SisterLove, Inc.
POLICY & ADVOCACY PROGRAM

INTERSECTIONS AT THE GRASSROOTS

A **Reproductive Justice** Analysis of Atlanta's HIV Epidemic

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www.sisterlove.org

SisterLove, Inc. is on a mission to eradicate the impact of HIV and sexual and reproductive oppressions on all women, their families, and communities.

January 2017

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ACKNOWLEDGEMENTS

The SisterLove, Inc. Policy and Advocacy Program would like to extend our deep gratitude to the many individuals and organizations that have contributed their time, resources, expertise, stories, and support to help make this report possible. We would specifically like to thank:

Courtney Anderson
Sequoia Ayala
Madison Burnett
Joseph Campbell
LaKeisha Coach
John Crawford
Dazon Dixon Diallo
Shakeema Faison
Sharron Fickling
Edith Amia Hall
Damaris Henderson
Hope Holloway
Joaquin Hubert
Connie Johnson
Tammy Kinney
Bex Kwan
Stephanie Laster
Marquisette Glass-Lewis
Tatiana Lima
Phyllis Malone
Nina Martinez
Kristi Matthews
Mel R. Medalle
Mo Morgan
Laurel Mustafa
Sonja Patterson
Tiffany Omi Pennick
Genevieve Razick
Krystal Redman
Sabrina Rewald
Arneta Rogers
Glo Ross
Benetta Standly
Charles Stephens
Vanessa Terrell
Masonia Traylor
Brooklyn Walls
Lisa Diane White
Cortez Wright

AIDS United
Georgia Coalition to End HIV Criminalization
Ford Foundation

FOREWORD

A Way Forward

On a hot summer day in Atlanta long ago, a bright-eyed young woman with the biggest smile disclosed her HIV status to me in a big empty classroom. We were the only two people in the room, and she shared her story with painful pauses and long stretches of sobs and tears. Her story began with her decision to get a tubal ligation that was being advertised as a pro bono service at a local hospital in South Carolina. She went on to describe what she thought would be a routine visit for a routine procedure, which turned into a horrific, terrifying, and unconscionable event. She was told that she tested positive for AIDS (not possible) and that the clinicians were not going to complete her tubal ligation on that day or any day—essentially refusing to provide any care at all on the basis of her health status. She was then promptly ushered down the back staircase and out the door with no further information or service.

Devastated by the incident, Joanne Wright[1] went through her own journey of depression, fear and suicidal ideation before finding the help she needed and moving to Atlanta. The experience at the hospital, and her subsequent linking up with women and women's organizations that supported her and her family, have all led to her legacy as a courageous Black woman, living in the Southeastern United States with HIV, who understands HIV as an issue of sexual and Reproductive Justice, in all its intersections and diverse components. She lives and embodies the core elements that have defined the principles, the philosophy and the work of SisterLove.

Joanne's story became a clarion call for the creation of SisterLove. SisterLove's programs and projects, while heavily focused on HIV and AIDS education, prevention and services, have always been conceived and implemented through the prism of fighting sexual and reproductive oppressions that lead to HIV contraction, and the subsequent challenges of living with HIV and AIDS.

The following report is a much-needed description and analysis of the most critical intersections that girls and women in Georgia face every day as they navigate the threats and challenges to their sexual and reproductive health and wellbeing. It is an important tool to help our communities, service providers, advocates, activists, policymakers and funding partners gain greater understanding of the multi-layered complexities of fighting an epidemic that is driven largely by social, structural, and political factors.

The ineffective approach to ending HIV through a variety of siloes including research, prevention, treatment, care, advocacy, policy and macro-level planning is counterintuitive to creating and implementing solutions that mirror the intersectional lives of individuals and communities impacted most by HIV. Women's lives are complicated and complex because of social, political, economic, sexual and cultural norms that leave little room for them to find solutions in one place or in one overall concept for change. Heteronormativity, sexism and misogyny, homophobia, transphobia, and racism, as well as general second- and third-class citizenry based on education, income, geography, heritage, and documentation are all factors that withhold protections of basic human rights and prohibit a robust response to HIV and AIDS and other sexual and reproductive health and rights challenges.

Intersections at the Grassroots: A Reproductive Justice Analysis of Atlanta's HIV Epidemic speaks to these issues through this intersectional lens to complicate one-dimensional views of our epidemic. We tell the story of the barriers that prohibit the advancement of human rights protections, as well as the assets that exist to lead us to our own solutions. I share our deepest "apprecialove" for the tremendous work and effort that has gone into the production of this manuscript.

We write this for Joanne, and the millions of women and girls just like her, whose stories are the touchable, tangible and most authentic elements of social change and social justice. We welcome you in our fight, and we wait for only ourselves to get it done.

In the Spirit of My Sisters,

Dázon Dixon Diallo, MPH
Founder/President

1 Name changed for confidentiality.

INTRODUCTION

The purpose of this report is to provide a critical Reproductive Justice (RJ) analysis of four major thematic areas shaping the HIV epidemic in Georgia, particularly in metro Atlanta. Consistent with SisterLove's experience serving women of color impacted by HIV and other sexual and reproductive health concerns, we focus most specifically on Black women living with HIV. The report will highlight the following drivers of the HIV epidemic at the state and local level:

- social determinants of health, with a specific focus on race- and class-based economic inequity;
- lack of access to comprehensive sexual and reproductive health education;
- systematic biomedical inequity and access to biomedical resources; and
- the restriction of sexual autonomy and self-determination through HIV criminalization and the policing of gender and sexuality.

We have selected these thematic issue areas because of their intersectional, multidimensional effects on Georgians' lives—spanning individual, interpersonal, and institutional levels of lived experience.

The angle of analysis utilized in this report reflects SisterLove's values as an intersectional[2] HIV and Reproductive Justice organization, and acknowledges that the health of communities does not occur in an apolitical vacuum, nor do individuals experience isolated health injustices separate from inequitable systems of power, resources, and decision making. Rather, sexual and reproductive justice is an integral pillar of social justice and self-determination. **We see Reproductive Justice (RJ) as the conditions of liberation that will exist when all people have the power and resources necessary to make their own decisions about their bodies, gender, sexuality, relationships, families, and communities, to create and choose their families, and to reproduce their communities as a whole** – all with dignity, self-determination, and genuine support. In continuing to expand the lens of RJ to encompass its intersections with HIV, we recognize and honor the work of Black women in the US South who first conceptualized this framework, as well as the nameless women of color, Indigenous women, and LGBTQ+ people of color across the US that continue to build our movement. Our method of analysis utilizes the intersectional Human Rights approach that characterizes RJ – with attention to the *structural* drivers of health, including the criminalization of sexuality, racism, anti-black violence, and rampant HIV stigma based in homophobia, transphobia, and misogyny. . Our perspectives and assertions are based on secondary research, focus groups, one-on-one conversations and interviews, and insights gleaned from hands-on experience in providing direct community health services, women and youth engagement programs, and advocacy with government bodies.

All people must be able to exercise the human right to health in an environment that provides: culturally affirming, affordable, and nondiscriminatory health resources; access to necessary sexual and reproductive health information; the political and economic resources necessary for basic human dignity; the self-determination necessary to nurture personal growth and community survival; and autonomy free from all forms of discrimination and violence. Drawing on these values, we aim to provide relevant facts, critique and explore policy perspectives, provoke further questions for research and action, and spark community mobilization and intersectionally-minded activism and advocacy grounded in this vision.

Our vision of RJ is far from our current state and local realities, in which our communities face multiple, intersecting forces of health injustice, stigma, and personal and structural violence—all of which contribute to our status as an epicenter of the HIV epidemic. Historically unaddressed racism, race-based economic and geographic segregation, homophobia, transphobia, and misogyny all shape our current health landscape. Contrary to widely held ideas about the HIV, individual behavior alone does not explain the health and violence crises that converge in this epidemic. Therefore, individual level interventions will not solve them.

While we focus on specific issues and communities in metro Atlanta in this report, we acknowledge that there are numerous other factors, groups, and areas disproportionately impacted by the structural drivers of the HIV epidemic throughout our state—such as rural areas—and beyond. We recognize the urgent need for improved research and action on HIV among trans and gender non-conforming people and among people in the sex industry. We also recognize the need for improved data collection on HIV among foreign-born individuals in the US, as well as the need to address our currently imprecise methods of aggregating multiple ethnic and racial groups

2 We draw on the foundational scholarship of Kimberle Crenshaw, who pioneered the critical theoretical lens of "intersectionality," which posits that interlocking social, political, cultural, legal, and institutional forces compound the impact of violence, discrimination, and oppression for those with overlapping marginalized social identities, such as women of color. See Crenshaw, K.W. (1993) Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. Available at: http://socialdifference.columbia.edu/files/socialdiff/projects/Article__Mapping_the_Margins_by_Kimblere_Crenshaw.pdf.

together in data collection, despite wide variations in economic, cultural, and social realities among various immigrant groups.

UNPACKING GENDER, SEXUALITY, AND LANGUAGE USED IN REPORT

In order to meaningfully grapple with policy and culture change related to the interlocking nature of sex, sexual and reproductive health, and self-determination, we must consider the ways in which gender and sexuality are socially-shaped constructs that have real world consequences in our lived experiences around sexual health and reproductive oppression. In our society's prevailing "male-female" binary gender system "man/male/masculine" and "woman/female/feminine" are the only two legitimately recognized gender categories. This setup eliminates any meaningful inclusion of those who do not identify neatly into one of these two categories and conform to the expected roles, behaviors, expressions, and appropriate forms of sexuality and desire associated with them, which can and does result in significant gender and sexuality policing and violence.

In this two-gender system, cisgender women (whose gender identity is the same as the sex they were assigned at birth) face individual and structural subordination to cisgender men and the institutions designed to center them. These two genders are expected to fulfill certain roles, behaviors, and practices. One salient effect of this gender system is that trans people (whose gender identity is different from the sex they were assigned at birth) and gender non-conforming people (whose gender identity and/or expression does not conform to binary expectations) are often made invisible, pathologized, and stigmatized. This binary gender system inherently implicates sexuality, as "men" and "women" are expected to be sexually and emotionally attracted to the "opposite" gender. As a result, the sexuality of lesbian, gay, bisexual, and queer (LGBQ) people is considered deviant insofar as it does not follow expectations imposed in a binary gender system that presupposes heterosexuality (between the "man" and "woman" gender identities recognized as legitimate in that system). Gender and sexuality are often improperly and inappropriately conflated in this framework, and compulsory heterosexuality (or "heteronormativity") therefore breeds violence, stigma, and discrimination at individual *and* institutional levels. These forces of gender-based oppression disproportionately impact trans and gender non-conforming people (TGNC), LGBQ people of color, and cisgender women of color.

For the purposes of this report, the common denominator is that our overarching binary gender system, in large part, fuels our public health crises around interpersonal and structural violence and discrimination against people across the spectrum of gender and sexuality. This binary gender system overlaps with prevailing systems of racism, racial ordering, and race-based violence and discrimination—in which people of color, and Black people in particular—are systematically devalued and oppressed. These systems are two of the most powerful organizing frameworks that shape our ongoing struggle to address HIV stigma specifically and HIV and AIDS disparities among the most impacted groups. We argue that these are the key protracted barriers that frustrate our efforts to address the social determinants that drive the epidemic—and that, if meaningfully transformed—could have the potential to stem the tide of HIV and other forms of sexual and reproductive oppression at deep cultural and political levels.

We recognize that our society's prevailing gender, sexuality, and race frameworks create power arrangements that have informed the HIV advocacy, provider, and research community's historically delayed response to meeting the specific needs of cisgender women in the US and internationally. We also recognize that the response has been even more egregiously delayed with respect to TGNC people, particularly trans women. Thus, we lack robust data that goes beyond research on individual "risk" behaviors.[3] Throughout this report, we have attempted to include relevant TGNC-specific data and information where available. The Glossary on page 63 contains explanations of language use, terminology, and acronyms.

