Good morning Chairman Mendelson, Chairman Grosso, and members of the Committee. Thank you for this opportunity to testify on the performance of the Office of the State Superintendent for Education (OSSE).

I am Walter Smith, Executive Director of DC Appleseed, and with me is Patrick Campbell, a DC Appleseed Board member and partner at Paul, Weiss. We are here today to address OSSE’s role in implementing the Healthy School Act and the importance of that role in ensuring that District youth receive appropriate education concerning the HIV/AIDS epidemic.

DC Appleseed and Paul, Weiss (along with Hogan Lovells) have been working together for over 10 years to address the impact of the HIV/AIDS epidemic on youth here in the District. Beginning in 2005, we have monitored education of District youth regarding the HIV/AIDS epidemic and have long called for comprehensive and systematic education on that issue in all DC public schools -- both DCPS and charters. As part of our effort, we strongly supported and testified concerning the adoption of the Healthy Schools Act (the HAS) in 2010. Since then, we have expressed concern that that Act was not being fully complied with regarding HIV/AIDS education in the schools and that this noncompliance was putting District youth at risk.

It is now clear that the failure to fully comply with the HSA has indeed put our youth at risk. Specifically, the most recent data from the HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) demonstrate an alarming increase in HIV infections among District youth that we think is at least in part attributable to the failure to provide young people in our schools with the effective education they need to protect themselves from the epidemic.

We are therefore reporting in our testimony: (1) the new data from HAHSTA on youth infections; (2) the requirements of the Healthy Schools Act regarding protection of youth from such infections; (3) the failure to implement those requirements; and (4) our recommendations regarding steps OSSE and the administration should take to address the situation, including both stepped up education as well as use of new prevention tools, such as PrEP.
HIV Infections among District of Columbia Youth

The 2018 Annual Epidemiology & Surveillance Report stated that new infections among District residents 13-29 years old not only rose between 2016 and 2017, but constituted 41% of all new infections.¹ This is approximately double the national average (21%) for new infections among that age group, and higher than any proportion over the past decade.² Youth are also falling well short of the goals in the Plan to end the HIV/AIDS epidemic that DC Appleseed jointly developed with the Mayor, HAHSTA, and the Washington AIDS Partnership at the end of 2016. One key goal of that Plan is that by the end of 2020 90% of all persons in the District infected with HIV be in treatment and have their viral load “suppressed” such that they will not infect others. Yet currently only 50% for those aged between 20 and 24 years have achieved that goal. Furthermore, infection rates among youth for other sexually transmitted infections have also increased: cases of chlamydia increased by 19% and gonorrhea by 36% for persons aged 15 to 19 years over the last year for which we have data.³

These recent data concerning District youth are highly troubling in two separate ways. First, they demonstrate that the District is falling short in educating and protecting these young people. And second, they demonstrate that the rise in youth infections is undermining the city’s Plan to address and end the HIV/AIDS epidemic.

As we reported in our December 2018 update on the 90/90/90/50 Plan: Ending the HIV Epidemic in the District of Columbia by 2020, the District had significant and steady declines in the number of new infections up to 2015, but that decline has not continued. In 2015, the year before the Plan’s adoption, the number of new District infections was 401; to meet the Plan’s goal of reducing that number by 50% by the end of 2020 will require no more than 200 new infections in that year. Though final 2018 statistics are not yet available, preliminary numbers suggest the District had at over 350 new infections that year.⁴ Roughly speaking, this means that halfway through the Plan, new infections have been reduced by only 12% – a long way from the Plan’s 50% goal.⁵ There appear to be several reasons for this, but the substantial increase in new HIV infections among young people is a significant contributing factor; and the Healthy Schools Act should be a key tool in addressing those new infections.

