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INTERVIEW | LAURA BROWDER & CRISTINA KINCAID | OCTOBER 13, 2017

Laura Browder: So Cristina, why don't you start by telling us your name and today's date.

Cristina Kincaid: Alright. My name is Cristina Kincaid and today's date is Friday October 13th, 2017.

LB: So why don't we start out by telling me something about where you grew up, your childhood, where you're from, all of that stuff.

CK: Yeah. I'm from Virginia Beach. That's where I grew up most of my life with my family. And then I moved to Richmond in 2002 to go to VCU.

LB: And how did you first hear about HIV and AIDS?

CK: Well the very first time I heard about it I was really small. I used to watch the news a lot when I was a kid. I remember seeing another little girl on TV who was similar to my age and she was crying because she was talking about how she had HIV and I remember being worried, like, "Is this something that I have?" You know? "How would I know?" But I didn't really have a full understanding of exactly what it was.

LB: And then…

CK: And then as I came to VCU I actually went through the Women's Studies program which is now the Gender Studies program. Through that program I did a lot of… at the time there was like a… more like a women's health track so I was really interested in that sort of work. And I did a lot of work with Planned Parenthood on campus. So I got involved with some, just like… sex education on campus and doing some advocacy work with Planned Parenthood, and that's when I got sort of more in tune with the sex ed. side, learning more about HIV, exactly what it was, how it was transmitted, along with other STI's as well.

LB: And from there what happened? How did you end up at the Health Brigade?

CK: Yeah! After I graduated I really knew that I wanted to work at a nonprofit and continue doing that sort of work. So I applied to a job here as a educator and a case manager with the CHARLIE program, which is a program that provides HIV and STI prevention education in prisons and jails and that also provides case management services to people who are living with HIV who had recently been released. And so that's how I ended up getting hired here.

LB: So tell me about your job. Tell me about what you do.

CK: Yeah! So now I've kind of transitioned out of that role, and I really oversee all of our HIV prevention efforts at the agency—so any HIV and STI education, HIV testing, all of those programs fall under my purview.

LB: Given that Richmond is in the top ten for a lot of STDs, and we have a hugely high HIV rate, you tell me something about how you work with those challenges, how you reach people who are difficult to reach.

01:37:00

CK: Yeah, so I would say one of the primary things that we do is street outreach. So we take our education messaging, condom distribution program, to areas of the city that we know have high incidence and high prevalence of HIV and other STDs. So we distribute condoms, talk about safer sex, and then we also provide HIV testing in those areas as well.

LB: When you say, "taking it to the streets," do you mean… What do you do? Do you have a van and you just sort of park somewhere or how do you figure out where the absolute best places are to reach people?

CK: Yeah, so… Data lets us know which zip codes have the highest prevalence and incidence. And through a partnership with the Richmond City Health District, we are able to use clinics that they have set up in various locations in the East End to set up as our home base. So we use those locations for testing but we are responsible for getting clients to come and get tested. So we walk around in the neighborhoods, hand out condoms, talk to people, and let them know that we are available for free HIV testing that particular time.

LB: So how many people will you interact with in a typical day of doing that work?

CK: You know, if the weather is good, we could see fifty people while we're walking around, maybe more. And we end up talking to a lot of people. And we definitely end up handing out a lot of condoms. We had out almost 200,000 condoms every year.

LB: That's a lot of condoms.

01:40:18

CK: Yeah.

LB: So what are the changes that you've seen over time in how the general public understands HIV and AIDS?

CK: I would say when I first started working here, that's almost nine years ago, there seemed to be, definitely… I've seen a growing in awareness of how HIV is transmitted and how somebody may be at risk for contracting HIV. So that understanding has grown a lot and I'm not… I think that there are a lot of HIV prevention education efforts, but I would imagine too that with the internet people have access to more information and can kind of Google, "How do I get it?" It seems like people are coming in for testing and making more informed decisions instead of making a decision out of just pure fear…which I think…I saw a lot more people coming in to get tested when I first started that were coming in that didn't know that much about HIV or how it

was transmitted, but they were concerned and wanted to get tested because they were just worried that they might have it even if they weren't sexually active. You know. They just have a worry there.

