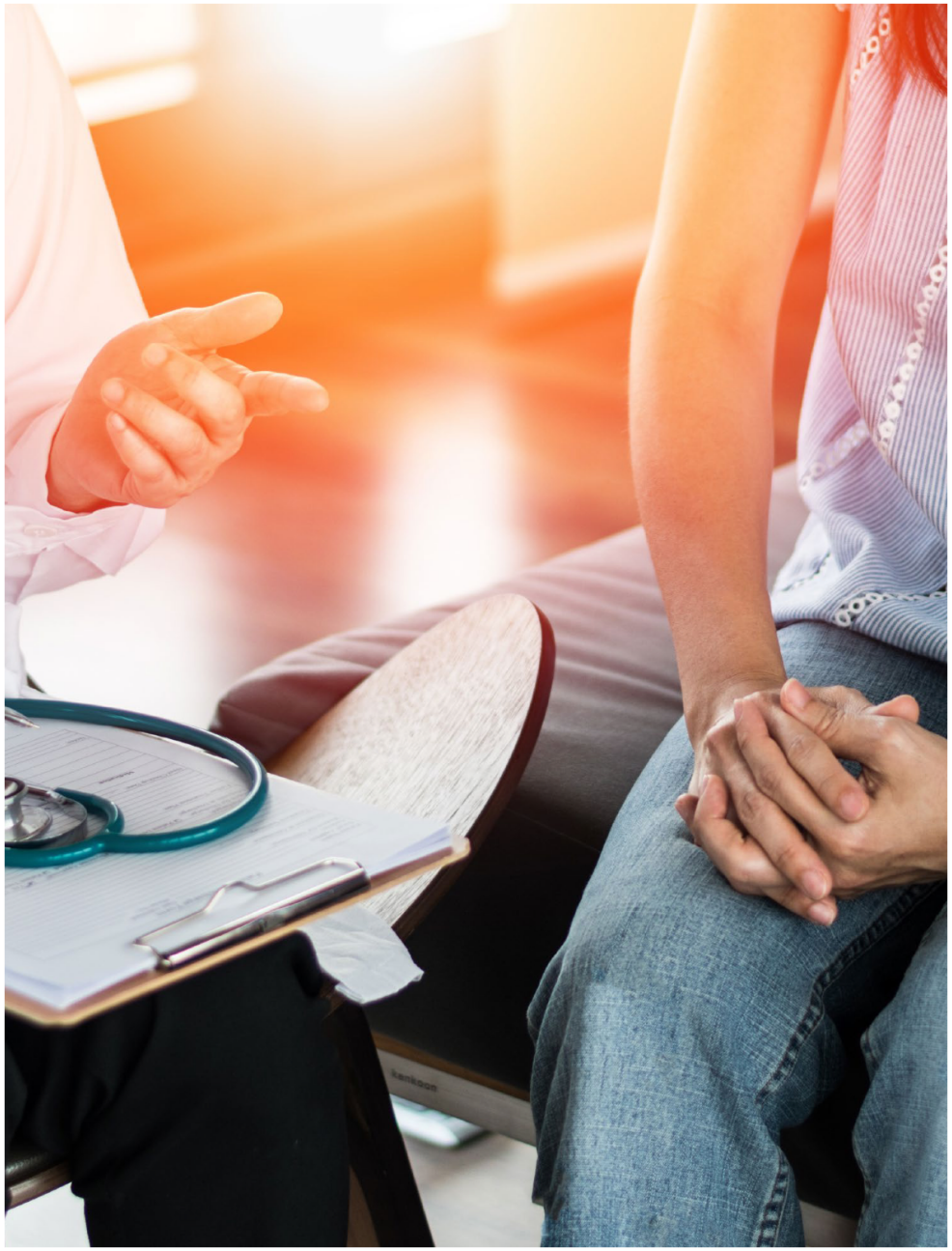


DC APPLESEED

THE STATE OF THE HIV/AIDS EPIDEMIC IN THE DISTRICT OF COLUMBIA

REPORT | DECEMBER 2021



INTRODUCTION

On World AIDS Day, DC Appleseed usually reflects on DC's progress toward ending the epidemic over the past year. This year, we are looking back over the past two years and the extraordinary effects of the Covid-19 pandemic on HIV-related work and public health in general. DC, like many other jurisdictions, experienced a shut-down in access to non-Covid medical care in the spring of 2020, challenges in access to and provision of care in the following months, and redirection of public health resources from other health issues to Covid.

At the same time, the District was working on developing and implementing a new plan to end the epidemic, funded by a grant from the Centers for Disease Control and Prevention (CDC). These efforts culminated in release of the new plan at DCEndsHIV.org (the "DC Ends HIV Plan" or "Plan") on December 4, 2020[1] and submission of the plan to the CDC on December 31, 2020[2]. Since the Plan's release, DC Health and the HIV/AIDS, Hepatitis, STD & TB Administration (HAHSTA) have continued to work on implementing this Plan while also coping with the demands of the Covid-19 pandemic and changes in HAHSTA leadership and staffing. DC Appleseed is proud to partner with HAHSTA's parent department DC Health and the Washington AIDS Partnership (WAP) on the development and implementation of this Plan.

