

# Fighting HIV/AIDS In Washington, D.C.

With an HIV prevalence rate comparable to some resource-limited countries, the District mounts a broad response.

**by Alan E. Greenberg, Shannon L. Hader, Henry Masur, A. Toni Young, Jennifer Skillicorn, and Carl W. Dieffenbach**

**ABSTRACT:** Washington, D.C., is the capital of the United States and is a major center for public health and health policy expertise. Yet the District of Columbia has an HIV prevalence rate among adults of 3 percent, on par with some sub-Saharan African countries. To date, the local public health response has not controlled the epidemic. The ways in which that response has been galvanized in recent years—through collaboration among the capital’s public health agencies, community and faith organizations, and research institutions—may be instructive to other jurisdictions combating HIV/AIDS. [Health Aff (Millwood). 2009; 28(6):1677–87]

WASHINGTON, D.C., HAS AMONG THE HIGHEST rates of HIV/AIDS in the United States.<sup>1</sup> In 2005, the rate of newly reported aids cases per 100,000 people in the Washington, D.C., population (117.7) was higher than those in comparable U.S. cities such as Philadelphia (96.6), Baltimore (68.3), New York City (50.7), Detroit (31.6), and Chicago (30.9).<sup>2</sup> As has been widely publicized, the capital of the richest country in the world was also found to have HIV prevalence rates comparable to those in many of the world’s resource-limited nations. By the end of 2007, more than 15,000 people were living with HIV and AIDS in D.C., representing roughly 3.0 percent of adult D.C. residents—a prevalence rate on a par with countries such as Nigeria and the Congo.<sup>3</sup>

A number of factors have contributed to the severity of the local epidemic. First, there may be a high proportion of local residents in populations at increased risk of HIV infection, such as men who have sex with men, injecting drug users, and high-risk heterosexuals. These populations have overlapping social and sexual

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networks. Second, Washington, D.C., has a relatively small population (fewer than 600,000 residents) compared with other U.S. cities with significant epidemics. Coupled with high numbers of HIV cases, these attributes yield relatively high HIV prevalence rates. Lastly, Washington, D.C., has notable levels of poverty and economic disparity, which may be associated with inadequate access to effective prevention and care services in the populations who need them most.

To date, the local public health and policy response has not controlled the HIV epidemic in the District of Columbia. The independent watchdog organization DC Applesseed cited a number of aspects of this response in its initial report on the Washington, D.C., HIV/AIDS epidemic in 2005.<sup>4</sup> These included an ineffective HIV/AIDS surveillance system that had not collected and disseminated data in a timely fashion; a history of frequent changes in HIV/AIDS leadership in the D.C. Department of Health; challenges in grants management; insufficiently broad HIV testing and condom distribution programs; inadequate education on HIV prevention for the general population and in schools; and weak needle exchange and substance abuse treatment programs.<sup>4</sup>

### **Recent Critical Events**

The release of DC Applesseed's detailed and well-publicized report chronicling these weaknesses was a watershed event, prompting renewed attention to HIV/AIDS in the District. In 2006 Mayor Adrian Fenty declared HIV/AIDS to be his number-one public health priority. Key members of the City Council, including its chairman, Vincent Gray, and the chair of the Committee on Health, David Catania, lent their considerable support.<sup>5</sup> Experienced and highly trained public health leaders were selected to direct the D.C. Department of Health and its HIV/AIDS Administration.

In March 2006, in response to the need for improved HIV/AIDS surveillance data to guide the epidemic response, a partnership was formed between the D.C. Department of Health's HIV/AIDS Administration and the George Washington University School of Public Health and Health Services.<sup>2,6</sup> As a result of this successful effort to improve HIV/AIDS surveillance activities funded by the Centers for Disease Control and Prevention (CDC) in Washington, D.C., the *DC HIV/AIDS Epidemiology Annual Report* for 2007 contained the first surveillance data about AIDS prevalence in the District that had been published since 2002, as well as the first surveillance data ever about HIV infections in D.C.<sup>6</sup> The report called the HIV/AIDS crisis a "modern epidemic" because of its severity, complexity, and sustained nature. It received widespread attention in the local and national media.

In June 2006 the Department of Health launched a citywide routine HIV screening campaign, "Come Together DC—Get Screened for HIV," the first of its kind in the United States.<sup>7</sup> The overarching goals of the campaign were to raise HIV/AIDS awareness in an effort to reduce stigma, expand the availability of routine screening, reduce HIV transmission, and help newly diagnosed people begin

receiving care and treatment services. The campaign provided access to rapid testing technology; recruited new HIV testing sites throughout the District, especially in areas with limited HIV services; marketed HIV testing to residents; and laid the foundation for an expanded HIV testing program in 2008.