01:40:18 Now we definitely see more informed clients coming in, coming to get tested, who even sometimes are asking, "What type of a test do you run here? Do you run the specific antibody test or are you running… you know… now there's better testing technology and the fourth generation combination test—are you running that test?" So a lot of times clients are calling me and asking me what type of test we run because they know what type of test is best for them in their situation, which is really cool to hear.

LB: That's amazing, actually.

CK: Yeah.

LB: Have you seen any changes in awareness or in the work you do as the opioid epidemic has increased, as injectable drugs are more and more commonly used?

CK: I think there's… I guess I've seen some additional efforts of work being kind of done across disciplines, especially with the opioid epidemic, definitely. We have some partners who have always reached out to us that serve people who use needles to inject drugs who do HIV testing with them. But we're definitely hearing more, "Can you come and set up with condoms at this event?" Or, "Can you come with information about the post exposure prophylaxis at this event?" That's geared towards either people who use needles to inject drugs, or people who provide services to that population. So I've seen a lot of that for sure.

LB: So how have treatments and people's willingness to use them changed since you started?

CK: It's changed dramatically. When I first started…and this was probably really only the first year that I was here…a doctor wouldn't necessarily start you on medications until your viral load…I mean excuse me, your CD4 count was relatively low. And then the standards changed while I was here to—if your CD4 count was at 500 or below they were gonna start you on treatment. And now the treatment guidelines say, if you're living with HIV, we wanna get you in to care and get you started on medical treatment as soon as possible. So that's changed a lot. The other thing is, we've been hearing this from some other agencies but, the CDC just came out last week and acknowledged that if people are virally suppressed—so that means they're taking their medication, their viral load is undetectable—they actually cannot transmit HIV to another person…which really changes a lot of things for people in that… 1. I think it gives people hope that…you know…I should…and a reason to be on medication because they could achieve this status. Whereas before the language was—you could just "reduce your risk" to transmit it to another person. I think it reduces a lot of that stigma as well because now you have HIV, but you may not necessarily be able to give it to another person, so that really I think changes that piece of people seeking out treatment and how they feel about taking medication.

LB: And Cristina, there's so many things that people coming to the exhibition will not know. So can you explain a little bit more, the numbers that you use, and what the context for them is. Like what someone without HIV, what their numbers would be, versus someone with HIV. Do you know what I mean?

CK: Yeah! So basically…there's two tests that somebody might get done if they were living with HIV. One of those tests would be a test to see how many CD4 cells they have in their body. So CD4 cells are those healthy immune system cells that fight off infection in your body. For somebody whose immune system is doing well, that number could be 800, 1200, depends on the person.

LB: Mhm.

01:43:55

CK: Somebody who's living with HIV would want that number to be high. Medications would help to suppress the virus so that those healthy immune system cells, that number, would be able to stay high, you'd stay healthier, have more defense against any outside infection. And then the other test that somebody may get is a viral load test. So that's actually a test that's testing for the copies of HIV per cubic milliliter of blood. So somebody would want that number to be really low. So if somebody's taking medications—that number can be lowered and lowered if the medication is working, you know, everything is going well. If that number gets to a point that is very low, it could be so low that it's undetectable, which is just undetectable by the tests that they do. Which means that at that point somebody would not be able to transmit to another person, which is a really good thing. And so when that viral load is low, there's a couple of the other pieces that it allows for those healthy immune system cells to replicate.

LB: Say you're HIV positive—how often would you get those two markers checked?

CK: It depends. I think at first people will get tested, will go in to see their doctor, every three months. That may be extended to every six months if somebody's doing really well. But definitely minimum two times a year.

LB: Okay, and when do you start to worry in terms of your CD4 count dropping? What's the number where things start to change?