AN OVERVIEW OF THE MULTIDIMENSIONAL FORCES SHAPING OUR HEALTH LANDSCAPE

Georgia has the fifth highest number of HIV diagnoses among all states[4], ranks first for primary and secondary syphilis[5], and is ninth in chlamydial infections[6] nationally. Georgia's perinatal HIV transmissions—which have been eliminated in other states and countries[7]—are higher than national averages[8]. Georgia has

3 Chung, C., et al. (2016) Some Kind of Strength: Findings on healthcare and economic wellbeing from a national needs assessment of transgender and gender non-conforming people living with HIV. Transgender Law Center.
4 Georgia Department of Public Health, HIV/AIDS Epidemiology Section (2014) HIV Surveillance Summary. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/HIV_EPI_2014_Surveillance_Summary.pdf
5 Georgia Department of Public Health (2015) STD Data Summary 2009-2013. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/MCH/STD/data_summary_2009_2013.pdf.
6 US Centers for Disease Control and Prevention (2015) Georgia—2015 State Health Profile. Available at: http://www.cdc.gov/nchhstp/stateprofiles/pdf/georgia_profile.pdf
7 Gutin, S. (2015) Perinatal Transmission of HIV is Preventable. Available at: http://caps.ucsf.edu/wordpress/wp-content/uploads/2010/11/MTCT-Revised-Sept-2015.pdf. Based on author interviews with staff from the Georgia Department of Public Health's Maternal and Child Health Division during July 2016, the authors expect the state agency to release new information on perinatal transmission rates in the near future.
8 Camacho-Gonzales, A. (2015) Missed Opportunities for Prevention Of Mother-To-Child Transmission In The United States. US National Library of

among the highest numbers of maternal death in the US.[9] In metro Atlanta specifically, young Black gay and bisexual men have a 60% chance of contracting HIV by the age of 30[10]. Among homeless youth in metro Atlanta, 28% are TGNC or LGBQ—and over half of trans youth report having survived a sexual assault.[11] New data compiled by the Solutions Not Punishment Coalition and the Racial Justice Action Center show that trans women—with the highest rates of susceptibility to HIV[12]—are subject to rampant profiling, harassment, and sexual violence by Atlanta Police Department.[13]

While our policymakers have made some strides in providing better access to prevention, care, and other health resources, Georgians still struggle to meet all their healthcare needs. For example, Georgia has declined to expand Medicaid despite the fact that 521,000 uninsured adults currently in the coverage gap would be eligible for the federally funded program if it were to do so[14]. Our state legislature has chipped away at the right to end an unintended pregnancy, passing a 20-week abortion ban in 2012[15], and providing anti-choice crisis pregnancy centers in Georgia with a two-million-dollar boost in funding in 2016.[16] The legislature acted positively by mandating opt-out HIV and syphilis testing for pregnant individuals in their third trimester in 2015. However, we have yet to see urgent action to address ongoing structural gaps driving our deplorable maternal death rate[17]—such as poor access to prenatal healthcare—identified by the state's Maternal Mortality Review Commission (MMRC) in its 2015 report.[18]

Fulton County makes up the largest land and population share of the City of Atlanta[19], and is home to over half of Georgians living with HIV. Our local governments and civil society must work towards comprehensive health justice and implement integrated structural responses, rather than engaging in piecemeal reform. The work of the Fulton County Task Force to End HIV/AIDS[20] and the creation of Fulton County's first public PrEP clinic are important steps in this direction. The Task Force has highlighted critical changes in our approach to prevention, care, and policy, and calls for immediate attention to the social determinants of HIV—including criminalization, unstable and unaffordable housing, food insecurity, trauma, low access to education, and widespread stigma. Fulton County Schools thwarted one of the strategy's goals in 2015 when local school board officials[21] voted to maintain abstinence-centered education in public schools[22], which serve young people in a county carrying over 64% of our state's HIV burden.

We must also contextualize individual poverty within the wider frame of economic policy and the race- and class-based spatial arrangement of Atlanta that has disproportionately disadvantaged Black communities over time.[23] When taking such context into account, it is unsurprising that many of the Atlanta zip codes with the highest poverty rates are the same zip codes with high HIV prevalence and are predominantly Black.[24] Currently, Atlanta has the highest income inequality and lowest chances of upward economic mobility of any city in the United States.[25] Atlanta

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Medicine, 29(12), 1511–1515. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4502985/.

9 Georgia Department of Public Health, Maternal Mortality Review Commission (2015) Georgia: Maternal Mortality: 2012 Case Review. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/MCH/MMR_2012_Case_Review_June2015_final.pdf.

10 Sullivan, P., et al. (2015). Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: A prospective observational cohort study. Annals of epidemiology., 25(6), 445f epidemiology.015). Available at: http://www.ncbi.nlm.nih.gov/pubmed/25911980.

11 Wright, E. (2016). 2015 Atlanta homeless youth count! : 2015 Atlanta Youth Count and Needs Assessment. Available at: https://issuu.com/gavoice/docs/aycna_final_report_may_2016_final/3?e=3167111/35350541.

12 Chung, C., et al. (2016) Some Kind of Strength: Findings on healthcare and economic wellbeing from a national needs assessment of transgender and gender non-conforming people living with HIV. Transgender Law Center.

13 Solutions Not Punishment Coalition (2016) The Most Dangerous Thing Out Here is the Police. Available at: http://dev.rjactioncenter.org/wp-content/uploads/2016/05/DangerPolice-16pg-4web.pdf.

14 Garfield, R. (2016) The Coverage Gap: Uninsured Poor Adults In States That Do Not Expand Medicaid. Available at: http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

15 Georgia General Assembly (2012) House Bill 954. Available at: http://www.legis.ga.gov/Legislation/20112012/127778.pdf ; See also Grinberg, E. (2016) The Abortion Ruling No One Knew About: Georgia's 20-Week Ban. CNN. Available at: http://www.cnn.com/2016/05/26/health/georgia-abortion-law-20-weeks/.

16 Georgia General Assembly (2016) House Bill 308. Available at: http://www.legis.ga.gov/Legislation/20152016/162278.pdf

17 Georgia Department of Public Health, Maternal Mortality Review Commission (2015) Georgia: Maternal Mortality: 2012 Case Review. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/MCH/MMR_2012_Case_Review_June2015_final.pdf.

18 Ibid.

19 Fulton County Task Force (2015) Phase I: Building the strategy to end AIDS in Fulton County. Available at: http://www.sisterlove.org/wp-content/uploads/2014/10/2015-1201-Strategy-to-End-AIDS-in-Fulton-County-Phase-I.pdf

20 Ibid.

21 O.C.G.A. 20-2-143 (2016). Available at: http://law.justia.com/codes/georgia/2006/20/20-2-143.html.

22 French, R. (2015) Fulton Schools Considers Changes to Sex-Ed Course. Available at: http://www.myajc.com/news/news/local-education/fulton-schools-changing-sex-ed-coursework-others-t/nnzr2/.

23 Bayor, R.H. (1996) Race & the Shaping of Twentieth-Century Atlanta. Chapel Hill and London: The University of North Carolina Press [hereinafter Bayor].

24 Rane, D., Kelly, J. (2013) HIV Surveillance Update. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/HIV%20Surveillance_Deepali%20Rane_Jane%20Kelly_07.22.13.pdf; PR Newswire (2012) Latest AIDSVu Data Illustrate Impact of HIV by Zipcode in Major U.S. Cities. Available at: http://www.prnewswire.com/news-releases/latest-aidsvu-data-illustrate-impact-of-hiv-by-zip-code-in-major-us-cities-160364965.html.

25 Alan, B., Holmes, N. (2015) Some Cities Are Still More Unequal Than Others—An Update. Brookings Institution. Available at: https://www.brookings.edu/research/some-cities-are-still-more-unequal-than-others-an-update/.

has historically championed economic and land use policies that have attracted wealth and development-based investments at the expense of expanding the wedge between rich and poor. This trend, coupled with official and informal racial segregation practices, has led to concentrated poverty in Black neighborhoods. Such policies have in part facilitated the steady elimination of public housing, increased gentrification and displacement, and the rapid closure in recent years of our city's dwindling number of homeless shelters[26]. This significantly impacts sexual and reproductive health on an individual level, as unstable housing and poverty has been linked to poorer HIV health risks and outcomes.[27] Unstable housing has also been linked to past or recent experiences of intimate partner violence[28], physical violence, and sexual assault[29].

These factors also impact health on a structural level. Insufficient local health resources and the geospatial concentration of poverty, coupled with low economic mobility and associated lack of health insurance, all perpetuate negative health outcomes for people living in communities most impacted by HIV. **Racial discrimination and segregation, which has guided the historical development of the spatial layout of the city—affect everything from housing access to food security and rental and lending protections—all of which bear on HIV in Atlanta's most impacted communities.**

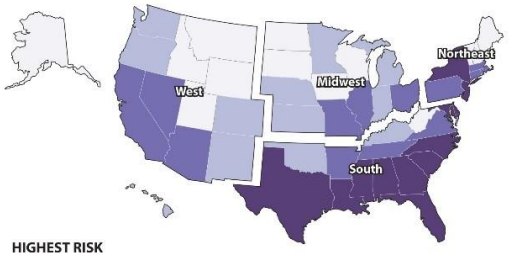
Many commentators have observed the US South's "perfect storm" of historical, structural, sociocultural, and geospatial factors that make it the region most impacted by HIV in the nation. The City of Atlanta and the State of Georgia are illustrative of many of these factors. Our report aims to provide a deeper exploration of some of the key factors and implications of the multiple forces that converge in our HIV epidemic, and how to address these drivers to achieve sustainable change.

26 Reed, K. (2016) City Council Votes To Allow Negotiations To Proceed Over Atlanta Shelter. Available at: http://www.11alive.com/news/local/peachtree-pine-homeless-shelter/328580107.
27Milloy, M.-J., Marshall, B. D., Montaner, J., Wood, E. (2012) Housing Status and the Health of People Living with HIV/AIDS. Current HIV/AIDS Reports, 9(4), 364–374. Available at: http://doi.org/10.1007/s11904-012-0137-5.
28 National Network to End Domestic Violence, Domestic Violence, Housing, and Homelessness. Available at: http://nnedv.org/downloads/Policy/NNEDV_DVHousing__factsheet.pdf.
29 Goodman, L., Fels, K., Glenn, C., Benitez, J. (2016) No Safe Place: Sexual Assault in The Lives Of Homeless Women. Available at: http://vawnet.org/material/no-safe-place-sexual-assault-lives-homeless-women.

THE STATE OF HIV IN GEORGIA AND NATIONALLY

With over 1.2 million[30] people living with HIV in the United States, HIV remains one of the greatest public health issues of our time. In the U.S. today, the majority[31] of HIV transmissions occur through sexual contact, with only 6% of new transmissions in 2014 attributed to injection drug use.[32] Since 2005, new HIV diagnoses have decreased by approximately 19%, a success that can be attributed to effective public health response strategies. Despite the success of these strategies, HIV prevalence within communities of color, particularly in the South, remain at an alarming rate.[33]

Lifetime Risk of HIV Diagnosis by State



HIGHEST RISK							LOWEST RISK	
State	One in "n"	State	One in "n"	State	One in "n"	State	One in "n"
District of Columbia	13	Nevada	98	Michigan	167	West Virginia	302
Maryland	49	Illinois	101	Oklahoma	168	Wisconsin	307
Georgia	51	California	102	Kentucky	173	Iowa	342
Florida	54	Tennessee	103	Indiana	183	Utah	366
Louisiana	56	Pennsylvania	115	Washington	185	Maine	373
New York	69	Virginia	115	Colorado	191	Alaska	384
Texas	81	Massachusetts	121	New Mexico	196	South Dakota	402
New Jersey	84	Arizona	138	Hawaii	202	New Hampshire	411
Mississippi	85	Connecticut	139	Oregon	214	Wyoming	481
South Carolina	86	Rhode Island	143	Minnesota	216	Vermont	527
North Carolina	93	Ohio	150	Kansas	262	Idaho	547
Delaware	96	Missouri	155	Nebraska	264	Montana	578
Alabama	97	Arkansas	159			North Dakota	670

Source: Centers for Disease Control and Prevention

Figure 1

ATLANTA: THE EPICENTER OF THE AIDS EPIDEMIC IN THE US SOUTH

The prevalence of HIV in Georgia and the US South is substantially higher than in the rest of the United States. **Nine states in the Deep South make up 28% of the overall US population, yet account for 40% of all new HIV diagnoses nationwide.[34] Georgia currently ranks fifth in the nation for the number of new HIV diagnoses.[35]** In 2013, Georgia reported over 3,000 new HIV diagnoses; young adults between the ages of 13-24 accounted for approximately 23% of those diagnoses.[36] Given the pervasiveness of HIV within Georgia's most densely populated communities, it is estimated that 1 in 51 Georgians are at risk of contracting HIV in their lifetime.[37]