In this report, we lay out progress made under the previous plan to end the epidemic, issued in 2016, describe the 2020 plan and its successes and areas for improvement, summarize the results of our interviews with community organizations who are on the front lines addressing the epidemic, and summarize our recommendations for moving forward. In the end, we conclude that the partnership among DC Health, DC Appleseed, the Washington AIDS Partnership and community organizations is critical to ending the epidemic and that the more collaboration that occurs among these partners the greater will be our success in reaching that mutual goal. A table of our recommendations can be found on page 21.

Based on our conversations with members of the community and our work with HAHSTA and DC Health leaders, DC Appleseed concludes that the District of Columbia is currently at a critical point in our work to end the HIV epidemic. We made great progress under the previous plan to end the epidemic, the "90/90/90/50 Plan," but we had not reached that plan's goal of a 50 percent reduction in new cases by the 2020 target date. DC has continued to make strides toward ending the epidemic during the Covid-19 pandemic, but like many jurisdictions, faced challenges to maintaining this effort while also responding to Covid. And, DC is in the early stages of implementing a new, bold Plan to end the HIV epidemic, but it needs to flesh out this plan with concrete metrics and goals, as well as establish stable leadership within HAHSTA to guide the District to achieve its goals.

PROGRESS ON THE 90/90/90/50 PLAN

DC's prior plan to end the epidemic, the 90/90/90/50 Plan, set goals of 90 percent of DC residents with HIV knowing their status, 90 percent of people diagnosed with HIV being in treatment, 90 percent of people in treatment achieving viral suppression, and a 50 percent decrease in new HIV diagnoses by 2020. As of 2019, the District had made progress toward these goals but was not likely to achieve all of them in 2020. In particular, reductions in new infections were occurring unevenly across DC's population. Youth, racial/ethnic minorities, and transgender persons had an HIV infection rate that exceeded their presence in the overall D.C. population. These population groups also may be among the most difficult to reach, suggesting that a heightened effort might be needed to reach the goal. As of this writing, data showing the results as of the end of 2020 are not yet available. We understand that HAHSTA has faced delays in compiling this data due, in part, to work on the Covid-19 pandemic.

2019 STATUS OF THE 90/90/90/50 GOALS[3]						
Ending the HIV Epidemic Measures (90/90/90/50)	**2015**	**2016**	**2017**	**2018**	**2019**	**2020 Goal**
Goal #1: 90% of HIV-positive District residents know their status	86%	86%	87%	88%	90%	90%
Goal #2: 90% of District residents living with HIV are in treatment	73%	76%	77%	77%	80%	90%
Goal #3: 90% of District residents living with HIV who are in treatment reach viral suppression	78%	82%	84%	85%	87%	90%
Goal #4: 50% reduction in new HIV diagnoses	399	379	371	335	282	196

We recognize that the Covid-19 pandemic has disrupted HIV testing and care around the world, and other jurisdictions have faced similar challenges to collecting complete data on new infections and linkages to care in 2020.[4] The 2020 data must be viewed "with an asterisk" noting that it was an unusual year, and understanding that any reduction in new diagnoses likely reflects a reduction in testing, but not necessarily an improvement in actual transmission rates. Increased efforts to ensure access to testing in 2022 will be needed to make up for the effects of the pandemic.



THE NEW PLAN: DC ENDS HIV

The 2020 DC Ends HIV Plan sets a goal of fewer than 130 new diagnoses per year by 2030. In 2019, the last year for which data were available before the Plan was announced, DC had 282 new diagnoses.[5] To reach this 2030 goal, the Plan raises the targets from the prior 90/90/90/50 plan to 95 percent of people living with HIV knowing their HIV status, 95 percent of people diagnosed with HIV being in treatment, and 95 percent of people in treatment achieving viral suppression. In addition, the Plan aims to increase utilization of pre-exposure prophylaxis (PrEP) to reach 13,000 HIV-negative individuals.

The vision of success under the Plan is, "The HIV epidemic has ended for all communities, resources are equitably available, and optimal health outcomes are attainable for everyone in the District of Columbia."[6] Focus populations for activities under the Plan include Black men, Black women, Latino gay men, young Black gay men, transgender individuals, and people who use drugs. HAHSTA developed the Plan after seeking input from members of these communities, and HAHSTA has continued to work on implementation of the Plan through continued community engagement with these and other communities at the grassroots level.