What the Healthy Schools Act Requires

We applaud the Council for passing the Healthy Schools Act (DC Official Code § 38-821.01 et seq.), a landmark law designed to improve the health and wellness of students attending all DC schools – with the understanding that it would help ensure better HIV/AIDS education.⁶ The HSA requires minimum weekly time (“at least 75 minutes of health education per week for students in grades K-8”) spent on effective

² Id at 5.
³ Id.
⁵ HAHSTA 2018 Report, at 5.
⁶ See Comm. on Gov’t Operations and the Environment, Report on Bill 18-564, Healthy Schools Act of 2010, Attachment B at 14 (“Health education teaches students about important topics such as HIV/AIDS prevention, another epidemic plaguing the District’s population. The Healthy Schools Act would phase-in health education requirements over a five year period in order to increase the amount of health education in schools.”); See also Joint Public Hearing on B18-564, Healthy Schools Act of 2010, Before the Comm. of the Whole and the Comm. on Gov’t Operations and the Environment (“As this Council knows well, HIV/AIDS is 100 percent preventable.”) Testimony of Adam Tenner, Executive Director of Metro TeenAIDS.
Health education. The HSA also grants OSSE “the authority to verify compliance” with the HSA, and mandates that OSSE measure students’ knowledge as it relates to its Health Education Standards, including those on health and sexual health education. OSSE works in concert with local education agencies to comply with the Healthy Schools Act and other requirements by evaluating health education through grade 12.

The HSA also directed the Mayor to adopt appropriate regulations to ensure compliance with the Act. While there are some regulations governing health education in District of Columbia schools, the official rulemaking contemplated by the HSA has never been completed. At present, without dedicated HSA regulations, sexual health education requirements come from agency interpretation of the HSA law and two older sections of the Municipal Regulations, “Comprehensive School Health Education” and “Human Sexuality and Reproduction.” The first requires comprehensive, age-appropriate, sequential K-12 health education that is monitored by OSSE for minimum proficiency in at least 11 content areas, the first of which is “HIV/AIDS and other sexually transmitted diseases.” The second requires that D.C. Public Schools offer age-appropriate “instruction in human sexuality and reproduction” as part of the regular curriculum in grades pre-K through 12, including information on “venereal disease” and “the process of making personal decisions.” While these older regulations may be enforceable on DC Public Schools, they were promulgated prior to the creation of the DC Public Charter School system in 1995, and prior to the enactment of the HSA in 2010.

Health Education Standards (HEA)
Under the HSA, OSSE is charged with setting the curricular standards for DC schools and has clarified that the curricular standards referred to in the HSA are the Health Education Standards, last revised in 2016. These revised Standards include core concepts in the prevention of HIV and other sexually transmitted infections across multiple grade bands. The HEA has glaring deficiencies that can be improved. While it addresses sexual health for grade 5 students, in the “Human Body and Personal Health” section, HIV and STIs are not mentioned or addressed until students are in grades 6 through 8, which the HEA groups together. This means students could be receiving no information at all about the HIV/AIDS epidemic until they are 13 or 14 years old. Similarly, while the Standards for what DC students should know by the end of

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7 DC Code § 38–824.02(b)(2). “Public schools and public charter schools shall provide health education to students in Grades Kindergarten through 8 as follows: [...] School year 2014–2015 and after: an average of at least 75 minutes per week.”

8 The HSA also specifies, only for grades K-8, that the health education requirements of Public and Public Charter Schools “shall meet the curricular standards adopted by the State Board of Education.” OSSE has since clarified that these are the Health Education Standards, which measure “the knowledge and skills that students need to maintain and improve their health and wellbeing, prevent disease, and reduce health-jeopardizing behavior.”

9 DC Mun. Regs. tit. 5-A § 2203.3(b). These regulations were promulgated by OSSE and are enforceable by the same.


11 DC Code § 38–828.01. “The Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], shall issue rules to implement the provisions of this chapter.” The Office of the State Superintendent of Education (OSSE) is specifically named throughout the HSA, with authority over disbursement of funds, program establishment, reporting requirements, etc.


13 DC Mun. Regs. tit. 5-E §2304.3(a).

14 DC Mun. Regs. tit. 5-E §2305.1.

15 See OSSE, Health Education Standards (HEA), section entitled “Human Body and Personal Health.”

16 See id., section entitled “STI/HIV testing/treatment” and “HIV/STI protection methods.”
grade 12 are more thorough, they need not be satisfied until the end of grade 12 and are not required by the Healthy Schools Act.

