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DC APPLESEED

SITUATION ANALYSIS

ENDING THE HIV/AIDS EPIDEMIC IN D.C.

DC APPLESEED CENTER FOR LAW AND JUSTICE
1111 14th Street NW, Washington, D.C. 20005

Introduction

The District of Columbia has one of the highest HIV/AIDS prevalence rates in the country. DC Appleseed Center for Law and Justice has been working with the District to change this since issuing a groundbreaking 2005 report that provided a systemic analysis of the District government's response to the HIV/AIDS epidemic and made recommendations for improvement. DC Appleseed followed this with annual report cards and membership in the DC Syringe Access Working Group, convened by the Washington AIDS Partnership to address policy challenges regarding syringe access and complementary services in the District of Columbia.

In 2016, DC Appleseed partnered with the D.C. Department of Health and D.C. Mayor Muriel Bowser to issue a strategic plan to end the HIV epidemic in the District. The 90/90/90/50 plan is named for its ambitious goals: 90% of DC residents infected with HIV will know their status, 90% of those diagnosed will be in treatment, and 90% of those in treatment will reach viral load suppression. Through these and other activities, the District will see a decrease of 50% in new infections by 2020. As described below, although progress has been made under the Plan, the District is not on track to meet the Plan's goals and much further work remains to be done.

1. The Status of the Plan

The District government and its community partners have worked hard on their 90/90/90/50 Plan: Ending the HIV Epidemic in the District of Columbia by 2020 ("Plan)".[1] However, the latest epidemiology report from the D.C. government[2] suggests that D.C. will not meet all of the Plan goals by 2020, and is particularly behind on: 1) ensuring that residents living with HIV are in treatment, and 2) that new infections decrease to 50% of 2015 levels or less by 2020. And, the levels of infection in certain District populations remain stubbornly consistent over the last few years.

D.C. saw only a 4.35% reduction in new infections overall between 2018 and 2017. While many public health interventions reach a plateau after a period of success, which seems to be the case at the national level,[3] New York, San Francisco, and Chicago are not experiencing plateaus in the levels of new infections but instead are seeing record successes.[4] The Philadelphia Department of Public Health reported that the number of newly diagnosed persons in 2018 was down 14.3% from 2017 with a notable decline of 35.8% in Black men who have sex with men, following years of steady declines in new HIV diagnoses since the mid-2000s consistent with national trends.[5] New York City reported particularly large reductions overall, citing fewer than 2,000 new infections for the first time since annual reporting began there in 2001 (an 11% reduction over 2017).[6] Closer to

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[1] District of Columbia Department of Health, *90/90/90/50 Plan: Ending the HIV Epidemic in the District of Columbia by 2020*, DCHEALTH.DC.GOV, https://dchealth.dc.gov/page/90909050-plan-ending-epidemic-district-columbia-2020https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2019%20Annual%20Report%20Appendices081519_0.pdf.

[2] District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA), *Annual Epidemiology & Surveillance Report: Data Through December 2018*, (Aug. 29, 2019), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2019%20Annual%20Surveillance%20Report_09062019.pdf.

[3] Centers for Disease Control and Prevention, *CDC Data Confirm: Progress in HIV Prevention has Stalled*, CDC Newsroom Releases, CDC.gov (Feb. 27, 2019), https://www.cdc.gov/media/releases/2019/0227-hiv-prevention-stalled.html.

[4] Steven W. Thrasher, *H.I.V. Is Coming to Rural America*, N.Y. TIMES, Dec. 2, 2019, at A27.

[5] City of Philadelphia Department of Public Health, *City Reports Promising Reductions in New HIV Infections*, *Press Releases*, PHILA.GOV (Nov. 1, 2019), https://www.phila.gov/2019-11-01-city-reports-promising-reductions-in-new-hiv-infections.

[6] NYC Health, *New HIV Diagnoses Fall to Historic Lows in NYC, Recent Press Releases*, NYC.GOV (Nov. 22, 2019), https://www1.nyc.gov/site/doh/about/press/pr2019/hiv-surveillance-annual-report-2018.page.

home, the state of Maryland reported its lowest number of new HIV cases since 1986.[7] To reach our goal of a 50% reduction in new HIV diagnoses by 2020, D.C. would have to see a reduction of 44.3% or 156 new infections from 2018 levels – which would be D.C.'s largest decrease ever, by far. This seems quite unlikely to happen and is the result of uneven progress under the Plan among different groups.

