

Running head: HIV/AIDS in Washington D.C.

**The Disproportionate Impact of HIV/AIDS Among Young (13-24), African  
American Females, East of the River, Washington D.C.**

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## **Justice and Peace**

The study of justice and peace provides a theoretical framework for equality and action in the community. It strives to develop, “practical solutions to problems of social inequality and injustice at all levels of society,” ([www.georgetown.edu/department/pjp/misssion.html](http://www.georgetown.edu/department/pjp/misssion.html)). Health disparities and the impact of social services on a community are important components of justice and peace in a community setting, as the inequitable distribution of health care contradicts the goal of a more just and peaceful world. Justice and peace studies represent a call for action, a call to productively identify and eliminate inequality in all settings, including health.

Racism, poverty and sexism, all forms of inequality, inhibit the development and implementation of justice and peace and play key roles in disparities in health in the United States. Investigating the equality of health care provided to a population is a basis for identifying justice and peace in the healthcare setting; quality and equality of health care pose legitimate concerns in justice and peace studies because they provide evidence of unjust social conditions. This thesis outlines equality of health care as it relates to young African American females affected by HIV/AIDS East of the Anacostia River, Washington, D.C. It explores basic epidemiological studies, identifies reasons for the disproportionate impact, investigates quality and quantity of services, and finally makes suggestions to help combat the level of inequality seen among African American women, ages 13 to 25, residing East of the River in Washington D.C., who are affected by HIV/AIDS.

The disproportionate effects of HIV/AIDS among African American women East of the River are portrayed by the incidence and prevalence of the disease among this population. In Washington D.C. over the past decade, prevalence of HIV among females has increased significantly – from 11 percent in 1991 to 33 percent in 2001. More alarmingly, 96 percent of

these new infections were among black women with the highest incidence rate recorded in Ward 8, East of the River (CDC, 2004, p.18). Furthermore, new HAART (Highly Active Anti-Retroviral Therapy) medications, proven to decrease viral load and thus disease transmission, halved the D.C. AIDS case rate from 1981 to 2001, yet only accounted for an 8 percent decrease in AIDS cases among Ward 8 residents (CDC, 2004, p.19). Clearly, epidemiological data suggest HIV/AIDS disproportionately affects young African American women East of the River through increased infection rates and decreased treatment availability. These inequalities mark the unjust social and health conditions among young African American women and necessitate further research and concentration on this phenomenon. I propose these infection rates directly reflect the quality of life east of the river, while decreased treatment rates reflect lack of health care services. I will therefore explore each of these issues in this thesis, relating them to HIV/AIDS among young African American women east of the river.

### **Scope of the problem**

In Washington D.C., the lives of young African American women residing East of the River are more challenging than for most U.S. citizens. The following section will outline the overwhelming disadvantages one faces growing up a female in Wards 7 and 8. Overall, poverty engulfs this area and gives birth to many other societal injustices including single mothers, violence, drugs, and limited education. This structural violence helps explain why HIV/AIDS thrives in disadvantaged communities.

**Poverty**

“(In the District), for every ten people in poverty, eight are black”  
(Rubin, 2002, p.16)

One in five District residents live in poverty, a number calculated annually by the Department of Health and Human Services (DHHS, 2004, p.11). According to this calculation, a family of 3 must make less than \$15,670 annually, a family of 4 less than \$18,850 annually and family of 5 less than \$22,030 annually (DHHS 2004 p.12). According to these guidelines, 20 percent of those residing in the District live in poverty as their annual income falls below poverty guidelines. The poverty rate in D.C. more than tripled in the 1990s, is higher than the national average for cities, and occurs primarily East of the Anacostia river in Wards 7 and 8 (Cohn, 2003, p.A03). Currently, the District hosts ten severely poor neighborhoods, with poverty rates exceeding thirty percent, all inhabited almost exclusively by African Americans and all lying East of the River (Cohn, 2003, p.A01). Overall, 109,500, or one in five, District residents live in poverty, the highest proportion in over forty years and an increase of 14 percent in the last ten years (Rubin, 2002, p.4).

Furthermore, African Americans in Washington D.C. represent 77 percent of all those living in poverty. Additionally, adult women ages 18 to 64 make up 34 percent of the District of Columbia’s poor (Rubin, 2004 p.4, 14). Overall this data suggests poverty in the District targets African American communities East of the River. An area known as East of the River, which includes Wards 7 and 8 (Southeast and sections of Northeast Washington D.C.), houses the majority of District’s poor. In fact, Southeast is not only the poorest area of the city, but the poorest area in the mid-Atlantic region (Rubin, 2002, p.24) For years, Southeast has boasted a reputation due to poverty, drugs, violence and crime, with Anacostia, the most notorious of

neighborhoods in Washington D.C., residing here. In Anacostia, the average neighborhood income of \$30,283 annually is 14% of the median income of the entire city (DC Agenda 2004). Yet, a recent study reported a family of two children and two parents must earn \$59,952 annually for basic living necessities in Washington D.C. in order to survive (SOME, 2003 p.1). In addition, 4,000 people and 12 public housing complexes reside in a half-mile section of Anacostia known as Washington Highlands (MacCubbin, 1995, p.1). Southeast is also plagued by chronic unemployment and illiteracy.

Ward 8, the southernmost section of the city, consists of an estimated 58,000 people, housing two high schools, Anacostia and Bellou, one police station, one junior high school and twenty-four elementary schools (www.dc.gov). It spans from Anacostia and the Potomac rivers in the west to Southern Avenue on the south and east. Its northern borders are Naylor and Morris roads and it also neighbors Prince George's County in Maryland. According to the 2000 Census, Ward 8 has the lowest median income, the highest unemployment rate and the highest number of single-parent households in the city. "In fact, the median household income...is 34% less...for households citywide" (Fountain, 1998, p.J1). In Ward 8, one in three live in poverty, yet nearly half of Ward 8 residents pay over 30 percent of their overall income for rent (DC Agenda, 2004, p.16). Overall, the poverty rate of Ward 8 is the highest in the District. Furthermore, according to DC census data, residents of Ward 8 are the poorest, most disadvantaged individuals in the District.

Ward 7, the easternmost point of the city, is 97 percent African American, boasting the largest percentage of African American residents in any Ward of the city (DC Agenda, 2000, p.1). It lies from the Anacostia River to the west to Naylor road in the east and borders Prince Georges County to the north. Nearly one half of the residents of Ward 7 have left in the past 25

years, as the population shrunk from 100,000 to 59,000 since 1975, due to crime and poverty (DC Agenda, 2004, p.1). One-third of the residents receive public assistance, and it hosts the second largest number of public housing units in Washington D.C. (Horwitz, 1998, p.J01). The overall poverty rate in Ward 7 is 25 percent with a 14 percent unemployment rate (DC Agenda, 2000). Overall, Ward 7 competes with Ward 8 for the most disadvantaged section of D.C.

Child poverty also poses a significant problem in Washington D.C., with increases of 24 percent in the last decade (p. 4). Overall, 35,000 children in the District live in poverty, a number representing 30 percent of the total child population of Washington D.C. (p.4, 15). Although urban flight has accounted for a 14.8 percent decrease in population, the number of children under 18 years living in Ward 8 has risen by 5 percent (DC Agenda, 2004, p.1). In fact, Ward 8 houses the highest population of children in the District, comprising 50 percent of all Ward 8 residents (DC Agenda, 2004, p.1). Yet, half of the children residing in Ward 8 live in poverty (Cohn, 2002, p.A01).

Child poverty also plagues Ward 7. Although the overall population of this Ward decreased by 10.8 percent in the past ten years, the child population increased by over 3 percent (DC Agenda, 2000, p.3). The child poverty rate is the second highest in the District at 37 percent (DC Agenda, 2000, p.5). In addition, both Wards 7 and 8 host the city's highest infant mortality rates. Between 1998 and 2000, the infant mortality rate increased by 81 percent and in 2000, Ward 8 infants died almost twice as often as any other infants in the city (DC Agenda, 2004, p.3).

Unemployment, a first cousin to poverty, also plagues D.C, as "the unemployment rate among D.C. residents has been 60 percent higher than the national average and double that of the surrounding region," (Drug Strategies, 1999, p.4). In fact, as of December 2003, the

unemployment rate of Washington D.C. was higher than any other metropolitan area in the nation as over 84,000 residents did not hold a job (Irwin 2004 p. E02). Lacking employment often means no income, a problem that further exacerbates the HIV/AIDS crisis in the District as one may not be able to pay for HIV related services or condoms.

### **Female Headed Households**

Ward 8 holds the second highest portion of both African Americans and female-headed households in Washington D.C., while Ward 7 claims the highest rate of both African Americans and female-headed households in the city, at 97 and 84 percent, respectively (DC Census, 2000). Overall, 93 percent of Ward 8 residents are African American and 20 percent, or one in four, are or were teen mothers (DC Agenda, 2000, p.3). As the area with the largest population of under 18 year-olds, eight in ten children in Ward 8 reside in female-headed households. Seven out of ten children living in poverty in Ward 7 live in female-headed households.