The Plan's goals are:

- **The District will have fewer than 130 new diagnoses of HIV per year by 2030.**
- **People living with HIV can easily and safely maintain optimal integrated health.**
- **We collectively acknowledge — and actively address — the impact of stigma and structural racism on sexual health and HIV outcomes.**

The Plan is structured around "the four pillars" of the federal Ending the Epidemic Initiative: Diagnose, Treat, Prevent, and Respond.[7] DC has added a fifth pillar: Engage. The Engage pillar is meant to address barriers to prioritizing HIV health, by reducing stigma, supporting stable housing and economic opportunity, ensuring cultural humility in services, and promoting accurate information. DC has developed preliminary metrics to measure progress on the first four pillars and is developing metrics for the fifth pillar.[8] Unlike the 90/90/90/50 Plan, the DC Ends HIV Plan did not have a detailed list of tasks to be implemented over the life of the Plan. Instead, the plan identifies "key activities and strategies" under each pillar. DC Appleseed has suggested a timeline for completion of these activities and strategies, and we are working with HAHSTA to develop agreement about this framework.

The Plan specifies that HAHSTA will track and report both HIV outcome and activity metrics to evaluate information regarding prevention, treatment, and education efforts at HAHSTA and throughout the community. This includes monitoring the 95/95/95 metrics described above and also measuring the work being done to improve diagnosis, prevention, treatment, and responsiveness to new diagnoses.

ACTIVITY AT HAHSTA

Despite the significant challenges over the past two years, HAHSTA has continued its work to support access to testing and care and community education and to implement the new Plan.

With the advent of the pandemic, HAHSTA, like other providers and agencies, was forced to make significant changes to its "normal" operations. **While the pandemic undoubtedly limited access to critical services, HAHSTA adapted some of its programs and support to enable community partners to continue their work in the midst of these challenges.** For example, HAHSTA provided funding to community partners for personal protective equipment (PPE) and the technology necessary to operate remotely.

After the initial lockdown in March 2020, the DC Health and Wellness Center[9] re-opened after two weeks. The Center has continued to provide free sexual health testing, treatment, and vaccination services by appointment throughout the pandemic, even while many other community clinics remained closed. It also began offering telehealth services to its clients in May 2020.

HAHSTA launched a significant new testing initiative in 2020. Through GetCheckedDC (and its website, GetCheckedDC.org), DC offers free at-home and walk-in testing for HIV and sexually transmitted infections (STIs). The program began offering at-home OraQuick HIV testing in June 2020.[10] By September 2020, 500 tests had been distributed and more than 2,200 tests were sent out by June 2021. Walk-in testing began at LabCorp patient service centers in DC, Northern Virginia, and suburban Maryland in September 2020.[11]

In March 2021, HAHSTA began TelePrEP services at the DC Health and Wellness Center, allowing patients to start PrEP using a telehealth consultation, home testing, and mail-order prescriptions.[12]

In April 2021, HAHSTA launched a Post-Exposure Prophylaxis (PEP) hotline, making DC only the second city in the country to offer this service. DC residents age 18 and older can call (202) 299-3PEP (3737) 24 hours a day, 7 days a week, to obtain a prescription for a PEP starter pack that can be picked up at a contracted Walgreens pharmacy. Individuals also can visit their healthcare provider or a community-based organization to receive a prescription. In the program's first 12 weeks, it received 112 calls requesting information about PEP, referred 75 patients to the DC Health and Wellness Center for intake, and 64 patients started PEP.

HAHSTA also hired an Ending the Epidemic Coordinator and continued to work on community engagement meetings, launching a housing program for people on PrEP, and building a dashboard to track data on progress toward ending the epidemic. DC Appleseed assisted HAHSTA with research on tools that could be used to measure stigma and assess the efficacy of programs to reduce stigma. In addition, HAHSTA signed a contract to acquire data on HIV medications and PrEP, without patient-identifying information, that could be used to measure success rates at achieving linkages to care and retention in care.

In addition to HAHSTA, another DC government agency implemented a positive change to support access to PEP and PrEP for Medicaid beneficiaries. On March 18, 2021, the DC Department of Health Care Finance announced that, effective April 1, 2021, all PEP and PrEP medications would be billed and paid through fee-for-service Medicaid instead of Medicaid Managed Care. Managed care plans had subjected these drugs to prior authorization requirements that could delay access to care. This change was intended to "address access barriers and create uniform access across the Medicaid program" and to raise awareness of HIV prevention guidelines and PEP and PrEP availability.[13]

In addition to the changes forced by Covid-19, DC Health made organizational changes to HAHSTA. In April 2021, Michael Kharfen, the longtime Deputy Director at HAHSTA, was replaced by interim Deputy Director Dr. Anjali Talwalkar. Since his departure, other agency leaders have also left the agency, including former Chief Medical Officer Adam Visconti. Dr. Anjali Talwalkar is serving as the interim director, and until recently, also served as the Interim Senior Deputy Director for Community Health Administration at DC Health. **Dr. LaQuandra Nesbitt, Director of DC Health, and Dr. Talwalkar have repeatedly shared assurances of their commitment to the partnership with DC Appleseed and the Washington AIDS Partnership and to continuing efforts to end the epidemic.** They are also considering how best to deliver services in a post-pandemic world and whether reorganization within DC Health and/or HAHSTA might best serve that goal.



FEEDBACK FROM THE COMMUNITY

To learn how the community of HIV advocates, researchers, and providers have been coping with these changes we conducted 15 interviews in October and November 2021. What we found was a community that is under stress, and very much concerned about the direction DC is heading, yet also is proud of their accomplishments and hopeful about the road ahead.