2. Uneven Progress under the Plan

D.C.'s progress on its four goals (knowledge of HIV status, connection to treatment, reaching viral suppression, and reduction in new HIV diagnoses) has been uneven across populations.

A. New Diagnoses

The share of new infections among the white population in 2018 had decreased by half from 2014, whereas the share of new infections among the Black population has increased every year except 2015, where it was close to flat. 2018 was actually the largest increase in the disproportionality of new infections among Black persons. Latinx persons continue to be significantly overrepresented as well, though with greater fluctuations.

Share of New HIV Infections Compared to Population Size by Race/Ethnicity[8]

Disproportionality	2014	2015	2016	2017	2018
White	40.1%	29.8%	35.4%	26.4%	19.1%
Black	141.7%	139.6%	144.5%	148.8%	156.2%
Latinx	92.0%	142.7%	106.0%	110.4%	84.4%

Likelihood of New HIV Diagnoses as Compared to White Population[9]

Disparity Compared to White	2014	2015	2016	2017	2018
White	1.00	1.00	1.00	1.00	1.00
Black	3.53	4.68	4.08	5.64	8.19
Latinx	2.29	4.78	2.99	4.19	4.43

One in three of the newly diagnosed HIV cases in the District between 2014 and 2018 were among people aged 20-29. In 2018, one in five of all newly diagnosed HIV cases in the District were attributable to youth aged 18-19. Among the population of men who have sex with men (MSM), who constitute approximately half of the District's new HIV diagnoses, 26 percent of new HIV diagnoses in 2018 were among those aged 13-24.

[7] [https://www.washingtonpost.com/dc-md-va/2019/11/26/maryland-records-lowest-number-new-hiv-cases-more-than-years/]

[8] Calculated from: District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA), *Annual Epidemiology & Surveillance Report Appendices: Data Through December 2018*, (Aug. 29, 2019), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2019%20Annual%20Report%20Appendices081519_0.pdf.

[9] Calculated from: District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA), *Annual Epidemiology & Surveillance Report Appendices: Data Through December 2018*, (Aug. 29, 2019), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2019%20Annual%20Report%20Appendices081519_0.pdf.

Viral Suppression

Only half of youth aged 13 - 19 or 20-24 diagnosed with HIV were virally suppressed in 2018, compared to approximately two thirds of the overall diagnosed population.

Among residents diagnosed with HIV who are white, 92.7% were ever virally suppressed, but only 80.1% of those who are Black and 85.1% of those who are Latinx.

Many fewer residents who are Black, under 20 years old, or who contracted the virus by intravenous drug use (IDU) or a combination of IDU and sexual contact, were virally suppressed within 12 months of an HIV diagnosis.

	Newly diagnosed between 2013-2017 and living in 2018	Virally suppressed within 12 months of HIV diagnosis	
	N	N	%
Race/Ethnicity			
White	295	204	69.2
Black	1,426	917	64.3
Latino	231	158	68.4
Other*	80	62	77.5
Unknown	19	13	68.4
Mode of Transmission			
Sexual contact	1,566	1,065	68.0
IDU	53	23	43.4
Sexual contact/IDU	43	18	41.9
Other**	6	5	83.3
RNI	383	231	60.3
Age at Diagnosis			
0-19	94	56	59.6
20-24	329	207	62.9
25-29	403	260	64.5
30-39	546	360	65.9
40-49	332	219	66.0
50-59	224	156	69.6
60 and older	123	83	67.5
Total	2,051	1,341	65.4

**Other race includes mixed race individuals, Asians, Alaska Natives, American Indians, Native Hawaiian and Pacific Islanders

*** Other: perinatal transmission, hemophilia, blood transfusion, and occupational exposure (healthcare workers)

Disproportionate progress across factors like race and age could explain the District's plateau. The District of Columbia HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA) has already held meetings with working groups over several months on how to improve outcomes for, and begun focused outreach to, "special populations" including Black men who sleep with men, Latinx residents, and youth.