The female-headed household epidemic occurring East of the river offers a glance into the lives of African American women residing there. The vast majority of households have one caretaker, one breadwinner, one authority, one parent. Oftentimes, raising children alone takes more money and time than two parent households. Being the sole provider of a household necessitates stress, paving the way for struggle. In fact, single parent households fall prey to poverty more often than two parent households as income is stifled by the lack of contribution from another care provider. A study by the National Low Income Housing Coalition stated that Washington D.C. is the least affordable place to live. In fact, one must earn nearly \$25.00 per hour full time or 152 hours per week of minimum wage in order to afford a two-bedroom house in the District (SOME, 2003, p.1) According to the Department of Housing and Urban

Development, the majority of public and section 8 housing are female-headed households with children (SOME, 2003, p.2).

## **Drugs**

Aside from the obvious consequence of HIV transmission from blood to blood contact through injecting drugs, individuals increase their risk of contracting HIV when under the influence of alcohol and non-injectable drugs (Ruiz, et al. 2000 p.xii). Using drugs and alcohol decreases a person's inhibitions and decision-making skills. They may engage in activities that are not normal for them. More specifically, once under the influence, a person may engage in unprotected sex, inject drugs or become so intoxicated they improperly use condoms. These examples portray the risk of drugs and alcohol, linking their usage to increased rates of HIV/AIDS.

Currently, drug abuse in Washington D.C. remains a significant problem. All age groups, particularly adolescents and adults, face drug dealers on a daily basis. For example, "one in four high school students said they were offered, sold, or given an illicit drug while on school property in 1997, up 56 percent since 1993" (Drug Strategies, 1999, p.1). Parents also acknowledge this problem, claiming, "more than half of adults in Washington have seen or heard about drugs being sold in their neighborhood, and about one-third consider it a serious problem," (Drug Strategies, 1999, p.12). In fact, substance abuse statistics in Washington D.C. soar above the national average in three major categories: prevalence of illicit drug use, age of onset of illicit drug use, and drug addiction. The 2000 District of Columbia Household Survey found nearly 10%, or 41,000, of all District residents reported using illicit drugs within 30 days prior to the interview, a rate 52% higher than the national average (Buford & Ramsey, 2003, p.2-3). More specifically, heroin, methamphetamine, steroids and injection drug use is shockingly more

prevalent in District high schools. Females in grades 9 through 12 reported they are three times more likely to use heroin, four times more likely to use methamphetamine, and two and a half times more likely to inject drugs than females in the same group nationwide (SAMHSA, 20020, table). These rates of injection drug use clearly contribute to HIV/AIDS prevalence among this high-risk age group.

Also contributing to the comorbidity of substance abuse and HIV/AIDS is the age of onset of illicit drug use. Currently, District residents average 14.5 years upon initiation of substance use, a rate of 2.5 years earlier than the national average of 17.0 years (Buford & Ramsey, 2003, p. 2-4). Also, the District boasts twice (8.9 percent) the national average (4.7 percent) of people living with drug addictions, with 18.9 percent of young adults ages 18 to 24 claiming dependency, defined by the physical or mental compulsion to continue taking drugs as a result of habitual administration of the drug (Buford & Ramsey, 2003, p.2-4). Furthermore, 20.5% of the 18-24 year-olds in the District admit to using illicit drugs in the past month while an overwhelming 64.8% of the population admits to alcohol use (Buford & Ramsey, 2003, p.2-2). Unfortunately, there is no specific data on adolescent and young adult women in this report. However, substance abuse in the District is clearly a significant problem with rates well above the national average – rates that may in fact contribute to the high prevalence of HIV/AIDS in the District.

Rates of alcohol use and abuse in our nation's capital also soar above national averages. In fact, "heavy drinking is 50 percent more prevalent among District adults than among adults nationwide," (Drug Strategies, 1999, p.1). Furthermore, 14 percent of adults ages 18 to 24 admitted alcohol dependency, compared to the national average of 9.2 percent. Again, high rates

of alcohol use, abuse and dependency may also increase the number of HIV/AIDS cases in the District.

As outlined above, evidence suggests D.C. has a serious substance abuse problem. The question remains, what is being done about it? Like numerous other areas of the country, government officials react by increasing spending on the criminal justice system while decreasing spending on drug treatment and prevention. Some interpret this as a last step resort – dealing with the consequence of drug abuse instead of the problem. In 2002, roughly 8,500 people entered substance abuse facilities, “this suggests that of the total 60,000 individuals needing treatment for a substance abuse problem, only about 14 percent of them receive it. This “treatment gap” denies almost nine out of 10 individuals needing treatment,” (Buford & Ramsey, 2003, p.2-6). Public treatment programs run off government grants. In Southeast Washington D.C., there are currently 4 public treatment facilities necessitating referrals for bed space. On average, waiting time for beds lingers at 6 months (Buford & Ramsey, 2003, p.2-7). Clearly, the lack of treatment facilities often exacerbate drug problems as those requiring beds are forced to live with their addiction for months after requesting detox or methadone maintenance programs.

## **Education**

Over 16 percent of Ward 8 residents between the ages of 16 and 19 drop out of school and only two thirds have a high school diploma (DC Agenda, 2004, p.5). Only 8 percent of Ward 8 residents have a college degree (2004). In Ward 7, the education crisis is just as bad with less than three quarters of residents graduating high school and only 12 percent owning a college degree (DC Agenda, 2004, p.5).

Educational attainment is oftentimes a direct indicator of poverty as less school years completed means less money paid. Persons lacking a high school degree average \$18,793 annually while high school graduates earn \$26,795 annually and Baccalaureate certificate holders earn \$50,623 annually (Post Secondary Education Opportunity, 2003, p.4). Even low-skill, minimum wage jobs such as McDonald's employees, offering minimum wage, now require at least a GED (high school equivalency test). Furthermore, parent education level and wages earned also may predict child educational attainment. Only 60 percent of children coming from households earning less than \$6000 annually become college freshman with a B average or better while over 75 percent of students coming from households earning \$50,000 annually hold a B or better (Postsecondary education Opportunity, 2003, p.17). Also, less than 60 percent of college freshman earning at least a B had parents who only finished grammar school. Meanwhile, 80 percent of children of parents with graduate degrees earn a B or better as college freshman (Post secondary Education Opportunity, 2003, p.35). This places Ward 7 and 8 residents in a high-risk category for poverty and stunted educational development in children, as education rates here are the lowest in the District.

During fieldwork, I taught an HIV prevention program to Anacostia high-school seniors. At least one fifth of my students could not read, and many others had reading levels well below the National average. Recently, a student read aloud the back of a colleague's t-shirt, and the entire class erupted in applause because the student was able to read. At Anacostia high school, reading is a privilege, not a given. Furthermore, eighth grade students at St. Thomas More Catholic School, also in Anacostia, read at sixth grade reading levels while third grade just began subtracting double digits. Both these grades fall well behind basic education levels.

Consequently, even for those attending school, District public schools student fall behind national educational attainment levels.

### **Life East of the River**

Overall, when studying HIV/AIDS among young African American residents east of the river, one must first become acquainting with everyday life there. Poverty, female headed households, drugs and lack of proper education all develop roadblocks to HIV prevention measures. It is naïve to assume one will worry about condom use when their children are hungry. In conclusion, we must pay close attention to the social injustices east of the river and view them as direct links to the HIV/AIDS epidemic.

## **Scope of the Problem – HIV among Women and Adolescents**

### **HIV among Women in the United States**

“The HIV/AIDS epidemic is now taking an increasing toll on women in the United States. Women now account for 30 percent of new HIV infections... Women of color, particularly African American, women have been especially hard hit and represent the majority of new infection among women” (Kaiser Family Foundation, 2003, p.1)

The face of AIDS is changing. Historically, the majority of people infected with HIV at the start of the epidemic were white homosexual middle-aged males. Therefore, those not belonging to this group often believe they are not at risk. However, HIV/AIDS is no longer a “homosexual disease”; the epidemic now targets a new group: racial and ethnic minorities, women, adolescents and young adults (Ruiz, et al., 2000, xi). Between 1986 and 1999, the proportion of women contracting HIV nearly tripled from 7 percent to 23 percent and “by 1999 females accounted for 58 percent of reported AIDS cases among 13- to 19- year olds and 38 percent of cases among 20- to 24- year olds” (Ruiz et al., 2000, p. 144). Also from 1998 through

2002, AIDS incidence increased by 7 percent among females, (DHHS, 2003, p.6). These statistics link the risk of HIV infection among women. However, women of color represent the largest risk group among females, and in 1999, “81 percent of new AIDS cases among women were reported among Hispanic and African-American women” although they only represented 23 percent of the female population in the United States (Ruiz, et al., 2000, p.143). In addition, African American women made up 64 percent of all new HIV infections among women in 2001 (Kaiser Family Foundation, 2003, p.1) This disproportionate rate of infection are alarming as, “AIDS case rate among African-American women (49 per 100,000) was more than 20 times the rate among Caucasian women (2.3 per 100,000)” (Ruiz et al., 2000, p.143). AIDS is currently the leading cause of death among African Americans between the ages of 25 to 44 (ruiz et al., 2000, p.144). Clearly, racial and ethnic minority women fall victim to HIV/AIDS at an alarming rate that is overwhelmingly disproportionate to Caucasian women.