This is compounded by the stark reality that many affected are unaware of their status. In Georgia, the rate of persons who are aware of their HIV-positive status is lower (73%) than the national average (87%).[38] More than one-quarter of all Georgians living with HIV are unaware of their status. Being aware of one's status is essential to obtaining timely treatment and care, which can significantly increase a person's chances of viral suppression and positive health outcomes. In 2014, it was found that one in two new HIV diagnoses in the Atlanta area had already progressed to AIDS—indicating that the person diagnosed had been unknowingly living with HIV and without adequate treatment for at least a year.[39]

30 US Centers for Disease Control and Prevention (2016) HIV basic statistics. Available at: http://www.cdc.gov/hiv/basics/statistics.html.
31 US Centers for Disease Control and Prevention (2016) HIV Surveillance Reports. Available at: http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html.
32 US Centers for Disease Control and Prevention (2016) HIV in the United States: At A glance. Available at: http://www.cdc.gov/hiv/statistics/overview/ataglance.html.
33 Ibid.
34 Southern HIV/AIDS Strategy Initiative (2016) HIV/AIDS in the U.S. Deep South: Trends from 2008-2013. Available at: https://southernaids.files.wordpress.com/2011/10/hiv-aids-in-the-us-deep-south-trends-from-2008-2013.pdf.
35 Georgia Department of Public Health (2016) HIV/AIDS Epidemiology Section HIV Surveillance Summary, Georgia 2014. Available at: https://dph.georgia.gov/data-fact-sheet-summaris
36 AIDSVu (2016) Georgia. Available at: http://aidsvu.org/state/georgia/; see also, Georgia Department of Public Health, HIV/AIDS Epidemiology Section Epidemiology Program. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/HIV_EPI_2013_Surveillance_Summary.pdf.
37 US Centers for Disease Control and Prevention (2016) Lifetime Risk of HIV Diagnosis. Available at: http://www.cdc.gov/nchhstp/newsroom/2016/croi-press-release-risk.html.
38 Georgia Department of Public Health, HIV/AIDS Epidemiology Section Epidemiology Program. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/HIV_EPI_2013_Surveillance_Summary.pdf.
39 Hagen, L. (2015) Half of Atlanta's Newly Diagnosed HIV Patients Have AIDS, Grady Testing Finds. Available at: http://news.wabe.org/post/half-atlantas-newly-diagnosed-hiv-patients-have-aids-grady-testing-finds.

In the words of Nic Carlisle, the executive director of the Southern AIDS Coalition: **"[T]he South is the epicenter of the [HIV] epidemic and really Atlanta is the epicenter of that."**[40] Fulton County accounts for half of HIV cases in the state, with the majority of new cases among young Black men and Black women. Approximately 64% of people in the state of Georgia living with HIV

BLACK WOMEN ACCOUNT FOR 75% OF ALL WLHIV GEORGIA.

reside in the Atlanta-Sandy Springs-Marietta Metropolitan Statistical Area (MSA).[41] Within the Atlanta metropolitan area, the most densely populated counties (Fulton, DeKalb, and Clayton, respectively) have new diagnoses rates exceeding the rest of the state. Young Black gay men over 18 in metro Atlanta have a 60% of contracting HIV by age 30.[42]

PEOPLE OF COLOR ARE DISPROPORTIONATELY IMPACTED BY HIV AND AIDS

Black women shoulder a disproportionate burden of the HIV epidemic. Nationally, in 2014, of all women diagnosed with HIV, an estimated 62% (5,128) were African American, 18% (1,483) were white, and 16% (1,350) were Hispanic/Latina.[43] **Black women account for 75% of all WLHIV in Georgia**, and Black men account for 60% of all men living with HIV in Georgia—despite making up only 31% of the state's overall population.

In Atlanta, a Black woman's chance of contracting HIV is 14 times higher than a white woman's.[44] Beyond initial diagnoses, Georgia has the second highest rate of Black women and girls living with HIV who have progressed to AIDS.[45]

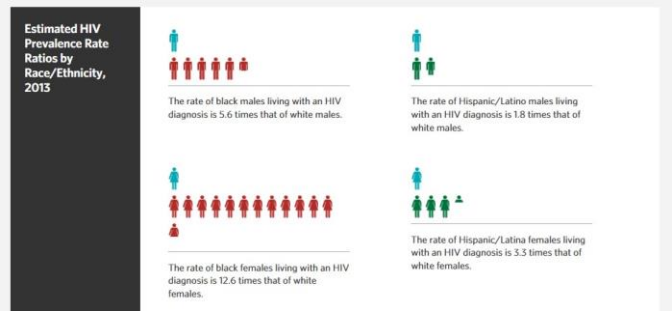


Figure 2 Estimated HIV Prevalence Rate Ratios by Race/ Ethnicity, 2013 (Georgia). (Available at: www.AIDSVu.org.)

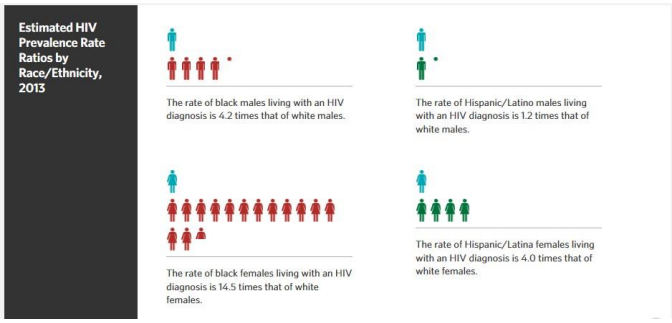


Figure 3 Estimated HIV Prevalence Rate Ratios by Race/ Ethnicity, 2013 (Atlanta). (Available at: www.AIDSVu.org.)

The disparate impact on Black women and girls is compounded by intersecting socioeconomic factors that impede access to and ongoing engagement in care and other supportive services. New HIV diagnoses declined by 40% among all women nationwide from 2005 to 2014. New rates of diagnoses declined the most among Black women, at 42%[46]—though Black women are still disproportionately affected among women overall. Despite the successful decline, Black and Hispanic/Latina cisgender women and trans women of color continue to bear the brunt of the HIV epidemic relative to white cisgender women. Although new HIV diagnoses have declined, challenges to access to care and treatment persist, and race- and gender-based inequality remain imbedded within the institutions and social structures WLHIV must navigate. Cisgender women make up a quarter of individuals living with HIV in the United States (and over

40 Powers, S. (2015) Why Atlanta is An Epicenter Of A New HIV/AIDS Epidemic. Available at: http://www.gpb.org/news/2015/07/22/why-atlanta-epicenter-of-new-hivaids-epidemic (emphasis added).
41 Georgia Department of Public Health (2016) HIV/AIDS Epidemiology Section HIV Surveillance Summary, Georgia 2014, Available at: https://dph.georgia.gov/data-fact-sheet-summaris.
; Fulton County Department of Health and Wellness High Impact HIV Prevention Program (2012) Available at: http://www.ryanwhiteatl.org/wpcontent/uploads/2016/03/otherresources/ComprehensivePlansStrategies/City-of-Atlanta-Jurisdictional-HIV-Prevention-Plan-Community.pdf.
42 Sullivan, P., et al. (2015). Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: A prospective observational cohort study. Annals of epidemiology., 25(6), 445f
epidemiology.015). Available at: http://www.ncbi.nlm.nih.gov/pubmed/25911980.
43 US Centers for Disease Control and Prevention. (2016) HIV Among Women. Available at: http://www.cdc.gov/hiv/group/gender/women/.
44 See Figures 2 and 3.
45 14.8 per 100,000 – next is Louisiana with 14.0 per 100,000. Top is DC with 47.6 per 100,000.
46 New HIV diagnoses declined 35% among Latina women, and 30% among white women.

50% globally), yet research on prevention and treatment methods specifically designed for GNC women remains lacking.[47] A concerted effort must be undertaken to reform existing policies that have proven unsuccessful in quelling the ongoing effect of the HIV and AIDS on Black women in Georgia.

HIV AMONG YOUNG PEOPLE AGES 13-24

Nationally, the continued prevalence of new HIV diagnoses among young people is particularly disquieting. At the end of 2012, an estimated 62,400 young people between the ages of 13-24 were living with HIV in the United States. **At that time, it was estimated that only two out of five young people living with HIV were aware of their status[48], compared to one in six adults who did not know their status.[49]**

People living with HIV who are unaware of their status may unknowingly transmit the virus to others through unprotected sex[50] or sharing needles. Furthermore, structural factors like lack of access to healthcare and having sex within same-race sexual networks have been shown to greatly increase individual vulnerability to HIV contraction among young Black gay and bisexual men.[51] **These findings dispel the myth that "risky individual behaviors" are the primary cause of HIV transmissions, and re-assert appropriate attention on structural level drivers of HIV.[52]** Young people as a group also have the lowest likelihood of being linked to care and achieving viral suppression.[53] National estimates show that only 78% of young people are linked to care within 3 months, and that only 16% of youth living with HIV have a suppressed viral load.[54]

Young "men who have sex with men (MSM)"[55] between ages 13-24 are disproportionately affected by HIV. In 2014, young MSM accounted for an estimated 19% of all new HIV infections in the United States and 72% of new HIV infections among young people.[56] Alarmingly, young Black MSM have experienced an increase in new diagnoses over the past decade, and between 2010 and 2014 that rate has only declined by 2%.[57] New diagnoses for Hispanic/Latino MSM have increased by 24%. In comparison, over the same period new diagnoses amongst white MSM have consistently declined by 18% overall.[58]

HIV AMONG TRANS INDIVIDUALS

Twenty eight percent of trans women in the US are living with HIV, and Black trans women are substantially more likely to test positive for HIV.[59] The National Transgender Discrimination Survey[60] found that trans people were more likely to be HIV-positive if they had been sexually assaulted because of their gender identity, did not have a high school diploma, had incomes below $10,000 per year, were unemployed, or had lost a job due to bias based on some facet of their identity. Additional risk factors that exacerbate the high incidence rate among trans women include "higher rates of drug and alcohol abuse, sex work, incarceration, homelessness, attempted suicide, unemployment, lack of familial support, violence, stigma and discrimination, limited healthcare access, and negative healthcare encounters."[61] **Stigma and discrimination against trans people significantly contributes to the heightened HIV risk among trans women and severely limits the ability to obtain clinically adequate and culturally competent care once they have tested positive.** Research detailing the prevalence among trans women remains lacking. This is in part due to the problematic previous categorization in research studies of trans women with gay and bisexual men and "men who have sex with men (MSM)." HIV remains a public health emergency among trans women of color and

47 US Centers for Disease Control and Prevention. (2016) HIV in the United States: At A glance. Available at: http://www.cdc.gov/hiv/statistics/overview/ataglance.html
48 Or 44% (25,300 out of 57,200). See US Centers for Disease Control and Prevention (2016) HIV Among Youth. Available at: http://www.cdc.gov/hiv/group/age/youth/ (finding that in 2012, out of 57,200 young people living with HIV, 25,300 were estimated to not know their status).
49 US Centers for Disease Control and Prevention (2015) Georgia 2015 State Profile. Available at: http://www.cdc.gov/nchhstp/stateprofiles/pdf/georgia_profile.pdf
50 Notwithstanding where persons are taking pre- or post-exposure prophylactics.
51 Sullivan, P., et al. (2015). Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: A prospective observational cohort study. Annals of epidemiology., 25(6), 445f epidemiology.015). Available at: http://www.ncbi.nlm.nih.gov/pubmed/25911980.
52 Id.
53 US Centers for Disease Control and Prevention. (2016) HIV Among Youth. Available at: http://www.cdc.gov/hiv/group/age/youth
54 Ibid.
55 The authors have included this term specifically because it is the term used in the data sources on which the information in this paragraph is based. Public health and medical researchers have used the term "men who have sex with men" to refer to men who have sex with men but who may or may not identify as gay or bisexual.
56 US Centers for Disease Control and Prevention. (2016) HIV Among Youth. Available at: http://www.cdc.gov/hiv/group/age/youth.
57 US Centers for Disease Control and Prevention (2016) HIV in the United States: At a glance. Available at: http://www.cdc.gov/hiv/statistics/overview/ataglance.html
58 Ibid.
59US Centers for Disease Control and Prevention (2016) HIV Among Transgender People. Available at: http://www.cdc.gov/hiv/group/gender/transgender/index.html
60 Grant, J.M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
61Human Rights Campaign (2016) Transgender People and HIV: What We Know. Available at: http://www.hrc.org/resources/transgender-people-and-hiv-what-we-know; US Centers for Disease Control and Prevention, HIV Among Transgender People. Available at: http://www.cdc.gov/hiv/group/gender/transgender/index.html.

is an integral part of addressing the adverse impact of HIV and sexual and reproductive oppressions upon all women and their communities.

