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The Health of Women and Girls in Louisiana: Sexual Health

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Purpose Statement

This report emerged from a continuous collaboration between three organizations that share the goal of working in partnership with the New Orleans community to promote women's equity: Tulane University's Mary Amelia Center for Women's Health Equity Research (MAC), Tulane University's Newcomb Institute (NI), and the Institute of Women and Ethnic Studies (IWES). As a follow-up to our previous reports on the health of women and girls in Louisiana and the Greater New Orleans Area (2013 Report on the Health of Women & Girls in Greater New Orleans and The Health of Women & Girls in Louisiana: Racial Disparities in Birth Outcomes released in 2017), we again delve deeper into select health indicators and reasons behind racial/ethnic and socioeconomic disparities. This second follow-up report broadly focuses on indicators of sexual health and the stark racial disparities in sexually transmitted infections (STIs) throughout Louisiana. Evidence-based and data-driven programs and policies are the most successful at improving and sustaining health. It is our hope that providing contextual data will enable us all to uphold sexual and reproductive health as a fundamental human right.

Protecting and improving sexual health for all persons in Louisiana is critical not only because of the state's dismal sexual health rankings but also because sexual and reproductive health freedoms have been under attack in recent years. The World Health Organization, recognizing the long-term and far-reaching impact of sexual health on individuals, communities, and societies, distinguishes sexual and reproductive rights as a human right and essential for eliminating infant and maternal morbidity and mortality.[1] Sexual and reproductive health and rights require access to quality sexual and reproductive health services (e.g., contraception and abortions), sex education, protection from and treatment of STIs, elimination of violence against women and girls, and sexual healthcare services tailored toward adolescents and LGBTQ+ populations.[1]

However, public policies continue to curtail sexual and reproductive rights in the U.S. Among others, affordable healthcare insurance remains out of reach for many in the coverage gap,[2] attempts to restrict abortion funding and access are omnipresent,[3] LGBTQ+ discrimination healthcare protections have been weakened,[4] and violence is a key contributor to maternal mortality.[5] Low-income and non-White people are especially harmed by these policies and practices. In the U.S., and especially in Louisiana, there is an urgent need to ensure equitable, accessible, non-discriminatory sexual and reproductive health, rights, and justice for all communities.[6]

This report focuses on the multiple socioecological contexts that may drive poor sexual health outcomes, including racial disparities within these outcomes, and with a specific focus on STIs. Ours is a purpose-driven goal to provide evidenced-based data to policy makers, academicians, healthcare providers, social workers, and others charged with using it to improve the lives of women, children, and families. We aim to work with these entities to enhance sexual health for all Louisianians. This report is very much in line with the missions of MAC, NI, and IWES.

MAC's Mission:

To advance equitable health and wellbeing for all women and their communities. The center believes that opportunities for health begin where people are born, grow, learn, work, and play and are shaped by the policies and systems that form the foundation of our society. As a center that values being responsive to the community, we recognize the importance of translating our research into action through training and advocacy. Through broad dissemination of our findings, we hope to initiate, facilitate, and advance progress on efforts to improve population health for women, as individuals with reproductive rights, parents with children and families, and community members.

NI's Mission:

To develop leaders, discover solutions to intractable gender problems of our time, and provide opportunities for students to experience synergies between curricula, research, and community engagement through close collaboration with faculty.

IWES's Mission:

IWES is dedicated to improving the mental, physical and spiritual health and quality of life for women, their families and communities of color, particularly among marginalized populations, using community-engaged research, programs, training and advocacy.

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Executive Summary

This report is a smaller, sub-study of our larger ongoing Report on the Status of Women and Girls, first published in 2013. In the larger report, we examined the health status of women and girls in Greater New Orleans and the state of Louisiana using indicators of health behavior, reproductive health, cardiovascular disease, infectious disease, and cancer, as well as select social determinants of health.

Given the magnitude and persistence of poor sexual health outcomes throughout Louisiana, and racial disparities in these outcomes, this sub-study focuses on indicators of sexual health with a special focus on sexually transmitted infections (STIs).

- **Louisiana ranks 49th for chlamydia, 45th for gonorrhea, and 46th for syphilis. Without treatment, chlamydia and gonorrhea can cause pelvic inflammatory disease (PID), which in turn can lead to infertility. Untreated syphilis can cause neurologic problems and risk of stillbirth among infected pregnant women.**

- **STI rates are five times higher among Black women than White women in Louisiana.**

This report uses the World Health Organization's definition of Sexual Health (*WHO, 2006, page 5*)[7]:

> *"Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respective approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*

Framed in a social ecological model (*Figure 1*), we explore reasons why high rates of STIs exist and racial disparities persist despite successful efforts to expand Medicaid health insurance coverage and more spending on healthcare than any other country in the world. We find that features of the communities in which women are born, grow, live, work, and play shape their opportunities to live healthy lives. For example:

- **Rates of STIs are higher in Louisiana parishes with higher levels of poverty, income inequality, and lower median household incomes.**

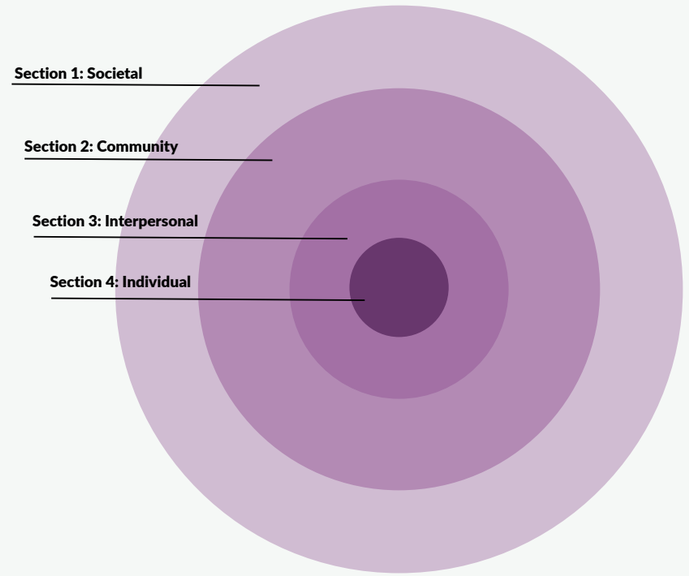
- **STI rates are higher among Black women than White women at every level of societal condition (poverty, unemployment, income inequality, median household income, and percentage of college graduates).**

Unmeasured factors, such as racism or access to and quality of healthcare, may explain these inequities in STI rates. Results also suggest that in addition to these features of the community, there are issues related to healthcare access that may also be contributing to suboptimal levels of sexual health in Louisiana. For example, in some parishes, there is a shortage of or complete lack of OB/GYNs or, at most, one or two publicly funded clinics that provide sexual and reproductive health services.

Furthermore, STI rates are high in Louisiana despite condoms being the most commonly used contraceptive method among women in Louisiana at risk of unintended pregnancy (i.e., 18–49, sexually active with one or more male partners, were not currently pregnant or trying to become pregnant, and had not had a hysterectomy). In addition, condoms are the least effective contraceptive method at preventing unintended pregnancy, and Louisiana has one of the highest unintended pregnancy rates in the country. Teenagers in Louisiana also have one of the highest teen pregnancy and birth rates in the country, yet Louisiana lacks a standardized and comprehensive sex education curriculum for primary and secondary school students.

Overall, this report highlights several opportunities to improve sexual health and advance health equity. Our recommendations include policies that increase investment in sexual and reproductive healthcare services, improve equitable socioeconomic opportunities, reduce violence, honor LGBTQ+ sexual and reproductive health needs, and follow the tenets of reproductive justice, among others. Since the sexual health indicators have likely been impacted by the COVID-19 pandemic (e.g., care-seeking behaviors, financial insecurity), these actions are especially crucial to efforts that uphold sexual and reproductive health as fundamental human rights necessary to ensuring all people in Louisiana have an equal chance of living healthy and safe lives.

FIGURE 1:
THE SOCIOECOLOGICAL MODEL AND ORGANIZATION OF THIS REPORT



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SECTION ONE

Factors Related to Sexual Heath and Sexually Transmitted Infections in Louisiana

- Sex Education
- Teen Sexual and Reproductive Health Outcomes
- Sexually Transmitted Infections and HIV/AIDS
- Contraception
- Insurance Coverage for Sexual and Reproductive Health
- Access to Sexual and Reproductive Health Providers and Clinics
- Abortion Laws
- Sexual Violence
- LGBTQ+ Health
- Pap Smear Utilization

Sex Education

There are **three major categories of sex education** in the United States: **sexual risk avoidance education** (SRAE), which teaches how to avoid all non-marital sexual activity (also known as abstinence-only or abstinence-only-until-marriage); **abstinence-plus,** which includes information about contraception and condoms in the context of abstinence messages; and **comprehensive sex education**, which provides evidence-based medically accurate information about abstinence and contraception to reduce the risk of unintended pregnancy and STIs in addition to other topics such as healthy relationships, communication skills, and human development.[8]

Louisiana permits abstinence-plus sex education in grades 7-12 (Orleans Parish permits sex education in 3rd grade and above), but schools are not legally required to teach sex education as per Louisiana Revised Statute 17:281 (1993).[9] While the law states that sex education must include factual information about reproductive biology, STIs, pregnancy, and childbirth, among other relevant topics, sex education must also include "information about parental responsibilities under the child support laws of the state".[9] State law prohibits the use of sexually explicit materials, the distribution of contraception on public school campuses, and advocating or counseling about abortion.[9]

Most parish school boards' (or charter operators') sex education policy is abstinence-plus reflecting Louisiana state law.[10] Twenty parishes have neither their own policy nor do they follow the state's policy, meaning they are not permitted to teach any sex education.[10] Five parishes—Orleans, Bossier, St. Charles, Concordia, and St. Landry—have their own state-approved sex education policy separate from the state's policy but they are still abstinence-emphasized.[10] Notably, Orleans Parish School District also allows for comprehensive sex education.[11] Following the reunification of Orleans Parish School Board in 2018, all New Orleans Public Schools are covered by OPSB's policy, however, some individual charter operators may establish their own sex education policies at schools they oversee as long as those policies are congruent with OPSB and state laws.[12]

