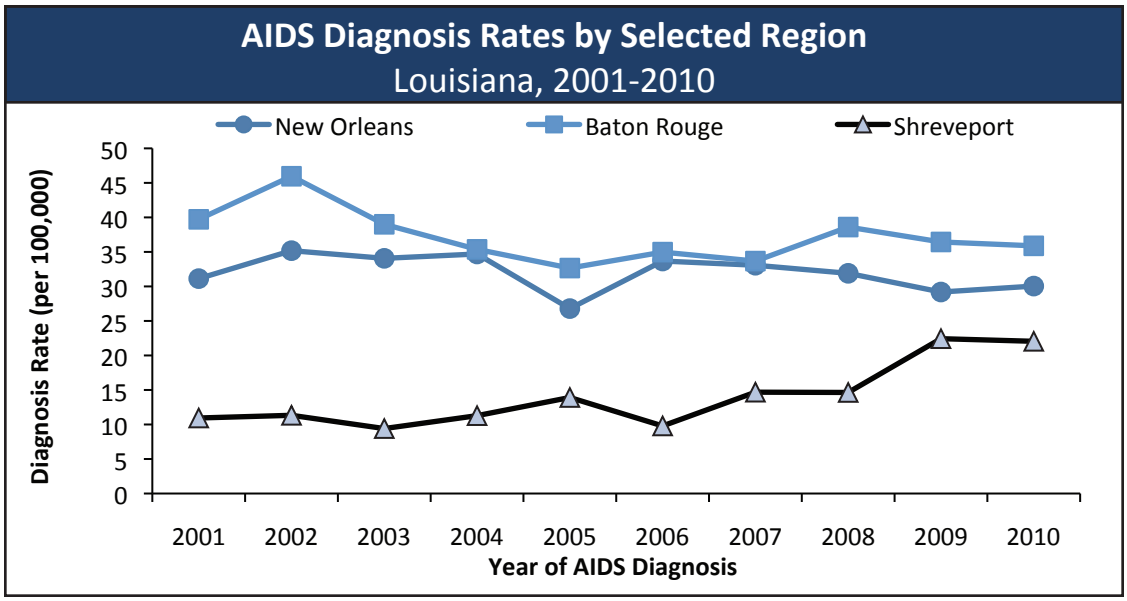
Centers for Disease Control and Prevention. HIV Surveillance Report, 2010. Vol. 22



- The AIDS diagnosis rate for females has fluctuated slightly over the past 10 years. In 2010, the AIDS diagnosis rate in females was 11.8 per 100,000 females.
- The AIDS diagnosis rate for males has also fluctuated within a relatively small range (low of 24.0 per 100,000 males and a high of 30.6 per 100,000 males). In 2010, the male AIDS diagnosis rate was 24.0 per 100,000 males.
- In 2010, the AIDS diagnosis rate in males was two times greater than the rate in females whereas in 2003, the male diagnosis rate was almost three times higher than among females.

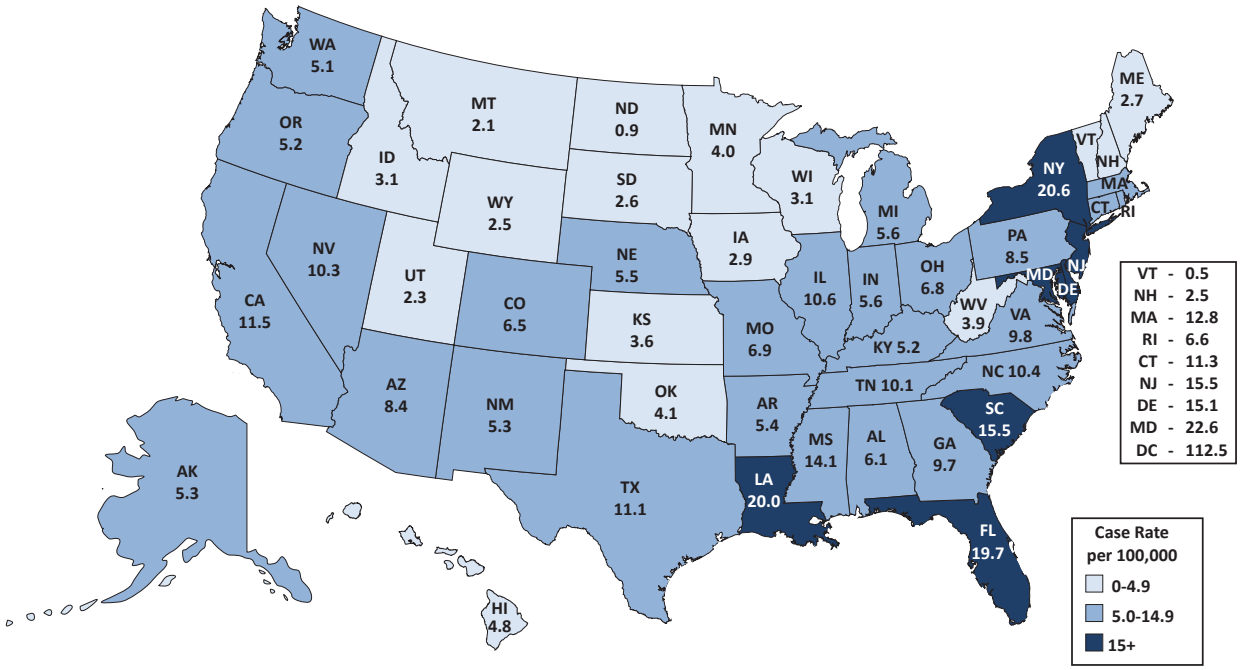


- From 2001 to 2002, the AIDS diagnosis rate for blacks increased by 13% but since then has decreased overall. In 2010, the AIDS diagnosis rate for blacks was 43.5 per 100,000 blacks which was three times greater than for Hispanic/Latinos and eight times greater than for whites.
- From 2007 to 2010, the AIDS diagnosis rate among Hispanic/Latinos decreased by 50% from 26.2 per 100,000 Hispanic/Latinos in 2007 to 13.0 per 100,000 Hispanic/Latinos in 2010.
- The AIDS diagnosis rate for whites has remained relatively stable over the last decade with a rate of 5.3 per 100,000 whites in 2010.



- The Baton Rouge region continues to have the highest AIDS diagnosis rate in 2010 of all nine public health regions (36 per 100,000) in Louisiana.
- In 2010, the New Orleans region had the second highest AIDS diagnosis rate (30 per 100,000 population). The AIDS diagnosis rate in Shreveport continues to be the third highest in the state, and in 2009 and 2010 reached its highest rate to date (22 per 100,000 population).

AIDS Rates in the United States (2010)[10]



- In the US, there were an estimated 33,015 new AIDS cases in 2010, for a national diagnosis rate of 10.8 AIDS diagnoses per 100,000 population. In 2009 the national AIDS diagnosis rate was 11.2 per 100,000 population.
- In 2010, Louisiana ranked 4th highest in state estimated AIDS diagnosis rates (20.0 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 (Vol 22). In 2009, Louisiana ranked 5th highest in state estimated AIDS diagnosis rates (19.4 per 100,000 population).

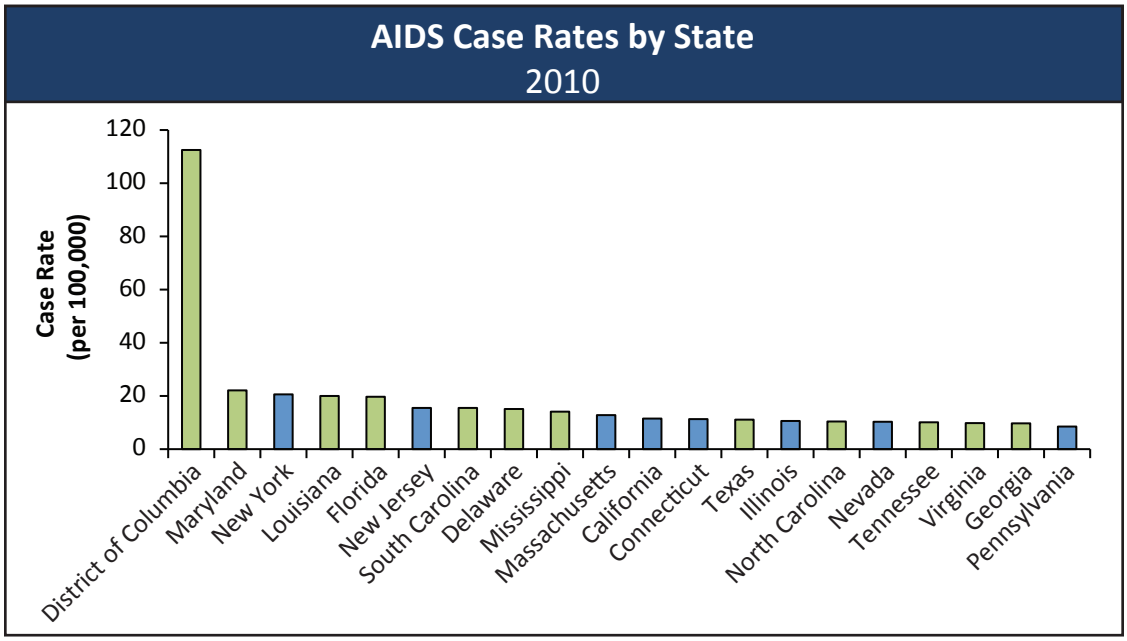
Characteristics of Persons Newly Diagnosed with AIDS

Characteristics of Persons Newly Diagnosed with AIDS Louisiana, 2009-2010				
	Persons First Diagnosed with AIDS in 2009		Persons First Diagnosed with AIDS in 2010	
	Number	Percent	Number	Percent
TOTAL	**793**	**100%**	**805**	**100%**
Sex				
Female	245	30.9%	273	33.9%
Male	548	69.1%	532	66.1%
Race/Ethnicity				
Black/African American	601	75.8%	628	78.0%
Hispanic/Latino	38	4.8%	25	3.1%
Other/Unknown/Multi-race	139	17.5%	146	18.1%
White	15	1.9%	6	0.7%
Age Group	**Age at AIDS diagnosis**		**Age at AIDS diagnosis**	
0-12	0	0.0%	1	0.1%
13-19	9	1.1%	12	1.5%
20-24	59	7.4%	67	8.3%
25-34	220	27.7%	224	27.8%
35-44	202	25.5%	210	26.1%
45-54	222	28.0%	196	24.3%
55-64	65	8.2%	77	9.6%
65+	16	2.0%	18	2.2%
Imputed Transmission Category				
Men who have sex with men (MSM)	354	44.6%	338	42.0%
Injecting Drug User (IDU)	139	17.5%	141	17.5%
MSM/IDU	46	5.8%	46	5.7%
High Risk Heterosexual (HRH)	251	31.7%	274	34.0%
Transfusion/Hemophilia/Other	2	0.3%	0	0.0%
Perinatal/Pediatric	1	0.1%	6	0.8%
Rural/Urban				
Rural	133	16.8%	127	15.8%
Urban	660	83.2%	678	84.2%

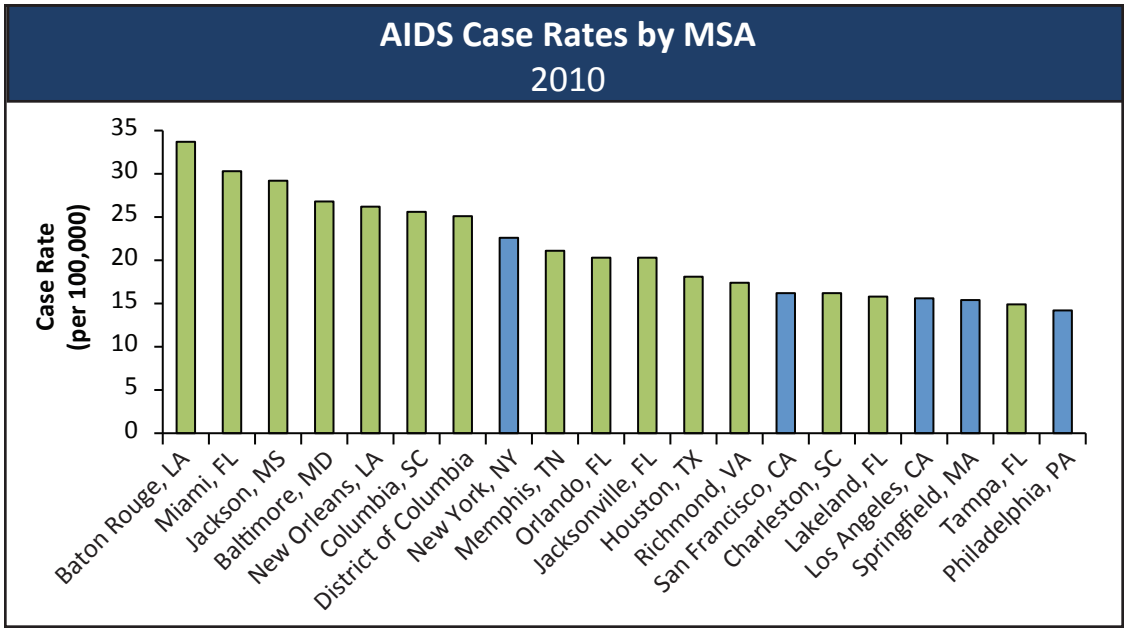
- In 2010, there were 805 new AIDS diagnoses in Louisiana, a 2% increase from 2009.
- From 2009 to 2010, the number of new female AIDS diagnoses increased by over 11% and the number of new AIDS diagnoses among males decreased by 3%.
- The number of new AIDS diagnoses increased among blacks and whites and decreased by 34% in Hispanic/Latinos.
- In 2010, the greatest number of new AIDS diagnoses were among people age 25-34, followed by people age 35-44. In 2009, the age group with the greatest number of new AIDS diagnoses was 45-54 year olds followed by people age 25-34.
- In 2009 and 2010, the greatest number and percentage of new AIDS diagnoses were in men who have sex with men, followed by high risk heterosexuals and injection drug users.
- The majority of AIDS diagnoses occurred in urban areas in 2010 (84%).

AIDS In The South, 2010

Southern states are disproportionately impacted by AIDS, as shown below. Seventeen states are included in the southern region of the US: 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.[11]



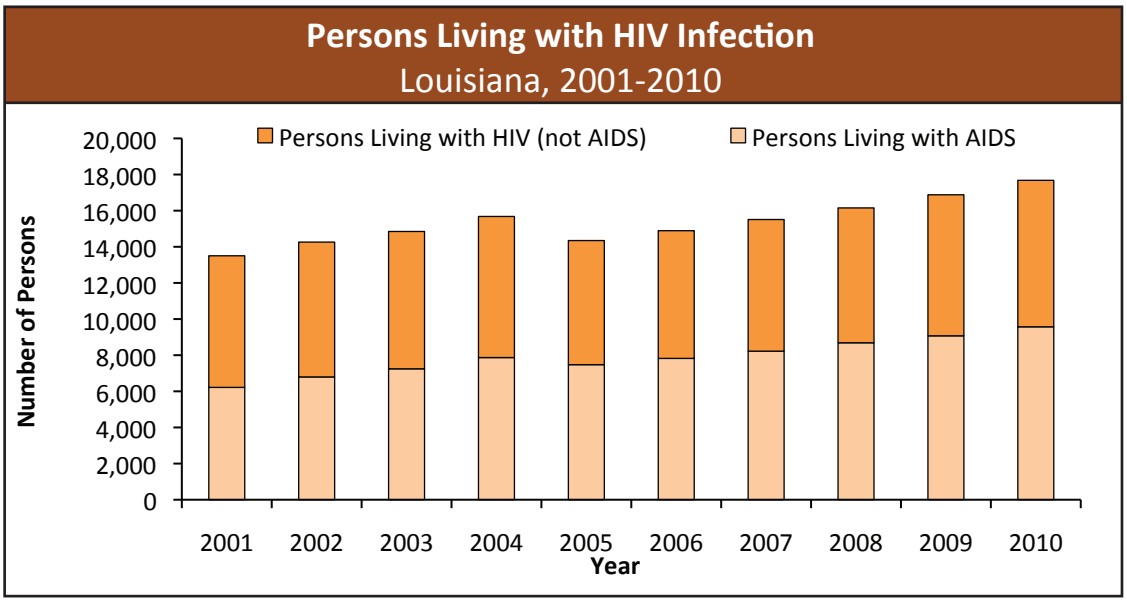
- In 2010, southern states represented 37% of the US population but over 40% of person living with AIDS and 46% of new AIDS diagnoses.
- Of the 20 states that had the highest AIDS diagnosis rates in 2010, 12 (60%) were in the South.



- Of the 20 metropolitan areas that had the highest AIDS diagnosis rates in 2010, 15(75%) were in the South. According to the CDC, the Baton Rouge metro area ranked 1st and the New Orleans metro area ranked 5th in estimated AIDS diagnosis rates in 2010 among metropolitan areas in the US with more than 500,000 persons. The Baton Rouge and New Orleans metro areas have both been in the top ten metropolitan areas with the highest AIDS diagnosis rates since 2004.

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 case 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 estimates that 20.1% of persons living with HIV are unaware of their infection status.[12]



- The number of persons living with HIV infection increased each year from 2000 to 2004. The decrease from 2004 to 2005 was 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 surpassed pre-Katrina numbers.
- At the end of 2010, 17,679 persons were known to be living with HIV infection in Louisiana, 9,572 (54%) of whom have progressed from HIV to AIDS.

Persons living with HIV Infection in the United States

At the end of 2008, the CDC estimates that there were 1,178,350 persons living with HIV infection in the US, including 236,400 (20.1%) who were not diagnosed. Of these 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 has been estimated that 25% of HIV-positive persons are undiagnosed or are unaware of their status. In 2008, the CDC released a new analysis that indicated that the percentage of HIV-positive persons who are unaware of their status had decreased from 25% to 21%. In 2011, the CDC released a revised estimate that 20.1% of persons were unaware of their status.

MMWR 2011; 60(21):689-693

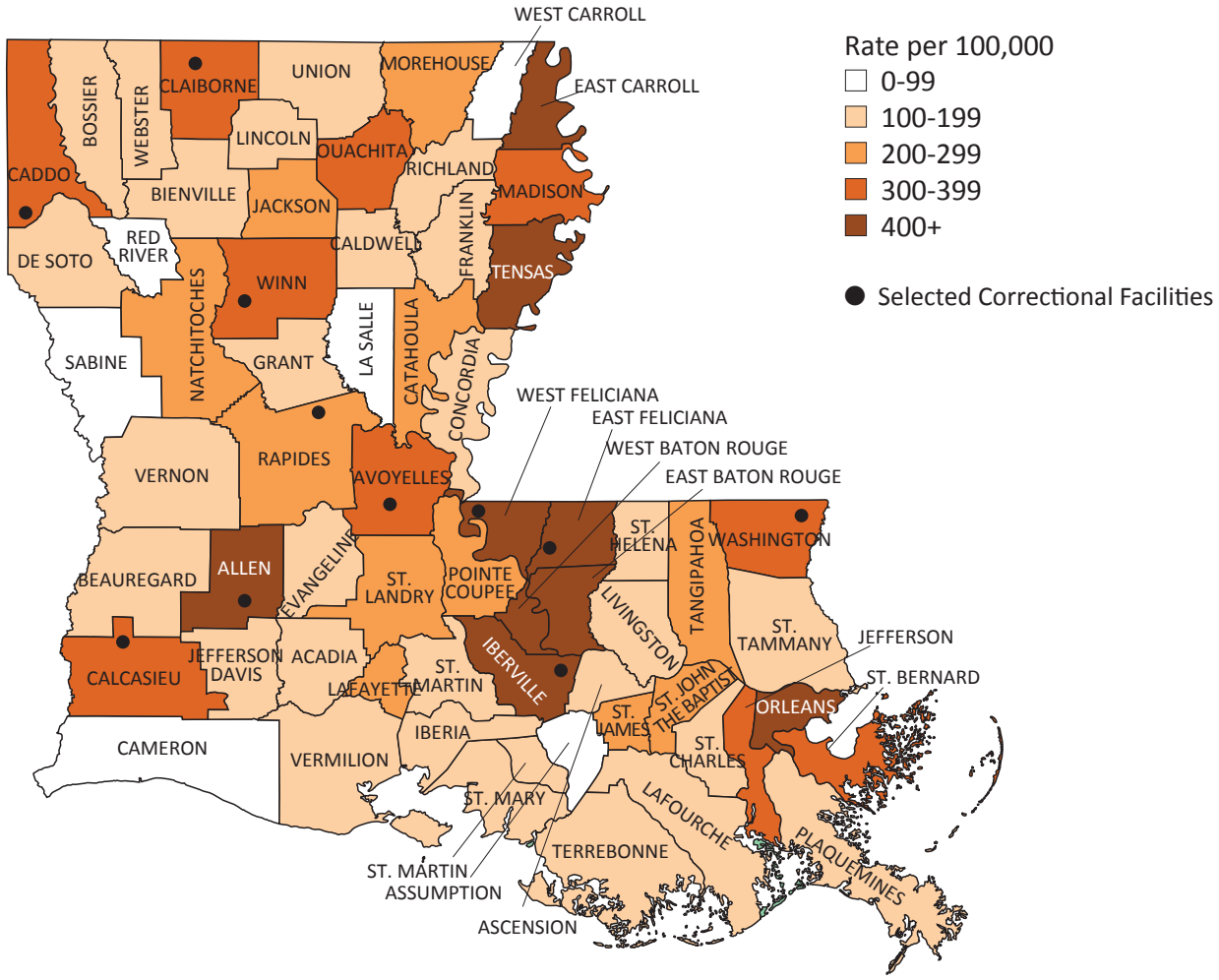
Characteristics of Persons Living with HIV Infection in Louisiana and Cumulative Louisiana Cases)

Characteristics of Persons Living with HIV Infection and Cumulative Cases Louisiana, 2010				
	Persons Living with HIV Infection as of 12/31/2010		Cumulative Persons with HIV Infection as of 12/31/2010*	
	Number	Percent	Number	Percent
TOTAL	17,679	100%	30,827	100%
Sex				
Female	5,213	29.5%	7,976	25.9%
Male	12,466	70.5%	22,851	74.1%
Race/Ethnicity				
Black/African American	11,855	67.1%	19,889	64.5%
Hispanic/Latino	641	3.6%	868	2.8%
White	4,991	28.2%	9,761	31.7%
Other/Unknown/Multi-race	192	1.1%	309	1.0%
Age Group	Age in 2010		Age at Diagnosis	
0-12	74	0.4%	320	1.0%
13-19	177	1.0%	1,202	3.9%
20-24	835	4.7%	3,786	12.3%
25-34	3,473	19.6%	10,814	35.1%
35-44	4,706	26.6%	8,852	28.7%
45-54	5,621	31.8%	4,158	13.5%
55-64	2,258	12.8%	1,278	4.1%
65+	535	3.0%	417	1.4%
Imputed Transmission Category				
Men who have sex with men (MSM)	7,961	45.0%	13,892	45.1%
Injecting Drug User (IDU)	2,826	16.0%	6,083	19.7%
MSM/IDU	1,442	8.2%	2,862	9.3%
High Risk Heterosexual (HRH)	5,172	29.3%	7,182	23.3%
Transfusion/Hemophilia/Other	175	1.0%	499	1.6%
Perinatal/Pediatric	103	0.6%	309	1.0%
Rural/Urban				
Rural	2,501	14.1%	3,705	12.0%
Urban	15,178	85.9%	27,122	88.0%

*Cumulative persons reflects the total number of HIV-infected persons diagnosed in Louisiana, including those who have died.

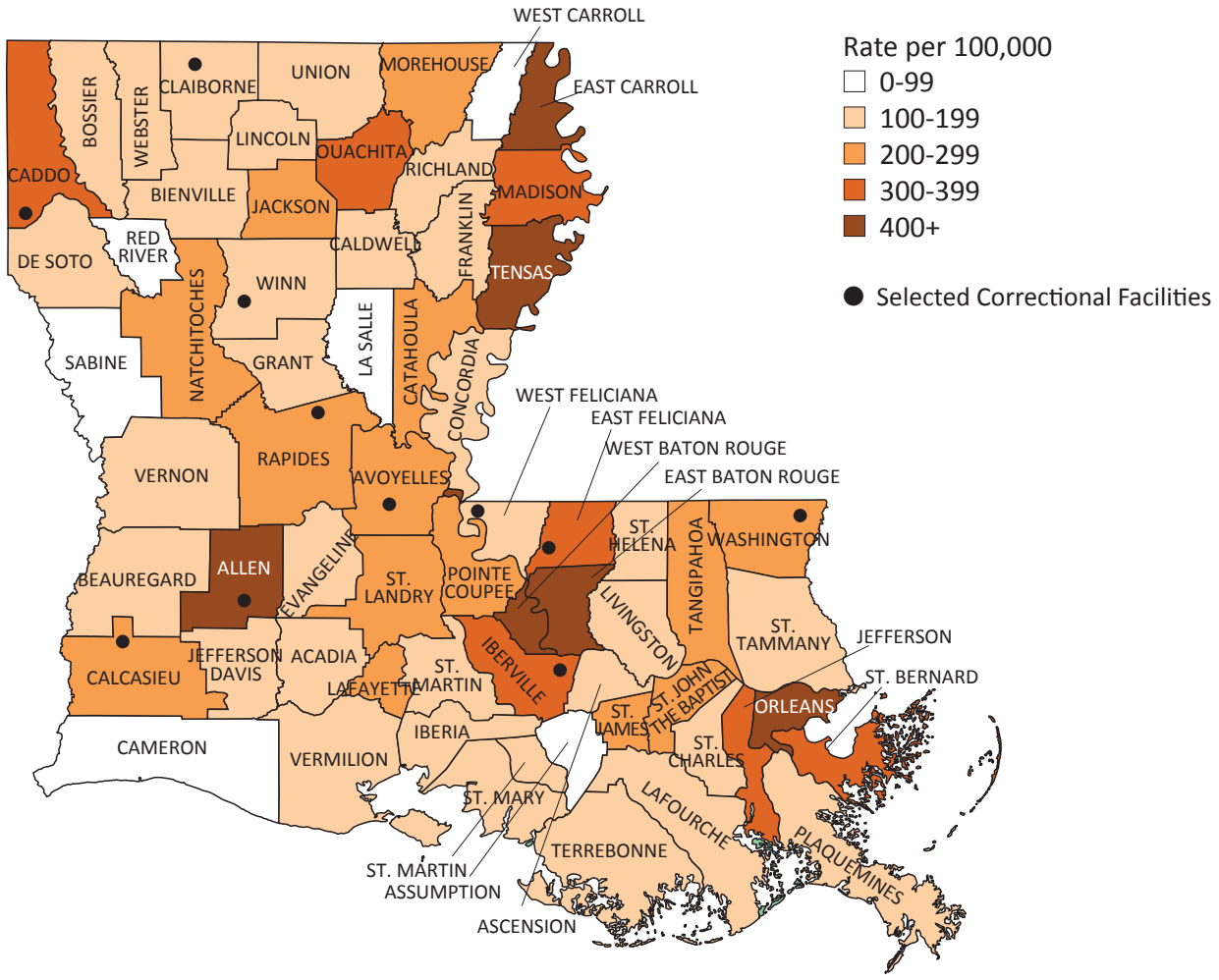
- In 2010, males made up more than 70% of all people living with HIV infection in Louisiana.
- Although blacks only made up 32% of Louisiana's population in 2010, they accounted for 67% of all people living with HIV infection.
- The majority of people living with HIV infection are between the ages of 25-54, live in urban areas, and are men who have sex with men or are high risk heterosexuals.

Persons Living with HIV Infection by Parish, Including State Prisoners
Louisiana, 2010



- 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.
- At the end of 2010, 19 parishes had a prevalence rate of HIV infection greater than 300 per 100,000. Many of the parishes with disproportionate prevalence rates have state correctional facilities that have reported a large number of HIV diagnoses.
- Although the majority of persons living with HIV reside in urban areas, 14% live in rural parishes.

Persons Living with HIV Infection by Parish, Excluding State Prisoners
Louisiana, 2010



- Louisiana has 12 state correctional facilities marked on the above two maps. Almost 20,000 inmates are located in these 12 facilities. State correctional facilities are located in Allen, Avoyelles, Caddo, Calcasieu, Claiborne, East Feliciana, Iberville (x2), Rapides, Washington, West Feliciana and Winn parishes.

- The map above displays the HIV infection prevalence rate by parish excluding HIV positive inmates in the 12 state correctional facilities.

- Parishes such as Washington, East Feliciana, West Feliciana, Iberville and Winn had significantly lower HIV prevalence rates once the prisoners were removed from the analysis. Other parishes such as Allen, Calcasieu and Caddo had only slightly lower rates once the prisoners were removed, but the prevalence rate still remained high due to other persons living in the parish with HIV.

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, 2009-2010

	Persons Diagnosed with HIV, 2009			Persons Diagnosed with HIV, 2010		
	New HIV Diagnoses	AIDS at Time of Diagnosis*	AIDS Within 6 Months of Diagnosis	New HIV Diagnoses	AIDS at Time of Diagnosis*	AIDS Within 6 Months of Diagnosis
Total	**1,213**	**24%**	**32%**	**1,174**	**24%**	**33%**
Sex						
Female	395	22%	29%	332	23%	33%
Male	818	24%	33%	842	24%	33%
Race/Ethnicity						
American Indian/Alaskan Native	5	40%	40%	3	33%	33%
Asian/Pacific Islander	6	17%	17%	6	0%	0%
Black/African American	919	22%	31%	867	23%	33%
Hispanic/Latino	60	33%	43%	34	38%	44%
White	219	26%	32%	249	24%	32%
Other/Unknown/Multi-race	4	25%	25%	15	20%	20%
Age Group						
0-12	5	0%	0%	5	20%	20%
13-19	43	7%	16%	65	6%	12%
20-24	215	11%	15%	220	8%	15%
25-34	372	20%	29%	339	19%	28%
35-44	248	26%	34%	228	31%	44%
45-54	228	37%	47%	219	35%	44%
55-64	84	33%	40%	84	42%	52%
65+	18	50%	56%	18	44%	56%
Transmission Category						
Men who have sex with men (MSM)	571	24%	32%	624	23%	31%
Injection Drug User (IDU)	148	29%	36%	138	33%	43%
MSM/IDU	48	23%	33%	42	24%	36%
High Risk Heterosexual (HRH)	441	21%	30%	365	22%	32%
Transfusion/Hemophilia/Other	0	0%	0%	0	0%	0%
Perinatal/Pediatric	5	0%	0%	5	20%	20%
Region						
1-New Orleans	384	21%	29%	366	25%	34%
2-Baton Rouge	310	20%	27%	305	26%	34%
3-Houma	40	28%	35%	58	31%	40%
4-Lafayette	87	25%	33%	97	19%	30%
5-Lake Charles	51	25%	37%	49	16%	18%
6-Alexandria	64	25%	33%	61	28%	33%
7-Shreveport	115	30%	34%	106	17%	28%
8-Monroe	72	33%	43%	59	19%	29%
9-Hammond/Slidell	90	28%	39%	73	27%	40%

*If AIDS diagnosis was within 1 month of HIV diagnosis

- Of the 1,174 persons diagnosed with HIV in 2010, 24% had an AIDS diagnosis at the time of their initial HIV diagnosis. Males, Hispanic/Latinos, and persons 55 and older were more likely to have an AIDS diagnosis at the time of their HIV diagnosis.

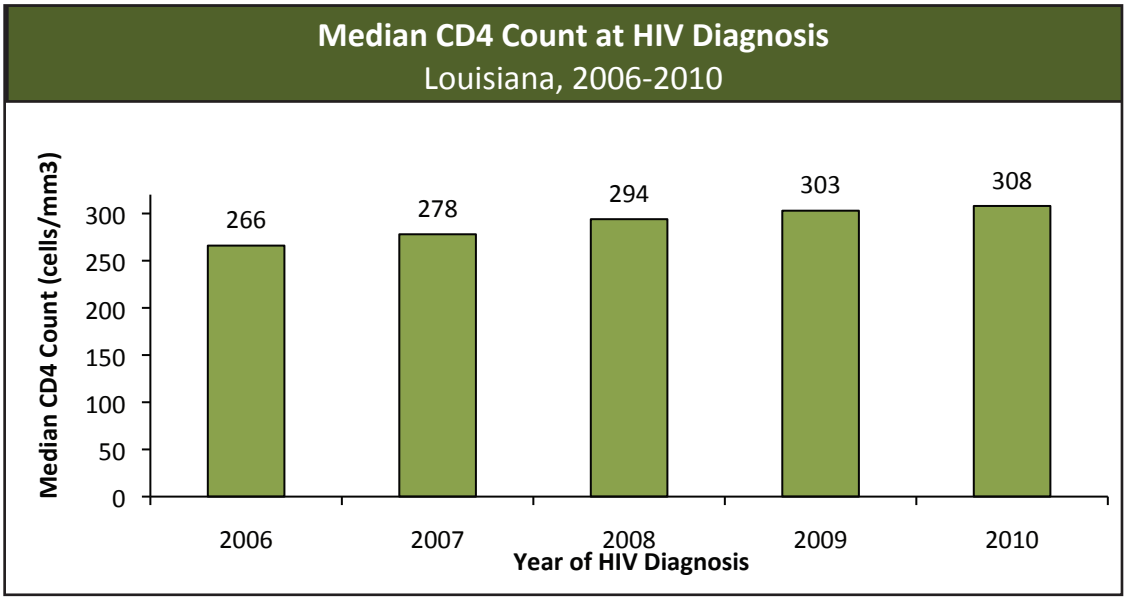
- Overall, 33% of persons had an AIDS diagnosis within six months of their HIV diagnosis. Hispanic/Latinos and persons over the age of 35 were more likely to have an AIDS diagnosis within six months.

