

Northern Virginia HIV Regional Prevention Plan

NVH CONSORTIUM

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See Page 27 for Complete List

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–VORA

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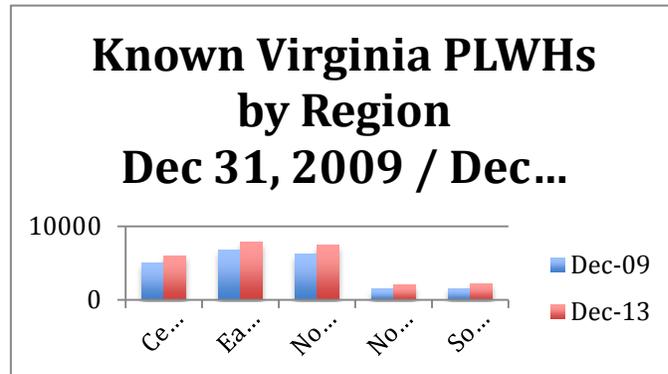
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INTRODUCTION

When there are 1.2 million individuals living with HIV in the United States, and of these over 25,600 are Virginians and 29% live in Northern Virginia (7,453)¹, action must be taken.

Despite strong advances in medical treatment, Virginians continue to contract HIV at an alarming number even though HIV is a preventable disease. In Virginia, the goal of the Northern



Virginia HIV Consortium is to see the number of new cases each year declining sharply. Instead, the rate of new infection remains relatively flat and another 900 new cases will likely be discovered in this year.

While HIV is now considered to be a treatable chronic illness, the truth is that the treatment medications (called HAART)² are extremely costly, require constant monitoring and adjustment, and

have significant and often permanent life changing side effects. HIV is not a simple disease to treat. It requires a lifelong commitment on the part of the person infected to achieve the best results. Unlike other chronic diseases, HIV is also an infectious disease – it is a disease transmitted from one person to another. Medications do play a key role in preventing transmission from one person to another, but this strategy alone is insufficient.

According to the **2010 National HIV/AIDS Strategy for the United States**, the added lifetime health care cost to provide HIV-treatment for a 20 year old diagnosed today exceeds \$350,000.

To address HIV in the U.S., a National Strategy was first announced in July 2010 and reaffirmed by President Obama in July 2013. Its goals are to:

- (1) Reduce the number of new infections,
- (2) Increase access to care and treatment, and
- (3) Reduce HIV/AIDS-related disparities.

To help guide state and local HIV prevention work, the National Strategy identifies (1) men who have sex with men, (2) African Americans and Latinos, and (3) substance users as the priority populations upon which to concentrate HIV prevention efforts across the country as these are populations most likely to become infected with HIV.

Northern Virginia's Prevention Priorities

¹ Virginia Department of Health, December 31, 2013 Annual Report, http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/DAta/QuarterlySurveillanceReport4_Q_12.htm

² "HAART" means Highly Active Antiretroviral Therapy.

The group of Northern Virginians that developed this report went a step further, and in 2012 identified priority populations upon which HIV prevention efforts be targeted in this region should be:

- (1) Persons with HIV and not in care (which also means without access to treatment medications), and
- (2) Men who have sex with other men, with an emphasis upon
 - (a) Men of color, and
 - (b) Youth and young adults of color up to age 29.

What Lead to This Report

While generous funds have been available across the nation through the Ryan White Care Act for treatment and supportive services for persons living with HIV, many other prevention efforts have been challenged by a shortage of resources.

In Virginia, this situation has been particularly acute. A mere \$200,000 of Virginia's own state general fund dollars were devoted to HIV prevention by the General Assembly in 1988. While the General Assembly has recognized the importance of HIV medications in prevention and has dedicated state funds toward HIV drugs, the Assembly has not added any state funds for prevention education. The recent decline in the number of organizations dedicated to HIV prevention education and the decline in HIV prevention programs in Virginia overall are indications of the limits to these resources. Such prevention education programs must be financed through federal, local and private grants or donations.

In 2010 the Washington AIDS Partnership, a coalition representing 35 Washington, D.C. area foundations, undertook an assessment of the region's response both in terms of caring for persons with HIV and in preventing transmission of the infection. This study, The Profiles Project: How the Washington, D.C. Suburbs respond to HIV/AIDS, was produced by the consulting firm Mosaica and released in April 2010.³

Key findings from that report included:

1. Prevention and HIV testing dollars are in short supply. Better coordination across state and county lines would help stretch funding farther, thus improving services
2. School based prevention is inconsistent and often timid and approved curriculum is not consistently implemented
3. Efforts to prevent HIV infection are a badly underfunded component of the fight against HIV
4. There are insufficient non-health department based HIV testing sites

³ Refer to Appendix D, page 36 for Mosaica report

Key recommendations contained in The Profiles Project report for Northern Virginia included:

1. Improve coordination of HIV prevention efforts across the region
2. Ensure maximum availability of rapid HIV tests
3. Institute standardized rapid HIV testing in emergency rooms
- 4. Develop a regional HIV prevention plan** [Highlight added.]
5. Implement regional social marketing campaigns and improve community outreach
6. Develop strong leadership for improved in-school HIV prevention education

In addition to this report and every four years, the Virginia Department of Health (VDH) prepares a comprehensive examination of HIV prevention efforts across the Commonwealth. The Virginia Jurisdictional HIV Prevention Plan identifies resources devoted to HIV Prevention, examines and prioritizes populations at risk of HIV infection, and also makes recommendations that help to guide how VDH grant dollars are allocated.

VDH does not have the resources to prepare more detailed and targeted prevention recommendations for the various Virginia regions. The Northern Virginia region chose to undertake this regional plan to both inform the public about the need for HIV prevention education that is focused on Northern Virginia, and to provide recommendations about where prevention resources may best be spent. Carol Jameson, who at the time was the Consortium's chair and Executive Director of the Northern Virginia AIDS Ministry (NOVAM), secured grants to support the regional prevention plan development from the Washington AIDS Partnership and the Northern Virginia Health Foundation.⁴ The Northern VA Health Foundation partnered with the Washington AIDS Partnership in sponsoring this work.

Under Carol's leadership, NOVAM organized the Regional Planning Group (RPG) that met over the course of two years to examine data and develop recommendations, beginning in 2010. The final report was completed by the Virginia Organizations Responding to AIDS (VORA) and presented to the Northern Virginia HIV Consortium in the fall of 2013. The report will be presented to the Northern Virginia Health Directors in June of 2014. (The members of the RPG are found in Appendix A of this report.)

How to Read the Report

This report is presented in three sections. The first section, Part One, begins with an overview of the extensive data reviewed by the RPG. Subgroups of persons known to be living with HIV in the region were identified by the RPG, and the data relevant to those groups were examined separately. (To assist today's reader; new data added from the 2013 Annual Surveillance Report and not considered by the RPG in 2011 are highlighted in *italics*.) In addition, anecdotal factors that may influence behaviors that put a person at risk of exposure to the HIV virus were identified by the RPG, and are listed with each subgroup.

⁴ The grants were made to the Northern Virginia AIDS Ministry (NOVAM), and the bulk of the work was performed under the guidance of NOVAM staff supported by the participation of Northern Virginia HIV Consortium members and others.

Part Two provides the RPG's decision on which of these groups should be targeted in Northern Virginia and why.

In the final section, Part Three, the recommendations for regional actions are grouped by type of prevention intervention that the RPG found to be critical strategies. The group did not prioritize the interventions advocating that each should be implemented. Collectively, these strategies would significantly reduce the opportunity for the spread of HIV and, therefore, the rate of new infection within the region.

PART ONE: PEOPLE LIVING WITH HIV IN NORTHERN VIRGINIA

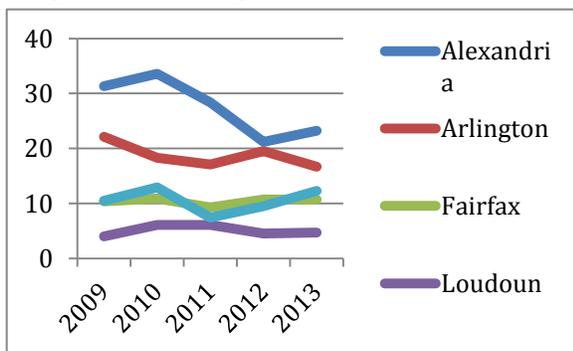
The Northern Virginia region proper consists of nine political jurisdictions: The Counties of Arlington, Fairfax, Loudoun, and Prince William, and the Cities of Alexandria, Fairfax, Falls Church, Manassas and Manassas Park.⁵

The region as defined for this report matches the state’s Planning District 8, supported by the Northern Virginia Regional Commission (NVRC). NVRC staffs the Northern Virginia HIV Consortium and its planning work is used to direct federal HIV treatment funds (Ryan White Parts A and B and HOPWA). The Consortium has also adopted a role in advising the region’s HIV prevention activities.

In this section, the data received by the RPG during its work is summarized for each of the subpopulations of persons known to be living with HIV in Virginia. The group spent considerable time examining the data provided by the Virginia Department of Health for the purpose of this report. The group then identified risk factors for each group, and brainstormed potential recommendations.

THE OVERALL REGIONAL DATA

At the close of 2011, there were 6,794 individuals known to be living with HIV⁶ in Northern Virginia, which represents 28% of all those living in Virginia at the time (24,264).



Since this work of the RPG in 2010 and 2011, the number of persons known to be living with HIV in Virginia has increased to 25,651 (December 31, 2013), a clear indication that the trends studied by the RPG continue. Of that number, 7,453 (29%) live in Northern Virginia.⁷

The chart at the left shows the rate of known new cases of HIV reported to the VDH from 2009-2013 for persons living in the 5 largest jurisdictions in the region. The overall incidence rate of HIV in Northern Virginia, or new cases per 100,000 population, follows:

2009	2010	2011	2012	2013
12.2	12.7	10.3	10.8	11.3

For chart demographics, see Appendix E

⁵ The Northern Virginia HIV Consortium represents jurisdictions extending beyond the PD8 jurisdictions for the purpose of prioritize funding for Ryan White Part A funding.

⁶ Special Note: HIV is the virus that causes AIDS. In the past, terminology referred to individuals who were living with HIV and those living with AIDS. Today’s preferred terminology is to refer to Persons Living with HIV disease (PLWH), whether the disease has progressed to AIDS or not.

⁷ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013.

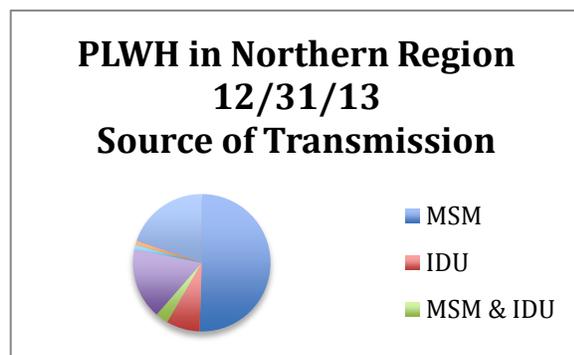
https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

The Centers for Disease Control and Prevention (CDC) estimates that for every 6 people known to be HIV positive, another person is in fact positive but unaware.⁸ Since medications were first widely used to reduce the impacts of HIV on the body in the early 1990's, research has proven that with regular use of prescribed drug therapies, the HIV virus can be suppressed to such low levels that transmission of the virus from one person to another can be prevented.

HIV prevention activities now include not only education that teaches the participant how to avoid exposure to HIV, but also education about the role that HIV-positive individuals can take to prevent the spread of HIV in both maintaining drug therapies and changing behaviors.

MEN WHO HAVE SEX WITH MEN (MSM)

Nationally, gay, bisexual, and other Men Who Have Sex with Men (MSM) of all races and ethnicities remain most severely affected by HIV. In 2009, 61% of those newly infected with HIV were MSMs. Within this group, men of color, particularly Blacks and Latinos, are disproportionately affected by HIV. *The 2013 Annual Surveillance Report indicates that 54% of the persons living with HIV were MSM.*⁹



Blacks continue to experience the most severe burden of HIV, compared to other races and ethnicities. Representing approximately 14% of the U.S. population, Blacks accounted for an estimated 44% of new HIV infections in 2009. Latinos represented 16% of the population and accounted for 20% of new HIV infections in 2009. Even more troubling, the greatest increase were young Black men, among whom cases increased by 67% in a three-year period.

*In the December 2013 Annual Surveillance Report, 47% of the known PLWH were black and 14% were Hispanic.*¹⁰

A recent CDC study¹¹ found that in 2008 one in five (19%) MSM in 21 major US cities were infected with HIV, and nearly half (44%) were unaware of their infection.

⁸ HIV in the United States: At a Glance, <http://www.cdc.gov/hiv/statistics/basics/ata glance.html>, retrieved May 29, 2014.

⁹ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013. https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

¹⁰ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013. https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

¹¹ Centers for Disease Control, "Prevalence and Awareness of HIV Infection Among Men Who Have Sex with Men – 21 Cities, United States, 2008". Morbidity and Mortality Weekly Report, 9-24-10

In Virginia, and Northern Virginia as well, MSM continue to have the highest number of new HIV infections. Of the 6,794 living with HIV as of December 31, 2011, 48% (3,261) self identified as MSM. *In December 2013, that number had risen to about 54% (4,052).*¹²

It is important to remember that the term “MSM” is used to describe a behavior; those who are MSM include persons who are self-identified gay and bisexual men, men who identify as heterosexual (neither gay or bi-sexual), and transgender women who retain male genitalia.

According to the Virginia Department of Health (VDH), the percentage of Virginians who identified as MSM, living with HIV/AIDS increased over 10% from 2009 to 2011; in Northern Virginia the rate of increase was 9% in just one year (2009 to 2010).

A VDH study of young African American MSM ages 16-24¹³, conducted in response to the growing number of persons found to be HIV positive in this population, found that 75% of those surveyed reported engaging in unprotected sex within the past three months, and 40% reported engaging in unprotected anal sex. Of those, 38% reported they had met their sexual partners online and 34% had met in clubs. When asked about why they do not use protection, reasons cited included sensation (sex feeling better without a condom), sex occurring on the spur of the moment, trusting a partner, and being in a relationship. A noteworthy 43% of the participants reported having experienced sexual abuse, which is reported in numerous studies to correlate with individuals at greater risk of having low self-esteem and engaging in sexual risk-taking.

Particular concern in Northern Virginia grew after the incidence of syphilis dramatically rose in 2010 and the trend continued. Arlington County had the highest rate of new cases with 34 cases diagnosed, an increase of 61% from the year before; 80% of those cases were in men who have sex with men, and 50% were also infected with HIV. Arlington reported that many of the individuals met their partners online, at bars and at “house parties.” Because syphilis causes genital sores there is an estimated two to five times the risk of contracting HIV when the syphilis chancre (sore) is present.

