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Volunteerism and the Fight Against HIV/AIDS in Post-Katrina Louisiana

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Volunteerism and the Fight Against HIV/AIDS in Post-Katrina Louisiana

by

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Undergraduate honors thesis under the direction of

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the Upper Division Honors Program.

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Dedication

This thesis is dedicated in honor of my grandmother, Brenda Jarrell, who passed away during this research. Her embodiment of the Good Samaritan spirit and commitment to education inspired me to complete this work.

ABSTRACT

On August 29, 2005 Hurricane Katrina made landfall off of Louisiana's southeastern coastline. The destruction of this storm only served to exacerbate an ongoing HIV/AIDS epidemic in southern Louisiana. Those infected and the volunteers and health care professionals who served them before the storm were cut off from one another. Like the architectural rebuilding of Louisiana, many non-profit volunteer organizations in Southern Louisiana are undergoing change. Conditions in post-Katrina Louisiana have caused increasing regional stratification within the HIV/AIDS community. This demarcation in geography and cooperative efforts has separated volunteers and their organizations from developing a statewide, unified culture of healing. Volunteerism has shrunk in size and scope in recent years. Non-profit organizations have had difficulty both retaining and training a new wave of volunteers to support and educate the community. The separation of volunteer support from city to city as well as by age, race, and education has hindered how each organization provides succor and education to the infected and at risk community. Within each organization, participant observation and individual interviews yielded the discovery of uniquely different volunteer cultures and behaviors created by the volunteers as they continue to rebuild HIV/AIDS support networks in post-Katrina southern Louisiana.

List of Abbreviations

AIDS-	Acquired Immune Deficiency Syndrome
BRASS-	Baton Rouge AIDS Society
CDC-	Center for Disease Control and prevention
ERI-	Entry Fusion Inhibitor
NRTI-	Nucleoside/Nucleotide Reverse Transcriptase Inhibitors
HIV-	Human Immunodeficiency Virus
HRH-	High Risk Heterosexual contact
LSU-	Louisiana State University
MSM-	Men who have Sex with Men
IDU-	Injection Drug Users
DHH-	Department of Health and Hospitals
NO/AIDS-	New Orleans AIDS Task Force
PLWHA-	People Living With HIV/AIDS
LOPH-	Louisiana Office of Public Health

*Names of volunteers have been changed to protect their anonymity

I. History of HIV/AIDS: a Global Community

In 1985, President Reagan first acknowledged the presence of an HIV/AIDS epidemic in the United States. This was five years after the Center for Disease Control and Prevention identified the growing infection in males from New York and California. All of the men were in their mid to early twenties yet suffered from opportunistic infections ranging from Kaposi's Sarcoma to *Pneumocystis carinii* pneumonia. These infections had only previously been seen in elderly patients and those suffering from tuberculosis. In the following decade, thousands of Americans perished from HIV/AIDS related complications. Blame, lack of education, and fear kept many from accessing clinical treatment and social support.

The stigmas associated with HIV/AIDS infection have prevailed into the 21st century, but not without the growth of national and community based relief groups combating this image. In Louisiana, these volunteer organizations suffered debilitating losses in number and efficacy after Hurricane Katrina. The consequences of these setbacks have had a multi-faceted effect on the men and women who serve within these organizations. The continued efforts of these volunteers to promote HIV/AIDS education and support to the afflicted in a post-Katrina environment, has met with significant setbacks both from outside and within the organizations themselves. However, the beginning of the HIV/AIDS epidemic goes back thousands of years earlier and to a different species entirely.

a. Evolutionary Pathways

The geographic and evolutionary origins of the Human Immunodeficiency Virus (Figure 1) have been debated by biologists and anthropologists alike. It would be much too narrow to take the anthropocentric view on HIV that it began and is centered on humans. In modern HIV/AIDS evolutionary circles there are five main theories of origin. However, it is mostly

accepted that the Human Immunodeficiency Virus is a descendant variation of the Simian Immunodeficiency Virus that affects modern monkeys. The closest SIV relative to HIV-1 (the most common and widespread form of HIV) was located in chimpanzees by Drs. Sharp and Hahn in 1999¹. This same theory also supports the geographic origination idea that HIV arose out of Central and West African nations. The unique variation on SIV compared with HIV is that SIV positive chimpanzees are asymptomatic. That is they do not succumb to debilitating, opportunistic infections or diseases which has been the main cause of HIV related deaths around the world.

Other theories that have garnered international attention include the Hunter Theory, the Contaminated Needle Theory, the OPV Theory, the Colonialism Theory, and the Conspiracy Theory (NO/AIDS 2008). The Hunter Theory works cohesively with the scientific discovery of SIV in chimpanzees, and is popularly accepted in many evolutionary circles. The theory argues that SIV originated in Central or Western Africa where chimpanzees were often hunted as a food source. Blood from SIV positive chimpanzees could often be transferred by consumption or open wounds on these early African hunters. From there, evolutionary experts argue that the virus mutated to become compatible with human hemoglobin (NO/AIDS 2007). The second more controversial theory also takes its origins from Africa. The Contaminated Needle Theory explains that disposable syringes, made popular in the mid 1950s, were used on multiple patients multiple times rather than being disposed after a single use. It was not economical for most African countries in the 1950s to pay for more syringes. The theory argues that HIV-1 was transferred to multiple patients because of this practice. However, denouncers of this theory argue that syringes were not widely used enough through Africa to warrant the AIDS pandemic (NO/AIDS 2008).

The Oral Polio Vaccine is another historically controversial theory. Proponents of this theory argue that HIV-1 was transmitted by the oral polio vaccine CHAT². CHAT was widely used as a polio vaccine in the major parts of Rwanda and the Congo. The controversy is based on CHAT's development through kidney cells of indigenous chimpanzees. Dr. Edward Hooper argued that contaminating the CHAT with SIV could have then led to an HIV-1 mutation in the populations of Rwanda and the Congo (NO/AIDS 2008). However, this is not widely believed as it is difficult to contract HIV-1 orally.

The final remaining accepted theories are the Conspiracy Theory and the Colonialism Theory. The Conspiracy Theory argues that HIV-1 was constructed as a potential weapon of biological mass destruction. The theory goes to argue that the targets of this virus were African American and homosexuals as their populations have suffered the most from HIV-1. This theory has never been proven but has given way to several smaller offshoot theories such as: HIV was put in smallpox vaccines for African Americans as well as homosexual trials for a Hepatitis B vaccine (BRASS 2009). The final theory, the Colonialism Theory, dates back the early 20th century. The argument was made that due to the colonization of Africa and the enslavement of its inhabitants, SIV was able to find weak enough sources to mutate on and develop into HIV-1. Inhumane working conditions and heavy labor would have been the major factors in the mutation of SIV to HIV on sickly Africans. Unfortunately while each theory has its proponents and detractors, none can officially be proven as the start of HIV-1 (BRASS 2009). There is not enough genetic and historical evidence to conclusively say how SIV mutated into HIV-1

b. Transmission and Progression

There are many modes and types of progression of HIV to AIDS. The CDC recognizes today that HIV is most often transmitted through various forms of sexual contact, infected needle

users, and through infected blood transfusions (CDC 1999). They also dispel the commonly held belief that HIV can be transmitted through sweat, saliva, insect bites, and tears. This myth contributed to much of the stigma and alienation that HIV positive victims experience today (CDC 1999).

One HIV positive male interviewed in New Orleans explained, “When I told my parents I had HIV they completely changed. Now I found out pretty early on in ’85 when everyone was running scared, but my parents I expected to accept that I was still the same person. They didn’t take it well, and for every family holiday after that they made me use my own set of utensils, cups and plates. No one else would touch this stuff because they were worried that if they ate off of a plate I had used they’d get HIV.” His experiences are not uncommon to many who found out they were HIV positive in the 1980s. Many HIV/AIDS organizations use education as their primary means of combating this type of ignorance in the unaffected population.

HIV progresses in four stages (Figure 2). At initial infection a patient is registered as having and Acute HIV infection. Patients often reported feeling rundown, having the flu, or a bad cold. This incubation period only lasts for several weeks or months after initial infection. Progressing to stage two means that patients have developed asymptomatic HIV (NO/AIDS 2008). Often called the rest period or the “honeymoon stage”, patients return to a perceived normal physical state. Here HIV can incubate from six months to twenty years. It is noted that this stage is asymptomatic; however some patients reported yeast infections and swollen lymph nodes. As HIV incubates and increases its viral load, the body’s T cells cannot replicate fast enough to eradicate the virus. Stage three or symptomatic HIV is the second to last stage of the virus. Patients reported experiencing excessive symptoms such as: Herpes Zoster, weight loss, thrush, diarrhea, night sweats, consistent yeast infections, abnormal PAP smears in women, and

fever. This is the stage at which most patients find they have been infected with HIV, if they are not regular testers. The final stage or advanced HIV (AIDS) is characterized by major health complications, opportunistic infections, and T cell counts of 200 or below (NO/AIDS 2008).

The progression from HIV to the Acquired Immunodeficiency Syndrome or AIDS is the final stage of the infection's progression. After a patient has had HIV for a certain period of time, the infection will eliminate a person's CD4+ T cell count³. T cells are the body's immune system building blocks. Without an adequate number of T cells, HIV positive patients will progress into the AIDS stage. With AIDS most individuals are highly susceptible to opportunistic infections including Tuberculosis, Pneumocystis, and some cancers such as Kaposi's Sarcoma. The CDC, in 1996, developed major drug therapies to elongate the incubation period (STAGE 3) between HIV and AIDS. Previously men and women only had about ten years before succumbing to stage 4 or AIDS (CDC 1996).

c. AIDS in the United States

In April of 1981 scientists at the Center for Disease Control and Prevention received reports of the presence of Kaposi's Sarcoma⁴ and Pneumocystis carinii pneumonia⁵ in young gay men from New York and California. The situation was unique as these conditions were originally only found in the elderly. With these reports, the CDC had its first documented cases of AIDS in the United States. The emergence of HIV and AIDS in the United States was most likely ten to twenty years before it was reported, but the inability to identify the disease outside of related opportunistic infections kept many scientists in the dark. In the CDC's *Morbidity and Mortality Weekly Report* for June of 1981, it was reported that a deadly strain of pneumonia was quickly making its way through the gay male population. As the CDC began to follow this

emergence of grave opportunistic infections in young gay males, they designated a task force to research the “Gay Related Immune Deficiency” or GRID.

In 1982, the CDC declared that GRID was in fact acquired immune deficiency syndrome or AIDS and was transmissible through blood. To provide social and medical support services the Gay Men’s Health Crisis⁶ was founded in New York City. This was the first volunteer organization created to support those infected with HIV/AIDS. From 1982 to 1985 over 7,000 deaths in the United States were listed as AIDS related, and the CDC in 1983 began its first screenings of blood banks for HIV/AIDS. The 1983 Annual CDC report claimed, “persons who may be considered at increased risk of AIDS include those with symptoms and signs suggestive of AIDS, sexual partners of AIDS patients, sexually active homosexual or bisexual men with multiple partners, Haitian entrants to the United States, present or past abusers of IV drugs, patients with hemophilia, and sexual partners of individuals at increased risk for AIDS” (CDC 1983).

Institut Pasteur and Dr. Robert Gallo claimed to have discovered the HIV virus by 1985, and President Reagan first addressed the US Congress about AIDS in his “Message to the Congress on America’s Agenda for the Future” in 1986 (NO/AIDS 2008). A growing fear of the HIV/AIDS epidemic began to develop into distinct social stigmas resulting in the arson of homes of PLWHAs and barring HIV positive students from school. The latter incident made 13 year hemophiliac Ryan White⁷ famous as he was refused entry to his classes after school administrators were notified of his HIV positive status. In the next three years, scientists developed the first rounds of HIV/AIDS drug therapies for mainstream use. The development of the drug therapy AZT⁸ was the first major breakthrough in HIV treatment in the US. By 1986

over 15,000 AIDS cases had been reported to the CDC, and the CDC advised HIV positive females against breastfeeding for fear of HIV transmission.

In May of 1988 the US released its first HIV/AIDS education and awareness initiative. The goal was to help citizens better understand AIDS, the risks, and how to prevent transmission. By 1990 Bristol Myers Squibb began marketing ddI⁹ and Roche began marketing ddC¹⁰ as alternatives to the commonly used AZT therapy. In April of 1990 Ryan White died from AIDS just months before Congress passed the Ryan White CARE Act¹¹. His death along with notable others such as actor Rock Hudson began to change how US citizens viewed the face of AIDS. By 1991 the CDC began reporting that HIV/AIDS positive health care providers should be barred from practice for the safety of their patients. As more became known about the risks and transmission pathways of HIV/AIDS, hysteria and fear of the disease began to abate in society. In 1994 the CDC began touting the benefits of condom usage to prevent the spread of HIV/AIDS, and by 1995 they reported that AIDS was the number one cause of deaths in Americans aged 25 to 44 (CDC 1995).

By 2000 the number of African American and Hispanic AIDS cases surpassed those of gay white males in the United States (CDC 2000). This shift in at risk demographics motivated notable celebrities like Jesse Jackson to begin publicly taking HIV tests is an attempt to motivate minorities to seek testing. The US Agency for International Development created the first national AIDS and sexual transmission initiative “ABC” or abstinence, being faithful, and condom use. In 2003 the anti-HIV drug Fuzeon¹² was put on the market. Unlike the other drug therapies before it, Fuzeon was able to prevent “the entry of HIV into human cells” (CDC 2003). By 2006 the CDC reported that there were 545,805 people living with AIDS in the United States. The increased number of AIDS patients was also related to the aging of the HIV population.

Through better drug therapies, counseling, and consistent primary care many people living with HIV/AIDS were surviving into their fifties and sixties (CDC 2006). Today AIDS ranks in the top three causes of death amongst African American men and women ages 25-54 (CDC 2008). The need for continued monitoring and preventative education in the United States will determine if HIV/AIDS cases continue to grow or decline in the 21st century.

d. Methodology

This research began after my first year of undergraduate study at Louisiana State University in Baton Rouge. In the wake of Hurricane Katrina, which made landfall during the first week of my college career, I felt compelled to become an EMT-Paramedic. In training during the summer of 2006, I learned about the HIV/AIDS epidemic through my clinical runs in the city of Baton Rouge. EMTs are exposed to many health issues while on call, and I came to know the infection first hand through my patients. After researching further, I uncovered the dramatic rise in HIV/AIDS cases in Louisiana over the past two decades. Being a volunteer EMT, I also questioned what motivation people had to become HIV/AIDS volunteers. This was the beginning of two years of research on HIV/AIDS and the volunteer organizations serving that community in southern Louisiana.

The culture within an HIV/AIDS volunteer organization is very confidential. Protection of the identities of volunteers and the infected community they serve is of the utmost importance. Historically, those infected and those associated with HIV/AIDS have been met with fear, disapproval, and even anger by mainstream society. Ignorance of the disease and its ramifications have largely contributed to this misunderstanding of an ever growing population. To learn more about these volunteer organizations and simultaneously protect their identities, I chose to train as a HIV/AIDS volunteer rather than as pure observer or part time interviewer. In

becoming a part of the volunteer community, I agreed to the same confidentiality that protects these men and women.

Using the ethnographic method of “participant observation” I was able to see firsthand how these organizations operate both in the clinical and the familial settings. Participating in volunteer training and social support events, like the NO/AIDS Walk of New Orleans and education and prevention testing in Baton Rouge, allowed my research to take on a more multi-dimensional purpose. Rather than solely relaying information about these organizations that has already taken place, I was able to form general conclusions about where these HIV/AIDS volunteers see their organizations going. In commuting between Baton Rouge and New Orleans for the past two years, I was able to work with and interview many different volunteers within non-profit HIV/AIDS organizations as well as some health care providers who specialize in HIV/AIDS.

Extensive notes were made about the kinds of volunteers they have, how they were started, and what they see for the future fight against HIV/AIDS. The differences between these organizations and their volunteers were highlighted over the course of this research. Later in the study, I noted how the effects of Hurricane Katrina have extensively changed and in many cases damaged the hierarchies that have been put in place to support these organizations. My research then included the effects of Katrina on these volunteers and their community. Based on geography and level of destruction, these organizations have fared differently in the past few years as they seek to mobilize the community to join the fight against HIV/AIDS.

After including New Orleans and Baton Rouge as the primary areas of research, I then chose to include how HIV/AIDS has spread to campus. Due to the nature of Southern University and Louisiana State University’s health centers, my research moved more towards interview

based study to gather information on their handling of the epidemic. However, in working with a former EMT colleague, I became involved in starting wholly new HIV/AIDS relief organization on LSU's campus. The creation of this organization and my intimate involvement with it allowed me to research the evolution of an HIV/AIDS organization from the beginning. This experience was unique, as the organizations I had previously worked with had been established all in the past two decades.