Healthy Schools Act Yearly Report and Healthy Youth and Schools Commission (HYSC) Report
OSSE is required to report annually to the Mayor, the DC Council, and the HYSC regarding the compliance of DC Public Schools and Public Charter Schools with the physical and health education requirements under the HSA, and student achievement with respect to the Health Education Standards. OSSE makes these reports available on its website in three categories: “Physical and Health Education Standards Reports,” “Farm to School and School Gardens Reports,” and “Environmental Literacy Reports and Updates.” Physical and Health Education Standards Reports are available for each year from 2011 to 2018.\(^{17}\)

The HSA also requires the HYSC to submit a report annually to the Mayor and Council which: 1) Explains the efforts made within the preceding year to improve the health, wellness and nutrition of youth and schools in the District; 2) Discusses the steps that other states have taken to address the health, wellness and nutrition of youth and schools; and 3) Makes recommendations about how to further improve the health, wellness and nutrition of youth and schools in the District.\(^{18}\)

Reporting by DC Public and Charter Schools to OSSE
All DC Public Schools and Public Charter Schools must also submit annual information related to compliance with the Health Education Standards (as well as the physical education requirements) and other aspects of the HSA to OSSE in the form of the School Health Profiles. OSSE is required to post the School Health Profiles on its website within 30 days of receipt of the information.\(^{19}\)

OSSE measures student knowledge of the Health Education Standards through the Health and Physical Education Assessment (“HPEA”), administered annually to fifth grade, eighth grade, and high school students in the year they complete a health course. This assessment includes questions on sexual health concepts.

Youth Risk Behavior Survey (YRBS)
Every two years, to understand the prevalence of certain health behaviors, OSSE administers the Youth Risk Behavior Survey (YRBS) to DC Public and Public Charter middle and high school students. Students complete the assessment by providing self-identified responses to questions regarding health behaviors, covering topics such as violence and safety, and disease prevention and sexual health.\(^{20}\) Notably, in the 2017 YRBS Report, OSSE found that among both DC middle and high school students, condom use during their most recent incident of sexual intercourse decreased as compared to previous years.\(^{81}\)

DC Public Charter School Board
In theory, the DC Public Charter School Board, in conjunction with schools’ individual boards of trustees, could also monitor DC Public Charter Schools’ compliance with the HSA by requesting on an annual basis sufficient documentation demonstrating compliance with the statute.\(^{21}\)

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\(^{19}\) DC Code § 38-826.02(d).


Failure to Implement the Healthy Schools Act

None of the oversight required by the HSA amounts to the systematic enforcement we believe is required to keep our children and youth healthy. In fact, the current oversight is insufficient precisely because no enforcement mechanisms are in place for non-complying DC schools. This deficiency in enforcement, however, does not rest with OSSE alone. Although there are some regulations governing health education in DC schools, the official rulemaking contemplated by the HSA has never been completed for DC schools. OSSE’s Health Education Standards, last updated in 2016, are not official regulations that went through the notice-and-comment process required for rules to have legally binding effect. For procedures to attain the force of law, the DC Administrative Procedure Act dictates that notice of proposed rulemaking must be published in the DC Register and “any interested person” must have the opportunity to comment.” Thus, OSSE is not empowered to enforce the Health Education Standards upon non-complying DC schools as legally binding requirements.

Based on research by DC Appleseed and Paul, Weiss, Rifkind, Wharton & Garrison LLP, not all DC schools appear to be meeting their obligations under the Act. Fourteen (out of 224) public and public charter schools did not complete the 2018 School Health Profile Questionnaire required by the HSA, and private schools were not even required to participate. Of those schools that participated, the average number of minutes of health education per week was almost a half hour short of the HSA’s 75-minute requirement – and yet this was the highest number of minutes reported since OSSE began tracking that information in 2010. Further, participation in the Health and Physical Education Assessment (HPEA), which measures how well students know the material required by the Standards, decreases as grade level increases. Overall, only 70.4% of students completed the HPEA in 2018.