B. Populations most affected in D.C. per the 2019 Epidemiology Report and Appendices

Black MSM

- Black MSM and Black MSM/IDU make up 27% of HIV cases living in D.C. in 2018
- 2 in 3 MSM newly diagnosed in 2018 were Black

Black Heterosexual Women

- Black heterosexual women make up 1% of HIV cases living in D.C. in 2018
- 9 in 10 women newly diagnosed with HIV in 2018 were Black

Latinx

- Of persons aged 30-39 years old living with HIV, a plurality, 29.9%, are Latinx

- Of transgender persons aged 30-39 years old living with HIV, a plurality, 46.4%, are Latinx

Men who have sex with men (MSM)

- MSM constituted approximately half of the District's new HIV diagnoses in 2018
- 62.6% of HIV cases living in D.C. in 2018 were MSM

Transgender Persons

- About 3% of D.C.'s population identifies as transgender (14,550 persons)
- 1.7% of living HIV cases are transgender persons
- 2% of D.C.'s transgender population is living with HIV
- 75% of the transgender population living with HIV is Black
- Over 60% are under 30 years old; 29.2% are 24 years old or younger

Youth

- 26% of new HIV diagnoses among MSM were among persons aged 13-24 years old
- 20% of new HIV diagnoses in 2018 were among persons ages 13-24 years old
- 1/3 of the newly diagnosed HIV cases in the District between 2014 and 2018 were aged 20-29
- 1/5 of all newly diagnosed HIV cases in 2018 were attributable to youth aged 18-19

3. Key Factors Affecting the Plan's Implementation

As part of its annual review of the District of Columbia's progress toward ending the epidemic, DC Appleseed conducted stakeholder interviews regarding the steps they believe are necessary to return to reductions in the infection rate. Based on those interviews and our knowledge of the current data, several key areas emerged that will need to be considered in a revised Plan for the District: (a) addressing social and economic conditions that affect access to care; (b) increasing access to PrEP; (c) providing greater outreach to at-risk populations and considering transportation issues; (d) improving sex education in the schools; (e) addressing barriers to testing; (f) enhancing needle exchange programs; (g) focusing on funding issues for programs most in need; and (h) addressing current data limitations. We address each of these in turn.

A. Social and Economic Conditions of Health

D.C. continues to experience a housing crisis, including a general lack of supply and a marked lack of units affordable to households with lower incomes and/or major competing expenses like chronic health conditions. In 2019, Mayor Muriel Bowser issued several documents intended to work together to contribute 36,000 units to D.C.'s overall housing stock, 12,000 of those affordable, by 2030.[10] These efforts could be implemented in a way that includes set-asides or preferences for persons living with HIV (PLWH), or otherwise help connect them to housing stability. In addition, although D.C. has a high insured rate, many people have inadequate mental or behavioral health coverage and can't afford treatment. The Plan recognizes the connection between behavioral and mental health services and HIV care; however, it does not dedicate any tasks to behavioral or mental health services for PLWH. Connecting PLWH to mental health services is critical for treatment adherence and viral load suppression.

Our stakeholders shared their thoughts on these barriers to the stability needed to allow residents to focus on physical health.

[10] "Affordable" here means units that cost no more than 30% of the income of a household making 80% of Area Median Income (today, $2,426 per month for a household of four).

- People are more likely to make doctor's appointment if they have a place to stay
- Persons experiencing homelessness may need housing stability to remain in HIV care
- Homeless persons with HIV would benefit from more accommodations at shelters such as medical beds
- Housing is important to help young people refocus on their health
- Significant investment in affordable housing that doesn't displace people is critical
- Health centers should provide extra help to those with behavioral and mental health issues; they don't have enough support for viral load suppression or treatment in general
- Treat mental health first to improve stability to take medicine regularly
- Family-based housing and harm reduction are needed so that mothers and their children can stay together while fighting addiction

The Plan dedicates several tasks to improving housing conditions for PLWH. Below are opportunities for additional or further action:

- Consider long-term housing opportunities and solutions not only for PLWH, but also for people who are at risk for, but do not have, HIV.
- Consider how to improve conditions for PLWH who experience homelessness. For example, the Department of Health could supply homeless shelters with medical beds and other supplies needed to treat PLWH. The District should also continue to make efforts to expedite transitions to permanent and affordable housing for PLWH and implement PLWH housing opportunity policies that improve health outcomes and facilitate treatment adherence.

DC Appleseed also recommends HAHSTA consider ways to link PLWH to mental and behavioral health resources, reduce stigma surrounding seeking mental health support, and incentivize psychiatrists and other mental and behavioral health providers to accept Medicaid.

B. Access to PrEP and PrEP Education

The District's original Plan recognizes the critical importance of PrEP in reducing new infections, and accordingly includes a number of tasks relating to PrEP education and access. Some examples of specific initiatives are:
Telemedicine Initiatives: The initiation of a telemedicine program in 2019 supporting pre-exposure prophylaxis (PrEP) use is encouraging, and HAHSTA should continue to take action to fully implement this program in 2020. The Plan also proposes a telemedicine initiative to support treatment adherence (Task 3.7).