CK: When we look at CD4 count, actually…just…I went to an appointment with a client so I've learned a lot about this. A doctor wouldn't necessarily use that as a form of diagnosis at this point. Because your CD4 count, you know, just for anybody, could get low if they got sick with something. Right? So I think really what they'd be looking at is that viral load count to see if it were creeping up.

LB: Okay.

CK: So that may be an indicator that the medication wasn't working…

LB: Okay.

CK: …and then would cause, potentially, your CD4 count to get lower.

LB: Okay so those are really the two numbers you need to be concerned about.

CK: Yeah.

LB: Now what are some of your biggest challenges as a healthcare provider dealing with HIV and AIDS?

01:46:22 **CK:** I would say, definitely, stigma is a huge challenge to get around. I think just the idea of… I think that's a huge challenge for our clients. To get into care, that may be a huge barrier if they're concerned about stigma from their peers or their family members or just having to walk into a clinic that's called an "infectious disease" clinic, and having to take a medication every single day can really…and just the general stigmas that go along with HIV, because people are often misinformed about how it may be transmitted, and may place value-based judgments on people who are living with HIV… All these things can pose challenges for people getting into care or even accessing testing. So anything that we can do to keep that messaging positive, to kind of break out of that stigma, is helpful for people to make sure that they're able to access testing and medical care.

LB: So what are some of the techniques you use to break down people's resistance to testing and treatment?

CK: I think, on a one-to-one basis, definitely education. Spending time talking to people, specifically for people who are newly diagnosed, just letting them know that a lot of times people will say, you know, they're concerned that they have an illness that may shorten their life span. And so being able to tell somebody, "If we can get you into medical care and get you on medications, you could live a long and healthy life. We wanna make sure that we get you into this care that can keep your quality of life high." Talking to people about managing HIV like a chronic illness and just kind of thinking about the kind of language that we use, so somebody using that person-centered language, so a person who's living with HIV and steering away from using words like…that can sound more negative…like "infected" or you know, using words that may define somebody by an illness. So trying to use those techniques when talking to a one-on-one person.

On a community level, I think the state health department has done a really good job of doing some big campaigns along with the Kaiser Family Foundation who has done some great ones as well with [unc. 01:49:02 wherever AIDS? program name?] that really shows people who are living with HIV. They have some really great videos and other kind of poster campaigns that allow people to see someone, see their image, or see a video, that shows this person living their life. And it may be somebody that you identify with to help to break down that stigma and somebody kind of speaking about it openly is really helpful.

LB: Yeah. Because I feel like whenever I talk to a healthcare provider or someone who works with people living with HIV—they all have stories to tell. Rodney [unc. 1:49:40 last name] can tell these stories about a client of his who's in his 70s, lives across the street from an infectious disease, but has literally chosen to die rather than go across the street to get treatment. Another doctor I was talking to told me about all of the people in their 20s that he sees in the ICU because they won't take their medications. And [Aisha Louvian unc. name spelling?] , over at the infectious diseases clinic at VCU, just told me a lot of their clients drive in from Charlottesville because they're so afraid of the stigma of having people see them walking into the clinic. How do you deal with that?

01:50:24

CK: Yeah. We've definitely had some of the same stories, of people who have come from specifically more rural areas to come into Richmond City to access testing or treatment because, you know, their doctor is a family friend and the rest of their family see that same doctor and all and nurses in the doctor's office go to church with your parents, you know, so… I think living in a town where more people know each other can definitely create those barriers for people. So trying to be as confidential as possible and ensuring people to their confidentiality, specifically with HIV testing and when we're helping to connect people to care I think is really key. And that's something that we always highlight, is that we can't share any of this information without your consent. And we take a lot of measures to protect all of your health information. So that's definitely something that we explain, you know, your partner or your parents can't contact us and ask what your test results are. Or your doctor's office can't call and ask what the…and we would not send your test results to your doctor's office unless you signed a release that says, "I want you to release this information to my doctor." So that can be helpful for folks.