It was my intention to observe very diverse non-profit volunteer organizations for the purpose of showing how multi-dimensional the treatment of the HIV/AIDS population can be. In conducting this research, I aimed to answer questions about volunteer motives and what will happen to the HIV/AIDS community if society remains apathetic or uninformed. Not only did this research allow me to become intimately acquainted with the HIV/AIDS issue within Louisiana, it also allowed me as a volunteer and an EMT to contribute to the community. This kind of community commitment and involvement was one of the most inspiring parts of this research. It was my hope that by the end of this study I would have inspired others to become volunteers in the HIV/AIDS community here in Louisiana.

II. HIV/AIDS in Louisiana

HIV and AIDS were central concerns for Louisiana very early in epidemic. Pervasive fear and distrust of the homosexual population during the early 1980s led to mistreatment, lack of HIV/AIDS primary care, and no social support system for those infected. HIV/AIDS prevention education was not implemented into most medical training programs until after 1983 (LOPH 1998). Ignorance of the infection and limited resources led to a sharp spike in HIV/AIDS infection rates in Southern Louisiana. As well as afflicting the homosexual population, HIV/AIDS was slowly and quietly making its way through the African and Hispanic American

communities in Louisiana. These minorities have historically been at risk due to large numbers living below the poverty line with no consistent primary care or health insurance (Figure 3).

Society and the government's delayed reaction to reporting and treating HIV/AIDS in Louisiana led to significant lag time in how the public was informed of current HIV/AIDS conditions through 1998. Delayed reaction by officials led to delayed acceptance of the infection by residents, and for the first decade of the AIDS epidemic most infected Louisiana citizens remained closeted about their condition. The creation of the NO/AIDS Task Force in 1983 was the first volunteer based social network for the infected and affected citizens of southern Louisiana. They were the only HIV/AIDS social services network in southern Louisiana for most of the 1980's.

By the 21st century, Louisiana was dealing with a full blown HIV/AIDS epidemic. Consistently placing in the top twenty for states with new and cumulative HIV/AIDS cases, health professionals and public health volunteers alike began to change how they treated people living with HIV/AIDS. As more was discovered about the transmission and spread of HIV/AIDS, grassroots volunteer organizations like NO/AIDS as well as new governmental programs like the HIV/AIDS program (HAP) within LOPH made significant strides in their support of the people living with HIV/AIDS (PLWHA). Volunteers and health care workers alike have had difficulty dealing with the impediments left in the wake of Hurricane Katrina.

a. Demography and Cultural Indicators: Before the Storm

Populations most at risk for contracting HIV/AIDS in Louisiana have also traditionally been some of the most discriminated against. In 1998 African Americans made up 55 percent of cumulative HIV/AIDS cases and 73 percent of new HIV/AIDS cases in southern Louisiana. Caucasians accounted for 42 percent of cumulative HIV/AIDS cases in Louisiana (LOPH 1998).

Southern Louisiana volunteers, due to racial and HIV/AIDS discrimination, were tasked with being health advocates and educators for the efficacy of PLWHAs and their families early in the fight. HIV/AIDS in Louisiana is predominately located in large urban areas, specifically New Orleans and Baton Rouge. Rural areas only accounted for 11 percent of cumulative HIV/AIDS cases in 1998 (Figure 4). By 1995 AIDS had become the leading cause of death in males ages 25-44, outranking cancers and heart disease (LOPH 1998)

The Louisiana Office of Public Health and the Center for Disease Control and Prevention have divided the Louisiana's PLWHAs and at risk groups into six subcategories¹³: men who have sex with men (MSM), injection drug users (IDU), high risk heterosexual contact (HRH), hemophilia//transfusion/transplant (Hemo/Transf), perinatal, and unspecified (LOPH 1998). There was a general consensus among HIV/AIDS advocates interviewed in this research that the MSM population has traditionally been the largest source of new infections in southern Louisiana. However, according to the LOPH a growing number of new HIV cases are attributed to high risk heterosexual contact (LOPH 1998). This growing change in the demography of PLWHAs has attributed to a shift in how volunteer organizations address HIV/AIDS education initiatives.

Aside from ethnicity and sexual behaviors, HIV/AIDS demographics are further divided by age, gender, education, and economic standing. The HIV/AIDS population in Louisiana during the 1980's was largely unreported and at very best the LOPH was only able locate about 85 percent of the infected population. One volunteer in New Orleans Michael* explained, "I got HIV in 1985, and I wasn't the first one of my friends to get it. Just like everywhere else it was a gay men's problem, and so we didn't get a lot of support. Back in the 80s it really did seem like it only affected gay white guys. I guess if we'd known then that more black people got it than us,

I would have tried harder to help out. But once I got over having HIV, I really only worked with other guys exactly like me.” This kind of cultural and ethnic stratification early in the HIV/AIDS epidemic of Louisiana kept many who were afflicted from connecting with one another and demanding social change.

Based on the earliest 1998 report from the LOPH, most persons contracting HIV/AIDS were between the ages of 25-34 (42%) and 35-44 (29%) (Figure 4). Even at the beginning of 21st century males accounted for 80% of all HIV/AIDS cases. Two statistics that have largely gone unreported until after Hurricane Katrina are education and economic standing. Affluent homosexual males were able to access better primary care for themselves and their partners, and higher education as well as prevention training contributed to why Caucasian MSMs were increasingly outstripped by African American MSMs in numbers. That same education and affluence contributed to how well publicized the HIV/AIDS problem was for Caucasian MSMs. The New Orleans volunteer Michael* again explained, “My partner and I both joined NO/AIDS Task Force to help out with the problem, but also so that we could get more people talking about it. Back in the 80s NO/AIDS was small but we had resources. We got support from the government and the Ryan White legislation gave us a huge boost in funds to help test and educate. But again had I known what we know now about who’s getting HIV in Louisiana we would have changed our community outreach.”

The last report before Hurricane Katrina hit was issued by the LOPH in 2004. Eight months before Katrina AIDS and HIV numbers were optimistic. There had only been a slight increase in numbers since 1999. In 2004 there were an estimated 24,762 people living with HIV or AIDS, and only 1,113 new cases were diagnosed (LOPH 2004). However, the face of AIDS was slowly changing. While male HIV cases were on the decline, women represented 31 percent

of new HIV/AIDS cases. African Americans still consistently had the highest percentage of new cases with 851 diagnosed in 2004. Most startling, before Hurricane Katrina, was that persons aged 13 to 24 were still the third largest group contracting HIV/AIDS in Louisiana (Figure 5).

By the time of the storm, HRH contact was the second largest exposure category (25%) with MSMs still retaining 48 percent of all HIV/AIDS cases. Before the destruction of Hurricane Katrina in 2005, many men and women with HIV/AIDS were seeking care at local charity hospitals and through federally subsidized outpatient programs. With male HIV cases in decline and a slowly increasing HIV/AIDS population, many AIDS volunteers and experts in Louisiana had reason to be optimistic about getting better control of the infection in the coming years. However with the evacuation of much of southern Louisiana to Texas, Mississippi, and other states the face of HIV/AIDS and its volunteers would be forever changed.

b. Conditions in Post-Katrina Louisiana

After Hurricane Katrina washed ashore in August of 2005, many PLWHAs and their medical-social support networks were destroyed. The evacuation of all regions south of New Orleans meant that over 5,000 HIV/AIDS positive persons were moved into new environments and previously unexposed locales. However, the biggest risks were not associated with PLWHAs moving to new homes, but how the storm interrupted medical care and social support. The need for consistent medical treatment is essential to many PLWHAs surviving as long as they do. However, medical offices were underwater and patients were in new cities with no record of their medical history; finding treatment and funding for those expenses became the largest reason why many Louisiana PLWHAs went without therapy for weeks or months after the storm. Volunteers who supported the HIV/AIDS community found they were unable to contact many of

their patients as well as unable to get back into the city to reestablish a relief network for many displaced HIV/AIDS positive residents.

After the storm abated, many nearby HIV/AIDS organizations were on hand to take in Louisiana PLWHAs, but even their own resources were strained by the storm. The Louisiana Office of Public Health began to republish its annual report a year and half after Katrina. The 2005-2006 annual report indicated that HIV and AIDS cases were still on the rise. However, an unsettling new statistic arose as Baton Rouge became the fourth highest city with new HIV/AIDS cases in the country. The need for better treatment and assessment in regions outside of the greater New Orleans was quickly becoming apparent.

Volunteers with New Orleans organizations were unable to get back into offices and action until many months after the storm, and even then many were unable to reach many of their previous clients. However, other areas of the state like Baton Rouge that had been previously second tier to the HIV/AIDS epidemic in New Orleans realized the growing infection rate in their own city limits. After New Orleans was opened back up to residents and in the months after Katrina, many HIV/AIDS patients continued to go without necessary care due to the closing of Charity Hospital. Charity had been the beacon for many uninsured HIV/AIDS positive patients needing emergency care and medicine. After Katrina, with the closing of Charity, many patients who remained uninsured were unable to set up appropriate treatment or apply for Medicaid.

In the two years after Hurricane Katrina, Louisiana experienced a four percent drop in its total population and 19 percent of the population was living below the poverty line (LOPH 2006). In 2006, there were over 1,000 new cases diagnosed in Louisiana, and many of those cases trended higher in central Louisiana regions like Baton Rouge. Women also represented 32 percent of the newly diagnosed HIV cases in Louisiana. The number of new diagnoses had

previously been on the decline from 2002 to 2006. However, in the wake of Hurricane Katrina and the disruption of primary care, HIV cases made a resurgence. A common trend before a rise in HIV rates is a rise in other types of sexually transmitted infections. “In 2006, Louisiana ranked 1st in the nation in primary and secondary syphilis rates (7.6 per 100,000), 3rd in gonorrhea rates (240.6 per 100,000) and 13th in Chlamydia rates.” (LOPH 2006). This rise in the number of STIs indicated that HIV cases would continue to increase in the coming years.

As of 2009, 28,843 cumulative cases had been reported in Louisiana for HIV/AIDS (LOPH 2009). The most common type of HIV/AIDS exposure was still men who have sex with men ranking at 48 percent, but high risk heterosexual contact represented one quarter of HIV/AIDS exposure in 2009. The continued rise in women contracting HIV/AIDS to 33 percent identifies an increasingly grave problem. The importance of sexual health advocacy in women from the ages of 25-34 has been a largely ignored subset of HIV/AIDS preventative education. Mostly geared towards an MSM population, many organizations in recent years have started to develop unique programs for women who may be engaging in sexual relationships with MSMs. The rise of the outwardly heterosexual MSM population in the African American communities has been a contributing factor in the rise of HIV infections in young African American females (LOPH 2009).

III. HIV/AIDS in New Orleans

The presence of HIV/AIDS in New Orleans was reported very early in the epidemic. By 1983, the first non-profit volunteer organization in Louisiana, the NO/AIDS Task Force, was started in New Orleans. Culturally speaking, the greater New Orleans area has long been viewed as a more urban and permissive region than any other in the state. The prevalence of HIV/AIDS in New Orleans as well as a large, established homosexual population led to an early community

mobilization in southern Louisiana in support of those affected by HIV/AIDS. By 1998 New Orleans was ranked 11th in new HIV/AIDS cases in large urban cities by the Louisiana Office of Public Health. However, after Hurricane Katrina the evacuation of the New Orleans displaced many of its HIV/AIDS positive residents. This dispersal has markedly changed the face of HIV/AIDS in New Orleans, but many argue that the change is only temporary as residents continue to migrate back to the city.

a. Demography and Cultural Indicators

Due to poor census reporting and voluntary testing, the earliest indications of the HIV/AIDS population in New Orleans are arguable. However, LOPH reports from 1984 yielded fairly obvious results for the greater New Orleans area (LOPH 1984). The disease affected primarily Caucasian males between the ages of 25 and 44 who engaged in homosexual relationships. This same pattern was seen in other large urban areas around the nation including: San Francisco, Miami, New York City, and others. As widespread hysteria about HIV set in, many PLWHAs were forced to keep their infection a secret from friends, family, and coworkers. In 1983, with the creation of the NO/AIDS Task Force, a rise in social consciousness and volunteer efforts in New Orleans marked a change in how PLWHAs were treated in the city.

With the increase in affordable and effective medication as well as better primary care, the number of New Orleans residents becoming infected with HIV was declining by 1998 (LOPH 1998). However, there was a slowly developing upward trend in HIV/AIDS cases for the African American population of New Orleans. The number of African American males who engaged in homosexual relationships and lived below the poverty line without health insurance was much higher than that of their Caucasian counterparts. However, by 1998 the LOPH and the Department of Health and Hospitals were reporting steady numbers for HIV/AIDS cases both in

and around New Orleans. This left many clinicians and volunteer relief organizations with reasons for optimism. By 2002 the number of PLWHAs in New Orleans had trended up again, but the city was no longer ranked number one in new HIV/AIDS cases. However the LOPH Annual HIV/AIDS report claimed, “The New Orleans region had the highest number of HIV/AIDS cases detected in 2002, and 44% of all persons living with HIV in Louisiana live in this area” (LOPH 2002). From 2002 to 2005 the number of HIV/AIDS cases continued to grow slowly in New Orleans, and the most common forms of exposure were men who have sex with men and injection drug users (Figure 6).

After Hurricane Katrina the numbers in New Orleans were severely disproportionate in 2005 and 2006, showing a markedly diminished population. The LOPH Annual report in 2006 revealed that New Orleans experienced a 33 percent drop in population size (LOPH 2006). Before Hurricane Katrina there were over 5,000 PLWHAs living in New Orleans, but by January of 2006 there were only 1,980 residents of New Orleans who were HIV/AIDS positive (LOPH 2006). This general dispersal of PLWHAs served to inflate numbers across other regions of the state. The loss of both volunteers and a diminished HIV/AIDS population had a detrimental effect on non-profit HIV/AIDS relief organizations in New Orleans. Limited resources and the inability to maintain contact with evacuated PLWHAs indicated that many HIV/AIDS positive former residents were not getting the important primary care and social support they were previously accustomed to. Michael Hickerson, an advocate for HIV/AIDS in New Orleans was quoted in POZ Magazine¹⁴ as saying, “Personally, I continue to be pessimistic about their [federal and state government] response to HIV and AIDS across the southern states. Very little advocacy has been done among and within the community. Elected and religious leaders continue to dance around the issue. So as a result, more people are continuing to be infected.

Look at New Orleans and the difficulty in getting resources onto the street. Is there any reason for optimism?” (Hickerson 2007).

In the past two years, New Orleans has seen a resurgence in its general population as well as in HIV/AIDS cases (Figure 7). This is attributed to the reestablishment of PLWHAs who were previously living in the city as well as newly infected residents. By 2008 there were over 6,000 New Orleans residents living with HIV/AIDS (LOPH 2008). After Hurricane Katrina there was a spike in Hispanic and Latino males entering the city, this influx of a migrant, minority labor force with undocumented medical histories will have a significant impact on STI numbers in the future. The need for a consistent HIV/AIDS relief network in New Orleans in the wake of Hurricane Katrina was largely filled by the volunteers of the NO/AIDS Task Force. However, as the number of current and new HIV/AIDS cases grows. Support services within NO/AIDS may become bloated and unable to properly serve the community as a whole.

b. NO/AIDS TASK Force: The First Generation

The NO/AIDS Task Force was begun in 1983 after a wave of new HIV/AIDS cases began to develop in the Gulf South region of the United States. The organization began as a “gay community-based direct action and support service setting for persons with HIV/AIDS” (Stewart and Weinstein 1997). Being the first of its kind in New Orleans and the entire Gulf South, NO/AIDS grew very quickly from providing support to local residents to the entire Southern Louisiana area as well as Mississippi. Today it is the largest non-profit organization for HIV/AIDS relief in the Gulf South, and has become an extensive volunteer organization completely committed to addressing the ever-evolving face of AIDS.

After Hurricane Katrina struck a devastating blow to Louisiana’s Gulf Coast, the volunteer network of the NO/AIDS Task Force was disconnected from those they committed to

serve. With access to the city cordoned off by the National Guard and rising floodwaters, volunteers were forced to evacuate rather than search for those HIV/AIDS positive residents they knew were trapped. One of the largest benefits in the US's modern medical system is uninterrupted and consistent care for communicable diseases. However, HIV/AIDS positive residents trapped in the New Orleans went without medication and monitoring for many weeks if not months. NO/AIDS volunteer Ashley* explained, "My mom and I were lucky. We evacuated to Houston, and stayed there for three months after Katrina. Although when I got back I heard about how some people were trapped here without their medicine and no car to get out of the city. It was so sad to hear, but if they don't have enough money for their medicine then how can these people have the means to leave for a hurricane?" This interruption in the volunteer advocate-client support system had detrimental effects on both the volunteers and the clients. Relocation of clients as well as volunteers to areas all over the country crippled the NO/AIDS Task Force's ability to maintain their mission of reducing the spread of HIV and protecting the rights and dignity of HIV affected individuals.