Prevention Campaigns: HAHSTA currently has the following campaigns that raise awareness of prevention strategies, including PrEP and PEP: U=U (endorsed in 2017), PrEP for Latinx Transwomen, PrEP for Transwomen, PrEP for HER: Dominate, Sex Is …, Sexual + Being. Community feedback noted that while there is awareness about Sex Is… and some awareness of U=U, other campaigns and initiatives are not as well known.

Our stakeholders also emphasized PrEP. They said D.C. needs to:

- Promote access to PrEP and make it cheaper/easier for patients to see providers for prescriptions
- Make PrEP available for free; cost barriers must be eliminated
- Form a partnership with pharmaceutical companies to provide medicine
- D.C. needs to disseminate information about PrEP in Spanish (and other languages)
- Dispel rumors about who can use PEP and PrEP (not only gay/transgender people over 16 years old)

DC Appleseed commends the District for its efforts related to PrEP programs so far and encourages HAHSTA to continue to build on these achievements. For example:

- Disseminating PrEP education materials and hosting PrEP education programs for patients in Spanish or other languages.
- Establishing programs that would ensure free PrEP for those who are uninsured or otherwise cannot afford PrEP until the coverage mandate takes effect for plan years after June 11, 2020. The District should, at a minimum, consider how to ensure access to donated PrEP for the neediest residents through the federal agreement with Gilead, and additionally should consider whether negotiating a similar agreement between Gilead and the District is feasible.
- Initiating a telemedicine program to support treatment adherence by leveraging the knowledge and relationships developed while implementing the PrEP-support telemedicine initiative.

C. Reaching Specific Populations

Youth, racial/ethnic minorities, and transgender persons have an HIV rate that exceeds their presence in the overall D.C. population. Further, progress that has been made toward ending the epidemic has benefitted those populations the least. The Plan recognizes the valuable role that community health workers play in connecting PLWH to medical care and improving long term adherence to treatment (Tasks 2.5, 3.4). Some examples of ongoing programs are:

IMPACT DMV: "Improve Measurable Participation and Access to Care and Treatment in the District, Maryland, and Virginia," a collaborative demonstration project designed to provide a regional system of care for both HIV-negative and -positive MSM and transgender individuals of color.

ECHO Collaborative: The end+disparities ECHO Collaborative is a national quality improvement focused on reducing disparities by increasing viral suppression rates in four disproportionately affected subpopulations of people living with HIV: MSM of Color, African American and Latina Women, Transgender People, and Youth.

Latinx/o/a Initiative: HAHSTA has been planning community forums that will inform program development at DC Health to meet the needs of the Latinx community in the District, Northern Virginia, and suburban Maryland (DC Eligible Metropolitan Area (DC EMA)).

Condom distribution: The District's free condom services continue to be an essential tool for preventing new HIV infections. Support for this program must continue moving forward. Additional avenues for advertising and distributing free condoms to high risk populations (such as youth and Black and Latino men having sex with men) may be beneficial – for example, offering free condoms in locations outside of schools and health clinics such as in social clubs, retail spaces, parks and libraries, or vending machines.

Our stakeholders said:

- Peer navigators and care navigators are key
    - Youth are more willing to disclose information to peers
    - Care navigators are particularly useful to youths who don't want to navigate spaces alone, and when they can take people to get tested that same day
    - Peer navigators do a lot of work for the community, but require extensive training

Several stakeholders emphasized that while the District has made progress in this area, further expansion of existing community health worker programs is needed. In addition, stakeholders highlighted that community health workers are most effective when they are deeply familiar with the communities they serve. For this reason, HAHSTA should continue to emphasize the importance of cultural competency as a key qualification for community health workers (and other healthcare providers).

Community stakeholders continue to emphasize that limited or inadequate access to transportation remains a barrier for individuals to get tested and access care. DC Appleseed recommends that HAHSTA improve access to reliable and convenient transportation, such as partnering with, or offering subsidized access to, Uber, Lyft, or other ride-sharing platforms, particularly for PLWH who may require frequent medical appointments in order to adhere to an ART regimen and achieve viral load suppression.