With a majority of state residents identifying as conservative (43%)[13] and Christian (84%),[14] it is no surprise that these political and religious attributes align with the widely held belief in Louisiana that premarital sex is unacceptable according to a 2019 national Pew Research survey.[15] However, many parents in Louisiana report that they would prefer their children are taught how to use and obtain birth control and condoms.[16] A 2018 statewide survey conducted by the Louisiana Public Health Institute (LPHI) among K-12 parents found that most (76%) parents want sex education to emphasize abstinence while also including information about birth control.[16] Nearly all (94%) felt that if their child were to have sex before marriage, they should be educated on how to prevent STIs and/or pregnancy.[16] The majority (>75%), regardless of individual religious affiliation, also support a mandatory sex education curriculum across the state.[16] Furthermore, a 2016 survey among 600 Louisiana parents/caregivers of school-aged youth conducted by the Institute of Women and Ethnic Studies (IWES) found that most (86%) were interested in a trauma-informed school-based sex education given that many (71%) agreed youth are exposed to high levels of trauma.[17] Trauma-informed school-based sex education considers traumatic experiences of youth and teaches evidence-based sex education with compassion in emotionally safe, respectful, and empowering environments.[17]

Only 11% of students in 6th to 8th grade and 16% of students in 9-12th grade were taught all 19 of the CDC's critical sexual education topics.

Louisiana has received federal support from several different funding streams for sex education (Table 1).[18,19] The Title V Sexual Risk Avoidance Education Program (Title V AOUM, established in 1996) is a state grant program for abstinence-before-marriage sex education. The Teen Pregnancy Prevention (TPP) Program provides support for evidence-based or innovative evidence-informed teen pregnancy prevention programs or evaluation of such programs. Personal Responsibility Education Innovative Strategies (PREIS) funds the development, replication, refinement, or testing of innovative models to prevent teen pregnancy, HIV, and other STIs. In Louisiana, Personal Responsibility Education Program (PREP) funds evidence-based programs that equally emphasize contraception and abstinence and teach adulthood preparation topics (e.g., healthy relationships and healthy life skills). The Division of Adolescent and School Health (DASH) supports the collection and reporting of limited data to YRBS and School Health Profiles. For more information about how these grantees use these funds, please see the Sexuality Information and Education Council of the United States (SIECUS): Louisiana State Profiles in Fiscal Year 2018 and 2017.[18,19]

Although most federal funds are aimed at school-aged children, the state law creates programmatic and implementation barriers and challenges and thereby limits the usability and evaluation of these federal funds. For example, some federal funding sources require an assessment of participants' sexual beliefs or practices for program evaluation purposes (e.g., PREP), but state law forbids testing, quizzing, or surveying students about their personal beliefs or practices regarding sex. Thus, such federal funds cannot be used in schools. However, the state law does not apply to community organizations and thus the Louisiana Office of Public Health provides subgrants to community-based organizations rather than schools.

While Louisiana can and does teach comprehensive sex education in schools, there is a need for more robust and standardized sex education as underscored by the state's sexual health rankings and statistics. STI rates among teens have been increasing since 2013[20] and Louisiana has the third highest teen pregnancy rate in the nation.[21] Furthermore, only 11% of students in 6th-8th grade and 16% of students in 9th-12th grade were taught all 19 of the CDC's critical sexual education topics in a required course.[18] *(Read more about topics taught in secondary schools on pages 5-8 of the SEICUS 2018 state profile.)* Thus, it is more important than ever to ensure Louisiana students are receiving the best and most comprehensive sex education so that they can make informed decisions regarding their health and safety.

TABLE 1: LOUISIANA RECIPIENTS OF FEDERAL FUNDS FOR SEX EDUCATION PROGRAMS, FISCAL YEAR 2017/2018

Federal Funding Source	Fiscal Year	Amount	Grantee
Title V Sexual Risk Avoidance Education Program (Title V AOUM)	2018	$1,319,100	Louisiana Office of Youth for Excellence
Teen Pregnancy Prevention (TPP) Program	2017	$1,249,999	Institute of Women and Ethnic Studies (IWES)
Teen Pregnancy Prevention (TPP) Program	2017	$1,742,029	Policy and Research, LLC
Personal Responsibility Education Innovative Strategies (PREIS)	2017	$851,681	Policy and Research, LLC
Personal Responsibility Education Program (PREP)	2017	$694,093	Louisiana Office of Public Health, HIV/AIDS Program
Division of Adolescent and School Health (DASH)	2018	$99,741	Louisiana Department of Education

**Fiscal year listed is for the most recently available data*

Teenagers in Louisiana have some of the highest STI rates in the United States.

Teen Sexual & Reproductive Health Outcomes

Sexually Transmitted Infection (STIs)

Teens and young adults in Louisiana have some of the highest rates of STIs in the country.[22] Sexually transmitted infection (STI) rates among 15-19 year-olds in Louisiana have been increasing since 2013.[20] In 2018, Louisiana's 13-19 years age group comprised 6% of new HIV diagnoses, while the 15-19 year-olds comprised 33% of new chlamydia cases and 23% of new gonorrhea diagnoses.[20] Females 15-19 years old had the highest age-specific rate of chlamydia in 2018 (6,215 per 100,000) and the second highest age-specific rate of gonorrhea (1,240 per 100,000), following 20-24 year old females (1,333 per 100,000).

Teen Pregnancy and Births

Louisiana had the fourth highest teen pregnancy (in 2017)[23] and third highest teen birth (in 2018)[21] rates in the country. Although teen births are falling nationwide, the teen birth rate remains high in Louisiana (27.5 vs. 17.4 in U.S., per 1,000 15-19 year-olds).[21] The teen birth rate in Louisiana ranged from 13.7 per 1,000 15-19 year-olds in Plaquemines Parish to 55.6 per 1,000 15-19 year-olds in Madison Parish in 2018 (*Figure 2*).[21]

While there has been a steady decline in teen births across all races and ethnicities in the US, racial inequalities persist.[21] The national teen birth rate in 2018 among non-Hispanic Black and Hispanic teens remained at least twice as high as that of non-Hispanic White teens (26.3 and 26.7 vs. 12.1 per 1,000, respectively).[21] In Louisiana, in 2017, the teen birth rate was lowest among White teenagers (22.1 per 1,000), highest among Hispanic teenagers (53.0 per 1,000), and the rate among Black teenagers fell in the middle (36.3 per 1,000).[24]

As a result of structural factors that limit teens' access to reproductive autonomy and healthcare,[25] unintended teen childbearing can have both short- and long-term consequences.[26] Racial inequalities in teen births extend to other pregnancy-related inequalities among teens, such as receipt of adequate prenatal care and infants born preterm or low birthweight.[21] There are also geographic and socioeconomic inequalities in teen birth rates. Teen birth rates are lowest in large urban counties and highest in rural counties[27] and in Southern states.[21] Additionally, teen birth rates are higher in counties where unemployment is higher and educational attainment and family income are lower.[28]

Teens in Need of Contraceptive Services

The steady decline in the teen birth rate nationwide is mostly attributed to more contraceptive use, of which a greater proportion is now use of the most effective contraceptive methods for preventing pregnancy (namely, intrauterine devices and implants).[29] (*Note: It is unknown which methods are used by adolescents in Louisiana as this data is not collected.*[30])

In Louisiana, 69,780 women younger than 20 were likely in need of public support for contraceptive services and supplies in 2015, ranging from a low of 20 in East Carroll, St. Tammany, and Vernon parishes to 1,810 in Orleans Parish (*See Figure 3*).[31] All adolescents are considered likely in need of public support for contraceptive services and supplies given their age and greater need for confidential care.[32]

Contraceptive Services

Among the 69,780 adolescents (younger than 20) in Louisiana in need of contraceptive services, 20% of this need was met by publicly supported clinics (9% of which was met by Title X providers).[32] *(See Access to Reproductive Health Clinics on page 28 for more information on publicly supported clinics and the Title X Family Planning Program)*. The 195 publicly-supported clinics throughout Louisiana served 13,610 adolescent female contraceptive clients and helped avert 3,740 pregnancies, 1,940 births, and 1,080 abortions.[32]

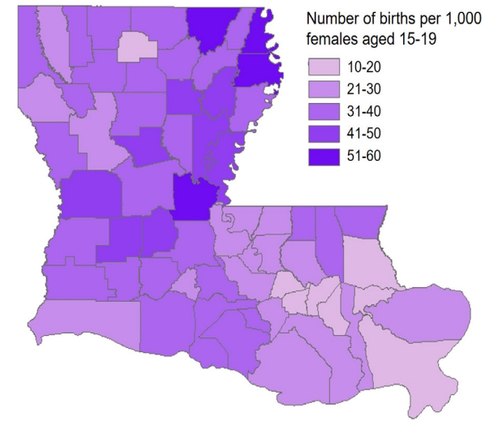


FIGURE 2:
BIRTH RATE AMONG WOMEN AND GIRLS AGED 15-19, IN LOUISIANA, 2018

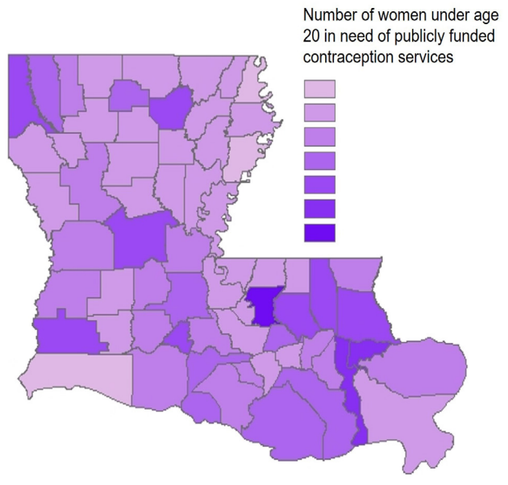


FIGURE 3:
NUMBER OF WOMEN AND GIRLS YOUNGER THAN AGE 20 WHO LIKELY NEED PUBLIC SUPPORT FOR CONTRACEPTIVE SERVICES AND SUPPLIES, 2016