### **HIV/AIDS among Women in the District of Columbia**

In 2000, the District of Columbia reported the highest AIDS case rate of 164 per 100,000 residents among all 50 states and U.S. territories compared to the national average of 16 per 100,000 (DHHS, 2002, p.8). As of 2000, AIDS prevalence rates among adults in Washington D.C. were 1,685.8 per 100,000 residents, a rate of over ten times the national average of 160.5 per 100,000 while the AIDS prevalence rates among children (80.8 per 100,000) were twenty times the national average of 4.2 per 100,000 (DHHS, 2002, p.7). As the city with the highest proportion of African Americans in the nation – estimated at 60 percent by the census Bureau – Washington D.C., and furthermore East of the River, whose demographic majority is overwhelmingly African American, claims the highest HIV/AIDS rates in the

country, particularly among African American females (DHHS, 2002, p.7). In fact, women account for nearly half the new cases in Wards 7 and 8 while only 28 percent of new cases among all District residents (Vargas, 2003, p. B01). Furthermore, “over half of the AIDS cases in the District of Columbia have been Black men, women, and children” (FMCS, 2003).

### **HIV/AIDS among Youth in the United States**

“Each year, hundreds of teenagers in the United States contract HIV, the virus that causes AIDS. Experts report that in recent years, there has been a lowering in the median age of HIV onset in the United States. And, while overall incidence of AIDS among U.S. populations declined during the 1990s, there has been no comparable decline in the number of newly diagnosed cases among young people,” (Human Rights Watch, 2002, p.3)

HIV infection is increasing most rapidly among young people. It is estimated that every minute, five people under the age of 25 are infected with HIV (CDC, 2000, p.3). Further estimates state that at least half of all new HIV infections in the United States are among people under the age of 25, and the majority of young people are infected sexually (Rosenberg et al., 2004, p.379). In the year 2000, 1688 young people in the nation ages 13 – 24 reported being infected with AIDS (CDC, 2004, p.2). In 1998 over half of all new adolescent infections occurred in females ages 13 to 19 and “young African Americans represented 61 percent of new AIDS cases among 13 to 19 year-olds (Futterman, 2000, p.10; CDC, 2004, p.2). Also alarming is the fact that over one half of all new HIV infections in the United States are among those under the age of 25 (CDC, 2004, p.2). From 1994 to 1997, 44% of all HIV infections among young people aged 13-24 occurred among females, and 63% among African-Americans (Center for Substance Abuse Prevention).

**HIV/AIDS among Youth in Washington D.C.**

“The city, I think, is very serious about HIV prevention. The problem is getting people, especially young people, to realize that they are at risk,”  
(Stacey Cooper, FMCS)

HIV/AIDS is affecting youth, particularly school-aged children and young adults in the Metro area at an alarming rate, specifically in poorer urban communities. In fact, the DC metropolitan area has the highest rate of cumulative AIDS cases in the U.S. (CDC, 2004, p.2).

This places children attending inner city schools, most of which are nonwhite, at greatest risk of infection due to their age and ethnic status. Recent statistics are alarming because they show that although there has been an overall decline in new cases reported, young people are the only group that has NOT shown a comparable decline for new cases. More specifically, DC public high school students are at risk as evidenced by 1999 survey that concluded 70% of males and 60% of females had already engaged in unprotected sexual intercourse. In fact, “the percentage of youth contracting HIV/AIDS are highest east of the Anacostia river in Wards 6, 7, and 8” (Hill, 2002, p.3). Furthermore, “adolescents are generally diagnosed with HIV/AIDS late in the course of the illness, relatively few receive care for HIV disease, and most do not know they are infected,” (Futterman, 2000, p.4) More specifically, Metro Teen AIDS, the only resource dedicated solely to youth living with HIV or AIDS, estimates of the 2,500 and 3,500 infected young people live in the Washington D.C. area, only 100 receive medical care ([www.metroteenaid.org/about/index.html](http://www.metroteenaid.org/about/index.html)).

## **HIV Risk Behaviors among Young African American Women**

Semen and vaginal fluid are two of the four body fluids that transmit HIV. Thus, sexual contact, vaginal, anal and oral, both heterosexual and homosexual, accounts for the majority of HIV infection nationwide (DHHS, 2003, p.7). Heterosexual contact as a mode of transmission has increased steadily since 1985, peaking at 15 percent of new infections in 1999 (Ruiz et al., 2001, p. 141). Furthermore, “the increases in AIDS cases among women is consistent with the increase of cases linked to heterosexual transmission” (Ruiz et al, 2001, p.142). Women are more susceptible to contracting HIV through vaginal intercourse as receptive vaginal sex boasts higher rate of HIV transmission than insertive vaginal sex. Consequently, the majority of females are infected with HIV through heterosexual contact.

Sexual contact, both homosexual and heterosexual, is the primary mode of HIV transmission, and accounts for roughly 72 percent of cases among all females living with HIV/AIDS nationwide (DHHS, 2003, p.7). Unfortunately, the District did not begin compiling infection rate data until December 2001, resulting in a lack of information regarding the percentage of women infected sexually (Vargas, 2003, p.2). However, heterosexual contact remains the number one mode of HIV transmission among women in the nation, and experts speculate the same occurs in the District.

### **Onset of Sexual Activity**

High school students in Washington D.C. report slightly higher rates of sexual activity than do students nationally (Youth Behavior Surveillance Survey [YBSS] 2000, p.16). More specifically, 61.6 percent of African American students in the District, compared to 60.8 percent

nationally, reported being sexually active (YBSS 2000, p.5). The increases in percentage points of females in the District engaging in sexual activity is slightly more drastic, as 53.5 percent admitted to having sex compared to the national average of 42.9 percent (YBSS, 2000 p.12). District females are also more likely to engage in risky sex behaviors. High school females reported condom use at a rate of 64.8 percent, 5 percentage points lower than the 69.7 percent rate nationwide (YBSS, 2000 p.12). Furthermore, 12.2 percent of females reported mixing drugs and sex while only 10.4 reported doing so nationwide (YBSS, 2000, p.13). Higher rates of sexual activity, both safe and unsafe, among District high school students increases the risk of contracting HIV through heterosexual contact and contributes to the prevalence of HIV/AIDS in Washington, D.C.

### **Incidence and Prevalence of other Sexually Transmitted Infections**

Women in Washington D.C., specifically women residing in Wards 6, 7, and 8 are at greater risk for contracting HIV infection due to the higher rates of sexually transmitted infections than other District residents. For example, 72 percent of chlamydia infections in Washington D.C. occurred among women between the ages of 10 and 24, while women of all ages accounted for 85 percent of overall chlamydia infections (CDC, 2002, p.19). Also, African American women accounted for 98 percent of all cases reported to STD clinics (p.19). Finally, 52 percent of Chlamydia cases occurred in wards 6, 7 and 8, with the highest incidence of infection (22 percent) in Ward 8.

In addition to chlamydia, the sexually transmitted disease morbidity report showed that in Washington D.C., African Americans make up 78 percent of gonorrhea infection during 2002, and 56 percent of total cases in the District occurred in Wards 6, 7 and 8 (CDC, 2002, p.1).

Furthermore, women ages 10 to 24 comprised 70 percent of all gonorrhea cases District wide (CDC, 2002, p.5).

As discussed above, young (13-24), African American women in Wards 6, 7 and 8 report the highest rates of Gonorrhea and Chlamydia in Washington D.C. These infection rates place them in high-risk categories for HIV infection for two major reasons: previous sexually transmitted infections point to risky sexually behavior, such as noncompliant condom use, that predispose individuals to HIV transmission. Also, comorbidity of infections occurs often and once an initial STI is reported, the individual is more susceptible to contracting an additional infection, such as HIV. In conclusion, Gonorrhea and Chlamydia rates among young, African American women in Wards 6, 7 and 8 point to an increase in risk for HIV comorbidity.

### **The “Down Low”**

“If we don’t react to this (“Down Low”) very quickly and aggressively, it’ll be like the 80s all over again. Instead of gay white men, we’ll be dealing with large numbers of young black men and their female partners” (Leone, 2004)

In February of 2004, researchers from the North Carolina Department of Health and Human Services H.I.V. prevention unit conducted the first major study focusing primarily on the emerging Down Low phenomenon. This study incorporated 84 black college males recently infected with HIV. Researchers found that although the majority were infected through sex with other men, one third reported bisexuality (Villarosa, 2004, p.2). This Down Low phenomenon, characterized by African American males who self-identify as heterosexual, often have female partners, but behaviorally have sex with both men and women. Consequently, this “down low” behavior represents a new era of HIV risk for African American females.