LB: Have you seen these challenges changing over the nine years that you've been doing this kind of work?

CK: So the challenges with stigma…I think…it's really interesting because we see people who are coming in who are better educated about HIV and we see these campaigns where people are openly talking about living with HIV, but then we still see a lot of clients who are still battling with some of the same issues around stigma that I saw when I first started here, you know, almost nine years ago. So it's definitely still there and it's something that we just have to actively work to try to combat on a regular basis.

LB: Why do you think so few people, outside of the health care community and the HIV community in general, have any idea that Richmond has an exceptionally high rate of HIV infection?

CK: I'm not really sure. Can you ask that question one more time?

LB: When I'm out and about, I feel like once a day someone will tell me, "Church Hill is the biggest food desert in the nation." Or maybe once a week someone will say, "We have the highest concentration of public housing anywhere south of New York City." But until I started thinking about this, working on this project, I had never heard that Richmond had an

exceptionally high HIV rate. And I mean, I do community-engaged projects all the time, that's my research, right? And everyone who I talk to in my community, people who are doing exactly the same kinds of projects, everyone was shocked. Why is it such a well-kept secret?

CK: I think that people are uncomfortable talking about topics of sex or drug use and I think because of that that can silence some of the discussion around HIV. Even sometimes medical practitioners feel uncomfortable talking about sex so it's entirely possible that you could go see your doctor and not have any questions asked about sex at all. But maybe you need an HIV test and that would be the place where that might be offered. I think because those topics can be taboo I think it's hard. I think that people either don't want to think about it or it's just a topic of discomfort for them.

01:54:32

LB: It is striking that the only time I've ever been asked about HIV in all my years of living in Richmond was when I was pregnant.

CK: Yeah.

LB: And that's when women are typically told to get tested and that's a health department mandate, right?

CK: Yeah. So pregnant women are all supposed to be offered an HIV test. But I guess just depending on when that happens, when someone is pregnant, so that's always really interesting. You know somebody offered a test at the beginning of their pregnancy and at the end of their pregnancy…because again, because people are uncomfortable talking about sex, they also may be uncomfortable with discussing the topic of their pregnant client having sex, which is kind of interesting. So I think again there's just a lot of discomfort in talking about those topics, and people don't wanna approach them. And people also have value-based judgments about sex and drug use, and I think, sometimes, kind of have their minds made up about how they think people are supposed to behave in certain arenas and so they end up judging people who fall outside of kind of their narrow scope of, I guess, of their own reality.

LB: That sounds like that's one of the big obstacles to preventing new infections in Richmond. Can you think of other challenges that you and other people in the HIV treatment and prevention community face in trying to reduce our incredibly high rate of infection?

CK: I think two ways where we could continue to reduce rates would be expanding the doctors' offices who are able to prescribe both pre- and post-exposure prophylaxis. So these are both biomedical interventions that could help people to prevent from contracting HIV. The post-exposure prophylaxis, or PEP, is something that somebody could take within 72 hours if they think they may have been exposed to HIV. But it is not…you know…not every doctor's office is gonna prescribe it. It's pretty difficult to get a prescription and then you know you have to kind

of go to your doctor and say, "Well, this is what I'm concerned that may have happened…" and so doctors may, again, place a value-based judgment about whether or not this is something that they want to prescribe. And then on top of that there may be some discomfort with prescribing HIV medication because they may think that they need…you know…that this is relegated to the world of specialists. But it could really prevent somebody from contracting HIV if they took it within that 72-hour window period.

LB: Why is it such a big deal to be able to prescribe PREP or PEP? Why is that different from any other prescription? Because all doctors have a prescription pad, right? So what's the difference?

CK: You know, I'm not sure. Again, I think, either doctors are not fully informed about the guidelines around writing prescriptions for either of those medications—which the CDC has guidelines on both which you can find on their website—but it's entirely possible that they may just…they may not necessarily know that much about it. I had somebody tell me that they went to their doctor and asked for PREP and their doctor came with something out of left field like, "Oh, I didn't know that you needed to lose weight…" or something. So the doctor didn't even know what the client was talking about.