Factors Contributing to Risk

What follows, and in each subgroup section below, are the results of brainstorming by the RPG to articulate the reasons or factors that influence behaviors leading to exposure to the virus, whether myth or fact. Many of these factors could be relevant to every subgroup discussed; the items included in this report are those most specific to the subgroup discussed.

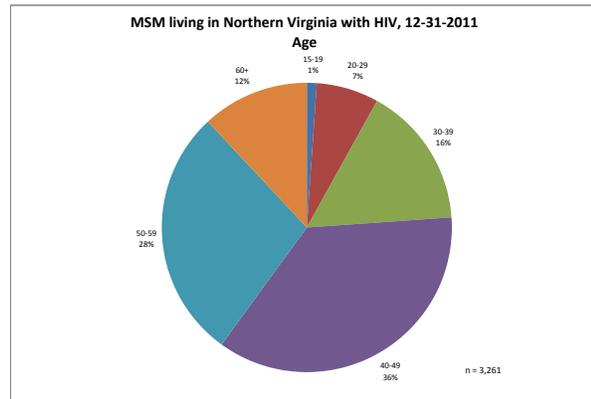
- *Stigma and homophobia may have a profound impact on the lives of MSM, especially their mental and sexual health. Internalized homophobia may impact men’s ability to make healthy choices, including decisions around sex and substance use.*

¹² Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013. https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

¹³ Virginia Department of Health, Division of Disease Prevention. “Report on Virginia’s Study of Young African-American Men who Have Sex with Men”, 3-26-10.

- *Stigma and homophobia may limit the willingness of MSM to access HIV prevention, testing and care, isolating them from family and community support, and creating cultural barriers that inhibit integration into social networks. Stigma is particularly strong in communities of color.*
- *Sex with older Black partners, particularly in the Black community. When HIV positive, they may have less access to HAART therapy as a result of reduced access to primary care.*
- *Cultural beliefs affect acknowledgement of behavior and risk; for example, in the Latino community homosexuality conflicts with the concept of machismo, or masculinity.*
- *Men who experience this stigma may be more likely to seek sexual experiences that involve risk, such as seeking sexual experiences with people they don't know found via the internet and who may not be willing to use condoms.*
- *Persons who fear being identified as gay often avoid seeking and utilizing prevention programs, such as HIV counseling and testing.*
- *A belief that HIV is an easily treated chronic disease that is not fatal produces a false sense of security; "so what, it's not a problem anymore."*

- *Racism, poverty, and lack of access to health care are barriers to HIV prevention services, particularly for MSM from racial or ethnic minority communities.*
- *Older men may be less likely to insist on condom use when with younger partners, out of a fear of rejection.*

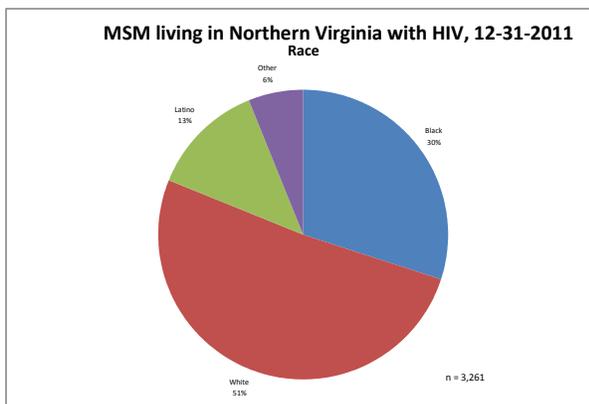


- *Some men indicate that the pleasure and intimacy they get through unprotected and spontaneous sex is more important than the risk of acquiring HIV.*
- *Persons who test negative for HIV may believe they are somehow protected from infection and have a false sense of security.*
- *MSM have an increased risk of other serious sexually transmitted infections (STIs); some studies have found the incidence of primary and secondary syphilis to be significantly greater in MSM than in men who have sex with women, and this rises with younger MSM. Infection with other STIs increases the risk for infection with HIV.*
- *HIV prevention programs are often not linguistically or culturally appropriate to the target population, or at an appropriate literacy level for certain populations.*

- *There is a belief among of certain MSM of color groups that sex with someone of the same race affords a protection against HIV infection.*
- *Men may correlate having an HIV test with being disclosed as gay. For men who are HIV positive, disclosure of their HIV status may leave them vulnerable to significant harm, including violence and being disclosed as MSM.*
- *A significant reluctance to discuss their sexuality with their primary care provider, coupled with primary care providers' reluctance to address this with patients.*
- *Underestimation of risk; one recent study found that 35% of individuals surveyed who were seeking an anonymous sexual partner did not believe that unprotected sex could lead to HIV and other STIs.*
- *Immigrants fear that knowing one's HIV status, if positive, can lead to deportation.*

AFRICAN AMERICANS

The African American community continues to be disproportionately affected by HIV. Blacks account for more new HIV infections, AIDS diagnoses, people estimated to be living with HIV disease, and HIV-related deaths than any other racial/ethnic group in the U.S. The epidemic has also had a disproportionate impact on Black women, youth, and gay and bisexual men, and



Blacks with HIV/AIDS may face greater barriers to accessing care than their white counterparts.

Blacks represent approximately 12% of the U.S. population, but accounted for an estimated 44% of new HIV infections in 2010. They also accounted for 44% of people living with HIV infection in 2009.^{14,15} In 2013, 47% of people known living with HIV in Northern Virginia were black.¹⁶

The rate of new AIDS diagnoses per 100,000 among Black adults/adolescents was about 10 times that of whites in 2010. The rate for Black men (75.6) was the highest of any group,

¹⁴ CDC. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 U.S. dependent areas—2010. HIV Surveillance Supplemental Report 2012;17(No. 3, part A).

http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf. Published June 2012.

¹⁵ CDC. Estimated HIV incidence in the United States, 2007–2010. HIV Surveillance Supplemental Report 2012;17(No. 4). http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol17no4/. Published December 2012.

¹⁶ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013.

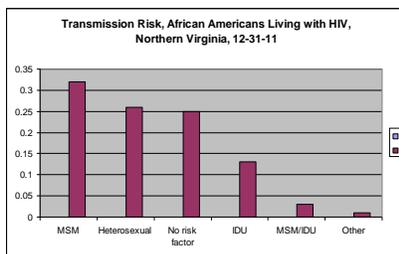
https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

followed by Black women (33.7). The rate of new HIV infections is also highest among Blacks and was nearly 8 times greater than the rate among whites in 2009. The District of Columbia, a close neighbor to Northern Virginia, has the highest rate nationally of Black individuals who are infected with HIV.

Although Black teens (ages 13–19) represented only about 17% of U.S. teenagers in 2009, they accounted for 70% of new AIDS diagnoses among teens in 2010. In Virginia, 53% of new HIV diagnoses in 2009 in youth ages 13-29 were Black.

Factors Contributing to Risk

- *There continues to be a great deal of stigma associated with being HIV positive in the African American community, especially when associated with men who have sex with men.*



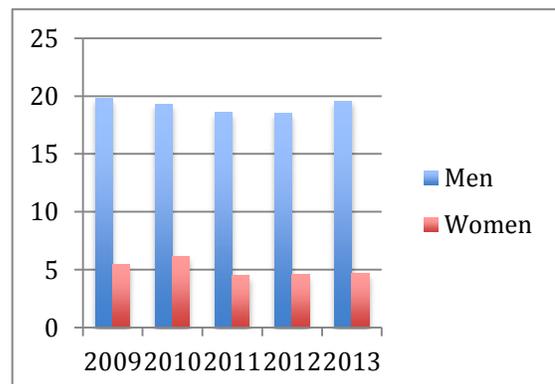
- *The majority of new HIV infections in heterosexual African American women are a result of having sex with men who also have sex with men.*
- *HIV Prevention programs often do not reach the target population because the population is not visible and willing to engage in prevention program activities.*

- *Racism, poverty, and lack of access to health care are barriers to HIV prevention services, particularly for MSM from racial or ethnic minority communities.*
- *A significant reluctance to discuss their sexuality with their primary care provider, coupled with primary care providers' reluctance to address this with patients.*
- *Poverty, with its associated lack of access to education, health care and support systems, increases the likelihood of not having access to health care and prevention education.*

WOMEN OF COLOR

At some point in her lifetime, 1 in 139 women will be diagnosed with HIV, according to the Centers for Disease Control. At greatest risk are women of color, particularly African American and Latinas. Women continue to be at risk of infection primarily through sexual contact with men who also have sex with men and fail to utilize protection.

In 2009, women comprised 51% of the US population and accounted for 23% of new HIV infections. Of the total number of new HIV

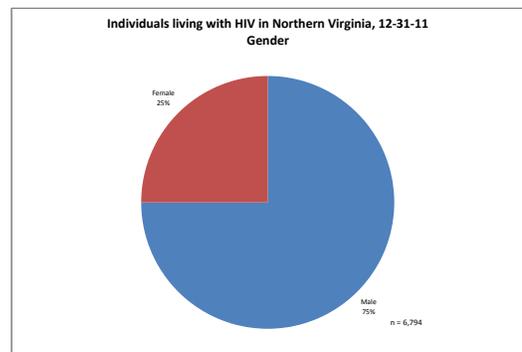


infections among women, 57% were African American, 21% were white, and 18% were Latina. The rate of new HIV infections among African American women was 15 times as high as that of white women and over 3 times as high as that of Latina women.

In Virginia, the chart on page 10 shows the rate of new diagnosis of HIV among women to be generally declining, while the rate for men seems to be reversing its downward trend.¹⁷

Factors contributing to Risk

- *Higher rates of HIV and other sexually transmitted infections (STIs) in communities of color lead to greater opportunities for exposure.*
- *Most women are infected with HIV through heterosexual sex. Some women become infected because they may be unaware of a male partner's risk factors for HIV infection or that their partner may be engaged in a concurrent sexual relationship with others during which protection is not used.*
- *Many women lack the skills to communicate their wishes and negotiate condom use.*
- *Women may be unaware of the risks involved with unprotected sex.*
- *Both unprotected vaginal and anal sex pose a risk for HIV transmission. Unprotected vaginal sex puts women at risk for HIV, and unprotected anal sex places women at an even greater risk for HIV transmission.*
- *Some women may not insist on condom use because they fear that their partner will physically abuse or leave them. This latter fear is especially acute for those who are financially dependent upon their partners.*
- *Many women are more concerned about pregnancy prevention than HIV infection and are less likely to use two forms of protection.*
- *Women of color are statistically more likely to have sexual relationships with men who have been previously incarcerated since men of color are more likely to be incarcerated (i.e., 1 in 9 black men are incarcerated who are ages 20-34, vs. 1 in 30 white men of the same age). Men who have been incarcerated are 2.5 times more likely to be HIV positive than men outside the penal system. Women whose partners are incarcerated may also be more likely to have more than one sexual relationship while their partner is incarcerated.*



¹⁷ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013. https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

- *Women who use drugs or other substances have an increased risk of HIV infection because they may have difficulty refusing unwanted sex or negotiating condom use when under the influence, and may exchange sex for drugs or money.*
- *The presence of other sexually transmitted diseases greatly increases the likelihood of acquiring or transmitting HIV. Rates of gonorrhea and syphilis are higher among women of color than among white women. Persons with other sexually transmitted infections are at much greater risk of infection with HIV. A study by the Centers for Disease Control found that nationally 25% of young women ages 15-19 had had at least one STI and this rose to 50% of African American young women.*
- *The risk of infection is greater because of socioeconomic issues associated with poverty, including limited access to high-quality health care, unstable employment and housing, and domestic violence.*
- *Women who have experienced sexual abuse may use drugs as a coping mechanism, find it difficult to refuse unwanted sex, exchange sex for drugs, or engage in risky sexual behaviors, all of which increase HIV transmission risk.*
- *Sharing equipment contaminated with HIV to inject drugs and other substances increases HIV risk. Being under the influence of drugs or alcohol can also lead to high-risk behaviors, such as unprotected sex.*
- *Having a sexually transmitted disease greatly increases the chances of HIV. Women of color are at even greater risk due to higher rates of gonorrhea and syphilis among the populations of persons of color compared to white women.*
- *In a CDC study of urban high schools, more than one third of black and Hispanic women had their first sexual encounter with a male who was older (3 or more years) [13]. These young women, compared with peers whose partners had been approximately their own age, had been younger at first sexual intercourse, less likely to have used a condom during first and most recently reported intercourse, or less likely to have used condoms consistently.*

LATINOS

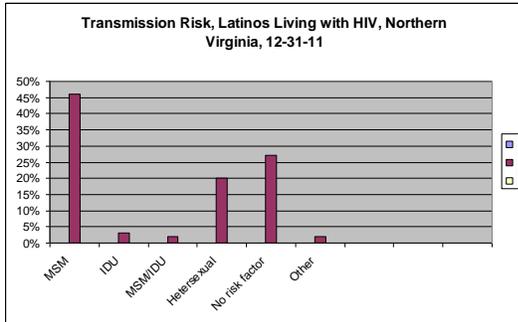
The Latino population is large and steadily growing in Northern Virginia. Latinos make up over 16 percent of the population in Northern Virginia¹⁸. In some areas of the region, the Latino population is significant; for example, Arlington is now the center of the largest Bolivian community in North America.¹⁹ The Latino population overall is found to be underserved, and suffers from disenfranchisement, cultural and linguistic barriers to receiving services, denial and other sociological manifestations that nurture high rates of HIV infection and health related problems.

¹⁸ United States Census, 2010 Data. <http://quickfacts.census.gov/qfd/states/51000.html>

¹⁹ Northern Virginia Demographics - http://en.wikipedia.org/wiki/Northern_Virginia

The Latino community continues to disproportionately be affected by HIV; in 2009, 20% of new HIV infections were identified as Hispanic. Of those Latinos diagnosed in 2010, 79% were in men, 81% of those men had identified having sex with other men. Latinos are more likely to be diagnosed late, after having developed symptoms of AIDS. Of the new AIDS diagnosis reported in 2010, 22% were Latino.

Newly infected Latino gay and bisexual men are much younger ; 45% of those infected as of 2009 were between the ages of 13 and 29.



Latina women, 21% of new HIV infections, are five times more likely to be HIV positive than white women.