## **Injection Drugs and HIV/AIDS – The Necessity of Needle Exchange Programs**

Research linking injection drug abuse and HIV/AIDS prevalence remain significant. Roughly one out of every three persons in Washington D.C. living with HIV/AIDS was infected via injection drug use (SAMSHA, 2002, p. 2-8). A research study in 1997 estimated 641 cases of HIV transmission in Washington D.C. could have been prevented with the implementation of a needle exchange program prior to the study, stating, “removing the government ban on the needle exchange program (NEP) funding and accelerating the growth of NEPs in the U.S. are public health priorities as urgent as any in the HIV epidemic” (Hugbee, 1997, p. 415). Recognizing the comorbidity of injection drug use and HIV/AIDS, many major cities implemented NEPs with funding from private donations

Needle exchange refers to the exchanging of used needles for clean ones. For every one used needle turned in to the needle exchange program (NEP), one clean needle is awarded to the donor, thus preventing HIV transmission through the sharing of used needles and improper disposal of used needles. Unfortunately however, current legislation does not support needle exchange programs in the District, despite three research polls conducted by the Lindesmith Center-Drug Policy Foundation, Kaiser Family Foundation and the Human Rights Campaign showing the majority of Americans (71%, 66%, and 55%, respectively) support needle exchange programs as primary HIV prevention methods (The Body, 2001, p.1).

Aside from the lack of support for NEPs, most states have also banned the purchasing of clean syringes or syringe equipment. In fact, “all 50 states have laws that restrict the sale, distribution, and/or possession of injection equipment; 49 states have drug paraphernalia laws that prohibit the manufactures, sale, distribution, possession, or advertisement of any device, including syringes, that may be used in preparing or injecting illegal drugs,” (Ruiz, et al., 2001,

p.115). These laws implemented in the spirit of lowering drug usage have backlashed. Instead of preventing substance abuse as proven by the lack of evidence, they have essentially promoted the reuse of drug paraphernalia, and thus the transmission of HIV and all other blood-borne diseases, especially Hepatitis C.

In 1995, U.S. Congress passed the Appropriations Bill (S.B. 1283) that prohibited the use of local and federal funding for needle exchange programs. The act even included a ban on privately used funds from organizations that also received federal funding. This Bill was set forth as a response to a nationwide legalization of the use of federal funds for needle exchange programs for the first time in U.S. history, overturning a prohibition policy set in 1988 (Hsu, 2002, p.1). For the last 8 years, the bill has been under constant scrutiny by AIDS activists.

Republicans began the debate in 1995 noting the absence of scientific data that supported a decrease of HIV infection as a result of needle exchange programs as well as a belief that such programs would increase the use of injection drug use, particularly heroin. However, since the beginning of the new nationwide needle exchange policy, the Centers for Disease Control and Prevention and the Department of Health and Human Services have made scientific discoveries that contradict these beliefs. In 1997, HHS found that needle exchange programs are, in fact, an effective form of public health intervention. Researchers concluded that not only do needle exchange programs decrease the rate of HIV transmission among people who use drugs but was also found in some cases to *decrease* the rate of intravenous drug use instead of encouraging it by providing users with treatment information and referrals (CDC, 2001). In fact, the National Institute of Health and the Institute of Medicine found in 1997, “needle exchange programs contribute to 80 percent reductions in risk behaviors in injecting drug users and a 30 percent or greater reduction of HIV transmission” (CDC, 2001).

In support of these findings, *PreventionWorks!*, Washington D.C.'s privately run needle exchange van, had 1,800 discussions about drug treatment with current users and made 400 drug treatment referrals for their clients in 2003 alone (*PreventionWorks!*, 2003, p.1). In addition, a private study of needle exchange program participants in the District noted, "a 50% drop in crack-cocaine use, 29% drop in the number of injections, and an 18% drop in heroin use as compared to the months prior to entering the program" (Fowler, 1999). However, despite empirical evidence that NEPs prevent HIV transmission *and* lower the rates of substance use, the Congressional debate and lack of funding continue.

In 1999, the ban was amended, many speculate as a result of scientific data found by the CDC supporting needle exchange, and permitted the use of private funds from publicly funded organizations. However many politicians, such as Rev. Jesse Jackson and D.C Mayor Anthony Williams, still believe further amendments to the Act are necessary. In 2000, however, lawmakers extended the ban to deny local tax support and prohibit needle exchange within 1,000 feet of schools, parks, day-care centers, public housing, and other areas with children (Hsu, 2002, p.1). Fortunately, in 2002, the Senate voted unanimously to end the two year-old ban of using taxpayer's money on the needle exchange program, however the victory was overturned by the House of Representatives. The debate continues, and as recently as December 5<sup>th</sup> 2003, the Senate again conceded to the House of Representatives and failed to lift the ban on the use of federal and local funds for the needle exchange program. Due to this legislation, the entire nation is banned from using federal funding for needle exchange programs, despite overwhelming support from the U.S. Surgeon General, The American Medical Association, The American Bar Association, The American Public Health Association, and The National Conference of Mayors to lift the ban (CDC, Needle exchange Facts). In addition to the ban on federal funds, the District

is currently the only American city also barred from locally raised funds to support such the needle exchange program.

Needle exchange programs are currently the most efficient, cost-effective HIV prevention techniques used today (Ruiz et al., 2001, p.35). The cost effectiveness is estimated to range from \$3,000 to \$50,000 per HIV infection prevented, competing with the use of AZT for decreasing perinatal transmission as the most cost-effective HIV prevention option (Ruiz, et al., 2001, p.35). Yet, despite the empirical evidence, federal and state governments lack the willingness to support this proven effective prevention measure.

Government sentiments, however, remain in the minority, as the Centers for Disease Control and Prevention, National Institute of Health, and Institute of Medicine all promote NEPs. In fact, the Institute of Medicine names the government's inability to promote NEPs a, "social, economic and cultural... barrier to the implementation of proven HIV prevention interventions and the efficient use of prevention resources" (Ruiz, et al. 2001, p. 8). More concrete, the National Institute of Health states, "studies show reduction in risk behavior as high as 80 percent in injecting drug users, with estimates of a 30 percent or greater reduction of HIV. The cost of such programs is relatively low. Needle exchange programs should be implemented at once" (NIH, 1997). Whether due to social stigma or moral superiority, the lack of funding for NEPs are a blow to current HIV prevention efforts. In fact, "the consequence is missed opportunities to prevent new HIV infections, resulting in lost lives and wasted expenditures" (Ruiz, et al., 2001, p.8). An additional cost-efficiency study estimates, "NEPs prevent HIV infection among IDUs, their partners and family members at a cost of \$9,400 per avoided HIV infection. Considering the lifetime cost of treating a person living with HIV/AIDS is approximately \$200,000, this represents a 95.3 percent savings per life," (The Body, 2002, p. 3). In conclusion, federal and

local governments would benefit from supporting NEPs. Not only do these programs prevent HIV transmission, but they also save money at both state and federal levels.

In response to current legislation and statistics, the needle exchange program *PreventionWorks!* was introduced to D.C. in October of 1998. *PreventionWorks!* runs the needle exchange van daily to eleven locations across D.C., the majority of which lay east of the river. Locations throughout the District are chosen based on their high rates of drug activity. In 2003, 350,000 contaminated needles and syringes were properly disposed of by the *PreventionWorks!* team and 350,000 less needles transmitted HIV. This program was established “to provide needle exchange and other harm reduction services in the District of Columbia. The mission...is to curb the spread of HIV and other blood-borne diseases among injecting drug users, their sexual partners, and newborn children” (*PreventionWorks!* pamphlet). Due to current legislation discriminating against needle exchange programs, *PreventionWorks!* runs solely on private donations. In addition to exchanging needles, *PreventionWorks!* also provides harm reduction kits, needle-bleaching kits, and harm reduction education to participants that includes referrals to treatment programs, medical clinics and support services. *PreventionWorks!* also offers on-site OraSure HIV testing that includes pre-testing and post-testing counseling

### **Sexual Code of Silence**

Two-thirds of parents say they have discussed sex adequately with their teens. One-third of teens say their parents have done so. This personal unease is a microcosm of the big picture (Feldt, 2002, p.2).

Unfortunately, there exists a “sexual code of silence” in the United States today, and reluctance to discuss the topic of sexuality prevails.