LB: Wow.

01:58:19

CK: Right? So sometimes they just…it might not have come across their radar. So they may not know about it. But the post-exposure…excuse me…the pre-exposure prophylaxis, or PREP, would be really great if we could have more doctors prescribing that. There are very clear guidelines around how to prescribe it, what sort of labs clients need to be able to take it, and it's just…you know…it's 2017. We have a pill that somebody could take every single day to reduce their risk of contracting HIV by 95%. So it's just another tool in the toolbox that we could use to prevent HIV. So the more providers that we have educated about it, and prescribing it, the better.

LB: So again, because people coming to this exhibition or visiting this archive will not know the CDC guidelines, could you talk a little bit about that on camera? How you reach doctors and educate them about it? And what are the obstacles to doctors prescribing PREP or PEP?

CK: Yeah, so, I think for some doctors, like I said, value-based judgments about prescribing those medications or discomfort with prescribing HIV medications to an otherwise healthy person. But then the other piece is just education. So it's not like there's a centralized group of doctors. You have private practices all over the city. So how do you reach all these doctors, you know, busy doctors' offices, to be like, "Hey! We wanted to tell you about this thing that we would like for you to prescribe." But for people who are interested in getting on it, there are a few places where you can go to get PREP. So the Richmond City Health District is one where you can get it free. There's no eligibility requirements. Health Brigade is another place where you can get PREP. We do have free clinic eligibility requirements. So when somebody becomes a patient, to be able to take PREP, you have to have your blood drawn every three months. You

need to be tested for HIV and STDs on a regular basis—that's every three months. And just talk to somebody about making sure you're taking the medication every day, making sure that you understand the risk and benefits of taking medication, so that's all part of informed consent, and so it's a really empowered decision that somebody can make as part of their health. Because they would make this decision that, "This is right for me at this point in my life." It may be that at a certain point somebody may decide, "I don't need to take this anymore." But if we know that people could take it, if it were more widely available, that would be really helpful because I think we could really reduce just the amount of transmission.

LB: Does insurance cover PREP?

CK: Most insurances do cover PREP. So I usually encourage people to call their insurance company to ask, you know, "Does my insurance cover it?" And Gilead, the manufacturer of PREP, actually has some great resources where they can help pay for medication copays, or if you don't have health insurance they can help to pay for the medication completely.

LB: Oh that's fantastic.

02:01:47

CK: Yeah. So there are resources available.

LB: So how's your understanding of HIV and the epidemic changed over the years that you've been working with HIV?

CK: I would say, I guess just I don't think that necessarily my ideas have changed but I guess just being in awe of all the changes that have happened in such a short period of time and especially as a young person coming in. So working in HIV, you know, in the 1980s and 1990s, I was young. You know? So I was not involved in HIV work so there are parts of the history that I don't know firsthand. I can only know from stories that other people have told me. And so I think just thinking about how long the epidemic has been around and how many advances we've had just in the last nine years, is really amazing. It makes me really excited to see what's going to happen in the next ten years. Could we have a vaccine? Could there one day be a cure? I mean there's a cure for hepatitis C, so that would be really amazing. So I just look forward to the future advancements to see what's coming next.

LB: It sounds really exciting.

CK: Yeah.

LB: You said that you've talked to a lot of people who are well-informed about HIV. What are some of the biggest misconceptions that you think the general public still has about HIV?

CK: I would say the biggest one is that people kind of think that even if they have been tested or if they've been in a monogamous relationship for twenty years, that HIV is something that could lie dormant and show up later on in life. So we know that's not true. As long as somebody's

getting tested on a regular basis, it's not going to just show up. As long as somebody's been tested, you would know. I mean obviously if somebody hasn't been tested that's where you kind of run into the danger of not knowing, so getting tested is the best way to know your status. But obviously at a certain point you would require some sort of medical intervention or you would start to get to sick and have to take those steps necessary to make sure that you've been taking care of your health. But a lot of people will just, even though they've been tested again and again, they'll just keep coming back because they'll be like, "Well I just need to make sure that it's not gonna…that it's not like hiding somewhere in my body." And also I think it's because of that undetectable status. I think sometimes people think that if somebody is detectable or if they hear that they think, oh, so that's…it could be…it could go undetected in your body and you wouldn't know. So that's definitely not the case.