Community stakeholders certainly expressed recognition that navigating the Covid-19 pandemic has been challenging for providers, for HAHSTA, and for public health agencies in general. In particular, stakeholders reflected on difficulties resulting from the pandemic such as disruptions in access to services like needle exchange programs and HIV testing. Nonetheless, there was consistent praise for DC's improvements overall. A number of community stakeholders noted taking pride in, both, how far DC has come as compared with where the District was 15-20 years ago, as well as in how far ahead of other localities DC tends to be in the realm of its treatment and prevention efforts. Many stakeholders specifically acknowledged DC's relative success with ensuring the accessibility of PrEP, as well as adopting innovative approaches to services, such as making at-home testing more readily available. There was a strong sense of recognition that DC had not only made great strides over previous years, but had truly become a leader among jurisdictions for its work on ending the epidemic. There were consistent commendations expressed for HAHSTA's past performance at effectively communicating with providers and stakeholders, and for generally maintaining a close connection to the needs of organizations most directly serving communities. Numerous stakeholders credited the District's successes in adeptly adapting services in the face of the Covid-19 pandemic, such as by expanding access to telehealth and increasing the accessibility of at-home HIV testing.

At the same time, community stakeholders expressed numerous concerns about developments that many feared could thwart DC's continued progress. **In particular, stakeholders consistently noted a lack of transparency around recent leadership changes at HAHSTA.** Generally, interviewees expressed respect for Michael Kharfen and his efforts to lead the District out of the epidemic, and they expressed a desire for increased communication from DC Health about how or whether the leadership changes presage other changes at the agency. Many also articulated feeling that there has been a shift leading to the deprioritization of HIV/AIDS as a public health priority, and a number wondered whether this perceived shift was indicative of HIV/AIDS advocacy becoming a victim of its own success. Stakeholders pointed to occurrences like the discontinuance or disruption of activities that were historically seen as critical to the success of addressing the epidemic, such as academic partnerships, clinical trial participation, and data-sharing meetings. A handful of stakeholders pointed to direct funding losses or funding delays that hampered their ability to sustain operations or retain personnel for certain key projects. A number of interviews also highlighted uncertainty regarding the status of DC Health's partnership with George Washington University. Further, our interviews revealed a general sense of uncertainty about who at HAHSTA to approach with questions around HIV/AIDS treatment and prevention activities given recent leadership changes, as well as a perceived and broadly expressed lack of clarity around HAHSTA's intended goals moving forward as compared with the clear and cohesive sense of direction felt under HAHSTA's previous leadership.

Stakeholders additionally expressed a lack of clarity around the goal of 130 or fewer new infections per year under the 2020 DC Ends HIV Plan. In particular, our interviews uncovered skepticism around how the metrics for this goal were chosen, whether this new goal would be reachable; and even if attainable, whether achieving this metric should be central to the overall objective of ending HIV/AIDS in the District.

Stakeholders also noted how, despite improvements in many areas, including getting affected populations into care, the District still has much more room for improvement in terms of making public health investments to keep people in care. The shortfalls in this area became particularly salient during the course of the Covid-19 pandemic, which heightened needs in areas already marked by socioeconomic disparities, including but not limited to access to housing and transportation, translation services, and digital literacy and access. In particular, technology access – and the realities of the digital divide as a facet of social determinants of health – was frequently raised as a notable concern that was exacerbated by the Covid-19 pandemic. While adaptations such as telehealth created improved access to care for many populations that may have otherwise dealt with logistical and financial barriers, a number of our interviewees noted that some of their client populations might lack phones, access to reliable wifi, and access to other basic technologies necessary to use newer forms of care delivery and outreach.

Notably, as a result of these types of Covid-related adaptations, while some populations were brought closer to care, other populations were pushed further away. As such, numerous stakeholders remarked on a greater need to help get patients back into care, and to keep them engaged in care long-term. This is a particularly urgent need for some of the most vulnerable communities affected by HIV/AIDS. One interviewee suggested that this objective could potentially be supported, in part, by easing the types of seemingly harsh rules that make it more difficult for patients to access care – for instance, rules dictating that occurrences such as a patient missing an appointment could result in that patient's access to HIV medications being curtailed.

It is also worth noting that a handful of respondents specifically highlighted STI prevention and treatment as an area that DC has not paid enough attention to, one that is essential to its efforts to ending the HIV/AIDS epidemic. Recognizing STI prevention (e.g., screening and education) and treatment efforts as critical opportunities to address some of the "upstream" causes of HIV transmission, a number of stakeholders expressed disappointment with the District's lack of attention to this area. Stakeholders emphasized the need for District public health officials to eliminate the siloes between STI and HIV/AIDS programming, and to recognize the untapped potential of STI screening as an early warning system for HIV transmission.