Sexually Transmitted Infections and HIV

Sexually Transmitted Infection (STIs)

Louisiana has some of the highest rates of sexually transmitted infections (STIs) in the country. Among women in 2018, Louisiana ranked 49th for chlamydia, 45th for gonorrhea, 46th for syphilis.[33] Without treatment, chlamydia and gonorrhea can cause pelvic inflammatory disease (PID), which in turn can lead to infertility.[33] Untreated syphilis can cause neurologic problems and risk of stillbirth among infected pregnant women.[33]

Moreover, there are striking racial disparities in STI rates both nationally and in Louisiana (*Table 2*).[34,35] For example, in the U.S. and in Louisiana, chlamydia rates are about five times higher among Black females than White females.[34,35] Gonorrhea rates among Black females are about 7 times higher than White females in the U.S. and about 5 times higher than White females in Louisiana.[34,35] Furthermore, rates of STIs (chlamydia, gonorrhea, and syphilis) within Louisiana vary widely by parish and race/ethnicity[35] and may reflect differences in access and uptake of healthcare for both STI prevention and treatment.[36] In 2019, the parishes with the highest rates of STIs were Madison and LaSalle (2281.8 and 3275.9 cases per 100,000 female population, respectively), whereas Cameron and Tensas had the lowest rates (226.6 and 363.6 cases per 100,000 female population, respectively) (*Figure 4*).[35]

The racial disparities in STI rates in Louisiana are particularly striking, with **the average STI rate among Black women five times the rate of White women** (2818.8 and 525.0 cases per 100,000 respective populations).[35] Racial disparities within parishes are also alarming (*Figures 5 and 6*). The STI rate among White women was lowest in Franklin and Claiborne parishes (180.5 and 185.5 per 100,000 White female population, respectively), while rates were 18 times higher among Black women in these parishes (3258.9 and 3203.9 per 100,000 Black female population, respectively).[35] One of the lowest rates of STIs among Black women was in Allen Parish (833.8 per 100,000 Black female population), but this more than twice as high as White women in Allen Parish (383.3).[35] STIs for Black and White women was highest in LaSalle, but rates were 18 times higher among Black women (23,298.0 per 100,000 Black women and 1297.6 per 100,000 White women).[35]

To better understand underlying root causes of these racial disparities, see Section II Societal Conditions (page 38) and Section III Community Conditions (page 44).

TABLE 2.
FEMALE CHLAMYDIA, GONORHEA, AND SYPHILIS RATES, BY RACE, UNITED STATES AND LOUISIANA, PER 100,000 RESPECTIVE POPULATION, 2018

	United States		Louisiana	
	Black	White	Black	White
Chlamydia	1411.1	1411.1	1411.1	1411.1
Gonorrhea	433.3	433.3	433.3	433.3
Syphillis	8.4	8.4	8.4	8.4

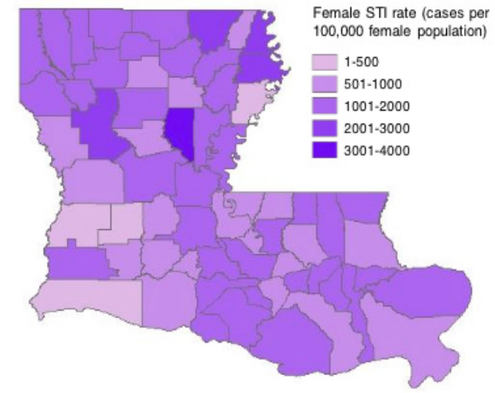


FIGURE 4:
TOTAL FEMALE STI RATE (CASES PER 100,000 POPULATION), 2019

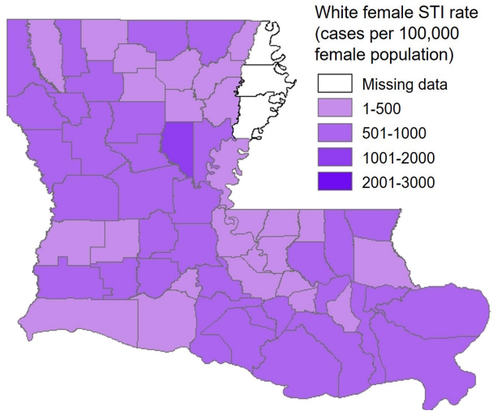


FIGURE 5:
WHITE FEMALE STI RATE (CASES PER 100,000 POPULATION), 2019

Note: Data missing in East Carroll, Madison, and Tensas Parishes

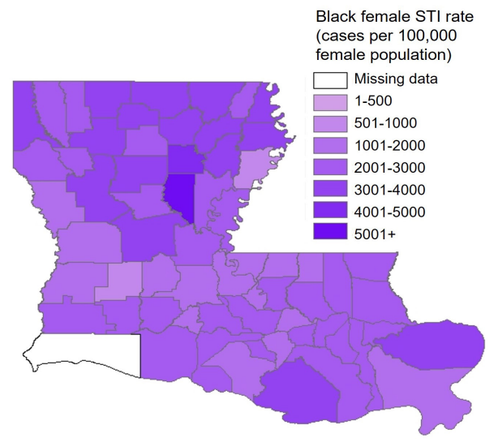


FIGURE 6:
BLACK FEMALE STI RATE (CASES PER 100,000 POPULATION), 2019

Note: Data missing in Cameron Parish

Part 2: HIV/AIDS

Louisiana ranked fourth highest in the nation for HIV case rates and AIDS case rates in 2018.[37] Among large metropolitan cities in the US, HIV case rates were 3rd highest in Baton Rouge and 7th highest in New Orleans, and AIDS case rates were 5th highest in New Orleans and 10th highest in Baton Rouge.[37]

Rates of new HIV diagnoses in 2019 in Louisiana were higher among males (76%) than females (22%).[37] Two-thirds of new cases of HIV and nearly three-quarters (74%) of new AIDS diagnoses were among Black persons, a cause for alarm in a state where Black people comprise only about one-third (32%) of the population.[37] Among women in Louisiana living with HIV in 2020, the vast majority were Black (81%), a number more than five times that of White women living with HIV (5175 vs. 918, respectively).[37] However, as of 2018, the HIV diagnosis rate among Black females was at its lowest in 10 years (22.9 per 100,000), significantly down from its peak in 2009 (43.4 per 100,000).[20]

Among large metropolitan cities in the US, HIV case rates were 3rd highest in Baton Rouge and 7th highest in New Orleans, and AIDS case rates were 5th highest in New Orleans and 10th highest in Baton Rouge.

While new AIDS diagnoses in Louisiana among men and women was twice as high as the national average in 2018, there have been improvements in recent years.[20] There were 419 new AIDS diagnoses in Louisiana in 2018, its lowest rate since 2010 (798 diagnoses).[20] Yet racial disparities in the AIDS diagnosis rate persists: 20.1 per 100,000 Black population, 7.8 per 100,000 Hispanic/Latinx population, and 3.4 per 100,000 White population.[20]

Furthermore, the small LGBTQ+ population of Louisiana carries an outsized burden of HIV/AIDS infections and disease. See LGBTQ+ Health chapter on page 34 for more information.

Perinatal HIV Exposure and Congenital Syphilis

Louisiana has one of the highest rates of perinatal HIV transmission and congenital syphilis in the US, and Black women in Louisiana carry a disproportionate share of the burden. The majority (83%) of pregnant women living with HIV in 2017 were Black, and most congenital syphilis cases occurring in 2018 were among Black women (77%).[20]

Louisana has one of the highest rates of perinatal HIV transmission and congential syphilis in the US, and Black women in Louisiana carry a disproportionate share of the burden.

Adverse birth outcomes, such as being of low birth weight or preterm, are more common among infants exposed to HIV and among those with congenital syphilis compared to all newborns in Louisiana (*see Table 3*).[20] However, although perinatal HIV exposure and congenital syphilis can be prevented with adequate prenatal care and disease treatment, too few women received such care. In 2017, whereas most (89%) pregnant women living with HIV in Louisiana received any prenatal care, only 20% received the recommended 14 or more prenatal care visits (up from 18% in 2016).20 Similarly, although all pregnant women with syphilis received some prenatal care in 2018, only 22% received the recommended 14 prenatal visits (up from 7% in 2017).[20] Barriers to care to prevent transmission include access to healthcare, low-income, and stigma.[20]

TABLE 3.
BIRTH OUTCOMES FOR ALL NEWBORNS, INFANTS EXPOSED TO HIV, AND CONGENITAL SYPHILIS CASES, 2017, 2018

	All newborns in LA (2017 and 2018)	Infants Exposed to HIV (2017)	Congenital Syphilis (2018)
Low birth weight (<2500g)	11%	25%	33%
Preterm (<37 weeks)	13%	23%	35%

Contraception

Nearly half (46%) of all pregnancies in Louisiana in 2014 were either unwanted or mistimed (wanted later), the third highest rate in the country. Of these, 63% ended in birth while 22% ended in abortion (15% ended in miscarriage or stillbirth).[38] Contraception allows women to control their fertility, thereby reducing the likelihood of unintentionally becoming pregnant or needing an abortion.

Contraceptive Use

About 3 in 10 Louisiana women at risk of unintended pregnancy do not use any method of contraception (*see Figure 7*).[39] Women were considered at risk of unintended pregnancy if they are aged 18–49, sexually active with one or more male partners, were not currently pregnant or trying to become pregnant, and had not had a hysterectomy.