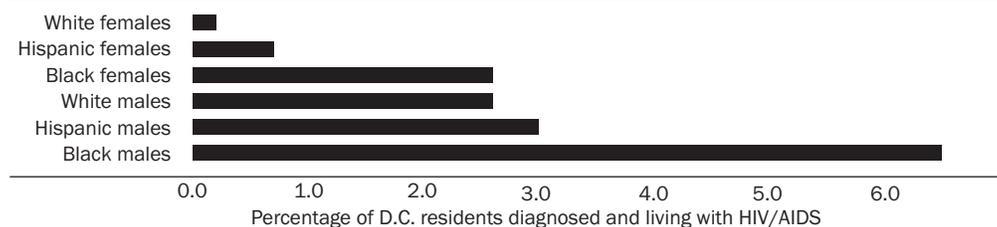
In 2008, the city’s annual HIV/AIDS epidemiology update reported the grim news that the overall HIV/AIDS prevalence rate among adult D.C. residents was 3.0 percent, with even higher rates in African American men (Exhibit 1).<sup>2</sup> Together with the previous year’s surveillance report,<sup>6</sup> the report helped the city further characterize its HIV epidemic. In effect, the city came to “know its epidemic,” including understanding which groups were affected (Exhibit 2), and began to develop a portfolio of prevention responses to achieve community-level impact.

### Portfolio Of Prevention Responses

■ **Testing.** HIV testing to help infected people learn their status early in the course of their infection is the nexus between prevention and care. In the District, studies suggest that between one-third and one-half of people who are positive are unaware of their status.<sup>8,9</sup> The city has therefore moved from a policy of providing testing to a policy of promoting it, actively encouraging residents to learn their HIV status, and building systems to make HIV testing a routine part of health care.

The District’s testing campaign—“Come Together DC—Get Screened for HIV”—was launched in June 2006. A key feature was the promotion of routine HIV testing in medical settings, with no separate written informed consent required and patients able to “opt out,” or choose not to be tested. In 2008, the District provided approximately 73,000 tests—an increase of 70 percent from 2007. Expanded HIV testing has already led to earlier diagnoses. An indicator of this is that, eighteen months into the program, on average, individuals’ first CD4+ count after diagnosis was 50 percent higher than previously. This suggests that testing was identifying infections earlier on, before immune systems were further com-

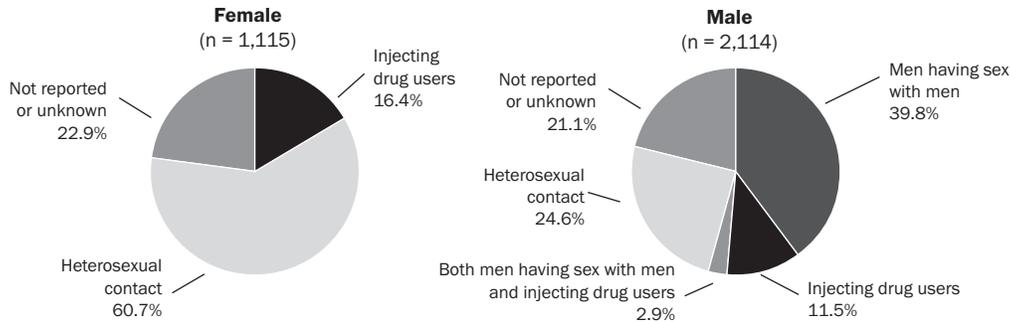
**EXHIBIT 1**  
**HIV/AIDS Prevalence Rates In The District Of Columbia, By Race/Ethnicity And Sex, 2007**



**SOURCE:** District of Columbia Department of Health. District of Columbia HIV/AIDS epidemiology update 2008 [Internet]. Washington (DC): DOH; 2009 Feb [cited 2009 Sep 24]. Available from: [http://dchealth.dc.gov/doh/lib/doh/pdf/dc\\_hiv-aids\\_2008\\_updatereport.pdf](http://dchealth.dc.gov/doh/lib/doh/pdf/dc_hiv-aids_2008_updatereport.pdf)