While some strides have been made to make HIV research more inclusive of TGNC people, many of the studies have focused significantly on trans women. The practice of excluding trans men in relevant sexual health discourse can contribute to structural health barriers and inequities.[62] Early studies conducted to determine the risk of HIV for trans men show that 0-3% of trans men self-reported a positive HIV status.[63] While these studies offer some insight, they were based on small, non-representative samples and do not conclusively highlight the HIV risks for trans men. A 2011 study[64] revealed that trans men who reported having sex with cisgender gay men were more likely to engage in condomless sex. Low rates of HIV testing and low perception of HIV risk among trans men who have sex with men, particularly in areas with high HIV prevalence rates among cisgender gay men, lead to a heightened likelihood of contracting HIV.[65] Accurate and culturally appropriate sexual health information for trans men is scarce. Reduced safer sex knowledge among trans men and/or misinformation may create a perception of low risk and decreased urgency in seeking testing. The social determinants affecting the health of trans men must be researched to better understand HIV risk, resilience, and to improve sexual health education and culturally relevant prevention practices.

62 Human Rights Campaign (2013) UCSF Center of Excellence for Transgender Health on Transgender Men & HIV/AIDS. Available at: http://www.hrc.org/blog/transgender-men-hiv-aids.
63 Sevelius, J. (2015) What Are Transgender Men's HIV Prevention Needs. Available at: http://caps.ucsf.edu/archives/factsheets/transgender-men
64 Rowniak, S., Chesla, C., Rose, C. (2011) Transmen: The HIV Risk of Gay Identity. Available at: http://repository.usfca.edu/cgi/viewcontent.cgi?article=1078&context=nursing_fac.
65 River, B. (2014) Trans Men: The Invisible Battle with HIV. Available at: http://www.hivequal.org/hiv-equal-online/trans-men-the-invisible-battle-with-hiv.

SOCIAL DETERMINANTS OF HEALTH AS DRIVERS OF THE HIV EPIDEMIC

Social determinants of health (SDHs) are conditions, environments, and social practices and attitudes that can shape the ways in which people are born, grow, live, work, play, worship, and age. SDHs must be distinguished from naturally occurring factors that affect health. SDHs are *socially determined*, human-made forces that affect overall quality of life, health outcomes, and health risks.[66] SDHs affect not only physical health risks and outcomes, but mental health as well. Better access to the SDHs has the potential to "enhance quality of life and can have a significant influence on population health outcomes."[67] Conversely, lack of positive access to SDHs translates to poorer health outcomes.

Photo Credit Mo Morgan (Sylvan Hills, Southwest Atlanta)

SDHs can be grouped into several broad categories, including resource availability, social practices, and environmental factors, among others. Resource related SDHs include, but are not limited to, access to healthcare, food, wealth and assets, income, education, and employment. SDHs are social and cultural attitudes and practices that shape one's health quality, risks, and outcomes. These SDHs can include, but are not limited to, racism, homophobia, transphobia, and discrimination based on health status.[68] Examples of environmental SDHs are air and water quality in one's neighborhood (mediated by political and economic forces), exposure to violence in the household, and over-policing in one's community.

SDHs are not static, but rather constantly in flux based on the "distribution of power, wealth and resources on local, national and global levels."[69] **They provide a useful lens with which we can go beyond an interrogation of individual behaviors and investigate and analyze the underlying structural forces that drive our multiple sexual and reproductive health challenges.**

While this report does not discuss all the many SDHs that exist, we will emphasize the role of discriminatory social attitudes and practices that shape our epidemic. We will now highlight economic inequity as a watershed SDH in the HIV epidemic, with implications for geographic concentration of poverty, health risks and outcomes, access to housing and food, and community economic and demographic stability.

ECONOMIC INEQUITY AS A SOCIAL DETERMINANT OF HEALTH

Economic "development" and "growth" in neighborhoods is not random, but is rather significantly determined by the prevailing political and economic ideologies that that drive preexisting spatial conditions. It is in this context that neighborhoods face barriers to "development"—such as concentrated poverty, economic isolation, political marginalization, lack of asset ownership, employment opportunities, and living wages, insufficient tax bases, disempowering spatial design, and lack of both residential and transportation mobility. Many of these converging realities are rooted in the history of de jure and de facto racial segregation that have historically shaped the development in the City of Atlanta, and have had the effect of concentrating poverty and health disparities—including HIV prevalence—in Black communities.[70]

With offices in the Adamsville and West End neighborhoods of Atlanta, SisterLove is strategically located in a region of the city heavily affected by HIV. The West End neighborhood in particular reflects the complex ways in which race mediates the specific types of community economic development programs that local officials have championed during different political eras—and how those policies have weakened community-based political and economic

66 World Health Organization (2008) Key Concepts of Social Determinants of Health, Available at: http://www.who.int/social_determinants/en/; Commission on the Social Determinants of Health, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Available at: http://www.searo.who.int/LinkFiles/SDH_SDH_FinalReport.pdf.
67 Office of Disease Prevention and Health Promotion, Social Determinants of Health. (2014). Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
68 World Health Organization (2008) Key Concepts of Social Determinants of Health, Available at: http://www.who.int/social_determinants/en/; Commission on the Social Determinants of Health, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Available at: http://www.searo.who.int/LinkFiles/SDH_SDH_FinalReport.pdf.
69 World Health Organization (2008) Key Concepts of Social Determinants of Health. Available at: http://www.who.int/social_determinants/en/.
70 See Bayor; PR Newswire (2012) Latest AIDSVu Data Illustrate Impact of HIV by Zipcode in Major U.S. Cities. Available at: http://www.prnewswire.com/news-releases/latest-aidsvu-data-illustrate-impact-of-hiv-by-zip-code-in-major-us-cities-160364965.html.

power over time, resulting in reduced access to health resources, and minimized the ability of local communities to address the SDHs on their own terms. **Understanding the historical and political context inherent to the City of Atlanta's development is imperative to achieve a more nuanced understanding of our current health challenges and creating empowering solutions to them.**

This section of the report is not intended to provide an in-depth case study; instead, we seek to highlight examples from the City of Atlanta to illustrate the ways in which economic inequity manifests in our health landscape and HIV epidemic, and the role of racial segregation in this process. The complexities of economic inequity affect the ability of communities heavily impacted by HIV to achieve both economic stability, safe and affordable housing, food security, and overall positive health and wellness outcomes. While not discussed at length in this section, it should be noted that affordable and reliable transportation is a key social determinant of health that is particularly salient for PLHIV, who require the mobility to travel efficiently to access healthcare, maintain employment, care for families, and maintain optimal health with dignity and self-sufficiency.

Our Environments Shape our Ability to Exercise our Human Right to Health

The ability to exercise the human right to health is directly shaped by our public and private environments, as well as our ability to live free from violence and discrimination.[71] Factors such as pollution and poor air or water quality, poverty rate, incidence of crime, lack of access to nutritious food, and lack of spaces for exercise and recreation, have been linked to increased mortality rates, general health status, disability rates, birth outcomes, prevalence of chronic conditions, health behaviors, and risk factors for chronic diseases and mental health.[72] It is critical to note that these realities are *outcomes* of systemic inequities, which have the effect of reinforcing cycles of concentrated poverty and poor community health outcomes.[73] **We posit that these inequities directly shape health risks and outcomes, are inherently discriminatory, and violate the human right to health.** Understanding the relationship between "place" and its impact on health is fundamental to addressing the social conditions that can advance or impair positive health outcomes.[74]

> ECONOMIC DEVELOPMENT RESTS UPON THE *POLITICAL* IDEOLOGIES THAT SHAPE *SPATIAL* CONDITIONS

Health starts in our homes, schools, workplaces, neighborhoods, and communities. Intergenerational cycles of chronic unemployment and poverty are not merely outcomes of economic restructuring or globalization. Rather, preexisting economic isolation, racial segregation, and political disempowerment of our most underserved neighborhoods have increased their vulnerability to larger economic forces that reduce the ability to prevent or mitigate cycles of poverty. This has translated to decreased *local* access to housing, employment, education, business opportunities, and the levers of political and institutional power.

Economically marginalized communities have also been subjected to a severely disproportionate share of environmental burdens due to the stifled ability to utilize conventional forms of political and economic power to intervene in environmental decision-making.[75] Recent studies show that environmentally hazardous facilities are strategically sited in poor neighborhoods—*particularly when prompted by demographic change*. This new evidence directly contradicts the notion that poor people are drawn to neighborhoods with a lower cost of living and higher concentration of environmental hazards. On the contrary, "[N]eighborhood transition may serve to *attract* noxious facilities."[76] This is of heightened importance for

71 The Wellmark Foundation. Healthy Communities 2016 Small Grant Program. Available at: http://www.wellmark.com/foundation/documents/Wellmark-Foundation-Healthy-Comm-RFP.pdf
72 Commission to Build a Healthier America (2008) Where We Live Matters for Our Health: Neighborhoods and Health. Available at: http://www.commissiononhealth.org/PDF/fff21abf-e208-46dd-a110-e757c3c6cdd7/Issue%20Brief%203%20Sept%2008%20-%20Neighborhoods%20and%20Health.pdf
73 Ibid.
74 Office of Disease Prevention and Health Promotion (2014) Social Determinants of Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
75 See Mohai, P. and Saha, R. (2015) 'Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies', Environmental Research Letters, 10(12), p. 125011. doi: 10.1088/1748-9326/10/12/125011; Collins, M.B., Munoz, I. and JaJa, J. (2016) 'Linking "toxic outliers" to environmental justice communities', Environmental Research Letters, 11(1), p. 015004. doi: 10.1088/1748-9326/11/1/015004 (finding that high-pollution producers "disproportionately expose communities of color and low income population to chemical releases.").
76 The Journal of Blacks in Higher Education (2016) Two Academic Studies Show that Polluters Target Minority Communities. Available at: https://www.jbhe.com/2016/02/two-academic-studies-show-that-polluters-target-minority-communities/ (citing the author of the studies). The academic studies can be accessed here: Mohai, P. and Saha, R. (2015) 'Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies', Environmental Research Letters, 10(12), p. 125011. doi: 10.1088/1748-9326/10/12/125011; Collins, M.B., Munoz, I. and JaJa, J. (2016) 'Linking "toxic outliers" to environmental justice communities', Environmental Research Letters, 11(1), p. 015004. doi: 10.1088/1748-9326/11/1/015004.

Atlanta communities in SisterLove's service areas facing rapid displacement and demographic change spurred by gentrification.