Condoms are the most common method of contraception among women in Louisiana (22.7%),[39] which are considered a least effective method for preventing unintended pregnancies.[40] The pill, a moderately effective method,[40] is the second most common method (17.9%).[39] While female sterilization is a highly effective method,[40] used by 15.1% of women at risk of unintended pregnancy, [39] it is a permanent procedure. Intrauterine devices (IUDs) are among the most effective methods and are reversible,[40] yet only 4.5% of women in Louisiana at risk of unintended pregnancy use these methods.[39]

In 2016, there were more than 345,000 women in Louisiana aged 13-44 in need of publicly supported contraceptive services and supplies, ranging from 300 in Tensas Parish to 37,590 in East Baton Rouge Parish (*see Figure 8*).[32] These are sexually active women who are able to become pregnant (i.e., not sterilized), do not wish to become pregnant in the given year, and are either younger than 20 years old or older than 20 with a family income below 250% of the federal poverty level.[32]

Only one-fifth (21%) of this need was met by publicly funded clinics (12% of which was met by Title X-funded clinics).[32] (*See Access to RH Clinics on page 28 for more information on publicly support clinics and the Title X Family Planning Program*). The 195 publicly-supported clinics throughout Louisiana served 71,040 female contraceptive clients, helping avert 15,240 pregnancies, 7,170 births, and 5,150 abortions.[32]

About 3 in 10 Louisiana women at risk of unintended pregnancy do not use any method of contraception.

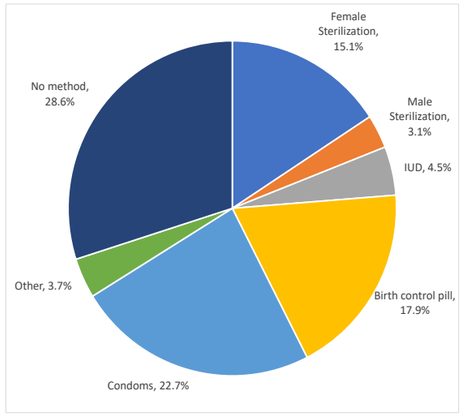


FIGURE 7: CONTRACEPTIVE USE BY WOMEN AT RISK OF UNINTENDED PREGNANCY, LOUISIANA, 2017, PERCENT[A,B]

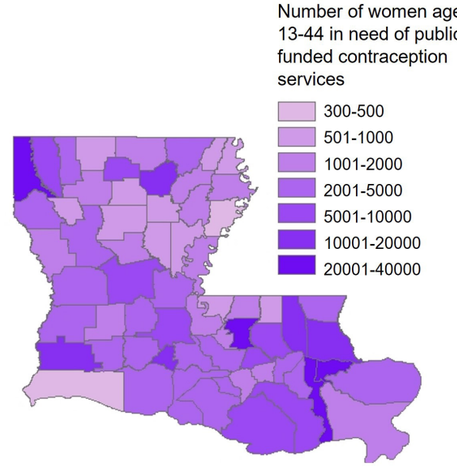


FIGURE 8: NUMBER OF FEMALES AGED 13-44 WHO LIKELY NEED PUBLIC SUPPORT FOR CONTRACEPTIVE SERVICES AND SUPPLIES, 2016

a. Women were considered at risk of unintended pregnancy if they are aged 18–49, sexually active with one or more male partners, were not currently pregnant or trying to become pregnant, and had not had a hysterectomy.
b. Data is not available for implants, injectables, patch, ring, and withdrawal because the estimate was unreliable (denominator < 50 respondents or a relative standard error > 30%)

Insurance Coverage for Sexual and Reproductive Health

Coverage Under the Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) was enacted in 2010. Provisions of the ACA included the ability for states to expand Medicaid income eligibility to persons making up to 138% of the federal poverty level. As of February 2021, 39 states and Washington DC had expanded Medicaid eligibility.[41] Louisiana formally adopted Medicaid expansion on June 1, 2016. By 2019, there were 619,635 adult (19-64) Medicaid enrollees in Louisiana (up from 377,083 in 2015 before Medicaid expansion).[42,43] Of these, approximately two-thirds (61.3%) were female.[43] There are several provisions and services covered by the ACA and Medicaid that specifically benefit women.[44,45] They are listed in the box on page 25.

These new insurance laws have led to increased health insurance coverage and improved health outcomes for women and children in expansion states. Overall, women in expansion states had earlier initiation into prenatal care, better pre-pregnancy healthcare, and had lower rates of infant and maternal mortality.[46]

As of 2017, the uninsured rate for women of childbearing age (18-44) was almost twice as high in non-expanded states versus Medicaid expansion states (16% vs. 9%, respectively).[46] Louisiana experienced one of the sharpest declines in the uninsured rate among women of childbearing age in the U.S., going from 26% uninsured in 2013 to 11% in 2017 (a 15% decline).[46] Additionally, the proportion of uninsured women in need of publicly funded contraceptive services decreased by 50% in expansion states; in Louisiana, there was a 37% decrease (from 32% in 2013 to 19% in 2016).[32]

Among postpartum women, nationally, the uninsured rates among women who gave birth in 2017 fell 47% for non-Hispanic White mothers, 41% for Black mothers, and 39% for Hispanic mothers since the passing of the ACA.[47] In Louisiana, the uninsured rate among women who gave birth in 2017, compared to 2015, fell by 69% for Black mothers (13% to 4%) and 22% for White mothers (9% to 7%), but increased by 16% among Hispanic mothers (49% to 57%).[48,49]

By parish, we can see increases in public insurance coverage post ACA-expansion (Note: public coverage includes Medicaid, Medicare, and coverage through the Department of Veteran Affairs; Medicaid coverage alone is unavailable at the parish-level). In 2015, an average of 18.5% of women in Louisiana had public insurance, ranging from 8.6% in Cameron Parish to 34.1% in East Carroll Parish. In 2019, the proportion of women with public insurance increased to 28.6% on the state level, ranging from 11.1% in Cameron Parish to 49.6% in East Carroll Parish. This increase in public insurance coverage across Louisiana parishes is visualized in Figures 9 and 10.

The following services are now covered:

- **Yearly well-woman visits for women under 65**
- **Genetic test counseling for women at higher risk of breast cancer**
- **Regular breast cancer mammography screenings for women over 40**
- **Cervical cancer screenings, such as the Pap smear, every 3 years for women 21 to 65**
- **Human Papillomavirus (HPV) test combined with a Pap smear every 5 years for women 30 to 65**
- **Counseling for sexually transmitted infections for sexually active women**
- **Chlamydia, gonorrhea, and syphilis screening for women at higher risk**
- **HIV screening and counseling pregnant women and sexually active women**
- **Contraceptive counseling and provision of methods of FDA approved contraceptive methods (This provision does not apply to health plans sponsored by exempt "religious employers")**
- **Domestic and interpersonal violence screening and counseling for all women**
- **Diabetes screening for women with a history of gestational diabetes who are not currently pregnant and who have never been diagnosed with type 2 diabetes**
- **Tobacco use screening and interventions**
- **Urinary incontinence screening**
- **Osteoporosis screening for women over 60**

Pregnant women also benefit from the following ACA-covered services:

- **Folic acid supplements for women who may become pregnant**
- **Anemia screening on a routine basis**
- **Hepatitis B screening for pregnant women at their first prenatal visit**
- **Preeclampsia prevention and screening for pregnant women with high blood pressure**
- **Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk**
- **Expanded tobacco intervention and counseling for pregnant tobacco users**
- **Urinary tract or other infection screening**
- **Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes**
- **Support and counseling for breastfeeding from certified providers**

Between 2013 and 2017, Louisiana experienced a 15% decline in the uninsured rate among women of childbearing age, one of the sharpest declines in the in the US.

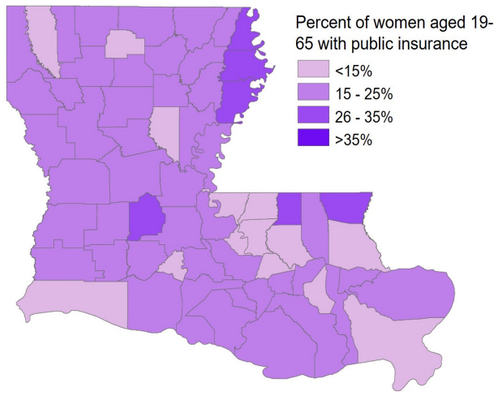


FIGURE 9:
PUBLIC INSURANCE COVERAGE AMONG WOMEN AGED 19-65, 2015

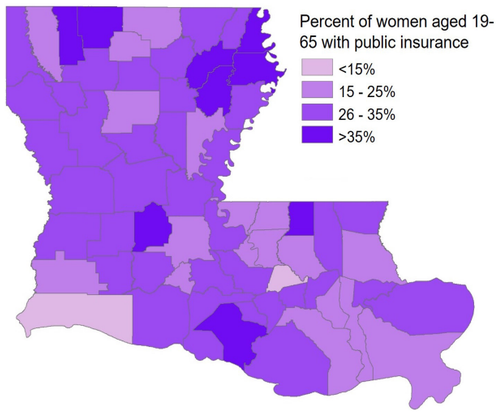


FIGURE 10:
PUBLIC INSURANCE COVERAGE AMONG WOMEN AGED 19-65, 2019

Access to Sexual and Reproductive Health Providers and Clinics

Access to OB/GYNs

Access to OB/GYNs for sexual and reproductive health services is vital because not every physician provides sexual and reproductive healthcare,[50] and OB/GYNs are essential for delivery of obstetric care for high risk patients.[50]

Availability of OB/GYNs strongly depends on where one lives. There is a shortage of OB/GYNs and perinatal healthcare providers in rural and medically underserved areas (MUAs).[50-52] MUAs are designated by the Health Resources and Services Administration (HRSA) as geographic areas with a shortage of primary care providers, high infant mortality, high poverty, or a high elderly population.[53]