- Injection drug users were more likely to have AIDS at the time of their HIV diagnosis and to have an AIDS diagnosis within six months of their initial HIV diagnosis compared to persons with other risk factors.

- Of the 9 public health regions in Louisiana, Houma and Alexandria had the greatest percentage of new diagnoses with AIDS at the time of HIV diagnosis, but Houma and Hammond/Slidell had the greatest percentage of new diagnoses with an AIDS diagnosis within six months.

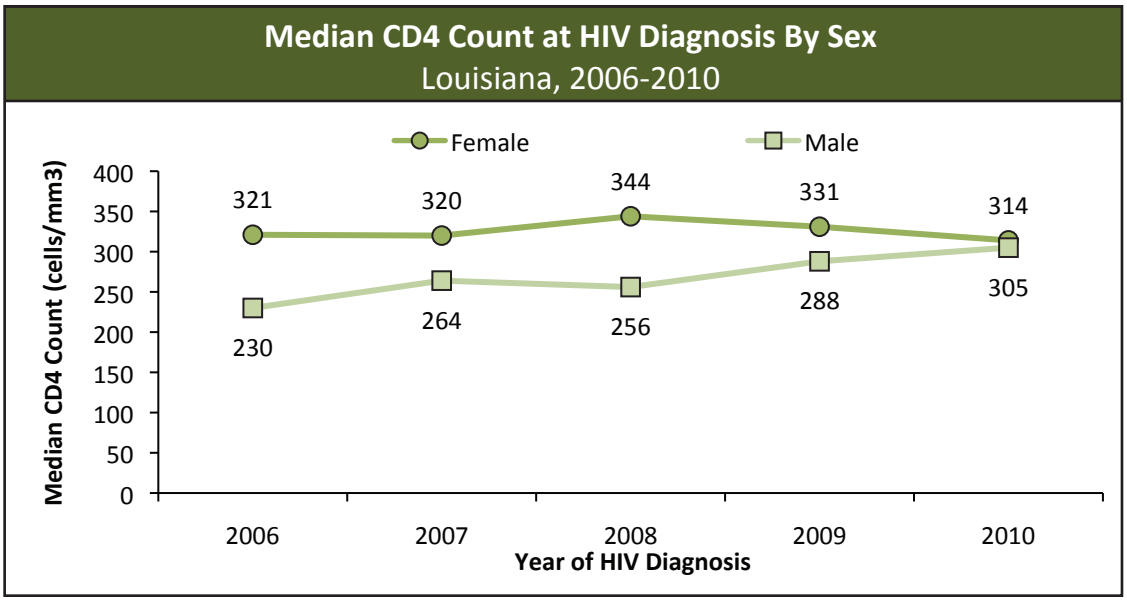
Median CD4 Count at Time of HIV Diagnosis

Another indication of persons being diagnosed late in their disease progression is an analysis of the CD4 count collected close to the time of a person's HIV diagnosis. T-cells are a type of white blood cell that plays an important role in a person's immune system. The human immunodeficiency virus specifically attacks and destroys a type of T-cell known as the CD4 cell. A normal CD4 count in a healthy, HIV-negative adult varies between 600-1200 CD4 cells/mm3. Because HIV attacks the CD4 cell, a count of CD4 cells is a good indicator of the progression of a person's disease. A CD4 count below 200 cells/mm3 is defined as an AIDS diagnosis and a CD4 count below 350 cells/mm3 is usually an indication that a person should begin medical treatment.[13]



- In 2010, the median CD4 count for persons diagnosed with HIV in Louisiana was only 308. Although this is a significant improvement since 2006, the fact that the median is below 350, which is an indication of the need for treatment, means that people are being diagnosed late in their disease progression.[14] More work must be done to get people diagnosed earlier and into treatment.

- The median CD4 count increased by 16% from 2006 to 2010.



- The median CD4 count for males has improved since 2006 while the median CD4 count for females has remained fairly stable. The median CD4 count for males and females in 2010 was essentially equivalent.

Louisiana Survival Data

Survival data examines how long a person lives once they have received an AIDS diagnosis (more than 12, 24, or 36 months post diagnosis). The most recent surveillance report from the CDC reported survival data for the nation from 2001-2005.[15] Below is an analysis of survival data for Louisiana in 2001-2005 to serve as a comparison to the national statistics.

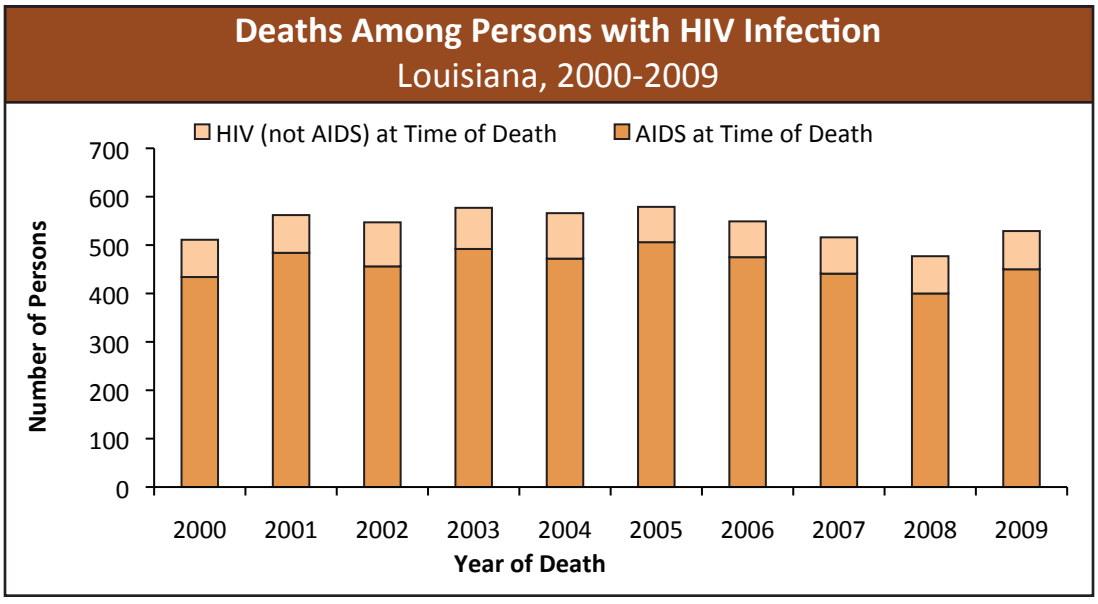
Persons Surviving More than 12, 24, and 36 Months After AIDS Diagnosis
Louisiana, 2001-2005

		Survival in Months		
	New AIDS Diagnoses	> 12	> 24	> 36
Total	**4,417**	**86%**	**80%**	**75%**
Year of Diagnosis				
2001	887	86%	80%	75%
2002	969	85%	80%	75%
2003	893	88%	82%	77%
2004	863	85%	79%	73%
2005	805	85%	80%	75%
Sex				
Female	1,381	87%	81%	75%
Male	3,036	85%	80%	75%
Race/Ethnicity				
Black/African American	3,366	86%	79%	74%
Hispanic/Latino	95	92%	88%	88%
White	920	87%	83%	80%
Other/Unknown/Multi-race	36	79%	70%	65%
Age				
0-12	9	100%	100%	100%
13-19	76	96%	96%	89%
20-24	266	91%	85%	80%
25-29	488	90%	85%	79%
30-34	671	92%	85%	82%
35-39	773	88%	82%	77%
40-44	826	86%	80%	76%
45-49	608	82%	77%	71%
50-54	363	80%	75%	69%
55-59	190	74%	66%	59%
60-64	84	64%	58%	56%
65+	63	65%	51%	46%
Imputed Transmission Category				
Men who have sex with men (MSM)	1,647	88%	83%	80%
Injecting Drug User (IDU)	1,078	80%	73%	64%
MSM/IDU	417	82%	75%	70%
High Risk Heterosexual (HRH)	1,228	90%	84%	80%
Transfusion/Hemophilia/Other	32	75%	75%	69%
Perinatal/Pediatric	15	100%	100%	100%
Region				
1-New Orleans	1,700	88%	83%	78%
2-Baton Rouge	1,172	84%	76%	69%
3-Houma	155	85%	79%	75%
4-Lafayette	298	84%	79%	74%
5-Lake Charles	202	87%	82%	79%
6-Alexandria	176	87%	80%	78%
7-Shreveport	297	86%	82%	78%
8-Monroe	243	82%	75%	68%
9-Hammond/Slidell	174	89%	84%	83%

- Nationally, 82% of people who received an AIDS diagnosis between 2001-2005 survived more than 36 months (3 years) past their diagnosis. In Louisiana, only 75% of persons with an AIDS diagnosis between 2001-2005 survived more than 36 months.
- In the US, males survived at the same percentage past 24 months and a slightly higher percentage past 36 months then their female counterparts; 85% of males and 85% of females survived past 24 months, and 83% of males and 81% of females survived past 36 months. In Louisiana, females had the same survival percentages as males past 36 months.
- Hispanic/Latinos had the best survival percentages in Louisiana, but the total number of diagnoses was small. Both nationally as well as locally, whites had higher survival percentages than blacks for all three times periods. Nationally, 84% of whites and 80% of blacks survived past 36 months; in Louisiana, 78% of whites and 74% of blacks survived past 36 months.
- In Louisiana, persons age 45 and older and persons with a reported history of injection drug use (IDU and MSM/IDU) had poorer survival outcomes. Nationally, injection drug users had the lowest survival rates of all transmission categories.
- Individuals in the Monroe region of Louisiana had the poorest survival outcomes of all nine public health regions (68% at >36 months); individuals from the Hammond/Slidell had the highest survival percentage (83% at >36 months).

Mortality of Persons with HIV Infection in Louisiana

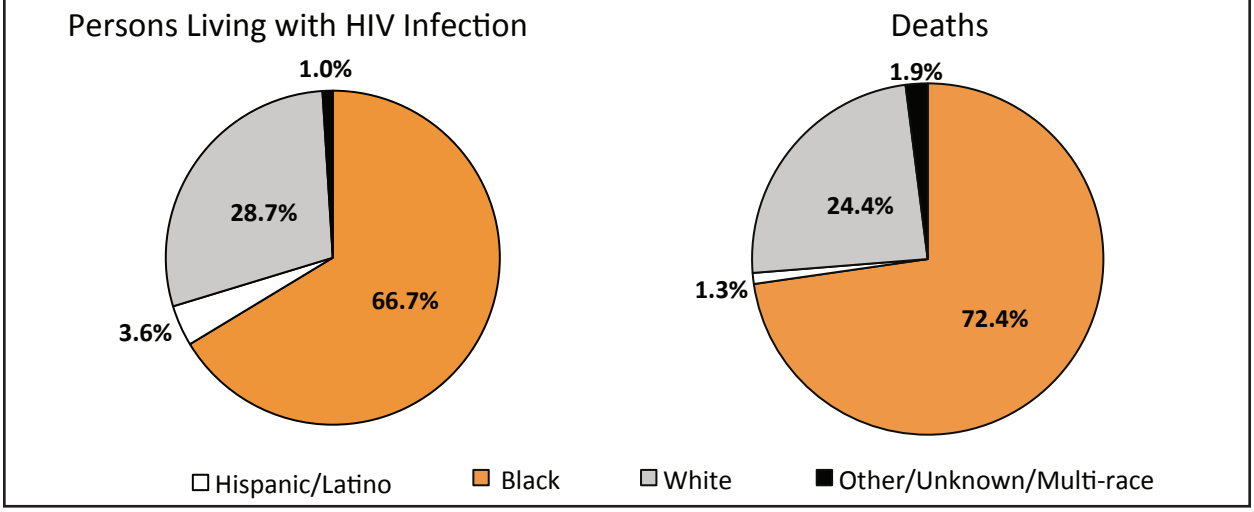
Data are collected on the number of persons with HIV infection who die each year. While individuals may die from HIV related illnesses, others may die from non-HIV related causes such as vehicle accidents, heart disease, or diabetes. The Louisiana death data described throughout this report includes all causes of death in persons living with HIV infection. The cause of death is not limited to HIV or AIDS and may be due to sepsis, cancer, accidental death, or other causes.



- In 2009, 450 persons with AIDS and 79 persons with HIV (not AIDS) died in Louisiana. From 2000-2009 deaths among persons with HIV (not AIDS) have remained relatively stable and the percentage with an AIDS diagnosis has fluctuated between 83-87%. *Mortality data for 2010 are not yet complete*.

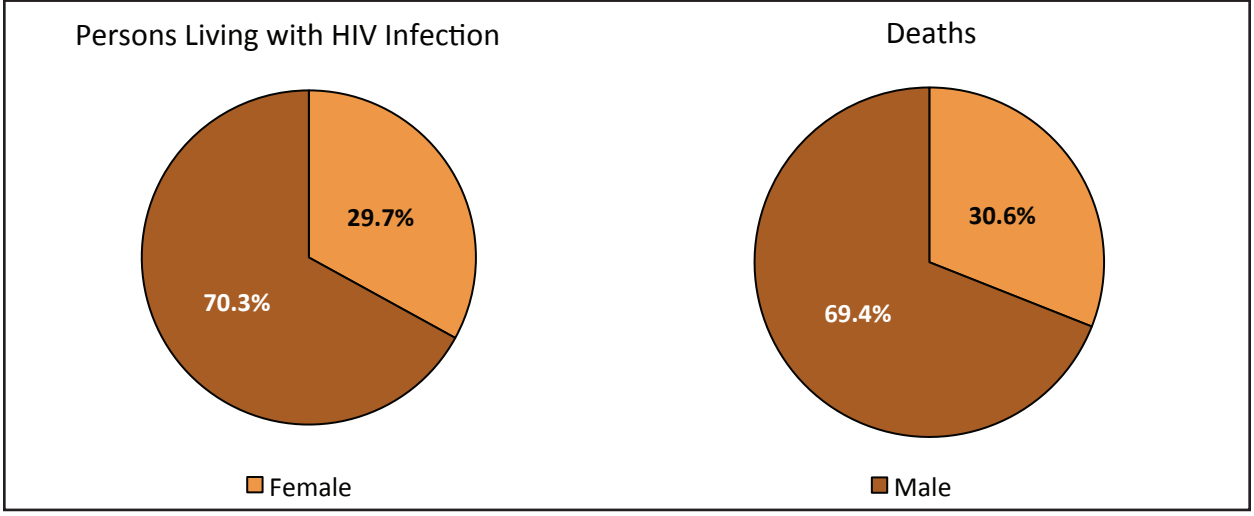
Comparisons between the demographic percent distribution of people living with HIV infection and persons with HIV infection who died can help identify if certain groups have higher mortality.

Persons Living with HIV Infection and Deaths in Persons with HIV Infection
by Race/Ethnicity, Louisiana 2009



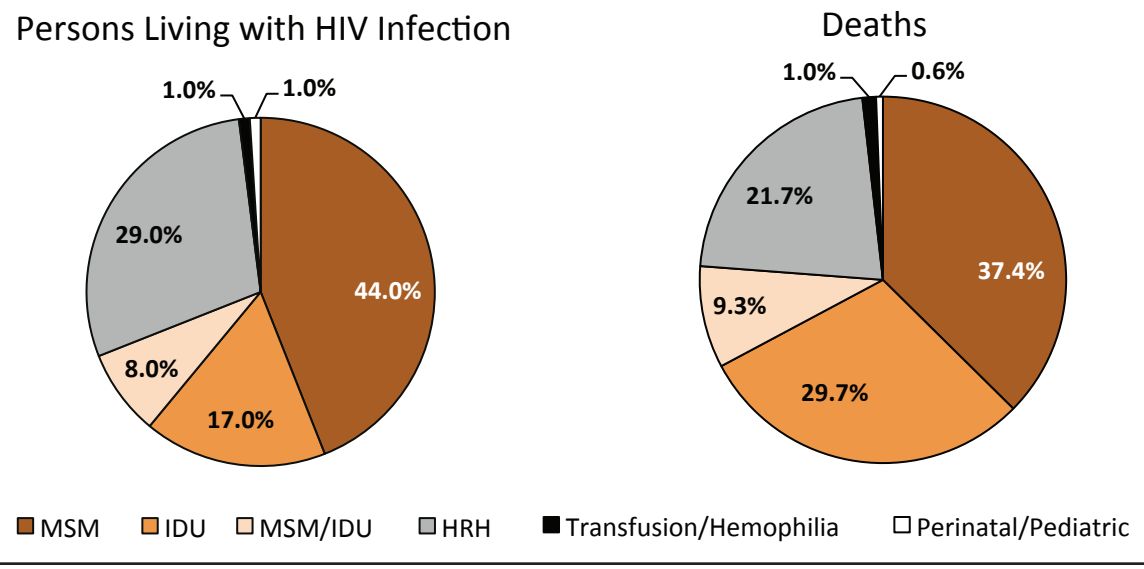
- Blacks are experiencing a disproportionate percentage of deaths compared to the percentage of persons living with HIV infection. In 2009, 67% of persons living with HIV infection were black yet 72% of deaths among persons with HIV infection were black. In contrast, 29% of persons living were white, but only 24% of the deaths were among whites.

Persons Living with HIV Infection and Deaths in Persons with HIV Infection
by Sex, Louisiana, 2009



- In 2009, females made up 30% of persons living with HIV infection and 31% of deaths in persons with HIV infection. Males made up 70% of persons living with HIV infection and 69% of deaths in persons with HIV infection. There does not appear to be a disparity in mortality by gender.

Persons Living with HIV Infection and Deaths in Persons with HIV Infection
by Transmission Category, Louisiana, 2009



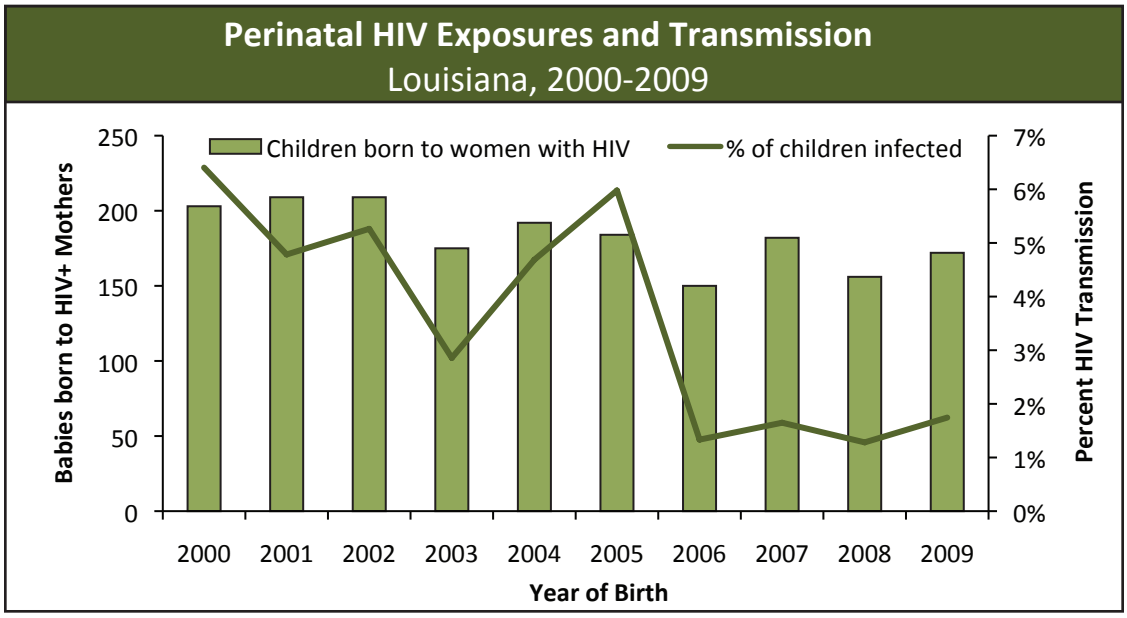
- Men who have sex with men (MSM) made up 44% of persons living with HIV infection in 2009, but only 37% of the deaths among persons with HIV infection were MSM.
- IDUs are experiencing a disproportionate percentage of deaths compared to other risk groups. Injection drug users (IDU and MSM/IDU) made up 25% of persons living with HIV infection but 39% of all deaths in persons with HIV infection in 2009.

Surveillance of Perinatal Exposure to HIV

Background on Perinatal HIV

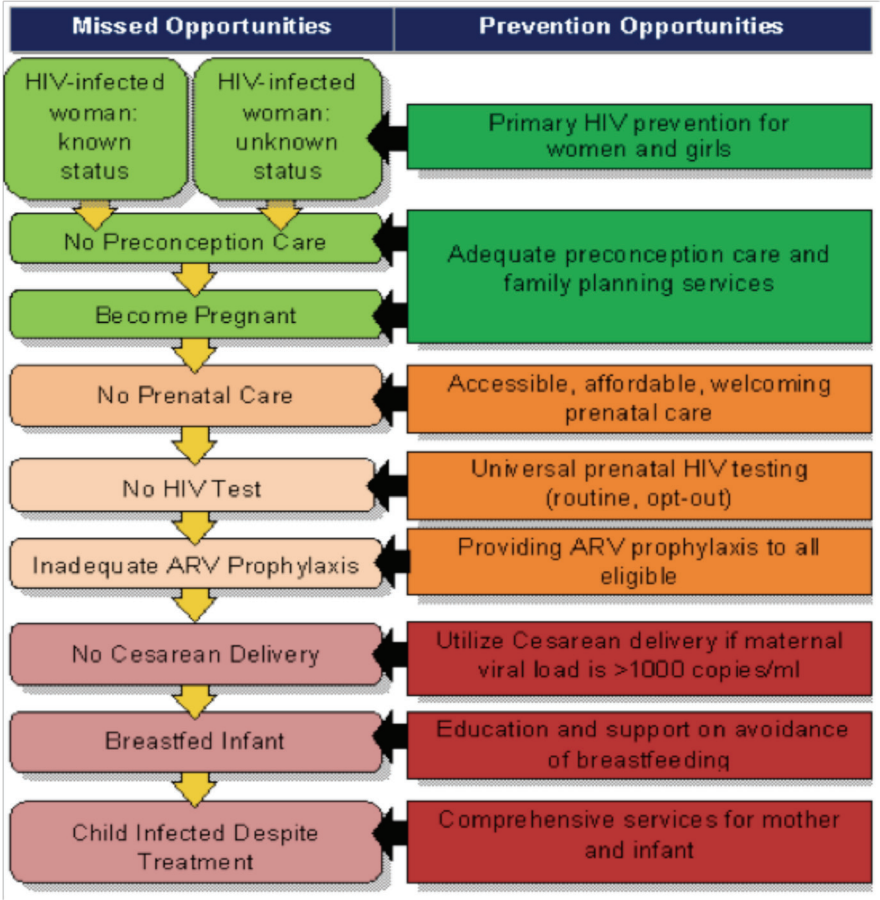
In 1994, the Pediatric AIDS Clinical Trials Group demonstrated that zidovudine (ZDV) could reduce the risk of mother-to-child transmission. As a result, the United States Public Health Service (USPHS) issued recommendations for the use of ZDV to reduce perinatal transmission. These guidelines are continuously updated to include additional treatment guidelines for HIV-infected pregnant women and their infants (available at: http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf). The CDC has published recommendations to include HIV screening 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.[16] Louisiana law (Louisiana RS 40:1300:13) requires any physician providing medical care to a pregnant woman to conduct an HIV test as a component of her routine prenatal laboratory panel unless the patient 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. In 2010, Louisiana updated Title 51 of the Louisiana Administrative Code: Public Health--Sanitary Code (available at: http://doa.louisiana.gov/osr/lac/books.htm) to require the explicit reporting of pregnancy in an HIV positive woman, as well as all HIV tests performed on children aged 0-6 regardless of result (positive or negative). Surveillance requires several rounds of tests to determine whether an infant is HIV positive or HIV negative. Changes to the Sanitary Code were necessary to ensure effective monitoring of all perinatal HIV transmissions.

The implementation of the USPHS guidelines in Louisiana has led to a significant decline in perinatal transmission rates, from a high of nearly 16% in 1994 to 1.7% in 2009. While this is the *2010 Louisiana STD/HIV Program Report,* perinatal cases are followed for up to two years to confirm a definitive negative status. For this reason, the data presented in this report are through 2009.



- In Louisiana in 2009, 172 infants were born to 167 women with HIV infection and three of the infants (1.7%) were infected with HIV.

In order to guide efforts for the prevention of perinatal HIV transmission, the Institute of Medicine developed a cascade of events leading to a mother-to-child transmission. The cascade shows the missed opportunities in perinatal HIV prevention:

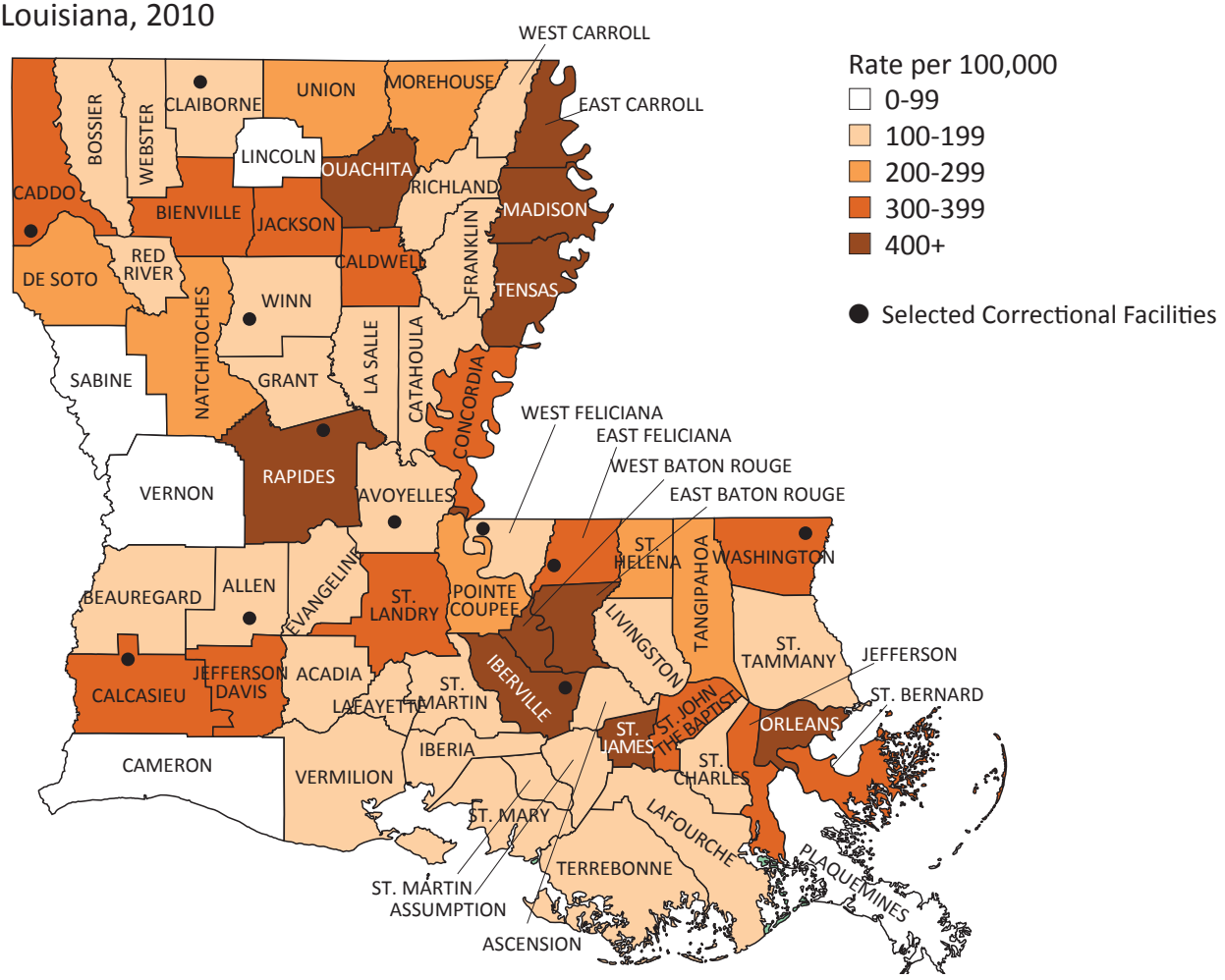


Following the cascade from top to bottom shows the broadest missed opportunities and prevention interventions down to the narrowest, for a case of perinatal HIV transmission where all opportunities and interventions were missed. Near the top of the cascade, the population affected and range of prevention programs are much larger, for example, preventing HIV transmission to all women and girls. Moving down the cascade, the missed opportunities become more specific as do the interventions; for instance, when no HIV test is offered during pregnancy, the recommended intervention is to implement routine, opt-out HIV testing during prenatal care. At the bottom of the cascade, if all opportunities are missed and an infant is infected with HIV, the only option for intervention is case management and linkage to HIV-specific medical care. When looking at the cascade, each category is narrower and narrower. So while there may be thousands of HIV infected women of reproductive age at the top of the cascade in Louisiana, there are usually only 1-3 cases of perinatal HIV transmission each year.

The map on the following page shows the first missed opportunity in the cascade: the 2010 HIV prevalence rate of women of childbearing age in Louisiana by parish of current residence.

Women of Childbearing Age Living with HIV Infection by Parish

Louisiana, 2010



- The areas with highest rates of HIV prevalence for women of childbearing age (15-44) were the New Orleans and Baton Rouge areas and the northeast section of the state.
- The majority of Louisiana's parishes have prevalence rates greater than 100 per 100,000 for women of childbearing age living with HIV infection. The high prevalence rates indicate that Louisiana would benefit from primary prevention of HIV in women and girls as well as preconception care and family planning services for women living with HIV.

Enhanced Perinatal Surveillance (EPS) collects data that are indicators of infant health such as birth weight, gestational age, parity, and substance use during pregnancy. Low birth weight, preterm birth, substance use during pregnancy, and high parity are elements shown to lead to poor birth outcomes. This demographic and birth outcome data assesses if certain populations are disproportionally affected, as well as to see how women with HIV compare to state and national averages.

Demographics of Mothers with HIV Infection
Louisiana, 2009

	HIV Positive Women Delivering in 2009	Percent
Total	**167**	**100.0%**
Race		
American Indian/Alaska Native	0	0.0%
Asian/Pacific Islander	0	0.0%
Black/African American	142	85.0%
Hispanic/Latino	3	1.8%
White	18	10.8%
Other/Unknown/Multi-race	4	2.4%
Age		
13-19	7	4.2%
20-24	57	34.1%
25-34	87	52.1%
35-44	16	9.6%
Transmission Category		
Injection Drug User (IDU)	21	12.6%
High Risk Heterosexual (HRH)	143	85.6%
Perinatal/Pediatric*	2	1.2%
Transfusion	1	0.6%
Substance Use During Pregnancy		
Yes	37	22.2%
No	128	76.6%
Unknown	2	1.2%
Parity		
1-2 Births	96	57.5%
3-4 Births	54	32.3%
5+ Births	16	9.6%
Unknown	1	0.6%
Delivery Type		
Vaginal	51	30.5%
Elective C-Section	85	50.9%
Non-Elective C-Section	30	18.0%
Unknown C-Section	1	0.6%
Region		
1-New Orleans	43	25.7%
2-Baton Rouge	58	34.7%
3-Houma	5	3.0%
4-Lafayette	18	10.8%
5-Lake Charles	6	3.6%
6-Alexandria	11	6.6%
7-Shreveport	11	6.6%
8-Monroe	12	7.2%
9-Hammond/Slidell	3	1.8%

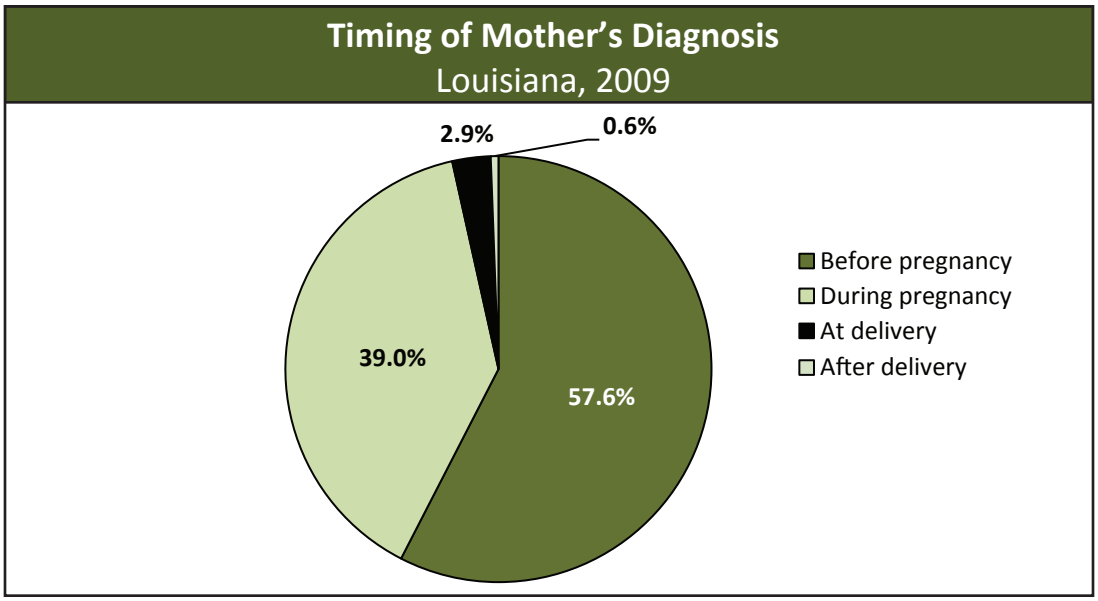
* Perinatal and Transfusion Transmission Categories are not imputed.