"Society's reluctance to openly confront issues regarding sexuality results in a number of untoward effects. This social inhibition impedes the development and

implementation of effective sexual health and HIV/STD education programs, and it stands in the way of communication between parents and children and between sex partners. It perpetuates misperceptions about individual risk and ignorance about the consequences of sexual activities and may encourage high-risk sexual practices. It also impacts the level of counseling training given to health care providers to assess sexual histories, as well as providers' comfort levels in conducting risk-behavior discussions with clients. In addition, the "code of silence" has resulted in missed opportunities to use the mass media (e.g., television, radio, printed media, and the Internet) to encourage healthy sexual behaviors." (Ruiz, et al., 2001, p.100).

The "code of silence" is further exacerbated by the Bush administration's abstinence-only referendum. The \$440 million in federal and state funds for HIV prevention for over five years represents roughly 80 percent of all money put towards HIV prevention measures (p.35). Yet no legislation currently prohibits the use of sex in advertisement. "Paradoxically, sex is both America's most popular topic and its most avoided secret," (Feldt, 2002, p.2).

### **Female Controlled HIV Prevention Methods**

Another major factor in HIV/AIDS prevalence among women comes from the lack of female-controlled prevention methods. Oftentimes women who attempt to negotiate condom use experience domestic violence as a result. Unfortunately, many researchers neglect this issue, assuming that all women have the choice of whether their partner uses a condom. Consequently, many women fall victim to risky sexual behavior as a result of domestic violence. "Female condom use has shown that the device empowers diverse populations of women, helping them negotiate protection with their partners, promoting healthy behaviors, and increasing self-efficacy and sexual confidence and autonomy," (Gollub, 2000, p.1377). However, female condoms are not always the answer. For women living in poverty, the cost of a female condom is often 5 dollars per female condom (American pregnancy Association, 2003, p.1). As a result, they must rely on negotiating the use of male condoms with their male partner. Additionally, few supermarkets and convenience stores carry female condoms resulting in a lack of accessibility.

Due to cost and decreased availability, female condoms may not protect poor women from HIV transmission in abusive relationships.

The development of topical microbicides mark the first possible victory in female-controlled prevention, however their use and effectiveness are still pending. Still in research trials, scientists hope microbicides will kill HIV and pathogens that cause STIs (CDC, 2003, p.3). Once available to the public, microbicides may eliminate disparities of HIV for women at risk of domestic violence and decrease the burden of the epidemic for all women.

## **Promoting Sexual Health**

### **Condoms vs. Abstinence-only Education**

Factors associated with condom use include the prevalence and effectiveness of STD education in schools and the accessibility of condoms. “Knowledge of appropriate condom use and widespread availability of condoms are especially important in promoting risk-reduction behaviors among youth” (Futterman, 2002, p.4). Unfortunately, the current abstinence-only education curriculum prohibits condom discussion except when demonstrating condom failures. Consequently, students receiving abstinence-only education miss imperative knowledge describing the 99% protection rate (from HIV) of latex condoms when correctly and regularly used. This suggests that school based programs that lack effective sex education, such as the abstinence-only agenda, actually discourage condom use, thus promoting HIV infection for two major reasons: abstinence-only education recipients lack knowledge about effective condom use and lack condom availability at the time of sexual activity (Futterman, 2002, p.4).

In contrast, “school-based programs that provide comprehensive health education in conjunction with school health clinics offer optimal opportunities to reinforce positive health

behavior and ensure routine screenings,” (Futterman, 2002, p.5). Certain influential programs include discussion of social influences and pressure, skills building and values identification (p.5). Such programs promote abstinence discussions *and* condom education as ways to promote safer sex education. Unfortunately, recent legislation mandates the teaching of abstinence-only education in many schools.

Although most States require HIV/AIDS and other STI education, federal funding for such programs focuses solely on abstinence-only education. In fact, the Bush administration is calling for an 83 percent increase in funding for abstinence education (Human Rights Watch, 2002, p.9). Currently, the government allocates \$100 annually to support “abstinence-only-until-marriage” education but supporters advocate increasing this sum to \$130 million (Human Rights Watch, 2002, p.9). Monies for these programs are provided by section 501(b) of the Welfare Reform Act, and define abstinence only education as follows:

Abstinence education means an educational or motivational program which:

- A) has it’s exclusive purpose, teaching, and social psychological, and health gains to be realized by abstaining from sexual activity;
- B) teaches abstinence from sexual activity outside marriage as the expected standard for all school aged children
- C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
- D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
- E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
- F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;
- G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
- H) teaches the importance of attaining self-sufficiency before engaging in sexual activity

(Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 501(b))

Additionally, federal government has markedly increased funding for abstinence-only programs while cutting comprehensive sexual education programs. For example, Planned Parenthood, a national organization dedicated to sexual health education has lost all federal funding – totaling 10% of the entire budget – and is now prohibited from entering many schools (Bailey, 2004, personal communication). Meanwhile, the Special Projects of Regional and National Significance-Community-Based Abstinence Education program (SPRANS-CBAE), a group supporting state and local abstinence-only education, recently doubled from \$20 million to \$40 million between 2001 and 2002 (Human Rights Watch, 2002, p.10). This program enlists even stricter guidelines than 501(b), including an age requirement of adolescents between the ages of 12 and 18. “The reality is that 90 percent of Americans have intercourse before marriage, and 50 percent of teens are sexually active by the time they leave high school,” (Feldt, 2002, p. 4). In other words, half of high school students need HIV/STI prevention (and pregnancy prevention) information because they are sexually active. In schools providing abstinence-only education, all of these students suffer by lacking this pertinent information.

These statistics prove organizations providing comprehensive sexual education that includes both abstinence and condom education, such as Planned Parenthood, prepare all students to take control of their sexual health, not just those abstaining from sex. When surveyed about abstinence-only education in the public school system, twenty year-old Xiomora Flores states, “There was nothing about birth control, how to use a condom, or where to go the morning after... Those are the classes about not having sex? Oh, but what if you are?” (Larson, 2002, p.9). Possibly more alarming is Helena Valentine, program administrator of Catholic Charities Teen Life choices program, an abstinence-only education program targeted to Ward 7 children. When asked about sex or contraception, Valentine responds, “There’s absolutely no discussion

of condoms...we say there's no such thing as safe sex" (Larson, 2002, p.1). These reactions clearly represent the fundamental flaw with abstinence only programs: teaching the only acceptable behavior for youth is abstaining from sex until marriage is naïve and misinformed.

According to the National Institute of Health,

Legislative barriers that discourage effective programs aimed at youth must be eliminated. Although sexual abstinence is a desirable objective, programs must include instruction in safe sex behavior, including condom use. The effectiveness of these programs is supported by strong scientific evidence (NIH, 1997).

In conclusion, abstinence-only programs are potentially harmful to youth because they target only those abstaining from sex while suppressing important HIV prevention information.

Another major problem with abstinence only education is the lack of scientific evidence supporting program effectiveness in promoting abstinence and decreasing pregnancy, STIs, and HIV/AIDS. In fact, the U.S. Department of Health and Human Services concluded that no proof exists that these programs decrease sexual activity, unwanted pregnancies, and STIs among teenagers in the U.S. (Devaney, 2002, p.1). Furthermore, Kirby et al. found in 1997 that,

Abstinence-only programs focus on the importance of abstinence from sexual intercourse, typically until marriage. Either these programs do not discuss contraception or they briefly discuss the failure of contraceptives to provide complete protection against pregnancy and STDs. To date, six studies of abstinence-only programs have been published. None of these studies has found consistent and significant program effects on delaying the onset of intercourse, and at least one study provided strong evidence that the program did not delay the onset of intercourse. Thus, the weight of the current evidence indicates that these abstinence programs do not delay the onset of intercourse (National Campaign to Prevent Teen Pregnancy, 2002).

Representing this trend is the inability for American teachers to stick to sexual education curriculum. A recent study found that teachers implementing such programs use personal opinions more often than medical fact to convey information (Darroch et al., 2000, p.32). In fact,

100 percent of teachers polled admitted they use-opinion based data when implementing HIV and STD education (Darroch et al., 2000, p.32). With 100 percent of teachers teaching opinion over fact, misinformation runs rampant. For example, a student at Anacostia high school reported such opinion-based information in a previous health education class stating a teacher told the class HIV and STDs are *not* transmitted through oral sex. This proves that HIV education taught through opinion over fact may actually spread ignorance and disease, as the student did not use protection during oral sex due to misinformation from his teacher.

However, public opinion favors comprehensive sexual education. A poll done by the Kaiser Family Foundation found Americans overwhelmingly favor abstinence, pregnancy and STD prevention when compared to abstinence-only. Specifically, 81 percent of Americans reported they believed their children should receive abstinence, pregnancy and STD information in sexual education classes while only 1 percent preferred abstinence-only education (KFF 1998 p.66). These trends prove the majority of American parents wish to provide their children with comprehensive sex education.