As of 2019-2020, 41% of parishes in Louisiana did not have a single OB/GYN

In Louisiana, every parish is considered an MUA.[53] In fact, there were 26 parishes in Louisiana without a single OB/GYN in 2019-2020 (*Figure 11*).[51] The rate of OB/GYNs per 100,000 population ranges from 2.1 in St. Bernard Parish to 43.1 in Orleans, with an average of 10.9 OB/GYNs in the 38 parishes with an OB/GYN.[51]

Description of Publicly Supported Clinics

Sexual and reproductive healthcare services can also be accessed through publicly supported clinics where services are provided by a variety of healthcare provider types (physicians, nurse practitioners, physician assistants, and nurse-midwives).[54,55]

Publicly supported clinics not only help avert pregnancies and abortions through their contraceptive services, but they also provide essential reproductive health services, such as STI testing and treatment and HPV vaccinations.[32] A publicly-supported clinic (e.g., public health departments, Federally Qualified Health Centers, or Planned Parenthood clinics) uses public funds, such as Medicaid and Title X, to provide free or reduced-fee contraceptive and reproductive health services to the general public.[32] The federal Title X Family Planning Program subsidizes contraceptive and reproductive health services by providing funding for thousands of safety net healthcare providers in low-income communities who serve low-income and uninsured clients.[56] The Louisiana Office of Public Health Reproductive Health Program has been part of the national Title X Family Planning Program since the 1970s.[57]

There were 195 publicly supported reproductive health clinics in Louisiana as of 2015, with at least one per parish (except unknown in Cameron and West Feliciana) (*see Figure 12*).[31] Together these clinics served 67,400 clients, with a high of 9350 in Orleans Parish and low of 80 in Tensas Parish (*Figure 13*). Collectively, these contraceptive services helped avert 15,240 pregnancies in 2016, of which many would have ended in birth (7,170) or abortions (5,150).[32] They also helped avert 2,460 cases of chlamydia among partners, 530 cases of gonorrhea among partners, and 200 cases of pelvic inflammatory disease (PID).[32] Pap smears and HPV vaccinations helped avert 40 abnormal cell cases and 20 cases of cervical cancer among clients.[32]

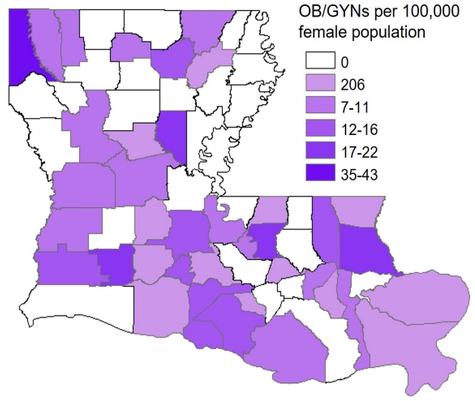


FIGURE 11: NUMBER OF OB/GYNS PER 100,000 FEMALES, 2019-2020

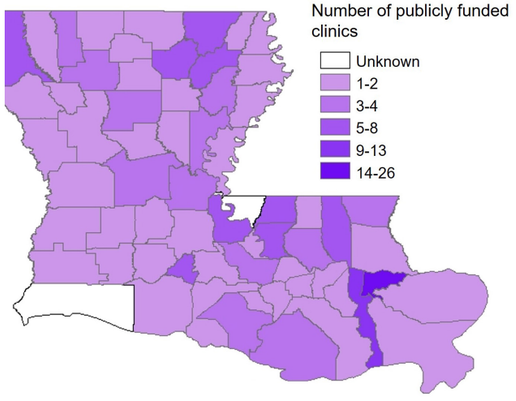


FIGURE 12: NUMBER OF PUBLICLY FUNDED CLINICS WITHIN EACH PARISH, 2015

Note: Data missing in Cameron and West Feliciana Parishes

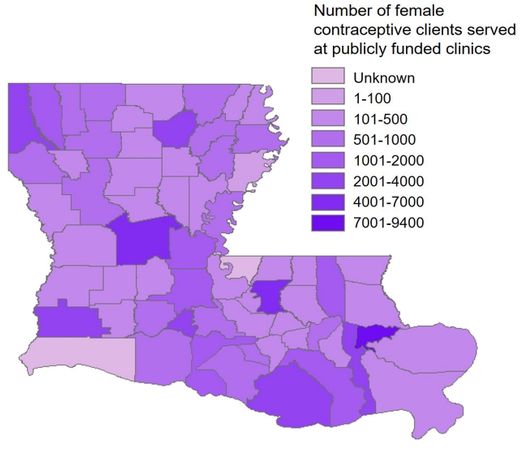


FIGURE 13: NUMBER OF FEMALE CONTRACEPTIVE CLIENTS SERVED AT PUBLICLY FUNDED CLINICS, 2015

Note: Data missing in Cameron and West Feliciana Parishes

Abortion Laws

Abortion Access

Louisiana is one of the most restrictive states in the U.S. when it comes to the provision of comprehensive reproductive health care services, including abortion care (*see Figure 14*). In 2017, approximately 94% of Louisiana parishes had no clinics providing abortions (compared to 89% nationally), and 72% of Louisiana women of reproductive age lived in those parishes (compared to 38% of women across the U.S.).[58] As of 2021, there were only three clinics in Louisiana that provides abortion care in the cities of New Orleans, Baton Rouge, and Shreveport.[59]

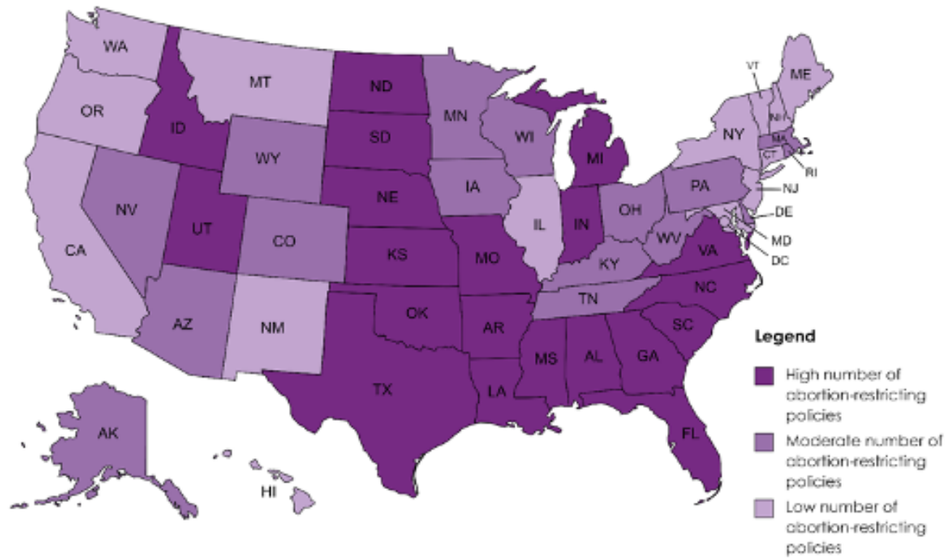
Limited access to abortion in Louisiana is the result of legislation that has defined who, where, when, and how women may obtain an abortion. Since the U.S. Supreme Court ruling in Roe v. Wade nearly 40 years ago, Louisiana has enacted more abortion restrictions than any other state (89 vs. 63 in Indiana, the second most restrictive state).[60] Most recently, in 2020, Amendment 1 passed as a constitutional amendment, resulting in the addition of language that nothing in the state constitution can be interpreted as securing or protecting a right to abortion or requiring the funding of abortion.[61] This amendment means that if Roe v. Wade – which protects the right to abortion without excessive governmental restriction – were ever overturned at the federal level, abortions in Louisiana would be illegal (as per the 2006 trigger law),[62] and would make it more difficult to litigate against the trigger law.[61]

As of 2020, the following abortion restrictions were in effect in Louisiana:[63]

- **State-mandated counseling before abortion** (i.e., abortion provider is required to read their patients information leaflets with language that dissuades patients from completing the abortion)
- **Mandatory waiting periods** of 24 hours between counseling and abortion services
- **Mandatory ultrasound** prior to abortion procedure (i.e., abortion provider is required to display or describe pre-abortion ultrasound images)
- **Mandatory parental/legal guardian's written consent** required for minors seeking abortion unless a judge grants special permission, a process which often requires a minor to find and pay for an attorney[64]
- **Gestational age restrictions** (i.e., limits on abortion after a specified point – e.g., 20 or more weeks of gestation – in pregnancy)
- **Use of telemedicine to administer abortion medication is prohibited**
- **Medication abortion must be provided by a licensed physician**, and the prescribing physician must be physically present when the patient takes the pill[65]
- **Licensed physician requirement** in providing abortion care (i.e., non-physician health care providers, such as physician assistants, advanced registered nurses or nurse midwives, are prohibited from providing abortion care)
- **Restrictions on public funding for abortion** (i.e., prohibitions against use of Medicaid funds to pay for abortions)
- **Private and public health insurers are prohibited from covering elective abortions**[66]

Several other abortion laws have been passed in Louisiana but are currently being contested in state courts.[67] These include HB386, which extends the mandatory waiting period from 1 to 3 days between certain required pre-abortion procedures and the performance of an abortion,[68] and HB606, which prohibits entities that perform abortions from receiving public funding for any purpose.[69] Senate Bill 184, which would ban abortions after six weeks gestation, is currently enjoined in litigation.[70] Notably, in June 2020, the U.S. Supreme Court ruled 5 to 4 in June Medical Services v. Russo that the 2014 Louisiana law requiring doctors performing abortions to have hospital admitting privileges was unconstitutional.[71]

FIGURE 14. STATE ABORTION POLICY CONTEXT



Sexual Violence

Sexual violence (SV) is defined as any committed or attempted sexual experience that is unwanted, in which consent was not freely given or an individual is not able to consent or refuse.[72] Some forms of SV include sexual harassment, sexual misconduct, and sexual assault.[72] Sexual violence can be committed by family, current or former partners, authority figures, friends, people in a workplace, strangers, dating partners, or in other relationships.