LB: Okay. Good, good, good.

CK: Yeah.

LB: So here's the question I ask everyone and I get all kinds of different answers. But why do you think that Richmond, of all cities, has crazily high rate of HIV infection?

02:05:04

CK: You know I think it is probably due to a lot of factors. But obviously being in an urban area. So it is a high-density living situation where you have a lot of people around and then kind of pockets, concentrations of poverty. But I think kind of like what we were talking about before, you know? If you pointed to some of the struggles that Richmond has…so we have places in the city that are food deserts or do not have the same type of resources to maybe medical care, maybe public transportation is not as reliable as it could be certain areas…you could see how all these different factors could all play into somebody's health outcomes. So HIV would just be one of those things among other health outcomes that I think could be negatively impacted. When you just don't have the correct resources or when your city maybe isn't putting the same amount of intention into a certain part of town than another.

LB: Because there's poverty all over the United States right? We have horrible public transportation everywhere.

CK: Yeah.

LB: There are lots of food deserts. So it still puzzles me. You know? Why Richmond? Why not Birmingham, Alabama? Or why not Wichita, Kansas? I mean there's so many cities, right? That face the same issues that Richmond does. So why us?

CK: Yeah I don't… Besides kind of thinking about it academically, I don't think I could really take a stab at why I think that it is or isn't a certain way. But I think that those would be really my best guesses. You know?

LB: Yeah.

CK: I guess just thinking about all…many things that may impact somebody's health outcomes. It's really like the best answer that I could come up with.

LB: It does seem crazy that we're in the top ten for a lot of STDs.

CK: Yeah. And there's been ebb and flow with that. I think depending on…you know we had kind of a spike a few years back and we had a CDC grant from the city that was able to kind of really lower some of those numbers. And then they start to creep back up again. I'm not sure exactly why that happens the way that it does. But…

LB: Do you ever get frustrated by all of the challenges that you face in a city with such high rates of STDs, HIV, so many seemingly insurmountable problems having to do with public transportation, poverty, food deserts, how do you kind of deal with that?

CK: I think thinking about…

Lorraine: Can I pause for one second?

LB: Yeah.

02:08:11

Lorraine: I'm so sorry. Okay.

Woman 1: This has been really interesting. Thank you for letting me sit in. I'm wondering if I should slip out while we're paused.

LB: You can. I mean I'm on my last question really.

W1: Okay.

LB: So…

W1: Okay, good, good. Then I can stay.

Lorraine: Okay. Sorry you guys.

W1: Now I have a gazillion questions for you.

LB: If you have questions and you want me to ask…

W1: No…

Lorraine: Sorry I didn't realize the battery light flashing on me. So… Laura, by the way, will you ask Cristina the first two questions again at the end just her name, where she's from and how she first heard about HIV?

LB: Yes.

Lorraine: Okay. Awesome. Alrighty. Okay I think we can…

LB: And you got the last answer right? About why Richmond? Perfect.

Lorraine: If I didn't get it here I got it here.

LB: Okay good.

Lorraine: Alrighty. Are you ready to continue?

LB: Yeah. So if you could say one thing to the general public about HIV? What would it be?

CK: I would say that HIV is not a casual contact disease. And that if you know somebody that's living with HIV, that you can hug them, you can kiss them, you can hold their hand, and that HIV is treated like a chronic illness, just like any chronic illness, like diabetes or hypertension. You can take medication for it. And now we know if you're doing really well on that medication, you can't transfer it to other people. I think that's really important for people to know.

02:10:42

LB: Those do sound like really important things. And now if you could just one more time tell me your name, the date, where and how you grew up.