Of the 6,794 individuals living with HIV in Northern Virginia as of December 31, 2011, 14% were Hispanic. *This percentage did not change in 2013 (1055 of 7453, or 14%).*²⁰

Factors Contributing to Risk

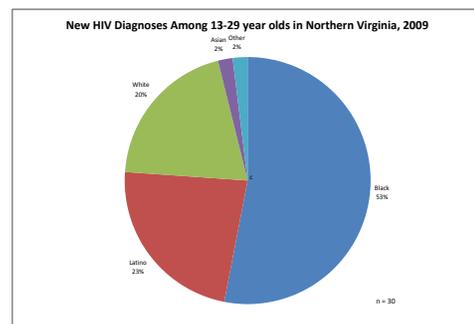
- *Cultural stigma and fear of discrimination avoid testing, treatment, counseling – there is a preference to not know their HIV status.*
- *There is a belief that if found to be HIV positive they may be deported.*
- *Substance abuse, particularly drinking, increases the likelihood of not taking precautions. Statistically, men from Puerto Rico are more likely to also engage in injection drug use than other Latino men.*
- *The presence of certain sexually transmitted infections (STIs) can significantly increase one’s chances of contracting HIV infection. A person who has both HIV infection and certain STIs has a greater chance of infecting others with HIV. The rates of STIs remain high among Latinos.*
- *The majority of Latino men contract HIV through sex with other men; they often have relationships with women as well. The women are often unaware of their male partner’s other sexual relationships.*
- *Gender roles, particularly machismo, prevent discussion among men and women about condom use and women lack the skills to negotiate condom use*

²⁰ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013. https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

- *HIV has the stigma of being known as a “gay disease”*
- *There is a lack of knowledge about how HIV is transmitted as well as a belief that if one has sex with someone of the same ethnicity they are protected from infection*
- *Many Latino families lack strong family support systems, especially men who are in the United States having left their families in their country of origin*
- *Latinos who do have HIV are less likely to remain in care because of challenges including language, fear of disclosure of their HIV status, low literacy levels in both Spanish and English, lack of a support system since they have not disclosed their HIV status to their family, and a lack of culturally and linguistically appropriate resources within their health care facility.*
- *Poverty, with its associated lack of access to education, health care and support systems, may increase the challenge of taking precautions*

YOUTH

Nationally, approximately 26% of new HIV infections are in persons ages 13-24 in 2010. Within that group, the majority are males who have sex with males (MSM), and within those, the largest number is young MSM of color. Perhaps more troubling is the CDC estimation that 60% of HIV positive youth are unaware of their status.²¹ A major study released by the Centers for Disease Control in August 2011 found that although the rate of new HIV infections overall had stabilized, the rate of new infections in African American MSM ages 13-29 has risen an amazing 48%.²² Overall, young MSM represented the group most severely affected, with 27% of all new HIV infections in 2009. The study also noted that HIV infection in the Hispanic community was three times that of the rate in the white community.



Young women of color are also at risk, and most often this is a result of their having been infected by a partner who was also MSM. Because of the stigma attached to homosexuality in communities of color, it is less likely for male partners to disclose MSM behavior and less likely the MSM behavior will involve condom use.

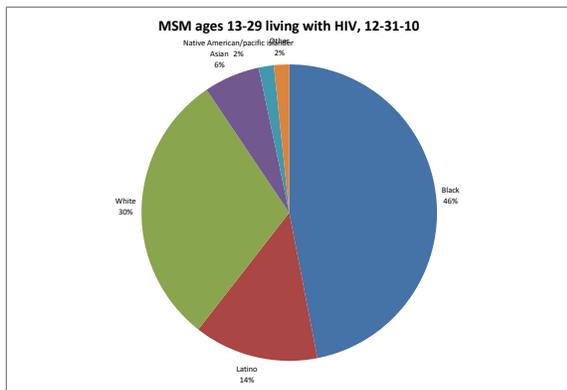
Mirroring the national trend, the prevalence of HIV among young MSM in Northern Virginia has been steadily increasing. 74% of those ages 13-29 living with HIV as of December 31, 2010 self identified as MSM, and of these, 73% were men of color.

²¹ Centers for Disease Control and Prevention, HIV Among Youth; <http://www.cdc.gov/hiv/risk/age/youth/index.html>, retrieved May 29, 2014.

²² Prejean, et al, “Estimated HIV Incidence in the United States, 2006-2009”. PLoS, 8-3-2011

Stigma and homophobia may have a profound impact on the lives of MSM, especially their mental and sexual health. Internalized homophobia may impact young men’s ability to make healthy choices, including decisions around sex and substance use. Stigma and homophobia may limit the willingness of MSM to access HIV prevention and care, isolate them from family and community support, and create cultural barriers that inhibit integration into social networks.

A 2010 Virginia Department of Health study of young African American MSM ages 16-24²³, conducted in response to the growing number of persons found to be HIV positive in this population, found that 75% of those surveyed reported engaging in unprotected sex within the past three months, and 40% reported engaging in unprotected anal sex. 38% reported they had met their sexual partners online and 34% had met in clubs. When asked about why they do not use protection, reasons cited included sex feeling better without a condom, sex occurring on the spur of the moment, trusting a partner and being in a relationship. A noteworthy 43% of the participants reported having experienced sexual abuse, which is known through numerous studies to put individuals at greater risk of having low self-esteem, and engaging in sexual risk taking.



When asked about why they do not use protection, reasons cited included sex feeling better without a condom, sex occurring on the spur of the moment, trusting a partner and being in a relationship. A noteworthy 43% of the participants reported having experienced sexual abuse, which is known through numerous studies to put individuals at greater risk of having low self-esteem, and engaging in sexual risk taking.

Virginia has taken a leadership role in addressing the prevalence of HIV among the young MSM of color population through its leadership in co-founding the community coalition known as THU FAM (Tenacity Health Unity Family Action Mentoring), an initiative by and for gay and bisexual men of color. THU FAM, launched in early 2011, set its mission to unite and empower communities of gay and bisexual men of color to improve overall health, reduce HIV and STIs, and to build self worth and triumph over stigma.

Individuals with a diagnosis of one or more sexually transmitted infections (STIs) are at greater risk of contracting HIV both because their diagnoses indicate a lack of protected sexual behavior and because STD infection increases their susceptibility.

A number of school systems in Northern Virginia conduct biennial Youth Risk Behavior Surveys. The most recent ones demonstrate a consistency of responses from the participating youth as to their sexual experiences. For example, in the 2013 report of the Fairfax county Youth Survey, 22.6% of the student respondents reported having had sexual intercourse in their lifetime in 2010, 2.26% in 2011, and 21.2% in 2012.²⁴ From the 2010 Youth Risk Behavior Survey in Arlington County report in March 2010, 31% of students reported ever having had intercourse.²⁵

²³ Virginia Department of Health, Division of Disease Prevention. “Report on Virginia’s Study of Young African-American Men who Have Sex with Men”, 3-26-10.

²⁴ Fairfax County Youth Survey, 2012-2013, A Publication of the Fairfax County, Va. And the Fairfax County Public Schools, Fall 2013, Table 57, pp. 79.

²⁵ 2013 Youth risk Behavior Survey – Grades 8, 10 & 12; Arlington county Schools, <http://www.apcyf.org/2014/01/yrbs/>, retrieved May 29, 2014.

Many of the same factors contribute to HIV infection in heterosexual youth, including a lack of accurate, comprehensive and sustained information delivered in a setting conducive to open and honest conversation, lack of opportunities to learn skills and discuss topics such as condom use, a lack of good negotiation and decision making skills, a belief they are invincible and that HIV belongs to “other people” combined with a belief that HIV is an easily treated chronic illness, the negative impact of drinking and substance abuse upon good decision making, and an overall lack of knowledge about sexual and reproductive health (including prevention of unplanned pregnancy and other sexually transmitted infections). Young women who experience dating violence are less likely to use condoms and less comfortable negotiating condom use. Socioeconomic factors, including financial dependence on male partners and low self-esteem, place young women at greater risk of infection.

Youth become homeless for many reasons. Some report being rejected by their families after coming out as gay, bisexual, lesbian or transgendered. Others are fleeing abusive homes. Some run away because of behavioral or substance abuse issues. These youth are at very high risk of contracting HIV and other STIs when they become affiliated with others HIV positive.

Factors Contributing to Risk

- *Having had their first sexual experience at a younger age.*
- *A belief that that the availability of treatment for HIV makes it a less threatening and easily treated chronic disease.*
- *A normal inclination to believe they are invincible.*
- *Reduced sexual impulse control.*
- *A lack of communication/negotiation skills regarding condom use.*
- *Social norms that equate unprotected sex with more pleasurable sex.*
- *Social norms that equate taking the HIV test with homosexuality and thus increased participation in HIV testing. Some individuals who do take HIV test and are negative more than once may begin to believe they are immune from infection.*
- *Some believe that having sex with a fellow member of the same race lowers the chances of infection.*
- *The use of substances that impair judgment and reduce inhibitions.*
- *Poverty increases risk, especially as it often limits access to health care services.*
- *Young MSM who are isolated and possibly estranged from their families are more likely to exchange sex for food or money (sometimes called survival sex); this is particular true of homeless youth, many of who are transgender. (See Transgender Section below.)*

- *If youth are HIV positive and entering the dating field may be significantly challenged in determining how to disclose their HIV status to their partners, making it more likely they will infect someone else and/or infect themselves with a different strain of HIV.*
- *Having a fear of violence associated with disclosing HIV status.*
- *The use of social networks to arrange anonymous sexual encounters.*

TRANSGENDER MEN AND WOMEN

Increasing numbers of individuals are in the process of altering their gender to be compatible with their gender identity.

Male to female transgendered individuals are at particularly high risk of becoming HIV positive. An estimated 25% of all MtF transwomen in the United States are estimated to be HIV positive. In Washington, D.C., 32% of transwomen are HIV positive, according to a needs assessment conducted in 2005.

Factors contributing to Risk

- *Young transwomen often face bullying in school and are less likely to finish high school and more likely to be very low income.*
- *Many struggle to find employment, housing and health insurance.*
- *They face difficulty accessing the required hormones and cannot afford gender reassignment surgery.*
- *The stigma associated with being transgender can lead to lower self esteem, increased likelihood of substance abuse, and a denial of risk.*
- *Low-income transwomen who retain male anatomy are more likely to engage in sex with other men as a means of earning income, i.e., selling sex for money. In these cases they have less ability to negotiate condom use.*
- *Transwomen who are low income sometimes have been known to use hormones obtained on the street or inject bathroom caulk to enhance their breasts, putting themselves at greater risk of HIV infection through shared needles.*
- *For those who are HIV positive, the fear of rejection and of not being able to exchange sex for money contributes to their unwillingness to disclose their HIV status, denying themselves HIV-treatment services*

- *Primary health providers are uncomfortable in addressing the particular health needs of transgendered individuals*
- *Many insurance plans specifically exclude coverage for care related to gender reassignment*

INCARCERATED

The rate of HIV positivity within the incarcerated community is estimated to be 5 times that of the general population. Statistics are not available for those who have become infected after they entered incarceration, but it is felt to be significant.

Factors Contributing to Risk

- *Being with a population that already has a significant number of persons who are HIV positive.*
- *Sexual behavior within the facility, especially men having sex with men.*
- *Sex is sometimes forced, increasing the chance of bodily injury and exposure to blood and body fluids.*
- *Post release – unprotected sex, sex for money, drug use – prevalent immediately after release. Prisoners who are also challenged by homelessness and mental illness after discharge are at especially high risk of engaging in behaviors that put them at risk of HIV infection.*

AFRICAN IMMIGRANTS

The African immigrant community, particularly those from Sub Saharan Africa, is growing in Northern Virginia. Anecdotally some believe that there has also been an increase in the number of those testing HIV positive. However, at the present time the Virginia Department of Health does not track HIV incidence in African immigrants separately from other Black people. Therefore, there is not quantitative data to support the theory. Others suspect that many African immigrants are coming into the country already HIV positive, but again there is no quantitative data available to support that premise.

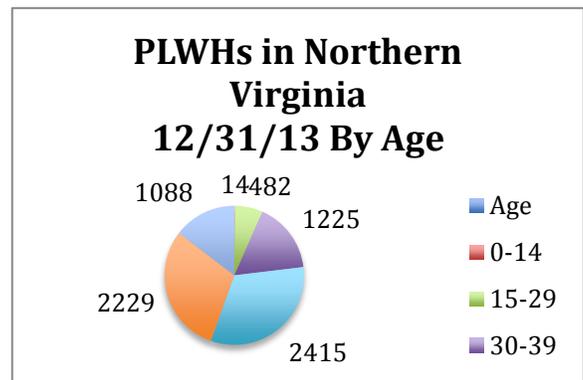
Factors Contributing to Risk

- *HIV/AIDS within the African community is viewed within the context of the country of origin, with differing cultures, religious and economic differences, as well as an often shared history of difficulty accessing medical care, high mortality associated with HIV, social isolation, and concerns related to immigration.*

- *Language and literacy challenges. Many come from Africa having experienced trauma and may have significant mental health issues.*
- *Substance abuse can influence poor decisionmaking and lack of commitment to safe behavioral practices.*
- *HIV positive individuals are often late coming into care because they have not been tested for HIV until they are quite ill.*
- *Some African cultures are very hierarchical and are not comfortable with discussions about sexuality and condom use, especially with the concept of educating women to be proactive about requesting condoms utilization.*
- *Many African immigrants automatically assume a diagnosis of HIV means death; this is exacerbated by their lack of exposure to the concept of preventive medicine and early intervention, and a belief that early treatment can hasten the progression of a disease instead of halting it.*
- *Some link a diagnosis with an assumption of having been engaged in illicit sexual encounters, or of being “gay” and thus do not seek or welcome HIV testing.*
- *There is significant stigma associated with male-to-male sexual contact within the African community, where the stigma associated with being MSM can lead to being disowned by a family and community. In some African countries it is against the law to have sex with another man, and in several it is punishable by death.*
- *There is fear of being known to be HIV positive and being shunned by their community and African immigrants who are HIV positive are known to go to tremendous lengths, including traveling out of state for care, to ensure their families and communities do not know their status.*
- *With the change in immigration law, HIV testing is not routine upon arrival to US, there is a reduced opportunity to diagnose and link into care (although good in terms of not deporting people).*

OLDER ADULTS

With the advent of effective medications that preserve and protect the lives of those living with HIV, there are increasing numbers of PLWHs living well beyond age 50. For these individuals, it is critical they continue to receive prevention messages. An estimated half of those living with HIV in the United States will be 50 or older by 2017, according to the Yale Medical School. *In Northern Virginia, 45% of*



the known PLWH were aged 50 or over in December 2013.

Older adults are also at risk of contracting HIV because they have many of the same risk factors for HIV infection that younger persons have.

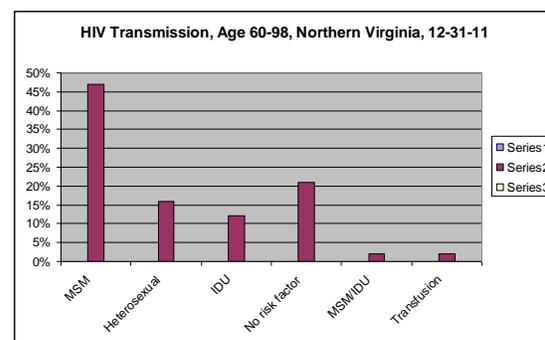
In 2009, persons aged 50 and older in the United States accounted for 16% of new HIV infections, and 23% of all new AIDS diagnoses, an increase from 17% in 2001. In addition, 39% of all deaths of persons with AIDS were aged 50 or older. Overall, 29% of those living with HIV are over the age of 50.