**NOTE:** The overall prevalence rate in D.C. was 3.0 percent in 2007.

**EXHIBIT 2**  
**Proportion Of Newly Reported HIV Cases Among Adults And Adolescents In The District Of Columbia, By Sex And Mode Of Transmission, 2001-2006**



**SOURCE:** District of Columbia Department of Health. District of Columbia HIV/AIDS epidemiology annual report 2007 [Internet]. Washington (DC): DOH; 2007 [cited 2009 Sep 24]. Available from: <http://doh.dc.gov/doh/cwp/view,A,1371,Q,603431.asp>

promised.<sup>2</sup>

The strategic scale-up of routine voluntary testing in medical settings was based in part on CDC HIV Testing Guidelines and in part on local data showing that approximately 75 percent of those newly testing positive had actually seen a medical provider within the previous year but had not been diagnosed.<sup>8</sup> Targeted medical settings include emergency departments (EDs), primary care settings, prenatal care and labor and delivery settings, as well as those in correctional facilities. These services do not require risk assessment prior to testing. Instead, they recommend offering testing to all people at least thirteen years of age using the service site.

For primary health care settings, particularly promising is a testing protocol called the Fifth Vital Sign model. The protocol was developed locally through collaboration between the D.C. Department of Health and Unity Health Care, a community-based health care organization that provides primary care services for approximately 80,000 clients annually. In this model, rapid HIV testing is offered to all clients at the same time that their weights, heart rates, breathing rates, and blood pressures are checked. If the client refuses testing, the physician offers a “second chance” at the end of the examination to have the test added to other routine laboratory tests.

During 2009 and 2010, additional expansion of the testing program will be under way. Efforts are being made at six out of seven hospital EDs in the District to offer routine voluntary testing, and at three managed care networks. Community-based organizations, such as Family Medical and Counseling Services, will increase HIV testing through expansion. A new marketing campaign (“Ask for the Test”) is planned, as is expansion of services that offer testing to recent partners of newly diagnosed people.

To make HIV testing as routine as possible, the District has never legislated

special additional consent requirements. However, some providers have had policies requiring additional mandatory counseling, and these have posed an impediment to routine testing. The D.C. Department of Health has been working with large providers to change these policies and fully incorporate the HIV screening model into routine consents and practices. It is working to update provider perspectives to emphasize that HIV screening is the standard of care and should be routinely offered.

Payment policies also were an issue, because not all payers agreed to pay for routine testing. However, in 2009 the District passed legislation requiring all payers—private and public—to pay for HIV screening in EDs. Recent national policy updates have also allowed Medicaid and Medicare to cover HIV screening in primary care settings.

■ **Relationships.** Research has highlighted the fact that many people have difficulty accurately assessing HIV risks in their relationships.<sup>8, 10</sup> This finding has emerged from the D.C. site of the National HIV Behavioral Surveillance system (funded by the CDC) and through social marketing research. Among heterosexuals in D.C. communities at risk, fewer than one-third used a condom the last time they had sex. Only half knew their partner's HIV status, and nearly half reported that their partner most likely had other partners during the previous twelve months.<sup>8, 10</sup>

In an effort to promote more accurate risk awareness and better decision making within relationships, information and social marketing materials in 2009 are focusing on three questions for couples: Do we know each other's HIV status; is it just the two of us; do we use condoms? In addition, services to allow couples to get tested and receive results together were implemented in D.C. in 2009.

■ **Condoms.** In 2006, the District became the second U.S. city (following New York) to launch a large-scale public-sector condom distribution program. Scale-up has been rapid: the District distributed 115,000 condoms in 2006, 1.3 million in 2007, and 1.5 million in 2008.<sup>11</sup> It is on target to reach a distribution rate of three million condoms per year by the end of 2009. As with other services, the District is shifting focus from condom provision (access) to condom promotion (use). Community-based organizations are encouraged to “adopt” nontraditional distribution sites such as hair salons, liquor stores, and clothing stores to help distribute condoms and educate clients.

■ **Targeted services.** Targeted services for especially high-risk, hard-to-reach, or vulnerable persons or populations remain a critical component of the overall prevention portfolio. In 2008 the District prioritized group- and community-level interventions over individual-level interventions, to serve targeted groups, such as men of color who have sex with men, at a higher scale. New interventions for injecting drug users and at-risk youth were also implemented.