- Mothers with HIV infection were predominately black (85%) and between 25-34 years old (52%). Almost 13% of the mothers with HIV infection were likely infected through injection drug use, two mothers were themselves infected through perinatal transmission, and one mother was infected through a blood transfusion.
- In 2009, 22% of women with HIV infection indicated using some sort of substance (alcohol, tobacco, and/or a narcotic) during pregnancy.
- The American College of Obstetricians and Gynecologists (ACOG) recommends that HIV-infected pregnant women with plasma viral loads of >1000 copies per milliliter be counseled regarding the benefits of elective cesarean delivery as a method to reduce HIV transmission.[17] In 2009, 30.5% of HIV positive women delivered vaginally and 51% delivered via an elective c-section.
- In 2009, 35% of women with HIV infection who gave birth lived in the Baton Rouge region, and 26% lived in the New Orleans region.

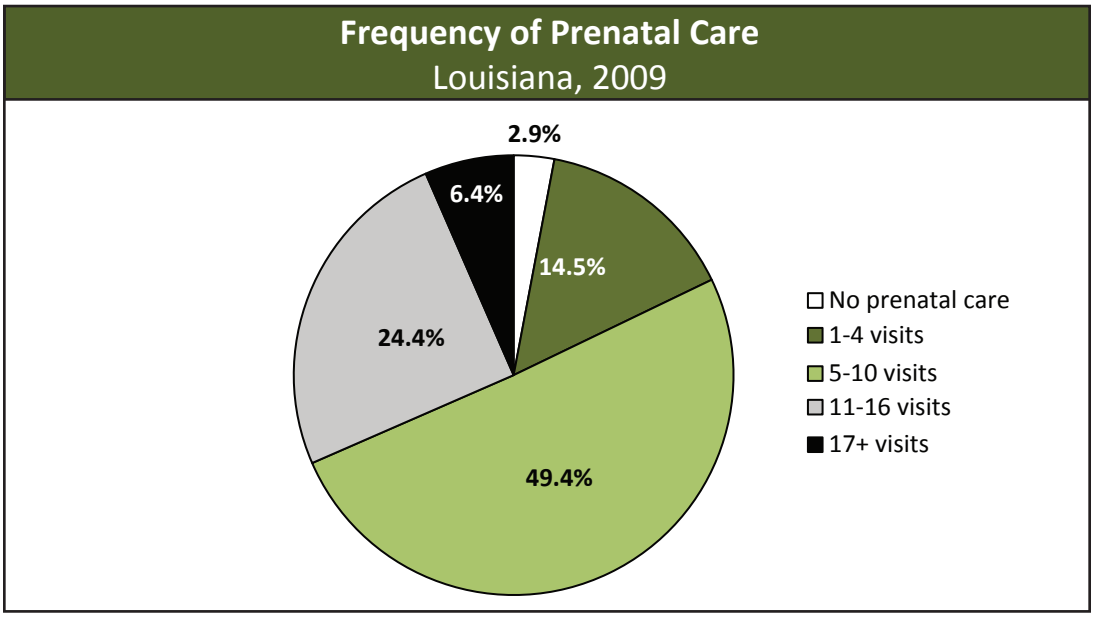
Birth Outcomes of HIV Exposed Infants
Louisiana, 2009

	Infants born in 2009	Percent
Total	**172**	**100.0%**
Birth Weight		
Very Low	6	3.5%
Low	31	18.0%
Normal	135	78.5%
Gestational Age		
Preterm	67	39.0%
Normal	105	61.0%

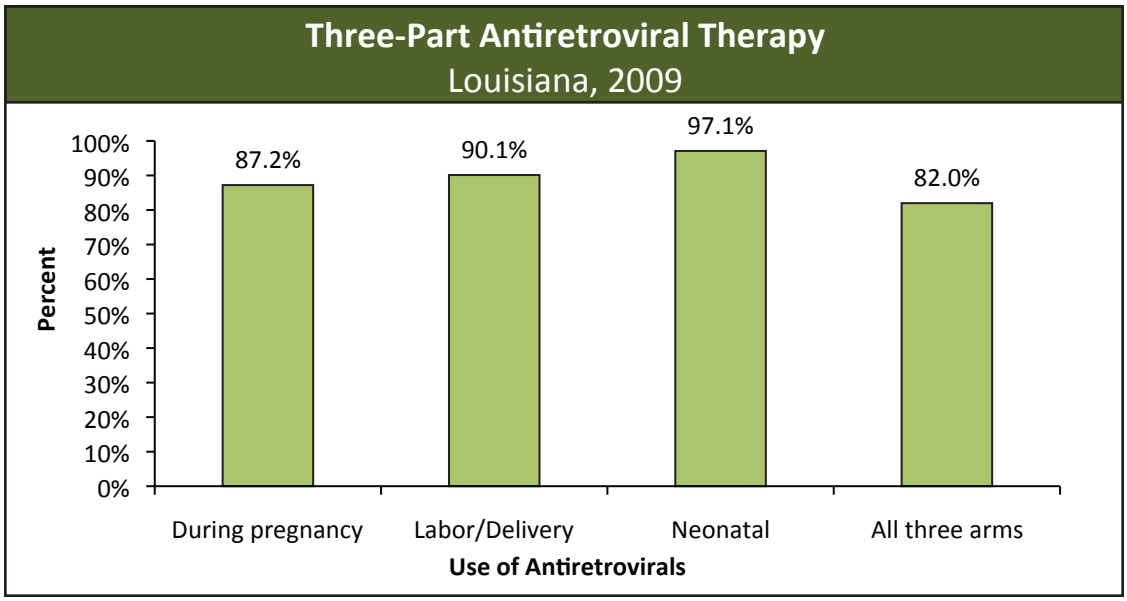
- Infants exposed to HIV had worse birth outcomes compared to state and national percentages. Among HIV exposed infants in Louisiana, 21.5% of infants were low or very low birth weight (<2500g), and 39% were born preterm (before 37 weeks gestational age). This is compared to all infants born in Louisiana in 2009 where 10.6% of babies were low or very low birth weight and 14.7% were born preterm. In 2009 in the United States, 8.2% of infants were low birth weight and 12.2% were born preterm.



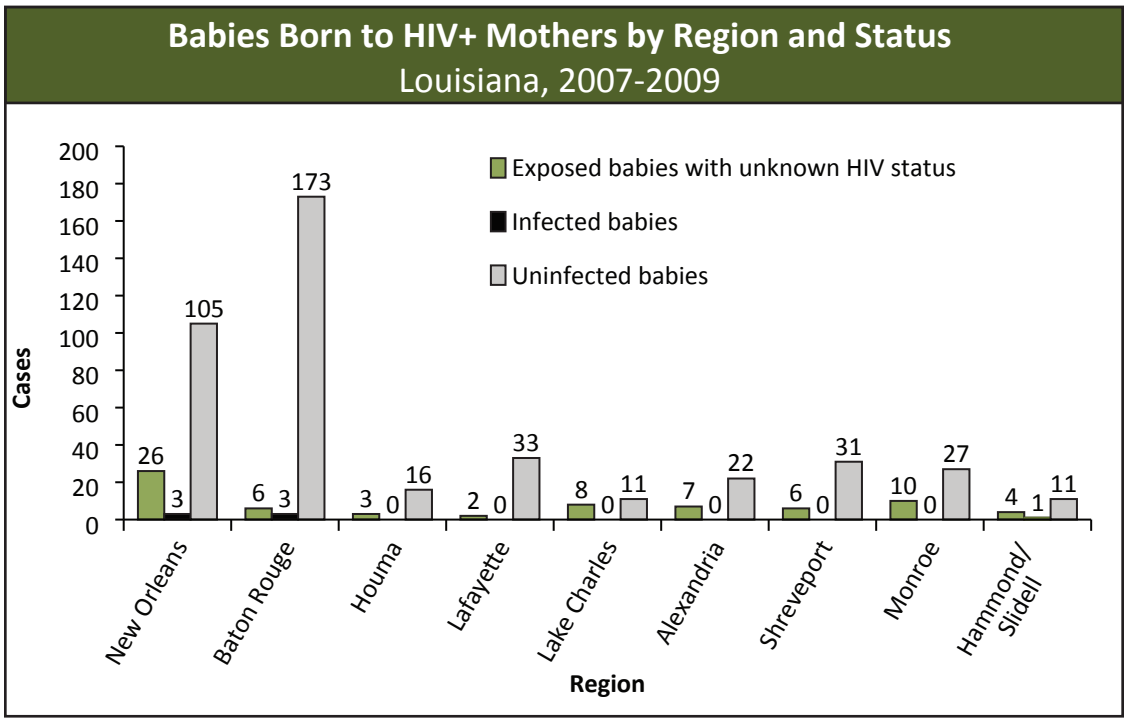
- In Louisiana, 58% of the women with HIV infection who delivered in 2009 were diagnosed with HIV prior to their delivery, and 39% were diagnosed during their pregnancy. Three percent were diagnosed with HIV at the time of delivery and <1% were diagnosed within 6 weeks after delivery. The percentage of women who know their HIV status prior to delivery has increased over time due to the increased emphasis on screening pregnant women.



- In 2009, three percent of mothers with HIV infection did not receive any prenatal care, and only 31% had more than 10 visits. 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 antiretroviral therapy during their pregnancy. However, since 2008, there has been a decrease in the number of women who did not receive any prenatal care at all (from 8% to 3%).



- Antiretroviral therapy administered to women with HIV during pregnancy, labor and delivery, and then to the newborn can reduce the rate of perinatal HIV transmission to 2% or less. In 2009, 87% of mothers received antiretroviral therapy (ARVs) during pregnancy; 90% received ARVs during labor and delivery; and 97% of infants received prophylactic ZDV shortly after birth. The infants who did not receive ZDV shortly after birth were due to hospital staff not knowing the HIV status of the mother. Overall, 82% of mother-infant pairs received all three recommended components of the antiretroviral prophylaxis protocol.
- Of the three infants born in 2009 who were infected with HIV, all of the mothers received prenatal care and the three-arm antiretroviral therapy. Despite pre-delivery treatment, all three mothers had detectable viral loads the month before delivery. One of the mothers was diagnosed within the month before she delivered.



- Births to women with HIV infection occurred in every region of the state. The Baton Rouge region had the highest number of births between 2007 and 2009, but the New Orleans and Baton Rouge regions had comparable perinatal transmission rates (2.2% and 1.6% respectively). The Houma, Lafayette, Lake Charles, Alexandria, Shreveport, and Monroe regions had no cases of perinatal HIV transmission during this time period.
- Fourteen percent of HIV exposed infants born during 2007-2009 continue to have an indeterminate HIV status. The percent of cases with an indeterminate HIV status has continued to decrease from 29% in 2005-2007 to 16% in 2006-2008. This decrease could be due to improved reporting, better access to testing, and better follow-up on infants. The aim is to continue to improve these processes to decrease the number of perinatal exposure cases with an indeterminate status.

Fetal Infant Mortality Review (FIMR)

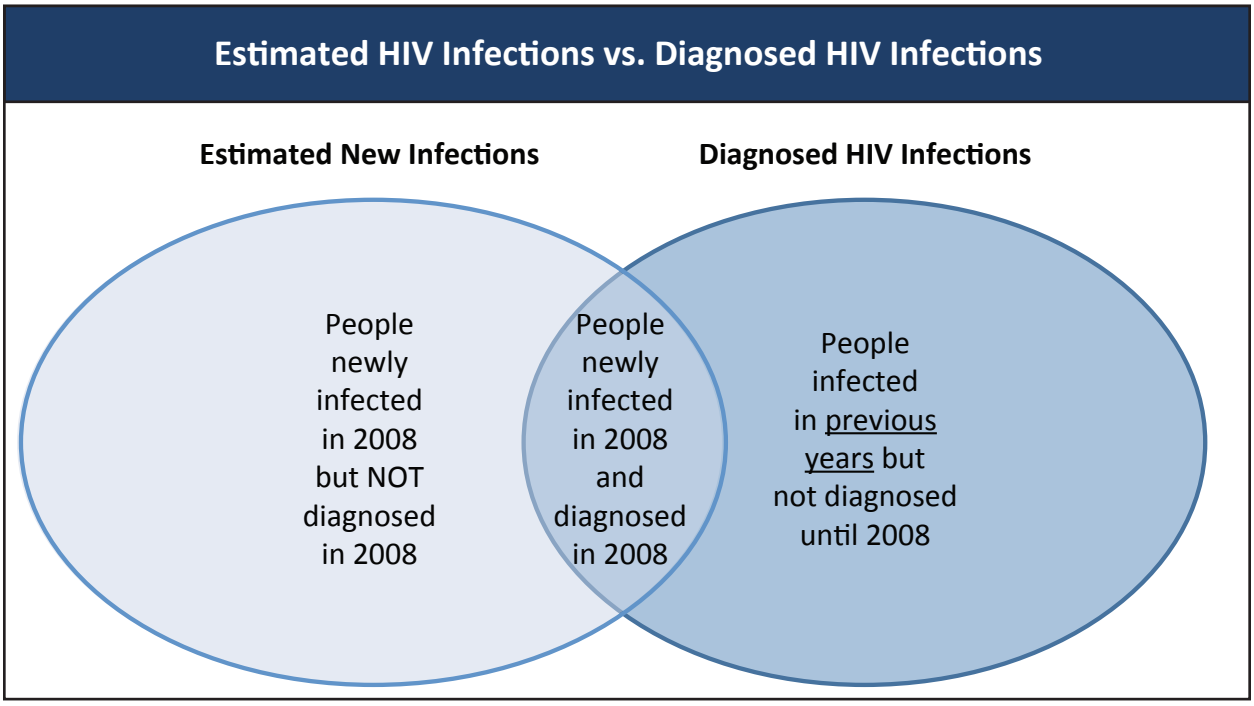
Since 2009, the Louisiana STD/HIV Program along with the Louisiana Maternal and Child Health Program were funded to carry out a perinatal HIV prevention methodology, based upon the Fetal Infant Mortality Review (FIMR), in the New Orleans metro area. The FIMR/HIV Prevention Methodology is an action-oriented 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:

The New Orleans FIMR/HIV Prevention Methodology was initiated in October of 2009 and the grant was renewed in October of 2010. Cases reviewed to date include all cases of perinatal HIV transmission from 2009 onward, as well as other cases with noted gaps in HIV or prenatal care. During the 2010-2011 grant year, 17 cases were abstracted and seven cases were interviewed. There were seven Case Review Team (CRT) meetings during which members reviewed 14 cases and made 70 recommendations to reduce perinatal HIV transmission in the New Orleans area. Louisiana has been funded for 2011-2012 to continue the FIMR/HIV Prevention Methodology in New Orleans and to expand to review cases in Baton Rouge.

HIV Incidence Surveillance

Historically, HIV surveillance data have been able to describe "who was newly diagnosed with HIV this year" or "who is currently living with HIV"; however, individuals may be diagnosed many years after they were infected, as shown in the *Late HIV Testing* section of this report. HIV incidence surveillance is intended to answer "who is becoming infected right now". The goal of HIV incidence surveillance is to determine how many newly diagnosed individuals have recently become infected and thereby provide more insight into how national, state, and local public health prevention programs are performing. Incidence surveillance utilizes a testing technology called Serological Testing Algorithm for Recent HIV Seroconversion (STARHS) that can help distinguish recent and long-term infections among newly diagnosed individuals. Together with testing and treatment history and other surveillance data, STARHS test results are analyzed using a statistical estimation methodology developed by the CDC which forms the basis of the HIV Incidence Surveillance (HIS) system. The HIS system was developed to generate timely and relevant estimates of the annual number of new HIV infections in the United States.

The HIV incidence estimation includes people who have recently become HIV infected including those who have not yet been diagnosed. Conversely, the number of diagnoses in a year contains people who were infected that year and in previous years. The diagram below shows how new infections relate to new diagnoses. It is estimated that in Louisiana, 69% of individuals newly infected in 2008 were not diagnosed in 2008 and were therefore unaware of their serostatus.



In August 2011, the CDC published an updated national estimate of incident infections in individuals aged 13 and above in the United States from 2006 to 2009. The estimates were based on data from 18 jurisdictions funded to conduct incidence surveillance, including Louisiana.[18]

- In 2006, there were an estimated 48,600 (95% CI: 42,400-54,700) new HIV infections.
- In 2007, there were an estimated 56,000 (95% CI: 49,100-62,900) new HIV infections.
- In 2008, there were an estimated 47,800 (95% CI: 41,800-53,800) new HIV infections.
- In 2009, there were an estimated 48,100 (95% CI: 42,200-54,000) new HIV infections.

Overall, from 2006 to 2009, the national incidence estimate did not change significantly and the CDC is still exploring the reasons for the large increase in 2007. No overall significant changes were seen among specific race/ethnicity groups or specific risk groups. However, a significant 21% increase in incidence

was seen in persons aged 13-29. This increase was driven by a 34% increase in incidence in young MSM. Among young MSM, there was a 48% increase in incidence among black men. Nationally, in 2008, 56% of incident cases were attributed to MSM, 30% to HRH, 11% to IDU, and 3% to MSM/IDU.i

Using the CDC methodology, SHP estimated the HIV incidence for Louisiana for 2006-2008. Data for 2009 may be unreliable and therefore excluded from the current incidence estimate. The table below reports the total number of new diagnoses and the estimated number of new infections for Louisiana. As can be seen, incidence estimates are similar to the number of annual diagnoses.

Comparison of Louisiana New Diagnoses and Estimated New Infections
Louisiana, 2006-2008

Year	2006	2007	2008
New HIV (non AIDS) Diagnoses	642	735	741
Total New Diagnoses	991	1,081	1,095
Estimated New Infections	1,008	1,172	1,017

The table below provides selected characteristics of the estimated incident cases in Louisiana.

Characteristics of Persons with Incident HIV Infections
Louisiana, 2006-2008

	2006			2007			2008		
	Cases	Percent	95% CI	Cases	Percent	95% CI	Cases	Percent	95% CI
Total	**1,008**	**100%**	**(569, 1447)**	**1,172**	**100%**	**(800, 1547)**	**1,017**	**100%**	**(719, 1315)**
Sex									
Female	174	17.3%	(55, 293)	348	29.6%	(196, 500)	326	32.1%	(200, 568)
Male	834	82.7%	(417, 1215)	824	70.3%	(499, 1153)	691	67.9%	(508, 1120)
Race/Ethnicity									
Black or Hispanic	680	67.5%	(348, 957)	981	83.6%	(656, 1318)	849	83.5%	(664, 1265)
White or Other	328	32.5%	(109, 519)	192	16.4%	(75, 313)	168	16.5%	(53, 328)
Age Group	**Age at Diagnosis**			**Age at Diagnosis**			**Age at Diagnosis**		
13-29	301	29.8%	(152, 408)	553	47.1%	(270, 649)	430	42.3%	(286, 574)
30-39	299	29.6%	(87, 470)	287	24.5%	(115, 364)	264	26.0%	(121, 407)
40+	408	40.4%	(141, 617)	333	28.4%	(131, 423)	322	31.7%	(121, 574)
Imputed Transmission Category									
Men who have sex with men (MSM)	561	55.7%	(221, 852)	614	52.3%	(312, 915)	501	49.2%	(311, 841)
Injecting Drug User (IDU)	188	18.7%	(17, 344)	133	11.3%	(27, 239)	153	15.0%	(35, 315)
High Risk Heterosexual (HRH)	259	25.7%	(95, 401)	427	36.4%	(244, 610)	364	35.7%	(212, 624)

As with the national estimates, it appears that new infections in persons age 13-29 are driving the epidemic in Louisiana. Approximately half of all new infections in Louisiana were attributed to MSM, over a third of new infections to HRH, and the remainder to IDU. New HIV infections among blacks and Hispanics make up the large majority of incident infections in Louisiana.

Because the HIS system is new and the methodology to estimate incidence is very complicated, analyzing state-level data has been challenging and is not yet considered to be fully reliable. For the purposes of planning programs and allocating resources, SHP continues to rely primarily on data from the program's long-standing surveillance system that monitors new diagnoses, prevalence, and mortality. However, data from the state's incidence surveillance system has provided some insights into the local HIV trends. These data can be used to identify gaps in testing and issues in access to care and may ultimately help to inform prevention efforts to target populations who are most at risk for HIV.

National HIV Behavioral Surveillance Survey

Initiated in 2003, the National HIV Behavioral Surveillance (NHBS) system collects behavioral data among people at highest 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".[19] New Orleans was among the 21 US metropolitan areas conducting NHBS in 2010. This study collects data from three target populations: men who have sex with men (MSM), injection drug users (IDU), and heterosexuals living in areas at high risk for HIV/AIDS (HRH), each in discrete annual cycles. The NHBS survey instrument contains items regarding sexual behavior, substance use, and HIV testing behaviors. In 2007, anonymous HIV testing of participants was added to NHBS.

Because many of the behaviors are highly stigmatized or illegal, the populations surveyed are considered hard to reach using traditional probability based sampling methods. Each cycle therefore utilizes specialized sampling methods for recruitment of participants in order to yield the most valid population estimates. MSM are recruited using a venue-based time-space sampling procedure, where individuals are approached within venues that are attended by MSM. Injection drug users are recruited 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 then continues in this fashion until a desired sample size is reached. HRH recruitment is conducted using a similar RDS procedure; however, the initial recruits or "seeds" are individuals who reside in areas that have been identified by staff as having high local rates of HIV infection and poverty.

Key Findings from the New Orleans NHBS Surveys:

Sexual Orientation and Disclosure

- A substantial portion of males in all three samples who identified as heterosexual were found to have been behaviorally bisexual by virtue of having had sex with both men and women. Approximately one in four men in the HRH and IDU samples had ever had sex with a man.
- Conversely, a percentage of individuals in all three cycles who identified as homosexual, gay or lesbian had had sex with both men and women in the past 12 months.
- Black MSM were more likely to identify as being bisexual (23%) than white (13%) and other race/ethnicity (18%) MSM.

Substance Use

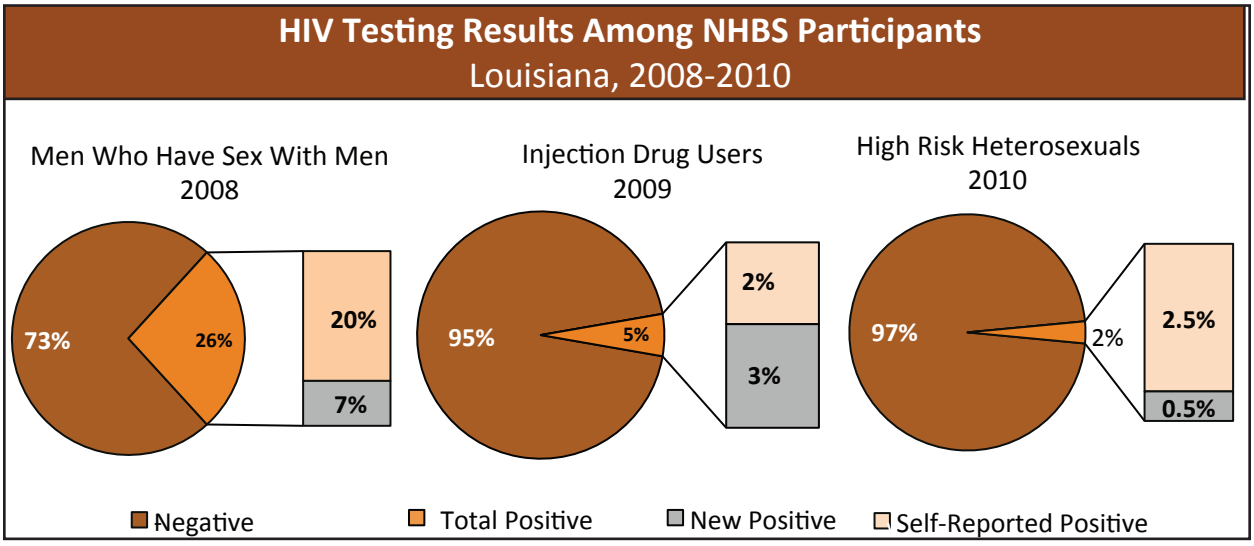
- Participants in the injection drug use cycle were most likely (87%) to also have used non-injection drugs during the previous 12 months followed by MSM (52%) and HRH (41%) participants.
- Among those who used non-injection drugs in the past 12 months, marijuana was the most commonly used substance in all populations: HRH (80%), MSM (80%) and IDU (74%). Crack (67%) and powdered cocaine (65%) were also commonly used in the IDU sample.
- Consistent with other national reports of methamphetamine use among MSM, 19% of MSM who were substance users had used methamphetamine in the past 12 months.
- Among those who injected drugs, heroin was the most commonly used injection drug among MSM (66%), HRH (73%) and IDU (77%).
- A total of 64% of IDU participants reported having shared injection equipment (cooker, works, cotton) and 41% of the IDU respondents reported sharing needles in the past 12 months.

Hepatitis

- Among those who had been told they have had hepatitis, hepatitis C was the most common diagnosis for both IDU (80%) and HRH (66%), while Hepatitis B was more common (57%) than Hepatitis C (33%) among MSM.

Testing

- MSM reported to having received their last HIV test at an HIV counseling and testing site or street outreach location (43%). IDU reported to being initially tested within a hospital or emergency room setting (30%) or in a correctional facility (18%) and HRH reported to being initially tested at public health clinics (15%), a hospital (13%) or a STD clinic (10%).
- IDU and HRH were significantly less likely to have been tested at a private doctor's office (5% and 6% respectively) than MSM (25%).



- Of the MSM who were tested, 73% were negative and 27% were positive. Of the MSM who tested positive, 74% were previously aware of their positive status.
- Of the IDUs who were tested, 95% were negative and 5% were positive. Of the IDUs who were positive, only 40% were previously aware of their positive status.
- Of the HRHs who were tested, 97% were negative and 3% were positive. Of the HRHs who were positive, 83% were previously aware of their positive status.
- Over 20% of the HRH participants reported having never been tested while 19% of the IDU participants and only 7% of the MSM participants reported never being tested for HIV.

The table on the following page is a demographic breakdown of the NHBS participants as well as survey responses from the three groups.

National HIV Behavioral Surveillance (NHBS) Louisiana, 2008-2010						
	Men Who Have Sex With Men (2008)		Injection Drug Users (2009)		High-Risk Heterosexuals (2010)	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**
Race/Ethnicity						
Black/African American	151	29%	344	56%	538	82%
White	306	58%	229	37%	70	11%
Other	71	13%	41	7%	48	7%
Sex						
Male	528	100%	504	82%	320	49%
Female	N/A	N/A	111	18%	336	51%
Age						
18-24	83	16%	13	2%	97	15%
25-29	73	14%	33	5%	72	11%
30-34	73	14%	59	10%	57	9%
35-39	83	16%	47	8%	46	7%
40-44	78	15%	89	14%	79	12%
45-50	71	13%	171	28%	129	20%
51+	67	13%	203	33%	176	27%
Sexual Identity						
Heterosexual or "Straight"	8	2%	540	88%	591	90%
Homosexual, Gay, or Lesbian	431	82%	11	2%	2	0%
Bisexual	89	17%	63	10%	62	9%
Other	0	0%	0	0%	0	0%
Sex	**Average number of sex partners in the past 12 months***					
Males						
Men	9.98		5.2		3.76	
Women	10.88		9.43		5.69	
Females						
Men	N/A		9.38		2.81	
Sexual Activity	**Proportion reporting unprotected sex during the last 12 months****					
Vaginal Sex						
M-F	53%		89%		90%	
F-M	N/A		90%		88%	
Injection Drug Use						
Ever Injected Drugs	62	12%	613	100%	123	19%
Injected in the Past 12 Months	18	3%	613	100%	45	7%
Shared Needle in Past 12 Mos.***	8	44%	250	41%	27	60%
Shared Works/Equipment in Past 12 Mos.***	8	44%	392	64%	36	80%
Non-Injection Drug Use						
In Past 12 Months	275	52%	536	87%	266	41%
Hepatitis						
Physician Diagnosed any Hepatitis	84	16%	179	29%	74	11%
Self Reported HIV Test						
Never Been Tested	35	7%	116	19%	133	20%
Negative	379	72%	430	70%	461	70%
Positive	98	19%	15	2%	17	3%
Did not return/Unknown/Other	16	3%	51	8%	45	7%

*Among those who reported sex specific to gender.
**Among those who reported having sex.
***Among those who injected in past 12 months.

Chapter 2

HIV Care and Services

Introduction to the Care and Services Unit

The Louisiana Office of Public Health STD/HIV Program (SHP) Care and Services Unit coordinates programs throughout the state for low-income individuals living with HIV infection to help ensure ongoing access to primary medical care and medications and to a continuum of high-quality community-based supportive social services. In 2010, SHP coordinated HIV-related care, treatment and support services for 5,859 people living with HIV infection in Louisiana. SHP's Care and Services Unit receives funding from two primary sources:

- For medical and supportive service programs, SHP receives an annual grant from the Health Resources and Services Administration (HRSA) through the federal Ryan White HIV/AIDS Treatment Extension Act of 2009. Ryan White resources are available through several programs or "Parts" that are awarded to states, cities, medical providers, and community-based organizations to assist low-income individuals living with HIV disease in accessing medical care and treatment (See "What is Ryan White Funding?" on page 62). SHP's funding is awarded through "Part B" of HRSA's Ryan White Program. The City of New Orleans and the City of Baton Rouge receive separate funding from HRSA under "Part A" of the Ryan White Program to administer medical and support programs in those jurisdictions. The amount of funding allocated to Louisiana each year is determined primarily by a federal formula that uses data collected through SHP's Surveillance Unit.
- For housing related services, SHP receives funds from the federal Department of Housing and Urban Development (HUD) through the State Formula Housing Opportunities for Persons With AIDS (HOPWA) program. These resources support a continuum of housing options for HIV-infected persons living in areas of the state outside of the greater New Orleans and Baton Rouge metropolitan areas, as these cities receive direct awards of HOPWA funds. The annual State Formula HOPWA award to Louisiana is also impacted by the number of AIDS cases reported by SHP's Surveillance Unit.

SHP contracts with medical centers and community-based agencies throughout the state to provide the following services at low or no cost to eligible clients:

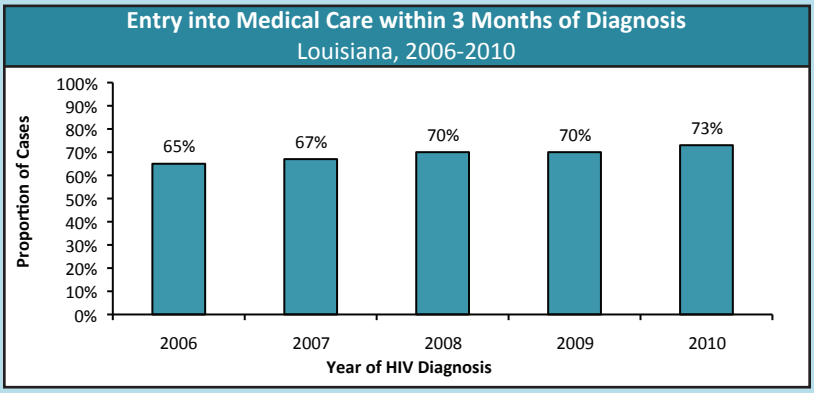
- assistance in obtaining HIV medications;
- payment of health insurance premiums, co-payments and deductibles;
- provision of medical case management;
- provision of support services: medical transportation, nutritional services, oral health care services, mental health and substance use treatment services, and emergency assistance;
- short-term and tenant-based housing assistance and support of community residences.

SHP's Care and Services Unit works with other programs that provide similar services with state or federal funding throughout the state in order to reduce gaps in services for clients. Specifically, SHP works closely with the state's other HRSA-funded Ryan White grantees, Louisiana Medicaid, the Louisiana State University (LSU) regional public medical centers, and other entities that provide services to low-income persons with HIV. These efforts are undertaken to reduce fragmentation in service delivery and strengthen the continuum of care.

National HIV/AIDS Strategy
Increasing Access to Care and Improving Health Outcomes for People Living with HIV

2015 Objectives:

- By 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis from 65% to 85%.
  - In 2010, 73% of newly-diagnosed persons entered care within 3 months, which is above the national average of 65% but below the 2015 goal of 85%.

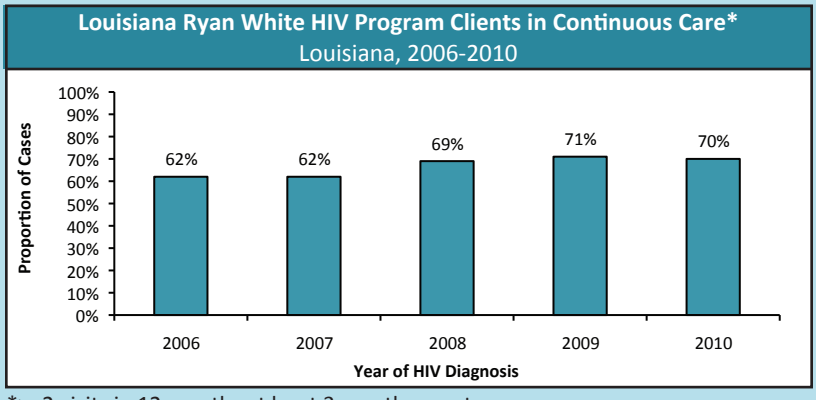


  - Males and blacks were less likely to enter care within 3 months.