The rates of HIV/AIDS, in persons 50 and older were 12 times as high among blacks and 5 times as high among Hispanics compared with whites.

In Northern Virginia, there were 1,088 persons age 60 and older known to be living with HIV disease in 2013. Statewide, 48 people were first diagnosed with HIV in 2013 were over 60, up from the 36 diagnosed in 2009 at that age.²⁶

Factors Contributing to Risk

- *Many older persons are sexually active but may not be practicing safer sex to reduce their risk for HIV infection*
- *Many older individuals underestimate risk/underestimate the number of partners others may have had*
- *Because of the greater number of older women vs. older men, older men are more likely to have multiple sexual partners*
- *Older individuals, especially women, may have limited skills related to negotiation of condom use even if aware of the potential risk*
- *Older women may be especially at risk because age-related vaginal thinning and dryness can cause tears in the vaginal area.*
- *There is no fear of pregnancy.*
- *Some older persons use drugs, including alcohol. HIV transmission through injection drug use accounts for more than 16% of AIDS cases among persons aged 50 and older.*



²⁶ Virginia Department of Health. Quarterly / Annual Surveillance Report, December 31, 2013. https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/data/QuarterlySurveillanceReport4_Q_13.htm

- *Some older persons, compared with those who are younger, may be less knowledgeable about HIV/AIDS and therefore less likely to protect themselves. Many do not perceive themselves as at risk for HIV, do not use condoms, and do not get tested for HIV.*
- *Older persons of minority races/ethnicities may face discrimination and stigma that can lead to later testing, diagnosis, and reluctance to seek services*
- *Health care professionals may underestimate their older patients' risk for HIV/AIDS and thus may miss opportunities to deliver prevention messages, offer HIV testing, or make an early diagnosis that could help their patients get early care.*
- *Physicians may miss a diagnosis of AIDS because some symptoms can mimic those of normal aging, for example, fatigue, weight loss, and mental confusion. Early diagnosis, which typically leads to the prescription of HAART and to other medical and social services, can improve a person's chances of living a longer and healthier life. In this population, there is more late stage diagnosis of HIV than diagnosis at the acute stage*
- *The stigma of HIV/AIDS may be more severe among older persons, leading them to hide their diagnosis from family and friends. Failure to disclose HIV infection may limit or preclude potential emotional and practical support.*

PART TWO: TARGETED POPULATIONS IN NORTHERN VIRGINIA

The incidence of HIV in Northern Virginia is significant and crosses all age, racial and transmission lines. While acknowledging the need for broad HIV prevention education efforts, the RPG believes that tailored prevention efforts are needed that address the unique challenges and opportunities within specific population group.

The RPG recognized that the history of limited prevention dollars available to the region represents the near future in support for prevention programs. With that in mind, it was important to the group to consider the limited prevention resources, the data in Northern Virginia, the apparent data trends, and the recommendations of those who are knowledgeable about the prevention of HIV infection.

With those factors in mind, the RPG selected the populations that should be at the highest priority for HIV prevention efforts in Northern Virginia:

- 1. Persons who are HIV positive and are not receiving ongoing, primary medical care including HAART**
- 2. Men who have sex with other men, with an emphasis upon:**
 - **Men of color**
 - **Youth and young adults of color up to age 29**

These target populations are consistent with the recommendations of the National HIV Strategies.

PART THREE: RECOMMENDATIONS FOR NORTHERN VIRGINIA

The National Prevention Information Network of the Centers for Disease Control states that successful HIV prevention programs are comprehensive, science-based and incorporate these elements:

- An effective community planning process
- Epidemiological and behavioral surveillance; compilation of other health and demographic data relevant to HIV risks, incidence, or prevalence
- HIV counseling, testing, and referral, and partner counseling and referral, with strong linkages to medical care, treatment, and prevention services
- Health education and risk reduction activities, including individual-, group-, and community-level interventions
- Accessible diagnosis and treatment of other STDs
- Public information and education programs
- Comprehensive school health programs
- Training and quality assurance
- HIV prevention capacity-building activities
- An HIV prevention technical assistance assessment and plan
- Evaluation of major program activities, interventions, and services

As the Regional Prevention Group (RPG) considered these elements, it focused upon the data that had been provided both by VDH and by local AIDS Service Organizations. Both quantitative data and front line experiences were considered, and the comments of every member of the group received equal consideration. The brainstormed comments provided another block of data that the RPG used to develop the recommendations that follow. (The unedited comments on prevention activities as they were collected in RPG meetings are found in the Appendix B.)

The RPG determined to divide its recommendations into six key areas that each must be met to successfully turn the curve of new cases of HIV each year to a downward trend line. While every prevention program will most likely not meet all six of these issue areas, the region as a whole must collectively address all six.

The recommendations that follow are not an indication of whether or not the activity is already in place within the region. Rather, they are intended for guidance to any organization, agency, or community group that chooses to invest in HIV prevention treatment and education work in the Northern Virginia region. The recommendations begin with its priority area – HIV Testing.

A. EXPAND HIV TESTING

1. Expand HIV testing across the region, with care that testing is structured to overcome barriers that prevent the service from being used, that reinforce attitudes against testing, or that pre-judge the results. Remove requirements for intensive counseling.
2. Expand Syphilis and STD screening sites throughout NOVA, with concurrent HIV testing.

3. Engage more of the private sector health care providers in testing regularly and for everyone.
4. Insist state certified community health centers, free clinics, and other similar providers be provided with free HIV tests to facilitate HIV testing at these sites.
5. Create HIV testing programs that are bundled with other health screenings such as cholesterol and blood pressure to couple HIV testing with another type of health screening.
6. Expand the successful Rainbow Tuesdays at Alexandria Health Department to more locations throughout the region.
7. Recognize the role that the ‘ball house’ community²⁷ can play in HIV transmission and prevention education, and facilitate testing programs directly within these communities. *In 2014, there are no known houses in Northern Virginia; however, these communities are known in Norfolk and in DC.*
8. Make available HIV testing of high-risk immigrants or incorporate HIV testing programs within programs in the region that serve new immigrants to the U.S.

B. REDUCE STIGMA

1. Improve an understanding of stigma, and a commitment to reduce stigma and discrimination, particularly within the public health and health care delivery communities that provide HIV treatment or testing services.
2. Provide public awareness campaigns targeted to help reduce stigma within the African American community, including public education and stigma reduction strategies. Groups that should be encouraged to participate include the faith communities; other groups of color such NAACP, black fraternities and sororities; funders; and testing sites.
3. Provide leadership on the need to reduce stigma among Latinos by increasing awareness of HIV / AIDS and providing prevention education among Latino men and women that focuses on breaking the stigmas and myths that surround HIV / AIDS.
4. For additional information about Stigma, see Appendix C page 33.

C. ACCESS TO CARE AND MEDICATIONS

1. Support Community Health Centers that provide health services for low income or uninsured individuals and link people with HIV to care.
2. Provide appropriate sources of HIV health care for Latinos.
3. Employ and train more bilingual staff in health care settings and partnership with community groups that provide HIV support services.
4. Develop system to document patterns of travel by persons living with HIV from diagnosis to treatment provider to learn if and where gaps in services may exist and how referrals among providers are currently working effectively.

²⁷ “Commonly called “Drag Balls”, balls are competitive dance and performance events based on categories that highlight the talents, creativity, skills and attributes of participants...Balls are organized and hosted by the heads of “houses”, which are chosen-family kinship networks that provide both community (in the form of safety, stability, and sometimes housing) and mentorship to community members (and especially youth), not only for the balls, but for life as a queer person.” *The Network for LGBT Health Equity, House Balls: Keeping LGBT Community Health in Vogue, Daniella Matthews-Trigg, February 21, 2013.*

5. Eliminate or prevent waiting list for any public HIV drug assistance program to facilitate access to medications for all.
6. Provide more cultural competency training for health care workers
7. Provide more sensitivity training for health care providers to build competency in the delivery of transgendered health care services
8. Provide education to primary care providers to ensure a discussion of sexual health is introduced by the provider
9. Make nPEP (non-occupational post exposure prophylaxis) therapies available. Any nPEP should be made available within 72 hours of a risk event, to any individual regardless of health insurance status, as a means to prevention HIV infection
10. Make PrEP (Pre-exposure Prophylaxis) therapies available. PrEP therapies should be made available to any individual that may choose to use this method as a means to prevention HIV infection

D. PREVENTION INTERVENTIONS

1. Support the use of HIV prevention programs that focus on education and behavior change strategies for the target populations, funded with grants and other resources.
2. Strengthen “Prevention for Positives” programs for all races, genders, and sexual orientations, and that are in place within the public and private health care delivery systems. Place a particular emphasis on programs that are designed to reach the region’s target populations.
3. Support prevention programs that reach young MSM, especially programs that consider the behaviors of young men of color.
4. Educate parents about HIV and education techniques, and offer resources to facilitate open communication with their teens
5. Connect with existing public and private substance abuse programs to reinforce effective methods of avoiding HIV transmission.

E. SUPPORT COLLABORATIONS AMONG PROVIDERS

1. Encourage HIV-service organizations to regularly evaluate collaboration with other agencies and programs that have an interest in the reduction of HIV in order to strengthen collaborations for improved program outcomes.
2. Enhance collaboration with groups trusted by target populations, especially Latino MSM's and young men of color.
3. Provide capacity building support for prevention-focused activities; one activity might be facilitated discussions with prevention-focused AIDS Service Organization’s to learn if centralizing certain administrative functions would help dollars go farther toward prevention programs.

4. Monitor VDH and federal epidemiological programs for assessments that document when the programs are working in reducing incidence rates; use these data to advocate for continued funding for programs working in targeted populations.

F. ADVOCACY

1. Monitor and advocate for public policies that assure the human rights of Latino immigrants living with HIV
2. Develop local or regional advocacy groups to educate city and county public officials to raise the issue of HIV prevention as a priority, and to develop and support new and innovative prevention initiatives at the local as well as regional or statewide level.
3. Through NVRC, educate the leadership in the region's jurisdictions to the issues that prevent the region from successfully acquiring resources necessary for effective HIV prevention²⁸
4. With "prevention for positives" activities, include advocacy for funding of other prevention education strategies to State leaders. Steer funding toward proven HIV-prevention programs targeting the priority population.
5. Create a Northern Virginia HIV/STI community calendar of testing and prevention events, using the web and social media methods to promote the events to the public.

To make this written report a living document, the RPG recommends to the Northern Virginia HIV Consortium that it review these recommendations each year and to assess if activities are or are not underway in all six areas. This review will provide the Consortium's members with up-to-date information on prevention activities already in place and where gaps exist. It would be the expectation that then members would work individually and collectively to fill those gaps.

²⁸ NVRC is a regional planning agency, sanctioned by Virginia Code, and led by local elected officials from each of the local governments in the region. NVRC is the governmental agency that also approves and monitors the administration of federal Ryan White and HOPWA funds awarded to the region.

APPENDIX A

RPG MEMBERS

Tim Agar	Northern Virginia Regional Commission (NVRC)
Phillip Bailey	Person Living with HIV (Loudoun county)
Shimeles Bekele	Ethiopian Community Development Council (ECDC)
Martha Cameron	Person Living with HIV
Marco Castillo	K.I. Services
Maynor Correa	Planned Parenthood of Metro Washington
Hugo Delgado	NOVA Salud
Debby Dimon	Alexandria Health Department
Suzanne Dorick	Fairfax County Health Department
Phylicia Echols	K.I. Services
Soraya Galeas	Planned Parenthood of Metro Washington
Lilibeth Grandas	Arlington Health Department
Kirstin Hansen	NOVAM
David Hoover	Inova Juniper
Cat Hulbert	Virginia Department of Health (central office)
Carol Jameson	Northern Virginia AIDS Ministry (NOVAM)
Kimberly Jappell	NOVAM
Ellin Kao	NOVA Salud
Sue Rowland	Virginia Organizations Responding to AIDS (VORA)
Beth Robinson	Loudoun Health Department
Oana Vasiliu	Virginia Department of Health (central office)
Christina Willut	Prince William Health Department

APPENDIX B

PREVENTION ACTIVITIES NECESSARY TO IMPACT CHANGE

What follows are the notes collected during brainstorming among the RPG members when asked to identify elements in prevention programs necessary for success.

MEN WHO HAVE SEX WITH MEN

- Accessible HIV counseling and testing in a setting that is comfortable for target population
- PreExposure Prophylaxis (PrEP) in a comprehensive HIV prevention program targeting HIV negative people who are at high risk (PrEP involves taking antiretroviral medication daily to lower the risk of becoming infected with HIV if exposed).
- Programs that utilize peer education
- Programs that are community-based
- Programs that are culturally and linguistically appropriate to the targeted population
- Partnerships with faith communities that include stigma reduction components
- Programs that utilize social media tools
- Programs that address stigma and discrimination, underlying issues, especially for HIV positive men also dealing with personal issues around disclosure
- Provision of education to primary care providers to ensure a discussion of sexual health is introduced by the provider

AFRICAN AMERICANS

- HIV prevention programs must be culturally appropriate and utilize educators from the African American community
- Increased HIV testing programs within the African American community
- HIV testing programs that are bundled with other health screenings such as cholesterol and blood pressure
- Access to condoms
- Programs for women that teach reproductive health, prevention of sexually transmitted infections including HIV, as well as help women to develop negotiation and communication skills

- For newly diagnosed persons with HIV, pro-active support from persons who are culturally knowledgeable to help ensure linkage into a care provider
- Cultural competency training for health care workers
- Collaborations with the faith community
- Programs that utilize peers educators
- Programs that are delivered in a safe and confidential manner, especially for non-identifying men who have sex with men

WOMEN OF COLOR

- Specifically address HIV prevention efforts to those also suffering from poverty by taking programs into neighborhoods and communities where they are accessible
- Utilize programs that are multi-session, small group and promote mutual support and learning
- Develop and implement programs that distribute female condoms
- Utilize programs that build skills in negotiation, communication, decision making and appropriate condom utilization, providing participants with the confidence to make healthy decisions for themselves
- Utilize programs that are culturally and linguistically appropriate
- Incorporate prevention and education into other settings such as family planning, Diabetes and high blood pressure clinics
- Build upon other successful programs that specifically target sex workers and implement in Northern Virginia

LATINO / LATINA

- HIV prevention programs that are culturally and linguistically appropriate and that utilize educators from the Latino community
- Increased HIV testing programs within the Latino community
- HIV testing programs that are bundled with other health screenings such as cholesterol and blood pressure
- Access to condoms

- Programs for Latina women that teach reproductive health, prevention of sexually transmitted infections including HIV, as well as help women to develop negotiation and communication skills
- For newly diagnosed persons with HIV, pro-active support from persons who are bilingual and culturally knowledgeable to help ensure linkage into a care provider
- Health care materials in Spanish that are suitable for multiple literacy levels
- Cultural competency training for health care workers
- Outreach to primary care physicians that provide care to the Latino community
- Collaborations with faith communities that serve the Latino community
- Programs that utilize Latino peers
- Programs that are delivered in a safe and confidential manner, especially for non-identifying men who have sex with men
- Collaborations with groups that attract Latino MSM, such as the pageant circuit

YOUTH

- Programs that are comprehensive and reach youth in their teens, preferably starting in middle school – and are respectful of developmental age
- Programs that are accessible, confidential and promote open discussions and questions
- Programs that involve peers as educators
- Programs that are interactive and include role playing to increase negotiation, communication and decision making skills
- Access to education materials in multiple formats that are culturally and linguistically appropriate
- Programs facilitated by members of the target population
- Use of social media
- Involvement of the faith community
- Access to free condoms

- Accessibility to free and confidential HIV testing with risk reduction counseling
- Sustained intervention rather than a one time program

TRANSGENDER MEN AND WOMEN

- Programs are needed that recognize the special needs of transgendered individuals, particularly transwomen who continue to engage in sex with men
- Best practice programs are considered to be those that address the unique psychosocial needs and challenges of transwomen
- Utilize transgendered peers in HIV prevention education
- Sensitivity training for health care providers to build competency in the delivery of transgendered health care services
- Addition to HIV tracking data of fields to capture transgendered persons, recommended as “gender at birth” and “current gender”

INCARCERATED PEOPLE

- Based on the model of the Illinois Dept. of Corrections, in collaboration with AIDS Foundation Chicago, provide HIV education within the prison system and through assigned case managers, and ensure those leaving the system are linked with treatment and care.
- Provide HIV testing to inmates prior to release from incarceration. In 2011, Virginia enacted a law offering such testing within 60 days of prisoners’ scheduled release.