Nearly half (47%) of reported sexual assault cases occurred when the survivor was between 25 and 59 years old, followed by children under the age of 18 (36%).

In 2020, there were 11 accredited sexual assault centers in Louisiana, two of which were also children's advocacy centers and seven were also domestic violence service providers.[73] Seven parishes did not have an accredited service provider. Accredited sexual assault centers provide 24-hour hotline assistance to survivors and their loved ones, accompany survivors for forensic medical exams, support survivors in navigating the criminal and civil justice systems as well as educational and workplace systems, and provide both short- and long-term support.[74]

A total of 8,006 hotline calls and 1,971 individuals who experienced sexual assault were reported in 2020 across all accredited centers.[1] Nearly half (47%) of reported sexual assault cases occurred when the survivor was between 25 and 59 years old, followed by children under the age of 18 (36%). Most survivors who reported were cisgender women (85%); identified sexual orientation was unknown (49%) or heterosexual (45%); and most identified as White (44%) or Black (34%). Approximately 12% of reported incidents involved a survivor with a physical, cognitive, or sensory disability, and 4% involved a survivor with a severe mental illness. Most reports (89%) identified the perpetrator as someone the survivor knew including an intimate partner, family member, friend, or authority figure.

All data are collected at intake at existing sexual assault centers. Therefore, it is very possible cases are underreported.[75] Underreporting to traditional avenues, including to sexual assault centers and to police, is a national issue that is reflected in Louisiana as well. Underreporting occurs when a survivor lives in an area that does not openly acknowledge sexual violence or where a lack of funding limits services. Additionally, a survivor may not feel comfortable reporting if they do not know an assault center can be trusted and they are concerned about confidentiality. Even though all Louisiana sexual assault centers have strict confidentiality and inclusivity policies, people who have experienced interpersonal and societal oppression from other service providers may be distrustful of a center. An individual reporting may also refuse to provide information about their identity, including sexual orientation and gender identity, if they are afraid of being discriminated against or discredited.[76] Rather than report to traditional avenues, people may disclose and seek help from more specific community organizations that serve their needs including LGBTQ+ organizations, online communities, with friends or family, or sometimes not at all.[76]

COVID-19 had a tremendous impact on safety, access to trauma-informed care, and prevention programming in 2020.[77-80] Stay-at-home orders/recommendations are important tools to stop infectious disease; however, such measures can exacerbate dangerous and abusive living conditions for both adults and children.[81] Economic uncertainty from unemployment and under-employment also creates stress in families, prevents people from leaving abusive work and home environments, and creates a strain on limited social support resources.[82] Perceptions and realities around service availability also impact survivors.[79,80] Forensic medical exam access varies based on personnel and examination room availability, and survivors are often reluctant to visit hospitals for fear of encountering COVID-19. As telehealth services and prevention engagement became the norm, people without reliable internet access or private areas for sessions in their homes were not able to receive the same services. Additionally, the devastation of the pandemic created a situation found in many disasters: survivors prioritizing their immediate, physical well-being and that of their family over seeking out mental healthcare and other services in the aftermath of sexual violence.

LGBTQ+ Health

The LGBTQ+ population comprises just 3.9% of the total population in Louisiana,[83] yet they experience outsized incidences of HIV/AIDS and violence, face additional barriers to healthcare, and are largely left out of sex education in the state.

Louisiana, particularly New Orleans and Baton Rouge, has some of the highest rates of HIV/AIDS in the country, and there are immense racial disparities in HIV/AIDS rates (see STI chapter on page 18 for more information).[20,37] There are also disparities in HIV cases and AIDS diagnoses within Louisiana based on sexual orientation and sexual behaviors. Gay, bisexual, and men who have sex with men (GBM) are at the greatest risk for HIV acquisition.[20,37] In 2018, more than half (57%) of new HIV diagnoses were among GBM, and within this group, the majority were Black (68%) and younger than 35 (69%).[20]

Late HIV testing in Louisiana is a worrisome occurrence whereby 15% of men and 9% of women received a concurrent AIDS diagnosis.[20] This is even more troubling among transgender women, who comprised only 2% of new HIV diagnoses in 2018 yet 10% of these women received a concurrent AIDS diagnosis.[20] Late HIV testing indicates a lack of interaction with the healthcare system until becoming symptomatic, which reduces the opportunity to take effective prophylactics to prevent HIV from becoming AIDS.[20] Indeed, it is well documented that LGBTQ+ persons face discrimination, inequitable treatment in the healthcare system, and other challenges that all act as barriers to care.[20,84-86]

There are also several social factors contributing to disparities in HIV cases among LGBTQ+ people in Louisiana and the US: stigma and lack of social support, poverty, ostracism, and discrimination.[20,84-86] Transgender persons face a particular set of challenges, such as being denied coverage for routine care because they are transgender.[86] In 2015, approximately one in four (27%) transgender persons in Louisiana did not see a doctor when they needed to because of fear of being mistreated as a transgender person.[87] These barriers and fears are echoed in a 2015 study among transgender people in New Orleans that found that trans people must carefully navigate a healthcare system where they have experienced discrimination and barriers to gender-affirming care.[88]

Moreover, the LGBTQ+ population faces an extreme threat of violence, as anti-gay crimes are on the rise nationally.[89] About half (47%) of transgender persons surveyed in 2015 reported being sexually assaulted at some point in their lifetime and one in ten (10%) were sexually assaulted in the past year.[86] A 2010 national survey found that gay and bisexual men were twice as likely to experience non-rape sexual violence when compared to heterosexual men.[90] (*See Sexual Violence chapter for more information, page 32*)

Inclusion of LGBTQ+ related information and perspectives in sex and health education across the state is limited and largely unknown. Since many parishes opt to not have their own sex education policy nor follow Louisiana's RS17:281 abstinence-plus law, which forms the basis for sex education in the state (*see Sex Education chapter for more information, page 12*).[9] The lack of standardized and mandatory curriculum underscores why, within required health education courses in Louisiana secondary schools (grades 9-12), only about one-third (32%) taught students about sexual orientation.[18] Furthermore, about one-fourth (24%) of these students were provided with curricula or supplementary materials that included HIV, STI, or pregnancy prevention information relevant to LGBTQ+ youth.[18]

Historically, support for LGBTQ+ people has been low in Louisiana,[91] but there is evidence this may be changing.[20,92-95] In 2017, the Louisiana State Senate signed into law domestic violence protections to LGBTQ+ victims.[96] That year, popular support for same-sex marriage increased to 48%, compared to 42% in 2013.[97] As the country trends towards a more diverse population[98] and more people identify as LGBTQ+,[99] it is essential that historically oppressed populations, including LGBTQ+ peoples, are able to attain equitable nondiscriminatory healthcare and achieve a better quality of life.

Pap Smear Utilization

Preventative reproductive health services are essential for the health of a community. The PLACES project (originally known as the 500 Cities Project) captures such data, along with other health risk indicators, in the 500 largest U.S. cities.[100]

Utilization of the Papanicolaou (Pap) smear test is the only indicator in the PLACES project related to sexual or reproductive health for women of reproductive age. Pap smear tests are used to analyze tissues in the cervix to detect any possible abnormalities, usually regarding cancerous anomalies.

The prevalence of women age 21-65 who have received a pap smear across the 500 cities included in the PLACES project ranges from a high of 85.9% in Carlsbad, CA to a low of 67.7% in Reading, PA. Within Louisiana, data is available for Baton Rouge, Kenner, Lafayette, Lake Charles, New Orleans, and Shreveport. The range of prevalence of Pap smear use in these large Louisiana cities is typically above the median and ranges from 77.6% (Lake Charles) to 80.6% (New Orleans) (*Table 4*).

TABLE 4.
RANK OF LOUISIANA CITIES ACCORDING TO PERCENTAGE OF WOMEN 21-65 YEARS OLD WITH PAP SMEAR TEST, 2016

Rank	115	125	155	203	242	281
City	New Orleans	Shreveport	Baton Rogue	Kenner	Lafayette	Lake Charles
Pap Smear Rate	80.6	80.3	79.9	79.2	78.4	77.6

2

SECTION TWO

Societal Conditions and STIs

- Poverty
- Unemployment
- Income Inequality
- Education
- Structural Racism

The conditions in which Louisiana women are born, grow, live, work, and age are shaped by policy choices that distribute money, power, and resources at local, national, and global levels. Health inequities arise when the distribution of resources unfairly benefits some groups more than others.

Societal Conditions

Poverty, Unemployment, Income, and Education

High levels of poverty, unemployment, income inequality, and low levels of educational attainment and median household income remain among the major societal factors that determine individual and population health in Louisiana.

In 2018, on average, 22% of the population across Louisiana parishes were living below the federal poverty level, and this proportion varied considerably from the lowest in Cameron Parish (10.3%) to the highest in East Carroll Parish (48.6%). Unemployment rates averaged 7.6% and varied from 3.6% (Plaquemines Parish) to 16.7% (Tensas Parish). The state percentage of college graduates was approximately 17%, with the highest proportion of those with a BA degree or higher living in Orleans Parish (36.8%) and the lowest was in East Carroll Parish (8%). The state average median household income was $43,324, ranging from $21,161 in East Carroll Parish to $76,589 in Ascension Parish. In addition, the Gini coefficient, which measures income inequality (i.e., the distribution of wealth in a population where 0 refers to perfectly equal and 100 indicates a perfectly unequal distribution of income) was 48.3, with the lowest income inequality (42.1) observed in Ascension Parish and the highest (66.5) in East Carroll Parish.