Newly Diagnosed Persons Entering Care in Three Months
Louisiana, 2010

	Percent
Sex	
Female	83%
Male	69%
Race/Ethnicity	
Black/African American	70%
Hispanic/Latino	79%
White	82%

- 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%.
  - Among Ryan White clients, the percent in continuous care has increased from 62% in 2006 to 70% in 2010 but is still below the 2015 goal of 80%.



*>=2 visits in 12 months at least 3 months apart

- By 2015, increase the number of Ryan White clients with permanent housing from 82% to 86%.
  - The Louisiana State Formula HOPWA program has achieved stable housing for 72% of its clients, which is below the 2015 goal of 86%. However, it is an increase of nearly 6% over the previous year.

National HIV/AIDS Strategy (www.thewhitehouse.gov)

Primary Medical Care, Medications and Support Services Coordinated through SHP: Louisiana's Ryan White "Part B" Program

Louisiana's Care and Services Unit administers Ryan White Part B funding for the provision of medications and support services for low-income HIV-infected persons living throughout the state (see "What is Ryan White Funding?" on page 62 for an overview of the federal Ryan White Program and Parts). These resources primarily ensure ongoing access to medical care and treatment for low income persons with HIV disease. Support services are intended to reduce barriers to accessing medical care.

Louisiana has a unique healthcare infrastructure that provides an array of medical services to residents through a partnership between public and private providers. In addition to many for-profit hospitals and private infectious disease specialists throughout the state, the LSU Health Care Services Division (HCSD) operates seven state-funded medical centers in the southern half of the state which primarily provide care to low income individuals who are uninsured or underinsured. Additionally, LSU-Shreveport oversees three medical centers in Shreveport, Monroe, and Pineville that provide similar medical services in the northern part of the state. All ten of these regional medical centers operate clinics that offer HIV-specific medical services. Of all persons living with HIV in Louisiana who are in care, 72% access care through the ten LSU regional public medical centers.

In addition, primary care is provided by independent community-based outpatient clinics supported with Ryan White Part A, C, and/or D resources; 12 facilities operated by the Louisiana Department of Public Safety and Corrections; and 3 Veterans Affairs Medical Centers (see map on following page). It is important to note that the Ryan White funding available to support HIV primary medical care in Louisiana is very limited when compared to state funds supporting the LSU regional public medical centers and federal reimbursements from Medicaid and Medicare.

SHP's Care and Services Unit works very closely with medical providers throughout the state to help connect the systems of care together through coordinated program implementation, collaboration, and where possible, program integration. Community-based HIV medical case management agencies (primarily funded through Medicaid or Ryan White Part A, B, or D programs) help link clients to the most appropriate medical and supportive services in their local area.

Managing HIV Disease: Resources for HIV Primary Care Providers

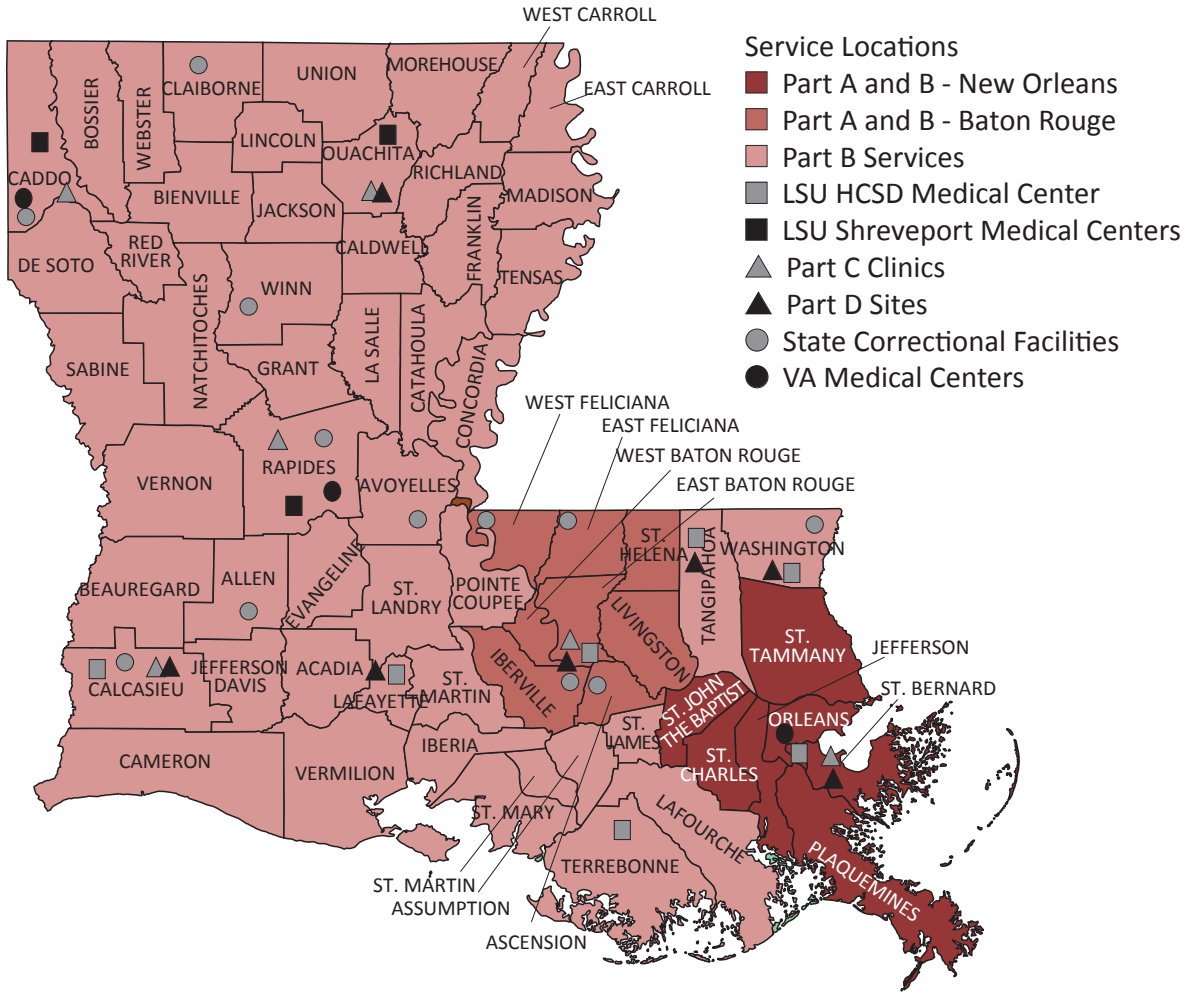
HIV is a complicated disease to manage – for both patients and their providers. Due to the complex nature of the medications and their interactions with other HIV and non-HIV pharmaceuticals, the U.S. Public Health Service (USPHS) provides a variety of treatment guidelines for physicians and prescribers. These guidelines are tailored for specific populations (adults, pediatric patients, pregnant females, etc.) and are "living documents" that are continuously updated to provide the most current treatment information to practitioners.

(http://aidsinfo.nih.gov/guidelines)

The federal Ryan White HIV/AIDS Program Part F component also funds technical assistance to medical care providers through regional AIDS Education and Training Centers (AETC). For Louisiana clinicians, support and training resources can be accessed through the Delta Region AETC in New Orleans.

(www.deltaaetc.org)

Ryan White Coverage and Service Locations, Louisiana



Assistance Obtaining HIV Medications

What does SHP do? *Contracts with the 10 LSU regional public medical center pharmacies to provide HIV-related formulary medications to qualifying clients*

Area covered: *Statewide*

The Louisiana AIDS Drug Assistance Program (LA ADAP) helps ensure that eligible low-income clients can access specific FDA-approved HIV medications. These pharmaceutical interventions have been proven to slow disease progression, reduce the risk of HIV transmission, enhance quality of life, and extend life. The allocation of resources to Louisiana ADAP comprises the greatest percentage of the Ryan White Part B award. Clients can apply to the program through private providers, the ten LSU regional public medical centers, and medical case management service providers. The Louisiana ADAP currently has 63 FDA-approved medications supported by the formulary.

2010: Major Challenges and Changes to the Louisiana ADAP (LA ADAP) Program

Between 2006 and 2010, client utilization of LA ADAP and expenditures on eligible services increased steadily without a corresponding increase in resources. These documented trends were the result of many factors, including but not limited to: increased targeted HIV testing, intensive efforts to link newly diagnosed persons into care, assertive activities to identify persons who knew their HIV status and were not in care, and the overall economic downturn with a corresponding loss of income and insurance benefits, coupled with level allocation of federal resources to Louisiana to address these growing needs. From January 1, 2008 to December 31, 2009, the cost of providing medication services through the LA ADAP increased by 33% while the number of clients served increased by 15%. As a result, in spring 2010, it was projected that LA ADAP would face a potential shortfall of $11.7 million.

These factors forced the implementation of cost-savings measures in order to avoid the need to dis-enroll all ADAP clients before the end of the budget period. The elimination of primary medical care contracts, as well as a decrease in contracted budgets for community-based organizations, yielded some savings. However, they did not offset the projected client need for core services funded through Ryan White Part B resources, and as such, LA ADAP was capped to new enrollment on June 1, 2010.

All individuals newly eligible for LA ADAP after June 1st have been referred to Patient Assistance Programs (PAPs) administered by pharmaceutical manufacturers. These individuals comprise the LA ADAP "Unmet Need" list. Unlike the concept embodied in a waiting list, these individuals are not waiting for medication, but rather are using the PAPs as their primary source of no-cost or low cost HIV-related medications for the duration of capped enrollment to LA ADAP. During 2010 and 2011, SHP staff has received referrals from all regions of the state for persons who would be eligible for LA ADAP, but cannot be enrolled in the program. As new federal resources have been received from HRSA due to the documented unmet need for ADAP medications for eligible low income HIV-infected persons (a little over $1 million in August 2010 and $3 million in August 2011), and as slots open up through routine attrition, individuals have been removed from the Unmet Need list and re-screened for enrollment into LA ADAP. At the end of December 2011, 2,039 individuals had been referred to the Unmet Need list since June 1, 2010. Of those, 1,445 have been removed as slots have become available.

Persons Utilizing ADAP and Persons Living with HIV by Region
Louisiana, 2010

	Persons Utilizing ADAP	Percent	Persons Living with HIV Infection	Percent
Region	**3,228***	**100.0%**	**17,679****	**100.0%**
1-New Orleans	1,278	39.6%	6,384	36.1%
2-Baton Rouge	790	24.5%	4,402	24.9%
3-Houma	82	2.5%	611	3.5%
4-Lafayette	237	7.3%	1,320	7.5%
5-Lake Charles	192	5.9%	961	5.4%
6-Alexandria	131	4.1%	736	4.2%
7-Shreveport	248	7.7%	1,378	7.8%
8-Monroe	151	4.7%	918	5.2%
9-Hammond/Slidell	119	3.7%	969	5.5%

* Region by dispenser, not client address
** Region by client address

- Approximately 64% of ADAP clients are from the New Orleans and Baton Rouge regions.
- The percentage of individuals receiving ADAP services in each region is comparable to the percentage of persons living with HIV infection in each region.

Who pays for HIV care and treatment in the U.S.?

According to the *Kaiser Family Foundation,* the major payer sources in 2010 for HIV-related care and treatment, including medications, were private insurance and federal funding sources such as Medicaid, Medicare, and the Ryan White HIV/AIDS Program. Unfortunately, the $12.2 billion in federal funding requested for all Ryan White Parts in the FY 2010 budget represents a 1% increase from FY 2009.

The main components of the federal Ryan White HIV/AIDS Program that pay for medications are the AIDS Drug Assistance Program (ADAP) and the Local AIDS Pharmaceutical Assistance Programs (LAPA). ADAP is available in every U.S. state and territory for persons who are low income, living with HIV and uninsured—although eligibility criteria and formulary medications vary from state to state.

Kaiser Family Foundation http://www.kff.org

Provision of Medical Case Management and Support Services

What does SHP do? *Contracts with community-based agencies to provide medical and non-medical case management and other critical supportive services to assist people living with HIV access medical care.*

Area covered: *Statewide, but excludes the New Orleans and Baton Rouge areas where Ryan White resources for similar services are awarded to these cities directly by HRSA.*

Medical and non-medical case management is a service that helps eligible clients navigate HIV medical care systems and access other support resources. Case managers help clients access supportive services through federal, state, and local community-based programs. When available, Ryan White Part B funding maybe utilized when there are no other resources to pay for oral health care services, transportation to medical appointments, mental health and substance use treatment services, emergency assistance payments and nutritional services.

- Of those persons known to be living with HIV infection outside of the Baton Rouge and New Orleans metropolitan areas, 2,307 persons received medical case management in 2010 supported by Ryan White Part B resources. An additional 1,719 received non-medical case management services.

- Oral healthcare needs for persons with HIV can be more pronounced than those of the general population due to side effects of the prescribed medications. When combined with poor oral health care histories, those persons seeking dental care may have more severe or more urgent needs.[20]

- The availability of medical transportation to low-income persons living with HIV infection is crucial to their access to medical care, especially in rural areas.

Payment of Health Insurance Premiums, Co-payments and Deductibles

What does SHP do? *Contracts with a single entity for the payment of health insurance premiums, co-payments, or deductibles for eligible clients.*

Area covered: *Health insurance premiums are paid for clients statewide, and the co-payment and deductible program was expanded to the New Orleans area on January 1, 2012.*

SHP's Ryan White Part B program supports comprehensive health insurance services to assist eligible clients maintain or obtain health insurance coverage. These services are provided through the Louisiana Health Insurance Program (HIP). Clients access these services by applying directly to the entity that administers the program or through the local agency that provides HIV medical case management services.

In 2010, SHP expended nearly $2,800,000 to provide insurance premium assistance and cost share assistance (i.e., co-payments or payments toward a deductible requirement) to 1,114 persons. Without this resource, the cost of their comprehensive HIV care would have been absorbed by other federal and state resources.

What is Ryan White Funding?

The Ryan White HIV/AIDS Program was first authorized by federal legislation in 1990 and was funded at $2.1 billion in 2010. The program is for those who do not have sufficient health care coverage or financial resources for coping with HIV disease. Ryan White fills the gaps in care not covered by these other resources. The majority of Ryan White HIV/AIDS Program funds support primary medical care and essential support services. A smaller but equally critical portion is used to fund technical assistance, clinical training and research on innovative models of care. Federal funds are awarded to cities, states, and local community-based organizations to provide HIV-related services to more than half a million people each year, under funding categories called Parts, as outlined below.

- ***Part A:*** *Grants to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs*)
  Provides grants to areas most severely affected by the HIV epidemic. In Louisiana, the cities of New Orleans and Baton Rouge receive awards directly from HRSA under Part A.
- ***Part B:*** *Grants to States and Territories*
  Provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a formula-driven Base award, ADAP earmark, and ADAP supplemental allocation, as well as a competitive Part B supplemental grant. These annual awards are made directly to the state of Louisiana and are administered through SHP.
- ***Part C:*** *Early Intervention Services (EIS) through Community-Based Non-Profit Entities*
  Funds comprehensive primary health care in an outpatient setting for people living with HIV infection. Eight clinics in Louisiana are currently supported through this resource. Part C funding from HRSA is the state's third major funding source for primary medical care for HIV-infected individuals living in Louisiana, after the allocation of state funds and federal reimbursements through Medicare and Medicaid.
- ***Part D:*** *HIV Healthcare for Women, Infants, Children, and Youth*
  Provides for family-centered outpatient or ambulatory care and support services for women, infants, children, and youth with HIV. In Louisiana there are three awards for services which are delivered in eight regions of the state.
- ***Part F:***
  - *Special Projects of National Significance (SPNS) Program*
    SPNS grants fund innovative models of care and support the development of effective delivery systems for HIV care. In Louisiana, three entities received funding through SPNS in 2010.
  - *AIDS Education and Training Centers (AETC) Program*
    Supports a network of 11 regional centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV infection. The AETC for Louisiana, Mississippi and Arkansas is based in New Orleans, LA.
  - *Dental Programs*
    Provides funding for oral health care services for people with HIV through the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP). The LSU School of Dentistry is the single grantee for the provision of these services in the state.
  - *Minority AIDS Initiative (MAI)*
    Provides funding to evaluate and address the disproportionate impact of HIV on African Americans and other minorities. In Louisiana, MAI funding is allocated annually to the Part A grantee (New Orleans), the TGA (Baton Rouge) and Part B (SHP).

Housing and Housing-Related Services: Louisiana's Formula Housing Opportunities for Persons with AIDS Program

SHP administers the State Formula Housing Opportunities for Persons With AIDS (HOPWA) program, funded by the federal Department of Housing and Urban Development (HUD). (See "What is the State Formula HOPWA Program?" on the next page for an overview of the federal program). The primary goal of HOPWA is to ensure stable housing for people living with HIV to prevent homelessness.

SHP's HOPWA services are available to eligible clients (those living at or below 80% of the Area Median Income or AMI) living outside of the New Orleans and Baton Rouge metropolitan statistical areas (MSAs). Similar services are available in those areas through HOPWA resources that are awarded directly to those city governments. SHP's main HOPWA services include:

- Short-term rent, mortgage, and/or utility payments to support eligible clients in their current housing;
- Tenant-based rental subsidies to maintain long-term housing;
- Operating costs and supportive services for residential facilities that are providing comprehensive housing services to persons with HIV;
- Permanent Housing Placement Services that help to pay rent and utility deposits and some moving expenses; and
- Identification of other housing resources within a community.

The federal HOPWA administration has set a goal for 2010 that 80% of all persons served through the State Formula HOPWA will be stably housed by the end of that program year. Currently, SHP estimates that Louisiana's State Formula HOPWA program has achieved stable housing for 72% of individuals served by the program. SHP continues to work toward meeting the 2010 HUD goal, even with reduced housing stock in many of the hurricane-impacted areas of the state. In 2010, there were 804 persons living with HIV infection who received housing services through State Formula HOPWA and an additional 539 family members who benefited from this assistance, for a total of 1,343 unduplicated individuals.

- Of the 804 HIV-infected clients who received housing services in 2010:
  - 25 were Veterans
  - 63 met the HUD definition of being chronically homeless
  - The vast majority (73%) had an income at or below 50% of the median income for their parish of residence
- Of the 1,343 beneficiaries of HOPWA-funded services in 2010:
  - 55% were male and 45% were female
  - 67% identified themselves as black/African American
  - 28% were dependent minors under the age of 18, 40% were persons between the age of 31-50, and 14% were 50 or older

How does stable housing affect health for people living with HIV?

The Community Health Advisory & Information Network (CHAIN) project is an ongoing prospective study of persons living with HIV in greater New York City conducted by the Mailman School of Public Health at Columbia University. This study has consistently found over the past 10 years that homeless individuals accessing supportive housing were more likely to engage in primary medical care than individuals who only accessed case management services. Stable housing was also shown to increase the possibility of being prescribed anti-retroviral medications. Additionally, those who received housing assistance were 2.5 times more likely to retain appropriate medical care as those who did not receive the assistance.

What is the State Formula HOPWA Program?

The U.S. Department of Housing and Urban Development (HUD) began the Housing Opportunities for Persons with AIDS (HOPWA) program in 1992 to address the specific needs of persons living with HIV and their families. This program is guided by the Fair Housing Act of 1968, as amended in 1990 to include the Americans with Disabilities Act. HOPWA distributes 90% of its program funds using a statutory formula that relies on AIDS statistics from the Centers for Disease Control and Prevention (CDC). Three quarters of HOPWA formula funding is awarded to qualified states and metropolitan areas with the highest number of AIDS cases. One quarter of the formula funding is awarded to metropolitan areas that have a higher-than-average per capita incidence of AIDS.

HOPWA State Formula Grants are awarded upon submission and HUD approval of a Consolidated Plan pursuant to the Code of Federal Regulations (24 CFR Part 91), which is published by the Office of the Federal Register. Metropolitan areas with a population of more than 500,000 and at least 1,500 cumulative AIDS cases are eligible for HOPWA Formula Grants. In these areas, the largest city serves as the Formula Grant Administrator. States with more than 1,500 cumulative AIDS cases (in areas outside qualifying cities that are eligible to receive HOPWA funds) are eligible to receive HOPWA State Formula Grants. Louisiana is a qualifying state.

HOPWA makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons medically diagnosed with HIV infection and their families. The funds can be utilized to:

- identify new housing options;
- pay rent, mortgage, and utilities in specific circumstances;
- support the operating costs of housing programs for persons living with HIV;
- provide supportive services that maintain persons in housing; and
- support the acquisition, rehabilitation, and development of housing specifically for persons living with HIV and their families.

Measuring the Service Needs of Persons Living with HIV

Similar to the 2008 Needs Assessment, the 2011 Needs Assessment consisted of a facility-based survey to consumers of HIV services using a self-administered instrument in both English and Spanish in the New Orleans EMA, and Regions 3 through 9. Peer coordinators were used to assist consumers in completing the survey instrument and to coordinate the return of completed surveys.

The 2011 survey instrument was a revised and adapted version of the 2008 Needs Assessment. Revisions to the instrument were made by SHP, with input from the New Orleans Regional AIDS Planning Council (NORAPC) and consumers. The instrument covered eight domains: general information; employment and income; medical care; housing; incarceration; mental health services; substance use services; and, supportive services.

The sampling approach relied solely upon convenience sampling. Any person living with HIV infection who was present at any of the participating agencies and was at least 13 years old during the survey administration period was eligible to complete the survey. Staff from SHP, NORAPC and the external contractor were in regular communication with each participating agency during the administration of the Needs Assessment to ensure that sampling targets were being met.

The Needs Assessment was conducted with the cooperation of 12 agencies across the state. One person at each agency was identified as the agency representative, serving as the point of contact for the external contractor. Peer coordinators were assigned to work in each agency and manage administration and collection of surveys. All individuals who were involved with the administration of the Needs Assessment

attended a training conducted by SHP or NORAPC. The training covered the administration of the survey, the instrument, management of incentives, and confidentiality agreements.

Receptionists, case managers, and peer coordinators were all involved in recruiting participants for the survey. Each consumer who agreed to complete the survey was given a survey packet, which included the paper version of the survey, instructions, an envelope in which to place the completed survey, and a pen. The instruction sheet explained the purpose of the Needs Assessment, how long it would take to complete the survey, that the survey was completely voluntary, and a reminder that respondents could only complete one survey. Consumers were assured that the survey was completely confidential, that their responses would not be used to identify them, and that the information collected would be used only for planning purposes. Consumers also were instructed not to write any identifying information on the survey itself or on the accompanying envelope. When available, consumers were given a private space where they could complete the survey. Peer coordinators and agency staff were available to assist participants as needed.

The external contractor made every effort to protect respondent confidentiality and privacy. In cases where the respondent's identity might reasonably be revealed with the data available, data was not published. This was also true where the number of cases in a cell was fewer than five or such other number which could, in the opinion of the researchers, result in the disclosure of confidential personal information.

The Needs of Persons Living with HIV Infection

The 2011 Needs Assessment was designed to gain a greater understanding of the current care service needs of low income persons residing in the New Orleans EMA and Regions 3-9, estimate the Unmet Need in primary medical care and HIV-related support services, and illuminate barriers to clients accessing and receiving those services. During the months of April and May 2011, 947 surveys were completed and returned for data entry and analysis—501 from the New Orleans EMA catchment area and 446 from Regions 3-9.

The respondents were similar in demographics to those persons receiving primary medical care and support services through Ryan White Parts A and B, ostensibly because the venues that were promoting the survey were heavily funded by Ryan White resources.

Demographic Information of Survey Respondents

- 61% were male, 36% female, 3% transgender.
- 68% were black, 27% were white, 5% identified as Hispanic/Latino.
- 15% were 13-29 years of age, 54% were 30-49 years of age and 31% were 50 years or older.
- 98% were US citizens.
- 30% had not completed high school, 7% had completed vocational training, 19% had completed some college, and 12% had a college degree.
- 62% were single or living alone, only 9% were married
- 6% of the female respondents were currently pregnant or had been pregnant in the last twelve months.

HIV Infection Status and History

- 85% were given their HIV diagnosis in Louisiana.
- 52% were HIV infected with no symptoms; 22% were HIV infected with symptoms and 23% had been diagnosed with AIDS. Unfortunately, 3% did not know their HIV health status.
- 38% of respondents were told of their HIV status in a hospital or Emergency Department; 22% were diagnosed at a local health center, 17% were advised of their status at a community based organization, and 11% received their diagnosis in a private doctor's office.

Employment and Income

- 71% of the respondents had not worked in the last six months, primarily due to health concerns and disability status; however, 13% were working full time.
- 24% reported having no income, 43% reported a monthly income of $1-$500, and 30% reported a monthly income of $501-$1000.
- Of those who responded, only 16% indicated that they had a source of income from a wage, stipend or salary. Nearly half received Food Stamps (43%), while 33% indicated that they had Supplemental Security Income (SSI), and 28% reported that they had Social Security Disability Insurance (SSDI).

Medical Care

- 42% indicated that they had Louisiana Medicaid and 30% were covered by Medicare. Nearly a third (31%) had no insurance, and only 5% had insurance coverage through their job.
  - 74% of people without health insurance said they could not afford insurance and 18% said they did not qualify.
- 57% reported that they were connected to care within one month of their diagnosis, and another 25% reported that they had received HIV-related medical care within one to six months after their diagnosis.
  - For those who did not get into care within 6 months of their diagnosis, 55% said they weren't ready to deal with their HIV status, 21% said they did not feel sick, 18% did not want anyone to know they were HIV-positive, 17% did not know where to go, 15% said they had too many other things to worry about, 12% couldn't afford it, 11% were homeless, and 8% couldn't get transportation.
- 87% of all respondents said they had received HIV-related medical care in the 6 months prior to survey completion.
  - Of those who did receive care, 74% went to an HIV clinic in a hospital/medical center, 13% went to a community clinic that serves only HIV-positive clients, and 5% when to a private physician.
- A majority of respondents (89%) indicated that they are taking HIV medication prescribed by a physician. Unfortunately, only 19% reported that they take their medicine most or some of the time.

Service Referrals and Linkage to Care

- 76% were referred into Medical Care at the time of their diagnosis and 57% received a referral for Case Management; 34% of respondents were referred to Health/HIV Education and 32% received a referral for a HIV Support Group. Unfortunately, 19% were not referred to any services.

Of those who responded to questions about service utilization:

- 85% indicated that they used Outpatient Medical Care and 65% reported that they had accessed Medication programs.
- A majority also reported utilizing Dental Care and Treatment/Adherence Counseling (65% and 51% respectively).
  - 50% did not receive needed Dental Care services, 26% did not receive needed Outpatient Medical Services, and 18% did not receive needed Medication programs.
- These results were not surprising, given the statewide ADAP Unmet Need list and the drastic cuts that were made in Outpatient/Ambulatory Medical Care and Oral Health Care in the FY 2010 cost containment efforts—prior to initiating the Unmet Need list.

For additional findings, the 2011 Needs Assessment can be found in its entirety on the Louisiana DHH website at http://www.dhh.louisiana.gov/reports.asp?ID=264&Detail=612.

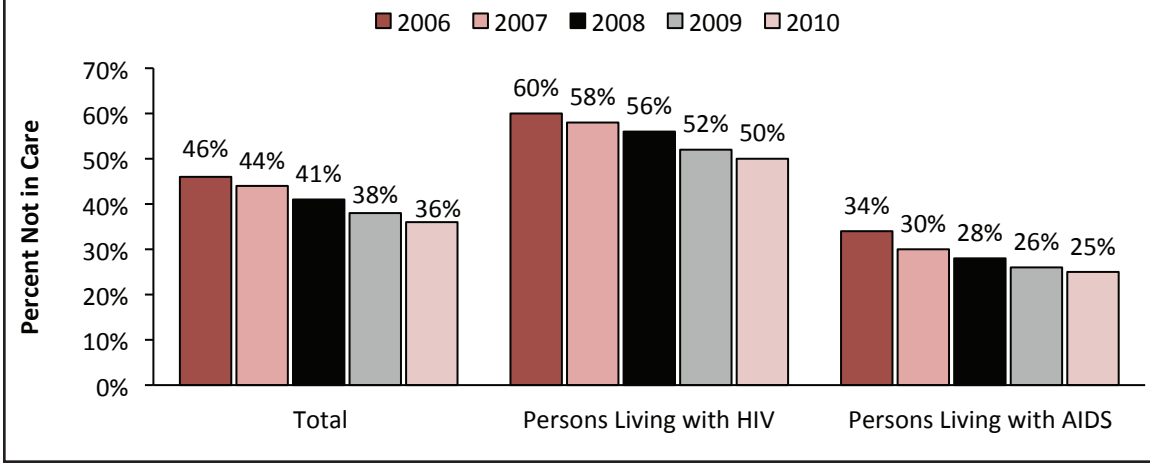
Assessing "Unmet Need" and Allocating Resources in Louisiana

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. As part of the annual resource planning and allocation processes, the federal Ryan White HIV/AIDS Program requires that Part A and B grantees take into consideration "unmet need" for primary medical care in their jurisdiction. 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.

The allocation of resources to reduce the amount of consumer unmet need is further supported by the current legislative requirements in the Ryan White HIV/AIDS Treatment Extension Act of 2009. Both Part A and Part B grantees must allocate a minimum of 75% of their annual award to Core Services in an effort to link low income HIV-infected persons into primary medical care and maintain them in those crucial services. Core Services for Part B include ADAP, Health Insurance Premium and Cost-Sharing Assistance, Core Medical Services (i.e., Ambulatory/Outpatient Medical Care, Local AIDS Pharmaceutical Assistance, Medical Case Management, Mental Health Services, Substance Use Treatment Services and Oral Health Care), Home- and Community-Based Care, Early Intervention Services, and Medical Nutrition Therapy. Support services may not exceed 25% of the annual Ryan White resource allocation and must be utilized to fund services that will engage a client with an HIV-related health care provider and support them in remaining in care, such as medical transportation.

In Louisiana, SHP's Surveillance Unit provides the data for estimating 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.

Unmet Need by Year and Status
Louisiana, 2006-2010



- The overall percentage of persons has steadily decreased since 2006 to 36% of all persons living with HIV infection in 2010.
- 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 seek out more frequent medical visits.

Unmet Need for Primary Medical Care Louisiana, 2010		
	2010	
	Percent in Care	**Percent Not in Care (Unmet Need)**
Overall	**64%**	**36%**
Persons living with HIV	50%	50%
Persons living with AIDS	75%	25%
Sex		
Female	70%	30%
Male	61%	39%
Race/Ethnicity		
Black/African American	64%	36%
Hispanic/Latino	44%	59%
White	65%	35%
Age Group		
0-12	80%	20%
13-24	66%	34%
25-44	63%	37%
45-64	64%	36%
65+	62%	38%
Region		
1-New Orleans	59%	41%
2-Baton Rouge	71%	29%
3-Houma	75%	25%
4-Lafayette	65%	35%
5-Lake Charles	54%	46%
6-Alexandria	62%	38%
7-Shreveport	60%	40%
8-Monroe	65%	35%
9-Hammond/Slidell	70%	30%

- Of persons living with HIV infection in 2010, only 64% had at least one primary medical care visit during the year.[21] Persons living with AIDS were more likely to have a medical visit (75%) compared to persons living with HIV (50%).
- Females, non-Hispanics, and persons under the age of 13 were also more likely to be receiving medical care.
- Persons residing in the Houma and Hammond/Slidell regions were most likely to be in care, while persons in the Lake Charles and New Orleans area were least likely to be in care.

Case management and supportive services provided to eligible clients through Ryan White and HOPWA resources are critical in linking HIV-positive persons to medical care and helping them access HIV-related care routinely. A very high percentage of clients who received Ryan White services in 2010 were successfully maintained in care during the program year.

Ryan White Clients in Care Louisiana, 2010			
	Total Client Number	**Number in Care**	**In Care %**
Tenant Based Rental Assistance (TBRA)	126	119	94.4%
Stably Housed	2,269	2,031	89.5%
Health Insurance Program (HIP)	1,200	1,140	95.0%
AIDS Drug Assistance Program (ADAP)	3,110	2,990	96.1%
Mental Health Services	141	129	91.5%
Substance Use Treatment Services	24	23	95.8%

* had a CD4 and/or VL in 2010

- NOTE: The unmet need estimate should be considered a maximum estimate. While Louisiana has comprehensive laboratory reporting requirements, laboratory reporting is not 100% complete. In addition, some people included in the surveillance system as living in Louisiana may have moved out of state or died. While SHP monitors lab reporting carefully and updates out of state information and vital status, this information is not complete.

HIV Care and Services Accomplishments and Challenges

AIDS Drug Assistance Program: Without a doubt, the most significant challenge faced by the Louisiana Ryan White Part B Program in 2010 was the projected shortfall of funding for LA ADAP, resulting in capped enrollment starting June 1, 2010. The re-allocation of Part B resources to Louisiana ADAP resulted in the reduction or discontinuation of supportive community services in the areas of the state outside of New Orleans and Baton Rouge. Despite these challenges, staff continued to strive towards improving services throughout the state.