There is no single policy or program that can address the many challenges that our neighborhoods face. Instead, **we call for integrated, comprehensive, community-controlled plans that are conducive to health and wellness as defined by the people who live and work within the communities themselves.** This shift is necessary to move away from our current system's method of addressing individual health and basic needs through siloed bureaucratic structures that use invasive methods and place inordinate demands on individuals and families in need of assistance. We must also acknowledge that our currently siloed system misses a significant opportunity to address the SDHs in order to reduce social stigma, discrimination, and the reliance on criminal punishment as a form of social control in underserved communities that face the greatest SDH challenges and barriers to physical and mental health.[77]

Photo Credit Mo Morgan (West End, Southwest Atlanta)

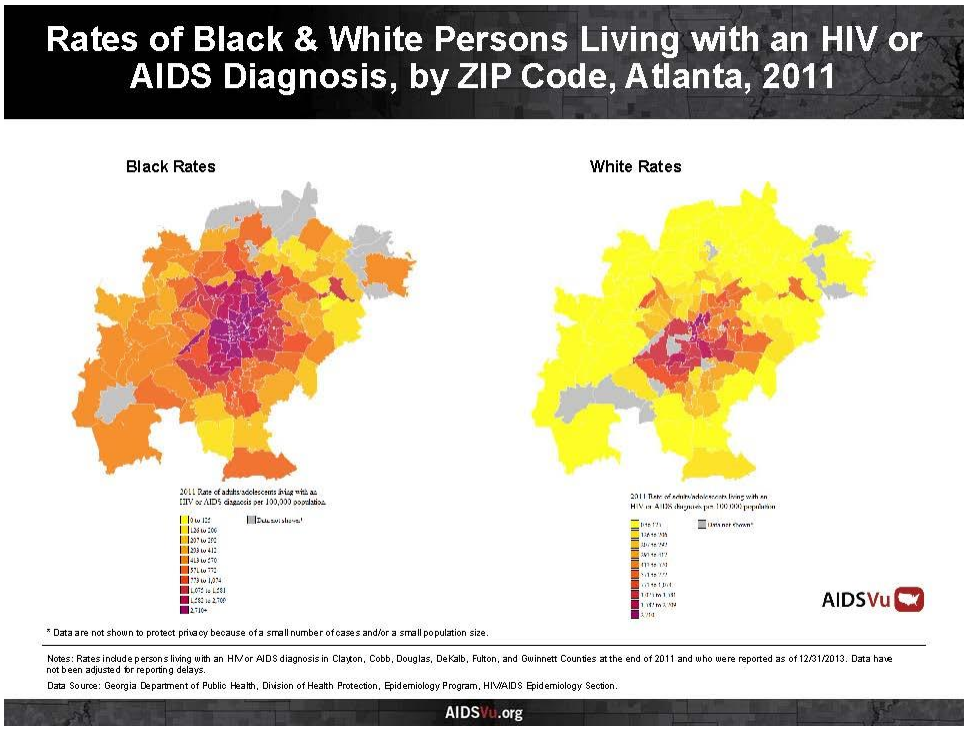
POVERTY AS AN INDICATOR OF HIV RISK

Poverty and lack of healthcare access exacerbate HIV prevalence rates in Georgia.[78] Economically and politically marginalized neighborhoods, like those to be discussed in this section, tend to have fewer health resources offering HIV preventive services like sexual health counseling and HIV testing—the latter being one of the most critical factors in addressing HIV disparities among Black Americans facing poor overall health access.[79] In Atlanta, there is a significant overlap between neighborhoods with high poverty and income inequity, lower educational attainment, and disproportionately high HIV prevalence levels.[80]

77 Poverty to Prosperity Program and the Center for American Progress, Economic Policy Team (2015) Expanding Opportunities in America's Urban Areas. Available at: https://cdn.americanprogress.org/wp-content/uploads/2015/03/UrbanRevitalization3.pdf; see also Bayor at 15-93.
78 See maps demonstrating the geographic overlap of HIV and poverty on page 18.
79 The Body (2012) What Really Fuels the HIV/AIDS Epidemic in Black America? Available at: http://www.thebody.com/content/65639/what-really-fuels-the-hivaids-epidemic-in-black-am.html?getPage=11.
80 PR Newswire (2012) Latest AIDSVu Data Illustrate Impact of HIV by Zipcode in Major U.S. Cities. Available at: http://www.prnewswire.com/news-releases/latest-aidsvu-data-illustrate-impact-of-hiv-by-zip-code-in-major-us-cities-160364965.html

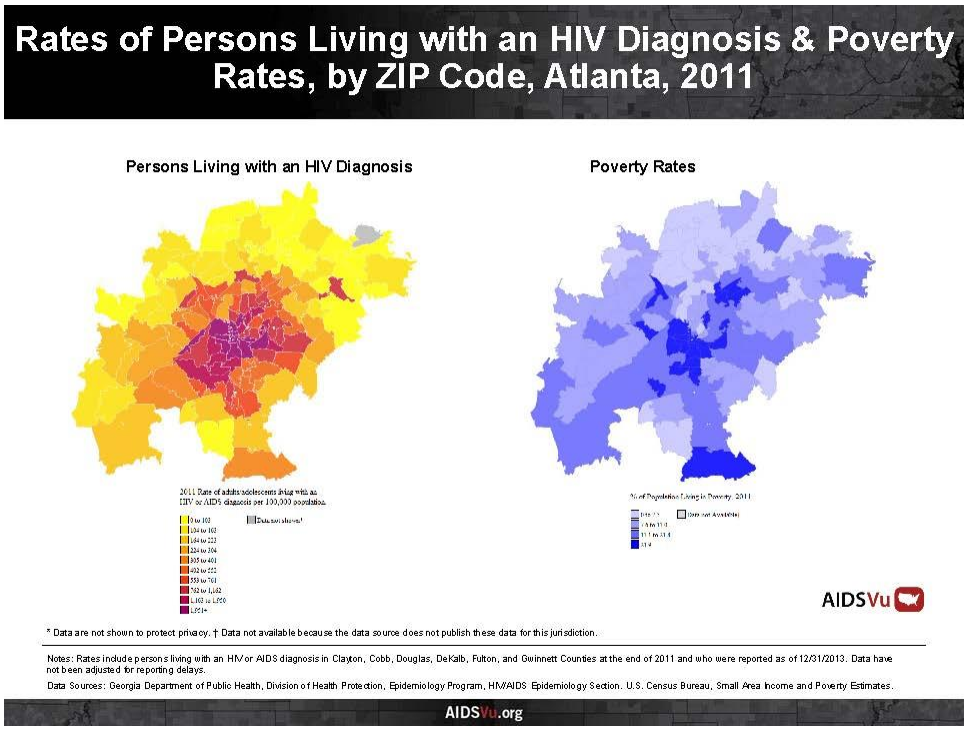
MAPS[81] OF THE SPATIAL ARRANGEMENT OF HEALTH, RACE, AND POVERTY IN METRO ATLANTA

HIV RATES AND RACE BY ZIPCODE

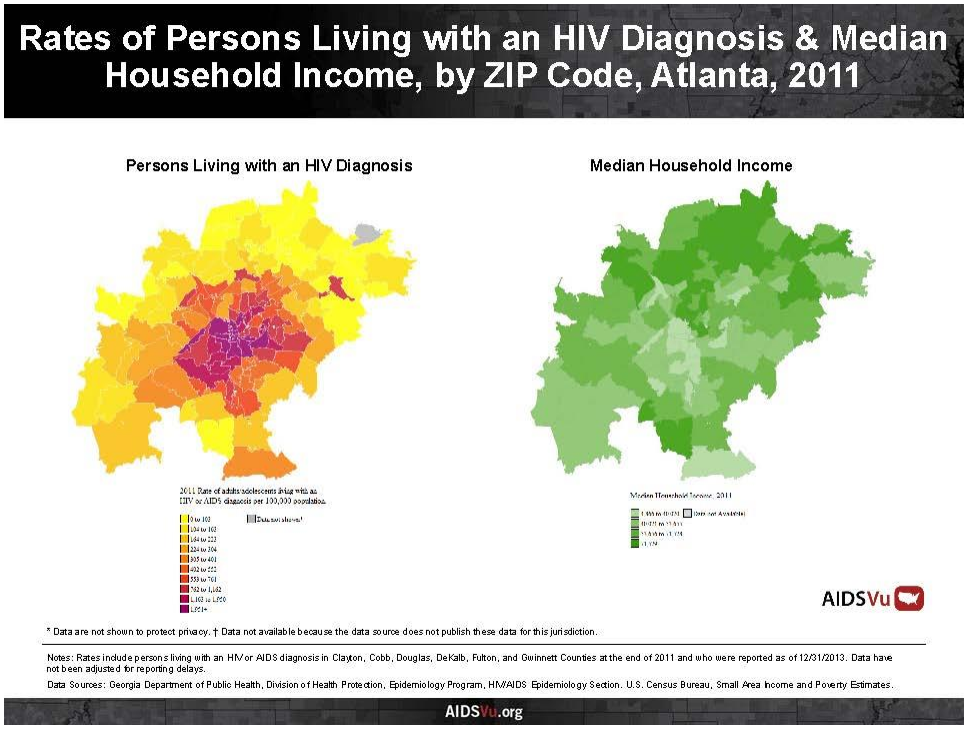


[81] The following five maps were all retrieved at: http://www.AIDSVu.org.

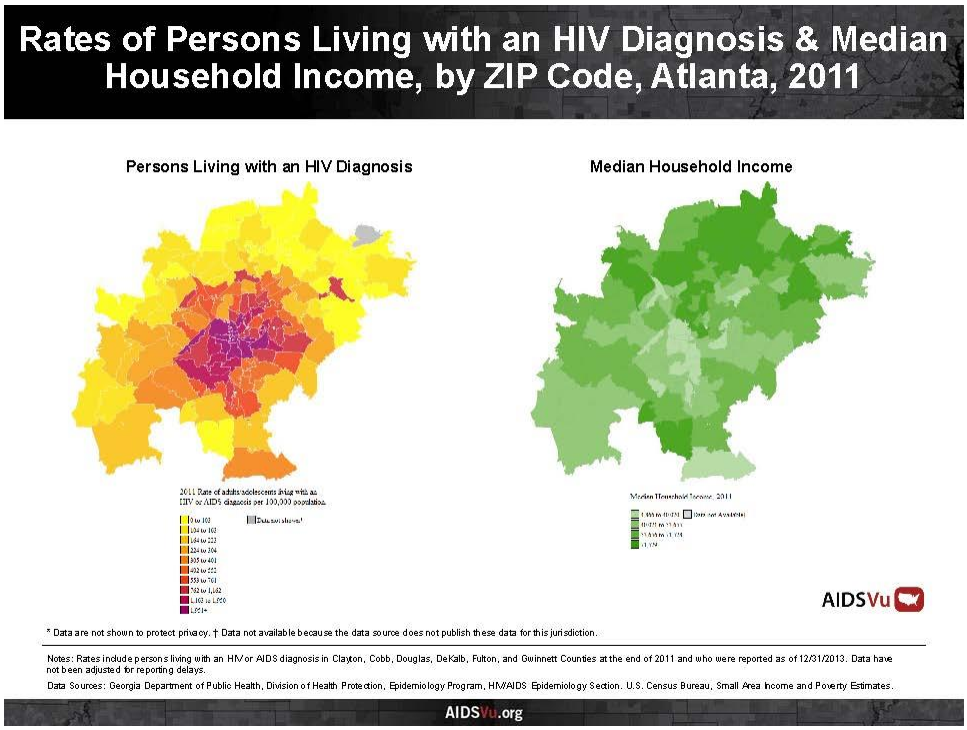
HIV AND POVERTY RATES BY ZIPCODE



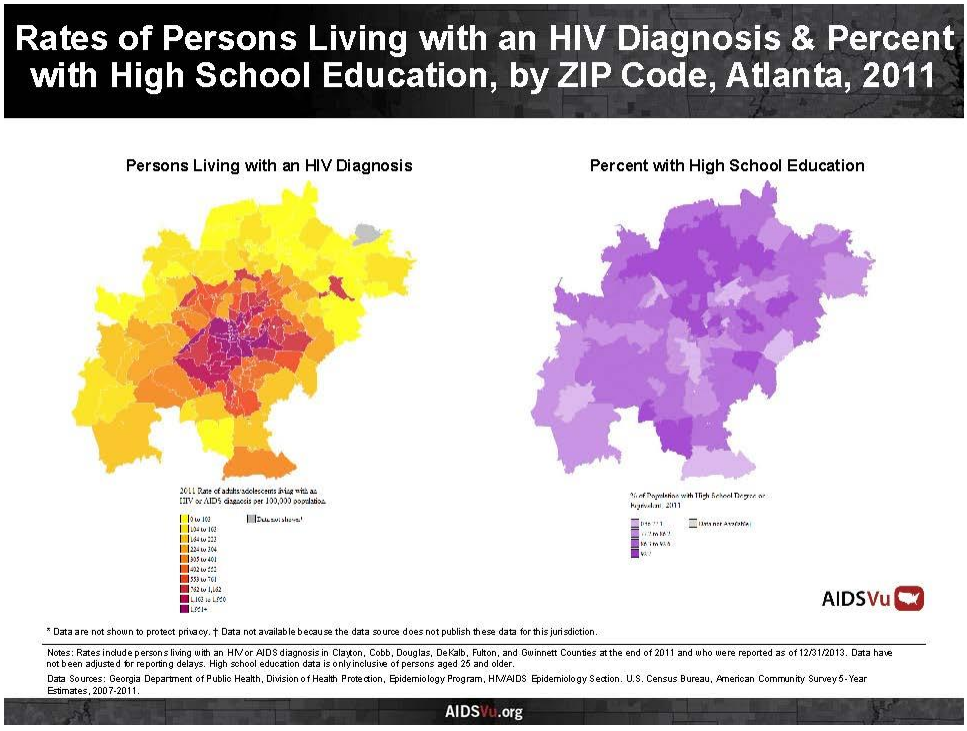
HIV AND INCOME INEQUALITY BY ZIPCODE



HIV AND MEDIAN HOUSEHOLD INCOME



HIV AND HIGHSCHOOL EDUCATION



As Dr. Patrick Sullivan, a local epidemiology professor at Emory University describes, HIV is a "public health emergency," citing a number of reasons for high HIV rates, including poverty.[82] **As a region, Southern states struggle with similar overlaps between HIV, "overall poorer health, high poverty rates, an insufficient supply of medical care providers and a cultural climate that likely contributes to the spread of HIV."**[83] Like most states in the Deep South, Georgia has refused to expand Medicaid and has among the highest number of uninsured residents in the country. This reality means fewer resources are available for the communities impacted by HIV that need prevention and treatment resources the most. Thus, a logical approach to addressing HIV must include "local, state and federal partnerships and address the multiple factors that contribute to the disproportionate epidemic in the South such as lack of resources and regional resource inequities as well as stigma and high STI rates."[84]

> "YOU NEED GOOD NUTRITION, YOU NEED HOUSING, ACCESS TO TRANSPORTATION, AND YOU MAY NEED PSYCHOLOGICAL OR SPIRITUAL SUPPORT."