HEALTHY SCHOOLS ACT

D.C.'s public and public charter schools have health education standards, including age-appropriate sexual health instruction, that are not regularly enforced.[14] A recent report from the D.C. Office of the Inspector General found not only that the District is out of compliance with the HIV education requirements of the District's Healthy Schools Act, but also that, as a consequence, there has been a significant and detrimental impact on students' health.[15] That OIG report, DC Appleseed's 2019 Situation Analysis prepared for HAHSTA,[16] and HAHSTA's 2020 Plan all acknowledge that the continuing rate of HIV infections among our young people is undermining our ability to meet the goals of the 90/90/90/50 Plan and to end HIV in the District.

The OIG Report

In November 2020, the OIG issued a report titled "Evaluation of Compliance with The Healthy Schools Act Health Education Requirements" (the "OIG Report"). The Report is the product of four months of fieldwork by the OIG team and the evaluation of several years' worth of data from various sources.[17] As laid out in the Report, the OIG "assess[ed] the extent to which OSSE and DCPS have implemented key provisions in the Healthy Schools Act ... in particular, curriculum standards that focus on health education and HIV/AIDS."[18] The Healthy Schools Act (the "HSA") was enacted by the D.C. Council in 2010 with the stated goal, in part, of ensuring improved HIV/AIDS education for D.C. schoolchildren, including by imposing minimum standards for the time spent on effective health education. The OIG Report highlights the widespread failure of D.C. public and charter schools over the past decade to comply with the requirements of the HSA, including those relating to HIV/AIDS.[19]

Among other things, the OIG Report found that:

- Nearly **one in three** DCPS middle schools self-reported their failure to provide 75 minutes per week of health education in 2019 as required by the HSA.[20]
- **Only 45.8%** of students who completed the 2019 Youth Risk Behavior Survey reported learning about HIV prevention in the last year (a decrease of more than 10% from 2012).[21]
- In that same survey, **only 63%** of sexually active middle school students (down 10% since 2012) reported using a condom during their last instance of sexual intercourse.[22]
- Student scores on the annual Health and Physical Education Assessment **dropped, on average, 14%** between the 2017-18 and 2018-19 school years.[23]

The OIG determined that the non-compliance with the HSA identified in its Report (and the outcomes that have resulted) could be mitigated by the issuance of formal regulations to implement the HSA's provisions. DC Appleseed agrees with this determination and believes that the adoption of specific regulations concerning HIV education in the public schools would not only bring the city into compliance with the HSA, but would also provide much needed increased protection of our students and further the joint 90/90/90/50 plan.

BEST PRACTICES PREVENTING HIV INFECTION AMONG YOUTH

Compliance with the Healthy Schools Act going forward will be key in preparing District youth to make healthy decisions, including those which will prevent the transmission of HIV and other sexually transmitted infections. Furthermore, it will be important to utilize what we know are best practices for effectively preventing HIV in youth in schools and across the board. While the Healthy Schools Act sets forth some requirements regarding HIV education in schools, there is inadequate time required for, or actually devoted in practice to, those efforts. Aside from Virginia, the jurisdictions we investigated require HIV-specific education for at least grades six through eight, including minimum hours of instruction. Local jurisdictions within Virginia do not have those requirements.

One resource for additional best practices to employ is the CDC's new initiative, "Ending the HIV Epidemic" ("EHE"). As part of its efforts to eliminate HIV, the CDC recently rolled out a new plan to eliminate HIV in the United States by 2030.[24] The CDC's new initiative targets 57 communities (a mix of cities, counties, and states) that account for more half of new HIV diagnoses.[25] The CDC's materials on its new initiative are general, not youth-focused; however, youth-focused information can be found in the materials published by various EHE-target jurisdictions. These materials can serve as useful best practice guides for the District. In particular, plans from Los Angeles County, King County (Seattle), and Baltimore are useful examples.

Los Angeles County named youth (defined as those under 29) as a focus population for its plan to end HIV. Furthermore, the county noted that those youth between 13 and 19 exhibited one of the lowest levels of linkage to HIV care.[26] In King County, as part of 2019 initiative, the county and city of Seattle launched a joint effort to increase condom use by placing 50 condom-filled boxes (dubbed "Condom Cubes") in various zip codes.[27] Finally, the City of Baltimore rolled out its plan to end HIV which discusses youth extensively.[28] Baltimore's plan (i) notes that youth in the city are disproportionately impacted by HIV and are often unaware of their legal rights, (ii) calls for revising testing structures to make them more youth-friendly and providing youth-focused incentives, (iii) calls for expanding sex education programs to reach populations not reached through school-based sex education programs, and (iv) calls for working with organizations to address PrEP distributions for youth-focused distributions.[29]

In addition to reviewing the EHE-target jurisdictions, DC Appleseed examined public school districts that are either geographically relevant (Fairfax, VA; Loudoun County, VA; Philadelphia, PA; and Montgomery County, MD) or could be considered "peer" cities, some of which are also targeted by EHE (Chicago, IL; New York, NY; Los Angeles, CA; and San Francisco, CA). The CDC reported on state-level jurisdictions' coverage of three core topics: sexual health prevention, HIV prevention, and STD prevention. Of those listed above, Pennsylvania, Maryland, Illinois, New York, and California all have state laws requiring that schools cover HIV prevention; Virginia has none. Only California has laws requiring STD prevention education; Virginia and Illinois have laws permitting it. Broader sexual health education is only legally required in Maryland, Illinois, and California. California is the only state among this group to require all three core topics be taught. There is also some detail available for legal curriculum requirements within these core topics.