Improved Data Management System: SHP has continued to customize CAREWare to improve its data reporting system. With the onset of required client-level data reporting, SHP staff have worked towards assessing and improving the functions of CAREWare, as well as training contracted providers to enter all data in a timely manner. In 2010, SHP received a HRSA Special Projects of National Significance (SPNS) information technology (IT) grant to establish a centralized storage network for four HRSA Ryan White grantees in the state. Partners include Part A New Orleans, Part A Baton Rouge, Part B Louisiana OPH SHP, and Part C NO/AIDS Task Force. Once this system is complete, providers will be able to share data on clients enrolled in multiple services, improving their ability to assess client needs, coordinate services across systems, and evaluate health outcomes.

Chapter 3

HIV Prevention

Introduction to HIV Prevention

The Louisiana Office of Public Health STD/HIV Program (SHP) Prevention Unit is responsible for behavioral interventions, educational activities and HIV testing/screening services that are focused on reducing the spread of HIV in the state. The program is supported with funding from the Centers for Disease Control and Prevention (CDC) and private foundation funding. The Prevention Unit is also charged with STD prevention activities discussed in the *STD Prevention and Services* chapter of this report.

Since the onset of the HIV epidemic during the early 1980's, targeted populations and interventions for reducing the spread of HIV have changed in response to shifts in the epidemic. HIV prevention is not a stagnant set of activities. Instead, HIV prevention has and will continue to change throughout the epidemic. SHP's HIV prevention activities currently focus on several areas:

- intervening with HIV-positive individuals to support and nourish their overall health and well-being, as well as empowering them to prevent the transmission of HIV;
- reducing stigma and understanding the impact it has on prevention efforts and those impacted by HIV;
- utilizing holistic outreach/recruitment services and integrated health services as a means to connect individuals to needed services;
- implementing evidence-based interventions; and
- providing a continuum of prevention programs and services rather than isolated programs, and addressing the range of issues that put individuals at risk of becoming infected with HIV or transmitting HIV, such as mental health issues, substance abuse, partner violence, unemployment, poverty, homelessness and other social and health issues.

In accordance with the National HIV/AIDS Strategy, the Prevention Unit will focus efforts to:

- intensify HIV prevention efforts in communities where HIV is most heavily concentrated;
- expand targeted efforts to prevent HIV infection using a combination of effective, evidence-based approaches; and
- educate persons in Louisiana about the threat of HIV and how to prevent it.

HIV prevention activities are focused on conducting or coordinating the following activities:

- HIV counseling, testing, referral and linkage services (CTRLS)
- Partner Services (PS)
- outreach/recruitment to high-risk individuals
- other behavioral interventions
- programs targeting HIV-positive individuals
- dissemination of HIV educational materials
- training and technical assistance on HIV CTRLS and other prevention interventions
- a statewide toll-free information line, "Infoline," for HIV, STD, hepatitis, and TB-related information and referrals (1-800-99-AIDS-9)
- a website with population specific information and referrals – www.HIV411.org
- a statewide, integrated planning process that includes state and local Ryan White jurisdictions, as well as CDC funded HIV prevention services/activities
- HIV awareness raising, stigma reducing events/activities
- integrated prevention services (i.e., LA Wellness Center Project)
- HIV prevention in Latino communities
- enhancing collaboration among community stakeholder groups (community-based organizations (CBOs), parish health units (PHUs), etc.)
- conducting process and outcome evaluation of prevention programs

National HIV/AIDS Strategy
Reduce New Infections

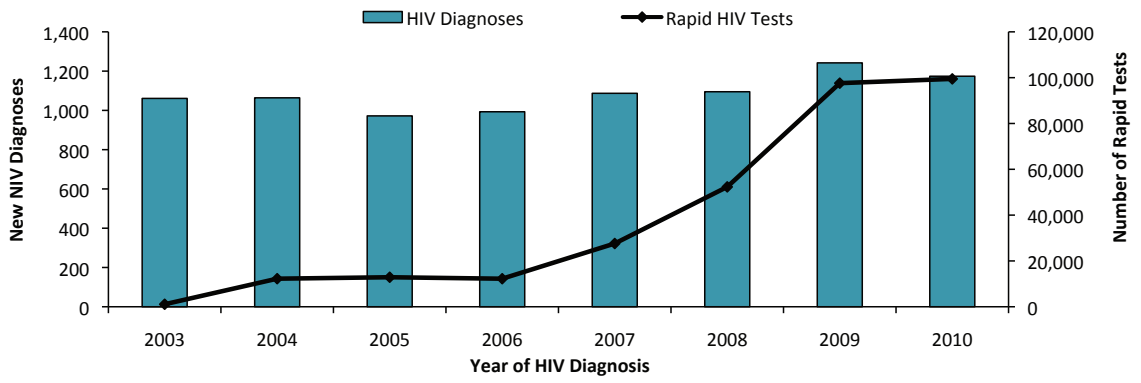
2015 Objectives:

- Lower the annual number of new infections by 25%.
- Reduce the HIV transmission rate by 30%.
- Increase from 70%-90% the percentage of people living with HIV who know their serostatus.

In 2011, Louisiana completed an incidence estimate to determine the number of new HIV infections in 2006, 2007 and 2008 in Louisiana. Review of this incidence estimate can be found in the HIV Surveillance chapter of this report.

In 2007, there was a large expansion of HIV rapid testing, particularly in emergency departments and correctional facilities. The CDC estimates that 20% of people who are infected with HIV are unaware of their status. Applying this percentage to the approximately 17,700 persons known to be living with HIV in Louisiana at the end of 2010, there are an estimated 4,425 persons either unaware of their status or undiagnosed living in Louisiana. Continued support of expanded rapid testing will increase the number of HIV diagnoses and decrease the number of people living with HIV who are unaware of their status.

New HIV Diagnoses and Number of Rapid Tests
Louisiana, 2003-2010



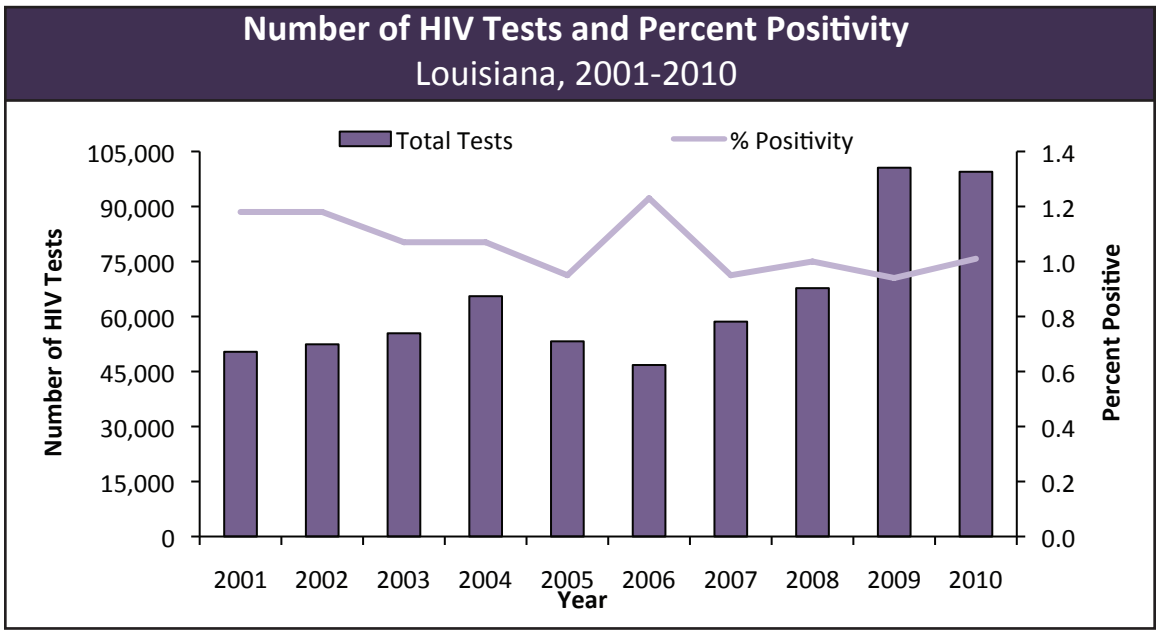
National HIV/AIDS Strategy (www.thewhitehouse.gov)

HIV Counseling, Testing, Referral and Linkage Services (CTRLS)

What does SHP do? *Ensures access to no-cost HIV testing*
Area covered: *Statewide*

SHP supports HIV testing through contracts with CBOs and through partnerships with parish health units (STD, family planning, TB, and prenatal clinics), hospital emergency departments, correctional facilities, substance abuse treatment programs, Federally Qualified Health Centers (FQHCs), and school-based health clinics. For persons who test positive, counseling, referral and linkage services (CTRLS) are provided to link individuals to medical care and other support services.

The graph below illustrates the number of HIV tests conducted through SHP's HIV CTRLS program. In 2010, there were a total of 99,465 HIV tests conducted, of which 1% were positive.



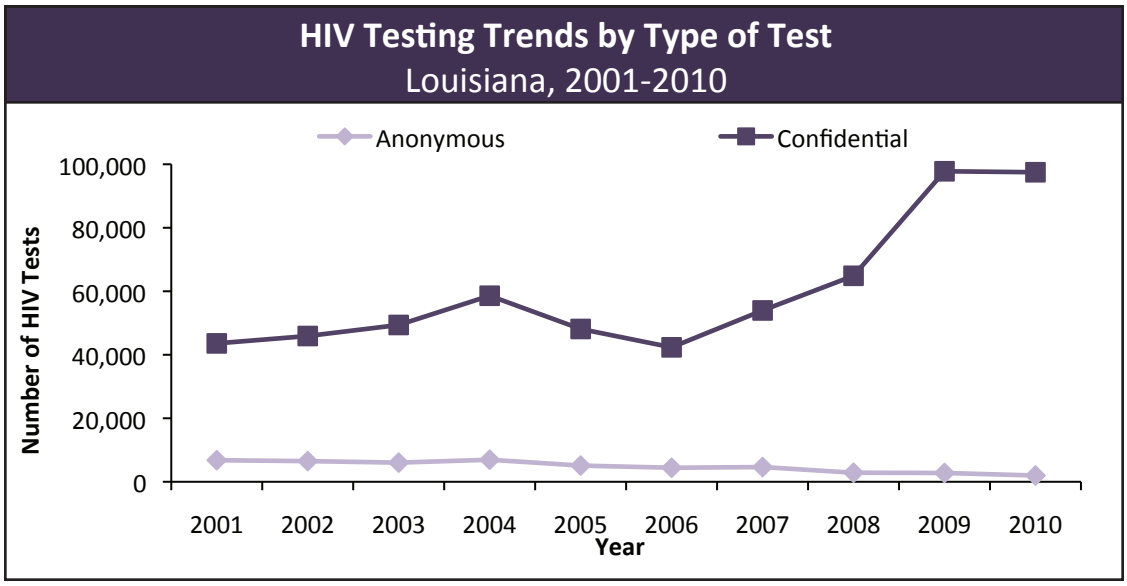
- Between 2000 and 2009, the number of HIV tests conducted has varied between a low of 46,769 tests in 2006 following testing disruption due to Hurricane Katrina, to a high of 100,571 tests in 2009. In 2010, there was a small decrease in the number of tests conducted but an increase in the number of positive tests obtained. Over the past ten years, the percent positivity rate has fluctuated around 1.0% with a peak of 1.2% in 2006.

- There were 1,006 persons found to be HIV-positive in 2010 through the state's publicly funded testing programs, accounting for 1.0% of the total tests. A total of 51% of the persons with an HIV-positive test were new HIV diagnoses to the HIV Surveillance system.

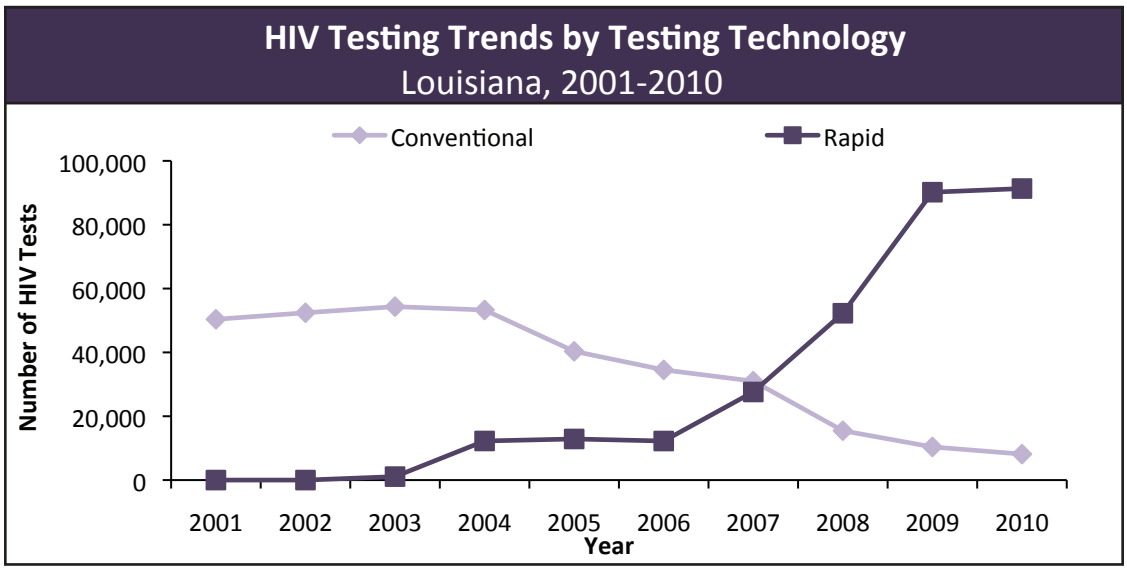
In Louisiana, both confidential and anonymous testing are offered.

- Confidential testing - the testing center records the person's name along with the results of his/her test. The only people with access to the test results are appropriate testing site personnel and appropriate SHP staff. Confidential testing is encouraged, as it facilitates entry into care for HIV-positive persons and allows for more accurate monitoring of the testing program, as well as patterns in risk behaviors reported by patients/clients.

- Anonymous testing - the tester's name is not given to the testing center and only the person who is having the test is aware of the results.



- The vast majority of tests in Louisiana are confidential, and the number of anonymous tests has decreased since 2000. From 2001 to 2010, the percentage of all tests that were confidential increased from 86% to 98%.



- In October 2007, Louisiana began an HIV testing initiative with the main goal of increasing the number of African Americans who are tested. Through this initiative, the use of rapid HIV tests and the locations where these tests were available was significantly expanded. The rapid HIV test allows individuals to receive their results in 10-20 minutes (depending on the device used and testing protocol at the site) and can easily be done at different testing locations that lack laboratory facilities required for conventional tests. In 2003, when rapid HIV testing began in Louisiana, 2% of the total tests were rapid and by 2010, 92% of the total tests were rapid tests.

The table below provides the characteristics of those receiving a SHP-funded HIV test in 2010.

HIV Tests by Characteristic
Louisiana, 2010

	Total Number Of Tests	% of Total Tests	Number of Positive Results	% Positivity Rate
Total	**99,465**	**100%**	**1,006**	**1.0%**
Gender				
Female	49,181	49.8%	246	0.5%
Male	49,549	50.2%	753	1.5%
Transgender - M to F	29	0.0%	7	24.1%
Transgender - F to M	4	0.0%	0	0.0%
No Gender Specified	*702*	-------	*0*	*0.0%*
Race/Ethnicity				
American Indian/Alaska Native	125	0.1%	2	1.6%
Asian/Pacific Islander	696	0.7%	6	0.9%
Black/African American	64,628	68.6%	790	1.2%
Hispanic	3,271	3.5%	18	0.6%
White	25,303	26.8%	154	0.6%
Multi-race	230	0.2%	6	2.6%
No Race/Ethnicity Specified	*5,212*	-------	*30*	*0.6%*
Age Group				
0-12	244	0.3%	0	0.0%
13-19	10,789	11.1%	28	0.3%
20-29	44,506	45.8%	369	0.8%
30-39	19,937	20.5%	252	1.3%
40-49	12,337	12.7%	224	1.8%
50+	9,307	9.6%	120	1.0%
No Age Specified	*2,345*	-------	*13*	*0.6%*
Transmission Category				
Men Who Have Sex with Men (MSM)	3,636	7.3%	268	7.4%
Heterosexual	44,848	90.4%	144	0.3%
Heterosexual/Injection Drug User (IDU)	1,036	2.1%	35	3.4%
MSM/IDU	77	0.2%	10	13.0%
No Risk Specified	*14,999*	-------	*118*	*0.8%*
Risk Information Not Reported	*34,869*	-------	*431*	*1.2%*

- Of the tests with a reported race, blacks accounted for 69% of total tests, compared to 67% of total persons living with HIV infection and 76% of total new diagnoses in 2010.
- Of the tests with reported gender, males accounted for 50% of the total tests while accounting for 71% of total persons living with HIV infection and 67% of total new diagnoses.
- Of the 49,597 tests that were reported with a risk, MSM accounted for only 7% of the tests while accounting for 45% of total persons living with HIV and 53% of total new diagnoses; heterosexuals accounted for 90% of the total tests while accounting for only 29% of total persons living with HIV and 31% of total new diagnoses. More work must be done to test a greater percentage of males and specifically MSM; however, risk information is not collected at the hospital emergency departments or at state correctional facilities, so the true number of MSM tested may be greater than the number reported here.
- Males had a higher positivity rate than females, and male-to-female transgender persons and MSM and MSM/IDUs had the highest percent positivity.

HIV Tests by Characteristic Louisiana, 2010				
	Total Number Of Tests	**% of Total Tests**	**Number of Positive Results**	**% Positivity Rate**
Total	**99,465**	**100%**	**1,006**	**1.0%**
Testing Site Type				
Parish Health Units - Clinic not specified	9,372	9.4%	34	0.4%
Sexually Transmitted Disease Clinics	30,925	31.1%	234	0.8%
Family Planning Clinics	7,191	7.2%	11	0.2%
Prenatal/OB-GYN Clinics	325	0.3%	1	0.3%
Tuberculosis Clinics	1,613	1.6%	6	0.4%
Community Based Organizations	10,640	10.7%	217	2.0%
Emergency Departments	15,027	15.1%	241	1.6%
State Drug Treatment Programs	2,397	2.4%	11	0.5%
Prisons/Parish Jails	17,261	17.4%	198	1.1%
Community Health Clinics	1,918	1.9%	27	1.4%
School/University	2,237	2.2%	14	0.6%
Other	559	0.6%	12	2.1%
Region				
1-New Orleans	36,022	36.2%	446	1.2%
2-Baton Rouge	15,713	15.8%	256	1.6%
3-Houma	2,969	3.0%	27	0.9%
4-Lafayette	9,784	9.8%	74	0.8%
5-Lake Charles	5,502	5.5%	37	0.7%
6-Alexandria	4,587	4.6%	21	0.5%
7-Shreveport	8,643	8.7%	75	0.9%
8-Monroe	7,963	8.0%	38	0.5%
9-Hammond/Slidell	8,282	8.3%	32	0.4%

- Persons testing in PHUs, which includes STD clinics, family planning clinics, prenatal/OB-GYN clinics, and TB clinics, accounted for 50% of all of the HIV tests and 28% of all positive tests in 2010.
- Emergency departments accounted for 15% of the total HIV tests and had the largest number (241) of positive results among all of the publicly supported HIV testing sites.
- CBOs, correctional facilities, and community health clinics were among the testing sites with the highest positivity rates in 2010.
- The New Orleans region conducted the greatest number of tests and had the second highest positivity rate (1.2%) of all nine public health regions. The Baton Rouge region conducted the second highest number of HIV tests but had the highest positivity rate (1.6%).

What are the Current CDC Testing Guidelines?

In 2006, the CDC released *"Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings."* The CDC and the U.S. Preventive Services Task Force recommends that screening for HIV should be performed routinely for all patients aged 13-64 years; all patients initiating treatment for TB should be screened routinely for HIV; all patients seeking treatment for STDs should be screened routinely for HIV during each visit for a new complaint; and all pregnant women should be screened, regardless of risk. The goal of these recommendations is to increase the number of HIV-positive persons who know their HIV status.

Louisiana responded to these recommendations in 2007 with House Bill 512, now signed into Louisiana's Revised Statue Chapter 40, sections 1300.12-13. Louisiana's HIV testing and counseling legislation now stipulates:

- HIV diagnostic testing offered as a routine medical screening will now be "opt-out" in certain settings such as hospital emergency rooms, STD clinics, correctional facilities, and drug treatment programs. This means persons certified to offer HIV tests will inform the person that an HIV test will be performed unless the patient refuses. If the patient decides to "opt out," it will be recorded in their medical record.
- The legislation now also stipulates that the opt-out testing can take place in healthcare settings, substance abuse treatment facilities, mental health treatment facilities, and correctional settings. Community-based settings must follow all of SHP's protocols.
- Opt-out testing will also be performed on all women who are pregnant.
- Physicians have the option of testing newborns who they feel are at high risk of having been exposed to HIV and whose mother does not have an HIV test result on record.
- Anyone receiving a positive HIV antibody test must be referred to follow-up medical services.

This expansion of legal authority allows Louisiana to further focus and expand HIV testing initiatives. The statutory changes also led to a complete revision of SHP's *Prevention Policies and Procedure Manual* detailing protocols, methods, and reporting requirements for all testing sites across the state. There are ongoing training programs for all persons involved in HIV testing.

Partner Services (PS)

What does SHP do? *Outreach to individuals newly diagnosed or newly reported with HIV to help ensure awareness of diagnosis and access to care, as well as to identify and anonymously inform partners of possible exposure to HIV and offer testing and referral to services.*

Area covered: *Statewide*

Partner Services (PS) is a high priority intervention in the CDC HIV Strategic Plan. PS is offered to persons who test positive for HIV to provide post-test counseling and referral into care, assist them in contacting their sexual and/or needle-sharing partners, as well as ensure that people are not only aware of their status but also understand what it means. PS provides an important opportunity to link HIV-positive individuals to care and case management, if needed. PS also reaches persons not receiving HIV CTRLS in other venues and provides HIV prevention education for both high-risk negative and HIV-positive individuals. Persons who test positive for syphilis are also contacted through PS as detailed in the *STD Prevention and Services* Chapter.

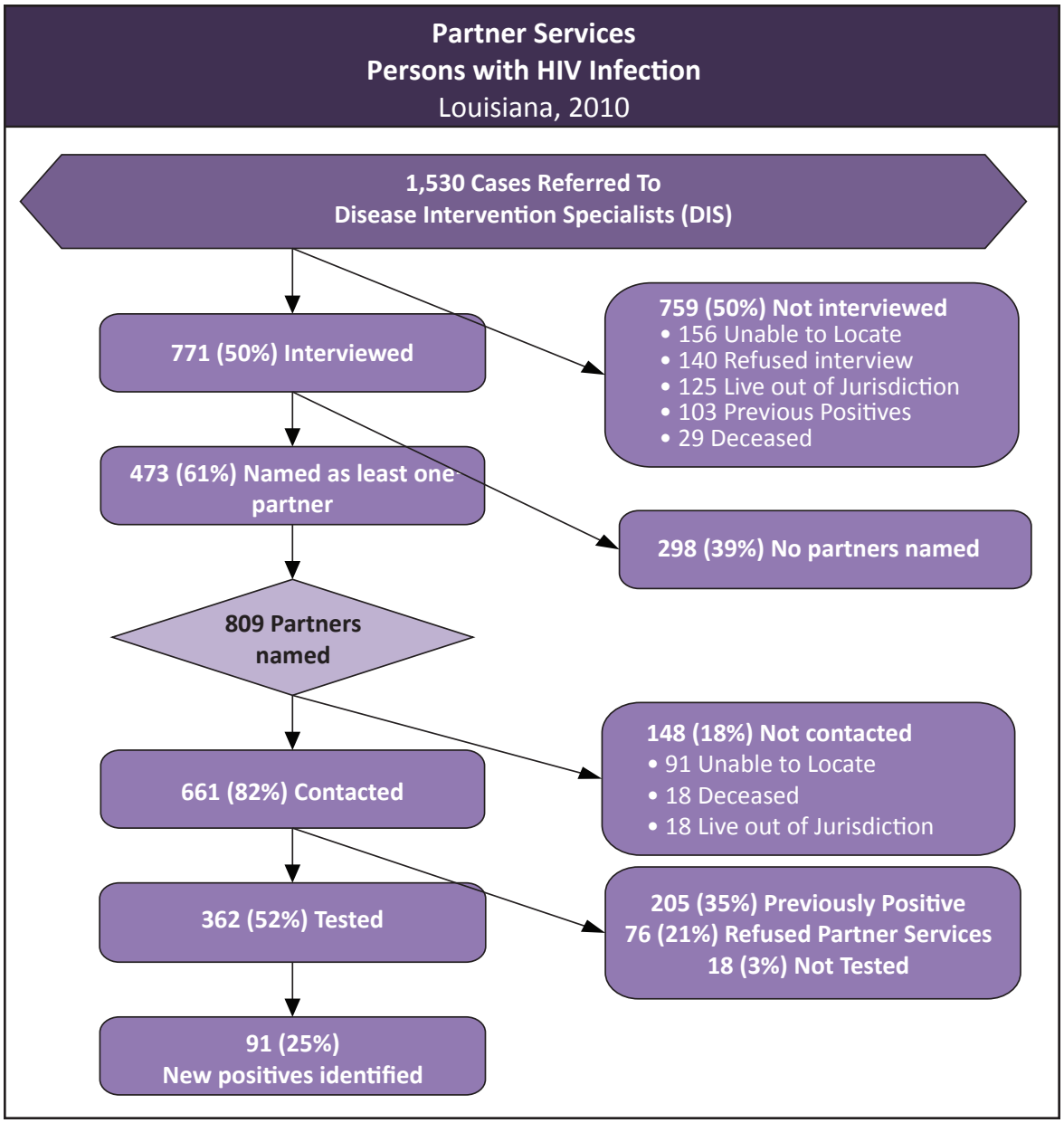
SHP maintains a cohesive, working relationship with CBOs, hospitals, and other health care providers to ensure all individuals newly diagnosed with HIV are offered PS, provided by trained Disease Intervention Specialists (DIS). Individual cases are assigned to a DIS, who is then responsible for offering PS following CDC standards and guidelines, as well as Louisiana's Sanitary Code.

When an individual is located, the DIS interviews and counsels the client to inform him/her of PS and, if the client agrees to receive these services, his/her partner referral options are discussed. The options are as follows:

- OPH/DIS referral - DIS notifies partners and refers them for testing without revealing the original patient's identity. This is the most frequently used option and the preferred option.
- Client referral - the patient agrees to notify partners him/herself and refer them for testing. It is difficult to verify if a partner has been notified with this method and, therefore, it is not preferable.
- Provider referral - the physician agrees to notify partners following CDC guidelines.
- Contract referral - DIS completes the notification when the infected person fails to contact their partner within an agreed upon amount of time.

If clients agree to have a DIS contact their partners, they voluntarily disclose information to aid in locating them. The DIS then confidentially locates and counsels partners regarding their possible exposure to HIV and provides HIV counseling, testing and referral services. During the process, the identity of the original patient is never revealed, nor is the gender, type of exposure, or exposure dates.

The CDC released revised recommendations for Partner Services in November, 2008 and Louisiana's policies and protocols have been updated in response to these new recommendations (www.cdc.gov/nchhstp/partners/Recommendations.html).



- In 2010, 1,530 HIV-positive persons were referred to DIS for PS, 771 of whom were interviewed (50%).
- From the 771 HIV-infected persons who were interviewed, a total of 809 partners were identified who may have been exposed to HIV. This resulted in 362 partners being tested; 91 (25%) of whom were positive.
- There has been an increase in the number of persons interviewed since 2001, when 31% of persons were interviewed. DIS often have trouble locating persons who are referred to them because individuals have moved, disconnected phone lines, provided incorrect addresses when they received their HIV test, or are homeless. People may also refuse assistance from DIS and, therefore, will not be interviewed. Efforts to increase the interview percentage are under way.
- The percentage of persons who newly tested positive in the partner-identified group has ranged from 10% to 25% during the last nine years.

Outreach to High-Risk Individuals

What does SHP do? *Contracts with CBOs to conduct holistic outreach to high-risk individuals and persons living with HIV infection.*

Area covered: *Statewide*

Outreach is a community-level intervention and occurs on the streets and/or community settings of the neighborhoods with the highest prevalence of HIV in Louisiana. Outreach is implemented in Louisiana based on the health agent model utilized in Brazil.[22] This model of outreach involves conducting an in-depth assessment of a community (including high-risk areas, current services, and locations where high-risk individuals congregate); developing deeper relationships with residents; and connecting them to needed services.

The goal of outreach is to:

- develop ongoing relationships with target area residents/visitors to provide information and referrals that will promote healthy behaviors and reduce the risk of acquiring or transmitting HIV and other STDs;
- connect agencies providing services to residents who need them; and
- develop collaborations with other HIV providers and other social service agencies to establish holistic referral networks.

The priority target populations for HIV outreach have been determined using HIV and STD surveillance information, CDC guidelines, and the community-based planning process. Outreach is concentrated among priority populations which include:

- persons infected with HIV
- men who have sex with men
- high-risk heterosexuals
- injection drug users
- special populations (homeless, migrant workers, people with Hepatitis C, youth, transgender, incarcerated/newly released)
- women with or at risk for HIV infection

Outreach and referral are conducted in fixed and active sites and consist of one-on-one interactions with individuals from targeted populations. Information and referrals are offered during outreach to promote healthy behaviors and reduce the risk of acquiring or transmitting HIV and other STDs.

On a yearly basis, a subsample of individuals is surveyed in the areas where outreach is conducted. Below are some of the highlights of the 2010 survey, when a total of 1,178 persons completed the survey.

Outreach Survey Results Louisiana, 2010	
	Percent
Sex	
Female	36%
Male	60%
Race/Ethnicity	
Black/African American	77%
Hispanic	2%
White	23%
2+ Partners in Prior 12 Months	
Males Reporting	56%
Females Reporting	32%
Condom Use	
Always	33%
Rarely or Never	22%
Used Condom at Last Sex	51%
Did Not Use Condom While Drunk or High	25%
Condom Availability	
Aware of Location of No-Cost Condoms	85%
Available at Home	71%
Bought Last Condom Used	23%
HIV Testing History	
Ever Tested	70%
Tested in Last 12 Months	60%
Had Contact with Outreach Worker in Last 6 Months	71%
High Rish Behavior in Last 12 Months	
Exchanged Sex for Money or Drugs	10%
Had a Sexually Transmitted or Venereal Disease	10%
Shot Drugs with a Needle	4%

- Blacks and males accounted for the overwhelming majority surveyed through outreach.
- More males than females reported having multiple sex partners in the last 12 months.
- 22% of participants responded that they “Rarely or Never” used a condom, and 49% did not use a condom the last time they engaged in sex despite the fact that 85% indicated they knew where to get a free condom.
- 70% of participants reported being previously tested for HIV and 60% of those who had been tested, were tested in the last 12 months.
- 10% reported exchanging sex for money or drugs in the past 12 months, 10% reported having an STD in the past 12 months, and 4% reported injection drug use in the past 12 months.

Prevention with HIV-Positive Persons

What does SHP do? *Provide programs that assist HIV-positive persons in becoming educated about HIV, encouraging them to enter or stay connected to care and overcome barriers that inhibit healthy decision making and risk reduction. Additionally, it helps HIV-positive persons who are at high risk for HIV transmission or other STD acquisition to reduce risk behaviors and address the psychosocial and medical issues that contribute to risk behavior or poor health outcomes.*

Area covered: *Statewide*

The CDC has prioritized HIV-positive individuals as the number one target population for prevention. In Louisiana, several interventions are implemented for this population: Healthy Relationships, Project Respect, and Thrive.

Healthy Relationships is a small-group session intervention consisting of five interactive sessions for men and women living with HIV infection based on the Social Cognitive Theory. During sessions, participants develop skills and build self-efficacy and positive expectations about new behaviors through modeling and practicing these behaviors and skills. Each objective of this Effective Behavior Intervention (EBI) has corresponding activities. The expectation and outcome of this intervention is that HIV-positive individuals incorporate the skills and knowledge into their lives and reduce and/or eliminate opportunities for transmitting HIV to a partner.

The objectives of Healthy Relationships are as follows:

1. Reduce unprotected anal, vaginal and oral intercourse
2. Increase correct and consistent use of condoms
3. Increase disclosure to sexual partners
4. Increase refusal of unsafe sex
5. Increase perception of social support

Project RESPECT is an individual level, two-session intervention that supports attainable risk reduction behaviors by increasing a client's perception of personal risks and emphasizes risk-reduction strategies. Trained in project RESPECT, the counselor works one-on-one with clients utilizing a 'teachable moment' to motivate clients to change behaviors, explore circumstances and context of risk behavior, and instigate an achievable step which supports a larger risk reduction goal. The counselor engages the client in role plays to increase the client's self-efficacy and provides the appropriate referrals for services not rendered through project RESPECT.

Thrive is a one-day program for people who are infected with or affected by HIV that promotes the message that they may not only survive, but thrive while living with HIV. This is a behavioral intervention consisting of informative presentations and support groups, and serves to support those who are HIV-positive to take care of themselves and their partners physically, mentally, emotionally, and spiritually. Focusing on holistic health in this manner leads to retention in medical care and a connection to the HIV organization(s) in the HIV-positive individual's area. During 2010-11, there have been three Thrive events in three Louisiana cities, reaching more than 90 consumers. Since the primary goal for Thrive is to identify and facilitate opportunities for consumers to engage in peer and advocacy activities, which provide them with holistic wellness strategies, by 2015, SHP plans to implement two Thrive events each year, reaching 240 consumers. All of these Thrive events will continue to be planned by a group of volunteer HIV-positive steering committee members with the support of SHP staff to coordinate the logistical requirements for each event.