PLHIV must be empowered and engaged in the continuum of care and HIV-negative individuals must have access to healthcare for diagnostic and preventive services as part of the continuum of *prevention*.[85] In addition to healthcare coverage, geographic proximity to care providers and availability of public transportation influence the ability to remain within the continuum of care.**[86]** Retention in care is significantly more challenging for PLHIV who are also grappling with poverty and associated stressors.[87] As Dr. Patrick O'Neal, Public Health's Director of Health Protection stated: "Initial linkage to care isn't as disparate as the retention of care. **You need good nutrition, you need housing, access to transportation, and you may need psychological or spiritual support.**"[88] Unfortunately, the concentration of poverty in Black neighborhoods in Atlanta directly interferes with proper access to each of these social determinants of health, among others—thereby exacerbating the disproportionate impact of HIV on these communities.

FOOD INSECURITY AND ITS IMPACT ON PEOPLE LIVING WITH HIV

Individual and community level access to adequate food and nutrition, as well as community power over food resources, are powerful indicators of place-based community sustainability and economic self-determination. The presence or absence of adequate food retailers and resources is often contingent upon the economic vitality of a neighborhood, and the ability to attract and retain major food retailers is often compromised for lower-income neighborhoods. On an individual level, the achievement of food security is directly contingent upon purchasing power, income level, and access to other social resources. Food and nutrition access is a key SDH that reveals serious gaps in policy designed to address the issue at a structural level, which has serious implications for PLHIV and communities highly impacted by HIV and other health disparities.

Food insecurity exists when an individual or community has limited or uncertain access to nutritionally adequate and safe foods, or a limited or uncertain ability to acquire adequate foods in socially acceptable ways.[89] Food security, on the other hand, exists when individuals and households can enjoy: the availability of nutritious food, reliable access to nutritious food, and appropriate access to nutritious food within a household—in order to live an active and healthy life.[90] Being food secure means having physical and economic access to food, as well as the physiological and intra-household ability to utilize food in order to achieve adequate nutrition.[91] Food security also requires that individuals have the ability to acquire adequate food and nutrition in ways that are not socially stigmatized (that is, without resorting to

82Redmon, Jeremy. HIV Epidemic Afflicting Georgia, the South: A 'public health emergency'. Atlanta Journal Constitution. (23 October 2015). Available at: http://www.myajc.com/news/news/state-regional-govt-politics/hiv-epidemic-afflicting-georgia-the-south-a-public/nn7n6/
83 Southern HIV/AIDS Strategy Initiative (2016) HIV/AIDS in the U.S. Deep South: Trends from 2008-2013. Available at: https://southernaids.files.wordpress.com/2011/10/hiv-aids-in-the-us-deep-south-trends-from-2008-2013.pdf.
84 Ibid.
85 Vangala, M. (2015) Metro Atlanta at the Center of a Burgeoning HIV Crisis. Georgia Health News. Available at: http://www.georgiahealthnews.com/2015/06/metro-atlanta-center-burgeoning-hiv-crisis
86 P., Jennifer A., et al. (2013) A Pandemic of the Poor: Social Disadvantages and the U.S. HIV Epidemic. American Psychology. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3700367/
87 Ibid.
88 Ibid.
89 United States Department of Agriculture, Economic Research Service (2016) Available at: http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx#security;
90 UNAIDS, World Health Organization, World Food Programme, HIV, Food Security, and Nutrition. Available at: http://www.unaids.org/sites/default/files/media_asset/jc1515_policy_brief_nutrition_en_1.pdf; Semba RD, Tang A.M., United States Agency for Development (1999) HIV/AIDS and Nutrition: A Review of the Literature and Recommendations for Nutritional Care and Support in Sub-Saharan Africa; Friis, H. (2005) Micronutrient Intervention and HIV Infection: A Review of Current Evidence. Available at: http://www.who.int/nutrition/topics/Paper%20Number%202%20-%20Micronutrients.pdf.
91 UN Food and Agriculture Organization, An Introduction to the Basic Concepts of Food Security. Available at: http://www.fao.org/docrep/013/al936e/al936e00.pdf.

emergency food supplies, scavenging, stealing, or other coping strategies).

Food security and adequate nutrition is of particular importance for PLHIV, as the combination of malnutrition and HIV can weaken the immune system and the body's ability to utilize nutrients optimally. This necessitates a higher energy intake for both adults and children living with HIV. Adults and children living with HIV have 10-30% and 50-100% higher energy needs, respectively—than their HIV-negative counterparts.[92] Compromised access to food and nutrition can lead to greater susceptibility to AIDS-related infections and can interfere with medication adherence and effectiveness.[93] Studies have shown that those who begin ART without adequate nutrition may also have reduced likelihood of survival.[94] Additionally, some ART medications require individuals to maintain a minimum intake of 500 calories per meal. Failure to obtain these energy requirements can result in decreased effectiveness of medications and increased risk of harm.

Food and nutrition insecurity is significantly compounded for individuals who live in "food deserts"[95]—areas with few to no supermarkets or other large grocery stores, and thus poor access to adequate nutrition and fresh foods.[96] In the absence of supermarkets, community food gardens, and farmers' markets, locally accessible food is limited to small food retailers like quickie marts and corner stores that do not offer products containing adequate nutrition.[97]

This is the reality for several of Atlanta's neighborhoods with categorically "low access" to food, as defined by the US Department of Agriculture.[98] Research has shown that Atlanta's food deserts are overwhelmingly located in neighborhoods with a high concentration of poverty *and* predominantly Black populations, which have been shaped by racial segregation and economic divestment over time.[99] At the state level, there are two million Georgians living in food deserts.[100] **Nearly 20% of Georgians are food insecure and are leveraging necessities in order to survive**.[101] Contrary to the common myth that low-income individuals and families spend less money on food, the reality is that they have less to spend on a weekly basis when compared to middle-to-high-income families, but spend comparatively the same amount of money on food over time.

Food subsidy programs are often narrowly focused on the food and nutrition needs of *individuals* (and their families), but the food security of place-based *communities* is rarely prioritized in the conceptualization of economic revitalization and development initiatives. That is, economic revitalization efforts may attract capital flows into previously economically marginalized areas (which can attract supermarkets, food retailers, and the development of community gardens)—but those market shifts often come at the expense of *displacing* lower income individuals and families who are more likely to experience food insecurity in the first place.

Under current policy regimes, food vulnerability is addressed most immediately at the individual level, but less attention is dedicated to transforming the food viability of existing local communities *in their specific geographic locations*, so that the individuals living within them can thrive and enjoy food security *across* income levels. The crisis of food insecurity is exacerbated by unstable employment and the lack of a living wage system—which can result in individuals and families being forced to choose between quality nutrition and providing other basic needs.[102] Food access is a powerful indicator of a community's political and economic power, and is another key SDH that overlaps with poverty and HIV prevalence in Atlanta.

The Historical Role of Race in Atlanta's Spatial Landscape

Racial and class segregation in Atlanta has facilitated the geographic concentration of poverty in predominantly Black areas—where the previously described SDH challenges are most salient.[103] The current spatial layout of the city follows racial lines: the area of Atlanta north of Interstate 20 is over 80% white, while 74% of Atlanta's non-white residents reside in Fulton and DeKalb counties.[104] The concentration of poverty in specific areas within these counties specifically, and metro Atlanta in general, has exacerbated income inequality. **Atlanta**

92 UNAIDS, World Health Organization, World Food Programme, HIV, Food Security, and Nutrition. Available at: http://www.unaids.org/sites/default/files/media_asset/jc1515_policy_brief_nutrition_en_1.pdf.
93 Ibid.
94 Ibid.
95 A low-income census tract with at least 500 people living at least one mile (in urban areas) or at least 10 miles (in rural areas) away from a supermarket or large grocery store. See US Department of Agriculture, Documentation. Available at: http://www.ers.usda.gov/data-products/food-access-research-atlas/documentation/.
96 American Nutrition Association. USDA Defines Food Deserts. Available at: http://americannutritionassociation.org/newsletter/usda-defines-food-deserts.
97 Ibid.
98 US Department of Agriculture. Food Access Research Atlas. Available at: http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/.
99 Ross, G. (2014) Food Deserted: Race, Poverty, and Food Vulnerability in Atlanta, 1980-2010. Ph.D. Atlanta: Georgia Institute of Technology.
100 Bonds Staples, G. (2015) Starving for Nutrition. Atlanta Journal Constitution. Available at: http://investigations.myajc.com/fooddeserts/.
101 Feeding America, Food Insecurity in Georgia. Available at: http://map.feedingamerica.org/county/2014/overall/georgia.
102 This view is informed by author interviews conducted in September 2015 with women living with HIV in or near the West End.
103 The Brookings Institution Center on Urban and Metropolitan Policy. Moving Beyond Sprawl: The Challenge for Metropolitan Atlanta. Available at: https://www.brookings.edu/wp-content/uploads/2016/06/atlanta.pdf.
104 Ibid.

residents who live in areas of concentrated poverty—which are most often in predominantly Black neighborhoods—face increased vulnerability to market changes beyond their control, and experience the brunt of these changes as impacts to their health, community, and environment.

This racialized landscape is a result of both official and informal policy guiding the development of Atlanta through de jure and de facto racial segregation and class discrimination against Black people. In the early 20th century, city officials used race-based zoning ordinances to prevent Black people from moving into white neighborhoods. After the Supreme Court of the United States formally prohibited the practice of explicit race-based zoning, the city used seemingly benign land use mechanisms that would have racially significant effects. With respect to Atlanta's zoning practices, local historian Ronald H. Bayor has remarked: *"Racial designations for city areas were discussed not in terms of a segregation ordinance but rather in terms of land uses, building types, and tenant categories that Atlanta's white leaders felt could legally bypass the court ruling."*[105] Many preexisting Black neighborhoods were located in areas zoned for "industrial" uses and were afforded less physical land for "residential" uses than those provided in white neighborhoods.[106] Restricted access to land depressed the ability of geographically concentrated Black communities to accumulate assets and wealth, catalyze ongoing indigenous economic development, and gain political power across class lines within the Black community.