Denise* a volunteer coordinator¹⁵ with NO/AIDS Task Force stated that she can "recall two distinctly different volunteer organizations: pre-Katrina NO/AIDS and post-Katrina NO/AIDS". Her involvement with NO/AIDS has been a major inspiration for many volunteers who have joined since Katrina. Training volunteers were often inspired by her loss and perseverance. She embodies the pure idea of a volunteer, the ability to give up one's comforts for the betterment of others. Working with NO/AIDS before and after Katrina, her goals for the organization and its volunteers have remained unchanged in the wake of Hurricane Katrina. Unwilling to settle, she actively advocates for the efficacy of clients and volunteers alike within NO/AIDS Before Katrina, NO/AIDS had recently received large amounts of federal and private

funding by the pharmaceutical company Pfizer to both grow the volunteer efforts of NO/AIDS and to provide funding for client support services for new drugs, education, and preventative supplies. Volunteer numbers and commitments were up for NO/AIDS as well as local business support for their major volunteer events like the annual NO/AIDS Walk and their Dining for Life dinner. The conditions of the volunteers as well as the efficacy of the organization changed in the period following Hurricane Katrina.

The role of the volunteer within NO/AIDS is in a sense very simple, to support those infected. However, the people who have become involved, some devoting their lives to the organization, are as multi-faceted as their reasons for becoming a part of NO/AIDS. These relationships and motives for helping the organization to survive in the wake of Hurricane Katrina are why NO/AIDS can be classified as a first generation volunteer organization with a well developed culture of healing and volunteerism. Established at the beginning of the HIV/AIDS epidemic in the United States, they are a model for the evolution of other organizations in southern Louisiana. Volunteers take on a dual responsibility to serve both the clinical and familial needs of the “client”. The idea that the volunteer should treat those they aid as their family but also as a patient highlights how volunteers are forced to serve dual purposes within the organization. For volunteers the experience is not a seamless and holistic culture of healing and acceptance. They must divide their behaviors in two so that appropriate care can be administered in clinical and familial settings for the PLWHAs.

This demarcation of behaviors was clearly difficult for many volunteers. One volunteer trainee Carol* said, “I wanted to join NO/AIDS cause I used to be an educator, but after Katrina I retired and have extra time, but I keep having trouble figuring out how to treat clients here. I think it would have been easier if one of my friends or family members had HIV, because I don’t

have the same personal experiences. I don't think I want one of these clients to be my learning curve." The mental and emotional stressors on volunteers as they worked to rebuild their lives as well as those of their clients were key factors in volunteer burnout after Hurricane Katrina. Volunteers at risk for burnout were often fatigued with the work and disillusioned by their contributions to the organization. For this research, burnout was defined as overextension and fatigue leading to diminished contribution or discontinuation of service by the volunteer. Bennet, Ross, and Sutherland in their study of burnout factors on HIV/AIDS volunteers found that personal affirmation alone could not keep volunteers from quitting. They found that volunteers were more active within an HIV/AIDS organization if there was a reward system in place for volunteers (Bennet et al 1996).

After Katrina there was a de-emphasis on the volunteer so that the immediate needs of the clients could be filled. The veneration of the client above the volunteer limits the recognition of this rewards system. The suffering and social stigma that many clients experienced in society outside of the microcosm that is NO/AIDS gives them a celebrated standing within the organization. Building up the esteem of clients can often keep volunteers from seeking out their own achievements within the organization. One method of reward that has remained unchanged since Hurricane Katrina is "client gratification". Volunteer coordinator Denise* explained, "There is no better feeling than when you help a person recognize they have a life even with AIDS. When I have clients call me and tell me about good T cell counts or a new relationship; I feel like their good experiences make my life better. It's easy to get wrapped up in it when people get their hope back." All services, fundraisers, and volunteer training is focused around how to treat the client as a whole, and how to give them as complete of a life as possible with

this new infection. However, with the stress of environment after Hurricane Katrina a reemphasis on the value of the volunteer needs to be addressed.

Volunteers are required to undergo day long training and education seminars so that they can serve their clients with the most appropriate and current information. To maintain the value of the client, there is a special terminology used with NO/AIDS. PLWHAs are not called victims, and HIV/AIDS is never allowed to be called a disease. Instead NO/AIDS trains their volunteers to use words like client, infection, and advocate so people with HIV/AIDS feel free of judgment. Many volunteers expressed difficulty with learning the “new NO/AIDS language”. The organization has been open for so long that there is clinical and familial rhetoric that volunteers must learn. Using words like “infections” is believed to dissociate the negative connotation attached to HIV. One volunteer educator Mark* explained that using words like “disease” reminds clients of dying and does not affirm the client’s right live life in the “new normal”.

The use of the word “client” and other terminology within NO/AIDS have separated the organizations functions more clearly. Terms like “baby”, “sweetie”, and “honey” are never used in volunteer functions involving testing and counseling, the clinical setting. However, when providing meals or emotional counseling, the familial setting, volunteers must take on the role as mother, brother, sister, or father. The need for volunteers to replace family and friend support systems lost because of an HIV/AIDS diagnosis is contradictory to the volunteer’s need to maintain a professional air and distance when seen as a health care advocate. This type of division between family member and clinician is often why many volunteers become burnt out after only a few years of volunteering.

While NO/AIDS is a non-profit, private organization not bound medically or legally by the same privacy laws as a hospital or doctor’s office, they have clearly published client rights¹⁶.

These rights promise to maintain the anonymity of the client, and only to perform actions for the benefit of the client that they so choose. They do not represent a legally binding contract but follow a specific grievance procedure with client advocates and a review board. One volunteer Michael* explained, “Making their treatment and counseling very clinical or ‘patient physician’ like we can better gain the trust of HIV/AIDS clients who are unwilling to fully disclose previous sexual encounters or current sexual behaviors. You wouldn’t want your mom to know that you had unprotected sex last night, but it might be something you tell your doctor so that they can get you the right care, and the only reason you’ll tell your doctor or your psychiatrist is because you know that can’t tell anyone else.”

Volunteers are expected at all times to maintain the complete privacy and anonymity of their clients. Such stringent volunteer privacy rules are difficult for many volunteers as they would like to share their work with their own friends and family. Drs. Snyder and Omoto, in their article on volunteerism, argue against this level of privacy. “For AIDS volunteers, it is possible that their work has not only beneficial effects on personal attitudes, knowledge, and behaviors, but also negative consequences of stigmatization and social censure. When it comes to societal issues, moreover, AIDS volunteerism may possess the potential for encouraging social change as volunteers transmit their new attitudes and behavior to their friends and associates and, by extension, to the broader social system” (Snyder, Omoto 1992).

This not only separates volunteers from their society outside of NO/AIDS, but also keeps many from truly celebrating their achievements within the organization. Veneration of the client is more important than veneration of the volunteer. However, after Hurricane Katrina NO/AIDS staff has focused on trying to keep volunteers aware of their own mental health. The sacrifice of the volunteer for the sake of the client is no longer a viable option in post-Katrina New Orleans.

With diminishing volunteer numbers and a growing infected population, NO/AIDS has struggled to maintain their holistic culture of healing and volunteerism.

Within this culture, no volunteer position is as valued as that of an HIV counselor. These volunteers are seen to be the elite group within the Task Force. These volunteers have trained for months logging many hours of role play to assume this position. Their responsibilities are to work directly with HIV/AIDS clients. Often these volunteers serve as a surrogate mental health professional. Counselors are the volunteers who administer the counseling before, during, and after an HIV test. They have the role of “sympathetic ear” to the concerns of the client. No volunteer position with the Task Force is as demanding as that of the HIV counselor. They are on a first name basis with all of their clients, and they are encouraged to speak about all aspects of the client’s lives to identify specific counseling needs.

In sessions the clinical role of the counselor, as described by two volunteer HIV counselors, helps the client to open up about personal concerns they may have. These concerns can range from how the infection will affect their sexual relationships as well as those with family and friends. This also allows the clients to practice being open about their infection with someone whom they have a personal relationship. At the same time there is the understanding that these counseling sessions are private, and what is said stays between client and counselor. However, HIV counselor’s inability to share with their own support system can often cause undue mental stress in the individual. One volunteer Denise* said, “We lose more volunteers from HIV counseling than anywhere else in the organization. The staff tries to stay aware when one of us is having trouble, and we have the right to switch out of counseling and into something more upbeat like meal delivery or fundraising. The goal is to not get so burnt out that you have to leave”

These other “upbeat” areas within the NO/AIDS Task Force are equally as important as HIV counseling when ensuring the kind of holistic care that PLWHAs deserve. Food for Friends and French Quarter education are why NO/AIDS is able to maintain their goal to heal the community and the infected as a whole. To focus solely on infected clients would mean that at risk individuals were not getting the support to advocate for their sexual health. So many HIV positive volunteers expressed anger and frustration about being infected by a selfish partner who did not reveal he or she was infected. These outreach branches of NO/AIDS help non-infected persons become more discerning about potential sexual partners and means of protection. Volunteer Mark* succinctly put it as, “People are going to have sex whether or not we tell them that HIV is a risk. The goal is to give them the best protection possible and hope that they use it.”

Satellite services like Food for Friends ensures that shut in HIV/AIDS clients can receive food, social stimulation, and medical care. This mobile meal service is how NO/AIDS is able to maintain relationships with clients who have begun to succumb to the disease. After Hurricane Katrina the Food for Friends programs was still very active in the community, and these volunteers were often the most gregarious members in the organization. Mobile food delivery requires volunteers who are willing to sit for a time at each resident’s home ascertaining their current situation. Some shut-ins were unwilling to open the door and asked that the food just be left outside or on the doorstep. Most often volunteers were unwilling to leave until the PLWHA opened the door to accept the food. Food for Friends volunteers deliver meals and administer social support for people who cannot leave their homes. The Food for Friends drivers maintains the same semblance of privacy use by HIV counselors. In many ways they serve the same purpose, just that their counseling and medical evaluation often takes place over spaghetti and meatballs.

The final major aspect of the volunteer culture in the NO/AIDS task force is preventative education. The training involved requires many volunteers to ignore previous moral codes and ideas of propriety. A position of complete openness is required to be a preventative education volunteer. Volunteers are trained to encourage clients to ask them any question they may be having about HIV/AIDS or how to alter their lifestyle to accommodate the infection. This openness often leads to questions of a sexual nature, and volunteers must be trained not to balk or react to any question posed. Ashley*, an education volunteer stated, “Sometimes you want to laugh because that’s what people do normally when someone mentions sex, but the problem with laughing is it teaches them to think that HIV/AIDS sex is wrong. The truth is it’s not as long as both people are consenting. It’s important that PLWHAs know even if they’re infected, unprotected sex with another PLWHAs can exacerbate their condition.”

To become a Community Awareness Network (CAN) educator required volunteers to learn how to show future clients the importance of a healthy sex life even if they are infected. The volunteers who do French Quarter outreach were considered “kind of crazy” by many of the other volunteers. These CAN volunteers seemed to thrive on the shock value that is often associated with discussing sexual preferences. During the outreach education training, volunteers were required to handle and instruct on the importance of condom usage, sex toy safety, and appropriate sexual practices for HIV positive clients. One trainee Alice* said, “This was actually a lot of fun, and I think it’s something that I can apply to my own life even though I’m not HIV positive. Because I know I have had sex with people I should have been more careful with. It’s also a little funny to see how some of the other volunteers don’t want to admit that they’re learning new things about how to liven up their own sex lives.” Volunteers with CAN traditionally went down to the Quarter on Saturday nights to hand out condoms, instructions, and

did demonstrations at local bars for patrons interested in learning how to have safer sex that night.

Within the NO/AIDS Task Force, volunteers are able to achieve a holistic culture of healing for their clients. However, when it comes to the role of the volunteer the division between familial and clinical settings keeps many from being able to fully integrate themselves into the organization. After Hurricane Katrina volunteer numbers dwindled significantly, and the death and destruction volunteers were dealing with in their own lives kept many from returning to the organization. As a larger focus has been put on keeping volunteers healthy, the organization is mending the divide that many volunteers felt they had to make between personal and volunteer lives. To achieve a truly holistic culture of healing and volunteerism NO/AIDS has discovered, in the wake of Katrina that volunteers must be venerated by the organization in their own way. Affirmation of services rendered and closer attention to the mental health of volunteers, has given NO/AIDS the ability to heal both their clients and their volunteers after the storm.

IV. HIV/AIDS in Baton Rouge

The HIV/AIDS epidemic traveled very quickly through Baton Rouge in the mid 1980s and early 1990s. Today, predominately African American urban areas are seeing some of the fastest growing rates of HIV/AIDS infections in the entire country. Baton Rouge, in particular, has the fourth fastest growing HIV/AIDS infection rate in the nation as of 2006 (LOPH 2006). Over the past two decades increasing insulation of the infected population within racial boundaries has divided the HIV/AIDS positive African American population from the rest of the community. The first wave of relief most PLWHAs have in Baton Rouge comes from the non-profit volunteer organization BRASS or the Baton Rouge AIDS Society. High risk behavior,

poor sexual advocacy, and poorer access to HIV/AIDS primary care have all contributed to the “second wave crisis” that Baton Rouge is experiencing today.

a. Demography and Cultural Indicators

The exact rate of HIV/AIDS growth in Baton Rouge was largely unknown until 1984. After the Louisiana Office of Public Health began publishing an annual report, about 85 percent of all HIV/AIDS cases in the greater Baton Rouge area were divulged. The community experienced a large growth in HIV/AIDS cases from 1984 until 1998. However, those becoming infected in Baton Rouge each year differed greatly from other urban areas across the United States. Baton Rouge, as a city, saw a 32.2 percent increase in newly diagnosed HIV/AIDS cases from 1989 to 1998 (Figure 8). In 1998 the leading cause of HIV/AIDS exposure in Baton Rouge was injection drug use, and the city surpassed New Orleans in newly diagnosed HIV cases.

As better testing and reporting standards were enforced in the city, the 21st century saw a continued increase in new HIV/AIDS cases for Baton Rouge. By 2002, Baton Rouge ranked seventh on the list of new AIDS cases in large urban areas (LOPH 2002). A new phenomenon developed in Baton Rouge as high risk heterosexual contact exposure increased. The “down low” phenomenon has been a particular issue in the African American community of Baton Rouge for the past ten years. Within this community, there are males who engage in anonymous, random sexual encounters with others males. This exchange is often for sex or drugs, but regardless the men who engage in this behavior do not consider themselves to be homosexual. Within the African American community, “keeping it on the down low” is a relatively secret practice. The men who engage in this DL behavior do not disclose their MSM encounters with female partners, and often have monogamous relationships with females while “keeping it on the DL”.

This practice has led to spike in the number of young African American females who test positive for HIV. Part of why preventative education has become so important for Baton Rouge is the DL phenomenon. Minority women in Baton Rouge who live below the poverty line are most at risk for contracting HIV. One Baton Rouge volunteer explained, “These girls don’t know how to tell a guy to go tested. Cause if they accuse him of keeping it on the DL he’ll walk away, and there goes the economic support they were relying on.” For economic or emotional reasons, these female minorities are at an increasing risk by not advocating for their own sexual health. This DL population has also largely contributed to the second wave crisis emerging in Baton Rouge today.

After Hurricane Katrina, Baton Rouge experienced a surge in population due to evacuations from Southern Louisiana. “The Baton Rouge region had both the highest number of new HIV diagnoses and the highest rate of new diagnoses (new cases per 100,000 population) in 2006. Previously, the New Orleans region had always had the highest number of new HIV diagnoses. The decrease in new diagnoses in the New Orleans area was primarily due to the large decline in the population following Hurricane Katrina in August 2005” (LOPH 2005-2006). The influx of new residents also caused a rise in HIV/AIDS cases (Figure 9). In the years following Hurricane Katrina, Baton Rouge has continued to rank in the top five cities with the highest HIV/AIDS rate in the country. As early as 2009, Baton Rouge was ranked second behind Miami for the highest number of HIV/AIDS cases per capita (LOPH 2009). The growing number of AIDS cases in Baton Rouge has become severely disproportionate, with African Americans representing 83 percent of cumulative HIV/AIDS cases in 2009 (LOPH 2009). Such a disparity has led to social and racial divisions that have impeded both volunteer efforts and PLWHAs attempts at social support and medical services.

b. The Baton Rouge AIDS Society: Making a Difference

The Baton Rouge AIDS Society or BRASS is the oldest non-profit volunteer organization based in Baton Rouge and supporting the surrounding communities. Created in 1998, the organization's volunteer network has grown to over fifty volunteers and a full time staff. BRASS, like NO/AIDS before it, was a grassroots effort to meet a growing need in the HIV/AIDS infected and at risk communities. Original volunteers were all personally affected by HIV/AIDS directly or within their social group. A cofounder, Aaron*, explained during a testing day, "If you see people getting sick and dying and these people are your friends and family, then God puts a burden on your heart to help. He wanted us to do this and I know He is why we're still working today." His contributions as well as those of his colleagues are why the organization has continued to proliferate in a community mostly unaware of HIV/AIDS. He explained that HIV/AIDS is something that everyone must live with, even if it isn't "sitting across the dinner table or living next door". Aaron* went on to explain, "The reason why we can't get people involved is because they don't know about it or it's so separate from their day-to-day lives that they push it to the back of their minds." His dedication to BRASS was evident in his own day to day commitment to spreading the preventative education initiatives proposed by the organization.