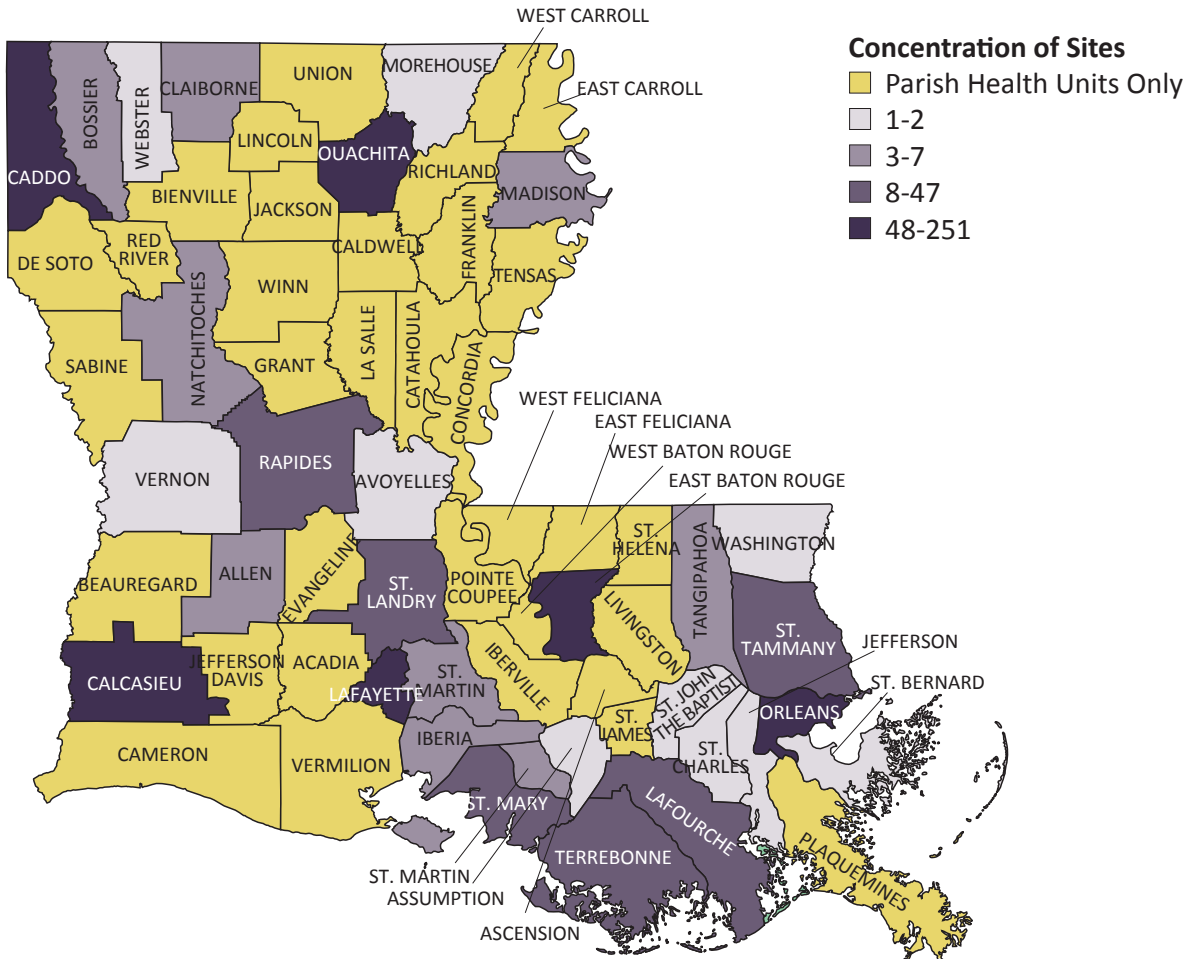
Condom Distribution

What does SHP do? *Distributes no-cost condoms through three different methods: 1) through 758 sites in high priority zip codes in each region; 2) through 64 parish health units and ten HIV clinics throughout the state, and 3) through one-on-one outreach activities conducted in high priority zip codes in each region.*

Area covered: *Statewide*

Condom distribution is an effective evidence-based intervention that is linked to structural- and community-level interventions implemented throughout the state. Structural-level condom distribution interventions are efficacious in increasing condom use, increasing condom acquisition or condom carrying, promoting delayed sexual initiation or abstinence among youth and reducing incident STIs. The Prevention Materials Distribution strategy aligns with the National HIV/AIDS Strategy. Specifically, condom distribution is intended to reduce new HIV infections by correlating the location and volume of condom distribution in each region of the state according to the prevalence and incidence of HIV.

Number of Condom Distribution Sites by Parish



- Of the 64 parishes in Louisiana, CBOs only distribute condoms to those sites in parishes with the highest HIV prevalence (parishes highlighted in purple).
- Parish Health Units (PHUs) serve as condom distribution sites throughout the state and overlap as condom sites in areas of high prevalence, as well as provide no-cost condoms in areas of low prevalence (parishes highlighted in yellow).

Public Information and Prevention Materials Distribution

What does SHP do? *Provide information to the public on STD/HIV/Hepatitis and provide materials that support STD/HIV prevention.*

Area covered: *Statewide*

The Prevention Unit coordinates the operation of the Louisiana HIV/STD Infoline (1-800-99-AIDS-9) and the www.HIV411.org website. The Infoline provides general information about HIV, other STDs, Hepatitis and TB, as well as referrals to HIV/STD testing, case management, and other services. Callers are from around the state with 42% from the New Orleans area. The www.HIV411.org website, which provides population-specific information, a referral search engine, and updates on events statewide, had over 24,000 page views and over 8,000 visitors (over half of whom utilized the referral search engine) in 2010. The Prevention Unit also coordinates the distribution of prevention materials and distributed over 150,000 brochures (7,500 of these in Spanish) on a variety of HIV, STD and Hepatitis topics, and over 800,000 no-cost condoms through 832 sites statewide in 2010.

Public Awareness

What does SHP do? *Increase the awareness of Louisiana residents on the impact of STDs and HIV in Louisiana and services available to them.*

Area covered: *Statewide*

The Prevention Unit works with its partners to raise awareness of STDs and HIV throughout the state by the observance of national HIV awareness days, large scale testing events, and special displays and activities.

In 2010, the Prevention Unit participated in National HIV Counseling and Testing Day; National Black HIV/AIDS Awareness Day; Latino AIDS Awareness Day; World AIDS Day; and the Kaiser Family Foundation's We Are Greater Than AIDS (WE>AIDS) Campaign targeting African Americans. Also, in collaboration with the Black AIDS Institute, Orasure Technologies and Alere, SHP conducted a statewide testing tour with stops in Shreveport, Alexandria, Lake Charles, Opelousas, Baton Rouge and New Orleans. The Prevention Unit also collaborated with the United Methodist Church at their statewide conference in Shreveport to offer HIV education, an exhibit of the Crowns of Glory, tours of clinics, and HIV testing. SHP coordinated HIV awareness and testing activities for the Bayou Classic and the Essence Music Festival, which are large scale events that attract thousands of African Americans to the city of New Orleans each year.

"WE>AIDS": SHP partnered with the Kaiser Family Foundation's www.greaterthan.org to create the "Louisiana>AIDS" campaign. HIV testing at the Bayou Classic and Essence Music Festival were two of the most significant events in which SHP utilized the "WE>AID"S and "Louisiana>AIDS" new media and social marketing materials. These two events have resulted in over 900 African Americans being tested for HIV in 2010 in Louisiana.

The Official State Farm **Bayou Classic Health Fair** is part of an annual football game held on Thanksgiving weekend. The HIV awareness project related to this event involved collaboration between SHP, Bickers Staff Group (BSG), the Kaiser Family Foundation, and Orasure Technologies Inc. State and national press conferences promoted the Health Fair and HIV testing on the internet, television and in newspapers. During one day at the Bayou Classic, 197 people received an HIV test and 83% received their test results.

The event was successful in increasing HIV/AIDS awareness. Based on results of a participant survey completed by 122 individuals, 54% of respondents are now aware of the "WE>AIDS" campaign, and 40% became aware of the HIV rapid test. Ninety-seven percent of respondents were black, and the majority were black females (63%). The majority (68%) of survey respondents were between the ages of 25 and 54 years of age. All respondents would recommend others to get tested for HIV and would come back to the event next year. Fifty percent of respondents heard about the testing event when walking by the HIV testing exhibit and 63% of all respondents were motivated to be tested to learn about their HIV status. The vast majority reported that their experience with the HIV Testing Counselor was "excellent" (76%) and more than half rated their HIV knowledge/awareness gained as "excellent" (69%).

Selected Characteristics of Bayou Classic Survey Respondents
Louisiana, 2010

	Number Responding	Number answering "YES"	Percent answering "YES"
Found out about HIV testing event by walking past health fair booth	119	60	50%
Motivated to come to HIV testing event to learn HIV status	117	74	63%
Now aware of the "WE>AIDS" campaign	110	59	54%
Now aware of the HIV rapid test	114	46	40%
Will recommend others to get HIV tested	109	109	100%
Will come back to this event next year	107	107	100%
Experience with HIV Testing Counselor was "Excellent"	106	81	76%
Knowledge/awareness gained about HIV was "Excellent"	105	73	69%

The Essence Music Festival, which takes place during the 4th of July weekend in New Orleans, was another successful testing collaboration with the Black AIDS Institute. Over a 3-day period, 768 attendees were tested for HIV, and 691 people (90%) received their results.

The event was successful in increasing HIV/AIDS awareness. Based on results of a participant survey completed by 550 people, 64% of respondents are now aware of the "WE>AIDS" campaign, and over a third (37%) became aware of the HIV rapid test. Ninety-four percent of survey respondents were black, and the majority were black females (80%). The majority (56%) of survey respondents were aged 25-44 years. Almost 100% of respondents would recommend others to get tested for HIV, and nearly the same percentage said they would come back to the event next year. Eighty percent of respondents are also aware of where to get an HIV test back home. Sixty-seven percent of respondents heard about the testing event when walking by the HIV testing exhibit and 58% of all respondents were motivated to be tested to learn about their HIV status. The vast majority reported that their experience with the HIV testing counselor was "excellent" (73%), and nearly the same percentage rated their HIV knowledge/awareness gained as "excellent" (70%).

Selected Characteristics of Essence Festival Survey Respondents Louisiana, 2010			
	Number Responding	**Number answering "YES"**	**Percent answering "YES"**
Found out about HIV testing event by walking past health fair booth	550	369	67%
Motivated to come to HIV testing event to learn HIV status	550	319	58%
Now aware of the "WE>AIDS" campaign	532	340	64%
Now aware of the HIV rapid test	448	166	37%
Will recommend others to get HIV tested	443	439	99%
Will come back to this event next year	431	414	96%
Know where to get HIV test back home	432	346	80%
Experience with HIV Testing Counselor was "Excellent"	448	327	73%
Knowledge/awareness gained about HIV was "Excellent"	446	312	70%

Crowns of Glory: Honoring African American Women Impacted by HIV
The Crowns of Glory display was established as a result of the significant impact HIV has had on African American women in Louisiana. The traveling exhibit is a group of over 30 hats decorated by family, friends, and community members honoring African American women who have been lost to the AIDS epidemic or are living with HIV infection. The exhibit is intended to provide a memorable visual display to increase the public's awareness of HIV among African American women

Programs Targeting Special Populations
What does SHP do? Target increased efforts at populations of special interest.
Area covered: Statewide

The Prevention Unit coordinates a number of programs that target populations of special interest because of the disproportionate impact the epidemic is having on them or the need for special emphasis to adequately reach them. Currently, these populations include pregnant women, African Americans, and men who have sex with men (MSM).

Preventing mother-to-child transmission of HIV (perinatal transmission): Louisiana has made great strides decreasing the perinatal infection rate from 4.5% in 2000 to less than 2% from 2006-2009. To move towards the elimination of perinatal HIV infection in Louisiana, SHP has undertaken two initiatives:

- Promoting routine, universal HIV screening of pregnant women on an opt-out basis and repeating HIV testing in the third trimester.
- Ensuring that appropriate HIV prevention counseling and therapies are provided for HIV-infected women to reduce the risk of perinatal transmission.

SHP has worked to ensure that women of child-bearing age are encouraged to be tested. This has been achieved through the continued implementation of routine HIV screening in STD clinics, prenatal clinics, family planning clinics, LSU hospital emergency departments, and CTRLS through CBOs. Women who are HIV-positive are referred to medical care and other support services. These referrals are followed up to ensure successful connections with the appropriate services. In addition to modifying legislation in 2007 to mandate the provision of "opt-out" testing for pregnant women, SHP has also partnered with health care providers to promote HIV screening of pregnant women through mailings to all OB/GYNS with the American College of Obstetricians and Gynecologists that includes detailed information about preventing perinatal HIV transmission.

SHP conducts a perinatal workgroup with members from the HIV Services Unit, HIV Prevention Unit and HIV Surveillance Unit. This workgroup provides updates from each unit on perinatal activities and coordinates efforts to achieve program goals of prevention and monitoring of mother-to-child transmission of HIV.

SHP also coordinates the HIV Fetal Infant Mortality Review (FIMR/HIV) in New Orleans as described in the *Surveillance of Perinatal Exposure to HIV* section of the *HIV Surveillance Chapter* of this report. In 2012, the FIMR/HIV project was expanded to Baton Rouge.

Cutting Out Stigma - The Louisiana Stylist Initiative 2010: The Louisiana Stylist Initiative, targeting primarily African American women, capitalized on the significant role beauty salons play in black women's lives as a major source of social support and community engagement. This project involved training beauty stylists on STD/HIV related health education and the promotion of lifestyle modification among their peers. The main goal of the initiative was for the stylists to increase their clients' knowledge of STD/HIV prevention, to motivate clients to reduce risky sexual behaviors and to increase their acceptance and utilization of HIV testing; all within the familiar and comfortable setting of their beauty salon. In 2010, five salons were trained for this initiative and implementation occurred in 2011.

Louisiana Wellness Center Project - Promoting total wellness among gay and bisexual men: The goal of the Louisiana Wellness Center Project is to prevent HIV and STD transmission among gay men and transgender individuals by offering holistic health and wellness services in a safe and welcoming environment. The project's pilot site, the Monroe Gay Men's Wellness Center (MGMWC), opened in Monroe, Louisiana in July 2009 and is a collaboration among Louisiana's STD/HIV and Hepatitis Programs and GO CARE, a non-profit AIDS service organization. The project functions as a bridge between existing resources in the community and those who are in need of those services. The aim is to engage members of the target population in the process of improving their overall well-being. During 2010, 91 clients attended the MGMWC and over half returned two or more times. The MGMWC provided STD and HIV screening, as well as mental health and substance abuse screenings and referrals to services. The primary care HIV physician volunteered her services and provided over 100 general health exams. In addition, 50 HIV tests and 67 syphilis screenings were conducted. Clients also received chlamydia and gonorrhea testing and screening for Hepatitis B and C.

2010 MGMWC programming included: smoking cessation, community-led spiritual services, support groups, and safer sex discussions. Of those served, approximately 42% had no health insurance, 36% of the clients said they had not used a condom the last time they had sex, and 37% had sex with two or more partners in the past three months. The psychosocial characteristics of the clients are described in the table below and demonstrate a need for mental health and substance use interventions. In response to this need, the MGMWC recruited a psychologist who volunteered her services each month and helped in providing mental health care and making appropriate referrals.

Psychosocial Characteristics of Wellness Center Clients at Intake Louisiana, 2010			
	Number Responding	**Number answering "YES"**	**Percent answering "YES"**
Currently Smoke	86	48	56%
2X or more in past mo. had 5 or more drinks on the same occasion	67	28	42%
Used drugs in past year	91	13	14%
Past year been in a relationship where physically, verbally or emotionally abused	91	9	10%
Ever forced to have sex against one's will	91	12	13%
Ever attempted suicide	91	7	8%
Ever diagnosed with depression	70	24	34%
Ever diagnosed with anxiety	70	14	20%
Ever diagnosed with both depression and anxiety	70	31	44%
Ever hospitalized for a mental health condition	91	14	15%

Adolescent Health

What does SHP do? *Contracts with CBOs to provide evidence-based HIV, STD and pregnancy prevention interventions through the Personal Responsibility Education Program (PREP). Works with Infertility Prevention Program sites to increase targeted chlamydia and gonorrhea screening for females under 26.*

Area covered: *Statewide*

Adolescents are a priority population statewide, due to extremely high STD rates, as well as teen pregnancy rates. SHP is addressing this priority population through evidence-based interventions for HIV, STD and pregnancy prevention, as well as targeted STD screening for females under 26.

PREP is a statewide teen pregnancy and HIV/STD program funded by the Administration for Children, Youth and Families, and the Family Youth Services Bureau. The PREP project replicates and adapts effective, evidence-based programs that have been proven to delay sexual activity, increase condom or contraceptive use for sexually active youth, or reduce pregnancy among youth. The PREP program also incorporates Adult Education Topics that encourage skill-building in areas including healthy relationships, adolescent development and education and career success. SHP is currently implementing two evidence-based curricula:

SIHLE (Sistas Informing, Healing, Living & Empowering) is a peer-led, social skills training intervention aimed at reducing HIV sexual risk behavior among African American teenage females, ages 14-18. The SIHLE program emphasizes ethnic and gender pride, and enhances awareness of HIV risk reduction strategies such as abstaining from sex, using condoms consistently, and having fewer sex partners. SIHLE is currently implemented in seven regions statewide (excluding New Orleans and Houma).

Project AIM is a youth development intervention designed to reduce HIV risk behaviors among African-American youth, ages 14-18. It is based on the "Theory of Possible Selves" and encourages at-risk youth to imagine a positive future and discuss how current risk behaviors can be a barrier to a successful adulthood. Project AIM uses group discussions, interactive small group activities and role playing to encourage

youth to explore their personal interests, social surroundings, and what they want to become as an adult. These activities allow youth to envision a future self, and to safeguard that future self through healthy decision making. In 2010, Project AIM was implemented at two sites in the Baton Rouge area and a third site began the process of adapting this intervention to be used specifically with gay and/or bisexual youth in the New Orleans area.

HIV Prevention Accomplishments and Challenges

Accomplishments

- Collaborated with the Louisiana Department of Public Safety and Corrections to complete implementation of HIV testing as a routine part of medical care for incoming inmates.
- Maintained rapid testing at LSU hospital emergency rooms, Orleans Parish Prison, Jefferson Parish Prison, and added new partnerships with community clinics, colleges, and universities.
- Expanded the implementation of holistic outreach and developed a comprehensive referral documentation and follow-up protocol.
- Maintained a wellness center targeting MSM individuals in Monroe.
  - Routinized STD/HIV testing and mental health/substance use screenings at the MSM wellness Center in Monroe.
- Established indicators for evaluating social marketing campaigns.
- Conducted successful large-scale testing events at the Essence Music Festival and Bayou Classic football game.
- Competed for and was awarded over $2 million dollars from the CDC to expand HIV testing and increase linkage to care.
- Partnered with the Louisiana Community AIDS Partnership in a successful five-year grant from the National AIDS Fund and Bristol-Myers Squibb to increase linkage to care and reconnecting of persons out of care.
- Awarded a grant for five AmeriCorps members focused on HIV prevention from AIDS United.

Challenges

- The continued promotion of HIV testing as a routine part of medical care for all persons 13-64 years of age. Although the continued promotion and maintenance of HIV screening as a routine part of medical care has proven to be a successful prevention strategy, maintaining and identifying funding to sustain and/or expand testing to additional healthcare venues continues to be a challenge.
- Addressing the issue of stigma which impacts an individual's perception of risk and testing behaviors, as well as accessing medical care for persons living with HIV infection.
- Current funding levels are not sufficient to adequately scale up successful efforts to reach the goals set forth in the National HIV/AIDS Strategy.
- Identifying community-based providers with expertise to access the hardest to reach populations including men who have sex with men, African American males, and HIV-positive persons not in primary medical care and other supportive services such as case management.

Chapter 4

Profile of STDs in Louisiana

Introduction to STD Surveillance

The Louisiana Office of Public Health STD/HIV Program's (SHP) Sexually Transmitted Disease (STD) Surveillance Program collects and analyzes data on cases 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.

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 do not receive additional follow up by regional staff except through two specifically funded small scale projects. These two projects involve follow-up by state office staff and are funded by the CDC (SSuN Project) and by Tulane University (Gonorrhea and Chlamydia Partner Services). A description of all STD partner services activities can be found in the STD Prevention and Services chapter.

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.

The data presented below represent all new cases of early syphilis, congenital syphilis, gonorrhea and chlamydia diagnosed in 2010 and reported to SHP before May 6, 2011. The report presents both counts of STD cases and STD case rates.

Louisiana consistently experiences some of the highest rates of STDs in the United States. Syphilis, chlamydia and gonorrhea are three commonly reported STDs. In 2010, Louisiana had the highest rate in the nation for primary and secondary syphilis and the highest congenital syphilis rate according to the CDC's *2010 STD Surveillance Report.* Additionally, Louisiana had the 2nd and 3rd highest rates in the nation for gonorrhea and chlamydia, respectively.[23]

In December 2011, SHP released the *Sexually Transmitted Diseases, Louisiana 2010 Annual Report* with extensive data analysis for early syphilis, congenital syphilis, chlamydia, and gonorrhea. This full report can be found online at www.std.dhh.louisiana.gov. The main highlights from that report are provided in this summary chapter.

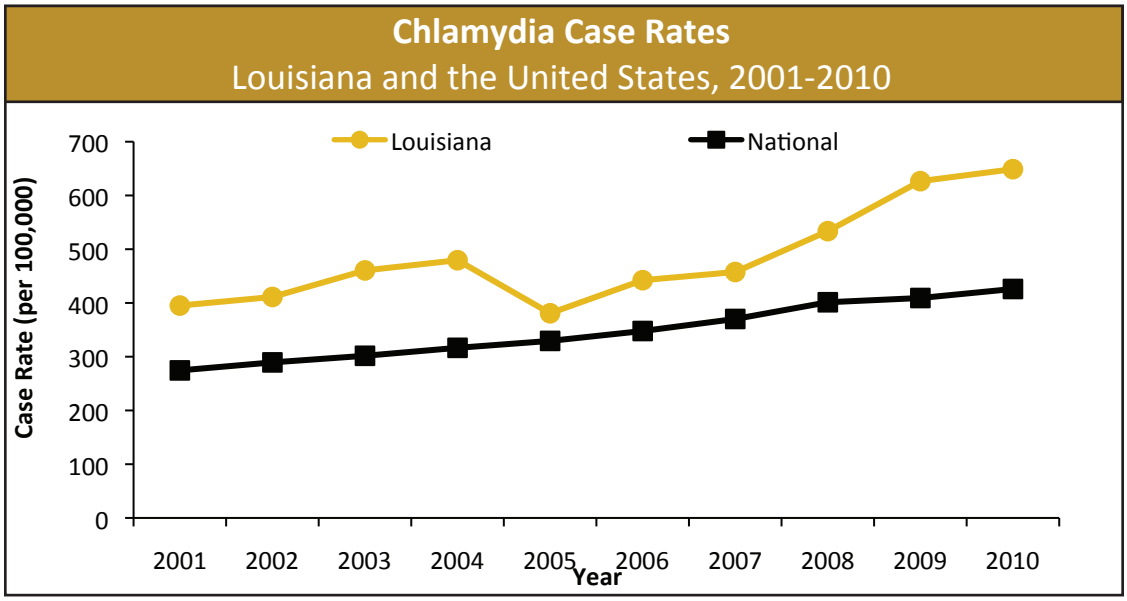
Trends in STD Cases
Louisiana, 2009-2010

Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Chlamydia	17,840	18,442	20,970	21,837	17,227	17,885	19,362	23,536	28,148	29,151
Gonorrhea	12,253	11,387	11,850	10,538	9,572	10,883	11,137	9,766	9,150	8,912
P&S Syphilis	173	152	183	332	278	342	533	721	742	547

In 2010, 29,151 chlamydia cases, 8,912 gonorrhea cases and 547 primary/secondary syphilis cases were diagnosed in Louisiana.

Chlamydia

Caused by the bacterium *Chlamydia trachomatis,* chlamydia is the most commonly reported STD in the United States. 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. As with other inflammatory STDs, chlamydial infection can facilitate the transmission of HIV infection. CDC recommends annual screening for chlamydia of all sexually active women younger than 26 years old.[24]



- In 2010, the chlamydia case rate in Louisiana was 643.0 per 100,000 population which was significantly higher than the national rate of 426.0 per 100,000 population.
- The chlamydia rate in Louisiana has almost doubled since 2005.
- In 2010, Louisiana ranked 3rd in the nation for chlamydia case rates behind Alaska (861.7 per 100,000 population) and Mississippi (725.5 per 100,000 population).[25]
- This rise in chlamydia cases may be due to the expansion of chlamydia screening practices, the use of increasingly sensitive diagnostic tests, an increased emphasis on case reporting from providers and laboratories, and improvements in the information systems used for reporting, but it may also reflect a true increase in morbidity. Louisiana's public health units have replaced genetic probe testing with the Amplified Nucleic Acid Test which captures more positive cases as recommended by the CDC.[26] In addition, screening for chlamydia is performed for all sexually active female patients aged 30 and under in Louisiana's family planning clinics.

Characteristics of Persons Diagnosed with Chlamydia

Characteristics of Persons Diagnosed with Chlamydia Louisiana, 2010			
	Cases	**Percent**	**Rate per 100,000**
Total	**29,151**	**100.0%**	**643.0**
Gender			
Female	20,582	75.6%	889.4
Male	6,659	24.4%	300.1
Unknown	*1,910*	*6.6%*	-
Race/Ethnicity			
Black/African American	16,038	80.6%	1,111.9
Hispanic	310	1.6%	161.0
White	3,554	17.9%	130.0
Other/Multi-race	*278*	*1.0%*	-
Unknown	*8,971*	*30.8%*	-
Age Group			
0-19	64	0.2%	10.3
10-14	467	1.6%	152.2
15-19	10,408	35.7%	3,185.0
20-24	11,070	38.0%	3,272.2
25-29	4,354	14.9%	1,307.8
30-34	1,485	5.1%	502.5
35-39	596	2.0%	215.6
40-44	257	0.9%	89.2
45+	450	1.5%	25.7
Region			
1-New Orleans	5,985	20.6%	716.5
2-Baton Rouge	3,898	13.4%	587.7
3-Houma	1,916	6.6%	470.7
4-Lafayette	3,302	11.3%	565.3
5-Lake Charles	1,470	5.1%	502.4
6-Alexandria	1,786	6.1%	576.6
7-Shreveport	5,663	19.5%	1,040.5
8-Monroe	3,107	10.7%	873.3
9-Hammond/Slidell	1,976	6.8%	365.1
Unknown	*48*	*0.2%*	-

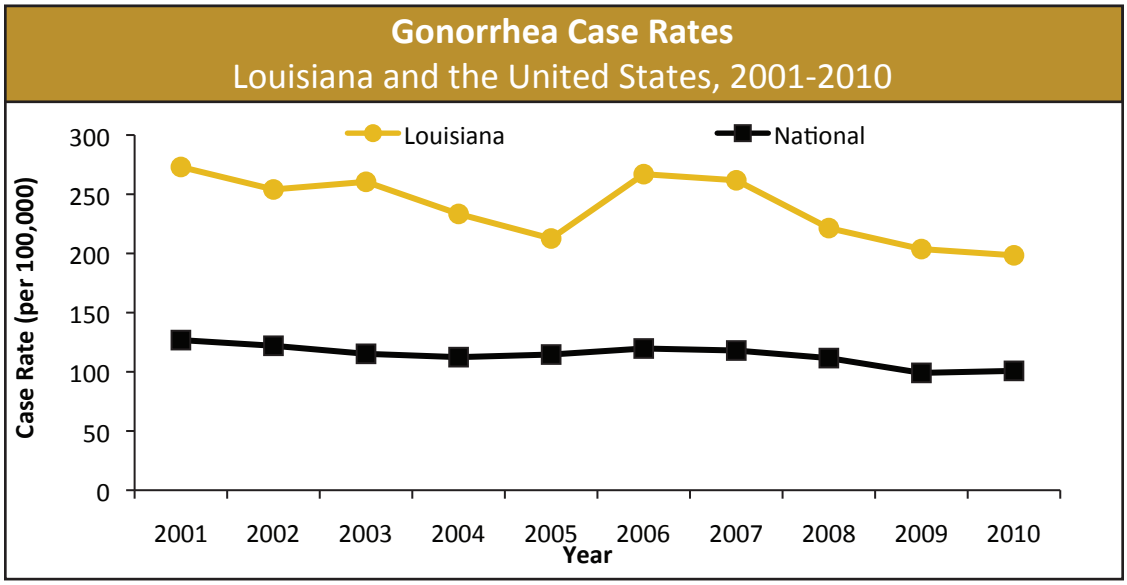
- There were 29,151 cases of chlamydia diagnosed in Louisiana in 2010. This represents a 3.6% increase in the number of cases from 2009, when 28,148 cases were diagnosed.
- The 2010 female chlamydia rate of 889.4 per 100,000 females was almost three times the male rate of 300.1 per 100,000 males. Over 75% of all new cases in 2010 were female. Females traditionally represent the population who access reproductive health care and, therefore, have more opportunities to receive chlamydia screening.
- Blacks represent the majority of new chlamydia diagnoses in 2010, (80.6%). This is a significant racial disparity, considering that blacks make up only 32% of Louisiana's population.
- The majority of cases were in persons aged 15-24 years. Many chlamydia testing services target women

within this age group.

- The New Orleans region had the greatest number of new chlamydia diagnoses, but the Shreveport region had the highest chlamydia case rate in 2010.
- The majority of chlamydia cases are received through laboratory reporting. These reports may not have complete demographic information; therefore, a significant number of cases are missing sex (1,910) and race/ethnicity (8,971).

Gonorrhea

Gonorrhea is caused by the bacterium *Neisseria gonorrhoeae.* 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 in babies.[27]



- In 2010, the gonorrhea case rate in Louisiana was 196.6 per 100,000 population which was almost double the national rate of 100.8 per 100,000 population.
- The gonorrhea rate in Louisiana has continuously declined since 2007, when the case rate was 256.7 per 100,000 population.
- Despite a 3.5% rate reduction from 2009 to 2010, Louisiana continued to rank 2nd in the nation for gonorrhea case rates. Mississippi ranked 1st in the nation (209.9 per 100,000 population) and Alaska ranked 3rd (182.3 per 100,000 population).[28]
- As of April 2007, quinolones are no longer recommended in the United States for the treatment of gonorrhea. Only one class of antimicrobials, the cephalosporins, is recommended and available for the treatment of gonorrhea. Since quinolones, such as ciprofloxacin, were frequently used to treat gonorrhea in previous years, this change in gonorrhea treatment likely contributed to the decrease in gonorrhea rates since 2007.[29]

Characteristics of Persons Diagnosed with Gonorrhea

Characteristics of Persons Diagnosed with Gonorrhea Louisiana, 2010			
	Cases	**Percent**	**Rate per 100,000**
Total	**8,912**	**100%**	**196.6**
Gender			
Female	4,827	57.7%	208.6
Male	3,541	42.3%	159.6
Unknown	*544*	*6.1%*	-
Race/Ethnicity			
Black/African American	5,737	86.6%	397.7
Hispanic	73	1.1%	37.9
White	816	12.3%	29.8
Other/Multi-race	*72*	*0.8%*	-
Unknown	*2,214*	*24.8%*	-
Age Group			
0-19	34	0.4%	5.5
10-14	134	1.5%	43.7
15-19	2,805	31.5%	858.4
20-24	3,115	35.0%	920.8
25-29	1,528	17.1%	459.0
30-34	621	7.0%	210.1
35-39	292	3.3%	105.6
40-44	161	1.8%	55.9
45+	222	2.5%	12.7
Region			
1-New Orleans	1,799	20.2%	215.4
2-Baton Rouge	1,095	12.3%	165.1
3-Houma	482	5.4%	118.4
4-Lafayette	875	9.8%	149.8
5-Lake Charles	375	4.2%	128.2
6-Alexandria	538	6.0%	173.7
7-Shreveport	2,101	23.6%	386.0
8-Monroe	1,185	13.3%	333.1
9-Hammond/Slidell	449	5.0%	83.0
Unknown	*13*	*0.1%*	-

- There were 8,912 cases of gonorrhea diagnosed in Louisiana in 2010. This represents a 2.6% decrease in the number of cases from 2009 to 2010.
- The 2010 female gonorrhea rate of 208.6 per 100,000 females was 31% greater than the male rate of 159.6 per 100,000 males. Females traditionally represent the population who access reproductive health care and, therefore, have more opportunities to receive screening.
- Blacks represent the majority of new gonorrhea cases in 2010, (86.6%). This is a significant racial disparity, considering that blacks make up only 32% of Louisiana's population.
- The majority of cases were in persons aged 15-24 years. Many gonorrhea testing services target women within this age group.

- The Shreveport region had the greatest number of new gonorrhea cases and the highest gonorrhea case rate in 2010.
- The majority of gonorrhea reports are received through laboratory reporting. These reports may not have complete demographic information; therefore, a significant number of cases are missing sex (545) and race/ethnicity (2,214).