CK: Yeah. So Cristina Kincaid. Today is October 13th, 2017. I'm originally from Virginia Beach. That's where I grew up with my family. And I came to VCU to do undergrad, do my undergrad degree in 2002. Then I started working here at the clinic in 2009.

LB: Perfect. Okay. You got all that Lorraine? We are good. Thank you!

CK: Yeah.

LB: Wonderful interview.

CK: Thank you.

LB: And just chock full of really good information. I just wanted to press you about all the stuff you could find on the CDC website because people going to the exhibition or going to the archive are not necessarily going to be doing that.

CK: Yeah.

LB: So your role really has been to lay it all out, right?

CK: Yeah, yeah.

LB: …in a really helpful way.

CK: Yeah, yeah.

LB: So thank you.

CK: Yeah, no problem.

W1: What sort of…We were talking about this a little bit a while ago regarding sex education in middle schools and kind of the education…you know…is RPS a partner with you all in trying to inform…

LB: That's a great question.

CK: We don't do any work with minors, we only work with adults. I know that Planned Parenthood does some work with the schools I think, and I think I know that Side by Side, not necessarily sex ed., but they do work with the publics schools around sexual orientation, gender identity, which probably has some crossover. They probably end up talking about sex ed. with them too making sure that they have inclusive programming.

LB: And yet…and yet…I just had a daughter graduate from TJ this past year and the only sex education they got was abstinence and there was absolutely nothing about sexuality or gender identity. I mean to what extent are we hamstrung by the state legislature and the state legislature's discomfort around everything having to do with sexuality.

02:13:16

CK: Yeah. 'Cause I know when I was at Planned Parenthood in like 2006, 2007, we had accepted as a state that abstinence-only education and then that went away for a while and then it's come back again. It seems to ebb and flow, I think, with whoever happens to… It seems to ebb and flow with whoever is the president. So depending on the president's political party…I feel like that's really where you see those cuts. 'Cause like right now we're seeing a lot of cuts to family planning.

LB: So that's all coming from the… the abstinence-only is all coming from the federal level? I thought it was coming from the state level?

CK: So the state puts matching dollars for sex ed. if I remember correctly?

LB: Okay.

CK: I'm trying to remember my talking points from twelve years ago so… So if you reject the abstinence-only education then you're rejecting that federal funding so you have to fund it all yourself. So you get that money and so then that's what you teach. You have to teach according to their guidelines which are…

W1: I mean that'd be interesting… I mean it's really about disease awareness and prevention.

CK: Yeah.

W1: Not sex education. So I wish there was some way in which within the schools, there could be a written-in curriculum around… in some… right? I mean I don't know [02:14:49 unc.] Does that exist?

CK: Yeah! There are kids. Jihad and I got paid to do…twice we did…the BART program with some kids in a Boys and Girls Club.

LB: What's the BART program?

CK: Becoming A Responsible Teen. And I think it's five sessions. And so we just go through and talk about HIV. I don't…I'm trying to...See I think…CDC and [unc. 02:15:18] just pulled away from a lot of those interventions because I think what's happening is a lot of the HIV prevention education has happened in a [unc. 02:15:26 silo?]. So we're like seeing them from a classroom and we're like, "Hey so here's all this HIV-prevention work." And then "Here's all this HIV prevention messaging. Here's how you tell somebody that you don't wanna use a condom." And then you have a twelve-year-old girl pull you aside and say that she's been sexually assaulted and you're like, "Holy crap." Or just like you realize that it goes deeper than just telling somebody, "Here's how you negotiate this condom." It's like, "Man. You got taken away from your family. You're living in a foster home." Or so a lot of times you end up…if you're not also addressing some of the other things that are happening I think it's better to do… which is more costly… is doing some one-on-one work or work in small groups. I think that has more to do with just sex ed. And I think in the schools specifically, especially in Richmond City, I just don't think that they have enough resources. They have too many students to be able to sit and do the extra work. The Anna Julia Cooper School is fabulous. Their executive director is fabulous. And they…

02:16:36

W1: Is Mike still there?