Yet, scientific evidence does not promote abstinence-only education as a means of HIV prevention. In fact, some studies show this form of education actually has the opposite effect on adolescents. This year, researchers found that virginity pledges delay the onset of sexual intercourse for up to 18 months *and those young people who took a virginity pledge were one-third less likely to use contraception when they did become sexually active* (Bearman & Bruckner, 2001). Furthermore, research also showed that in communities with high rates of virginity pledges, overall STD rates were also significantly higher than those communities not pledging (Bearman & Bruckner 2004). In Minnesota, three schools implementing the Education Now and Babies Later abstinence-only curriculum, found the number of participants saying they

would “probably” have sex during high school doubled (Professional Data Analysts, Inc. 2004). In Arizona, a four-year evaluation report stated there was no change in sexual behavior with abstinence-only education (Lecroy & Milligan Associates, Inc. 2003). Finally, in Pennsylvania, the initiative was found to be largely ineffective in reducing sexual onset and promoting attitudes and skills consistent with sexual abstinence (Siecus Public Policy Office 2004). These findings have since been eliminated from the Pennsylvania Department of Health Website (2004). Furthermore, locating research rebuking abstinence-only education is increasingly challenging as many DOH websites and the DHHS website have removed such information.

However, studies targeting adult women at risk for HIV infection report increases in condom use when properly educated. In fact,

Data from a variety of settings demonstrate the ability to prevent HIV risk behaviors in women. A randomized trial involving a cognitive behavioral intervention aimed at inner-city women with high risk of acquiring HIV through heterosexual contact provides some of the strongest evidence of impact. Three months after intervention, women in the intervention reported a doubling of condom use from 26 percent to 56 percent for all intercourse occasions; no such change occurred for women in the comparison group. A second randomized trial, targeted at pregnant women, shows similar results at a 6-month follow-up (NIH 1997).

Furthermore, comprehensive sexuality information programs have, “found to be effective in delaying the onset of sexual intercourse, reducing the number of sexual partners, and increasing contraception and condom use, “(Kirby et al. 1997, Kirby et al. 2001, Satcher, 2001). Research also shows students attending schools with condom education are less likely to be sexually active and more likely to engage in safer sex behaviors by using condoms (Blake, et al., 2003). In addition, “comprehensive sexuality education programs can delay the onset of sexual activity, reduce the number of sexual partners among sexually active youth, and reduce the rates of unintended pregnancy and STDs” (The United Nations Programme on HIV/AIDS, 1997).

In conclusion, abstinence-only education lacks a critical component of HIV/AIDS education and prevention: condoms. A federally mandated school-based HIV/AIDS education that includes all aspects of HIV prevention is a critical step in stopping the spread of HIV. Such a program should abandon abstinence-only education and instead include condom education *and* abstinence discussions and be required in *all* middle and high schools in the country, including Catholic schools.

### **Self-esteem Programs**

An additional type of sexual education exists. Self-esteem education incorporates both abstinence and condom education, providing the most comprehensive form of sexual education available to schools. Currently, the most well known program implementing this type of education is “The Making Proud Choices! Curriculum” developed by Loretta Sweet-Jammott from the University of Pennsylvania. The goal of the curriculum is to, “empower young adolescents to change their behavior in ways that will reduce their risk of becoming infected with HIV and other STDs and their risk of pregnancy” (Sweet-Jammott, 2004). Curriculum outcomes include an increase in knowledge about HIV, STD and pregnancy prevention, belief in the value of safer-sex (including abstinence), improvement in the ability to negotiate safer-sex and abstinence, increasing correct condom use, having stronger intentions of using condoms when sexually active, having a lower incidence of HIV/STD sexual risk-taking behavior, and taking pride in choosing responsible sexual behaviors (Sweet-Jammott, 2004). For its proven prevention methods, the CDC has chosen this particular curriculum to be implemented in schools nationwide. Yet, due to its comprehensive educational strategy, no funding from the federal government exists to provide this curriculum to schools and it therefore does not reach nearly as many adolescents whom it would benefit.

**Teen Voice!**

Unfortunately, The Making Proud Choices! Curriculum does not exist East of the River. In reaction to the lack of programs, the American Red Cross employs a peer education program entitled “Teen Voice!” This program works as an information program and prevention strategy. It trains young people throughout DC and its surrounding areas in HIV/AIDS education and prevention. “Teen Voice!” also trains teachers on how to deliver this information effectively to school-aged people, particularly those attending low-income public schools. I volunteer as a “Teen Voice!” peer educator and have worked with the program for two years. Although this program is successful and vital to its recipients, there are also barriers.

“Teen Voice!” works, but the audience is minimal. We only present maybe fifteen times a month to a select few. Recently, the program has been expanding and now includes an eight-week HIV, STD and pregnancy prevention course similar to “The Making Proud Choices! Curriculum”. Over the last eight weeks, I taught this eight-week “Teen Voice!” curriculum to Anacostia high school seniors. Our class sized at 30 students out of the nearly 1,000 who attend the school. Unfortunately, volunteer numbers fall short of the growing need for comprehensive sexual education in D.C. public schools. This year alone, eight public schools asked for the curriculum, which is free, but only two schools were granted the curriculum for lack of Red Cross certified peer education volunteers. The problem in attracting volunteers is obvious – we don’t get paid and not everyone is able to commit to a two-hour block of time (during work hours!) once a week. Furthermore, once a school accepts our volunteers, the percentage of students actually receiving the program is exceedingly low. Lack of an audience again stems from the inability to provide enough educators for each school. Furthermore, the Red Cross must make and maintain solid school contacts, usually a teacher or school nurse. Once a contact is

made, the individual only represents a select few in the school – For instance, our Anacostia contact is a PE teacher and only has class during period three for those seniors (60 total) enrolled in the class. Then, one must take into account truancy, leaving at times as little as 15 students in any given class period.

The curriculum commenced April 30, 2004 and results were impressive. During week one, no one in class knew the acronym for HIV or AIDS, the difference between latex and sheepskin condoms, or the possibility of contracting an STD through oral sex. By week six, students literally begged us to call for a school-wide assembly to present this vital STD, HIV and pregnancy prevention information. Nearly 75 percent of students taught reported they had no previous sexual education in school. Finally, by week 8, most students not only knew the acronyms for HIV and AIDS, but were able to define the term immunodeficiency. They also described the differences in condom materials, risks of unprotected oral sex, when and how to get tested, differences between confidential and anonymous testing, appropriate condom demonstrations, influences of drugs and alcohol on sexual risk taking, influence of peer pressure on sexual risk taking, and different ways to say no. In addition to the wealth of knowledge retained by the students, another amazing phenomenon occurred: the class size nearly doubled as students heard by word of mouth of our curriculum and attended class even though they were not registered. Judging by the reaction at Anacostia high school, comprehensive sexual education is both greatly needed and well received in D.C. public schools.

## Role of Society

### The Media

The media--whether television, movies, music videos, video games, print, or the Internet--are pervasive in today's world and sexual talk and behavior are frequent and increasingly explicit. More than one-half of the programming on television has sexual content (Cope and Kunkel, in press). Judging by current advertisements depicting various music videos and Hollywood movies, the majority of current media overwhelmingly portrays sexuality or eroticism (Greenberg et al, 1993; DuRant et al, 1997). In addition to movies and television, the internet has developed into a major pornographic database. In fact, "among young people, 10-17 years of age, who regularly use the Internet, one-quarter had encountered unwanted pornography in the past year, and one-fifth had been exposed to unwanted sexual solicitations or approaches through the Internet" (Finkelhor et al, 2000).

Unfortunately, media behaviors seldom promote sexual health. Condom use, monogamy and family planning rarely gain a role in television or movies. In fact, the recent American obsession with HBO's *Sex in the City* portrayed one major idea: sex. Unfortunately, this program also promoted irresponsibility by ignoring conversations regarding condoms while simultaneously exploiting conversations about sex. Yet, this is only one example of the overall irresponsibility of Hollywood to promote safer sex behavior. In fact, some may conclude that the industry actually promotes risky sexual behavior. Realizing this obvious dilemma, the surgeon general recently called the media to action:

The media do, however, have the potential for providing sexuality information and education to the public. Media, in all its forms can be engaged, by both public

and private entities, in a national dialogue to promote sexual health and responsible sexual behavior. This dialogue should be a long-term effort and should treat sexuality issues responsibly, accurately, and positively. With respect to media programming, the portrayal of sexual relationships should be mature and honest, and responsible sexual behavior should be stressed. Finally, it is also important that young people, as well as adults, be educated to critically examine media messages (Satcher, 2001).

### **Government Organizations**

The Ryan White Care Act of 1990 allocates funds to improve quality of care for individuals and families living with HIV/AIDS (PL 101-381). The Ryan White Care Act represents the largest authorization of Federal funds specifically designated to provide health and social services to low income, uninsured, or under insured persons infected with HIV. The Health Resources and Services Administration (HRSA), a program within the Department of Health and Human Services (DHHS), manages the federal funds for the Ryan White Care Act (HRSA, 2000).