AFRICAN IMMIGRANTS

- Increase/initiate programs to link new African immigrants into public health system.
- Hire and train more multi-lingual and culturally sensitive health care providers and peer educators; coupled with written materials in native languages
- Avoid stigma and discrimination in the health setting by establishing an environment of tolerance and acceptance; provide sensitivity training to private and public medical providers
- Identify/initiate activities to increase awareness of HIV/AIDS among African immigrants, focusing on breaking stigmas and myths that surround HIV/AIDS and homosexuality
- Incorporate health messages into arts – music, theatre – or house parties

- Work through influential families in community – community health workers
- Incorporate HIV prevention and counseling in the medical setting and as a routine health check.
- Directly address stigma of AIDS as barrier to care and prevention.
- Engage with faith communities within specific African immigrant communities
- Support specific funding streams for prevention, research, and care programs for the African immigrant population.

OLDER ADULTS

- The CDC recommends routine HIV screening for adults including persons up to age 64. (Persons aged 64 and over should be counseled to receive HIV testing if they have risk factors for HIV infection.) Routine testing is intended not only to identify persons who are unaware that they are HIV infected but also to remove the stigma of being tested. Making testing routine for older persons can help open a discussion about risk behavior between a physician and an older person.
- Prevention strategies should be developed for older persons who are potentially at risk for HIV infection: education to increase awareness and knowledge, skills training to help them negotiate risk-reduction behaviors, and messages that are age-appropriate and culturally sensitive.
- Intervention strategies to help older women negotiate safer sexual behavior are especially important.
- Targeted HIV prevention programs for senior centers and retirement communities
- Availability of condoms in retirement communities
- Utilization of other health prevention education approaches that have been successful with older adults

APPENDIX C

STIGMA:

Stigma is a complex social process.

Stigma is a degrading and debasing attitude of the society that discredits a person or a group because of an attribute (such as an illness, deformity, color, nationality, religion etc. The resulting coping behavior of affected person results in internalized stigma. This perceived or internalized stigma by the discredited person is equally destructive whether or not actual discrimination occurs. Stigma destroys a person's dignity; marginalizes affected individuals; violates basic human rights; markedly diminishes the chances of a stigmatized person of achieving full potential; and seriously hampers pursuit of happiness and contentment.

When stigma is associated with a medical condition or disability it prevents individuals from seeking evaluation and treatment, disclosing the diagnosis to the people most likely to provide support and in following treatment guidelines. While there are many illnesses such as leprosy that have been severely stigmatized in the past, it is generally agreed that HIV/AIDS is the most stigmatized medical condition in the history of mankind. While society elevates the status of those receiving treatment for some conditions such as cancer or serious injuries as heroes, those who have acquired HIV are subjected to layers upon layers of stigma with assumptions that these individuals are deserving of punishment for their "assumed behavior that led them to get HIV" and they are often shunned.

Stigma prevents individuals from getting tested for HIV, seeking medical care, disclosing diagnosis and in adhering to treatment and follow up. Fear of social abandonment and losing intimate partners prevents many with HIV from sharing the diagnosis with their loved ones and sexual partners. **Stigma has become a major reason why HIV epidemic continues and millions of people are getting infected and dying with HIV every year.**

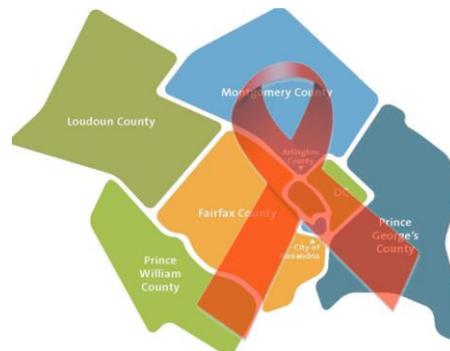
Credit to Howard University.

APPENDIX D

The Profiles Project:

How the Washington, DC Suburbs Respond to

HIV/AIDS



Northern Virginia's Response to HIV/AIDS - The Profiles Project

Introduction: This report summarizes information from the benchmarking reports on the response to HIV/AIDS in the five Northern Virginia Health Districts: Alexandria City, Arlington County, Fairfax (which includes Fairfax County and Fairfax and Falls Church cities), Loudoun County, and Prince William (which includes Prince William County and Manassas and Manassas Park cities). The information in those reports comes from a combination of group meetings and individual interviews with key informants in each jurisdiction (such as Health District/county HIV/AIDS program personnel, other HIV/AIDS providers, providers of non-HIV-specific health and human services, and PLWH); discussions with area planning bodies; interviews with officials responsible for Family Life Education/sexuality education curriculum in most of the jurisdictions and with knowledgeable educators in the other locations; consultation with the project's Northern Virginia Advisory Group; an online survey of safety net clinics; interviews with state HIV/AIDS officials; review of surveillance data obtained from the state and program funding information from state and area sources; and review of a large variety of written and online materials (such as state prevention plans, local health plans, funding applications, needs assessments, Statewide Coordinated Statement of Need, minutes and handouts from planning and advisory body meetings, online and printed resource guides, and provider websites). Information was obtained during 2009. The reports used a set of benchmarks developed by Mosaica based on 15 years of work with Ryan White programs across the country, and reflect advice from the Northern Virginia Advisory Group, other key informants, and national and local HIV/AIDS experts.

Information in this report was reviewed and updated at the end of 2009. It provides a snapshot in time on response to HIV/AIDS by health departments, schools, other public agencies, hospitals and clinics, community-based nonprofit groups, planning bodies, and other entities in the five Northern Virginia health districts. The identified action areas indicate areas where work is needed by these entities, consumers, and other residents, and reflect information from key informants as well as use of the benchmarks.

The Northern Virginia Region

Action Areas

The health
family
City and

Population: The Northern Virginia Health Region has a population of about 2.1 million, up almost 14% from 2000. Districts vary in size from Alexandria at about 141,000 to Fairfax at 1.04 million. It has lower unemployment and higher income than Virginia as a whole. In September 2009, the unemployment rates in the major jurisdictions (Alexandria the four counties) ranged from a low of 4.2% in Alexandria to a high of 5.4% in Fairfax County; the Virginia state unemployment rate was 7.6.7%. The median family income in these five jurisdictions ranged from \$95,000 (Prince

William County) to \$128,000 (Arlington County); the state's median family income was almost \$73,000. The region is racially and ethnically diverse. All jurisdictions are majority White non-Hispanic. The African American population is largest in Alexandria and Prince William County, the Latino population in Prince William County and Manassas, and the Asian population in Fairfax County. Most jurisdictions have a populations that are about one-fourth foreign born. The region has a high level of educational attainment. In Prince William County, 37% of residents have at least a bachelor's degree; in the other four large jurisdictions, nearly well over half of residents are college graduates (the rates range from 56% in Loudoun County to 68% in Arlington County).

HIV/AIDS: As of December 31, 2008, there are 6,008 people living with HIV/AIDS (PLWH) in the Northern Virginia region, according to the Virginia Department of Health (VDH) - 52% have an AIDS diagnosis and 48% have HIV but not AIDS. This represents a prevalence (living case) rate of 297 per 100,000 population - about 0.3% of the population is known to be HIV- positive. This is slightly higher than the Virginia rate of 263. About 29% of the state's PLWH live in Northern Virginia. The largest *number* of PLWH (2,287 or 38% of the region's PLWH) live in the Fairfax Health District, which also has by far the largest overall population. HIV/AIDS prevalence (living case) rates are higher in the most urbanized areas of Northern Virginia - Alexandria (894) and Arlington County (621), and lowest in Loudoun County (83). In Northern Virginia, 308 people were diagnosed with HIV or AIDS in 2008. The HIV/AIDS incidence (new case) rate in the Northern Region 15.2 cases per 100,000 population, slightly above the 14.7 rate for the state as a whole. HIV/AIDS incidence rates are above the state level in the Alexandria, Arlington, and Prince William Health Districts. One-fourth of the people living with HIV or AIDS (PLWH) in Northern Virginia are women; the proportion of women ranges from a low of 18% in Arlington to a high of 31% in the Prince William Health District. Almost half (48%) of PLWH are African American or African, 37% are White non-Hispanic, 12% Hispanic, and 3% other. The risk factor for almost half (46%) of all PLWH was men having sex with men (MSM); heterosexual sex was second (22%).¹ These incidence and prevalence data are based on where an individual was diagnosed, not where s/he currently lives. PLWH frequently move within and across states. The assumption made, in the absence of other data, is that in-migration equals outmigration.

Note: Population data are 2006-2008 averages from the Census Bureau's American Community Survey, unless otherwise indicated. HIV/AIDS surveillance data : as of December 31, 2008, and were provided by the Virginia Department of Health.

Action Areas	Summary of Facts and Findings
#1 - HIV Education and Prevention in the Public Schools	
<p>Provide a consistent community voice on school system advisory bodies and in meetings, in support of age-appropriate Family Life Education (FLE) including HIV education and safer sex methods, with condom demonstrations</p> <p>Work for:</p> <ul style="list-style-type: none"> • Improved state and local curriculum that includes sexuality education and HIV prevention methods • Consistent use of full curriculum in all schools • Enhanced teacher training, and use of Health Department or nonprofit experts to handle challenging units • Increased use of nonprofit prevention experts in the schools to provide after-school programs and presentations as well as help teach classes • Monitoring and evaluation of curriculum and its implementation 	<p>There are great variations in what Family Life Education (FLE) includes with regard to HIV prevention, when and how it is taught, and whether and to what extent experts from the Health Department and nonprofit organizations (like NOVAM) are allowed in the schools to help teach units and/or provide after-school sessions for interested students. [In addition to obtaining information from key informants, Mosaica was able to interview the public school official responsible for FLE in all counties except Prince William.]</p> <p>State law and opt-out procedures: Virginia law calls for Family Life Education instruction, but does not mandate inclusion of either sexuality education or HIV/STI education. When such topics are covered, both abstinence and contraception must be covered. Parents have the right to opt out of FLE classes on behalf of their children. School systems vary in how they publicize and manage opt-out procedures; all report low opt-out rates, generally 2% or less.</p> <p>Curriculum used: The State of Virginia provides curriculum mandates and guidelines. Some counties say they use primarily the state FLE curriculum, while others - such as Arlington and Alexandria - add considerable content. Most systems have some FLE units at the elementary, middle, and high school levels; sexuality education may begin as early as 4th grade or as late as middle school.</p> <p>Teachers and teaching: Use of the curriculum varies considerably across schools, with the principal often the primary decision maker and teachers making varied and inconsistent use of FLE curriculum. Important factors include who teaches the classes, how much training they receive, their comfort level with the subject matter, and how much flexibility they are given. Key informants described situations in which teachers uncomfortable with a particular unit or topic (often sexuality education, HIV prevention, or condom use) did not cover it or did allow any student questions. There are great variations in teacher preparation, from a few hours as required by the state to 15 hours of training to a required three-credit graduate course. Teacher monitoring appears similarly varied. Arlington County described a two-year evaluation of its program using outside evaluators.</p> <p>Use of outside experts: All the school systems allow some external experts on HIV prevention, such as public health nurses and/or NOVAM, in some schools to do some</p>

Action Areas	Summary of Facts and Findings
<p>prevention services, which can lead to large cost savings by preventing infections³</p> <ul style="list-style-type: none"> • Explore possibilities (including joint fundraising) for a joint regional social marketing or media campaign with a prevention and testing message 	<p>current state of HIV prevention, testing, and care. This information will be used as part of the new Epi Profile and the next Comprehensive Plan.</p> <p>The HIV Prevention Subcommittee of the Northern Virginia Regional HIV Consortium works with other providers to develop a variety of HIV outreach and prevention activities tied to particular days such as National HIV Testing Day and World AIDS Day. One stated purpose of the Consortium is to serve as a planning body for HIV prevention and health and social services for people living with and affected by HIV/AIDS." It offers a regular opportunity for those providing prevention activities to meet, network, and develop collaborative activities. It does not prepare regional planning documents, and participation is voluntary, but it has the potential to improve prevention planning and coordination across the region.</p> <p>County prevention planning: None of the Northern Virginia Health Districts has a prevention plan or a process for prevention planning and coordination at the county level. Arlington's STI Strategic Intervention Team, a part of the Partnership for a Healthier Arlington, has expressed interest in doing prevention planning. Alexandria's HIV/AIDS Commission has not taken on a planning role. The other counties have no entity that could easily take on prevention planning or coordination.</p> <p>Primary prevention: Primary prevention programs (efforts targeting individuals not known to have HIV) are limited and underfunded - and are being further reduced due current budget shortfalls. The region once had access to federal funds for prevention from the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA), through the Substance Abuse Prevention and Treatment Block Grant Program, but Virginia lost funding in 2008 because AIDS its incidence rate went below 10 cases per 100,000 population. Generally, Health Department staff offer some prevention education in places like HIV/STI clinics, but rely largely on nonprofit organizations to provide community-based prevention services. Several regional nonprofit prevention providers target specific populations based on age, race/ethnicity, sexual orientation, and risk factors. Key informants agree that most provide caring and competent services, but funds are increasingly limited. Fairfax County key informants, public and private, noted the need for primary prevention initiatives that target not only identified populations with high levels of HIV/AIDS, but also population groups that may not yet have high HIV rates - because the general population is at some risk.</p>