These failures have demonstrable consequences. Of the students who completed the HPEA each year, overall scores decreased over the three years for which there is data – particularly in grade 5 and high school. The most recent overall average scores for each grade level are: grade 5, 72%; grade 8, 69%; high school, 57%. In the 2017 YRBS Report, OSSE found that among both DC middle and high school students, condom use during their most recent incident of sexual intercourse decreased as compared to previous years. Although some charter school teachers report using standards-aligned health education curricula, including those obtained through OSSE’s curriculum training or curricula library, without dedicated attention or enforcement from the Public Charter School Board or individual schools’ independent boards of trustees, the actual implementation and oversight of sexual health education in charter schools present a challenge.

In DC Appleseed’s 2017 report (on 2016 data), we brought attention to the fact that the provision of sexual health education in public and public charter schools is critical in the effort to reduce HIV infections and

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22 See DC Mun. Regs. tit. 5-A § 2203.3(g) governing DC Public and Public Charter high school education. See also DC Mun. Regs. tit. 5-E § 2304.3(a).
23 DC Code § 2-505.
25 Id. at 32.
26 Id. at 28.
27 Id. at 36.
28 Id.
expressed our concerns that sexual health education is not uniformly implemented across all public schools, including independent charter schools. Additionally, we urged the Council to consider providing additional oversight of the HSA’s implementation at that time.\(^{30}\) Remedying low participation and enthusiasm for health education across all schools is vital to arm students with evidence-based facts and skills that can lead to a reduction in new HIV infections. The striking rate of new infections among youth and interviews with stakeholders suggest that sexual health education has not been, and is still not, uniformly implemented in accordance with the HSA.

**Pre-Exposure Prophylaxis (PrEP)**

We strongly believe that a renewed focus on HIV/AIDS education in schools should be coupled with increased access to PrEP. Given the recent federal Food and Drug Administration (FDA) approval of PrEP for use in high-risk adolescents,\(^ {31}\) and the alarming increased infection rate for D.C. youth, we believe that PrEP availability should extend to minors. Current DC law enables minors to access sexual health services without parental or guardian notification or approval, including testing and treatment in public high schools.\(^ {32}\) DC Health has stated plans to make PrEP available for adolescents and provide financial assistance through the existing PrEP Drug Assistance Program, as well as to work with school-based health centers and community partners to make sexual health services more available to youth.\(^ {33}\) We endorse these plans and note that adequate nursing staffing at D.C. schools will be needed to make sure that PrEP is appropriately available through school health centers.

**Recommendations**

To better protect our youth from contracting HIV and other STI's, and to reduce the spread of new infections across the population at large, DC Appleseed recommends the following.

1. That the Mayor exercise her rulemaking authority to create an enforceable HSA that will fully aid students in learning about sexual health, which would potentially decrease the rate of new youth infections for HIV and other sexually transmitted infections.
2. That OSSE monitor HIV/AIDS education in all DC public schools both to ensure compliance with the HSA and to ensure best practices are adopted in conducting effective comprehensive for sexual health education in those schools, including HIV/AIDS education.
3. That OSSE conduct interviews with educators and youth to determine the reasons for low participation rates in and poor performance on the School Health Profile Questionnaire and Health and Physical Education Assessment.
4. That OSSE explore new ways to ensure effective HIV/AIDS education for the city’s youth, in addition to the mandated education in the classrooms.
5. That PrEP be made available and accessible to youth, through outreach and access to health services at schools and other youth-serving locations, and through an adequately funded PrEP Drug Assistance Program.

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\(^{32}\) DC Mun. Regs tit. 22-B §600.7(c).

\(^{33}\) HAHSTA 2018 Report.
DC Appleseed will be publishing a supplemental progress report on the 90/90/90/50 Plan this spring, focusing on new infections among youth and identifying other areas where there is room for significant improvement. We look forward to working with OSSE, HAHSTA, other parts of the Bowser Administration, community partners, and this Council to make sure that we protect our youth and meet or exceed our 90/90/90/50 goals. We look forward to answering any questions that you may have. Thank you for your time.