Highways and roads were employed for segregation purposes in several instances throughout the 20th century, and were "used as barriers and boundaries to hold the black community in certain areas."[107] By 1960, the Atlanta Bureau of Planning documented that "there was an 'understanding' that the proposed route of the West Expressway [I-20 West] would be the boundary between the White and Negro communities."[108] The administration of Mayor Hartsfield from 1937-1962 employed significant structural changes to alter the racial arrangement of the city, the legacy of which is entrenched in Atlanta today. His administration oversaw the development of yet another freeway running from north to south that would serve as a barrier between the business district and Black neighborhoods.[109] While leaders touted economic reasons for such decisions, Hartsfield was also explicit regarding their race-based purposes. Zoning and roadway decisions were highly politicized and designed to slow Black movement into white neighborhoods, stifle Black mobility, maintain segregated neighborhoods, and to simultaneously drive down the amount of land available for low-income housing and locate such housing in Black neighborhoods.[110]

Hartsfield specifically advanced policies to keep Atlanta a majority white upper class city, slow white flight migration outside of city limits, and control the growth of the Black population within city limits.[111] He openly advocated for white political control of the city, warning that failure to limit Black people's presence in the city would be to "hand them political control of Atlanta, either as a majority or a powerful minority vote [.]"[112] And while some affluent Black individuals attempted to promote policies in their best financial interest (which would have negative impacts on poor Black individuals), white leaders prioritized racial segregation over advancing the economic interests of middle and upper class Black people. For example, middle class Black communities attempted to prevent the creation of low-income housing in Southwest Atlanta, which was already predominantly Black, but to no avail. Bayor notes that this phenomenon "reveals…the predominance of race over class in city policy."[113] This was consistent with Mayor Hartsfield's openly professed preference for *"whites over blacks of any income level"*[114], and his objective of maintaining "the proper white balance" in the city.[115]

The City of Atlanta has continued to promote development regimes that do not serve the interests of the city's most spatially marginalized residents, who live in predominantly Black neighborhoods with a high concentration of poverty. Despite being the first city to develop "public housing" in 1936, it was also the first to destroy its public housing. The City of Atlanta demolished several housing projects to make way for the Centennial Olympic Games in 1996, and had completely destroyed all public housing by 2011.[116]

Southwest Atlanta and the Historic West End

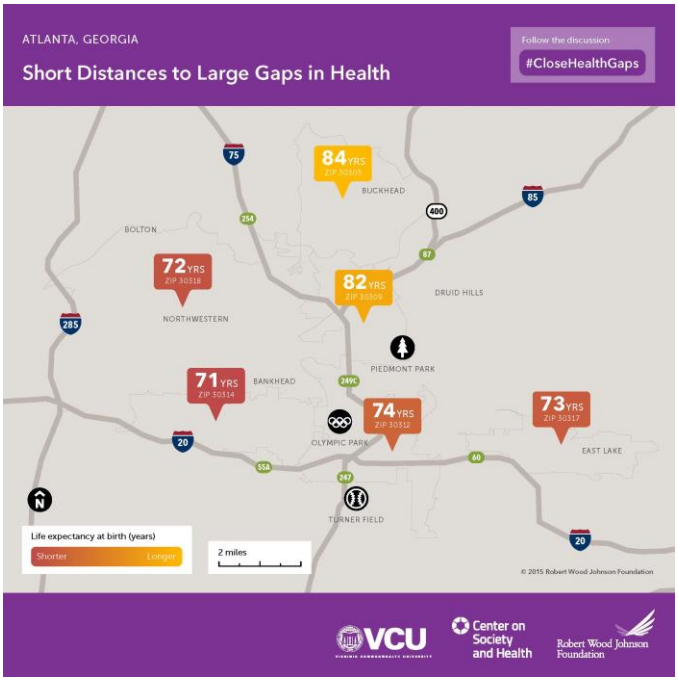
Southwest Atlanta, particularly the historic West End, reflect many of the complex legacies borne from Atlanta's multilayered history of economic and spatial development. Southwest Atlanta has been a stronghold of culture and history in the city and the West End is one of its oldest and most historic neighborhoods. Southwest Atlanta also contains many of the zip codes most impacted by HIV, and life

105 Bayor.
106 Ibid.
107 Ibid. at 55.
108 Ibid. at 61.
109 Stone, C.N. (1989) Regime Politics: Governing Atlanta, 1946-1988. Lawrence, Kansas: University Press of Kansas.
110 See Bayor at 53-93.
111 Bayor at 86.
112 Ibid.
113 Bayor at 79.
114 Bayor at 86.
115 Bayor at 87.
116 Garlock, S. (2014) By 2011, Atlanta Had Demolished All of Its Public Housing Projects. Where Did All Those People Go?. Available at: http://www.citylab.com/housing/2014/05/2011-atlanta-had-demolished-all-its-public-housing-projects-where-did-all-those-people-go/9044/.

expectancies in Southwest Atlanta zip codes are among the lowest in the city.[117] In fact, life expectancies plunge by a decade when a person is born in a Southwest Atlanta zip code, just a few miles from northwestern zip codes.[118]

The West End became a desirable suburban community in the 1880s, and grew rapidly in population and prosperity, so that by 1930 there were more than 22,000 residents.[119] By the 1960s the neighborhood had become home to many Black Americans—as racial segregation and land use and political policies progressively concentrated the population of Black communities in the region in which the West End is situated. Despite decades of market shifts and demographic changes, the West End has remained a central hub of Black culture and local business. In recent years, however, many neighborhoods in Southwest Atlanta have been the target of burgeoning development initiatives[120] that will likely lead to accelerated gentrification in the region inclusive of neighborhoods like the West End.

LIFE EXPECTANCY DISPARITIES BY ZIPCODE[121]



The racial and class fluctuations in Southwest Atlanta also relate to the desegregation efforts of the 1960s—which reflects the phenomenon that took place in cities across the United States, and particularly Southern states, following the passage of the Civil Rights Act of 1964. Like cities and towns throughout the South, Atlanta was not prepared to fundamentally transform the underlying framework of white supremacy that formed the basis of local racial ordering, despite segregation being declared illegal. **Atlanta took steps to formally desegregate while failing to structurally shift the balance of power between the races across class lines—while simultaneously projecting its image as the "capital of the South" *(focused more on economic growth than with maintaining racial division.)*** This image was based on earlier iterations of the same narrative of cooperation known as the "The Atlanta Way."

While Atlanta marketed its reputation as "the city too busy to hate," Atlanta's Black residents found that significant structural changes did not follow desegregation. This was particularly pronounced in the failure to address inequitable patterns in housing and land access that had been long in the making. Although the passage of the Fair Housing Act in 1968[122] officially banned discriminatory housing

117 Virginia Commonwealth University, Center on Society and Health (2015) Mapping Life Expectancy: 12 Years in Atlanta. Available at: http://www.societyhealth.vcu.edu/work/the-projects/mapsatlanta.html.
118 Ibid.
119 National Park Service. West End Historic District--Atlanta. Available at: https://www.nps.gov/nr/travel/atlanta/whd.htm.
120 Ibata, D. (2016) Atlanta's Westside is now a federal 'Promise Zone'. Available at: http://www.ajc.com/news/local/atlanta-westside-now-federal-promise-zone/W1L0vFAFEUzc3Plp0qdIIN/.
121 Virginia Commonwealth University, Center on Society and Health. Available at: http://www.societyhealth.vcu.edu/media/society-health/pdf/LE-Map-Atlanta.pdf.
122 42 U.S.C. 3604.

practices predicated on race (among other categories), de facto segregation continued—oftentimes in concert with the support of political leaders.

HISTORICAL REALITIES MUST BE CONSIDERED WHEN ADDRESSING THE GEOGRAPHIC OVERLAP BETWEEN HIGH HIV & HIGH POVERTY PREVALENCE

Southwest Atlanta, and neighborhoods like the West End were particularly impacted, as Black community members sought to acquire property (a key factor in building wealth and accumulating assets) in neighborhoods previously unavailable to them. From the construction of physical barricades[123] to the enactment of discriminatory zoning ordinances, the remnants of these de facto segregation practices are evident in these same communities today.

We argue that these historical realities must be considered when addressing current public health challenges in neighborhoods in which high HIV and poverty prevalence overlap. Individuals navigating the cross sections of longitudinal social, economic, and political oppression in communities like the West End are often mischaracterized as being the *cause* of stigmatized challenges such as unemployment, crime, substance use, environmental hazards, and poor sexual and reproductive health. Rarely are such communities recognized for their practices of resilience and innovation that have continued despite the systematic deprivation of growth, sustainability, and structural level self-determination over their communities via a combination of social, political, and economic mechanisms of control.

Implications of Neighborhood "Revitalization"

Development-based community revitalization efforts often fail to be accountable to the needs defined by the people living within the very communities such initiatives purport to "revitalize." The Atlanta BeltLine Initiative project, and other economic development initiatives have successfully generated billions of dollars in revenue and attracted commercial business and housing developers, yet those most likely to suffer the negative consequences of such initiatives—such as prohibitively high cost of living, displacement, small business vulnerability, and reduced culturally-specific visibility—*are least likely to enjoy an influential seat at decision-making tables.* Stable housing is of high priority for PLHIV, who require the privacy and consistency necessary to adhere to treatment and maintain optimal physical and mental health.

Community development efforts in Black communities with high levels of concentrated of poverty are often touted for their potential to stimulate economic activity and reduce crime rates. This type of development may trigger market stimuli that can lead to gentrification and displacement of Black individuals and families with fewer assets and lower purchasing power parity. Essentially, the "revitalization" of neighborhoods does not necessarily translate to meaningful change for those who are too economically and politically marginalized to meaningfully *participate in and gain* from market changes. Just solutions require addressing the underlying political, economic, and social constraints that continue to impose disadvantages upon these communities in the first place.

123 In December 1962, Mayor Ivan Allen Jr. ordered barricades to be built across two Atlanta streets to discourage black citizens from purchasing homes in an adjacent all-white neighborhood. The controversy started in Peyton Forest, a prosperous, white subdivision of Cascade Heights in Southwest Atlanta. The surrounding area was undergoing a racial transition that made white residents uneasy. When Dr. Clinton Warner, a Morehouse graduate, bought a house there, white homeowners asked the mayor to erect barriers on Peyton Road and nearby Harlan Road to prevent further "intrusion." The Board of Aldermen approved the legislation on December 17, and Mayor Allen quickly signed it. Early the next morning, city maintenance crews, consisting mostly of black workers, erected wooden barriers saying "Road Closed." Unfortunately, these measures and others that never received public attention effectively extended the existence of segregated neighborhoods. See Crater, P. (1968) Atlanta's Berlin Wall. Available at: http://www.atlantamagazine.com/civilrights/atlantas-berlin-wall/.

A Tough Look at the Atlanta BeltLine Initiative (ABI)

The Atlanta BeltLine Initiative (ABI) is a citywide redevelopment initiative currently underway in Atlanta with the goal of combining rail, walkway, greenspace, housing, and art along a trail spanning 45 in-town neighborhoods, including the West End.[124] The Atlanta Bureau of Planning's (ABP) Equitable Development Plan purports to implement their redevelopment initiative in a holistic manner, guided by principles of equitable and sustainable development designed to achieve lasting economic, environmental, and social improvements.[125] Led by the ABI Board of Directors, the development champions mixed-use livable communities, creation of improved transit systems, and social programming.

Photo Credit Mo Morgan (Westview, Southwest Atlanta)

The promises of the ABI have not been shared equally among Atlanta residents. Gentrification has led to rising rent costs, escalating property values (increasing property taxes), and widening income disparities within communities. Since the initiation of the BeltLine construction, an estimated $10 billion dollars has been generated and 15,483 units of housing have been created. Of those units, a mere 2,200 are designated as "affordable housing units." Individuals and families are being displaced, and earnings disparities are growing in a city that already has the highest rate of income inequality in the nation.

The existing "affordable housing programs" that do exist are out of reach for many that reside in the city. For example, in 2015, Atlanta BeltLine, Inc. teamed up with local lenders through the Federal Home Loan Bank of Atlanta to improve affordable homeownership opportunities in Atlanta BeltLine neighborhoods. Qualified homebuyers were eligible for down payment assistance of up to $45,000 and for housing rehabilitation assistance up to $25,000 (via the leveraging of a second mortgage on new or existing homes). To qualify for participation in the down payment assistance program, families must earn below 80% of the Area Median Income.[126] For a family of four, the income cap for participation in the down payment assistance program is $54,000, which is prohibitively low based on the average cost of living for a family of this size. According to the Economic Policy Institute, a family of four—comprised of two adults and two—need an average of $63,888 per year to secure a modest standard of living.[127] Thus, the homeownership program requires participants to earn nearly $10,000 less than the amount necessary to maintain a decent standard of living, while simultaneously requiring applicant hopefuls to possess the capital needed to purchase a home, a well-established positive credit history, and the ability to secure a home loan.

This proposed pathway to home ownership is discriminatory and misguided, as many of the individuals who would be eligible for this program likely lack the capital (based on program income caps) and ability to secure a home loan. Nationally, only 44%of African-Americans and 46% of Hispanics/Latinos are homeowners. By comparison, white homeownership stands at 73%.[128] Mortgage loan denials have contributed to some of the racial disparity in homeownership. While facilitating avenues to homeownership may prove successful for some, it is not a viable solution for most. In Atlanta, the net share of Black homeowners decreased by 9.4% from 2000-2010.[129] Housing programs should focus attention on improving renter supports, creating laws and policies that will protect renters from wide fluctuations in rental costs and other costs of living, and developing relevant homeownership programs that meet applicants where they are and facilitate their purported objectives.