■ **Harm reduction programs.** In December 2007, Congress lifted the nearly ten-year ban that had prohibited the District from using public monies for harm reduction programs for injecting drug users. The city's governing council and mayors had

long called for these services, including needle exchange. By March 2008, D.C. funded four organizations to be part of DC NEX, a program delivering a minimum package of harm reduction information, needle exchange, condoms, and referrals for HIV testing and drug treatment. Between October 2008 and June 2009, DC NEX exchanged nearly 210,000 needles, referred 1,490 clients for HIV testing, linked 278 clients to drug detoxification and treatment, and distributed nearly 215,000 condoms.<sup>12</sup> The model of adding DC NEX to organizations already serving active drug users facilitated rapid and cost-efficient scale-up.

■ **Youth.** HIV in the District is largely a disease of adults; most new diagnoses occurring in people in their thirties and forties.<sup>2</sup> However, rates of sexually transmitted infections other than HIV among youth are high, reflecting the presence of risky behavior. There exists a clear need to build awareness and foster protective behavior among youth that can accompany them into adulthood.

In 2007, a collaboration of more than thirty public and private agencies produced a three-year Youth and HIV Prevention Plan. It was instrumental in increasing the availability of condoms in schools, and it paved the way for Health Learning Standards in D.C. public schools that include comprehensive sexual health. Three evidence-based curricula have been adopted for elementary, middle, and high schools. In 2008, outreach for sexually transmitted infection screening and treatment for gonorrhea and chlamydia was piloted in two high schools and summer programs for close to 2,000 youth. The program was expanded to six high schools and 5,000 youth in 2009. It will reach twenty high schools and 12,000 youth in 2010. The fact that 9–14 percent of youth have tested positive for these diseases has highlighted the critical need for such services.<sup>11</sup>

Additional innovative programs have targeted young people. These include “RealTalkDC,” a social marketing program that incorporates text messaging; “Parents Matter!,” a parent-child communication curriculum for the parents of pre-sexual fourth and fifth graders; and “D-Up!,” a community-level intervention for young men of color who have sex with men.

■ **Expanding the circles of response.** To fully realize a sustained transformation of the District’s response to HIV, new organizations with distinctive reach and impact on residents must be recruited into the response. Expanded circles of engagement seek to promote community-based initiatives, routinely engage faith-based organizations, and ensure that more youth agencies are competent to deal with issues around HIV.

In 2007, the D.C. City Council established the Effi Barry HIV/AIDS Program in honor of the former First Lady of D.C. This is a two-year organizational and technical capacity-building program designed to help small community and faith organizations compete for HIV/AIDS funding and grants. It also helps them integrate HIV/AIDS programming into their core mission and activities. To date, more than fifty have participated in the program.<sup>13</sup>

The District is home to faith organizations that have led in the response to

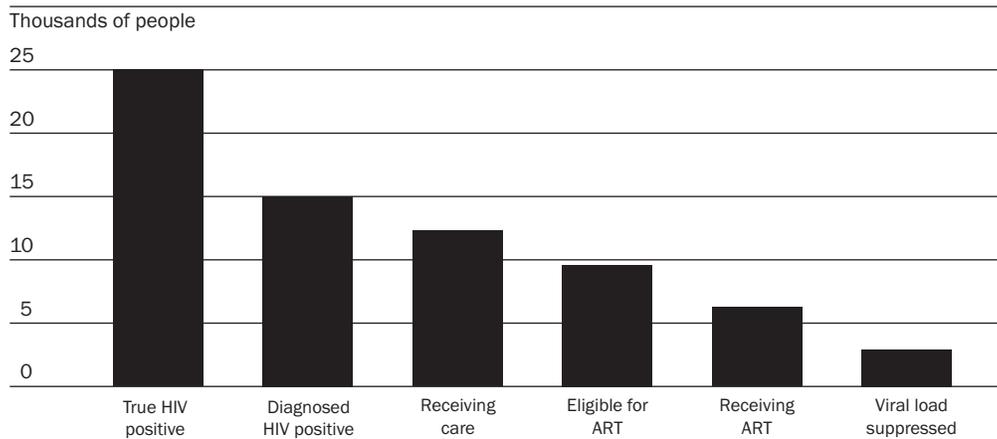
HIV/AIDS since the early days of the epidemic. Given the tremendous reach and authority these organizations hold, expanding their engagement is critical. In 2008 the Department of Health convened the Places of Worship Advisory Board of leading faith organizations active in HIV, and it funded an ecumenical capacity-building organization targeting faith leadership. Initial outreach to, and a survey of, approximately 400 faith organizations in D.C. has been completed.