For over a decade, the Act has dramatically improved the quality of life for people living with HIV and their families, reduced the use of costly inpatient care, and increased access to care for under-served populations, including people of color. The Act was amended in 1996 and again in 2000. With each amendment, the scope and cultural awareness of the Act evolves. Most recently, amendments included funding for individuals recently released from correctional institutions, substance abuse prevention and treatment, and a duty to study the demographics of underserved populations affected by the disease (HRSA, 2000). Estimates claim over 500,000 people living with HIV/AIDS benefit from the funds introduced in the Ryan White CARE Act, and over 60 percent of those are minorities (HRSA, 2004).

Title I of the act distributes money to metropolitan areas disproportionately affected by the disease. Consequently, Washington D.C. qualifies for this aid because it hosts the highest AIDS case rate in the country. Money received under Title I funds organizations providing outpatient services, case management, home health and hospice care, housing, nutrition services and transportation (HRSA, 2004). Local governments distribute funds to these specific areas as they see fit. In Washington D.C., due to the severity of the AIDS epidemic among the African American community, supplemental funding for Areas with Substantial Need for Services (ASNS) exists. This clause reserves \$5 million dollars for areas where over 30 percent of the HIV/AIDS cases occur in African Americans or Latinos (HRSA, 2004).

Also supplementing Title I funds is the Minority HIV/AIDS Initiative. The Department of Health and Human Services, in conjunction with the Congressional Black Caucus, established additional funding for HIV/AIDS assistance in minority communities. In 1998, they announced a plan to supplement CARE funding by \$156 million dollars to combat the HIV/AIDS crisis for racial and ethnic minorities (HRSA, 2000). Each year, funding and scope of services improve, so that

In FY 1999, the Initiative targeted African American and Hispanic communities. In FY 2000, the Minority AIDS Initiative (MAI) was created to include all communities of color. The Initiative began in FY 1999 with \$156 million, and the funding to support the expanded programs increased to \$251 million in FY 2000, and \$350 million in FY 2001. MAI funds target programs to enhance effective HIV/AIDS efforts that directly benefit racial and ethnic minority communities in three broad funding categories: technical assistance and infrastructure support, increasing access to prevention and care, and building stronger community linkages to address the HIV prevention and health care needs of specific populations (HRSA, 2004).

In 1999, the Minority HIV/AIDS Initiative also introduced the Minority Community Health Coalition Demonstration Program that distributed money to the 15 metropolitan areas

with the most prevalent HIV/AIDS rates named by the CDC's HIV/AIDS Surveillance Report of 1997 and 1998 (Office of National AIDS Policy). Washington D.C. fell under this category and slowly climbed to the top of the ratings as the years progressed.

Title II gives money to States, resulting in zero benefit for Washington D.C. Under this Title, grants are given to States for health care and support services for people living with HIV/AIDS (Johns Hopkins, 2000). Again, the State government decides distribution of money to these services.

Title III of the act allocates funding for testing, education, prevention, medications, primary care, and social services. More specifically,

Support is provided to primary care providers through local health departments, homeless programs, community and migrant health centers, hemophilia centers and family planning centers. Major services provided under Title III are primary care services for low-income, medically underserved persons in existing primary care systems and clinical prevention services through medical, educational and psychosocial services (PL 101-381).

The majority of private and public services in Washington D.C., such as the comprehensive HIV Community Coalition, an HIV/AIDS resource for residents east of the river, receives all of its funding through Title III of the Care Act.

Title IV provides family-centered care primarily to the poor, racial minorities, and those who lack sufficient housing and transportation. It is intended to support women, children, adolescents and families already utilizing comprehensive, community based care systems (Hopkins). However, despite the severity of the epidemic among young, African American women in Washington D.C., only one supplemental grant under Title IV was reserved for the District. This additional grant allocated \$12.2 million dollars to local health departments, community centers and hospitals throughout "hot spot" areas (Office of National AIDS Policy).

Unfortunately, the Children's Hospital Special Immunology Service was the only recipient of funding in D.C (National AIDS Policy).

The AIDS Drug Assistance Program (ADAP), enacted under Title II, allocates essential medications to those who lack funds or insurance. People living with HIV/AIDS may spend upwards of \$3000 per month on Antiretroviral drugs (Office of National AIDS policy). Without the medication assistance in Title II of the Ryan White Care Act, many would be unable to afford necessary medications.

There is no doubt the Ryan White Act improves the quality of life for many living with HIV/AIDS through funding of clinics, education, medication, and more. Many living with HIV/AIDS name this Act their "saving grace," as they lack appropriate health care funds. Although hard to critique this blessing, more could benefit from the Act. With 500,000 receiving aide of the close to 1 million infected, this leaves nearly half of those living with HIV/AIDS without government assistance. Furthermore, residents of Washington D.C. living with HIV/AIDS are precluded from monies distributed in the CARE act because D.C. lacks statehood.

However, both the Ryan White Care Act and ADAP are greatly needed by HIV/AIDS infected women living east of the river due to the overwhelming poverty characterizing this area.

## **Non-Profit Organizations in the District**

### **HIV Community Coalition**

As a result of health care inequality East of the River, privately and publicly run organizations are taking over the fight against HIV and AIDS. The HIV Community Coalition, or HCC, is one such organization that works as a resource center for those affected by

HIV/AIDS. It provides referrals to a vast number of agencies throughout the District, from food kitchens to housing facilities to health care centers. HCC outreach workers literally hit the streets and advertise the organization, speaking with as many people as possible about getting tested and finding resources.

HCC also partners with many organizations in order to effectively reach as many potential participants as possible. For instance, HCC outreach workers often shadow the needle exchange van. As people wait to exchange needles, outreach workers discuss HIV prevention and resources for people living with HIV/AIDS with the participants. They also partner with Delta, an organization dedicated to assisting women living with HIV/AIDS. In March 2004, both organizations put together a “pamper” day where positive women were provided with lunches, facials, makeovers, massages, yoga classes and various other health enhancements activities. This marked the first pamper day of many more between HCC and Delta.

Another major component of HCC is the food program. Members of the food program collect, organize and distribute food to over 5 locations throughout the district, while also providing soup and sandwiches to anyone who comes into the office. Currently Safeway donates food on Mondays and Fridays allowing HCC to distribute hot meals and canned good to So Other Might Eat, Catholic Charities, and public housing offices.

### **Metro TeenAIDS**

Another major resource for young African American women living east of the river is Metro TeenAIDS located in Eastern Market, which in addition to having a peer education program, also works as a hangout, or “safe house”, for those inflicted with and working to prevent the disease. The program is much more liberal than its Red Cross counterpart and is also the only resource in the District dedicated solely to serving youth infected with HIV or AIDS. It

receives a grant from the Centers for Disease Control and Prevention. Over the past 12 years, Metro TeenAIDS, “has provided education programs and prevention resources to over 150,000 young people, family members, and youth workers” ([www.metroteenaid.org/about/index.html](http://www.metroteenaid.org/about/index.html)). Their mission includes mobilization, community awareness, prevention, collaboration, and dealing with numerous other adolescent issues such as self-esteem and peer groups.

Metro TeenAIDS runs three major programs in addition to their affiliation with the Ryan White National Youth Conference. These programs include street outreach and case finding, counseling/testing site evaluations and referrals, and an information center. Aside from doing general outreach work, the street outreach and case finding primarily targets homosexual males and females living in public housing. It attempts to identify at-risk behavior while providing them with HIV/AIDS prevention and testing information. This program also gives general “HIV101” information sessions upon request.

Metro TeenAIDS counseling/testing site evaluations and referrals program is a way for volunteers to assess the legitimacy of various programs. “Members conduct ‘undercover’ referrals to determine which testing sites follow guidelines established by professionals in adolescent health care ([www.metroteenaid.org/Programs/programs.html](http://www.metroteenaid.org/Programs/programs.html)). Once assessed, the organization then provides the public with a list of selected sites they evaluated and approved. These lists are then used for street outreach information packets.

The third and final program run by Metro TeenAIDS is an information center. The center is located on Pennsylvania Avenue in Eastern Market and serves as a resource for anyone who walks in. Numerous packets and pamphlets on the latest HIV/AIDS information are readily available for the public, and new materials are consistently being updated. Information from Metro TeenAIDS is also posted on their website.

### **Sasha Bruce Youthwork**

Sasha Bruce Youthwork was founded in 1974 as the Washington Streetwork Project when runaways and street kids typically congregated in the Georgetown and Dupont Circle area. The mission focused on getting these kids reconnected with their homes. In 1976 Sasha Bruce, a volunteer for street kids and daughter of Ambassador David Bruce died, and her family donated funds to the Washington Streetwork project in her memory. Eventually, Sasha Bruce's mother opened the Sasha Bruce House, a safe haven for troubled youth. Over the next few decades, the project has seen numerous additions to its scope and mission and eventually took the name Sasha Bruce Youthwork (SBY).