Like NO/AIDS before it, the success of BRASS has been based on continued "community mobilization and social change". BRASS is best described as a second generation volunteer culture. Being only eleven years old, the organization still has many goals to achieve, but it is quickly evolving into the primary HIV/AIDS relief organization for central Louisiana. Branching out beyond Baton Rouge, volunteers within BRASS now serve infected populations in Port Allen, Plaquemine, and St. Gabriel. In just ten years BRASS has efficiently and quickly

established a hierarchical support network that actively works to promote community awareness and efficacy of PLWHAs. To become a fully holistic culture of healing and volunteerism, BRASS will need to evolve into a multi-tiered testing and counseling center along with preventative education.

Similar to NO/AIDS, BRASS volunteers have a well developed culture of healing. By using social structures and kinship values already present in the community, volunteers focus their efforts on three large areas: testing, education, and community outreach. In the process of evolving into a large and multi-faceted AIDS relief organization, BRASS volunteers are still hindered by a lack of manpower which can lead to volunteer burn out and discontinuation of service. Along with limited resources, the stigma and fear associated with HIV/AIDS is still a prevalent concern in Baton Rouge. The intentions of BRASS volunteers are called into question more often than in a larger setting like NO/AIDS. Stephanie* a volunteer with BRASS explained, “I think people in Baton Rouge are still very scared of the idea of AIDS. They also don’t hear enough about the HIV/AIDS problem because most of the people getting HIV here are African Americans living on the poverty line. I think it’s difficult for the volunteers to put themselves in the HIV victim’s shoes, because they’re different or they’re of them.”

Most BRASS volunteers agreed that HIV/AIDS positive persons are seen as an accepted but separate minority within the community. The volunteers also expressed anger and frustration at the racial and gender stereotypes in Baton Rouge that erode BRASS’s ability to reach all infected and at risk people. Interviewing volunteers revealed the consensus that Baton Rouge is behind in AIDS relief because residents think that the infection is a “black people problem”. To combat those racial and social stigmas still attached to the HIV/AIDS, volunteers heavily promote their AIDS 101 class. This seminar mirrors the volunteer training program used at

NO/AIDS. However, BRASS offers it as a class rather than a training program so that participants do not feel obligated to join the organization in order to be educated. Breaking down these social barriers has become the chief goal for many volunteers, and as a result they teach their AIDS 101 class in schools, businesses, churches, and any other entity that would like information.

Aside from offering AIDS 101, BRASS offers to conduct “home health parties” for groups seeking more information on safe sexual practices and HIV/AIDS prevention. These “parties” are smaller more intimate affairs between the community and BRASS volunteers. Coming to people’s homes often gives volunteers the benefit of a peer-to-peer relationship with the group. The relaxed setting is what many volunteers believe gives them the ability to humanize HIV/AIDS and mobilize the community. One volunteer Chris* believed, “It’s so much easier to speak with people in their houses. It’s where they feel more comfortable, and if they are relaxed then people don’t get their backs up as easily when we try to talk about sex, HIV, or other touchy subjects like the needs for testing. If we think the people we are talking to may have been exposed to HIV, then having them in a comfortable environment is the best way to get them to agree to get tested.” To bridge the gap between the idea of HIV/AIDS and sexually advocating for themselves, home health party volunteers address prevention and protection from all sexually transmitted infections. Volunteers within BRASS have realized that they do not have the same kind of footing in the community as other non-profits like the YMCA, and as a result try to make these education initiatives as universally relatable as possible.

Mobilizing the community of Baton Rouge has been difficult for BRASS volunteers. However, commitment to one another and the PLWHA community has created fairly tight knit culture of volunteerism within the organization. It has also fostered an “us” and “them” mentality

in some volunteers. Some volunteers have found it difficult to remain open minded about the uneducated portions of Baton Rouge. One volunteer Tim* expressed, “the only way we are going to get people help is if they stop looking at HIV as a black problem or a gay man’s disease or some secret thing. They have to realize there are HIV positives living all around them. Maybe if more people in Baton Rouge realize their neighbors are being affected, they’ll get on board with the effort.”

There are several factors hindering this transition to a truly holistic healing culture. BRASS’s smaller scale efforts to reach the community do not gain the same kind of publicity and turnout as larger organizations. Operating out of homes, churches, and school gyms for events limits their ability to provide a cemented and constant forum for HIV/AIDS discussion. “We don’t get the same kind of turnout from volunteers or the public because there are lots of people in Baton Rouge who have never heard of us. If we can’t get the word out when we’re having like a condom wrapping day or a mobile testing day, then volunteers and interested people won’t know to show up” explained volunteer coordinator Amanda*. Many potential BRASS volunteers still see a separation between themselves and clients. There are still pervasive stigmas attached to people who work frequently with HIV/AIDS positive individuals. This separation and lack of equality between volunteer and client keeps many from offering their services to the organization. With clients and volunteers unwilling to take responsibility for eliminating these cultural dividers, the progress of BRASS towards effective and holistic healing is impeded.

Fear of HIV/AIDS still severely limits BRASS’s efficacy within the community. The stigma of the infection both inhibits and contributes to volunteer burnout within BRASS. Snyder, Omoto, and Crain found in their study on HIV stigmas that many who were unprepared for the

social consequences of becoming an HIV/AIDS volunteers were more likely to burnout early in their service (Snyder, Omoto, and Crain 1999). Many BRASS volunteers were a part of the organization at its advent. Their commitment extends beyond racial divisions and economic disparity, but those very conditions limit the initiative many have to join in the fight against HIV/AIDS. “Potential stigmatization also prevented non volunteers from helping an AIDS organization, whereas reports of actual stigmatization predicted AIDS volunteers' burnout from their work and hastened their decisions to quit” (Snyder, Omoto, and Crain 1999). However, volunteers within BRASS are able to maintain their culture of healing and volunteerism because they are supported by one another. The rewards system present in BRASS is different in many ways from NO/AIDS. As a smaller organization many volunteers rely more on inner personal affirmation, and the joy of sharing their work with their families and friends. The freedom and motivation volunteers have to share with others about the humanity of HIV/AIDS gives them the power to affect social change. The recognition of that power is often reward enough for many BRASS volunteers.

The smaller size of the organization also allows for more freedom within their volunteer culture. Volunteers are encouraged to engage in and maintain personal relationships with those they counsel. This is unique; it is a mirror of what many volunteers at NO/AIDS did in the early 1990's when they were still a young organization. With the evaluation of newer and older HIV/AIDS organizations during this research, it became evident that there was a distinct evolution that takes place within the volunteer community and the organization at large. Many of BRASS's community efforts like home health parties, condom wrapping, and mobile testing are specific hierarchical branches within the volunteer network of NO/AIDS. The more limited levels of organization within BRASS, indicates that they have yet to reach the maturity of a first

generation AIDS relief organization with a truly holistic culture of healing. In the wake of Hurricane Katrina, BRASS has begun a developmental process on the path to become the same kind of multi-functional organization that NO/AIDS now embodies.

V. HIV/AIDS ON CAMPUS

The prevalence of HIV/AIDS on college campuses has grown steadily since the 1980's. The lack of education and services offered by most Student Health Centers, and their emphasis on more treatable sexually transmitted infections has hindered college based AIDS education. This is crucial considering most entering college students have limited knowledge of STI prevention and HIV/AIDS protection. DiClemente, Forrest, and Mickler, in their study on college student HIV awareness, reported, "While students demonstrated a high level of knowledge with respect to AIDS transmission, they were also likely to possess many misconceptions about casual contact as a route of HIV transmission. HIV-related sexual risk-taking behavior was also substantial. A large proportion of students reported never using condoms during sexual intercourse and having had multiple sexual partners" (DiClemente, Forrest, and Mickler 1990). When polling students at random during the December AIDS Memorial Quilt Event, most were unable to identify common warning signs for HIV, most effective means of protection, and which parts of the population are most at risk.

The difficulties that student campus volunteers face are unique. HIV/AIDS education and stigma are often first addressed at college. This is coupled by the fact that many students will have their first sexual encounter while at university but without adequate protection or education on safe sexual practices. Student health advocates and college HIV/AIDS counselors interviewed at Louisiana State University- Baton Rouge and Southern University- Baton Rouge face

conditions very different from their NO/AIDS and BRASS counterparts. College based HIV/AIDS volunteers focus more on education and prevention than management and counseling.

The Louisiana college population is largely unaffected and unaware of the growing AIDS epidemic in the state. Focus here is less on the individual and more on reaching and affecting a large group of students. Rather than have volunteers try to address an HIV/AIDS affected community, their sole focus is to promote prevention and social change in the community. With a limited number of infected students, the goal of volunteer organizations within LSU and Southern University was education based. The personal goal of many volunteers on both campuses was to create a culture of openness, education, and communication. Students educating students in the campus environment is the most popular form of HIV/AIDS prevention at LSU and Southern University. However as the number of new AIDS cases continues to grow in post-Katrina Louisiana university health centers have begun to take a more active role in HIV/AIDS testing, education, and counseling.

a. Louisiana State University: Emergent Change

In the aftermath of Hurricane Katrina, Louisiana State University was able to transform their Pete Maravich Assembly Center into the largest acute care field hospital in the history of the United States (Figure 10). Physicians, nurses, and students alike joined together to volunteer support and medical care to displaced victims of the storm. Their efforts speak volumes about the campus' ability to mobilize in the face of medical crisis. However this same energy and efficiency has yet to be applied to a university wide HIV/AIDS health and education program. According to a Student Health Center counselor, "LSU does not have a problem with HIV or AIDS. In fact, in all the years that LSU has conducted HIV tests, we have never had a positive test come back for our students."

Students at LSU can receive HIV testing, but the test is not advertised on the Student Health Center website or in the Health Center itself. A student must make an appointment alerting the health center that they need an HIV test. There are no specific HIV/AIDS advocacy volunteers or counselors in place at the Center to handle the mental fallout associated with fear of infection. Only blood tests are administered at the LSU Health Center which requires a two to three day wait period. Implementation of the OraQuick¹⁷ system has long been overdue. For counseling or further treatment students are referred outside of the university to a primary care physician or a community group like the Baton Rouge AIDS Society.

The LSU population as a whole is uniformed of the dire situation affecting Baton Rouge today. Ignorance and lack of social consciousness have even led some student to incorporate the infection their sports cheers. Sitting next to a male student at a football game, I had the misfortune of hearing him yell, “Hey Tebow [starting quarterback for the University of Florida] you have AIDS. Your mom has AIDS.” This kind of crass humor is part of why many young HIV/AIDS positive persons do not disclose their condition to their peers. The conclusion can be made that HIV or AIDS positive students on campus either graduate before finding out they are infected or are seeking testing and treatment outside of the university. However, with the recent creation of LSU’s first on campus HIV/AIDS student organization, AIDS Reach LSU, better education and coordination between students and the health center will likely be achieved.

b. AIDS Reach LSU

AIDS Reach LSU was begun in 2007 as an idea between several premedical students at LSU who also worked as paramedics in the Baton Rouge area. Experiencing the growing HIV/AIDS epidemic in Baton Rouge first hand was the largest motivating factor for these students to form the campus organization. One of the creators of AIDS Reach LSU explained, “I

got my first experience with AIDS when my sister contracted the disease, and that is what developed my interest in educating more people our age about the risks of HIV and AIDS. It is so easy to prevent with proper care and attention, but I think that our peers feel like they are immortal or at least invincible to some extent. It keeps them from seeking out the appropriate education to protect them from HIV. So I think it is our job to make them aware of the risk that they are unknowingly taking.”

The volunteers within AIDS Reach LSU were uniquely different from all of the other organizations interviewed. Researching them from their advent showed how difficult it is to establish trust and support for HIV/AIDS awareness where it had previously been ignored. There were some similarities drawn between AIDS Reach and the second generation AIDS organization BRASS. The early development of AIDS Reach showed a complete emphasis on education and social change, which was in large part how BRASS began. The volunteers had not established a culture of healing like NO/AIDS or BRASS, because they were not actively seeking out clients to counsel or creating a holistic health environment. Rather, their original goals were education and support of existing HIV/AIDS volunteer organizations. Based on their age and services AIDS Reach LSU classifies as a third generation HIV/AIDS relief organization.

AIDS Reach volunteers had created a culture of acceptance within their organization, and were in the process of becoming a relief organization for infected students at LSU. Through the efforts of the creators and founding members, AIDS Reach scheduled several awareness events in its inaugural year. However volunteers quickly experienced similar events that NO/AIDS volunteers had met with at the advent of their organization in 1983. At one LSU sponsored student organization event, AIDS Reach volunteers set up tables to provide information about their organization and the current conditions of HIV/AIDS in Baton Rouge. While many students

ignored the table, several persons approached with curiosity or criticism of the group. One male student initially asked what the group was about, and volunteers explained to him the mission of AIDS Reach. He then refused to take any pamphlet or information packet offered and also refused to shake the hands of the members behind the table for fear of contracting AIDS. He said, “I just don’t think you can be sure you don’t have AIDS if you spend all day working with those people. It’s easier than you think to get AIDS so I’m just going to be cautious. It’s not that I don’t like what you’re doing, but I just know I would get AIDS if I spent all that time working with them. I mean how can you be so sure that you don’t have HIV right now?”

Ignorance like this on campus is why the volunteers of AIDS Reach quickly made their primary goal educating the LSU community about the human face of AIDS. Many students signed up in the first year to be members of AIDS Reach but would only attend events at LSU where they had no interaction with HIV/AIDS positive members of Baton Rouge. This prevalence of social stigma and fear is indicative of an emergent organization that has yet to mobilize the community in favor of PLWHAs. The inability to provide volunteer support for the Baton Rouge AIDS Society hindered AIDS Reach’s ability to promote awareness and understanding of the disease. The stress of having to attend every event weighed heavily on founding members and the creators of AIDS Reach LSU. One founder Rachel* complained, “I just felt like this is one of the major socio-medical issues of the 21st century, and people would be passionate about HIV/AIDS because we’ve grown up knowing it was our responsibility to eradicate it. It’s difficult to listen to people be so narrow in their understanding of HIV.”

There were parallels drawn between the beginning of AIDS Reach and the start of the NO/AIDS Task Force and BRASS. All volunteer groups were met with limited interest, stigma, and ignorance at their advent. NO/AIDS and AIDS Reach both started as education

organizations, but NO/AIDS quickly grew to become a comprehensive support network for HIV/AIDS positive persons. AIDS Reach volunteers, in the first two years, were only able to maintain their original goals of educating LSU about AIDS and affecting social change. However, by the end of 2008, AIDS Reach garnered recognition and funding from the University to continue their work. This turning of the tide in support of the organization also indicates the beginning of a transition to a more hierarchical structure of volunteerism.

Limited cooperation with the Baton Rouge AIDS impeded AIDS Reach volunteers from experiencing the full benefits of volunteer work in the first two years of operation. Many students never attended the home health parties or condom wrapping events held by BRASS, and only a few went through the HIV/AIDS certification course offered. The lack of interest in AIDS Reach in its inaugural year led many volunteers to burn out. They could not handle the load of school and volunteer support services required by the organization. One volunteer said, “I just got to college and I didn’t realize how hard it would be to be premed and involved on campus. I still really want to help with AIDS Reach, but I don’t have time during the week to attend events or do table sits [organization promotion].” She like many other volunteers quit the organization to focus more on education or another social commitment.

AIDS Reach LSU’s greatest detracting factor was volunteer retention. Older, more established organizations like NO/AIDS and BRASS had already undergone this ebb and flow in commitment at the beginning. However, they also were able to proliferate because of support from federal, state, and local governments. This same level of aid was not extended to the AIDS Reach organization, and as a result its survival on campus can be solely attributed to the commitment of its founding members. That core motivation that spurred the founders to become

HIV/AIDS volunteers was also the same reason why they were involved in the health care profession.

The goals of AIDS Reach by the end of 2008 were twofold: to grow the organization beyond the bounds of LSU and to continue to educate the community about the human face of HIV/AIDS. The slower development of AIDS Reach gave many of the older volunteers an opportunity to counsel incoming participants on the importance of maintaining one's commitments to the organization as well as providing support for faltering members. The reward system in place for volunteers of AIDS Reach was markedly different from that of NO/AIDS or BRASS. Volunteer rewards were measured more by the number of events held and persons reached. Without the same basis in client care, gratification came in a more internal form. Unable to see the change in awareness in individual students, AIDS Reach volunteers were affirmed by the physical growth of their organization. The initial diminutive size of AIDS Reach may have helped its founding members to become a stronger organization, as the group succeeded or failed based on their work and achievements. The bond forged by these inaugural members also provided them with a forum to vent frustrations about HIV/AIDS ignorance on campus as well a social support net for volunteers struggling with class and extracurricular events.