State Law Requirements for Sexual Health Education

	Contraception Addressed	Abstinence Instruction Required	Local Entity May Choose/Approve Curriculum	Parent/Guardian May Opt-out
PA	None	Yes	Local Jurisdictions	Yes
MD	Yes	Yes	Not Addressed	Yes
VA	None	Yes	Schools	Yes
IL	Yes	Yes	Local Education Agencies	Yes
NY	None	Yes	Not addressed	Yes
CA	Yes	No: Abstinence-only education is banned	Not Addressed	Yes

In addition to state and local laws and regulations that govern health education, and HIV education more specifically, where available we have identified relevant points from each district's health education curriculum. Available curricula from our closest neighbors is laid out in more detail below.

Curricula in Neighboring Virginia and Maryland Jurisdictions

	Grade 6	Grade 7	Grade 8
Commonwealth of Virginia	• Etiology, effects, and transmission of HIV • Broad range of community healthcare and safety agencies available and their functions • Role of the family physician, local health department, police and fire and other safety services, and community services provided by religious organizations	• Consequences of preteen sexual intercourse • Updated, factual information regarding several sexually transmitted infections, including HIV, and unintended pregnancy • Reputation, guilt, anxiety • Emotional, psychological, financial implications of sexual activity and parenting • before marriage • Reasons for avoiding risk-taking behavior • Benefits of postponing sexual activity • Causes, symptoms, treatment, prevention, and transmission of sexually transmitted infections, including HIV • Community resources that provide testing and treatment of sexually transmitted infections including HIV	• HIV transmission and prevention • Behaviors that put one at risk of HIV, stressing abstinence from risky behavior • Dispelling myths regarding the transmission of the infection • Use of condoms in preventing the spread of HIV
Loudon County	• Etiology, effects, and transmission of HIV	• Causes, symptoms, treatment, prevention, and transmission of STIs, including HIV • Community resources for testing and treatment of sexually transmitted infections and HIV	• HIV transmission and prevention • Behaviors that put one at risk, stressing abstinence from risky behavior • Dispelling myths regarding HIV transmission • Use of condoms in preventing the spread of HIV
Fairfax County		• List common STIs, and identify behaviors which eliminate an individual's risk of contracting STIs • Categorize STIs as curable and incurable • General overview of transmissions, signs and symptoms, treatments, short- and long-term consequences, and prevention • Abstinence from both sexual contact (including oral sex) and intravenous drug use as the only way to eliminate the risk of contracting STIs	• Causes, effects, modes of transmission, treatment, and prevention of STIs. • curable (bacterial and Categorize STIs as curable and incurable • Define oral and anal sex are and identify as risk factors for the transmission of STIs • Sexual abstinence and abstaining from intravenous drug use as the only way to eliminate the risk of contracting STIs • Risk factors including the use of alcohol and drugs and their effect on decision making • Reliable methods of pregnancy and disease prevention • Define contraception • Information about barrier and hormonal methods of contraception including specific examples of each method, how the methods work, how they are obtained, and their relationship to disease prevention • Abstinence emphasized as the only method that is 100 percent effective in preventing pregnancy and the most effective method of minimizing the possibility of contracting STIs

	Grade 6	Grade 7	Grade 8
State of Maryland	N/A	• *Beginning no later than grade 7* • Refraining from sexual activity is the best method to avoid STIs, including HIV, and unintended pregnancy. • Medically accurate information about contraception and condoms • Prevention and treatment knowledge, skills, and strategies to reduce susceptibility and manage diseases, such as STIs, including HIV."	N/A
Montgomery County	N/A	• Abstinence is the most effective method to prevent pregnancy and STIs • Condoms can prevent pregnancy and STIs • Abstinence from sexual activity is a healthy, safe, and responsible decision for adolescents	• How the perception of norms shapes sexual practices and how to validate abstinence from sexual activity as a healthy, safe, and responsible decision. • Formulate reasons for maintaining sexual • abstinence including protection from HIV/AIDS • Persuade others to practice abstinence and avoid risky sexual behaviors that may lead to contraction of HIV, STIs, and/or unwanted pregnancy

There are several key takeaways from this evaluation:

- The level of health education instruction, and HIV prevention education specifically, varies widely amongst public school districts
- All of these districts are subject to state law requiring at least some level of HIV prevention education in secondary schools
- Most of the public school districts place primary emphasis on abstinence as the most effective means of avoiding sexual transmission of HIV and other STIs
- Many of these districts introduce the concept of HIV prevention in health education classes before students reach middle school