Today, Sasha Bruce Youthwork is a private, nonprofit agency that offers a multitude of services to youth and their families. SBY, “delivers comprehensive services to meet the urgent needs of at-risk youth and their families and is a key provider of youth and family services in Washington D.C. and the surrounding community” ([www.sashabruce.org](http://www.sashabruce.org)). SBY believes strongly in empowering youth and their families to be catalysts of their own change. The majority of SBY residents are African American women, many of whom previously resided east of the Anacostia river.

Sasha Bruce Youthwork offers 14 different programs for youth and their families, one of which is the AIDS Prevention Services. This program provides prevention and education to at-risk youth, including sex-workers, court adjudicated youth, runaway and homeless youth, teenage mothers, and youth living in shelters. AIDS Prevention Services utilizes a variety of tactics in providing HIV and AIDS education to program targets. These strategies include street

outreach, prevention case management, education/school presentations, and outreach work at various citywide functions.

### **Our Children, Inc.**

Our Children, Inc. is a mentoring program for at-risk youth that seeks to provide an array of programs to motivate the youth to, “succeed in life and academic challenges, envision a new future for themselves, and develop skills to accomplish their goals and reach their highest potential” (Hill, 2002). Our Children, Inc. is a relatively new program that has been functioning only since April 2001 and has a centrally located main office in northwest that is accessible to numerous social services. The goal of Our Children, Inc. is to provide the youth with the necessary skills and opportunities in order to become a functioning member of society.

The educational component of Our Children, Inc. is located in Southeast and focuses primarily on HIV/aids, substance abuse prevention, STDs, case management, mental health counseling and negotiating and life skills. The funding for this HIV/AIDS prevention component as well as ORA-SURE testing provided comes from the Department of Health, HIV/AIDS administration. This funding enables Our Children, Inc. to work towards its mission of “enhancing the quality of life for African American children in the Metropolitan area by providing...education, counseling, and testing services that will empower our children to live a productive and wholesome life” (Hill, 2002). The overall goal of this educational component is to provide facts and tools necessary for testing and preventative healthcare for the youth involved.

### **Family and Medical Counseling Service, Inc.**

Family and Medical Counseling Service, Inc. (FMCA) is a community based non-profit organization that works to promote the health of individuals and families in the community.

FMCA headquarters are located in Southeast Washington, D.C., therefore providing available, comprehensive care to African American women residing there. FMCA offers a holistic approach to overall health, working with the mind, body and soul by endorsing emotional and physical health as equal components of one's overall well being. The staff at FMCS offers a "client-centered, supportive environment" and hosts an assortment of professionals including social workers, nurses, dieticians, case managers, physicians, addiction counselors, doctors, treatment specialists, discharge planners, etc. With such a wide range of staff and volunteers, the scope of service at FMCS is also broad, offering information and referral services, counseling/psychotherapy, for individuals of all ages and families, primary medical care, youth/adolescent prevention and education, substance abuse counseling, case management, HIV/AIDS prevention, outreach, counseling and testing, entitlements counseling, parenting skills, nutrition counseling and support groups. The overall mission of FMCS is to utilize, "a community-base, culturally appropriate approach to provide comprehensive, holistic services that promote the emotional and physical health of families and individuals" (FMCS, 2000).

Project Ujima is the component of FMCS that deals primarily with HIV/AIDS. The word Ujima is of African descent meaning collective work and collective responsibility. The HIV/AIDS services provided by Project Ujima include case management, community outreach, primary medical care, nutrition counseling, support groups substance abuse counseling, psychosocial services, HIV counseling and testing, food bank, and discharge planning. Project ujima is supported by the DC Department of Health, Administration for HIV/AIDS.

### **Healthy DC Foundation**

The Healthy DC Foundation was originally founded in 1989 as the DC General Hospital Foundation to provide quality medical care for all residents of the District regardless of

socioeconomic status, specifically vulnerable populations and those who lack insurance.

Therefore, many participants are young African American women east of the river, The Foundation focuses primarily on major health issues and disparities in the district including but not limited to sexual assault and abuse, HIV/AIDS prevention and treatment, and colon cancer prevention and education. Healthy DC uses a variety of tactics such as education, training, research, media programming, public development and community collaboration to promote the health of the community. The overall goal of the Healthy DC Foundation is to build a stronger and healthier community through education, outreach, and service.

Renue is a new initiative from the Healthy DC Foundation for HIV positive women, primarily Black women, residing in Ward 8. The new initiative was developed to meet the need of women residing in the Ward with the highest number of incidences (new cases) of HIV infection. (Healthy DC Foundation, 2002). The Foundation believes these women are disproportionately exposed to various stressors related to an HIV positive diagnosis such as poverty, single parenthood, poor nutrition, and homelessness and is therefore committed to providing a “nurturing, supportive environment” that will help relieve some of this unwanted stress. Specific stress reduction techniques implemented by Renue include but are not limited to yoga, tai chi, meditation, and acupuncture. The program also serves as an information resource for HIV positive women and their children that addresses major stressful issues such as nutrition, legal custody of children, housing, obtaining public assistance, and image and sexuality issues. Renue also provides referrals for legal assistance, medical assistance, counseling and finding safe housing.

## **Us Helping Us**

Us Helping Us, People Into Living is the sole organization in D.C. that specializes in prevention and care services for black gay, bisexual and transgender men living with HIV and AIDS. Founded in 1988, Us Helping Us was founded by African American gay and bisexual males who believed AIDS was a significant public health crisis with limited resources. This resource indirectly helps young African American women east of the river as it provides care for potential partners on the “Down Low.” It is also located in Navy Yard, Southeast, therefore the majority of the participants reside here, east of the river. The program eventually evolved into a volunteer organization providing holistic services and information for people living with HIV and AIDS. In 1992, their mission statement advocated, “holistic therapies as a complement to drug therapy, and as an important factor in the quality of life of persons with HIV/AIDS” (Us Helping Us, 1992). In 1993, the organization received its first private foundation grant from the Washington AIDS Partnership, and in 1994 they also began receiving money from the Ryan White Title I grant. In 1995 the group, with urging from the public, added prevention programs for HIV negative men. In 2000, Us helping Us conducted the first needs assessment survey for bisexual and transgender men of color in the District, and the second largest survey of its kind ever conducted in the United States.

For nearly 20 years, Us Helping Us has been committed to, “reducing HIV infection in the African American community by specializing in HIV prevention and support services for black gay and bisexual men and transgender persons” (Us Helping Us, 2002). They also offer programs for heterosexual men and women and HIV testing and counseling for anyone interested. Other programs provided by this group include case management, prevention case management, support groups, help line, transgender drop in center, and holistic health seminars.

They recently developed a new support group entitled “The Living Room” which offers discussion and counseling for those recently diagnosed within the last year.

Us Helping Us takes confidentiality very seriously. They are located in an unmarked building that allows for privacy of participants. Furthermore, they advertise their calls on the “down low” which is the term used for bisexual and gay black men who are not open with their sexual orientation.

## **Conclusion**

Overall, young African American women residing east of the river, Washington D.C. disproportionately suffer from HIV/AIDS. When studying the problem, one must first critique life east of the river: poverty, single parenting, drugs and lack of education all directly relate to the increased incidence and prevalence of HIV/AIDS among this group. In other words, “while women are quite concerned about being infected with HIV, the threat of death is not enough to persuade black women to protect themselves if it means being alone and with less income,” (Villarosa, 2004, p.2) We must first alleviate hopelessness by providing African American women living east of the river with basic human needs such as food, shelter, education, and safety. Another form of structural violence, HIV/AIDS rates will only decrease once these needs have been met.

In combating the epidemic, we must first educate. Providing comprehensive AIDS, STD and pregnancy prevention in schools reduces sexual risk behavior and therefore the spread of HIV. Gaining federal funding for comprehensive sexual education, while abandoning unproven abstinence-only education will provide all public

schools with pertinent information for students to take control of their sexual health. This will also reduce HIV incidence and prevalence.

Needle Exchange programs reduce the risk of HIV transmission for injection drug users. NEPS have been clinically proven to reduce HIV risk behavior while either decreasing or remaining constant the number of drug users in a community. Providing federal funding for needle exchange programs will decrease rates of HIV/AIDS for the over one-third of women who are infected via injection drug use.

Current nongovernment, nonprofit organizations in Washington D.C. provide a multitude of services for women infected with and affected by HIV/AIDS. All programs include nonjudgemental attitudes, referral services, and education on HIV/AIDS. The only suggestion regarding these programs is a proposed increased focus on promotion. As displayed by my students at Anacostia high school and the participant at Preventionworks, people living with HIV/AIDS do not always know where or how to look. By following the example of Metro Teen AIDS, organizations should implement rigorous campaign efforts to promote their programs, targeting those who are unaware of available services.

Overall, HIV/AIDS in Washington D.C. is progressing at an alarming rate. Young African American females living east of the river are currently the highest risk category and should be the focus of prevention efforts. By targeting this group, overall incidence and prevalence of the epidemic will decrease, and District residents may be able to control the growing epidemic in their own backyard.

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