AIDS Reach received little support from the Student Health Center at LSU. However at the end of this research in 2009, they were in the process of creating a partnership with the Student Health Advocates. One advocate who was also a member of AIDS Reach explained, "HIV and AIDS are being found more often in people our age than 20 years our senior. It's important that we try to set up a partnership between the health center and AIDS Reach to provide the best education for LSU students possible. I see too many of my friends take sexual risks I would not, but I have more information than they do because I want a career in medicine.

However I think that they deserve access to the same information I have, and they can then make their own choices.”

Financial support from the LSU student government gave the volunteers the ability to achieve one of their most significant goals since the start of the organization, hosting an LSU sponsored World AIDS Day event. World AIDS Day is an internationally celebrated event focusing on people afflicted with HIV/AIDS and those who have dedicated their lives to fighting the disease¹⁸. They were able to develop a two day event to commemorate their first World AIDS Day experience. AIDS Reach displayed part of the AIDS Memorial Quilt¹⁹ in the Cotillion Ballroom of the Student Union. Hundreds of fliers and announcements were made about the event, and over one hundred students, faculty, and Baton Rouge citizens came to see the quilt and hear a little about HIV/AIDS awareness. This single event’s success has since spurred many volunteers to join AIDS Reach and become involved in on campus education initiatives. With its continued and successful growth, AIDS Reach stands to become a beacon for HIV/AIDS awareness and volunteer effort at LSU. The perseverance of those first volunteers is why AIDS Reach will initiate its third year of activity in the fall of 2009.

AIDS Reach LSU was the most unique volunteer organization investigated in this research. Following its members from the time that they began the group to the time that many graduated gave an intriguing view of the potential for humanitarianism in college. Many of the volunteers are now headed to medical school or grad school, but each graduating member expressed their desire to continue to promote HIV/AIDS awareness in the community. One volunteer Melanie* explained, “I know that the problems with HIV/AIDS will not go away because I’m leaving school. I know that when I become a doctor I may treat many patients who have AIDS. I think that my time with AIDS Reach gave me a maturity about the disease that I

previously did not possess. I came into the group in part to bolster my resume, but meeting people with the disease and making LSU more aware will save lives. It's been a truly validating experience." That was the true success of AIDS Reach volunteerism. The idea that one does not have to have a condition to become passionate about its prevention, and to inspire people to commit to HIV/AIDS education for the rest of their lives were the tenets on which AIDS Reach was founded. The continued efforts of this organization on campus will create a better educated, socially aware, and protected student body in the future.

c. Southern University: a model campus

Southern University has been in operation since the end of the 19th century in Baton Rouge. The university is a predominately African American with deep connections in the local community. Southern is known for many things, like their football team, but also for their commitment to HIV/AIDS education and prevention on campus. No other Louisiana university has made the same funding and volunteer commitments geared towards eradicating HIV/AIDS in the college based population. In Baton Rouge, the HIV/AIDS epidemic is considered to be an African American problem. As a result, Southern University has created multiple opportunities to bridge the gap between their own HIV/AIDS education programs and those of the greater Baton Rouge area. Their commitment to education, testing, and counseling is a model for other Louisiana colleges as HIV/AIDS makes its way onto campus. The Southern University Health Center has been providing HIV rapid testing and counseling or referral services to its students free of charge for the past decade. Testing is tied into their university fees so that all students at Southern have a hand in making on campus HIV testing possible for their peers. For more comprehensive counseling or primary care setup they have the means to connect their students

with volunteer organizations like the Baton Rouge AIDS Society, with which they are intimately involved.

After interviewing students, volunteers, and health care providers at Southern, it was noted that they have little integration with the LSU system for HIV/AIDS support. The two campuses stay fairly separated on issues such as HIV/AIDS and testing. Southern in many ways represents what LSU could become through funding and support. The need for LSU to better develop this culture of healing among its students is felt by some at Southern. One Southern student who attended the World AIDS Day Quilt viewing at LSU noted that, “Some people in Baton Rouge are scared of HIV/AIDS and others are apathetic because they think it should be handled within racial boundaries. Like if it’s a predominately African American problem then leave it up to them to handle it. I guess it’s the belief that people respond better to what is familiar to them.” Many students at Southern feel that Baton Rouge has turned a blind eye to the issue. The students also noted that they felt Southern did an above average job of educating them and providing outlets for expressing their concerns, fears, and experiences with HIV/AIDS.

In interviewing a student health volunteer at Southern she revealed that, “The Student Health Center website provides all of the information students need in order to access testing and counseling for HIV and AIDS.” Readily accessible information like this encourages students to be their own sexual health advocates. Stressing a woman’s right to say “NO” and the right to have a partner tested before sexual activity, further empowers Southern students to make the most informed decisions about their health. One health care provider interviewed explained, “We can give them the tools to be safe. We can’t hold their hands while they’re making these decisions, but with technology being what it is now we can get the correct information to them first. Relying on their friends or boyfriends or girlfriends for sexual advice often leads to the

misinformation circulating today. For instance, I once had a student tell me that she heard if you have oral sex then you cannot get HIV. Which is wrong, the mucosal glands in your throat make you susceptible. It's that kind of information we are trying to eliminate."

Southern University's campus wide commitment to HIV/AIDS education was a model used in part by the new LSU organization AIDS Reach. Taking from Southern the idea that education and awareness are the two greatest tools to prevention, AIDS Reach modeled their campus outreach programs to mirror this idea. Southern University receives AIDS awareness support from the health center and the campus at large. Every year Southern participates in the National Black HIV/AIDS Awareness Day²⁰. Like World AIDS Day at LSU, this is their main event of the year for HIV/AIDS education and prevention. Not only is this one of Southern University's greatest outreach opportunities, it also sponsors empathy and understanding of the disease amongst their student body. In many cases, students are empowered for the first time to take an HIV test or sign up to volunteer with the Baton Rouge AIDS Society. Shirley Wade, the Clinical Director of Southern's Student Health Care was quoted as saying "We are hosting these events because HIV/AIDS is disproportionately affecting the African American community, especially African American women."

Southern's groundbreaking Advocacy for Women program seeks to address this exact problem. More and more young African American women each year are contracting HIV. This is at a higher rate than injection drug users. They are known by the volunteers at NO/AIDS and BRASS as HRH's or high risk heterosexual contacts. According to a female student volunteer at Southern, the term is a little misleading. She argued, "High risk heterosexual contact a blanket stereotype of these women's sexual activities. Women whose boyfriends engage in DL [down low] behavior are considered to qualify as HRH's, but what people don't understand is that

sometimes it's not an option for these women to ask a boyfriend about homosexual encounters. That is the whole problem with the DL phenomenon, because they keep it on the 'down low' means their girlfriends aren't supposed to know. It's almost like the don't ask don't tell policy in the military." She went on to explain how important women's advocacy was to combat Baton Rouge's second wave crisis²¹. This is the idea that there is second wave of much stronger HIV cases coming in the next decade, and that these new patients will be younger and less likely to detect their initial HIV infection.

Southern University's HIV/AIDS volunteer network and their advocacy programs for underrepresented HIV populations is a model that could be implemented within the LSU system. The staff and volunteers at Southern understand that they are not a hospital and are not equipped to become an HIV triage unit. However, they do believe that they are the first wave of defense that many of the students will experience in sexual health advocacy. The openness and support that these volunteers and health care providers receive protect many from the risk of burnout that plagues other organizations. The idea that education and awareness are the best tools that they could give their students is a constant theme at their AIDS initiative events. The commitment of Southern's health care providers to get the AIDS dialogue ball rolling, undoubtedly saves the lives of many students every year. This model has yet to be incorporated within the LSU system. However with the continued support of the AIDS Reach LSU initiatives, partnered with a greater role by the Baton Rouge AIDS Society, LSU may soon see a reversal in their policy on HIV/AIDS education and testing on campus.

VI. Assessing the Future of HIV/AIDS Relief in Louisiana

Several conclusions can be drawn from this research concerning the future of HIV/AIDS relief in Louisiana. Continued cooperation between local volunteer organizations and community

mobilization will determine the ways in which PLWHAs are treated in the future. Volunteers in Louisiana meet many of the “in the now” needs that HIV/AIDS positive persons have. They are the front line for Louisiana’s HIV/AIDS positive community. The presence of these organizations has not only provided a model by which new volunteers train, but also allowed state and local governments to focus more on the importance of funding for programs, consistency in treatment options, and housing alternatives. The future of volunteerism in HIV/AIDS organizations will rely on how much support their volunteers receive from these government entities as well as private funding.

a. The Second Wave Crisis

This symbiotic relationship between private and public sectors had served the Louisiana HIV/AIDS positive community well until August 2005. After Hurricane Katrina, HIV/AIDS positive persons lost both their private and public forms of support. The Department of Health and Hospitals reported at a four percent spike in HIV/AIDS positive patients going without primary care just one year after the storm (LOPH 2009). The future of HIV/AIDS relief in Louisiana will be crippled by another Hurricane Katrina-like event. Any future displacement of local volunteers along with their governmental counterparts will again eliminate the continuance of clinical and familial support that so many patients are dependent upon. For the future of HIV/AIDS relief in Louisiana to be successful, volunteers must maintain consistent communication with their “clients” in the immediate days and weeks after a disaster.

Regardless of the state’s continued potential for natural disaster, there are many emerging factors that contribute to the fragility of ongoing and future volunteer efforts. Many researchers have proclaimed that parts of the US, including Louisiana, are experiencing a “second wave crisis”. AIDS numbers have largely stabilized by the beginning of the 21st century due to better

medicine, preventative education, consistent care, and earlier detection. However, in the past five years states like Louisiana have seen a sharp rise in their new cases of HIV. This second wave of HIV positive victims has stunned many volunteers and physicians alike.

HIV and AIDS were quickly becoming two of the most managed terminal infections in the United States. Volunteers interviewed at NO/AIDS and BRASS attributed this uptick to poor sexual education in high school and college. The populations most at risk in the next ten years are young African American males and females. The issue of the second wave crisis is that these persons will remain healthy and infected for many years before they reach Stage III symptomatic HIV. Ignorance of one's infection puts every sexual partner after that at risk for exposure. One BRASS volunteer Sarah* stated, "The kids who come in here now for medicine or OraQuicks [rapid HIV test] have often already progressed from HIV to AIDS. They are too young and healthy for us to see signs of HIV within the first months of infection. They can go years without noticing the effects of HIV, and then their T-cell counts drop so low that we find they have progressed to AIDS. I mean if they have no regular primary care who is going to run a blood panel on a 20 year old? It's frustrating because there's no communication in that age group about how to have safe sex."

b. Concerns for Educators and Governmental Response

The future of HIV/AIDS relief in Louisiana will succeed or fail by volunteers or government officials better educating this youth community about the risks of unprotected sex and the benefits of regular STI testing for sexually active members. Currently there is no high school based program in Louisiana for sexual advocacy and HIV awareness, and local volunteer groups focus their efforts more on support and education of already infected individuals. The Louisiana Department of Education has developed an HIV/AIDS training program for educators

and students. However, the tenets of the BART program or the Becoming and Responsible Teen program are based in communication development and refusal of sexual behavior that might put them at risk for contracting an STI (BRASS 2009). Better partnerships between these groups and university organizations like AIDS Reach LSU would create a unique opportunity to establish better preventative education for the at risk high school and college populations

Creating consistency in education and testing will require cooperation at a high school level. This is difficult because of the similarities between pregnancy prevention education and STI prevention. After interviewing student health nurses at several public schools in the greater New Orleans and Baton Rouge areas it was concluded that they only administer a test if asked. One nurse who worked in a St. Bernard Parish public school expressed her desire to have STI information days at her clinic, but had largely been unsuccessful. She explained, “A couple of weeks ago I had a teen come in here and ask me for an HIV test because he had had an anonymous sexual encounter with another male over the weekend. This wasn’t his normal pattern of behavior, but he put himself at a huge risk by having unprotected, anonymous sex. There’s no discourse between these students or their primary care source about how to have safer sex that also empowers the teen to advocate for their sexual health needs. The young man came to me for a test so that he wouldn’t have to go to his mother and explain what he had done.”

The future of HIV/AIDS relief in Louisiana will require that the needs of this youth culture are addressed in the open. A recurrence of shame and fear among teenagers about sexual practices keeps them from seeking help. Education about life with HIV/AIDS and the risks of other STIs needs to be an incorporated part of the student health curriculum. With the appropriate information, students will then have the power to advocate for themselves in a sexual relationship. This applies to the college based population as well. Better education and

empowerment of the individual will give these students the opportunity to make safer decisions when choosing a sexual partner and choosing when to engage in sexual activity. The dangers befalling this youth and young adult set go beyond the fear of an unwanted pregnancy. HIV/AIDS is a terminal infection, and one that educators have the ability to speak with their students about.

In order to stave off a growing second wave crisis, much of the volunteer and education efforts of the state should be focused on a comprehensive testing and outreach network for these students. According to the interviewed student health nurses, there are no avenues for these teens and young adults to seek counseling at school or at home. HIV/AIDS positive students are often referred to outside treatment sources, but many of the volunteer outreach groups focus on adult counseling and events that alienate this group. For the future of HIV/AIDS relief to succeed in Louisiana volunteer groups must create more age specific opportunities for young adults. Implementing the same support network used on the older HIV/AIDS positive adult population for teens and young adults will add to the longevity of the volunteer group, and also allow for newly infected young adults to have a safe and confidential forum for discussion.

c. Aid to Volunteers: A Social Support Network

In the aftermath of Hurricane Katrina, most of the HIV/AIDS volunteer networks established along the Gulf Coast were in a state of upheaval. Volunteers desperate to get back to New Orleans could not and volunteers in Baton Rouge were inundated by evacuees many of whom needed immediate treatment. In the future, a better communication system between these volunteers would allow for consistent treatment of HIV/AIDS positive patients as well as peace of mind for volunteers. The most damaging effect on New Orleans volunteers in the post-Katrina environment was their loss of relationships with their HIV/AIDS clients. Comprehensive mental

health care for HIV/AIDS volunteers is necessary if private and governmental organizations want to retain these counselors and advocates.

The pressures associated with living in a post-disaster zone clearly affected every volunteer interviewed within the NO/AIDS Task Force. A volunteer coordinator explained, “People can’t take it anymore. It used to be that their lives were ok or stable, and the only mentally fatiguing thing was coming to work to deal with HIV clients all day. Before Katrina when they went home, they could get away from the stress and destruction of dealing with the infection. The problem now is that when my volunteers go home there is no relief. Money problems, losing neighbors and friends, and having deal with the same stress in their HIV positive clients is too much for most of them. As a result, we have trouble hanging on to truly committed volunteers. They burn out too quickly now, and there’s no one coming in behind them.”

The decrease in volunteer participation, state and federal funding, and an increase in HIV/AIDS positive victims has put the volunteer organizations of Southern Louisiana in a uniquely stressful situation. To prevent further volunteer burnout, mental health needs to be addressed within the organizations for volunteers as well as patients. The mental health counselors are already available within many of the larger organizations like NO/AIDS or BRASS, but their services have routinely been saved for HIV/AIDS clients only. If volunteers go to the organization to help their HIV/AIDS positive counterparts, they can also seek appropriate treatment for depression, post traumatic stress disorder, and other mental illness. This would begin to repair the culture of healing that was so integral to the identity of the Louisiana HIV/AIDS volunteer organization.

Healing the volunteers at the same institution where they work to heal the mind and body of HIV/AIDS patients affords volunteers with the unique opportunity to repair themselves alongside their clients. In the future, HIV/AIDS relief in Louisiana will require that volunteer numbers grow significantly to meet the needs of the second wave crisis emerging in New Orleans and Baton Rouge. Creating an HIV/AIDS volunteer network that serves not only the clients but the volunteers will improve retention rates, and ensure that volunteers are staying healthy as well. So much of the HIV/AIDS volunteer organization is based on this idea of holistic wellness. A psychiatrist with the NO/AIDS Task Force related that, “We can’t just treat the medical needs of HIV and AIDS positive persons, and then expect them to fix the social and emotional issues that befall their newly infected condition. The hardest, most important work volunteers do here at NO/AIDS is patient counseling. This clearly means that while we can set up appropriate medical treatment, needs of the patient are more often based in assessing their fear, shame, and ability to comply with the requirements of their new life. It is hard to counsel, and the advocates often burn out because they become too weary of taking on the psychosocial issues of their clients.” Before Katrina that counseling was geared more towards clients, but as the stress of rebuilding these organizations mounts that same idea of keeping the “whole” healthy must apply to volunteers in the future as well. A truly holistic culture of healing requires that both HIV/AIDS clients and their volunteer advocates achieve the same restorative experience through one another and their organization.