### From Treatment Provision To Treatment Promotion

The District is committed to providing access to high-quality HIV care and treatment services to all District residents. Primary HIV care is provided at a number of different clinical settings in Washington, D.C., ranging from academic medical centers (George Washington, Georgetown, and Howard Universities; Washington Hospital Center, Veterans Affairs Medical Center, and Children’s National Medical Center) to community-based clinics (Family Medical and Counseling Services, La Clinica del Pueblo, Unity Health Care, and the Whitman-Walker Clinic). Because the expansion of HIV testing should lead to more people being diagnosed with HIV and referred to care and treatment quickly, the District projects ongoing scale-up of treatment services over the next several years.

Focusing on community-level impact of treatment requires not only looking at health outcomes for individual clients, but also considering population-level coverage and impact. All too often, missed steps in the treatment pathway (Exhibit 3) can lead to a relatively low proportion of HIV-infected people fully benefiting from HIV treatment. Suppression of the virus through treatment can decrease illness severity and death, and it may lead to decreased HIV transmission. D.C. has therefore shifted from a model of treatment provision to treatment promotion—

**EXHIBIT 3**  
**The “Treatment Cascade” From HIV Diagnosis Through Suppressed Viral Load**



**SOURCE:** Estimates from the D.C. Department of Health.

**NOTES:** Starting from a hypothetical number of people testing positive (25,000). ART is antiretroviral therapy.

encouraging residents to actively use and benefit from available clinical services.

To maximize population outcomes, the District is focusing on the so-called Four Rs of HIV care: recruitment, recapture, retention, and results. For “recruitment,” D.C. will create an HIV “medical home” model with enhanced services to help patients gain access to providers and navigate the system. For “recapture,” a local provider, Family Medical and Counseling Services, developed a model that is successfully reconnecting to services clients who are “lost” to care, a model that will now be replicated in other settings. For “retention and results,” there is an enhanced focus on encouraging patients’ adherence to appointments and treatment. Current expansion of electronic medical records, automated appointment reminders, and text-messaging follow-ups provide new opportunities for more frequent and regular interactions between providers and patients.

### **Research And Care Activities Of A Novel Federal-City Partnership**

A new effort, the DC Partnership for AIDS Progress, between the National Institutes of Health (NIH) and the D.C. Department of Health, has the overarching goal of creating new approaches to address the local epidemic. The Partnership has four initial “pillars,” or activities, described here.

■ **DC Cohort.** The Partnership is currently assessing the feasibility of establishing the DC Cohort, a real-time public health database with information on all consenting HIV-infected people undergoing care or treatment at major clinics in D.C. The database would enable clinicians and public health officials to improve the quality of HIV care by assessing treatment effectiveness over time and determining the proportion of HIV-infected adults who are receiving appropriate care.

■ **HIV Prevention Trials Network.** Two new NIH-supported HIV prevention trials have recently been launched by the George Washington University in Washington, D.C. The first will determine the feasibility of an HIV behavioral intervention among men of color who have sex with men. The second is assessing how to develop programs to reduce HIV risk among women at high risk of HIV infection.

■ **Test and Treat.** An initiative is being developed to assess whether expanded HIV testing, improved linkage to highly effective care, and enhanced treatment adherence can have a population-level impact in reducing HIV transmission in D.C.

■ **Provision of expanded HIV subspecialty care.** The clinical spectrum of disease for HIV-infected patients in D.C. is similar to that seen throughout the nation. A large segment of patients have access to antiretroviral drugs and may live for decades without developing traditional AIDS-defining opportunistic infections and cancers. However, patients on long-term therapy are not entirely free from consequences of their HIV infection. Liver, cardiovascular, and renal diseases, along with metabolic disorders and non-AIDS-defining cancers, are now the major causes of illness and death in such patients.

If patients are uninsured or underinsured, they are more likely to have poor ac-

cess to HIV-related subspecialty care for liver disease, psychiatric illnesses, metabolic diseases, and AIDS-related malignancies. A survey of D.C. providers has also noted that patients frequently lacked access to clinical research that could help improve care in minority populations.<sup>14</sup>

The Partnership agreed to develop a program for underinsured patients. The program will improve access to HIV-related subspecialty care and to clinical research—and create sustainable capacity for this subspecialty care and research. As a result, subspecialty clinics are now being embedded in existing community-based clinics. Local universities and teaching hospitals were approached to discuss sharing staff and ideas for developing the clinics. This program will provide professional services (physicians and other licensed independent practitioners), while host clinics will provide space, laboratory tests, imaging, and pharmaceuticals, and will recoup costs, in accordance with routine clinic procedures.