D. Sex Education

The current Plan includes several tasks directed at fostering more comprehensive sexual education for DC's youth population, including thorough implementation of the Healthy Schools Act in DC Schools (Tasks 4.13, 4.14, 4.15). D.C.'s public and public charter schools do have some health education standards, which include age-appropriate sexual health instruction, but they are not regularly enforced.[11] Other examples of current initiatives include:

> "Sex Is…" Youth Advisory Board: Paid staff provide outreach and education to their peers, alongside the staff of DC Health. The campaign is also available on multiple social media platforms. Attention has been given to creating eye-catching media and a unique focus on youth involvement and development.
>
> Parks & Rec Pilot: This pilot program presented a sexual health and wellness curriculum at 6 Department of Parks and Recreation sites throughout the District for teens aged 14 to 15 years old.

Many community stakeholders strongly emphasized the role that sexual education should play in preventing new HIV infections in the youth population. This area will be key to the District's continued progress in reducing new infections in the high-risk youth population.

The stakeholders interviewed shared many specific concerns and suggestions on this topic:

- Promote better condom use in youth population
- Require more health teachers in DC public schools, especially middle schools, providing health education about preventing HIV
- Educate young adults who did not have a high school education regarding sex education
- Introduce idea of HIV testing when people are looking for jobs and in the GED process
- Provide longer period of sexual health education in schools; funding for schools to hire people with skill set to teach sex education
- Take an aggressive approach towards sex education and training in the work of adolescent health and pregnancy prevention
- Address combatting sexual violence as a way to allow young women more control over sex decisions in their relationship, including whether to use protection

DC Appleseed has met with D.C. education leaders and encourages HAHSTA to build upon their willingness to better implement sex education in schools.

[11] http://www.dcappleseed.com/wp-content/uploads/2019/03/OSSE-Oversight-Testimony-2.21.19-Patrick-Campbell-and-Walter-Smith.pdf

E. Barriers to Testing

HIV testing is a foundational element of the Plan, and a critical first step in HIV treatment. HAHSTA has expanded testing initiatives and continues to work to increase the success of testing programs. However, stigma around HIV, which populations see the greatest prevalence of infection, and the ways it can be contracted, continue to pose barriers to testing and treatment. Cost and lack of motivation were identified as well.

HAHSTA has been convening community panel discussions to address attitudes that can become barriers to accessing services for both HIV negative and positive individuals. These panel discussions attempt to help participants—e.g. community health workers, case managers in the EMA, conference attendees at the United States Conference on AIDS—take a fresh look at sexual health in a more positive light.

Interviewees shared many insights:

- More education about Undetectable = Untransmittable (U=U) would be effective for fighting stigma
- Adding HIV to other blood testing would remove stigma attached to asking for an HIV test
- More people speaking about their HIV status would combat stigma
- Mobile vans that provide incentives for testing would be helpful, but some emphasized that these must be limited, timely, and closely monitored
- Ensure that STD testing sites are open when the school day is over
- Subsidizing transportation for testing or treatment is effective
- Tracking people through insurance payments disincentivizes testing
- Youths not wanting to share information with parents (or whoever's insurance program they're on) is a significant barrier to testing

Community organizations reported that women who experience violence may not feel they have control over whether to use protection, some women struggle to adhere to their own treatment because they are focused on caregiving, and some medical providers don't bring up PrEP with women or are dismissive of women requesting. Appleseed encourages HAHSTA to involve HIV education in programs that empower women and to educate medical providers about how to helpfully engage in conversation about HIV with women patients.

Many community stakeholders highlighted Undetectable=Untransmittable (U=U) as an important initiative for destigmatizing HIV and AIDS. At the same time, stakeholders largely reported that their communities are not aware of U=U. DC Appleseed recommends that the District invest in public education and social media campaigns to increase awareness of the U=U program.

HAHSTA should consider additional initiatives and new tactics to test individuals they haven't been able to reach through conventional testing programs, such as policies and solutions that would render HIV testing entirely confidential, particularly for youth who do not have their own insurance (*e.g.*, free testing programs for youth) and providing incentives for people to get tested.

F. Syringe Access Programs

Many community stakeholders emphasized the importance of maintaining and further expanding established public health practices. As the District government and community partners work to update the Plan and allocate related funding, the ongoing value of these public health strategies should not be overlooked. One such area is syringe ("needle") exchange.

Needle exchange programs**:** The District's needle exchange program can be credited as a driving force in the steep decline in new HIV diagnoses in the people who inject drugs (PWID) population between 2008 and 2017. However, there was a notable decline in needles exchanged in 2017 and 2018, particularly due to the increase in new HIV diagnoses in the PWID population from 2017 to 2018.[12]

New services: In 2018, several new programs were integrated into a new syringe exchange request for applications (RFA) to provide a more comprehensive service portfolio. Providers are enthusiastic about the new services but find that they don't have the funding to bring on additional staff who can cross-train and also purchase needed supplies.