Action Areas	Summary of Facts and Findings
	<p>Community-based prevention outreach: Prevention outreach funds are especially limited. Most Northern Virginia residents, including those engaging in high-risk behavior, are unlikely to encounter a prevention program unless they actively seek out such services and know where to look for them. County health personnel generally say they have few or no resources or programs devoted to bringing primary prevention services to the community.</p> <p>Social marketing: As of the end of 2009, there was no regional social marketing or other ongoing media outreach with a prevention message, and very little at the city or county level. Arlington's STI Strategic Initiative Team has identified this as a high-priority need, as have several other counties. Fairfax Health District has worked with the Northern Virginia Clergy Council for the Prevention of HIV/AIDS to develop a 14-minute video called "Break the Silence," which was to be disseminated to faith-based and other community entities. Prince William has a consistent prevention message, <i>Know how to protect yourself from HIV/AIDS</i>, that is integrated into HIV and other prevention efforts, especially teen pregnancy prevention and efforts to reduce risky behavior and encourage healthy lifestyles among teenagers. Arlington key informants emphasized the value of social marketing to motivate people, especially young adults, to get tested.</p> <p>VDH indicates plans for a social marketing campaign in three regions of Virginia beginning in 2010. It will promote HIV prevention and care among people who are living with HIV and will address stigma.</p>
#3 - Counseling, Testing, and Referral (CTR)	
<p>Work for:</p> <ul style="list-style-type: none"> • Increased community testing options, based on a county or regional prevention plan • Increased availability of rapid test kits, including kits or funding for nonprofit groups and safety net clinics • Adoption of CDC recommended guidelines for opt-out testing in all healthcare settings - with emphasis on clinics and 	<p>The level and accessibility of counseling and testing vary greatly by health district. In some areas, HIV testing occurs primarily in health departments; in others, residents have access to multiple testing sites and organizations. Many opportunities for testing in clinics, emergency departments, and community settings are lost through a lack of coordinated planning, priority, funding, and/or rapid test kits.</p> <p>CDC recommendations: Most medical providers in Northern Virginia are not following CDC recommendations for routine opt-out testing in all healthcare settings. The Commonwealth of Virginia supports CDC's recommended opt-out HIV testing in medical facilities and in hospital emergency departments. Only two of ten Northern Virginia safety net clinics surveyed (three of which are federally qualified health centers) said they follow the CDC</p>

Action Areas	Summary of Facts and Findings
<p>individual physicians</p> <ul style="list-style-type: none"> • Testing in hospital emergency departments⁴ • Adoption of testing and referral policies by all safety net clinics • Bulk buying or other means of reducing the cost of test kits that for qualified providers that either do not receive test kits from the state or the counties/health districts or require more test kits than they receive 	<p>guidelines. Educating safety net clinic personnel and private physicians about the CDC guidelines was specifically identified as a high priority in Loudoun and Arlington counties.</p> <p>Testing in hospital emergency departments: One hospital in the region, Inova Alexandria Hospital, has initiated rapid testing in its emergency department. Other hospitals have thus far declined to consider this option, which is favored by CDC and supported financially through the states. Some hospitals reportedly test only in relation to an immediate treatment need, and refer everyone else to the health department for testing; many never get to the health department.</p> <p>Testing locations and coordination: In some parts of the region, HIV testing occurs primarily in health departments, sometimes during limited time periods, and many high-risk individuals are not being reached. In other health districts, residents have access to multiple testing locations and organizations. For example, Alexandria Health Department provides testing in multiple sites (including its Adolescent Clinic, new Rainbow Clinic, and community locations), and collaborates closely with nonprofit providers. K.I. Services and NOVAM provide testing in community locations throughout the region, limited primarily by resource constraints. Key informants in Fairfax County noted that few entities conduct "proactive" rapid HIV testing -- that is, the person is offered the test rather than coming to request testing. Staff at most of the health departments said they would like to see testing in additional locations, but lack the resources to accomplish this.</p> <p>Access to rapid test kits: The Virginia Department of Health expects health districts to use rapid tests for what it defines as the highest risk populations, in situations where rapid tests are needed - such as venues where people might not return for test results if conventional testing is used. Some Northern Virginia health departments, clinics, and nonprofit providers report insufficient access to rapid test kits. For example, Loudoun County reported not having rapid test kits, a hospital-based program in Prince William County indicated a desire to do testing but a lack of funds for test kits, and safety net clinics in several counties said they cannot afford the kits. Arlington County reported that it has adequate supplies, but that this may be a result of using the less expensive "finger sticks" rather than "mouth tests." One halfway house in Fairfax County reported that a lack of test kits has meant monthly conventional testing with a one-month wait for results; this long wait interferes with its behavior change efforts. Prevention funds provided to the state by the CDC have been decreasing for years; the state received less prevention funding for 2010 than it did in 2001.</p>

Action Areas	Summary of Facts and Findings
	<p>VDH is working hard to maximize the use of rapid tests despite funding limitations, and has increased the number of rapid tests conducted every year since 2004. However, funding remains a serious barrier. For entities not receiving test kits through VDH, there is no coordinated cross-county process to maximize access through bulk purchases or negotiations to obtain best prices. There is widespread agreement that people are lost to testing where conventional testing is used in settings other than the individual's medical home or a place the person being tested visits regularly. Key informants hope that with new Ryan White legislation mandating 5 million HIV tests a year and requiring Ryan White Part A and Part B programs to focus on testing people and linking them to care, access to test kits and related resources will increase.</p> <p>Testing in clinics: There has been no collaborative effort to ensure that non-HIV/AIDS focused primary care providers such as federally qualified health centers (FQHCs), free clinics, and other safety net clinics are informed about HIV testing and adopt and consistently follow clear policies on HIV testing and referrals. A 2009 survey of ten such clinics in Northern Virginia - none of which have HIV/AIDS-specific funding - found that only six do testing, none does rapid testing, four have policies around testing people as a part of physical examinations, and five have policies about testing people who are believed to be high-risk and present with symptoms of HIV/AIDS. As a result of the Profiles Project, the area safety net clinics, through the Northern Virginia Health Services Coalition (NVHSC), have made addressing this issue a Coalition goal for 2009-2010. NVHSC plans to work with Mosaica, Inova Juniper, K.I. Services, and NOVAM to develop policies and strengthen collaboration and referral arrangements with HIV/AIDS service providers.⁵</p>
#4 - Comprehensive Continuum of HIV/AIDS Prevention, Testing, and Care Services	
<p>Work for:</p> <ul style="list-style-type: none"> • Greater service access and choice for Northern Virginia PLWH and a regional system of care • Improved needs assessment and planning related to unmet need and HIV/AIDS as a chronic illness • Structured communication and 	<p>PLWH in Northern Virginia who seek services and are eligible for care under the federal Ryan White program can generally obtain HIV-related medical care, medications, and medical case management quickly, at low or no cost. They can also access some other medical-related and support services. However, some needed services can be difficult to obtain. There is no metropolitan-wide coordinated system of HIV/AIDS prevention, testing, and care. In some ways the Northern Virginia continuum of care operates like five separate systems, with PLWH often accessing primarily services located in or near their health district. The overall safety net in Virginia is relatively weak, which amplifies health disparities for low-income, uninsured PLWH.</p>

Action Areas	Summary of Facts and Findings
<p>coordination between providers of HIV-related primary medical care and medical homes</p> <ul style="list-style-type: none"> • Ryan White Part A funding for early intervention services or other mechanisms for getting people tested and into care • Adoption of a pharmacy plan that ensures continued rapid access to medications in Northern Virginia 	<p>VDH data indicate that the region has had challenges in bringing PLWH into care: the state estimates that 62% of PLWH in Northern Virginia who know their status are not receiving regular HIV-related medical care. HIV disease is becoming a chronic illness, with more and more people entering care each year and (thankfully), fewer dying. Responding to this reality requires responses such as effective links between prevention and care, increased service capacity, and enhanced PLWH disease self- management skills.</p> <p>Availability of care: Some care services are readily available to PLWH in Northern Virginia; others are less available, and PLWH sometimes must go a considerable distance to obtain them. One important factor is federal funding guidelines. Medicaid, Medicare (available to PLWH who are on disability), and Ryan White funds are the main public resources for HIV/AIDS care. Ryan White programs are generally required to spend at least 75% of their funds on 13 identified core medical-related services (such as medical care, medications, medical case management, mental health services, and substance abuse treatment), and may use up to 25% for 16 identified supportive services that must contribute to positive medical outcomes (like transportation, food, housing, psychosocial services, child care, and linguistic services). The District of Columbia spends 81% of its Ryan White Part A funds on core medical services. Virginia, with a much less generous Medicaid program and no statewide equivalent of the DC Alliance (which pays for care for non-Medicaid eligible low- income uninsured people), is heavily dependent on Ryan White funds for services like HIV- related medical care and medical case management. In 2009, 91% of Part A funds and nearly 98% of Part B funds for Northern Virginia are allocated to core services, leaving very little for support services.</p> <ul style="list-style-type: none"> • Medical care, medications, and medical case management: Eligible PLWH in Northern Virginia who seek care can obtain quick access to HIV-related medical care and medical case management. Most low-income and uninsured PLWH who request services receive immediate referrals for these services to Inova Juniper, which has multiple locations and provides the largest array of services of any AIDS service provider in Northern Virginia. Clients who live in Alexandria or Loudoun County also have the option of obtaining services at their local health department clinic. Eligible PLWH can obtain access to HIV-related medications through the state Ryan White Part B AIDS Drug Assistance Program (ADAP). In Northern Virginia, ADAP eligibility and enrollment are

Action Areas	Summary of Facts and Findings
	<p>handled at any local health department or through Patient Services, Incorporated, the contractor solicited to implement and conduct centralized eligibility determinations and enrollment for individuals who apply for Virginia ADAP, pick up medications at a local health department. Whitman Walker Clinic once provided another provider alternative with a wide range of services, but closed its Arlington facility in March 2009. Inova Juniper opened an additional clinic in Arlington to help fill the resulting service gap. Hospitals in Northern Virginia accept PLWH for inpatient care. Some health districts reported challenges in finding physicians willing to provide subspecialty care for PLWH.</p> <ul style="list-style-type: none"> • Mental health and substance abuse treatment: Mental health and substance abuse treatment often require considerable waiting time, given limited Ryan White resources and large state cuts to the Community Services Boards (CSBs) that provide these services. Inova Juniper also provides both services, and works with several health districts to minimize the wait. Waits appear to be longest in the two health districts that are farther away from the District. Some CSB contract adjustments were reportedly made at the end of 2009 to make mental health services more available in Loudoun County. • Oral health: Dental services are more readily available in some locations than others. Inova Juniper contracts with private dentists, but sometimes has trouble finding dentists to work with. Ryan White funds for dental care sometimes run out before the end of the year - but PLWH are more likely to obtain dental care than low-income people who do not have HIV or AIDS. There is no dental school in the region, so there is no dental student clinic. Northern Virginia Community College has a dental hygiene program that offers some dental services, and the Northern Virginia Dental Clinic provides dental services to medically indigent area residents through referral from a service provider. • Transportation: Transportation is a serious concern in parts of some health districts, particularly in more rural areas where there is little public transportation. Transportation is not a serious problem in Alexandria or Arlington, but is a considerable challenge in Loudoun and Prince William Health Districts and in some parts of the Fairfax Health District. Ryan White-funded transportation services such as van rides, bus tokens, subway fare cards, and some taxi rides, are provided primarily by the Inova Juniper Program and NOVAM, but resources are limited. • Housing: The high cost of housing throughout the region makes it very difficult for PLWH

Action Areas	Summary of Facts and Findings
	<p>to obtain affordable housing. Ryan White provides only short-term housing assistance; some emergency rental and utilities assistance is available. The Northern Virginia Regional Commission (NVRC), which coordinates Ryan White Part A and Part B funding in Northern Virginia, also serves as the administrative agent for the Housing Opportunities for Persons With AIDS (HOPWA) program in Northern Virginia. It receives a subcontract from the District of Columbia, the HOPWA grantee for the region. NVRC in turn contracts with Northern Virginia Housing Service and several other entities including housing departments in Prince William and Arlington Counties. HOPWA funds provide tenant rental assistance vouchers and short-term rent, mortgage, and utility assistance. Sometimes PLWH cannot find a landlord who will accept the voucher. There is only one HIV-specific housing facility in the region, the 12-unit Agape House in Fairfax.</p> <p>Sometimes PLWH can obtain housing as a result of co-occurring conditions like mental health issues or because they are disabled. Service providers note that the lack of safe, affordable housing can have severe negative effects on PLWH treatment adherence and health.</p> <ul style="list-style-type: none"> • Food: Funding for food programs is limited, and there is considerable reliance on non- HIV charities. Inova Juniper provides emergency food assistance. There is a contractor in the District that is funded to provide home-delivered meals and groceries, but key informants say it has strict guidelines and serves only PLWH who are homebound and/or seriously ill. Several counties report difficulty in getting food delivered to PLWH in their caseloads, which they attribute to waiting lists and/or the need for deliveries beyond the Beltway. K.I. Services has a food pantry for its clients. Most counties have food banks or other food programs, many of them faith-based. However, key informants indicate that these groups often are not familiar with the dietary needs of PLWH, and it is hard to get enough fresh vegetables and fruit. • Other support services: Some support services are not readily available, sometimes because they must be obtained from a single provider (like legal services) or from providers that do not receive HIV-specific funding (like groceries). Services may be available in only one Northern Virginia Health District, which may mean traveling a considerable distance. • Services for the formerly incarcerated: K.I. Services has VDH funding for the Comprehensive HIV/AIDS Resources and Linkages for Inmates (CHARLI) project, a

Action Areas	Summary of Facts and Findings
	<p>prevention/care project that provides HIV testing, pre-release planning, transitional case management, and follow-up for HIV-positive individuals transitioning from correctional facilities back into the community. K.I. has established relationships with adult correctional facilities in several Northern Virginia counties.</p> <p>Unmet need: According to the most recent estimate by the Virginia Department of Health, 62% of PLWH in Northern Virginia who know their HIV status are not receiving HIV-related medical care. VDH believes this figure is an over-estimate, however, since the in-care estimate does not include data from payer sources such as private insurance, Medicaid Health Maintenance Organizations (HMO) or the Department of Veterans Affairs. More coordination is needed between prevention and care, as well as effective models for bringing PLWH into care. There are limitations in linkages between testing and care, outreach to HIV-positive people, and dissemination of information about service availability for PLWH who cannot afford to pay for care. VDH has initiated several creative collaborative projects involving prevention and care, such as a bilingual <i>fotonovela</i> addressing HIV prevention, testing, linkages to care, stigma, and homophobia. It is not clear how it has been used in Northern Virginia; it was not mentioned by local agency or provider staff. Many of the counties indicated that too few people are aware of available services. Some key informants would like more and better needs assessment information about PLWH who are not in care</p> <ul style="list-style-type: none"> - who they are, where they live, and what barriers are keeping them from seeking or remaining in care. The new Ryan White legislation places a major focus on getting people tested and into care, but Northern Virginia has not allocated Ryan White Part A or Part B funding to early intervention services (EIS) to reach, test, and refer into care; unlike outreach, EIS is considered a core medical service. Some Part B Minority AIDS Initiative (MAI) funds have been provided to the region for outreach and education efforts to link and retain HIV-infected clients in ADAP and core services. <p>Planning for HIV disease as a chronic illness: As HIV disease becomes a chronic illness</p> <ul style="list-style-type: none"> - with more and more people entering care that they may require for many years - some HIV/AIDS and medical specialists in the region see a critical need to adapt the system of care so that those in need of intensive services receive them, and disease self-management is emphasized. They also see a need for more explicit linkages and communications between clinics providing a medical home but not involved in HIV specialty care (like the region's FQHCs and free clinics) and HIV medical providers. No safety net clinics in Northern Virginia have HIV-specific funding,