At the conclusion of this research, there was one issue in Louisiana that must take precedence. The growing HIV/AIDS epidemic that has taken over the greater Baton Rouge area is continuing to spread throughout the city and its surrounding areas. The overwhelming number of new cases reported in Baton Rouge each year, since Hurricane Katrina, indicates that the

second wave crisis is upon us. The need for better advocacy, testing, and community mobilization will make the difference in diminishing this growing phenomenon. The community as a whole must begin to respond to this issue on a united front. With the numbers before us, this can no longer be considered an ethnic or economically influenced issue. It is now an “everyman” issue in the city of Baton Rouge. As the numbers continue to increase, the city’s mainstream society will no longer be able to separate themselves from those who are infected. Better medical care, earlier discovery of individual infections, and the spread of preventative education into the high school and middle school populations will stem the spread of this disease in the future. However, until it is universally accepted by the Baton Rouge community, the prevention of HIV/AIDS will continue to lag behind its unhindered growth.

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APPENDIX A NOTES

1. “The phylogenetic relationships of these viruses exhibit little correlation with those of the host primate species, indicating that cross-species transmissions have occurred on numerous occasions (62). Most notably, the two groups of viruses giving rise to AIDS in humans both appear to have resulted from multiple independent transmissions from other species. It has been clear for some time that feral sooty mangabeys are the source of the HIV-2 epidemic in West Africa (10, 20, 21, 46), while very recent work has implicated chimpanzees of the subspecies *P. troglodytes troglodytes* in Central Africa as the natural reservoir of HIV-1 (19, 34, 35, 53, 54, 68). Other transmissions have occurred both in captivity and in the wild. For example, SIV infection of several species of macaques (*Macaca* spp.) has resulted from accidental introduction of SIVsm in North American primate centers (22, 27, 50), while a yellow baboon (*Papio hamadryas cynocephalus*) in Tanzania (37), a chacma baboon (*Papio ursinus*) in South Africa (69), and a patas monkey (*Erythrocebus patas*) in Senegal (8) have each become infected in the wild by viruses derived from the local sympatric species of African green monkeys. These examples all reflect comparatively recent cross-species transmission events, readily identifiable by virus-host phylogenetic discordance within the major primate lentivirus lineages. In addition, deeper branchings within the phylogeny are at odds with the relationships among the species inferred to be the natural host for each lineage. The five major viral lineages are approximately equidistant, and yet four comprise viruses naturally infecting *Cercopithecidae* (Old World monkeys) while the fifth is found in apes. Furthermore, it is remarkable that the recently characterized SIVlhoest falls within the same lineage as SIVmnd (28), since l'hoest monkeys are closely related to other members of the genus *Cercopithecus* while mandrills are more closely related to mangabeys (*Cercocebus* spp.) (25). Thus, cross-species transmissions greatly complicate any attempts to determine the evolutionary origins of this group of viruses or the timescale of primate infection. For this reason, it is of interest to identify groups of viruses that may have evolved in a host-dependent fashion.” (BEER 1999).
2. “One theory of the origin of AIDS is that it developed from contaminated vaccines used in the world's first mass immunization for polio. There are a number of reasons why this theory is plausible enough to be worthy of further investigation.
 - The location coincides dramatically. The earliest known cases of AIDS occurred in central Africa, in the same regions where Koprowski's polio vaccine was given to over a million people in 1957-1960.

- The timing coincides. There is no documented case of HIV infection or AIDS before 1959. Centuries of the slave trade and European exploitation of Africa exposed Africans and others to all other diseases then known; it is implausible that HIV could have been present and spreading in Africa without being recognized.
- Polio vaccines are grown (cultured) on monkey kidneys which could have been contaminated by SIVs. Polio vaccines could not be screened for SIV contamination before 1985.
- Another monkey virus, SV-40, is known to have been passed to humans through polio vaccines. A specific pool of Koprowski's vaccine was later shown to have been contaminated by an unknown virus.
- In order for a virus to infect a different species, it is helpful to reduce the resistance of the new host's immune system. Koprowski's polio vaccine was given to many children less than one month old, before their immune systems were fully developed. Indeed, in one trial, infants were given 15 times the standard dose in order to ensure effective immunization.

If this theory is correct, it has serious ethical, health and policy implications. In particular, it points to the danger of interspecies transfer of material through vaccinations, organ transplants, etc., which could lead to new variants of AIDS as well as other new diseases. As well, studying the theory may lead to insights about responding to AIDS and preventing new diseases.

On several occasions, critics have claimed that the theory has been refuted. The Wistar Committee in 1992 said the death of a British sailor in 1959, whose tissues later tested positive for HIV, made the theory implausible. However, several years later, more sensitive tests showed no HIV in the tissues.

In 2001, reports were published that polio vaccine samples held in Philadelphia from the 1950s showed no immunodeficiency viruses. This was trumpeted as a refutation of the theory. Edward Hooper later produced evidence that US-produced vaccines had been amplified in Africa using chimpanzees as a substrate, thus showing the theory could be correct.

Scientists have spent a lot of effort trying to refute the polio-vaccine theory of the origin of AIDS, but very little trying to refute the conventional view, that blood from an SIV-infected chimpanzee got into humans via hunting or eating. There is very little direct evidence to support the conventional view, which explains neither the timing nor the location of the origin.

Scientific journals have been reluctant to publish articles about the polio-vaccine theory. For example, *Nature* has received substantial submissions about the theory from at least six scholars but has not

published any of them. Opponents of the theory have used defamation threats and legal actions to discourage publication. The result is that editorial prerogative and legal action have given the false impression that critics of the theory have been unanswered.” (Hooper 2008)

3. “T-cell tests are reported as the number of cells in a cubic millimeter of blood. There is some disagreement about the normal range for T-cell counts but normal CD4+ counts are between 500 and 1600 and CD8+ count between 375 and 1100. CD4+ counts drop dramatically in people with HIV. In some cases, the count drops to zero. T-cells are a type of lymphocyte or white blood cell. They are a vital part of the immune system. There are two main types of T-cells. T-4 cells or CD4+ cells are “helper” cells. They lead the attack against infections. T-8 cells or CD8+ cells are “suppressor” cells. These cells end immune response. CD8+ cells can also be “killer” cells that destroy cancer cells and other virus infected cells. T-cells are distinguishable by specific proteins on the cell surface. T-4 cells have CD4 molecules on the surface. This cell is also called a CD4 Positive or CD4+. When a human is infected with HIV. The cells that are most infected are T-4 or CD4+ cells. The virus becomes a part of the cells and when the cells multiply to fight an infection, they also make more copies of HIV. When someone is infected with HIV for a substantial period of time, the number of T—or CD4+ cells in their body goes down. In other words, their T-cell count goes down. This is a sign that the immune system is weakening. It is believed that the lower a person’s T-cell count, the more likely he or she will become ill. There are millions of different families of T-cells. Each family is designed to fight a specific type of germ. When HIV reduces the number of T-cells, some of these families are completely obliterated. The HIV infected person can lose the ability to fight off particular germs. When this happens, the body becomes a target for opportunistic infections. The ratio of CD4+ cells to CD8+ cells is sometimes reported. This is calculated by dividing the CD4+ value by the CD8+ value. In healthy individuals, this ratio is between 0.9 and 1.9 or about 1 to 2 CD4+ cells for every CD8+ cell. In people infected with HIV, this ration drops greatly, at times resulting in more CD8+ cells than CD4+ cells. Since cell values are affected by time of day, fatigue and stress, it is better to have blood drawn at the same time of day and at the same laboratory for a more accurate count. Infections have a large impact on T-cell count. When the body fights and infection the number of white blood cells (lymphocytes) increases. CD4+ and CD8+ count increase also. Immunizations can have the same affect. T-cell counts should not be checked until at least two weeks after recovery from an infection or after an immunization. The variability of T-cell counts has caused some doctors to examine T-cell percentages. These percentages refer to total lymphocytes. If a patient’s tests report CD4+%= 34%, that means that 34% of the lymphocytes were CD4_ cells.

This percentage is more stable than the number of T-cells. The normal range of CD4+ cells is between 20% and 40%. A CD4+ percentage below 14% indicates serious immune damage. It is a sign of AIDS in people with HIV infection. The CD4+ cell count is a key measure of health of the immune system. The lower the CD4+ count, the greater damage of HIV. Patients with a CD4+ count of less than 200 or a CD4+ percentage of less than 14% is considered to have AIDS according to the CDC.” (NO/AIDS 2008)

4. “Kaposi sarcoma is a disease in which malignant (cancer) cells form in the tissue lining the lymph vessels under the skin or in mucous membranes. Kaposi sarcoma is a cancer that causes lesions (abnormal tissue) to grow under the skin, in the lining of the mouth, nose, and throat, or in other organs. The lesions are usually purple and are made of cancer cells, new blood vessels, and white blood cells. Kaposi sarcoma is different from other cancers in that lesions may begin in more than one place in the body at the same time. Human herpesvirus-8 (HHV-8) is found in the lesions of all patients with Kaposi sarcoma. This virus is also called Kaposi sarcoma herpes virus (KSHV). Most people infected with HHV-8 do not get Kaposi sarcoma. Those infected with HHV-8 who are most likely to develop Kaposi sarcoma have immune systems weakened by disease or by drugs given after an organ transplant.” (National Cancer Institute 2009)

5. “Pneumocystis carinii pneumonia (PCP) is a fungal infection of the lungs. PCP is a pneumonia caused by the fungal organism *Pneumocystis carinii* (now renamed *Pneumocystis jiroveci*). This organism is common in the environment and does not cause illness in healthy people. However, *Pneumocystis carinii* can cause a lung infection in people with a weakened immune system due to any of the following conditions: cancer, chronic use of corticosteroids or other medications that affect the immune system, HIV/AIDS, and solid organ or bone marrow transplant. PCP was a relatively rare infection before the AIDS epidemic. Before the use of preventive antibiotics for PCP, up to 70% of people in the U.S. with advanced AIDS would develop PCP. PCP in those with AIDS usually develops slowly and is less severe. People with PCP who do not have AIDS usually get sick faster and are more acutely ill. Symptoms include: cough -- often mild and dry, fever, rapid breathing, and shortness of breath -- especially with activity” (National Institute of Health 2009).

6. "Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. We provide prevention and care services to more than 15,000 men, women and families that are living with, or affected by, HIV/AIDS in New York City, and advocate for scientific, evidence-based public health solutions for hundreds of thousands worldwide. GMHC fights to end the AIDS epidemic and uplift the lives of all affected" (GMHC 2009).
7. "Ryan White was an Indiana teenager with hemophilia who contracted AIDS through a blood transfusion. He courageously fought AIDS-related discrimination and helped educate the Nation about his disease. Ryan White was diagnosed with AIDS at age 13. He and his mother Jeannie White Ginder fought for his right to attend school, gaining international attention. Ryan was featured on countless television shows and magazine covers and was the subject of a television movie about his life. Ryan White died on April 8, 1990, at the age of 18, just a few months before Congress passed the AIDS bill that bears his name-the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act. The legislation has been reauthorized three times since-in 1996, 2000, and most recently in with the most recent 2006 enactment renaming the program as the Ryan White HIV/AIDS Program" (Health Resources and Services Administration 2009).
8. "AZT also known as Retrovir is a nucleoside/nucleotide reverse transcriptase inhibitor or NRTI. Other common NRTIs include: Combivir, Emtriva, Epivir, Atripla, Epzicom, Hivid, Trizivir, Truvada, Videx, Videx EC, Viread, Zerit, and Ziagen. NRTIs, sometimes called "nucleoside analogues" or "nukes," contain faulty versions of the building blocks (nucleotides) used by reverse transcriptase to convert RNA to DNA. When reverse transcriptase uses these faulty building blocks, the new DNA cannot be built correctly. In turn, HIV's genetic material cannot be incorporated into the healthy genetic material of the cell and prevents the cell from producing new virus. While nucleotide analogues (Viread is the only nucleotide analogue approved at this time) are technically different than nucleoside analogues, they act very much the same way. In order for nucleoside analogues to work, they must undergo chemical changes (phosphorylation) to become active in the body. Nucleotide analogues bypass this step, given that they are already chemically activated" (AIDSMEDS 2009).

9. ddI is another NRTI form of drug therapy. It is marketed as Videx by Bristol Meyers Squibb (NO/AIDS Task Force 2008)
10. ddC is another NRTI form of drug therapy. It is marketed as Hivid by Roche (NO/AIDS Task Force 2008).
11. “The 2006 Ryan White legislation changed how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country. Key changes included: revised method for determining eligibility for Part A (formerly called Title I) funds gives priority to urban areas with the largest number of people living with HIV/AIDS while also helping mid-size cities and areas with emerging needs, revised method for distributing Part A funds directs money to metropolitan areas with the highest number of people living with HIV/AIDS. It also encourages outreach and testing, which will get people into treatment sooner and save more lives, more money will be spent on direct health care for Ryan White clients. Under the 2006 law, grantees receiving funds under Parts A, B, and C (formerly called Titles I, II and III) must spend at least 75 percent of funds on Core Medical Services, the 2006 law recognizes that HIV/AIDS has had a devastating impact on racial/ethnic minorities in the U.S. African Americans accounted for approximately half of all HIV/AIDS cases diagnosed. The 2006 law codifies the Minority AIDS Initiative under the Ryan White HIV/AIDS Program.” (Health Resources Services Administration 2006)
12. “Fuzeon is a popular entry fusion inhibitor. Another popular EFI is Selzentry. Entry inhibitors work by preventing HIV from entering healthy CD4 cells (T-cells) in the body. They work differently than many of the approved anti-HIV drugs—the protease inhibitors (PIs), the nucleoside reverse transcriptase inhibitors (NRTIs), and the non-nucleoside reverse transcriptase inhibitors (NNRTIs)—which are active against HIV *after* it has infected a CD4 cell. Entry inhibitors work by attaching themselves to proteins on the surface of CD4 cells or proteins on the surface of HIV. In order for HIV to bind to CD4 cells, the proteins on HIV's outer coat must bind to the proteins on the surface of CD4 cells. Entry inhibitors prevent this from happening. Some entry inhibitors target the gp120 or gp41 proteins on HIV's surface. Some entry

inhibitors target the CD4 protein or the CCR5 or CXCR4 receptors on a CD4 cell's surface. If entry inhibitors are successful in blocking these proteins, HIV is unable to bind to the surface of CD4 cells and gain entry into the cells” (AIDSMEDS 2009).

13. **“DEFINITIONS OF THE EXPOSURE CATEGORIES-** For the purposes of this report, HIV/AIDS cases are classified into one of several hierarchical exposure (risk) categories, based on information collected. Persons with more than one reported mode of exposure to HIV are assigned to the category listed first in the hierarchy. Definitions are as follows:

- i. **Men who have Sex with Men (MSM):** Cases include men, who report sexual contact with other men i.e. homosexual contact or bisexual contact.
- ii. **Injection Drug User (IDU):** Cases who report ever using drugs that require injection - not other routes of administration of illicit drug use.
- iii. **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, or heterosexual contact with a person known to be HIV-infected.
- iv. **Hemophilia/Transfusion/Transplant (Hemo/Transf):** Cases who report receiving a transfusion of blood or blood products prior to 1985.
- v. **Perinatal:** HIV infection in children resulting from vertical transmission from an HIV+ mother.
- vi. **Unspecified:** 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 represent logistical issues of surveillance and do not imply that modes of transmission other than sexual, blood, and perinatal are suspected. “Unspecified” cases include: persons for which the surveillance protocols to document the risk behavior information have not yet been completed 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 his/her sexual partners.” (LOPH 1998)

14. NOVEMBER 2007 – POZ MAGAZINE- The South Shall Rise Again by **Jimmie Briggs** – “*In the two years since POZ last charted AIDS in its new U.S. epicenter—the South—infection rates have continued to rise in the region. In 2005, the South accounted for 41 percent of people with HIV in the nation; today, it’s home to 45 percent of new AIDS cases. The regional epidemic is further complicated by the lingering effects of Hurricane Katrina and an unnatural disaster: poor federal AIDS funding.* According to the Centers for Disease Control (CDC), the South now accounts for 45 percent of all new U.S. HIV infections—and 50 percent of all American AIDS deaths. The causes for the region’s spike in new infections are as varied and contentious as they were in 2005: extreme poverty, wobbly AIDS-service infrastructure, comparatively low federal funding (northern and western metropolitan areas are still granted the vast majority of federal AIDS dollars), a high minority concentration (which has traditionally eluded HIV-prevention efforts) and a large rural population (which has difficulty accessing basic care and services). Scores of people with HIV, community-based organizations, foundations, public health officials and, slowly, faith-based groups are raising a louder call for greater awareness and support in the South. Even before AIDS arrived, in 1981, the region had long been home to the 10 American cities with the highest rates of sexually transmitted infections. But now, not only are seven of the 10 states with the highest AIDS rates in the South, but more survivors of the disease live in Southern states than anywhere else in the country. To tackle the disease in such diverse states as Mississippi, North Carolina or Louisiana means understanding the complex array of factors contributing to its spread and responding with cultural sensitivity and accuracy. While there is certainly reason for pessimism and disappointment with state and federal responses to HIV/AIDS in the South, there have been notable successes and lessons learned which could be applied throughout the country. Andrew Spieldenner, director of programs at the National Association of People With AIDS (NAPWA), notes that “many of the Southern states have taken creative steps in meeting the needs of people living with HIV in their jurisdictions, including those with health departments, elected officials, faith-based groups and other businesses servicing the same populations. Some of this has been necessary in order to maximize resources; some of it has come out of extensive relations already existing in the respective communities.” (POZ MAGAZINE 2007)

15. Denise*, a volunteer coordinator with the NO/AIDS Task Force, in many ways embodied the familial air of the organization. She sets an example emulated by most volunteers in their interaction with the administration and clients. She is an open and honest woman, who joined the organization after the death of her husband from AIDS in the early 1990's. Her fight against AIDS started in 1984 when her husband received an HIV positive blood transfusion. Within five years of becoming infected, her husband contracted the AIDS related cancer, non-Hodgkin's lymphoma. Denise and her husband knew about his HIV positive status before he contracted cancer. She maintains that even though her husband was HIV positive, their sex life remained unchanged. She explained that with the use of condoms, she never contracted the infection from her husband. However, after contracting non-Hodgkin's lymphoma, Denise explained that her husband's disease progressed rapidly and in 1992 he passed away. Denise then devoted herself fulltime to raising her five year old daughter and relying on help from her family after her husband's death. She stressed that her daughter was her top priority, but that as her daughter became a teenager Denise began looking for a way to help others with HIV. She is a native of New Orleans, and had heard about NO/AIDS from friends. Denise started with the organization as a volunteer, but through attention and work ethic took far more coordination responsibilities. Denise believes that every PLWHA deserves to have the same strong family support system that she had during her husband's illness.