This information suggests that, in order to improve upon the HIV/AIDS education already in place in the Washington D.C. public schools, there are several steps DCPS and the OSSE could consider. Many districts include HIV education as a subject in the health curriculum for grades 6, 7, and 8. According to the report issued by the D.C. Office of the Inspector General in November 2020, **"DCPS focuses on HIV prevention only in 7th grade. It is nearly nonexistent in the 6th grade curriculum and appears just briefly in the 8th grade scope and sequence."** Additionally, those D.C. health education standards addressing HIV that are in place **do not focus on the societal influences and pressures that might cause middle school students to engage in behavior that puts them at risk of contracting HIV and other STIs.** Districts like those in California are subject to standards requiring them to teach students about such pressures and ensure that they are able to identify and react appropriately to them.[30] Structural and subject changes like these have the potential to impact the effectiveness of HIV prevention education in D.C. public schools, though they cannot make up for a lack of resources or time devoted to the topic.

Given some of the limitations of curricula in these neighboring and peer US jurisdictions, such as the focus on abstinence education, it also is helpful to look at how jurisdictions abroad are trying to reach youth with important information about HIV. The following are at different phases of completing the United Nations' HIV goals.

United Kingdom

The UK was one of the first countries to meet the UNAIDS 90-90-90 targets. The UK government have made various efforts to make HIV knowledge, testing and treatment more accessible for the youth. Public Health England publishes guidance and information about HIV testing on the government's official website, which help people understand how to get tested and increases the accessibility of HIV testing.[31] Getting tested for HIV is fairly easy—one can go to a sexual health clinic or a community testing site, or ask his/her GP for an HIV test, or request a self-sampling kit online from a website run by an NGO in partnership with National Health Service (www.freetesting.hiv). Attending a GP or sexual health service to have a test for HIV and ordering the self-sampling kit from www.freetesting.hiv is free of charge in the UK, no matter what the residency status of the person being tested is.[32] If a person is diagnosed HIV positive at the clinical service, he or she will be referred for HIV care and treatment, which is free to all throughout the UK regardless of his or her residency status too. Promoting free testing and treatment eases the economic pressure on people who want to know their status or are living with HIV/AIDS, which is one of the biggest impediments the young people are facing.

China

China has witnessed a steep increase in the new HIV infections among young people over the past few years. One of the targeted prevention strategies to control the epidemic among the youth group in China is to provide accessible and affordable HIV testing. The State Council of China issued the Thirteenth Five-Year Plan (2017–22) for HIV prevention and control in 2017 and indicated that China will "explore strategies to promote HIVST through selling kits in pharmacies and online". NGOs and Chinese health departments have been working with e-commerce platforms to increase the frequency and prevalence of HIV testing.

It has been reported that each hour of 2017, about 220 HIV self-test kits (110 packages) were sold by a single online pharmaceutical store in China.[33] Many HIV-infected students refrain from coming forward and getting tested by school clinics, afraid to be "kicked out of the school, or be recorded as a 'HIV carrier' in file that may affect their future career".[34] The readily accessible online testing kits have become an effective way of resolving these issues and increasing uptake of HIV testing in the youth group.

Singapore

HIV/AIDS related education in Singapore is included in the broader sex education curriculum. All government primary schools, secondary schools, junior colleges, and centralized institutes in Singapore are required to implement the Ministry of Education Sexuality Education curriculum. Knowledge about HIV/AIDS is taught in the Empowered Teens (eTeens) program, one of the three main programs in the current sexuality education curriculum. According to the guideline published by the Ministry of Education (latest updated on 1 February 2021), the eTeens program is for secondary 3 students (school years age 14-15) and year 1 students in junior colleges or centralized institutes (school years age 16-17), and covers (i) information on sexually transmitted infections (STIs) and HIV; (ii) abstinence, and how to avoid contracting STIs and HIV and (iii) skills on making responsible decisions, being assertive and how to say "no" to sexual advances and resist peer pressure.

Stakeholders in Singapore have been making efforts to reduce the barriers to testing, as the barrier to HIV testing is believed to be one of the reasons that contribute to the 20% undiagnosed population who are living with HIV.[35] For example, Action for Aids Singapore (AFA) has been running programs including anonymous testing sites and mobile testing vans.





DC APPLESEED'S RECOMMENDATIONS

As the District emerges from the peak of the Covid-19 pandemic, community providers, activists and stakeholders are tasked to get back on track to achieving their ambitious goals for tackling the HIV epidemic. It is critical that District leaders build and maintain momentum for ending the epidemic. DC Health should work with community organizations and providers to not only reestablish or stabilize successful initiatives that may have encountered obstacles during the pandemic, such as needle exchange programs, but also refine and carry forward successful lessons, resources, and skills cultivated during the pandemic, such as telehealth capabilities and at-home testing. DC also needs to continue to make progress at removing administrative barriers that prevent patients from reengaging with care programs when there is a lapse in treatment.