These economic conditions were associated with the STI rates (positive STI tests per 100,000 population) across parishes. Parishes with higher levels of poverty (*Figure 15a*) and income inequality (*Figure 15b*) had 4% and 6% higher rates of STIs, respectively. Parishes with higher median household incomes had 2% lower STI rates (*Figure 15c*), yet unexpectantly, parishes with higher percentages of college graduates were associated with 1% higher STI rates among the female population (*Figure 15d*).

Associations between societal conditions and STI rates varied by race. Among the Black population, higher parish-level poverty and income inequality were associated with 2% and 6% higher STI rates, respectively, whereas higher median household income was associated with 1% lower STI rates. In other words, STI prevalence rates were significantly higher among Black women living in economically deprived parishes and lower in wealthier parishes. Among the White population, only higher percentages of college graduates were associated with 1% lower STI rates suggesting that, overall, contextual factors may be potential contributors to racial inequities in sexual health.

Next, we examined if rates of STIs within Black and White populations varied according to different levels of societal conditions (poverty, unemployment, income inequality, median household income, and percentage of college graduates). We found that STI rates (per 100,000 women) were higher among Black women at every level of societal condition, which means that **Black women living in the most advantageous conditions** (e.g., low poverty or low unemployment) **had considerably higher rates of STIs than White women living in the most disadvantageous conditions** (e.g., higher poverty or higher unemployment). Unmeasured factors, such as racism or access to and quality of healthcare[36,101] may explain these inequities in race-specific STI rates.

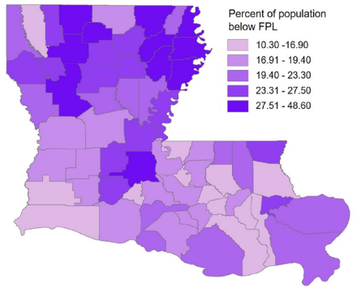


FIGURE 15A:
POPULATION LIVING BELOW THE FEDERAL POVERTY LEVEL (FPL)

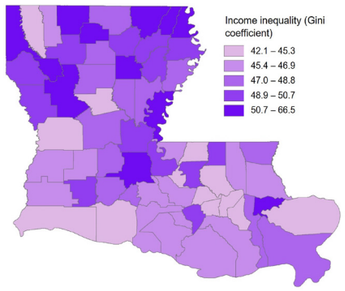


FIGURE 15B:
INCOME INEQUALITY

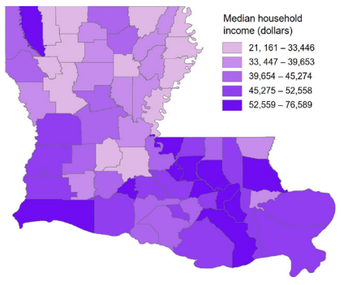


FIGURE 15C:
MEDIAN HOUSEHOLD INCOME

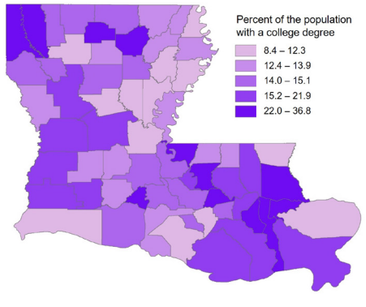


FIGURE 15D:
EDUCATIONAL ATTAINMENT

Structural Racism

Growing evidence has documented the multiple ways in which experiences of systemic, structural, and interpersonal racism affects women's – particularly Black women's – health, contributing to vast racial disparities in sexual and reproductive health.[102,103] Broadly, structural racism is defined as a system in which public policies, institutional practices, cultural norms and representations work in various, often mutually reinforcing ways to produce and perpetuate racial inequities in opportunities and resources.[104]

In this section, structural racism is measured as parish-level racial inequality in college educational attainment, median household income, median earnings, homeownership, unemployment and incarceration. Across the 64 parishes, the degree of structural racism varies widely (*see Figure 16*). For example, racial inequality in median household income and educational attainment across all parishes was 2.0 suggesting that, on average, median income among White households was double the median income among Black households, and the percentage of White people age 25 and older who had attained a college degree was twice as high as the percentage of Black people age 25 and older with a college degree. The greatest degree of racial inequality was evident in incarceration rates, where the incarceration rate of Black people was on average 3.6 times higher than the rate of incarceration of White people. In addition, the unemployment rate among Black people was more than double the rate among White people, while whereas White people had 1.7 times higher median earnings and were 1.6 times more likely to be homeowners.

We explored whether these indicators of parish-level structural racism were associated with the rates of STIs among women living in the parish *(see Figure 16 in which darker color indicates parishes with greater degrees of structural racism)*. Racial inequality in median household income (*Figure 16a*) and college educational attainment (*Figure 16b*) were associated with 59% and 17% higher STI rates among the total female population. Among the Black female ¬population, parish-level racial inequality in homeownership (*Figure 16c*) was also associated with 54% higher rates of STIs. **Structural racism was not statistically related to STI rates among the White female population suggesting that structural racism at the parish level may be particularly detrimental for Black women's health.**

STRUCTURAL RACISM INDICATORS ASSOCIATED WITH CRUDE STI RATES ACROSS LOUISIANA PARISHES

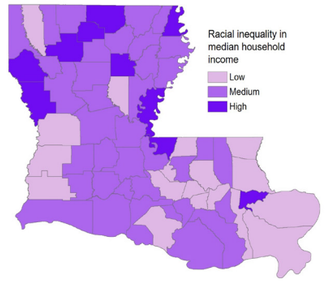


FIGURE 16A: RACIAL INEQUITY IN MEDIAN HOUSEHOLD INCOME

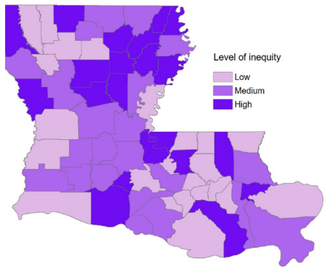


FIGURE 16B: RACIAL INEQUITY IN COLLEGE EDUCATIONAL ATTAINMENT

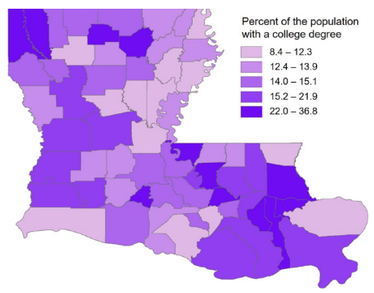


FIGURE 16C: RACIAL INEQUITY IN HOME OWNERSHIP

3

SECTION THREE

Community Conditions and STIs

- Poverty
- Unemployment
- Income Inequality
- Racial Residential Segregation
- Violence

The conditions in which Louisiana women are born, grow, live, work, and age are shaped by policy choices that distribute money, power, and resources at local, national, and global levels. Health inequities arise when the distribution of resources unfairly benefits some groups more than others.

Neighborhood-Level Factors Associated with STIs

Neighborhood characteristics influence sexual behaviors[105] and STI risk, such as poverty (HIV)[106,107] and racial segregation within the neighborhood (HIV and STIs).[108-110] Among women in the South, STIs are associated with living in neighborhoods with greater social disorder (e.g., violent crime, poverty, vacant housing) and more social disadvantage (e.g., more alcohol outlets and percent renter-occupied housing),[111] but STIs are less likely among women in neighborhoods where a greater percentage of residents have a primary care provider.[112] Women have greater risk of acquiring STIs during pregnancy if they live in neighborhoods with higher degrees of racial segregation or income inequality.[113]

Entrenched racial inequities in Louisiana are magnified within its urban centers as demonstrated through poverty rates, income inequality, residential segregation, and violence. In Louisiana metro areas, poverty rates are greater than the national average and median household incomes are lower than the national average.[114] Several large metropolitan areas in Louisiana (e.g., New Orleans, Shreveport, Monroe, Lafayette, Baton Rouge, and Lake Charles) have some of the worst rates of income inequality in the country,[115] and these inequalities may have become exasperated in Lake Charles due to lingering effects of Hurricane Laura in 2020.[116,117] New Orleans ranks fourth worst for most unequal distribution of income among large cities in the U.S.,[118] and it is the second most segregated large city in the U.S.[119] Three of the top most dangerous cities in the U.S. are in Louisiana (Shreveport, #50; Baton Rouge, #38; New Orleans, #19).[120] These 2018 rankings are based on the violent crime rate per 100,000 population, the number of homicides, the poverty rate, and the unemployment rate.[120]

RECOMMENDATIONS

Many of the root causes underlying the sexual and reproductive health indicators, outcomes, and inequities in this report are interrelated. Practice and policy interventions that focus on the experience of historically oppressed groups can improve sexual and reproductive health for all people in Louisiana. Structural racism impacts all indicators of sexual and reproductive health and may represent an overarching solution to removing inequities in these outcomes. Dismantling structural racism will require policies that purposefully aim to create equitable opportunities for health and well-being where women and their families live, work, and play. Recommendations in this section are organized by level of the Social Ecological Model to demonstrate how cross-cutting efforts and cooperation across sectors are needed to reduce disparities in sexual and reproductive health, enhance opportunities for equitable health, and enable all women and girls in Louisiana to live healthy and happy lives.

Recommendations: Societal

1. Increase health insurance coverage

Healthcare is more accessible to those with insurance and concerted statewide efforts to reach the one in ten adult women in Louisiana who are uninsured would improve health outcomes.

2. Increase access to sexual and reproductive health services (including abortion, preventative services, STI prevention and treatment, and contraception)

Access to sexual and reproductive health services, via OB/GYN or publicly funded reproductive healthcare clinics, depends on where one lives. Accessibility can be expanded in several ways:

- Primary care physicians and pediatricians should also receive training in sexual health to reach more of the populace,[121,122] and this training should include how to provide tailored high-quality inclusive services for LGBTQ+ persons.[123-125]

- Changes in statewide policies can make care delivery and reimbursement more hospitable to advanced practiced registered nurses (APRNs) and physician assistants, such as removing the collaborative practice agreement (CPA) mandate for APRNs[126] and eliminating the law that prevents them from performing abortions.[63]

- School-based healthcare programs in Louisiana should be allowed to provide contraceptive services, as such services have a demonstrated ability to increase STI testing, increase use of more effective methods of contraception, and reduce teen pregnancies and abortion.[127-129]

3. Advance reproductive justice

The tenets of reproductive justice ("the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities")[130] should be upheld and honored by all those directly and indirectly involved with providing sexual and reproductive health services to people of all genders, races, and socioeconomic backgrounds.