16. CLIENT RIGHTS WITHIN THE NO/AIDS TASK FORCE

- a. RESPECT, COURTESY AND CONFIDENTIALITY- Health and social service providers have the right to be treated with respect and courtesy at all times.
- b. GIVING CORRECT AND COMPLETE INFORMATION- You are responsible for giving to your provider accurate and complete information about your health condition and social situation, medications used, past and current treatments and the names and addresses of other providers you are using or have used. You must give this information to the best of your ability.
- c. SEEKING FACTS ABOUT YOUR CASE- You are responsible for asking questions about the care you are receiving if you do not completely understand it. This means that you should know about the risks, benefits, and financial aspects of your care. You

also have the right to have your advocate(s) ask about this information.

- d. FOLLOWING THE TREATMENT PLAN- You are responsible for following treatment plan that you and your providers have agreed upon. You have the responsibility to tell your provider right away if you decide to stop your treatment or go against your provider's advice. You are responsible for what happens to you.
- e. SCHEDULED APPOINTMENTS- You are responsible for keeping appointments that you and your provider have scheduled. If you have to cancel, you are responsible for telling your provider that you will not be there.
- f. COMMUNICATING YOUR FINANCIAL NEEDS- You are responsible for giving accurate and complete information about third party payers (such as insurance companies, Medicaid, Medicare) to your providers and their facilities. You should also make sure that you give them any forms that they may ask for, or to send in any forms that are required of you as soon as you possibly can. You also have the responsibility to talk to your providers about your financial situation, regarding your financial needs, and tell them if you need help in figuring out what your financial needs are before you start receiving services from your provider.
- g. RULES AND REGULATIONS OF SERVICE PROVIDER ORGANIZATIONS- You are responsible for following the rules and regulations of your providers and their agencies/facilities.
- h. VOICING COMPLAINTS AND GRIEVANCES- You are responsible for voicing complaints and presenting grievances in an appropriate and timely manner. You should do this by following the providers' grievance policy and procedure, and you may ask for help in doing this if you need it.
- i. CONTINUING CARE- Whenever you leave a providers' facility or care, you are responsible for asking when and where to go for more treatment and follow-up services

17. "The OraQuick Rapid HIV Test screens for HIV-1 antibodies in a person's blood obtained by a finger stick. The test is produced by OraSure Technologies, INC. and correctly identifies 99.6% of the people who were infected with HIV-1 and 100% of the people who were not infected with HIV-1. The testing process is simple. The fingertip is cleaned with alcohol and pricked with a lancet needle to obtain a drop of blood. The blood is collected in a specimen loop and transferred to a small vial containing a premeasured volume of developing solution. The blood is mixed into the solution and the loop is discarded. A test stick is then inserted into the vial and the test results can be read in twenty minutes. Contraction of the HIV-1 virus within three months can be detected." (NO/AIDS 2008)
18. "Twenty-one years ago, a summit of health ministers realized that a united global effort was required to halt the spread of HIV. As a result, World AIDS Day emerged as the first international health day in December 1988. The aim of World AIDS Day is to bring to people's attention the worldwide challenges and consequences of the epidemic - ultimately halting the spread of HIV and improving the lives of people living with the virus. Each year the campaign is an opportunity for organizations throughout the world to highlight the HIV pandemic in order to raise awareness and bring about change
- a. **What is the theme for World AIDS Day 2008?**

The UK theme for World AIDS Day 2008, "Respect & Protect", is inspired by the UNAIDS and World AIDS Campaign ongoing international theme, "Leadership". The international theme is developed as an overall theme which each country is encouraged to adapt to suit more specific issues around the epidemic in their region. Each year NAT translates the international theme into a slogan to reflect HIV issues in the UK, developing a theme and call to action relevant to HIV in the UK, and producing new and unique visuals and materials to accompany the theme. By consulting our customers, young people and people living with HIV, Respect & Protect translates the global theme "Leadership" for a UK audience, setting out an agenda for individuals to take the lead in their own life.
 - b. Respect & Protect is inclusive and highlights the responsibility everyone has to transform attitudes to HIV and encourage actions that stop its spread.
 - c. Respect & Protect inspires individuals to consider the different roles they can play: show respect by always treating people living with HIV fairly, respecting their confidentiality

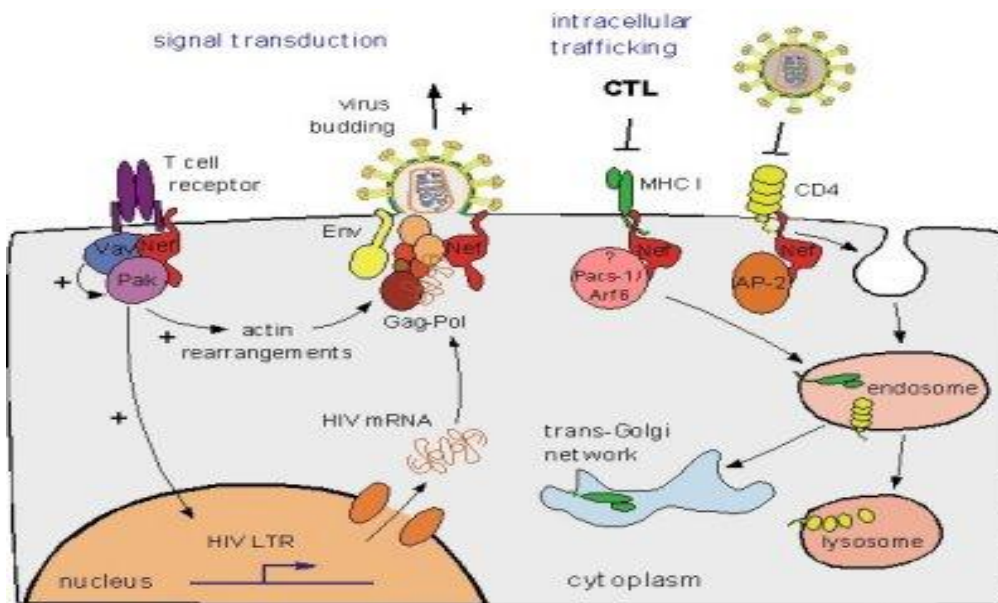
and challenging prejudice wherever it occurs, respect themselves and their partners by always practicing safe sex to protect their sexual health.” (World AIDS Day 2008)

19. “Founded in 1987, The AIDS Memorial Quilt is a poignant memorial, a powerful tool for use in preventing new HIV infections, and the largest ongoing community arts project in the world. Each "block" (or section) of The AIDS Memorial Quilt measures approximately twelve feet square, and a typical block consists of eight individual three foot by six foot panels sewn together. Virtually every one of the more than 40,000 colorful panels that make up the Quilt memorializes the life of a person lost to AIDS. As the epidemic continues claiming lives around the world and here in the United States, the Quilt continues to grow and to reach more communities with its messages of remembrance, awareness and hope.” (AIDSQUILT.ORG 2009)
20. Black HIV/AIDS Awareness day was created in 2001 as a way of promoting HIV/AIDS awareness in the African American community. Today BHAA Day is celebrated on university campuses across the country, through HIV testing, education forums, and HIV counseling.
21. Traditionally second wave crises occur in third world and developing nations. However, as the United States sees a resurgence in their HIV/AIDS cases, medical officials are warning of an impending re-epidemic occurring in minority populations like Hispanic and African American urban areas. Areas like New Orleans and Baton Rouge with large minority populations are increasingly at risk.

APPENDIX B. FIGURES

1. Figure 1 Illustration of an HIV-1 Virion and Its Synthesis
2. Figure 2 The Four Stages of HIV Progression
3. Figure 3 Distribution Chart of Persons Living Below the Poverty (LA 2000)
4. Figure 4 Demographics of HIV Infected Persons (HIV/AIDS) 1998
5. Figure 5 Characteristics of HIV Infected Persons in Louisiana 2004
6. Figure 6 New HIV Diagnoses- the New Orleans Region 2005-2006
7. Figure 7 Persons Newly Diagnosed with HIV/AIDS Region 1: New Orleans 2009
8. Figure 8 Regional AIDS Cases and Rates Diagnosed in Louisiana 1989-1999
9. Figure 9 Characteristics of Persons Newly Diagnosed with HIV 2005-2006
10. Figure 10 Image- LSU PMAC Field Hospital during Hurricane Katrina

Figure 1- Illustration of an HIV-1 Virion and Its Synthesis



The HIV-1 virion uses the host cell membrane to form

the viral envelope. This envelope is covered by gp41 and gp120 surface proteins as well as Major histocompatibility complex class II (MHC II) proteins inserted into the lipid envelope. Inside the lipid envelope, the matrix formed by Gag protein p17 holding the RNA containing core in place. The cylindrical core not only stores the viral RNA and various proteins, it also contains complementary RNA synthesized by the viral reverse transcriptase. (Stanford 2005)

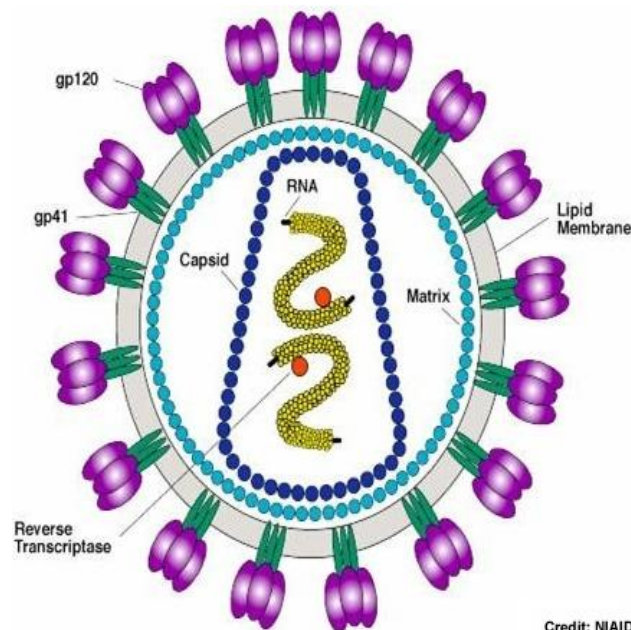


FIGURE 2- The Four Stages of HIV Progression

Regional Infectious Diseases Unit, City Hospital, *P D Welsby*, consultant physician

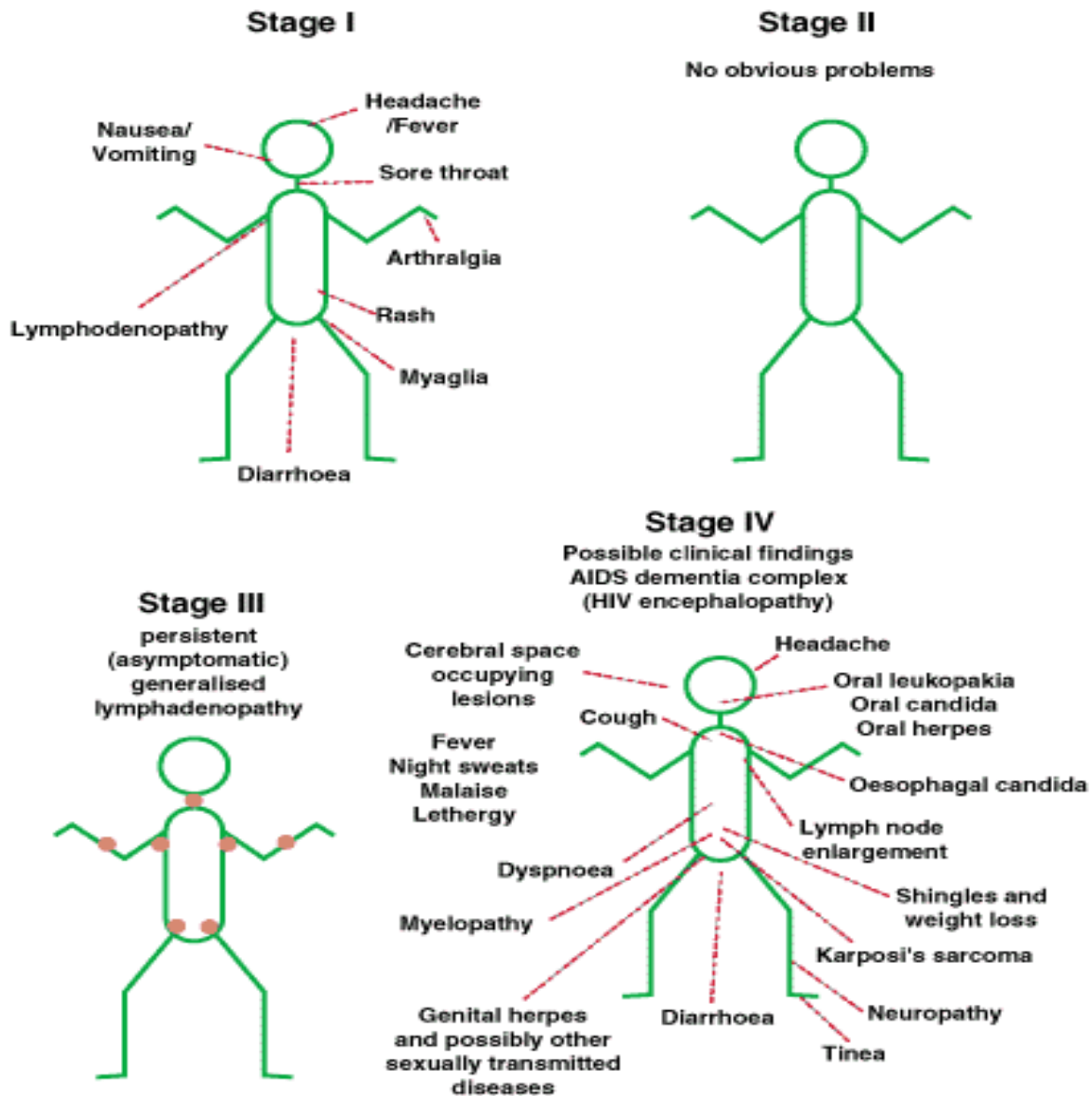


FIGURE 3- Louisiana Office of Public Health 2000 Annual HIV/AIDS Report

Distribution of Persons Living Below the Poverty Level During the Past 12 Months by Sex and Age Group for Parishes of >250,000 Population, Louisiana, 2000								
Below poverty level, %								
Age group	East Baton Rouge		Jefferson		Orleans		Statewide	
	Males, % (N=34,201)	Females, % (N=49,204)	Males, % (N=23,456)	Females, % (N=31,162)	Males, % (N=57,140)	Females, % (N=75,500)	Males, % (N=370,499)	Females, % (N=505,738)
≤25	74.3	53.7	59.4	40.9	56.3	47.6	59.9	46.8
26-44	11.3	26.2	13.2	27.3	22.7	28.2	17.1	25.4
45-64	7.4	10.6	18.8	18.7	18	17.1	15.4	16.3
≥65	7	9.5	8.5	8.5	3.1	7.1	7.6	11.5
Source: Census 2000, US Bureau of the Census and Louisiana Census Data Center Profile								

FIGURE 4- Louisiana Office of Public Health Annual Report 1998

Demographics of HIV-Infected Persons (HIV/AIDS) ^a						
Persons with HIV/AIDS First Detected in 1998			Persons Living with HIV/AIDS		Persons with HIV/AIDS Cumulative	
<i>This column reflects persons with HIV infection (HIV/AIDS) whose confidential positive status was first detected in 1998 and reported to the health department. Due to the potentially long delay from HIV infection to detection, some persons may have been diagnosed with AIDS at the time HIV was first detected.</i>			<i>This column reflects the minimum estimate of persons living with HIV by the end of 1998. This column includes persons living with AIDS.</i>		<i>This column reflects the total number of HIV-infected persons reported as having been diagnosed with HIV or AIDS in the state. This represents the minimum number of cases of HIV infection in the state, including those who have died.</i>	
	Cases	Percent ^b	Cases	Percent ^b	Cases	Percent ^b
TOTAL	1,243	100%	11,488	100%	18,891	100%
Gender						
Men	850	68%	8,598	75%	15,149	80%
Women	393	32%	2,890	25%	3,742	20%
Ethnicity						
African-American	910	73%	7,029	61%	10,419	55%
White	297	24%	4,087	36%	7,926	42%
Other	34	3%	340	3%	511	3%
Unknown	2	< 1%	32	< 1%	35	< 1%
Age Group	(Age at HIV Detection)		(Age at End of 1998)		(Age at HIV Detection)	
under 15	8	1%	205	2%	288	2%
15 - 24	207	17%	2,230	19%	2,845	15%
25 - 34	435	35%	4,826	42%	7,853	42%
35 - 44	395	32%	3,089	27%	5,456	29%
over 44	198	16%	1,136	10%	2,440	13%
Exposure Group^c						
MSM ^d	249	40%	3,570	44%	7,611	51%
IDU ^d	163	26%	1,948	24%	3,044	21%
MSM & IDU	31	5%	818	10%	1,488	10%
HRH ^d	164	26%	1,490	18%	2,005	14%
Transf/Hemo	14	2%	167	2%	436	3%
Perinatal	5	1%	154	2%	223	2%
Unspecified Exposure ^e	617	50%	3,340	29%	4,083	22%
Urban/Rural Parishes						
Urban	1,033	83%	9,501	83%	15,544	82%
Rural	182	15%	1,382	12%	2,139	11%

^a HIV data collection started in 1993. Positive results of anonymous tests are not included due to the likelihood of repeated tests.