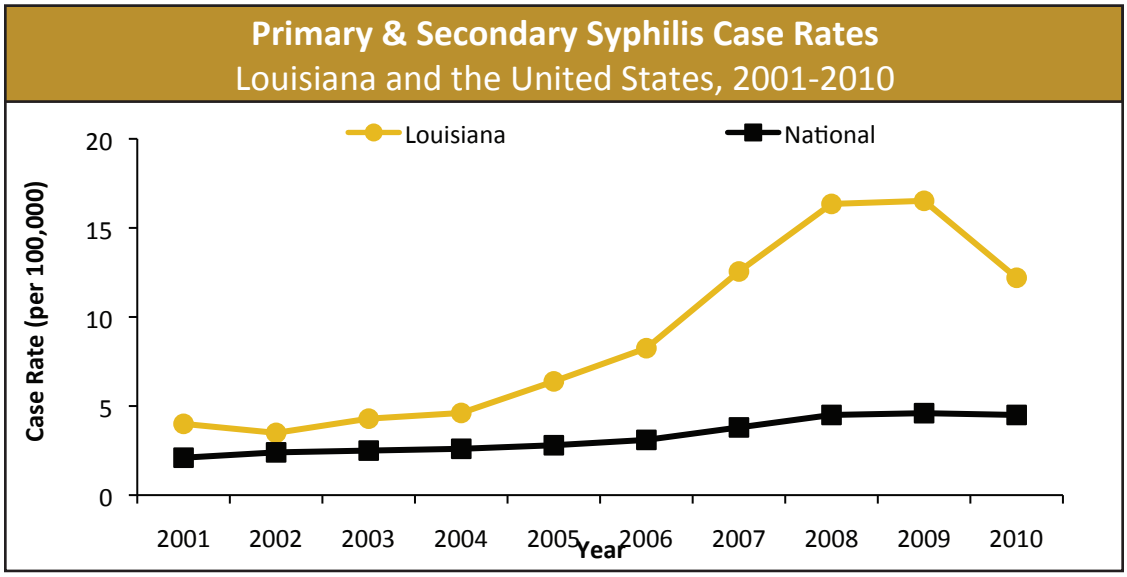
Syphilis

Early Syphilis

A syphilis diagnosis with less than one year duration is considered to be "early syphilis." This designation covers the primary, secondary, and early latent stages of syphilis.

Primary and Secondary Syphilis

Syphilis is one of the three most commonly reported STDs. It is caused by the bacterium *Treponema pallidum* and is 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. 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.[30]



- In 2010, the primary and secondary (P&S) syphilis case rate in Louisiana was 12.1 per 100,000 population, which was almost three times the national rate of 4.5 per 100,000 population.
- The P&S syphilis rate in Louisiana increased dramatically from 2003 to 2009, but in 2010, there was a 27% rate decrease from 16.5 per 100,000 population in 2009.
- Despite the rate decrease from 2009 to 2010, Louisiana remained first in the nation for P&S syphilis case rates. Louisiana has ranked first in the nation since 2006. Georgia (8.1 per 100,000 population) and Mississippi (7.7 per 100,000 population) ranked 2nd and 3rd respectively in 2010.[31]

Characteristics of Persons Diagnosed with Primary and Secondary Syphilis

Characteristics of Persons Diagnosed with Primary & Secondary Syphilis Louisiana, 2010			
	Cases	**Percent**	**Rate per 100,000**
Total	**547**	**100.0%**	**12.1**
Gender			
Female	252	47.0%	10.9
Male	284	53.0%	12.8
Unknown	*11*	*2.0%*	-
Race/Ethnicity			
Black/African American	449	89.6%	31.1
Hispanic/Latino	4	0.8%	2.1
White	48	9.6%	1.8
Other/Multi-race	*6*	*1.1%*	-
Unknown	*40*	*7.3%*	-
Age Group			
0-19	0	0.0%	0.0
10-14	2	0.4%	0.7
15-19	90	16.5%	27.5
20-24	169	30.9%	50.0
25-29	100	18.3%	30.0
30-34	58	10.6%	19.6
35-39	28	5.1%	10.1
40-44	29	5.3%	10.1
45+	71	13.0%	4.1
Region			
1-New Orleans	78	14.3%	9.3
2-Baton Rouge	45	8.2%	6.8
3-Houma	36	6.6%	8.8
4-Lafayette	76	13.9%	13.0
5-Lake Charles	35	6.4%	12.0
6-Alexandria	16	2.9%	5.2
7-Shreveport	190	34.7%	34.9
8-Monroe	46	8.4%	12.9
9-Hammond/Slidell	25	4.6%	4.6

- In 2010, there were 547 P&S syphilis cases diagnosed in Louisiana, a 26% decrease compared to 742 cases diagnosed in 2009.
- Approximately 90% of the 2010 P&S syphilis cases with reported race were black, reflecting the significant health disparity that exists in Louisiana.
- In 2010, 53% of P&S syphilis cases with reported sex were male. The case rate for males and females was fairly equal in 2010.
- Almost 50% of cases occurred in persons under the age of 25 and only 13% of cases occurred in persons aged 45 and older.
- The greatest number of new P&S syphilis cases occurred in the Shreveport region. Shreveport also had the highest P&S syphilis case rate.

- A greater amount of follow-up occurs with syphilis cases, including the provision of partner services by Disease Intervention Specialists (DIS). For this reason, more complete demographic information is collected on syphilis cases.

Early Latent Syphilis

Early latent syphilis is defined as an infection which has occurred within the previous 12 months and is no longer in the primary or secondary stages. If not detected and treated early, syphilis may lead to long-term health problems including blindness, dementia, paralysis, and other damage to internal organs.[32]

Characteristics of Persons Diagnosed with Early Latent Syphilis

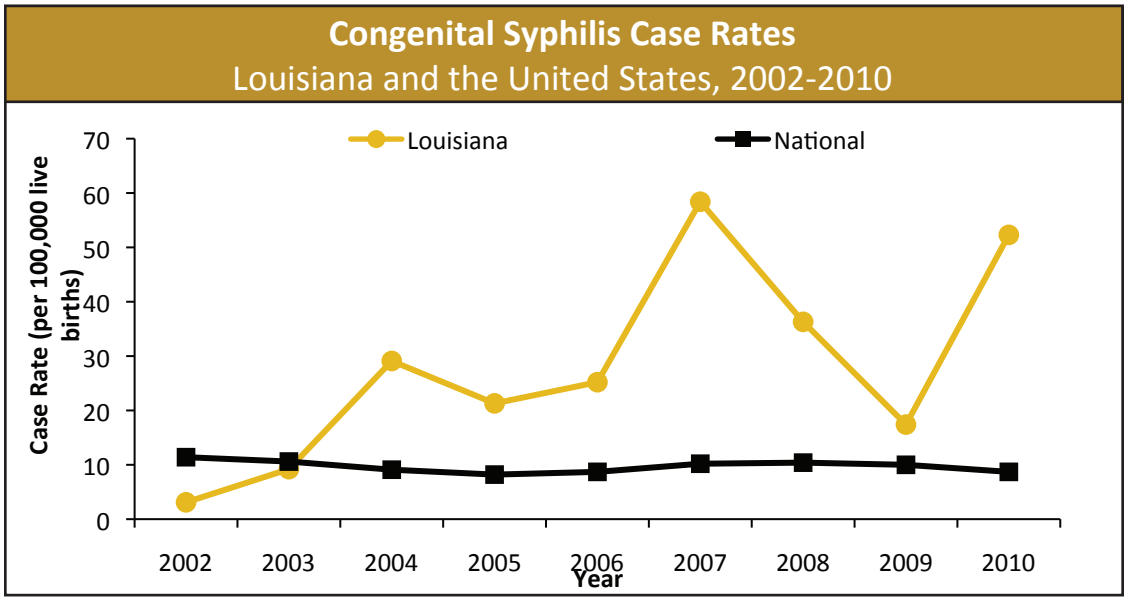
Characteristics of Persons Diagnosed with Early Latent Syphilis
Louisiana, 2010

	Cases	Percent	Rate per 100,000
Total	**740**	**100.0%**	**16.3**
Gender			
Female	406	56.9%	17.5
Male	308	43.1%	13.9
Unknown	*26*	*3.5%*	-
Race/Ethnicity			
Black/African American	566	84.7%	39.2
Hispanic	9	1.3%	4.7
White	93	13.9%	3.4
Other/Multi-race	*5*	*0.7%*	-
Unknown	*67*	*9.1%*	-
Age Group			
0-19	0	0.0%	0.0
10-14	3	0.4%	1.0
15-19	98	13.2%	30.0
20-24	218	29.5%	64.4
25-29	148	20.0%	44.5
30-34	90	12.2%	30.5
35-39	54	7.3%	19.5
40-44	39	5.3%	13.5
45+	90	12.2%	5.1
Region			
1-New Orleans	182	24.6%	21.8
2-Baton Rouge	110	14.9%	16.6
3-Houma	46	6.2%	11.3
4-Lafayette	86	11.6%	14.7
5-Lake Charles	24	3.2%	8.2
6-Alexandria	23	3.1%	7.4
7-Shreveport	204	27.6%	37.5
8-Monroe	32	4.3%	9.0
9-Hammond/Slidell	33	4.5%	6.1

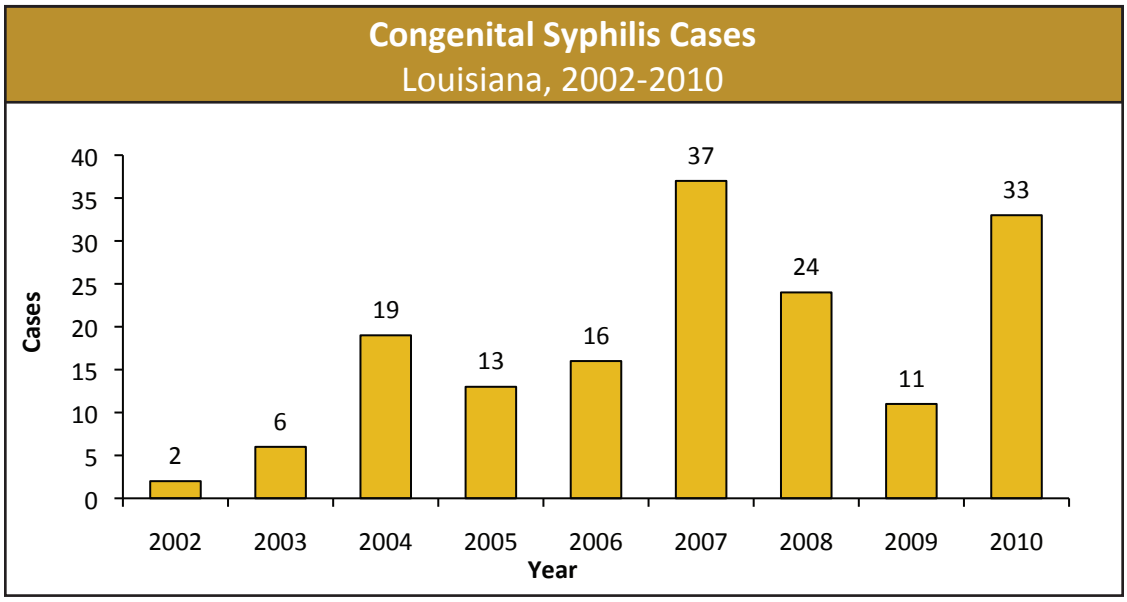
- The majority of new early latent syphilis cases were among females and blacks.
- Approximately 43% of cases occurred in youth and young adults under the age of 25, and only 12% of cases occurred in persons aged 45 and older.
- The Shreveport region had the greatest number of early latent syphilis cases and the highest case rate in 2010.

Congenital Syphilis

Congenital syphilis cases occur when a pregnant woman with syphilis passes the infection on to her infant in utero or during delivery. This can result in stillbirth, death of the newborn, or significant future health and developmental problems. Congenital syphilis can be prevented by early detection of maternal infection and treatment at least 30 days before delivery. Trends in congenital syphilis tend to follow trends for early syphilis in women with a one to two year lag. Louisiana's regional surveillance staff are the primary investigators for possible congenital cases. Once the surveillance staff have completed their investigations, all reports are submitted to SHP for a Quality Assurance Review prior to submitting to CDC.[33]



- Louisiana's congenital syphilis rate has historically been greater then the national rate. In 2010, Louisiana's congenital syphilis rate of 52.3 per 100,000 live births was over 5 times the national rate of 8.7 per 100,000 live births. Only 26 states in the nation reported one or more cases of congenital syphilis.



- In Louisiana, there were a total of 33 congenital syphilis cases reported in 2010. This was a 200% increase in cases compared to 2009 in which 11 cases were reported. The number of congenital syphilis cases has drastically fluctuated since 2002.

Congenital Syphilis Louisiana, 2010		
	Number	**Percent**
Total	**33**	**100%**
Case Definition		
Presumed Case	30	90.9%
Syphilitic Stillbirth	3	9.1%
Maternal Race/Ethnicity		
Black/African American	29	87.9%
Hispanic/Latino	0	0.0%
White	3	9.1%
Other/Unknown/Multi-race	1	3.0%
Maternal Age Group		
13-19	7	21.2%
20-24	10	30.3%
25-34	12	36.4%
35+	4	12.1%
Region		
1-New Orleans	7	21.2%
2-Baton Rouge	3	9.1%
3-Houma	1	3.0%
4-Lafayette	4	12.1%
5-Lake Charles	0	0.0%
6-Alexandria	3	9.1%
7-Shreveport	11	33.3%
8-Monroe	2	6.1%
9-Hammond/Slidell	2	6.1%
Frequency of Prenatal Care		
No Prenatal Care	6	18.2%
1-4 Prenatal Visits	9	27.3%
5-10 Prenatal Visits	6	18.2%
11+ Prenatal Visits	7	21.2%
Unknown	5	15.2%

- In 2010, 88% of mothers of congenital syphilis cases were black, and 21% of mothers were aged 13-19 and 67% were aged 20-34.
- The highest percentage of congenital syphilis cases were born in the Shreveport Region (33%), followed by the New Orleans Region (21%).
- In 2010, 45% of mothers of congenital syphilis cases received less than 5 prenatal care visits, and 18% of the mothers received no prenatal care.
- In response to the large increase in congenital syphilis cases reported in 2010, the CDC conducted a Regional Ethnographic Assessment (REA) in the Shreveport region in October 2011 and a statewide epidemiological assessment of all potential congenital syphilis cases. The findings from these two interventions are still being evaluated.

Chapter 5

STD Prevention and Services

Introduction to STD Prevention and Services

Sexually Transmitted Disease (STD) prevention operations are based on the Centers for Disease Control and Prevention's (CDC) eight essential functions.

1) **Leadership and Program Management:**
   Louisiana STD prevention systems are developed, implemented and supported with funding from the CDC and the State of Louisiana. The STD/HIV Program (SHP) office, in collaboration with health care and community partners, provide leadership to determine and define STD prevention needs and priorities. The program routinely reviews, revises or develops systems to ensure reporting laws and reporting requirements affecting STDs are current. Partnerships and collaborations with correctional facilities, public and private health agencies and medical providers, and community-based organizations are important to accomplishing STD prevention goals and objectives.

2) **Evaluation:**
   STD priorities are in part based upon data analyses, related research, and other relevant information. The SHP office oversees program operations and evaluation activities to ensure high quality targeted STD prevention efforts in the state.

3) **Training and Professional Development:**
   Training addresses the continuing evolution and challenges of public health. STD resources are used to provide training for program staff and other professionals involved in the efforts to control STDs. Clinical training is offered to public health clinicians to enhance their ability to evaluate and manage STD patients.

4) **Surveillance and Data Management:**
   Surveillance is essential to a STD prevention program, and is considered one of the highest priority public health functions. Surveillance can assist programs to better plan, implement, and evaluate efforts to control STDs. STD Surveillance is described in the previous chapter of this report.

5) **Partner Services:**
   Partner services (PS) are offered and provided to help persons infected with syphilis. Partner services are a critical tool for identifying a patient's needs and connecting the patient to appropriate care. Additionally, PS involves conducting follow-up of partners who are at risk of exposure to infection and it is a powerful tool for understanding the dynamics of disease transmission. PS can also provide the basis for assessing local epidemiologic conditions, targeting resources, and evaluating program performance.

6) **Medical and Laboratory Services:**
   Services with STDs involve quality accessible medical care and laboratory services, with integrated screening for HIV, diagnosis and treatment services for individuals infected with an STD or suspected of exposure to an STD. High quality laboratory services are also provided to public health programs and community health care partners.

7) **Community and Individual Behavior Change:**
   Behavior change projects are identified and implemented in collaboration with HIV prevention services.

8) **Outbreak Response:**
   STD prevention programs create and utilize plans to rapidly detect and respond to outbreaks. Outbreak plans are created based on assessments of disease trends, established disease thresholds and availability of resources with assistance from community partners. STD outbreak response plans are ideally evaluated annually.

Areas of Special Emphasis

The Louisiana STD prevention program is currently involved in several special projects funded by CDC, the state of Louisiana or outside funders. Here are a few of these ongoing projects:

- The Gonorrhea and Chlamydia Partner Notification Project is an evaluation of the cost effectiveness of partner notification, funded by Robert Wood Johnson Foundation in collaboration with Tulane University.
- Internet Partner Services (IPS) is a web-based partner notification project.
- The Infertility Prevention Project (IPP) promotes chlamydia and gonorrhea screening for young women and monitors the incidence of these STDs.
- The STD Surveillance Network (SSuN) Project is a network of 12 states and independently funded cities collecting enhanced information at the STD clinic-level and at the population-level of reported gonorrhea cases.
- The Gonococcal Isolate Surveillance Project (GISP) monitors antibiotic resistant gonorrhea.
- Syphilis Elimination includes contracts with several CBOs in high morbidity areas to increase syphilis testing and conduct education to high risk populations.

Partner Services

Partner Services (PS) are a broad array of services that are offered to persons with syphilis, HIV or other STDs and their sexual partners. By identifying infected persons, confidentially notifying their partners of their possible exposure, and providing infected persons and their partners a range of medical, prevention, and psychosocial services, partner services can improve the health not only of individuals, but of communities as well.[34] Even though partner notification is considered the most effective means of identifying and treating infection among exposed partners, it is highly resource intensive.[35] In Louisiana, PS is focused on syphilis and HIV cases only. Despite the high incidence of gonorrhea and chlamydia, partner notification for these two STDs has not been adopted as a routine practice in Louisiana. A small scale PS project for gonorrhea and chlamydia is discussed in the Gonorrhea and Chlamydia Partner Services section below.

In Louisiana, PS are offered to persons who test positive for syphilis to determine whether they have received and understood their test results, whether they have received referrals to medical care and other needed social services, and whether they have accessed medical services, including treatment. Also discussed is the need for an individual to notify his/her sexual partners about their possible exposure to syphilis and offer PS as a means of assisting the individual with such notifications. PS are also offered to persons who test positive for HIV, as discussed in the HIV Prevention chapter of this report.

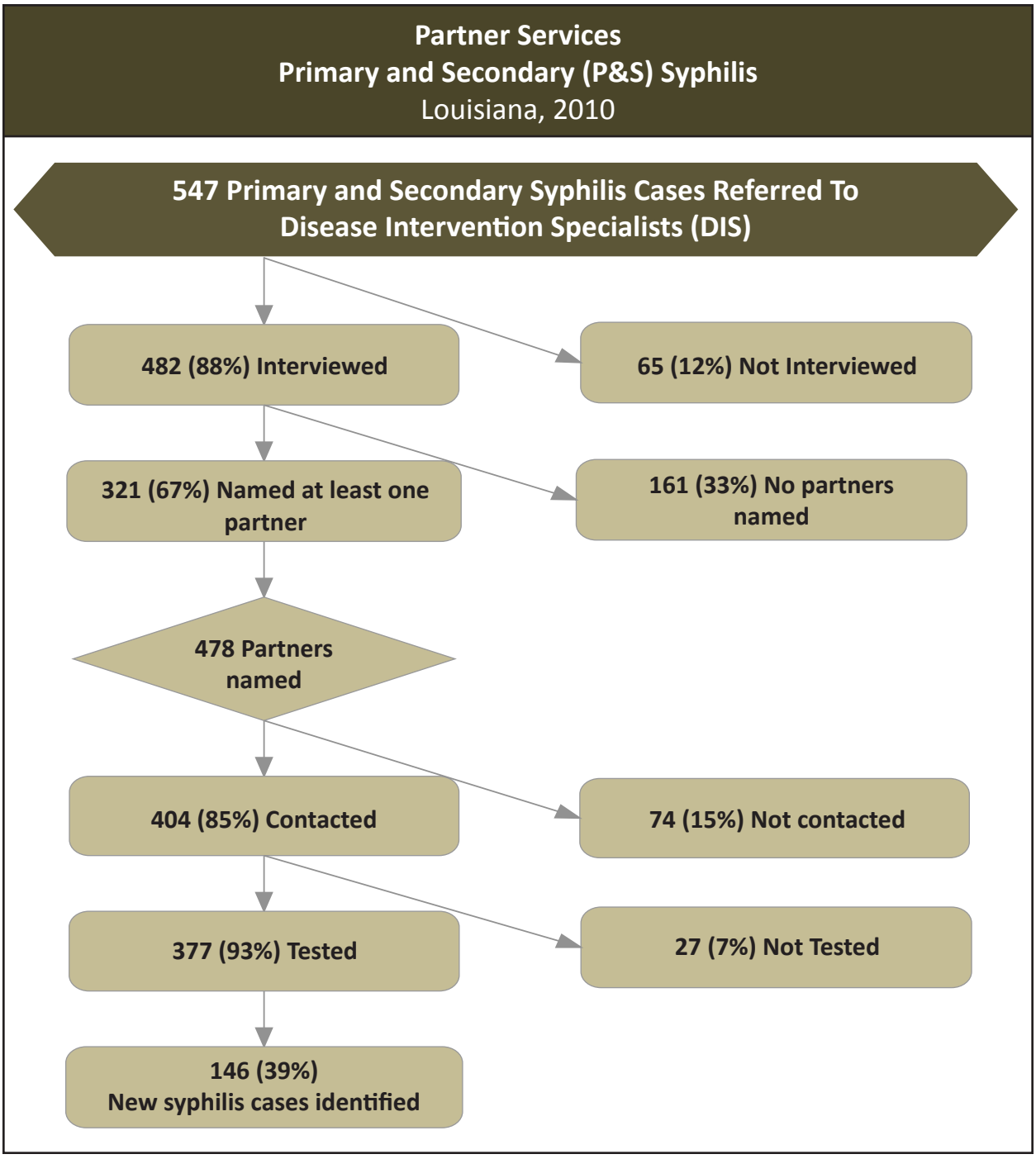
Partner services are provided by trained Disease Intervention Specialists (DIS). Individual cases are assigned to a DIS, who is then responsible for offering PS following CDC standards and guidelines, as well as the State of Louisiana Sanitary Code.

When an individual is located, the DIS interviews and counsels the client to inform him/her of PS and, if the client agrees to receive these services, his/her partner referral options are discussed. The options are as follows:

- OPH/DIS referral - DIS notifies partners and refers them for testing without revealing the original patient's identity. This is the most frequently used option and the preferred option.
- Client referral - the patient agrees to notify partners him/herself and refer them for testing. It is difficult to verify if a partner has been notified with this method, and therefore, it is not preferable.
- Provider referral - the physician agrees to notify partners following CDC guidelines.
- Contract referral - DIS completes the notification when the infected person fails to contact their partner within an agreed upon amount of time.

If clients agree to have a DIS contact their partners, they voluntarily disclose information to aid in locating them. The DIS then confidentially locates and counsels partners regarding their possible exposure to syphilis and provides syphilis counseling, testing and referral services. During the process, the identity of the original patient is never revealed, nor is the gender, type of exposure, or exposure dates.

The CDC released revised recommendations for Partner Services in November, 2008 and Louisiana's policies and protocols have been updated in response to these new recommendations (www.cdc.gov/nchhstp/partners/Recommendations.html).



- In 2010, 547 persons were referred to the DIS for syphilis partner services, 482 (88%) of whom were interviewed.
- From the 482 persons who were interviewed, a total of 478 partners were identified who may have been exposed to syphilis. This resulted in 404 partners being contacted, and 377 (93%) of those partners were tested for syphilis.
- Of the 377 partners tested for syphilis, 146 (39%) were newly diagnosed with syphilis.

Gonorrhea and Chlamydia Partner Services

Since July 2010, SHP has collaborated with Tulane University on a two year partner services project funded by Robert Wood Johnson Foundation. As part of this project, gonorrhea and chlamydia cases detected at the Delgado STD clinic in New Orleans and the parish health unit in Shreveport are selected for telephone interviews. Three trained telephone interviewers are provided with the contact information of the positive cases. The interviewers make up to seven attempts to contact and interview the patient to elicit sex partners and obtain the partners contact information. If a patient cannot be reached after the first two attempts, then the interviewers send a letter to the patient's address requesting them to contact the interviewer. Information regarding sex partners are only collected if the interaction took place within 60 days from the date the test specimen was collected. If an index case does not have any sex partners within 60 days of specimen collection, then information on the most recent sex partner is obtained. Once partner information is obtained from the index cases, they are contacted by the interviewers and referred for medical evaluation and treatment.

Results from these interviews will be reported in the subsequent SHP Program Report. Interviews did not begin until November of 2010 after interviewers were hired and trained.

Internet Partner Services

The internet is a powerful medium for communication and a valuable tool for facilitating STD/HIV Partner Services. Research has shown the internet to be a venue for risky behaviors which facilitate STD/HIV transmission, as well as for disease control and health promotion. Access to the internet has become nearly universal for most Americans, and program areas and health departments have been encouraged to incorporate the internet into their prevention efforts. With the rise of internet-based social networking and dating sites, increasing numbers of high-risk populations are meeting online to arrange anonymous sexual encounters. As a result, individuals who are newly diagnosed with STDs/HIV may know only the screen names and/or email addresses of their sex partners.

SHP has implemented procedures for contacting partners of individuals who test positive for syphilis, gonorrhea, chlamydia, and HIV, via the internet. Modeled after successful launches by other states and following national guidelines, SHP has laid the groundwork for reaching at-risk Louisiana and out of jurisdiction residents to provide STD/HIV services via the internet. Patients who test positive for any of these four infections are counseled about the need for their partners to be tested. Many patients have stated that they meet partners online and do not have other locating information. These partners are contacted anonymously by the Louisiana Internet Partner Services Coordinator.

Infertility Prevention Program (IPP)

The Infertility Prevention Program (IPP) is a national data collection campaign for public health surveillance purposes, primarily to monitor chlamydia and gonorrhea prevalence and guide STD prevention and control efforts. IPP was developed to protect the reproductive futures of young women by providing screening and treatment options. IPP is a collaboration between the CDC and the Office of Population Affairs (OPA) of the Department of Health and Human Services (HHS). The federal funds from IPP help support chlamydia and gonorrhea screening and treatment services for low-income, sexually active women attending family planning, STD and other women's health care clinics. This program has shown that routine screening of women can reduce chlamydia and gonorrhea prevalence and the complications caused by these STDs.[36]

Chlamydia is the most frequently reported communicable disease in the US. Since 1984, reported cases have increased dramatically, reflecting the growing availability of inexpensive and accurate screening tests. Collaboration between Family Planning, STD programs and Public Health Laboratories is integral to removing barriers to effective screening and early prevention. Between 20-40% of untreated chlamydia

infections lead to Pelvic Inflammatory Disease (PID), of which 20% develop infertility. Untreated gonorrhea infection can also lead to PID.

IPP screening sites in Louisiana include STD clinics, family planning clinics, parish health units, detention centers, school based health clinics, drug treatment centers and community health centers. A total of 146 IPP sites in Louisiana collected specimens in 2010.

Chlamydia Positivity at Infertility Prevention Program (IPP) Screening Sites
Louisiana, 2010

Screening Site	Total Tests	Positive	Positivity (%)
Total	**81,023**	**11,380**	**14%**
Parish Health Unit (all)	63,535	8,849	14%
Parish Health Unit (Family Planning visit type only)	*31,551*	*3,009*	*10%*
Parish Health Unit (STD visit type only)	*31,732*	*5,801*	*18%*
Parish Health Unit (other visit type only)	*252*	*39*	*16%*
STD Clinic	8,432	1,296	15%
Family Planning Clinic	139	8	6%
Other*	8,917	1,227	14%

*Includes detention centers, school based health clinics, drug treatment centers and community health centers

- In 2010, the Louisiana Office of Public Health tested 81,023 persons for chlamydia and gonorrhea as part of IPP. From 2009 to 2010, there was a 10% increase in number of screenings.
- Of those tested, 11,380 cases of chlamydia were identified, a 14% positivity rate. In addition, 3,776 cases of gonorrhea were identified, a 5% positivity rate. Of all specimens submitted, 1,566 individuals were infected with both gonorrhea and chlamydia, a 2% positivity rate.
- As part of IPP, 82% of the women in family planning clinics and 90% of the women in STD clinics who tested positive for chlamydia and gonorrhea were treated within 30 days of their specimen collection.

STD Surveillance Network (SSuN)

The STD Surveillance Network (SSuN) is a dynamic network of 12 state and local health department-based STD prevention and control programs following common protocols to address surveillance and program evaluation issues of national, state, and local interest. SSuN activities include: "monitoring the prevalence of STDs, HIV, viral hepatitis, and risk behaviors in MSM, assessing trends in the burden of genital wart disease in patients attending STD clinics, monitoring HIV testing coverage in patients attending STD clinics, and implementing population-based enhanced gonorrhea surveillance."[37]

There are two data collection components included in SSuN: 1) A clinic component where data such as demographics, STD history, exam findings, lab results, and risk behaviors are collected from 100% of patient visits at a STD clinic in New Orleans; and 2) An interview component which includes data collection from interviews of patients diagnosed with gonorrhea who live in Orleans or Jefferson parish.

STD Surveillance Network (SSuN) Clinic Findings
Demographic Characteristic of Patient Population
Louisiana, 2010

	Louisiana SSuN Cases	Louisiana SSuN %	National SSuN Cases	National SSuN %
Total	**5,667**	**100%**	**217,412**	**100%**
Gender				
Male	3,321	59%	132,601	61%
Female	2,343	41%	84,504	39%
Transgender	2	0%	220	0%
Unknown	1	0%	87	0%
Sex of partners among males				
Men Who Have Sex with Men (MSM)	476	14%	22,519	17%
Men Who Have Sex with Women (MSW)	2,667	80%	75,875	57%
Transgender	0	0%	2	0%
Unknown	178	5%	34,068	26%
Age Group				
≤14	11	0%	488	0%
15-19	571	10%	23,228	11%
20-29	2,979	53%	105,087	48%
30-39	1,175	21%	47,359	22%
≥40	931	16%	41,214	19%
Unknown	0	0%	31	0%
Race/Ethnicity				
White, non-Hispanic	489	9%	42,977	20%
Black, non-Hispanic	4,975	88%	116,004	53%
Asian, non-Hispanic	21	0%	7,038	3%
Hispanic	168	3%	40,850	19%
AIAN	0	0%	507	0%
Other/Multi-Racial	6	0%	6,515	3%
Unknown	8	0%	3,521	2%
Prevalence of Selected STDs				
HIV	75	1%	3,627	2%
Gonorrhea	294	5%	9,983	5%
Chlamydia	498	9%	17,807	9%
Syphilis	196	4%	2,681	2%
Genital Warts	113	2%	5,860	3%

- The percentages of male and female clinic patients and the age distribution of patients in Louisiana are similar to the national SSuN data (59% and 61% respectively).
- In Louisiana, 88% of the clinic patients are black, non-Hispanic, while nationally, it was 53% in 2010.
- The prevalence of gonorrhea and chlamydia in the Louisiana STD clinic is similar to the national SSuN prevalence (5% and 9% respectively); however, the prevalence of syphilis in Louisiana was slightly higher (3% in Louisiana and 2% nationally).

The second component of the SSuN project involves conducting interviews on patients diagnosed with gonorrhea who live in Orleans or Jefferson parish, regardless of the facility where they were diagnosed. These interviews are conducted over the phone by trained interviewers. In 2010, the SSuN project only reported on interviews conducted from January to August 2010. The table below compares the interviews conducted in Louisiana to the interviews conducted nationally for this time period. From January to August 2010 a total of 155 interviews were conducted in New Orleans on patients diagnosed with gonorrhea.

STD Surveillance Network (SSuN) Population-based Findings
Demographic Characteristics of Interviewed Patients with Gonorrhea
Louisiana and National Data, January to August 2010

	Louisiana SSuN Cases	Louisiana SSuN %	National SSuN Cases	National SSuN %
Total	**155**	**100%**	**3,456**	**100%**
Gender				
Male	92	59%	1,831	53%
Female	63	41%	1,613	47%
Transgender	0	0%	0	0%
No answer/Default	0	0%	12	0%
Sex of partners among males				
Men	18	20%	801	44%
Women	69	75%	991	54%
No answer/Default	5	5%	39	2%
Age Group				
≤14	0	0%	15	0%
15-19	33	21%	811	24%
20-29	77	50%	1,754	51%
30-39	25	16%	514	15%
≥40	20	13%	359	10%
No answer/Default	0	0%	3	0%
Race/Ethnicity				
White, non-Hispanic	14	9%	687	20%
Black, non-Hispanic	139	90%	1,900	55%
Asian, non-Hispanic	0	0%	65	2%
Hispanic	1	1%	590	17%
AIAN	0	0%	11	0%
Other/Multi-Racial	1	1%	129	4%
No answer/Default	0	0%	74	2%

- For the interviews conducted from January through August of 2010 in Louisiana, 59% of interviewed gonorrhea patients were male and 41% were female. Nationally, only 53% of the interviewees were male.
- Of men interviewed in Louisiana, 20% of men reported having a male sex partner in the last 3 months compared to 44% of male patients interviewed nationally.
- The age distribution of interviewed patients in Louisiana was similar to the national results; however, the race distribution differed with 90% of interviewed patients in Louisiana being black compared to 55% nationally.