Action Areas	Summary of Facts and Findings
	<p>Medications: Most Ryan White eligible PLWH receive their medications through the Ryan White Part B AIDS Drug Assistance Program (ADAP) or the State Pharmaceutical Assistance Program (SPAP), managed by the Virginia Department of Health. ADAP offers a full formulary of HIV-related medications, exceeding requirements of the federal HIV/AIDS Bureau. Income eligibility is now 400% of the Federal Poverty Level (FPL).⁶ The income limit was raised to 400% statewide in January 2009; the previous limit was 333% in Northern Virginia (300% in the rest of the state). The ADAP income limit is 500% of FPL in Maryland and the District of Columbia. Until recently, local health departments/health districts were responsible for ADAP eligibility determination. In 2008, VDH centralized Virginia ADAP eligibility determination and enrollment under a contractor. PLWH who may be eligible for Medicaid (a small number, given Virginia's Medicaid system) or Medicare (those who have AIDS and have been determined to be disabled or are elderly) may get their medications through those programs.</p> <p>SPAP is designed to conserve ADAP funding by maximizing Medicare Part D prescription drug coverage, paying monthly Part D premiums and co-pay costs for HIV-positive clients who are disabled and/or elderly and have incomes between 135% and 300% of FPL. At the end of 2009, SPAP served about 150 clients statewide. Due to funding limitations, SPAP was expecting a co-pay assistance waiting list in 2010, with affected clients to be moved back to ADAP to ensure continued access to medications. Local health departments were notified to expect an increase in ADAP caseload.</p> <p>Virginia's ADAP program is considered efficient and responsive, providing "bridge" medications so PLWH do not go without their meds while eligibility for other programs is being determined. One concern is that the method of dispensing descriptions is changing. VDH is closing its regional pharmacies, and all ADAP medications are to be dispensed through VDH Pharmacy Services in Richmond. Individual prescriptions are to be shipped to local health departments for client pick up within 1-3 business days. It is not yet clear how the new system will work. Public and private providers expressed great concern about this situation; some would like to see contract pharmacies or a mail-order pharmacy. In early 2010, VDH indicated that the Alexandria Health Department Pharmacy would remain open in a very limited capacity and continue to provide medications to ADAP clients that receive services through the Alexandria Health Department.</p>

Action Areas	Summary of Facts and Findings
#5 - Population-appropriate Services	
<p>Work for:</p> <ul style="list-style-type: none"> • Collaboration so that PLWH can get tested in any Northern Virginia County or in the District or Suburban Maryland • A system of allocations and contracting that provides parity in access to care for PLWH in Northern Virginia • Other procedural changes that lead to increased client choice, so any resident of the metro area may obtain care from any Ryan White provider in the metro area • Portability of care so PLWH can change residence within the metropolitan area without having to change providers 	<p>Most Northern Virginia providers are committed to providing population-appropriate care for PLWH based on characteristics such as language, race/ethnicity, gender, sexual orientation, and age. Many have multicultural staff. Services are generally described as of high quality, and several providers offer multiple services at the same facility. However, PLWH differ in their preferred size and type of service provider, and PLWH in Northern Virginia have limited choices in where to get care. Most PLWH have access only to service providers located in Northern Virginia, and health departments generally serve only residents of their health district. The lack of choice complicates efforts to make services known, bring PLWH into care promptly, provide population- appropriate care regardless of place of residence, and retain PLWH in care.</p> <p>Culturally appropriate services: Providers in Northern Virginia typically work hard to ensure culturally and linguistically appropriate services primarily through hiring of diverse staff and training staff.</p> <p>Community-based and minority providers: Northern Virginia has a small and shrinking number of community-based AIDS service organizations (ASOs) and non-HIV-specific community-based organizations (CBOs) funded for and engaged in HIV/AIDS prevention, testing, and care. There are even fewer AIDS groups that are run by communities of color. Limitations on funds for support services and reductions in prevention funding have made the situation worse. Community providers are described as valued community partners by key informants in most counties. They are seen as offering a flexibility that is difficult for a public agency or large organization to achieve. Some PLWH are more comfortable obtaining services from a small organization, or from an organization whose staff and board look like them. Having so few community-based organizations as part of the service system can be a barrier to care for some PLWH.</p> <p>Limited provider choice: Most Part A programs allow PLWH to seek services in any part of the service area; this metro area does not. Generally, PLWH must obtain services without crossing state lines. PLWH in care in Northern Virginia often have limited choice in where they obtain services, since there are few providers within most service categories, and health departments generally provide services only to residents of their health district.</p> <p>Research indicates that finding the right medical provider "match" is an important factor in</p>

Action Areas	Summary of Facts and Findings
	<p>adherence to medications and retention in care.⁷ The HIV medical providers in Northern Virginia appear both competent and committed. However, PLWH differ in what kind of service environment and clinician they want. Since the closure of the Whitman Walker Clinic, there is no nonprofit clinic option for PLWH in Northern Virginia; none of the area's federally qualified health centers or free clinics has funding for HIV-related medical care. Insured PLWH have more options; the area has a number of infectious disease doctors in private practice or working for managed care organizations including Kaiser Permanente.</p> <p>Fund allocations process: The main determinant of the current system of care is the way in which Ryan White Part A HIV/AIDS treatment funds are allocated. Part A funds go to major metropolitan areas, and the grantee is the chief elected official of the jurisdiction providing services to the largest number of PLWH. In the Washington eligible metropolitan area (EMA), that is the Mayor of Washington, DC. The allocations process in Washington currently involves dividing up service dollars for the District, Northern Virginia, and Suburban Maryland based on the number of living AIDS cases in each jurisdiction. West Virginia also has a 1% set aside. While changes to the current criteria and process are under discussion, the current formula does not take into account a jurisdiction's number of HIV cases, trends in the epidemic, poverty levels, or differences in the availability of other funding streams and sources of care like Medicaid. It appears likely that a more comprehensive allocations process - even one that simply considered both diagnosed HIV and AIDS cases - would result in additional funding to Northern Virginia. Under the current process, the administrative agent - in Virginia the Northern Virginia Regional Commission - is responsible for procurement that directs funds to service categories as specified by the Metropolitan Washington Ryan White Planning Council, which receives (and usually follows) recommendations from the Northern Virginia Regional HIV Consortium. Providers funded with Northern Virginia's Part A funds are, with very few exceptions, located in Northern Virginia.</p> <p>Geographic parity in access to care: PLWH in Northern Virginia cannot choose to go to Maryland or the District for care. With a few exceptions, they have access only to services provided within Northern Virginia. NVRC contracts for services with the funds allocated to Northern Virginia, primarily with Northern Virginia providers. When Whitman Walker Clinic closed its Arlington facility, NVRC redirected the funds to Inova Juniper and asked it to open an additional facility in Arlington. This site provided a medical provider in Arlington, but it also meant that all the former Whitman Walker clients had to change medical providers in order to</p>

Action Areas	Summary of Facts and Findings
	<p>receive their care in Northern Virginia. There are many diverse service providers in the EMA, and more categories of services are available to residents of the District. But because of the allocations and funding procedure, PLWH may not go to another jurisdiction for care.</p> <p>Other choice issues: Some services (currently including ADAP) need to be obtained through the local health department. PLWH who are undocumented or have undocumented family members may be unwilling to seek testing or care at a public agency in Northern Virginia, particularly given the laws in one county that make county employees responsible for immigration enforcement. Some legal immigrants are similarly unwilling to go to a health department because they believe that if their HIV status is known, they will be unable to obtain citizenship. Inova Juniper will see PLWH clients at any of its facilities in Northern Virginia, but the health departments do not have procedures in place to address this concern about location. Stigma and confidentiality are important issues for other PLWH, especially in more rural parts of Northern Virginia. Many want to obtain services where they are not known.</p> <p>Part A "off the top" (OTT) funding: Two providers, La Clinica del Pueblo and the National Association of People with AIDS (NAPWA), receive special Part A "off the top" funding - funds separated before the rest of the funding is allocated to the four state jurisdictions. La Clinica receives OTT funding to provide HIV-related medical care to immigrants living anywhere in the EMA. In addition, La Clinica has OTT Minority AIDS Initiative (MAI) funds for high-need immigrants, who must be newly diagnosed or out of care in addition to meeting Part A requirements. La Clinica funding covers primary medical care and case management, mental health services, linguistic services, and support groups. While Mosaica was told about this funding by DC Health Department staff and by Planning Council members, La Clinica is not included on the otherwise comprehensive NVRC HIV/AIDS resource website - which does list NAPWA and Children's National Medical Center as having services available to residents of Northern Virginia. This is apparently an oversight that NVRC can easily fix. In the <i>2009 EMA Directory of HIV/AIDS Services</i> prepared for the EMA, La Clinica is listed as a medical provider only for the District of Columbia. Some Northern Virginia jurisdictions reported considerable difficulties in serving Spanish-speaking Latinos, but the availability of La Clinica's services is not well known in Northern Virginia.</p>

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Action Areas	Summary of Facts and Findings
	<p>Non-portability of care: Because care is not portable across jurisdictions, a PLWH who moves to Virginia from the District or Maryland, or vice versa, must find a new physician and other new service providers. This may negatively affect retention in care.</p>
<p>#6 - PLWH and Other Community Involvement</p>	
<p>Work for:</p> <ul style="list-style-type: none"> • Increased Northern Virginia HIV Regional Consortium responsibility for regional prevention and care planning • Advisory groups or other mechanisms to provide county- specific community (including PLWH) input regarding HIV/AIDS, including advocacy to increase priority and attention given HIV/AIDS prevention, testing, and care • Increased coordination between the Consortium, the statewide Community Planning Group, and the Metropolitan Washington Ryan White Part A HIV Health Services Planning Council, through the engagement and leadership of Northern Virginia representatives 	<p>The Northern Virginia HIV Regional Consortium has purposes consistent with doing planning for and coordination of HIV prevention and care services. However, Virginia does statewide planning for prevention and for state-controlled Ryan White Part B funds. This has left the Consortium underutilized and the region without a coordinated planning process. Two counties have entities that offer community input into the county response to HIV/AIDS, but neither specifically requires PLWH involvement.</p> <p>Northern Virginia Regional HIV Consortium roles and potential: The Consortium, staffed by the Northern Virginia Regional Commission, serves as the planning body for Ryan White Part B, the state-run program. Its bylaws specify a role in HIV prevention community planning, though the state's Community Planning Group (CPG) is located in Richmond, where prevention planning is done. The Consortium is a key mechanism for community and PLWH involvement. However, with the focus on statewide planning, key informants described the Consortium's best defined responsibility as recommending service priorities and funding allocations to the EMA Planning Council. The Consortium actively recruits consumers and engages them in the Part A priority setting and resource allocations process. The Consortium is becoming more engaged in HIV prevention planning due to the efforts of its current chair. It has an education and prevention committee. In addition, VDH increased integration of prevention and care planning within the CPG in the summer of 2009 and indicated that the state's CPG is now reviewing regional data at its meetings. The Consortium has the potential to play a redefined regional planning and coordination role.</p> <p>Consortium membership: Consortium membership is large (reportedly 110 members) and diverse, and the goal is to have 25% of the members be PLWH.</p> <p>Regional representation on other planning bodies: Northern Virginia has prescribed representatives serving on the Ryan White Part A Planning Council and representatives on the State CPG, which became an integrated prevention and care planning group in May 2009. They presumably bring broad skills and interests. Six Northern Virginia representatives (three providers and three consumers) served on the VDH committee that developed the</p>

Action Areas	Summary of Facts and Findings
	<p>most recent three-year Statewide Comprehensive Plan for HIV Services (SCP) and Statewide Coordinated Statement of Need (SCSN), both Ryan White requirements.</p> <p>Recent changes in the structure of the state CPG are promising, as are its goals of client input and increased collaboration between prevention and care, and among Ryan White funded and non-Ryan White providers. However, it is too soon to know what impact it will have on Northern Virginia. Nor does the Virginia CPG have the capacity to create regional prevention planning in a metropolitan area that includes Northern Virginia, Suburban Maryland, the District of Columbia, and two counties in West Virginia - each with its own statewide prevention planning. The Ryan White Part A Planning Council is the only metropolitan planning body that crosses state lines.</p> <p>However, there is no structured coordination among Northern Virginia residents who serve on the CPG, the Consortium, and/or the Planning Council. It does not appear that they work together in any organized way to ensure attention to the needs of the region. For example, they might urge that Part A and Part B needs assessments address specific topics important to the region, encourage metropolitan area-wide prevention or social marketing efforts, strengthen the role of the Consortium vis-a-vis the other bodies, and urge changes in the focus of state comprehensive plans so they provide epidemiological and needs assessment breakdowns by region.</p> <p>County advisory groups: Of the individual counties and health districts, Alexandria has an official HIV/AIDS Commission, and Arlington has a working group engaged in HIV prevention. Arlington's STI Strategic Initiative Team (SIT) is a part of the Partnership for a Healthier Arlington, and recently organized itself into working groups to address number of key HIV prevention and testing issues. Neither group requires specific PLWH involvement.</p>
#7 - Leadership in Responding to HIV/AIDS	
<p>Work for:</p> <ul style="list-style-type: none"> Public leadership on HIV/AIDS through the Health Officer or another key elected or appointed official - including ensuring visibility of the issue as a key health district/county concern and responsibility, and a 	<p>There is great variation in the extent to which Northern Virginia communities take leadership on HIV/AIDS prevention, treatment, and/or care. Almost every county has deeply committed staff at the program operations level. Arlington and Alexandria, which have the highest rates of HIV/AIDS, appear actively engaged at leadership levels, as is Fairfax County. Loudoun County and Prince William County senior health and county officials appear largely unengaged in the local response to HIV/AIDS. However, the HIV/AIDS program manager in Loudoun County plays a strong leadership role, apparently with county support.</p>