^b Percentages might not add up to 100% due to missing values and rounding errors.

^c Percents for identified exposure groups represent the distribution among those with a specified exposure.

^d MSM: Men who have Sex with Men (non-IDU); IDU: Injection Drug Users; HRH: High Risk Heterosexual.

^e Unspecified Exposure refers to cases whose exposure group is under investigation or unknown.

1998 Louisiana HIV/AIDS Surveillance Report - Louisiana Office of Public Health

FIGURE 5- LOPH Annual HIV/AIDS Report 2004

Characteristics of HIV Infected Persons^a in Louisiana						
	Persons First Diagnosed with HIV in 2004		Persons Living with HIV/AIDS in 2004		Cumulative Persons with HIV/AIDS	
	<i>This column reflects persons with HIV infection whose confidential positive status was first diagnosed in 2004 and reported to the health department</i>		<i>This column reflects the minimum estimate of persons living with HIV as of December 31, 2004. This column includes persons living with AIDS.</i>		<i>This column reflects the total number of HIV-infected persons diagnosed with HIV or AIDS in the state. This represents the minimum number of cases of HIV-infection in the state, including those who have died.</i>	
	Cases^b	Percent^c	Cases	Percent	Cases	Percent
TOTAL	1,113	100%	15,068	100%	24,762	100%
Sex						
Male	764	69%	10,722	71%	18,815	76%
Female	349	31%	4,346	29%	5,947	24%
Ethnicity						
African American	851	76%	10,022	67%	15,388	62%
White	229	21%	4,519	30%	8,687	35%
Hispanic	24	2%	441	3%	573	2%
Other/Unk/Multi-Race	9	1%	86	1%	114	<1%
Age Group	(Age at HIV Diagnosis)		(Age in 2004)		(Age at HIV Diagnosis)	
0-12	15	1%	132	1%	287	1%
13-24	215	19%	863	6%	3,716	15%
25-34	270	24%	3,374	22%	9,060	37%
35-44	313	28%	5,782	38%	7,514	30%
45-54	206	19%	3,692	25%	2,997	12%
55-64	74	7%	992	7%	876	4%
65+	20	2%	233	2%	312	1%
Exposure Category^d						
MSM ^e	258	52%	4,435	45%	8,654	49%
IDU ^e	66	13%	1,979	20%	3,798	21%
MSM & IDU	23	5%	830	9%	1,661	9%
HRH ^e	129	26%	2,196	23%	3,030	17%
Transfusion/ Hemophilia	4	1%	120	1%	406	2%
Perinatal/ Pediatric	15	3%	193	2%	288	2%
Unspecified Exposure ^f	618	56%	5,315	35%	6,925	28%
Urban/Rural Parishes						
Urban	933	84%	12,786	85%	21,631	87%
Rural	180	16%	2,282	15%	3,131	13%
Facility of Diagnosis						
Private	374	34%	3,694	25%	4,543	18%
Public	739	66%	11,374	75%	20,219	82%

^a HIV data collection started in 1993. Positive results of anonymous tests are not included due to likelihood of repeat tests.

^b Cases within subgroups may not add up to totals due to unknowns.

^c Percentages may not add up to 100% due to rounding.

^d Percentages for identified exposure groups represent the distribution among those who reported a specific exposure. The percentage for the unspecified exposure group represents the percent among the total.

^e MSM: men who have sex with men (non-IDU); IDU: injection drug user; HRH: high-risk heterosexual.

^f Unspecified Exposure refers to cases whose exposure group is under investigation or unknown.

FIGURE 6- LOPH Annual HIV/AIDS Report 2005-2005

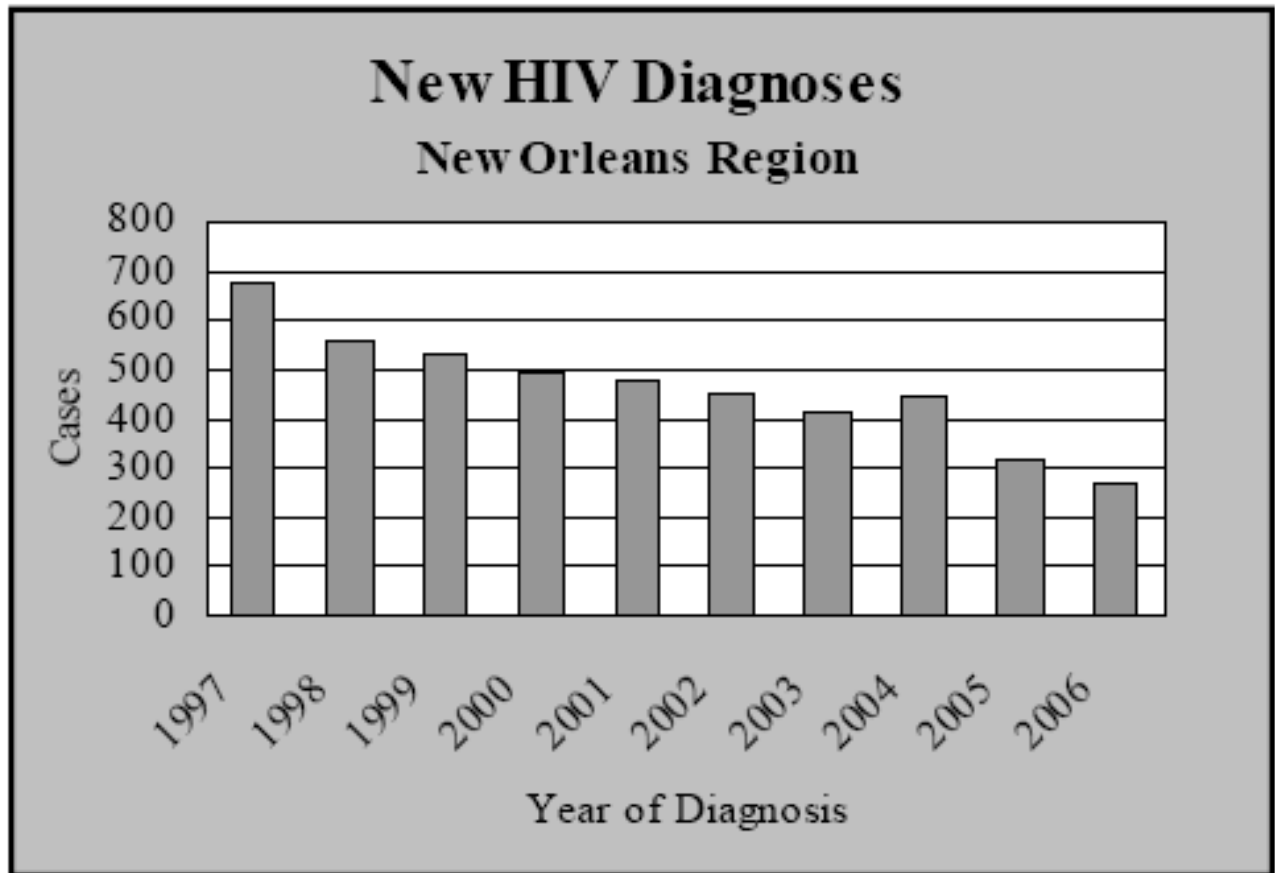


FIGURE 7- LOPH First Quarterly Report 2009

Persons Newly Diagnosed with HIV/AIDS

Region 1: New Orleans Region

HIV CASES DIAGNOSED January - December 2008

- 392 persons were newly diagnosed with HIV in Region 1.

<u>Gender</u>	Cases	Percent	<u>Race/Ethnicity</u>	Cases	Percent
Men	279	71 %	Black, Non-Hispanic	256	65 %
Women	113	29 %	White, Non-Hispanic	87	22 %
Total	392	100 %	Hispanic	38	10 %
			Asian/Pacific Islander	4	1 %
			Unknown	3	1 %
			Multi-race	4	1 %
			Total	392	100 %

<u>Age at Detection</u>	Cases	Percent	<u>Cases with a reported risk:</u>	Cases	Percent
0 - 12	2	1 %	Men who have sex with men	124	67 %
13 - 24	83	21 %	Injection drug use	14	8 %
25 - 34	120	31 %	Men who have sex with men and inject drugs	3	2 %
35 - 44	86	22 %	Heterosexual contact	41	22 %
45+	101	26 %	Perinatal	2	1 %
Total	392	100 %	Total	184	100 %
			<i>No Identified Risk</i>	208	

AIDS CASES DIAGNOSED January - December 2008

- 275 persons were newly diagnosed with AIDS in Region 1.

<u>Gender</u>	Cases	Percent	<u>Race/Ethnicity</u>	Cases	Percent
Men	189	69 %	Black, Non-Hispanic	172	63 %
Women	86	31 %	White, Non-Hispanic	73	27 %
Total	275	100 %	Hispanic	27	10 %
			Asian/Pacific Islander	1	<1 %
			Unknown	2	1 %
			Total	275	100 %

<u>Age at Diagnosis</u>	Cases	Percent	<u>Cases with a reported risk:</u>	Cases	Percent
0 - 12	1	<1 %	Men who have sex with men	73	51 %
13 - 24	17	6 %	Injection drug use	19	13 %
25 - 34	74	27 %	Men who have sex with men and inject drugs	6	4 %
35 - 44	80	29 %	Heterosexual contact	44	31 %
45+	103	37 %	Transfusion/Hemophilia	1	1 %
Total	275	100 %	Perinatal	1	1 %
			Total	144	100 %
			<i>No Identified Risk</i>	131	

FIGURE 8- HIV Annual Report 1998 Louisiana Office of Public Health

Regional AIDS Cases and Rates Diagnosed in Louisiana, 1989 - 1998										
Public Health Region ^a	1989		1990		1991		1992		1993	
	#	Rate ^b	#	Rate	#	Rate	#	Rate	#	Rate
I: New Orleans Region	367	35.4	407	39.3	563	54.4	576	55.5	620	59.8
II: Baton Rouge Region	69	12.7	71	13.0	112	20.3	168	30.1	206	36.5
III: Houma Region	22	6.0	28	7.6	23	6.2	32	8.6	39	10.4
IV: Lafayette Region	49	9.9	49	9.9	55	11.0	70	13.8	74	14.4
V: Lake Charles Region	25	9.6	29	11.2	32	12.2	33	12.5	47	17.6
VI: Alexandria Region	21	6.7	31	9.9	45	14.3	44	14.1	47	15.6
VII: Shreveport Region	37	7.4	49	9.8	59	11.8	85	16.9	64	12.7
VIII: Monroe Region	21	6.1	35	10.1	43	12.4	51	14.6	50	14.2
IX: Slidell/Hammond	22	6.2	28	7.9	39	10.8	52	14.1	53	14.0
TOTAL ^c	633	15.0	727	17.2	971	22.9	1,111	26.0	1,200	28.0
Public Health Region ^a	1994		1995		1996		1997		1998	
	#	Rate ^b	#	Rate	#	Rate	#	Rate	#	Rate
I: New Orleans Region	584	56.5	490	47.5	570	55.7	446	43.8	366	36.1
II: Baton Rouge Region	196	34.5	215	37.7	265	46.3	214	37.1	186	32.2
III: Houma Region	43	11.4	32	8.5	40	10.5	24	6.3	30	7.8
IV: Lafayette Region	61	11.8	54	10.4	54	10.3	63	12.0	44	8.3
V: Lake Charles Region	51	19.0	47	17.3	40	14.5	50	18.2	35	12.6
VI: Alexandria Region	47	15.5	57	18.8	46	15.2	25	8.4	26	8.6
VII: Shreveport Region	60	11.9	72	14.2	46	9.0	55	10.8	57	11.2
VIII: Monroe Region	62	17.6	53	15.0	43	12.2	40	11.3	36	10.2
IX: Slidell/Hammond	45	11.6	62	15.5	59	14.4	42	10.2	35	8.3
TOTAL ^c	1,149	26.6	1,082	24.9	1,163	26.7	961	22.1	818	18.7
^a Regions reflect the Public Health Regions as listed on page x.										
^b Rates per 100,000 persons in region.										
^c Totals include cases with missing regional data; therefore, cases in each year may not add up to totals.										
1998 Louisiana HIV/AIDS Surveillance Report - Louisiana Office of Public Health										

FIGURE 9- LOPH Annual HIV/AIDS Report 2005-2006

Characteristics of Persons Newly Diagnosed with HIV Louisiana, 2005-2006				
	Persons First Diagnosed with HIV in 2005^a <i>This column reflects persons with HIV infection who were first diagnosed in 2005, including persons who had AIDS at time of HIV diagnosis</i>		Persons First Diagnosed with HIV in 2006 <i>This column reflects persons with HIV infection who were first diagnosed in 2006, including persons who had AIDS at time of HIV diagnosis</i>	
	Cases^b	Percent^c	Cases	Percent
TOTAL	979	100%	1,052	100%
Sex				
Female	345	35%	339	32%
Male	634	65%	713	68%
Race/Ethnicity				
African American	718	73%	718	68%
Hispanic/Latino	27	3%	36	3%
White	216	22%	278	26%
Other/Unk/Multi-Race	18	2%	20	2%
Age Group				
0-12	14	1%	4	<1%
13-24	178	18%	189	18%
25-34	264	27%	315	30%
35-44	258	26%	263	25%
45-54	194	20%	202	19%
55-64	56	6%	57	5%
65+	15	2%	22	2%
Exposure Category^d				
MSM ^e	285	52%	301	54%
IDU ^e	63	12%	67	12%
MSM & IDU	23	4%	28	5%
HRH ^e	161	29%	161	29%
Perinatal/ Pediatric	14	3%	5	1%
<i>Unspecified Exposure^f</i>	<i>433</i>	<i>44%</i>	<i>490</i>	<i>47%</i>
Urban/Rural Parishes				
Urban	878	90%	924	88%
Rural	101	10%	128	12%
^a HIV data collection started in 1993. Positive results of anonymous tests are not included. ^b Cases within subgroups may not add up to totals due to unknowns. ^c Percentages may not add up to 100% due to rounding. ^d Percentages for identified exposure groups represent the distribution among those who reported a specific exposure. The percentage for the unspecified exposure group represents the percent among the total. ^e MSM: men who have sex with men (non-IDU); IDU: injection drug user; HRH: high-risk heterosexual. ^f Unspecified Exposure refers to cases whose exposure group is under investigation or unknown.				

FIGURE 10- Louisiana State University PMAC as a field hospital after Hurricane Katrina



Figure NIH Clinical Center- Clinical Center News: Stories of Hope and Heartbreak from the Front Lines October 2005 – Kathryn Boswell

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