CK: Yeah. And they do a really good job of utilizing trauma-informed care in their school. I mean he says it. He's like, you know, "Our teachers have to be a million things." You know. It's like…how are you supposed to teach a kid how to do algebra if they say like, "Well my uncle was just shot in my living room last night." You know what I mean? These are the types of

things that you see kids going through and it's like, "Well… yeah… that kid might not do well in ESOL today." You know what I mean? Like…so…I think that's where it gets really frustrating. You're just like, "Well I'm doing this work. I'm doing this prevention education, but…" So I'm working with adults and I'm like, well this person has a mental health education that they can't get treatment for because they don't have insurance that covers it or you know whatever else may be happening with this person. So I think it goes deeper than just like doing these role plays and kind of talking about it. And I think that's what makes it so complicated. There's just a lot of other things, you know, all those messages we get from society around sex that are like wrapped into these conversations. So like you know me and Jihad sitting out there and doing a funny role play about like… You're supposed to use the kids and we're like, "We are not gonna have the kids do this because it's gonna be too raucous. So Jihad and I are like sitting on a fake couch and he's like, "Come on baby, let's go upstairs." They're all like hootin' and hollerin' just loving it you know? And I'm like, "No! I'm not doing that with you." You know, we like do the little role plays or whatever. I mean they enjoyed it but I don't know like… Are you taking that back to do it somewhere else? I don't know. I don't know what the dynamic of your relationships are. You know… what's going on outside of here. This may just be a little comic relief for you at the end of the day. You know…

W1: Well there's nothing wrong with that you know.

CK: Yeah.

W1: Talking about trauma-informed care—that's such a big focus across nonprofits and schools in Richmond today. So maybe that's another… I mean it really is…this is associated with so many other things within the families and within the children you know in that as you talk about all the ways in which our families and children are impacted today that that is another moment for HIV AIDS education without any… it's just… that among many other things that we're trying to share information about and educate families about.

02:19:30

CK: Yeah. We've really… [unc. 02:19:16 VH?] has really started rolling out the trauma-informed care like really piecing all these other things together. I know they have a… CDC grant right now that's happening in the eastern region, so that's where it's kind of starting where they're doing navigation for people who are HIV negative. We do a lot of navigation for people who are positive. We're like, "Let's get you here. Let's get you this. Let's get you that. Everything you might need." But what about this person who comes in who's like, "I'm negative but I never use condoms and also I have a mental health condition that I'm not really getting treatment for and…I'm hungry." So you know being able to navigate people to those other resources. So the work is really moving to expanding services for anybody who walks into the door to make sure they're getting all these other things—specifically their basic needs met. Because you're like probably not going to use a condom if you don't know where you're going to sleep tonight. Right? So being able to do some of that stuff. Hopefully we'll be able to see that expand out across the state as more resources get put into that sort of intervention.

W1: Are there enough locations where the folks looking for testing can go in Richmond. I mean Richmond City Health District is an incredible partner.

CK: Yeah.

W1: Are there other sort of holes in our landscape that really need to be filled in terms of access?

CK: I mean we have…we're lucky to have quite a few places that are doing testing. Crossover does testing. Minority Health Consortium does testing. Zachiah just opened up. Nations Foundation, last year, they're doing testing. So… we… I think we have quite a few places where people can get tested that we can refer back and forth in. I think each place has their niche, their thing that they do really well, and a place where somebody may feel more comfortable going, which is pretty cool. So I think that, I mean, it's possible that we could still use more, but you can also go to Walgreens and get a free HIV test, some Walgreens, so I think the testing expansion has been really good. But I think it's some of those other things, some of those other supportive services it would be nice to see that move out.

LB: That's great. Thank you.

CK: Yeah. Sorry I didn't know you were recording.

Lorraine: It just keeps rolling until we're really done. Awesome.

END TIME: 02:21:45