Action Areas	Summary of Facts and Findings
<ul style="list-style-type: none"> • commitment to regional leadership • As the economy improves, allocation of county funds for HIV/AIDS services • County leadership working collaboratively for a regional system of prevention, testing, and care • Coordinated outreach and social marketing throughout the region, to encourage testing and early entry into care • Improved local access to information about HIV/AIDS testing and care on the city/county website and through other strategies • More visibility of VDH resources and information, including links from county/health district websites to specific HIV/AIDS data, reports, and resource information on the VDH website 	<p>Structure: In most jurisdictions, HIV prevention, testing, and care seem to be coordinated through a single unit within the health department. In Arlington, public health services are part of the Department of Human Services.</p> <p>Leadership attention to HIV/AIDS: Alexandria and Arlington appear to view HIV/AIDS as a public priority, perhaps because they have higher HIV/AIDS rates than the other health districts. Fairfax County officials have also taken leadership on addressing HIV/AIDS, including faith-based efforts. For example:</p> <ul style="list-style-type: none"> • Alexandria is the only Northern Virginia health district with an official HIV/AIDS Commission. It has a public clinic that provides HIV/AIDS care, entered into a public-private partnership to open the Rainbow Clinic as a central screening unit for gay, bisexual, and transgender men, and is extremely active in HIV prevention and testing. • Arlington County's Chief Medical Officer played a leadership role in the establishment of a new Inova Juniper clinic in Arlington to serve clients from the Whitman Walker Clinic. Reduction in the number of new HIV/AIDS cases is one of the major goals of the Partnership for a Healthier Arlington. Virginia health districts were all asked by the state to conduct a strategic planning process using an approach called MAPP (Mobilizing for Action through Planning and Partnerships). Arlington's report and plan include a goal related to HIV/STI prevention. • The Fairfax County Health Director participated with the newly created Northern Virginia Clergy Council in the region's first HIV/AIDS Prevention Faith Summit for teens and adults in March 2009; a second summit is planned for 2010. • In Loudoun County there appears to be very limited public leadership on HIV and AIDS at the policy level, although there has been some policy staff participation in an AIDS Day event, and some support for addressing HIV/AIDS on the County Council. The person responsible for HIV/AIDS services is an active and visible leader and advocate for services for PLWH. • Prince William Health District does not appear to be public leadership attention to HIV/AIDS. <p>State versus county responsibility: The state-based public health system in Virginia appears to influence the extent to which some counties consider HIV/AIDS and other health issues to be a county versus a state responsibility. The individuals staffing health district HIV/AIDS programs in Prince William, Loudoun, and Alexandria are Virginia Department of</p>

Action Areas	Summary of Facts and Findings
	<p>Health employees; Arlington and Fairfax sought special arrangements with VDH to make them county employees. In Prince William, officials emphasized that HIV/AIDS services are provided by the Health District, under VDH supervision, not by the county. One key informant explained that providing HIV/AIDS services is controversial, so everyone benefits by having these services viewed as a state responsibility.</p> <p>This view that health care is largely a state or federal responsibility is in sharp contrast to the role played by Alexandria, which operates a public clinic for the medically underserved and several specialized clinics, and Fairfax County, which supports a network of service providers that provide free or low-cost care to uninsured residents.</p> <p>Publicizing services - websites: Websites provide an interesting example of how health districts and counties do (or do not) make known their HIV/AIDS services. The NVRC HIV/AIDS online resource directory lists testing, education, prevention, ADAP certification, and referral services as categories of service provided by each health district, and provides a link to the county website.</p> <p>Counties vary tremendously in the ease with which a searcher not starting at the NVRC online directory can find out what HIV testing or care services are available and where to go for them. For example, as of the end of 2009, the health district page on the Prince William County website does not mention ADAP or medications. It is similarly challenging to find HIV/AIDS services on the Loudoun County website. The Health Department page has a list of services on the left that includes "Community Health," but that provides information on HIV testing only. To learn about the other HIV/AIDS services provided, you need to go to "Related Links" and click on "Health Services." However, a click on what seems to be the general government web address from the NVRC online directory of HIV/AIDS services and providers leads immediately to the information about care services, including a useful though somewhat outdated list of HIV/AIDS resources. Fairfax County requires you to click "Program and Services" from the Health Department webpage; there is a search function, but it brings up events rather than a list of services.</p> <p>The other websites are much easier to navigate. For example, Arlington County lists several types of HIV/AIDS services on its alphabetical directory of county services. The Alexandria home page has a search function that lets you input HIV/AIDS and get to a full list of HIV/AIDS services.</p> <p>The VDH website provides information about HIV/AIDS services. As of the end of 2009, a</p>

Action Areas	Summary of Facts and Findings
	<p>more user-friendly, searchable HIV resources database was being planned. VDH also has a statewide, toll-free hotline that provides information and referrals to local resources.</p> <p>However, local residents often do not know what information is available on the VDH website or how best to access it. Most county/health district websites do not provide links to VDH. Fairfax County does provide a link, but only to the VDH homepage. The local websites do not mention or guide residents to specific VDH resource information related to HIV/AIDS.</p> <p>Local funding for HIV/AIDS services: Most health districts do not provide much local funding for HIV/AIDS; they meet state requirements, usually in the form of staff salaries or staff time. Several have a history of providing some funds to community groups.</p> <ul style="list-style-type: none"> • Fairfax County government provides financial support to ensure that PLWH receive medical care and related services. In addition to supplementing Health Department funds from state and federal sources, the county provides funds to Inova Juniper, and makes grants through the Consolidated Community Funding Pool to area nonprofits for HIV/AIDS services. • Arlington provides some limited county funding to community-based HIV providers through a broader funding category, and Alexandria has done so in the past. Current economic conditions appear to have negatively affected such funding. • Loudoun County provides in-kind support (such as partial staff salaries) for its HIV/AIDS services, but does not budget funds for HIV/AIDS services. However, key informants believe that the county would support essential services if a budget shortfall in Ryan White funds should occur. The county does not appear to have a history of funding nonprofit HIV/AIDS groups, but it has provided some funding to nonprofit organizations for other health-related purposes. • Prince William Health District does not appear to budget any local resources for HIV/AIDS beyond state matching requirements. It has no history of providing HIV-related funding to community groups, though it has provided funding for clinics. <p>Coordination: Most health districts have no mechanism for regular meetings of HIV prevention, testing, and care providers, HIV-funded and not HIV-funded, to share information, enhance coordination, and problem solve. In several locations, the key informant sessions scheduled for the Profiles Project were used by participants for such purposes, suggesting a need for such meetings. Only Loudoun County has periodic meetings of HIV/AIDS service providers (funded and unfunded). A key informant indicated that a similar type of meeting will begin in 2010 in Prince William County, with NOVAM, a</p>

Action Areas	Summary of Facts and Findings
	community provider, playing a lead role and the Health District providing meeting space. Some limited regional coordination on HIV/AIDS occurs through the Health Officers Committee of the Metropolitan Washington Council of Governments. It provides an "address" for policy-level discussion.

¹ Surveillance data come from the Health Informatics & Integrated Surveillance Systems within the Virginia Department of Health, and were provided in response to a specific request by Mosaica for 2008 data. A great deal of surveillance data is available on the Department's website, but a full epidemiologic profile with health district-specific data is not prepared often, and it can be difficult to identify complete and easily used data online. Up-to-date comparable epi data for the Northern Health Region as a whole and the individual counties can be obtained directly from VDH surveillance staff, who are both knowledgeable and responsive.

² "Dealing with Legal Matters Surrounding Students' Sexual Orientation and Gender Identity." National School Boards Association, 2004. See <http://www.nsba.org/DealingwithLegalMattersSurroundingSexualOrientation>.

³ See Holtgrave David R., "Costs and consequences of the US Centers for Disease Control and Prevention's recommendations for opt-out HIV testing." *PLoS Med.* 2007; 4(6):1011-1018.

⁴ Information about how to implement emergency department testing is available online. See Williams Torres, G., Reiter, J. Wright, C.S. *HIV Testing in the Emergency Department: A Practical Guide*. www.edhivtestguide.org accessed on December 31, 2009. The guide was developed with funding from the Centers for Disease Control and Prevention.

⁵ The report on findings from the online survey, Northern Virginia Health Services Coalition Member Clinics and HIV/AIDS: Summary of Online Survey Results," is one of the products of the Profiles Project, and is available on the Mosaica website, www.mosaica.org.

⁶ For 2009, \$10,830 for a person living alone, \$22,050 for a family of four. See <http://aspe.hhs.gov/poverty/09poverty.shtml>.

HIV/AIDS care often cost \$22,500 per year, and can cost well over \$275,000 over a person's lifetime. Prevention efforts are therefore quite cost-effective.

⁷ See, for example, E Abel, L Painte, "Factors that influence adherence to HIV medications, perceptions of women and health care," *Journal of Association of Nurses in AIDS Care*, 2003, and S. Bakken, W. Holzemer, M. Brown, G. Powell-Cope, J. Turner, J. Inouye, K. Nokes, I. Corless, "Relationships Between Perception of Engagement with Health Care Provider and Demographic Characteristics, Health Status, and Adherence to Therapeutic Regimen in Persons with HIV/AIDS," *AIDS Patient Care and STDs*, April 2000, 14(4): 189-197.

Demographic Data for Page 5 Overall Regional Data

Rates of Newly Diagnosed HIV Disease Cases by Health District in Northern Virginia, 2009-2013

	Alexandria Health District					Arlington Health District				
	2009	2010	2011	2012	2013	2009	2010	2011	2012	2013
Total Rate per 100,000	32.7	33.6	28.4	21.2	24.2	23.5	17.8	17.1	19.9	17.8
Gender										
Female	18.1	15.1	13.4	8.0	9.1	4.6	2.9	3.7	6.3	7.1
Male	48.1	53.5	44.4	35.3	40.1	41.9	32.8	30.5	33.5	28.4
Age at Diagnosis										
<15	0.0	0.0	0.0	0.0	0.0	0.0	7.1	0.0	0.0	0.0
15 - 24	30.5	45.8	62.9	48.6	16.3	35.7	24.3	30.1	26.8	13.6
25 - 34	34.8	38.0	22.5	16.8	30.8	22.8	12.2	9.8	25.4	20.6
35 - 44	63.9	84.7	27.6	38.4	55.7	41.0	33.5	37.8	33.7	24.4
45 - 54	66.1	10.7	63.4	36.3	20.1	31.6	3.5	33.9	25.9	36.2
55+	12.7	17.7	20.3	6.7	13.0	15.1	5.2	4.9	7.2	11.8
Race/Ethnicity										
Black, non-Hispanic	72.5	74.3	88.4	53.2	70.5	104.5	55.5	61.8	56.4	50.9
White, non-Hispanic	19.9	14.4	8.9	15.2	8.8	16.2	11.0	9.9	12.5	12.3
Hispanic (all races)	22.7	53.3	21.1	8.2	15.9	18.8	38.2	24.4	38.2	22.8
Asian/Hawaiian/Pacific Islander	11.0	10.6	0.0	0.0	18.3	5.1	0.0	13.4	4.3	16.8
Amer. Indian/Alaska Native	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
Multi-race/Unknown										

Data reported to the Virginia Department of Health (VDH) as of December 2014; Accessed by HIV Surveillance, VDH, March 2015.

Rates for case counts less than 12 (marked in gray) are considered unstable and should be interpreted with caution. Rates per 100,000 population.

Rates of Newly Diagnosed HIV Disease Cases by Health District in Northern Virginia, 2009-2013

	Fairfax Health District					Loudoun Health District				
	2009	2010	2011	2012	2013	2009	2010	2011	2012	2013
Total Rate per 100,000	10.8	11.1	9.7	10.6	11.1	4.0	6.1	6.1	4.5	4.6
Gender										
Female	5.4	5.1	4.5	2.9	3.9	1.3	5.1	1.8	1.2	1.7
Male	16.3	17.2	14.9	18.6	18.5	6.7	7.1	10.6	7.8	7.5
Age at Diagnosis										
<15	0.0	0.0	1.8	0.4	0.9	0.0	0.0	0.0	0.0	0.0
15 - 24	8.7	9.1	10.5	13.1	11.4	0.0	0.0	14.7	2.7	2.6
25 - 34	23.8	30.6	19.2	26.6	21.9	7.0	11.5	6.8	8.9	13.1
35 - 44	19.2	18.8	17.0	15.7	22.2	8.4	11.9	9.9	8.1	4.8
45 - 54	14.5	9.4	13.3	7.8	15.8	6.6	10.2	7.8	7.5	5.4
55+	5.9	5.3	2.7	6.7	3.3	2.3	4.2	3.9	1.8	5.1
Race/Ethnicity										
Black, non-Hispanic	47.9	51.4	33.9	45.8	50.8	12.0	25.3	34.0	15.1	18.5
White, non-Hispanic	5.3	5.5	4.4	5.6	6.7	3.5	3.0	5.3	3.3	0.9
Hispanic (all races)	13.6	15.6	17.9	15.7	9.0	3.1	15.6	0.0	4.6	15.3
Asian/Hawaiian/Pacific Islander	4.9	1.9	3.8	2.7	4.0	2.4	2.0	0.0	3.6	1.7
Amer. Indian/Alaska Native	0.0	42.5	0.0	41.2	0.0	0.0	0.0	0.0	0.0	0.0
Multi-race/Unknown										

Data reported to the Virginia Department of Health (VDH) as of December 2014; Accessed by HIV Surveillance, VDH, March 2015.

Rates for case counts less than 12 (marked in gray) are considered unstable and should be interpreted with caution. Rates per 100,000 population.

Rates of Newly Diagnosed HIV Disease Cases by Health District in Northern Virginia, 2009-2013

	Prince William Health District				
	2009	2010	2011	2012	2013
Total Rate per 100,000	11.2	13.2	7.6	9.0	11.5
Gender					
Female	5.2	7.0	4.2	2.9	4.8
Male	17.3	19.5	11.0	15.3	18.2
Age at Diagnosis					
<15	0.0	0.0	0.0	0.0	0.0
15 - 24	10.5	21.7	9.6	17.0	24.1
25 - 34	24.5	26.3	18.0	16.2	20.2
35 - 44	17.0	16.4	12.1	14.5	7.8
45 - 54	20.4	14.6	4.2	8.3	21.9
55+	2.9	9.5	6.3	4.7	4.5
Race/Ethnicity					
Black, non-Hispanic	31.2	36.5	18.8	22.3	28.7
White, non-Hispanic	6.2	4.0	2.1	3.8	3.8
Hispanic (all races)	9.4	15.3	12.6	7.4	14.1
Asian/Hawaiian/Pacific Islander	0.0	0.0	0.0	7.3	0.0
Amer. Indian/Alaska Native	0.0	0.0	0.0	66.3	0.0
Multi-race/Unknown					

Data reported to the Virginia Department of Health (VDH) as of December 2014; Accessed by HIV Surveillance, VDH, March 2015.

Rates for case counts less than 12 (marked in gray) are considered unstable and should be interpreted with caution. Rates per 100,000 population.