To improve the coordination of patients' care among primary care and referral centers, strong communication links will be established to assure the timely transfer of clinical information. In addition, regular online conferences will be held to optimize the likelihood that providers share a common clinical knowledge base and approach to therapy.

The D.C. partnership anticipates that these high-quality, academically oriented clinics will be a magnet for attracting committed subspecialists to join the dedicated health care providers currently serving the HIV-infected community in D.C. These subspecialists are expected to provide expanded services and to attract research and health services grants to support more robust clinical programs.

## **Community Response**

The challenge for the community response in the District is how best to contribute toward developing a “model HIV/AIDS response” in D.C. There are many community stakeholders and many different kinds of “communities.” Consequently, the epidemic response must be varied, textured, and not monolithic. Community perspectives, experiences, needs, and feelings about the health care system and about HIV medical and social service providers must be heard and respected. The response must also adapt quickly to demographic, socio-cultural, health, and economic conditions and trends.

In the District, there are several organizations that began as HIV/AIDS service providers but have now expanded to provide primary health care in addition to treating HIV and medical conditions related to the infection. For example, the Whitman-Walker Clinic initially focused its programs on serving gay, bisexual, transgender, and lesbian clients. La Clinica del Pueblo (Clinic of the People) focused on Spanish-speaking clients, while Family Medical and Counseling Services began its service provision implementing support groups and HIV testing. Unity Health Care provides generalized medical care to a large population, with HIV care provided by generalists in consultation with HIV specialists. Given

underserved populations' limited access to health care services for HIV, renal failure, diabetes, heart disease, substance abuse, and mental illness, these organizations have been able to adapt rapidly in response to changing community needs.

In contrast, midsize community-based organizations, such as the Women's Collective (services for women living with HIV/AIDS), Us Helping Us (services for black gay men), and Metro Teen AIDS (services for youth), continue to be very population-specific. This increases their ability to serve as an "on-ramp" for linkage to primary care providers offering HIV testing, and to groups using CDC evidence-based interventions. These providers target a variety of populations and are able to offer services to address specific psychosocial needs, which can be neglected in traditional medical care settings.

As an example, Community Education Group offers population-specific services in Anacostia (a D.C. neighborhood) to an underserved heterosexual African American community. These include job training, community-based research, and capacity development services for community- and faith-based organizations. Community Education Group provides HIV testing for community residents with subsequent referral to care. It also hires and trains local residents as well as those recently released from incarceration to conduct HIV testing and outreach, and it provides capacity training for new community and faith organizations.

Prevention activities can benefit greatly from the participation and support of community groups. Previously in D.C., condoms had been largely distributed as an add-on to existing HIV testing, care, and treatment services. To improve the distribution and proper use of condoms, community groups are now working in D.C. to develop geographic and population-specific distribution plans to ensure that condoms get to people who can and will use them.

Flexibility from the D.C. Department of Health, as well as from the community, will be required to interrupt the trajectory of HIV/AIDS in the District. Fiscal challenges across the board require strategic and financially prudent actions. Effective use of resources means that providers must partner more effectively. Organizations could cooperate or co-locate to reduce administrative overhead, and specialists could focus on particular populations or services. New systems for the creation, expansion, and maintenance of mobile and portable medical services, and developing "medical homes" for people living with HIV, may have to be expanded to increase access for underserved populations.

### **Monitoring The Impact Of The Renewed Response**

Data from a variety of complementary CDC-funded surveillance systems will be used to monitor the impact of the overall epidemic response, including the HIV/AIDS Reporting System, the National HIV Behavioral Surveillance System, the Behavioral Risk Factor Surveillance System, and the Youth Risk Behavioral Surveillance System. Population-based surveys of HIV infection and HIV risk factors could provide valuable information, although none as yet are planned.

## Conclusion

Although it will take several years to assess impact, there is hope that the comprehensive efforts described will begin to reverse trends in HIV/AIDS in the District. We believe that there are five key elements to the renewed public health response: leadership of local government, “knowing our epidemic,” strategic partnerships, bringing interventions to scale, and independent monitoring of the response. These lessons learned may inform the epidemic response in other settings and the development of a U.S. national strategic HIV/AIDS plan.

*The authors acknowledge the tireless efforts of the numerous people who are committed to the prevention and treatment of HIV/AIDS in Washington, D.C.; and the resilience and vitality of the more than 15,000 people living with HIV/AIDS in the nation's capital.*

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