At the institutional level, DC Health needs to work on building and maintaining meaningful and productive lines of communication with community stakeholders at both the grassroots and the grass tops level. Effective communication across community organizations and DC Health will eliminate barriers to collaboration and confusion in the community. DC Health also should create opportunities for organizations to work together to share resources to solve health, housing, and educational challenges. Dr. Nesbitt has expressed an eagerness to meet with the community, share her vision, and address concerns, and we encourage DC Health to take advantage of every opportunity to make that happen. The periodic meetings WAP organized at HAHSTA's request in the past were useful, and DC Appleseed and WAP stand ready to help organize such meetings in the future. We also recommend continuing and expanding the affinity group conversations that DC Health launched as part of the new Plan. Ending the epidemic requires this kind of sustained communication between the District government and all levels of the community.

Further, DC Health and providers need to renew commitments to actively collecting, maintaining, and assessing data. Open lines of communication and robust data systems will enable the District to respond more effectively and agilely, as new problems arise, and as old problems become harder to tackle.

Moreover, DC Health needs to more fulsomely develop and implement the strategy to achieve the goal of no more than 130 new infections by 2030. Such a strategy should provide actionable guidance to community stakeholders and include detailed plans for implementation that include thoughtful interim metrics on awareness of status, linkages to care, viral suppression, prevention activities, and key data points that reflect the inherent complexities of the HIV epidemic. We recognize that the strategies will need to evolve over the life of the Plan, in response to both the Covid-19 pandemic and changes in HIV testing, prevention, and care, but establishing interim metrics now will help all stakeholders work steadily toward the ultimate goal. The strategies should separately address the unique problems and barriers facing each of the most vulnerable and highly impacted communities and the interim steps to be taken to work with those communities to reach the goal of ending the epidemic.

In addition, DC Health must adequately fund and support efforts to achieve the ambitious goal set out in the new Plan. Traditionally, DC has been aggressive and proactive in capitalizing upon federal and private funding. These efforts must continue, especially as local public health funding streams are reduced to pre-Covid norms. Such ancillary funding will help ensure that local funding is used most efficiently and efforts can be maximized overall. Also, special efforts are needed to ensure that funding and investments have a wide reach across the District, including to traditionally underserved communities, and to provide stable funding to essential community providers. DC must ensure that its syringe exchange programs remains fully funded, as well.

Successfully implementing these recommendations requires stable leadership at HAHSTA. Currently, DC Health is in the process of filling gaps in leadership. These roles need to be filled with competent and dedicated public health professionals committed to ending the HIV epidemic. Further, in addition to actively engaging with the community, effective leadership must establish and clearly relay DC Health's goals, priorities, and actionable efforts.

Finally, the District needs to implement the Healthy Schools Act requirements to begin empowering young people with quality, evidence-based sexual health education, connecting students to sexual health services, and establishing safe and supportive school environments.

Ending the HIV epidemic will require an extraordinary effort and effective collaboration across community leadership and stakeholders. With the same resourcefulness, dedication, and coordination that enabled DC to make tremendous progress in the fight against HIV over the past decades and to mitigate harm from Covid-19 over the past two years, together, we can finally end the HIV epidemic in DC.



SUMMARY OF DC APPLESEED'S RECOMMENDATIONS

- **Maintain momentum on ending the epidemic:**
  - **Continue successful efforts** such as at-home testing, increased PrEP access, and funding safe needle exchange programs.
  - **Improve communication between community and DC Health** by having regular meetings with key stakeholders to discuss DC Health goals, work outcomes and operational needs of organizations and institutions.
  - **Create opportunities to share resources** between health, housing, and educational institutions and organizations.
  - **Collect/maintain/assess data** and engage key organizations and institutions who support the collection, maintenance, and assessment of data.
  - **Remove administrative barriers** that prevent constituents from reengaging with care programs when there is a lapse in treatment.
- **Create a detailed strategy for implementation of the 2020 DC Ends HIV Plan, with interim goals and metrics to guide work to reach no more than 130 new cases in 2030.** The strategy needs to address the unique needs of each of the most
- **Obtain resources to implement the plan for the benefit of all affected communities.** DC has been a leader at using federal and private funding, and DC Health should continue to seek those opportunities to use local funding most efficiently. Funding sources for all community stakeholders should be stabilized year-to-year as is feasible.
- **Establish stable leadership at HAHSTA by filling open roles, clearly communicating DC Health goals and priorities, and addressing confusion in the community.**
- mplement the Healthy Schools Act requirements to ensure that DC's children learn critical lessons about how to prevent the spread of HIV.

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END NOTES

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16. DC Appleseed Situation Analysis: Ending the HIV/AIDS Epidemic in DC, Dec. 19, 2019, https://www.dcappleseed.org/library.
17. In connection with the report, the OIG interviewed "[D.C. Public School System ("DCPS")] health educators and principals, [Office of State Superintendent of Education ("OSSE")] and DCPS Central Office personnel, and a member of the Healthy Youth and Schools Commission." The team also reviewed applicable health education standards, School Health Profiles submitted by D.C. public schools, recent Health and Physical Education Assessment results, and Youth Risk Behavior Survey reports, among other data sources. See OIG Report, Appx. A.
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20. OIG Report, at 4.
21. Id. at 6.
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