Included in the SSuN interviews are a variety of questions about risk behaviors conducted by the interviewee in the 3 months prior to the interview. The number of responses from Louisiana's SSuN interviews was quiet small but still included in the national data as shown below.

STD Surveillance Network (SSuN) Population-based Findings
Reported Risk Behaviors in Previous 3 Months
National Data, January to August 2010

	National SSuN Cases	National SSuN %
Internet to meet sex partners		
Women	34	11%
Men Who Have Sex with Men (MSM)*	324	37%
Men Who Have Sex with Women (MSW)**	45	6%
Anonymous sex		
Women	94	14%
MSM	275	36%
MSW	171	20%
Giving or receiving money or drugs for sex		
Women	23	8%
MSM	37	5%
MSW	29	7%
Incarceration of self or sex partner		
Women	346	20%
MSM	78	14%
MSW	213	19%
HIV-positive partner		
Women	16	1%
MSM	112	15%
MSW	8	1%

* MSM were defined as men who reported having sex with another man in the 3 months before STD testing

** MSW were defined as men who reported having sex with women only within the 3 months before STD testing or who did not report the sex of their sex parter but reported that they considered themselves straight/heterosexual.

- Of the gonorrhea patients interviewed nationally from January to August 2010, 37% of MSM reported using the internet to meet sex partners compared to 11% of women and 6% of MSW.
- Nationally, 36% of the MSM reported having anonymous sex in the past three months compared to 14% of the women interviewed and 20% of the MSW interviewed.
- A large percentage from each of the three groups reported incarceration of themselves or a sex partner in the past three months (20% of women, 14% of MSM, and 19% of MSW).
- Very small numbers of women and MSW reported having sex with an HIV- positive partner in the past three months but 15% of MSM reported having sex with an HIV-positive partner in the past three months.

Gonococcal Isolate Surveillance Project (GISP)

The Gonococcal Isolate Surveillance Project (GISP) was established in 1986 to monitor trends in antimicrobial susceptibilities of strains of N. gonorrhoeae which is the bacterium that causes gonorrhea. These data are collected in the U.S. in order to establish a basis for the selection of therapies to treat gonorrhea. GISP is a collaborative project among selected STD clinics, five regional laboratories, and the CDC. Data from this project have been used to revise the CDC's STD Treatment recommendations.

In GISP, isolates are collected from the first 25 men with urethral gonorrhea attending STD clinics each month in approximately 28 cities in the U.S. At regional laboratories, the susceptibilities of these isolates to various medications (penicillin, tetracycline, spectinomycin, ciprofloxacin, ceftriaxone, cefixime, and azithromycin) are determined.[38]

Louisiana has participated in GISP since 1998, with the Delgado STD clinic in New Orleans designated as the sentinel site. Each month, urethral smears are collected from men complaining of urethral discharge. Louisiana contributed 256 samples to this national study in 2010.

Other Prevention Activities

Syphilis Outbreak Response

Syphilis Outbreak Response is a three-phase plan to address an outbreak of syphilis. The plan includes activities by staff in the following sections: Surveillance, Epidemiology, Data Management, Clinical/Laboratory, Prevention/Health Promotion, Field Operations and Central Office. The three phases are as follows:

1. Outbreak Detection
2. Outbreak Investigation and Response
3. Outbreak Closure and Evaluation

In 2010, there were no outbreak response efforts.

Syphilis Elimination

The Syphilis Elimination Effort (SEE) is a national initiative that brings together health care providers, policy makers, community leaders and state and local public health agencies to reduce syphilis rates in the United States. In Louisiana, SHP staff contributed during HIV prevention and services planning meetings to provide guidance on STD and HIV morbidity, co-infections, and opportunities for collaboration. In 2010, SHP participated in the Tri-State (Arkansas-Louisiana-Texas) syphilis elimination work group. This workgroup holds quarterly conference call amongst various staff in the three states to discuss activity and morbidity trends as well as efforts within the states to address these trends.

SHP also contracted with two CBOs in New Orleans and Baton Rouge. These organizations schedule outreach screening activities in identified areas or venues to recruit individuals in high-risk sections of the area, including a screening program at Baton Rouge Parish Prison. The CBOs reported back the number of people screened and the positivity rate/number of new cases identified. In addition, quarterly meetings were held including CBO staff, Disease Intervention Specialists and Department of Corrections.

SHP's surveillance staff routinely conducts provider visitations to inform new and current medical providers of disease reporting requirements and to promote state and federal recommendations for the testing and treatment of STDs.

SHP's Laboratory Supervisor contacts laboratories and promotes electronic laboratory reporting (ELR). The supervisor works closely with the regional surveillance staff to monitor and address issues in lab reporting. The goal of the Laboratory Supervisor is to have SHP receive 100% of positive syphilis tests results conducted in the state.

Chapter 6

Evaluation

Introduction to the Evaluation Unit

The Louisiana Office of Public Health STD/HIV Program (SHP) Evaluation Unit collaborates with SHP's Prevention, Services, Regional Operations, and Surveillance Units to review program activities, measure program effectiveness, and continually apply these results for program improvement. The Evaluation Unit assists with the creation of evaluation plans for each program, the design of data collection protocols, and the training of staff regarding evaluation techniques and principles. The Evaluation Unit conducts the following types of evaluation activities:

Evaluation Activities Louisiana SHP Office	
Formative Research	**What have we learned in the past and how can we design a program to best address the needs of the population?** • Review existing research • Assist with designing intervention • Develop data collection forms • Gather data in the early stages of the intervention or program Implementation
Process Monitoring	**What services were delivered and what populations were served?** • Review program activities • Determine the populations served • Determine the services provided • Analyze trends to inform program planners
Process Evaluation	**Were the programs implemented as intended and did they reach the intended population?** • Assess planned versus actual program performance over a period of time for the purpose of program improvement and future planning
Outcome Monitoring	**Did the expected outcomes occur?** • Collect and summarize outcome data • Review program-associated outcomes in order to determine the extent to which program objectives are being met
Outcome Evaluation	**Did the intervention cause the expected outcomes?** • Collect data before and after an intervention (or from persons who had an intervention, and those who did not) • Determine whether behaviors, attitudes, or health outcomes changed as a result of the intervention
Impact Evaluation	**What long-term effects did the program or intervention have on HIV infection?** • Examine trends in new HIV diagnosis, health status, morbidity, and mortality of HIV-infected persons

*Modified from CDC's NHM&E Workshop "Evaluation Terms, Explanations, and Sample Questions"

Where and how are evaluation data obtained?

The Evaluation Unit oversees the National HIV Behavioral Surveillance (NHBS) project, the Continuous Quality Improvement (CQI) activities, and collects and summarizes data from the STD/HIV Prevention, Care and Services, and Surveillance Units of SHP. Data for some programs are collected by SHP staff, but SHP also relies on service providers throughout the state to collect and submit process-level data to SHP on an ongoing basis.

Evaluation of Prevention Interventions

The Prevention Unit funds HIV counseling, testing and referral services; contacts partners of HIV-infected persons for education, testing and referral; implements targeted prevention activities through its subcontractors, and supports community-wide awareness events, including social marketing and media. In 2010, SHP funded 28 contracts to 16 community-based organizations (CBOs) to implement CDC-approved interventions across Louisiana. Interventions were targeted to groups identified as high-risk, including men who have sex with men (MSM), and high-risk heterosexuals, particularly black and Latino persons who engage in high-risk behaviors. Evaluation data collected for prevention programs include client-level data on HIV-testing sessions, referrals, partner services, and small group session attendance, and aggregate-level data on outreach activities. The process and outcome measures for selected prevention interventions that are monitored on an ongoing basis are shown in the table below.

Evaluation of Prevention Interventions

Program	Process and Outcome Measures
HIV Counseling, Testing and Referral Services	• Number of HIV tests conducted annually and percent seropositive • Percentage of clients who receive their test results • Percentage of HIV-negative clients who receive an appropriate referral to needed services • Percentage of HIV-positive clients who receive an appropriate referral to HIV medical care and other needed services and the percentage who access HIV medical care
HIV Partner Services	• Percentage of newly-diagnosed persons who are interviewed by a Disease Intervention Specialist • Percentage of persons interviewed who name at least one partner • Percentage of named partners who receive an HIV test • Number of new HIV positive persons identified through HIV Partner Services
Outreach and Referral	• Number of referrals made during outreach and the percentage of referrals that were successfully accessed

In 2010, the Evaluation Unit also supported evaluation activities of several special projects to enhance prevention activities. Some of these projects included:

- Evaluating HIV Partner Services and Internet Partner Services (IPS) trainings focusing on partner elicitation and use of IPS in the field
- Evaluating the cultural competency of CBOs and SHP staff
- Evaluating the 2010 Street Outreach Survey results
- Evaluating large-scale testing events, such as the Essence Festival and the Bayou Classic
- Evaluating the Prevention with Positives Risk Management intervention
- Evaluating services provided through an MSM Wellness Center in Monroe, Louisiana
- Evaluating the Thrive! Workshop for HIV+ participants at baseline and follow-up
- Evaluating the 2010 Louisiana CBO meeting: BUILDING CAPACITY FOR THE FUTURE

Evaluation of STD Prevention Interventions

The STD/HIV Program, through the collaborative efforts of staff in the Data Management/Analysis, Regional Operations and Evaluation Units, is in the process of developing an STD-specific Performance Measures Report that lists key national (federally funded) and state performance indicators. This quarterly assessment will be a performance and communication tool to regional administrative and program staff providing: a) a snapshot of progress being made in reaching performance measures in each region; b) comparison against the program's objectives; and c) opportunity for discussion with staff and partners from each region to better assist with monitoring and improved performance measures. The report will include morbidity trends, case management and disease intervention index, field outcomes, and user system status for both P&S syphilis and HIV cases that are assigned and investigated. Future discussions and flexibility of variables are inherent within the report as the Louisiana STD/HIV Program looks toward the improvement and accomplishment of its overall objectives.

The CDC Performance Measures for selected STD prevention interventions that are monitored on an ongoing basis are shown in the table below.

Evaluation of STD Prevention Activities

Program	Process and Outcome Measures
Treatment of Chlamydia	• Among clients of Infertility Prevention Program (IPP), designated family planning clinics, the proportion of women with positive CT tests who are treated within 14 and 30 days of the date of specimen collection. • Among clients of STD clinics, the proportion of women with positive CT tests who are treated within 14 and 30 days of specimen collection.
Treatment of Gonorrhea	• Among clients of Infertility Prevention Program (IPP), designated family planning clinics, the proportion of women with positive GC tests who are treated within 14 and 30 days of the date of specimen collection. • Among clients of STD clinics, the proportion of women with positive GC tests who are treated within 14 and 30 days of specimen collection.
Treatment of P&S Syphilis	• Proportion of P&S syphilis cases treated within 14 and 30 days of specimen collection.
Syphilis Partner Services	• Proportion of P&S syphilis cases interviewed within 7, 14 and 30 calendar days from date of specimen collection. • Number of contacts prophylactically treated within 7, 14 and 30 calendar days from days of interview of index case of P&S syphilis. • Number of contacts newly diagnosed and treated within 7, 14 and 30 calendar days from day of interview of index case, per case of P&S syphilis.

Evaluation of HIV Care and Services

The major goals for evaluation of care and services for persons living with HIV infection include:

- Evaluating and revising care systems to meet emerging needs
- Ensuring access to quality HIV care
- Evaluating the impact of Ryan White program funds

Evaluating the impact of Ryan White Program funds

The Evaluation Unit routinely reviews program indicators in order to evaluate the impact of Ryan White program funds on the health status of persons living with HIV infection.

Evaluation of HIV Services Activities

Program	Process and Outcome Measures
ADAP	• Percentage of ADAP enrollees who are reviewed for continued ADAP eligibility at least two or more times in the measurement year.* • Percentage of new anti-retroviral classes included in the ADAP formulary within 90 days of the date of inclusion of new anti-retroviral classes in the PHS Guidelines for the Use of Antiretroviral Agents in HIV-positive adults and Adolescents during the measurement year.* • Percentage of ADAP enrollees who were in medical care during the measurement year.
Part B Direct Services	• Percentage of Part B clients who had two or more medical visits in an HIV care setting in the measurement year.* • Percentage of Ryan White Part B clients who had permanent housing during the measurement year.
HOPWA	• Percentage of HOPWA clients seen at Part B providers who were in medical care during the measurement year.
Assessment and Referrals	• Percentage of new Ryan White Part B case management clients who were screened for mental health, substance abuse, & domestic violence referral need. • Percentage of new Ryan White Part B case management clients who needed and accepted a mental health treatment referral. • Percentage of new Ryan White Part B case management clients who needed and accepted a substance abuse treatment referral. • Percentage of Ryan White Part B case management clients who reported having had an oral health exam in the past calendar year. • Percentage of Ryan White Part B case management clients who requested assistance from their case manager to make an oral health exam appointment.
Corrections	• Percentage of HIV-positive clients newly discharged from the Louisiana Department of Corrections who entered medical care within six months of discharge.

*HRSA HIV/AIDS Bureau Indicators

Evaluating and revising care systems to meet emerging needs

The Evaluation and Care and Services Units routinely review data collected by each contracted agency to ensure contract objectives are being met. In 2010, the Care and Services Unit provided 20 contracts to 19 organizations in Louisiana for care and treatment services, including assistance in paying for health insurance premiums and all related cost share expenses (co-payments, deductibles, etc.); obtaining HIV medications through the AIDS Drug Assistance Program (ADAP); oral health care; medical and non-medical case management; support services, such as medical transportation, nutritional services, and emergency assistance; and short-term and tenant-based housing assistance. Each of these contracts specified process and outcome reporting requirements for all services provided, and SHP staff continuously assess the overall service needs of persons living with HIV disease and modify systems and resources allocations as needed to improve service delivery.

A significant evaluation component for the Care and Services Unit was the implementation of the Continuous Quality Improvement (CQI) plan. The CQI Steering Committee meets routinely to review client service utilization data and make recommendations for performance improvement. Participation is statewide and among all Ryan White Parts. In addition three CQI subcommittees were established to assess existing systems of care, determining quality of services, and recommend activities that would improve access, increase utilization and enhance quality.

Oral Health CQI Subcommittee: To address the lack of data on clients' dental needs and experiences, the HAP Oral Health CQI Subcommittee designed and implemented a survey in 2008 and 2009. All Part B-funded case managers and several Part A/TGA providers administered this survey to over 2000 clients in 2008 and 2009. Some of the key findings show marked improvement from 2008 to 2009: the percent of respondents who had visited a dentist during the past year increased from 49% to 56% and the percent who were "very satisfied" with their last dental visit increased from 56% to 61%. A major barrier, "not knowing where to find dental care" decreased from 24% to 12%. However, the percentages for the two primary barriers, not affordable and lack of transportation, increased. In order to emphasize the importance of oral health care, oral hygiene kits were also distributed to the respondents.

During FY 2010, budget reductions to Part B contractor agencies forced many providers to make crucial choices regarding scarce allocations to essential services. In 2009, $291,372 was expended by Part B-funded CBOs on Oral Health Care; in 2010, only $81,811 was allocated to Oral Health Care services. Given the limited staff and the more urgent ADAP priority activities, SHP staff decided not to conduct an Oral Health Survey in 2010. However, in a continuing commitment to advancing oral health care knowledge throughout the state, additional oral health kits were distributed to agencies during the month of October 2010 (National Dental Hygiene Month) and case managers were asked to talk with clients about the importance of oral health care. Over 1,000 oral health care kits were distributed to thirteen agencies throughout the state.

Mental Health/Substance Abuse (MH/SA) Services Subcommittee: In 2009, this subcommittee revised the primary assessment tool used to capture clients' MH/SU treatment needs. The current MH/SU Screening Tool is more accurate and efficient and better able to capture referrals. In 2010, 98% of all clients newly enrolled in case management received the MH/SU Screening Tool at intake. The HAP CQI goal is to have 100% of all newly enrolled clients screened using the tool and then receive the appropriate referrals.

Also, in the fall of 2009, an improved system was developed to document referrals. Besides documenting the referral on the MH/SU Screening Tool, the case manager enters the referral and referral follow-up information in CAREWare. The following narrative summarizes the screenings conducted during 2010: 99% of new clients received MH, SU and domestic violence (DV) screenings, which is substantially higher than the previous year (84%). Of all 853 clients screened, (includes both new clients and those who came in for a reassessment), 100% had a mental health screening and 99.6% had a substance use screening. Thirty-seven percent (315 of the 853 clients) needed a mental health referral and 166 of the 850 clients screened for substance use (20%) needed a referral for those treatment services. CAREWare data shows that 50% of the mental health referrals and 18% of the substance abuse referrals were completed. Efforts will be made in 2011 to improve these rates, which will include increased monitoring and site visits made to the CBOs.

The MH/SU Subcommittee also compiled a comprehensive Resource Directory of MH and SU providers by region, which focused on referral agencies that had been used successfully by clients. The Resource Directory provided contact information, services/programs offered at each referral agency, and typical wait times. This resource was shared with the SHP Prevention unit and posted on the HIV411.org website. There will be continual updates to the Directory and website since needs assessment data continues to demonstrate the greatest barrier to receiving mental health and substance abuse services was "client not aware of these treatment options."

Many of the primary medical care quality management activities and outcomes data are collected by the Louisiana State University Health Care Services Division (LSU HCSD) public hospital system and shared with the CQI Steering Committee. Consistently, clinical quality indicators at these regional medical centers meet or exceed the USPHS guidelines for those persons living with HIV infection.

Medications Access Subcommittee: The Medications Access Subcommittee, which also acts as the LA ADAP Advisory Group, conducted a survey among all Part A and Part B CBOs on medication adherence counseling/services provided at each CBO. The findings indicated that of the 16 CBOs surveyed, 15 provide medication adherence counseling, primarily offered by case managers. Several case managers requested materials and training regarding adherence counseling and the Medications Access Subcommittee has acted on these recommendations.

Ensuring access to quality HIV care

The primary focus of Part B Medical Case Management and Ryan White-funded supportive services is to facilitate access to and retention in care. Programmatic objectives are tied to improving the timeliness and effectiveness with which a newly identified person can be enrolled and maintained in medical care and case management with the theory that persons fully engaged in routine care will experience fewer medical complications and a slower immune system decline. The Evaluation and Surveillance Units review laboratory data to routinely monitor whether persons living with HIV infection are accessing primary medical care. Persons who do not have at least one primary medical care visit in a 12-month period are considered to have "unmet need." Persons who have at least one CD4 or viral load test result in a calendar year are considered to be "in care," and those who do not are considered to be "out of care." Historically, an estimated 40-55% of the population living with HIV infection in Louisiana appears to be "out of care" when using this annual unmet need indicator. In 2010, the percent of persons with unmet need dropped to 36%.

Another concern is that persons enter the care system much too late and in a state of physical decline. In 2010, 24% of newly identified persons living with HIV infection received an AIDS diagnosis simultaneously with their HIV diagnosis, and an additional 9% progressed to AIDS within six months of their HIV diagnosis. The 2010 HIV surveillance data of newly diagnosed persons were also analyzed in order to determine the percentage of those who entered care within 3 months of diagnosis. The overall percentage of those entering care within 3 months was 73%.

Chapter 7

Appendices

The appendix contains additional tables relevant to the Surveillance chapter of this report, Chapter 1. Immediately following the tables are the Technical Notes.

Included Tables

Trends in HIV Infection, Louisiana, 1979-2010

- 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 2010.

New HIV Diagnoses by Region and Year, Louisiana, 2001-2010

- This table includes the number of New HIV Diagnoses from 2001 to 2010, for each of the nine public health regions in Louisiana.

New AIDS Diagnoses by Region and Year, Louisiana, 2001-2010

- This table includes the number of New AIDS Diagnoses from 2001 to 2010, for each of the nine public health regions in Louisiana.

Geographic Distribution of HIV in Louisiana, 2010

- This two page long table includes new AIDS Diagnoses in 2010, HIV Diagnoses in 2010, HIV Case Rate in 2010, Persons Living with HIV Infection in 2010, and Deaths in Persons Living with HIV Infection in 2009 for each of the nine public health regions and the 64 parishes of Louisiana.

Deaths among Persons with HIV Infection, Louisiana, 2009

- This table contains the demographic breakdown of Persons with HIV Infection who died in 2009 in Louisiana.

Trends in HIV Infection Louisiana, 1979-2010				
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	15
1984	146	84	187	36
1985	383	151	498	100
1986	483	242	852	158
1987	756	417	1,391	244
1988	781	450	1,954	292
1989	1,039	613	2,638	429
1990	1,211	708	3,466	436
1991	1,556	937	4,568	542
1992	1,754	1,064	5,698	678
1993	1,717	1,135	6,726	768
1994	1,656	1,105	7,653	821
1995	1,496	1,043	8,330	905
1996	1,526	1,123	9,144	787
1997	1,525	945	10,213	558
1998	1,285	847	11,097	524
1999	1,254	790	11,555	496
2000	1,195	823	12,805	511
2001	1,145	887	13,502	562
2002	1,188	969	14,260	547
2003	1,058	893	14,848	577
2004	1,065	863	15,680	566
2005	972	805	14,346	579
2006	991	766	14,891	549
2007	1,081	802	15,510	516
2008	1,095	845	16,152	477
2009	1,213	793	16,879	529
2010	1,174	805	17,679	374*

*Data are not complete

New HIV Trends by Region and Year Louisiana, 2001-2010										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Louisiana	**1,145**	**1,188**	**1,058**	**1,065**	**972**	**991**	**1,081**	**1,095**	**1,213**	**1,174**
1-New Orleans	473	445	417	441	322	248	323	355	384	366
2-Baton Rouge	302	312	249	251	271	305	310	298	310	305
3-Houma	30	36	35	27	34	38	45	43	40	58
4-Lafayette	67	90	97	75	77	72	67	75	87	97
5-Lake Charles	46	53	40	38	43	40	54	55	51	49
6-Alexandria	59	61	41	47	39	50	43	49	64	61
7-Shreveport	77	73	74	85	69	96	115	106	115	106
8-Monroe	63	74	56	62	61	83	74	52	72	59
9-Hammond/Slidell	28	44	49	39	56	59	50	62	90	73

New AIDS Trends by Region and Year Louisiana, 2001-2010										
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Louisiana	**887**	**969**	**893**	**863**	**805**	**766**	**802**	**845**	**793**	**805**
1-New Orleans	379	358	346	350	267	223	263	268	238	251
2-Baton Rouge	240	278	238	216	200	225	221	251	201	238
3-Houma	30	33	35	28	29	42	31	32	34	48
4-Lafayette	42	77	57	56	66	65	57	62	51	63
5-Lake Charles	36	39	47	42	38	35	39	38	42	29
6-Alexandria	34	37	35	39	31	31	32	36	42	37
7-Shreveport	57	59	49	59	73	52	78	78	78	53
8-Monroe	43	53	45	45	57	48	39	40	55	44
9-Hammond/Slidell	26	35	41	28	44	45	42	40	52	42

Geographic Distribution of HIV Louisiana, 2010						
Region	**Parish**	**AIDS Diagnoses in 2010***	**HIV Diagnoses in 2010**	**HIV Diagnosis Rate 2010****	**Persons Living with HIV Infection 2010**	**Deaths 2009**
Statewide		**805**	**1,174**	**26**	**17,679**	**529**
Region 1		**251**	**366**	**44**	**6,384**	**159**
	Jefferson	60	87	20	1,644	44
	Orleans	183	266	77	4,585	110
	Plaquemines	1	2	n/a	32	3
	St. Bernard	7	11	31	123	2
Region 2		**238**	**305**	**46**	**4,402**	**128**
	Ascension	9	13	12	184	5
	East Baton Rouge	185	243	55	3,369	108
	East Feliciana	5	7	35	153	4
	Iberville	26	26	78	394	5
	Pointe Coupee	2	2	n/a	49	1
	West Baton Rouge	5	5	21	108	3
	West Feliciana	6	9	58	145	2
Region 3		**48**	**58**	**14**	**611**	**21**
	Assumption	3	1	n/a	20	3
	Lafourche	11	13	14	97	3
	St. Charles	7	8	15	84	2
	St. James	2	0	0	54	0
	St. John the Baptist	7	15	33	107	3
	St. Mary	8	8	15	75	1
	Terrebonne	10	13	12	174	9
Region 4		**63**	**97**	**17**	**1,320**	**41**
	Acadia	4	9	15	95	2
	Evangeline	3	5	15	59	2
	Iberia	6	10	14	109	3
	Lafayette	31	40	18	631	22
	St. Landry	11	22	26	248	6
	St. Martin	3	7	13	96	3
	Vermilion	5	4	n/a	82	2
Region 5		**29**	**49**	**17**	**961**	**20**
	Allen	2	2	n/a	226	2
	Beauregard	2	2	n/a	40	1
	Calcasieu	21	41	21	633	16
	Cameron	0	0	0	2	0
	Jefferson Davis	4	4	n/a	60	1

Geographic Distribution of HIV Louisiana, 2010						
Region	**Parish**	**AIDS Diagnoses in 2010***	**HIV Diagnoses in 2010**	**HIV Diagnosis Rate 2010****	**Persons Living with HIV Infection 2010**	**Deaths 2009**
Statewide		**805**	**1,174**	**26**	**17,679**	**529**
Region 6		**62**	**61**	**20**	**736**	**29**
	Avoyelles	6	4	n/a	133	5
	Catahoula	0	0	0	23	3
	Concordia	3	5	24	38	4
	Grant	1	4	n/a	27	1
	La Salle	3	9	60	13	0
	Rapides	16	33	25	393	15
	Vernon	3	6	11	53	0
	Winn	5	0	0	56	1
Region 7		**120**	**106**	**19**	**2,150**	**61**
	Bienville	1	2	n/a	28	1
	Bossier	8	12	10	156	9
	Caddo	32	73	29	904	37
	Claiborne	3	3	n/a	58	2
	De Soto	1	3	n/a	48	2
	Natchitoches	5	9	23	105	2
	Red River	0	0	0	6	5
	Sabine	0	0	0	19	2
	Webster	3	4	n/a	54	1
Region 8		**44**	**59**	**17**	**918**	**40**
	Caldwell	1	2	n/a	16	0
	East Carroll	2	1	n/a	33	3
	Franklin	0	3	n/a	25	2
	Jackson	2	2	n/a	38	1
	Lincoln	4	5	11	60	3
	Madison	0	1	n/a	48	2
	Morehouse	3	8	29	64	1
	Ouachita	23	25	16	509	23
	Richland	4	7	34	38	4
	Tensas	3	3	n/a	36	0
	Union	2	1	n/a	40	1
	West Carroll	0	1	n/a	11	0
Region 9		**42**	**73**	**13**	**969**	**30**
	Livingston	7	12	9	146	5
	St. Helena	0	0	0	15	2
	St. Tammany	10	17	7	330	6
	Tangipahoa	19	38	31	310	10
	Washington	6	6	13	168	7

*AIDS diagnoses will be included in counts of HIV diagnosis (3rd Column) for persons first detected with HIV at an AIDS diagnosis or within the same year; therefore numbers from the two columns should not be added.
**Rates per 100,00 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, 2009		
	2009 Deaths	**Percent**
Total Deaths	**529**	**100%**
Diagnosis at Death		
AIDS	450	85.1%
HIV	79	14.9%
Sex		
Female	162	30.6%
Male	367	69.4%
Race/Ethnicity		
Black/African American	383	72.4%
Hispanic/Latino	7	1.3%
White	129	24.4%
Other	10	1.9%
Age at Death		
0-12	0	0.0%
13-19	3	0.6%
20-24	5	0.9%
25-34	68	12.9%
35-44	142	26.8%
45-54	177	33.5%
55-64	97	18.3%
65+	37	7.0%
Imputed Transmission Category		
Men who have sex with men (MSM)	198	37.4%
Injection Drug User (IDU)	157	29.7%
MSM/IDU	49	9.3%
High Risk Heterosexual (HRH)	115	21.7%
Transfusion/Hemophilia/Other	7	1.3%
Perinatal/Pediatric	3	0.6%
Region		
1-New Orleans	159	30.1%
2-Baton Rouge	128	24.2%
3-Houma	21	4.0%
4-Lafayette	41	7.8%
5-Lake Charles	20	3.8%
6-Alexandria	29	5.5%
7-Shreveport	61	11.5%
8-Monroe	40	7.6%
9-Hammond/Slidell	30	5.7%
Rural/Urban		
Rural	83	16.0%
Urban	446	84.0%

Program Report Technical Notes

Report Format

Previous Program Reports contained only HIV and AIDS data. The 2010 Program Report is the first effort to combine HIV, AIDS and STD data into a single report. More complete 2010 STD data is available in detail in the STD Annual Report, released in December 2010. The STD Annual Report can be found on the DHH website, http://dhh.louisiana.gov/std. This STD/HIV Program Report is divided into six chapters, Introduction to the HIV Epidemic, HIV Care and Services, HIV Prevention, Introduction to the STD Epidemics, STD Prevention and Services, and Evaluation.

Tabulation of Data

This report includes all STD information entered at the STD/HIV Program office as of May 6, 2011 and all HIV information entered as of August 14, 2011. Chlamydia, gonorrhea, syphilis, congenital syphilis, HIV and AIDS cases diagnosed through 2010 are included in this report. The 2010 data are very complete and are not adjusted for a potential reporting delay. Due to reporting and collection delays for deaths and pediatric HIV cases, those data are reported only through 2009 to ensure complete data.

Census Data and Rate Calculation

For all 2010 rates, the 2010 census data was obtained from the U.S. Census Bureau. For all rates calculated for years 2001-2009, mid-year estimates for populations were obtained from the U.S. Census Bureau. 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 2010 for the New Orleans Public Health Region 1, the 2010 Census populations for the four parishes within Region 1 are added together equaling a regional population of 835,320 persons. Then the number of new HIV diagnoses in Region 1 in 2010, 366 new diagnoses, is divided by the totaled population, 835,320 persons to get 0.000438. This number is multiplied by 100,000 to result in an HIV case rate of 43.8 per 100,000 population for Region 1 in 2010.

Recent Changes in HIV and AIDS Terminology

Previously the term HIV/AIDS was used to refer to three categories of diagnoses collectively: a diagnosis of HIV (not AIDS), a diagnosis of HIV infection with a later diagnosis of AIDS within the same year, and concurrent diagnoses of HIV and AIDS. For this report, the term *HIV Infection* was substituted for *HIV/AIDS* to represent the same three categories.

In previous reports, risk categories were referred to as *Mode of Exposure* or *Exposure Categories.* For this report, risk categories were referred to as *Transmission Categories.* All of the transmission categories selected for this report are described below under "Definitions of Transmission Categories."

Interpretation of HIV Data

Antiretroviral treatment regimens are initiated earlier in the course of HIV infection than in the past. These therapies postpone and/or prevent the onset of AIDS, resulting in a decrease in AIDS incidence. Consequently, recent AIDS incidence data can no longer provide the basis of HIV transmission estimates and trends, and the dissemination of surveillance data now places an emphasis on the representation of HIV-positive persons. Throughout this report, all AIDS data are depicted by characteristics at year of AIDS diagnosis under the 1993 AIDS case definition, and HIV data are characterized at year of HIV diagnosis (earliest positive Western blot or detectable viral load reported to the health department).

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 or persons who have only been tested anonymously.

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.

HIV Case Definition Changes

The CDC HIV and AIDS case definitions have changed over time based on knowledge of HIV disease and physician practice patterns. The original definition for AIDS was modified in 1985.[39] The 1987 definition[40] revisions incorporated a broader range of AIDS opportunistic infections and conditions and used HIV diagnostic tests to improve the sensitivity and specificity of the definition. In 1993, the definition was expanded to include HIV-infected individuals with pulmonary tuberculosis, recurrent pneumonia, invasive cervical cancer, or CD4 T-lymphocyte counts of less than 200 cells per ml or a CD4 percentage of less than 14.[41] As a result of the 1993 definition expansion, HIV-infected persons were classified as AIDS earlier in their course of disease than under the previous definition. Regardless of the year, AIDS data are tabulated in this report by the date of the first AIDS-defining condition in an individual under the 1993 case definition.

The case definition for HIV infection was revised in 1999 to include reports of detectable quantities of HIV virologic (non-antibody) tests.[42] The revisions to the 1993 surveillance definition of HIV include additional laboratory evidence, specifically detectable quantities from virologic tests. The perinatal case definition for infection and seroreversion among children less than 18 months of age who are perinatally-exposed to HIV was changed to incorporate the recent clinical guidelines and the sensitivity and specificity of current HIV diagnostic tests in order to more efficiently classify HIV-exposed children as infected or non-infected.

Most recently, the surveillance case definitions were revised in 2008 for adults and adolescents (age ≥13 years).[43] 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.

Definitions of the 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 men who report sexual contact with other men, i.e. homosexual contact or bisexual contact.

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.

Additional Notes

- All percentages displayed in this report are rounded to either one or zero decimal points. Due to this rounding, they may not equal 100% when summed.
- When calculating rates, if the numerator was <5, the rate is considered unstable and marked as 'n/a.'

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