4. Reduce poverty, increase economic and educational opportunities, improve housing

- In alignment with the Reproductive Justice tenet to raise families in safe and healthy places, large scale improvements in sexual and reproductive health within Louisiana are only possible if there are sustained and significant efforts to improve the socioeconomic conditions in which women live.

- Universal basic income programs throughout the world have demonstrated reductions in poverty, positive impacts on the labor markets, education attainment, and improved health and well--being.[131] These programs are growing in popularity in the U.S. as a potential solution to reduce poverty and income inequality.[132]

- After the first year of the 2019 city-led guaranteed income program in Stockton, CA, where 125 residents received unrestricted $500 per month for two years, employment and productivity increased, stress decreased, well-being and mental health improved, and recipients used the money to pay off debt and pay for necessities.[133]

- The Magnolia Mother's Trust piloted a 1-year program to fight poverty by providing monthly $1,000 payments to 20 very low-income Black mothers in Jackson, MS in 2019.[134] With the payments, all recipients were able to meet basic needs and felt more hopeful about the future, and most were able to finish high school and pay their bills without additional support.[134] A second cohort of 110 women began in March 2020, but results are not yet available.[134]

- In December 2020, New Orleans received a half a million dollars to start a guaranteed income program for some of its residents who are struggling to pay their bills.[135] Details of the program were unavailable at time of publication of this report.

- Improve housing. The federal Moving to Opportunity for Fair Housing Demonstration Project (1994-1998) demonstrated that public housing residents who received housing vouchers and counseling to move into low-poverty areas had better health outcomes (e.g., decreased risk of obesity and improved mental health and wellbeing) compared to those who received a housing voucher to move anywhere and those who stayed in public housing.[136]

5. Increase public funding for sexual and reproductive health services

Given the need for publicly-funded reproductive health services in Louisiana, robust federal funding for and widespread availability of the Title X Family Planning Program is needed.[137] Comprehensive patient-centered contraceptive training among healthcare providers who receive public funding (e.g., primary care providers within Federally Qualified Health Centers and department of health community clinics) has been shown to increase the capacity of contraceptive services.[138] Furthermore, it is welcomed news that the Biden-Harris administration is currently planning to rescind the harmful Title X gag rule from the Trump administration which banned Title X providers from performing or discussing abortions.[139,140]

Recommendations: Community

1. Implement comprehensive sex education

To improve, understand, and support adolescent teen sexual health, Louisiana should: require standardized evidence-based comprehensive sex education in all school districts and allow data collection on sexual risk behaviors by the CDC's Youth Risk Behavior Survey.[141] Without robust data collection, evaluation of sex education programs and teen sexual health will remain incomplete and insufficient.

2. Prevent sexual violence

Sexual violence prevention can take many forms. Primary prevention is about stopping violence before it happens, secondary prevention is about trauma-informed initial response, and tertiary prevention is about long-term support and accountability.

- Primary prevention takes place at multiple levels across the social ecological model. The following examples of primary prevention efforts would improve health outcomes and should be expanded across the state:
    - Changing policies and environments to promote safety. Examples include alcohol awareness and family-friendly Mardi Gras zones in Washington Parish, working with college students organizing for safe campuses in Baton Rouge, promoting youth civic engagement in the Caddo-Bossier area, and passing state laws allowing survivors of sexual assault to terminate housing leases early.
    - Educating children, young adults, and adults to build skills for healthy lives and relationships and promote prosocial norms. Examples in Louisiana in 2020 include Coaching Boys into Men in high school boys football programs in Northeast and Southeast Louisiana and a podcast and media campaign around masculinity and bystanders based in Northwest Louisiana.
    - Promoting empowerment, resilience, and financial literacy for girls and young women, as well as other marginalized groups, such as girls' leadership programs in Acadiana, New Orleans, and Monroe.
- Examples of secondary and tertiary prevention efforts to serve survivors and promote accountability include:
    - Louisiana should fund trauma-informed, confidential, inclusive survivor services throughout the state with transportation and telemedicine options for those in rural and/or underserved areas. Despite being one of the few states without state funding for sexual assault services, Louisiana's sexual assault centers served nearly 2,000 survivors in 2020, a year with added challenges from hurricanes and the global pandemic.
    - Allow the CDC Youth Risk Behavior Surveillance System (YRBSS) to collect information about young people's experience with sex, including sexual violence, to help both prevention and survivor service programs to ensure that they are reaching Louisiana youth.
    - We can all work to ensure that we are well-informed, trusted people. Studies have shown that the reaction from the first person to whom a survivor discloses can play a vital role in their future healing. If a friend, colleague, or family member tells you that they have been sexually assaulted, believing them, knowing available resources, and listening are crucial tools. Avoid asking them intrusive questions (such as "why were you there?" or "why did you do that?") or making directive statements ("you should report it to the police" or "you should confront them.") If someone trusts you with this disclosure, it's important to honor that trust.

3. Build equitable communities

Unfavorable community conditions, such as poverty, income inequality, and racial residential segregation are detrimental to sexual and reproductive health.[110] Strategies to reduce STIs, HIV/AIDS and violence should include efforts to improve economic opportunities and housing equality while reducing violence.[110] Communities that are intentionally built to create economic and educational opportunities, offer affordable housing, and enhance quality of life have been shown to reduce violence, increase employment, and improve school performance.[142]

- The Bayou District Foundation, a purpose-built community, covers a 13-block area in the Gentilly neighborhood of New Orleans.[143] It includes Columbia Parc, a mixed-income housing development on the former grounds of the St. Bernard Public Housing Complex, which was one of the most dangerous areas to live in pre-Katrina New Orleans and now crime is virtually nonexistent.[143] There are also schools for infants through high school (the "cradle to college education pipeline"), a community health clinic, and plans for grocery and drug stores are underway.[143]

Recommendations: Interpersonal

1. Address institutional racism

Healthcare providers and insurers should acknowledge racism's harmful role in health inequities and explicitly make equity a goal.[6]

- The New Orleans-based National Birth Equity Collaborative provides racial equity training to advance health equity.[14]
- The Community Health Training Institute provides resources for understanding and addressing health equity in their Health Equity Toolkit: https://hriainstitute.org/blog/176-chti-health-equity-toolkit

2. Address stigma (HIV/STIs/LGBTQ+)

All reproductive healthcare providers should understand the specific health issues impacting people with HIV, other STIs,[123,145] and/or LGBTQ+ persons and be trained in how to effectively counsel and provide health services to meet the unique needs of these populations.[124,125]

- The National LGBTQ+ Health Education Training Center lists 10 things that health organizations can do to create inclusive environments for LGBTQ+ care: https://www.lgbtqiahealtheducation.org/wp-content/uploads/Ten-Things-Brief-Final-WEB.pdf

3. Expand and diversify the healthcare workforce

Expand the sexual and reproductive healthcare workforce by developing adequate reimbursement models, residency training programs, and incentives to increase the availability of multidisciplinary healthcare providers in rural and underserved areas, including OB/GYNs, midwives, and primary care providers with training in sexual health.[146-148]

4. Expand responsibility for addressing STIs

Include parental training and education as part of a broad agenda to respond to STIs among adolescents and young adults.

- Primary care and pediatric healthcare sites should provide training materials for parents to facilitate conversations about sexual health.[110]

Recommendations: Individual

1. Increase education about sexual health

All students in secondary school should receive evidence-based comprehensive sexual education that includes risk reduction strategies for pregnancy, STI and sexual violence prevention, and LGBTQ+ specific guidance.

- The CrAFT Curriculum, developed by the Institute of Women and Ethnic Studies (IWES) to serve Louisiana students, is currently in three New Orleans schools, and it integrates comprehensive sex education with gender-transformative and trauma-informed concepts within a human rights framework.[149]

A word about the data used in this report and the COVID-19 pandemic

This report uses the most recently available data, and all the data was captured before the COVID-19 pandemic. However, more recent reporting shows women, particularly women of color, are especially vulnerable to the far-reaching economic, health, and livelihood impacts of the pandemic.[150,151] Furthermore, the pandemic has created seismic shifts in healthcare access and policies, for better and for worse. We advocate for the permanent continuation of policies enacted under emergency during the pandemic that can reduce barriers to sexual health now and into the future. For example, federal support for the expansion of telehealth services, including for sexual and reproductive health services like contraceptive counseling, is beneficial beyond a pandemic context.[152] Also, during this time, Louisiana removed the burdensome collaborative practice agreement for advanced practice registered nurses (APRNs), thereby temporarily enabling them to practice to the full extent of their training.[126] Conversely, some pandemic response policies harmed women's ability to access needed health services and should be avoided in future public health crises. For example, Louisiana is one of several states that tried to limit or restrict access to abortions during the COVID-19 pandemic by deeming abortions as "elective" or "nonessential".[153] Instead, abortion access should be treated as the essential sexual health service it is, and the abortion pills (mifepristone and misoprostol) should be easily accessed via pharmacies and/or home-delivery.[152,154] Although the FDA approved abortion pill access via telemedicine and mail delivery during the COVID-19 pandemic on April 12, 2021,155 women in Louisiana (and 18 other states) are unable to benefit from this lifted restriction since abortion pills via telemedicine is prohibited and the prescribing physician must be present when the patient takes her first pill.[65,137] Thus, it is imperative and more urgent than ever that policies and programs to improve sexual health among people in Louisiana reflect the principles of reproductive justice by promoting healthcare access and enabling all women to achieve their reproductive goals.

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