The District should examine the decline in needles exchanged in 2017 and 2018 and, if appropriate, consider additional funding or other resources to ensure that needle exchange programs remain robust in the future. Additional funding would also lessen the burden on providers now responsible for broader service delivery.

G. Funding Issues

DC Appleseed recommends that HAHSTA further assess its funding categories and map what is needed to fully implement and scale up successful strategies in the existing Plan, in addition to funding new initiatives intended to bridge remaining gaps.

- Some entities dropping out of Title X program funding after regulatory changes in 2019 may impact demand for community-based health services in the District and could influence the allocation of funding or other resources in the future.
- DC Appleseed recommends that the District allocate a significant portion of new funding sources to bolster promising initiatives in the current Plan, such as community health workers and clinics, peer navigators, and sexual education for youth, in addition to utilizing these resources to explore new approaches for combating HIV in the District.

H. Data Shortcomings

DC Appleseed notes several issues with the data presented in the 2019 Annual Epidemiology & Surveillance Report that HAHSTA should review and address when recalibrating the current Plan later this year:

- HIV+ Individuals Who Know Their Status (Goal 1): The 2019 Epi Report did not include an updated estimate of the percentage of HIV+ individuals who know their status. The measurement of progress on this goal may be improved with implementation of various data collection strategies included in the Plan. HAHSTA should revisit its 2018 estimate in order to gauge progress on this important goal.
- Defining "Percentage of HIV-diagnosed Individuals in Treatment" (Goal 2): Goal 2 should be defined more precisely to clarify whether the goal is to achieve 90% of those diagnosed in care (attending medical visits) or in treatment (on and adhering to anti-retroviral therapy). Because the research is clear that antiretroviral therapy is key to viral suppression and decreased transmission, the correct definition, in our view, relates to active treatment adherence.
- Incomplete/Missing Data: The rate of missing or "unknown" data rose for several key metrics in the latest Epi Report. For instance, the proportion of newly-diagnosed HIV cases where race/ethnicity is "unknown" increased from 2.4% in 2017 to 8.1% in 2018, and the proportion of new cases where Mode of Transmission is "unidentified" increased from 18.8% to 27.5%. Both are quite concerning – throwing significant uncertainty into the information that guides all the District's prevention and treatment efforts.

[12] *See* 2019 Epidemiology Report at 24.

In addition to tracking the District's progress, collection of complete data, particularly demographic and mode of transmission information about newly diagnosed HIV cases, is essential in order for the District to effectively respond to individual new infections as "sentinel events." DC Appleseed recommends that HAHSTA identify the reasons for the observed increases in missing or unknown data and take appropriate steps to remedy gaps and ensure comprehensive data surveillance moving forward.

- Additional Data on Risk-Related Activities: DC Appleseed recommends that HAHSTA explore the collection and analysis of additional data concerning risk-related behaviors in high-risk populations. Although the District is to be commended on making strides towards the goals set in the Plan, it should identify strategies for effectively identifying and targeting "difficult to reach" populations that have fallen through the cracks of HAHSTA's existing framework. DC Appleseed recommends that HAHSTA consider the collection of additional data on risk-related activities, such as rates of condom use and/or unprotected sexual contact, IV drug use, chronic school truancy/dropping-out, survival sex, exposure to sexual education and information about PrEP, and access to medical care, among particular high-risk demographics (cross-referenced by age, gender identity, race/ethnicity, and geographic location within the District). These data may allow HAHSTA to better tailor additional initiatives that effectively target "difficult to reach," at-risk subpopulations in the District.

Conclusion

DC Appleseed is very happy to provide observations from our annual reviews and from our communications with stakeholders. We look forward to continuing in these dual roles, and to reprising the role we undertook in the joint effort to draft D.C.'s first Plan. We applaud efforts that HAHSTA has begun to fine-tune its outreach to and solicitation of input from age, racial and ethnic, sexual identity, language, and other groups, which we think is critical to regaining a faster pace in ending the epidemic. We hope that HAHSTA will pair its internal expertise with that of organizations on the ground to ensure that its efforts to tailor interventions for populations that are seeing the least benefit of the District's overall progress will be most effective. We also encourage, and will be pleased to assist, HAHSTA to improve its data collection and communication. We look forward to seeing the end of the HIV epidemic in our city.