Gentrification and displacement must be addressed with urgency and culturally responsible approaches that allow existing residents to remain in their communities and promote their decision-making

124 Atlanta BeltLine. The Atlanta Beltline: The 5Ws and Then Some. Available at: http://beltline.org/about/the-atlanta-beltline-project/atlanta-beltline-overview/.
125 Beltline Equitable Development Plan. Available at: http://beltlineorg.wpengine.netdna-cdn.com/wp-content/uploads/2012/04/Atlanta-BeltLine-Equitable-Development-Plan.pdf.
126 Atlanta BeltLine, Atlanta BeltLine Housing Initiative. Available at: http://fhlb.beltline.org/.
127 Economic Policy Institute, Family Budgets in the Atlanta/Sandy Springs/Marietta, GA metro area. Available at: http://www.epi.org/resources/budget/budget-factsheets/#/122
128 Atlanta Black Star, (2013) Only 44 percent of African-Americans Compare to 75 Percent of Whites in Homeownership. Available at: http://diversitydata.org/Publications/Homeownership_brief_final.pdf; See also, Chiles, N. (2013) Housing Discrimination: African-Americans, Hispanics Still Paying Higher Costs. Available at: http://atlantablackstar.com/2013/06/12/housing-discrimination/.
129 Ibid.

power over issues that will affect significant changes in their neighborhoods. SisterLove affirms the urgent need for affordable housing in Atlanta, increased protections for renters, and heightened regulation of landlords who conduct unlawful evictions and fail to maintain habitable rental properties. The displacement of families and communities must be addressed to ensure the public health needs of those most affected are met.

ADVOCACY RECOMMENDATIONS

Advance Multipronged Strategies to Advance the Human Right to Adequate Food and Nutrition

Food and nutrition insecurity among PLHIV and food vulnerability in Atlanta's low-income neighborhoods present an urgent issue that policymakers cannot ignore. Atlanta's economically marginalized communities face heightened poverty and food insecurity, which is not a reflection of poor individual choice or moral failing. Rather, the existence of food deserts and food vulnerability in Atlanta's poor neighborhoods is the result of protracted political inequity, place-based racial segregation, capital flows and demographic changes facilitated by outside actors. These are the forces that have concentrated poverty in Black and working class neighborhoods over time.[130] Likewise, household and individual level food insecurity is directly correlated with poverty, insufficient food assistance resources, lack of stable employment and living wages, and lack of community control over local food production and resources. Food vulnerable communities need collaborative economic development approaches that are responsive to the highest priority needs of individuals and families—**and PLHIV facing food insecurity need strategies that integrate both individual level food and nutrition security *and* community level food stability with deliberate measures to facilitate community control over food access and to preserve the ability of existing communities to remain in their neighborhoods despite exogenous market shifts.**

State and local officials should prioritize resource allocations and community planning initiatives in food vulnerable areas that support access to affordable and accessible supermarkets and other food resources, such as community gardens, food store cooperatives, and locally owned restaurants and other small food businesses. Development plans must strategize incentives to facilitate the placement of such resources in locations that currently lack them, and ensure that they are easily accessible via public transportation. Policymakers should also reform food subsidy programs to ensure that food insecure individuals and families have both physical and geographic access to food, as well as adequate means to afford them. Policymakers must seriously address the gap between individual-level food cost supports and community-based solutions.

We posit that a commonsense place to start would be to institute housing and land use monitoring and assessment policies that protect existing individuals and families from gentrification-based displacement (which exacerbates food insecurity), provide cash and asset support for small food business owners necessary to weather market shocks from external capital injections, and increase community-driven, place-based, food production and access resources in economically marginalized neighborhoods. Strategies that integrate these principles have the potential to create jobs, decrease environmental degradation associated with large spatial-scale food production, incentivize local low- or no-cost food distribution by regulating food waste, increase community access to and participation in the production of fresh foods, and increase agricultural knowledge and cultural preservation of food practices.

Protect Affordable Housing for People of All Incomes and Educational Backgrounds

Access to stable and affordable housing is of urgent importance for PLHIV who must be able to consistently access care, store and take their medications as prescribed, and enjoy the privacy of their own living space.[131] On the other hand, unstable housing has been linked to intimate partner violence[132], formally and informally trading sex for shelter, drug use, and incarceration.[133] Research has shown that housing can serve as an effective "intervention to address public and individual health priorities, including disease prevention, health care access and effectiveness, and cost containment."[134]

Current economic development projects within the City of Atlanta have increased displacement. Local county and city officials must take appropriate steps to protect existing low-income renters and homeowners threatened by capital injections into the real estate market throughout the city. An affirmative step would include the enactment of inclusionary zoning laws to ensure the designation of new housing units for low-income individuals and families. Government subsidized housing options must be preserved and rehabilitated, and must prioritize proper health and safety of residents. Landlords of all types of rental properties must be held to higher legal standards for maintaining habitable living conditions for tenants of all income levels. Business and political leaders who wish to increase housing access should focus on **improving renter**

130 Ross, G. (2014) Food Deserted: Race, Poverty, and Food Vulnerability in Atlanta, 1980-2010. Ph.D. Atlanta: Georgia Institute of Technology.
131 AIDS.gov, Housing. Available at: https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/taking-care-of-yourself/housing/
132 Positive Women's Network-USA (2014) PWN-USA Applauds Federal Progress Addressing the Intersections of Violence Against Women, HIV, and Trauma. Available at: https://pwnusa.wordpress.com/2014/10/15/pwn-usa-applauds-federal-progress-to-end-vawhiv/.
133 The National AIDS Housing Coalition (2005) Housing is the Foundation of HIV Prevention and Treatment. Available at: http://www.nationalaidshousing.org/PDF/Housing%20&%20HIV-AIDS%20Policy%20Paper.pdf.
134 Ibid.

supports, creating laws and policies (such as rent ceilings) that will protect renters from wide fluctuations in rental costs and other local costs of living, and developing relevant homeownership programs that meaningfully facilitate their purported objectives.

Finally, the rampant unemployment plaguing low-income Black communities in Atlanta is in part attributable to geographically concentrated poverty, which drives down community access to education, employment, healthcare, and asset and wealth development—which locks communities in cycles of generational poverty. The state's workforce development program should conduct a needs assessment regarding employment opportunities and living wages. In addition to workforce development, state and federal agencies should prioritize programs that allocate financial resources and technical, transactional support for small businesses and local entrepreneurs as catalysts of indigenous community economic development—rather than relying on powerful outside economic interests to "invest" in depressed communities without accountability to long term residents and the needs of the most financially vulnerable. At the same time, insufficient access to employment opportunities should not interfere with the ability of people to remain stably housed. On the contrary, prioritizing access to permanent housing through the "housing first" approach has been shown to significantly increase the likelihood of individual stability and self-sufficiency—and should thus be considered a parallel strategy to advancing employment opportunities and economic stability.

BIOMEDICAL EQUITY IN ACHIEVING REPRODUCTIVE JUSTICE FOR WLHIV

Biomedical equity means that all people have access to the biomedical technologies and treatments involved in the delivery of high quality healthcare—without barriers like cost, location, transportation, physical or mental ability, childcare, discrimination based on sexuality, gender identity or expression, race or ethnicity, health literacy, socioeconomic background, or education. Biomedical equity means access to comprehensive anti-retroviral therapy (ART) to ensure each person's ability to achieve and maintain an undetectable viral load and enjoy the fullest extent of sexual and reproductive freedom. For people who are not living with HIV, biomedical equity requires access to and information about pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and new technologies like microbicides.

The research and marketing of biomedical tools must be conducted in a way that is inclusive of and responsive to the needs of communities that are marginalized in our existing systems. Comprehensive information about biomedical tools and access must be assured for individuals, communities, and healthcare providers in a way that is culturally competent, trauma-informed, and devoid of stigma, discrimination, or judgment. This means ensuring new treatment and prevention technologies are immediately accessible to communities that are the most affected by HIV, particularly trans people, Black cisgender heterosexual women, and young Black gay and bisexual men. Finally, biomedical equity requires acknowledgment of the history of biomedical oppression facing women and other marginalized communities in the US.

Biomedical inequity and oppression is a structural driver of HIV that is under-analyzed and disproportionately focuses on individual behavior and choice. This section of the report seeks to critically analyze how biomedical inequity violates the human rights of all people to enjoy access to the full range of advanced biomedical research and technologies. Specifically, it provides an overview of the different biomedical technologies that are currently available to people living with and at risk of HIV in Georgia. It also discusses the policies that impede access to these tools and analyze how biomedical inequity impacts Georgians' sexual and reproductive wellbeing.

BIOMEDICAL INEQUITY AS A REPRODUCTIVE JUSTICE ISSUE IN THE US

Globally, women make up more than 50% of PLHIV, and account for approximately one of the PLHIV in the United States. Black women in the US experience the highest rate of HIV diagnoses that have progressed to AIDS.[135] Despite the severely disproportionate impact of HIV on Black women in the US, and upon women globally, there is a severe lack of research on HIV treatment and prevention technologies that are specific to women, and particularly women of color.

ALL PEOPLE HAVE THE HUMAN RIGHT TO BE FREE FROM BIOMEDICAL VIOLENCE AND ENJOY THE BENEFITS OF ETHICAL SCIENTIFIC PROGRESS

This section will demonstrate that inequitable access to prevention, treatment, and care is a violation of women's human rights to dignity, freedom from torture, and freedom from cruel and degrading treatment.[136] These violations remain largely ignored as a matter of history and current reality. Women of color, and particularly women of African descent, have been forcibly exploited for biomedical research gains. During the period of chattel slavery, members of the medical community conducted forced gynaecological experiments on enslaved Black women—which formed the basis of research that shaped modern-day gynaecology practiced by clinicians today. This practice of exploitation continues to manifest in various forms, including forced and coerced sterilization.[137] The exploitative and coercive practices sanctioned, and at times sponsored by the US government has led to generational mistrust of the medical community. Black women's bodies and their reproductive freedom has been systematically violated. The fundamental right to parent or not to parent has been categorically denied to Black women and has been significantly dictated by political, social, and economic institutions.

The US South has its own sordid biomedical history that has bred distrust of the medical community among Black women. For example, at Atlanta's Grady hospital, between 1967 and 1978, women were injected with Depo Provera, a long acting contraceptive without their consent or awareness that the drug was still in its testing stages. Most the women were Black and low-income, and the side effects of Depo Provera—in this incident and in others to follow once the drug was approved by the FDA—were rarely shared with women before injection.[138] The long acting contraceptive Norplant was administered throughout the United States in a similarly exploitative manner. Reducing Black women's control over their reproductive health was a tactic used with for explicitly racist intentions to slow the growth of Black communities in the United States. The biomedical inequities that Black women currently face in the context of the HIV epidemic are another iteration of biomedical inequity.[139]

135 US Centers for Disease Control and Prevention (2016) HIV Among Women. Available at: https://www.cdc.gov/hiv/group/gender/women/

136 See Convention on the Elimination of All Forms of Discrimination Against Women, International Covenant on Civil and Political Rights, International Covenant on Economic, Social, and Cultural Rights.

137 Many state sanctioned sterilization programs have come to light in recent years. For example, nearly 150 women reported being coercively sterilized in California prisons between 2006 and 2010. See Schwarz, H. (2014) Following reports of forced sterilization of female prison inmates, California passes ban. Available at: https://www.washingtonpost.com/blogs/govbeat/wp/2014/09/26/following-reports-of-forced-sterilization-of-female-prison-inmates-california-passes-ban/

138 Dorothy Roberts (1998) Killing the Black Body. Vintage.

139 The Women's Interagency HIV Study (WIHS) is one of the largest comprehensive studies designed to investigate the progression of HIV in women. The WIHS began in 1993 in response to growing concern about the impact of HIV on women. Despite the disparate impact that HIV has had on [Black] women in the South, the WIHS delayed researching the effects of HIV on women until 2013. See Emory News Center (2013) NIH $11.9 million grant expands national women's HIV study to Southeast. Available at: http://www.news.emory.edu/stories/2013/08/wihs_grant/index.html.

HIV PREVENTION IN GEORGIA

It is long overdue that we expand access to biomedical tools for HIV prevention and treatment for the most impacted communities in Georgia. Communities affected by HIV require increased and holistic access to preventative measures, care, and treatment linked to the services that individuals may already be receiving (e.g. at family planning clinics, dentists, and homeless shelters). Direct services and wraparound services that allow people to better maintain adherence to healthcare is necessary to achieve biomedical equity in the in Georgia's current HIV public health crisis.

PLHIV's potential for increased livelihood and wellbeing has improved drastically since the development of antiretroviral therapy (ART) in 1996. This potential has grown exponentially in recent years with the development of new HIV prevention and treatment methods. While condoms remain effective tools to prevent HIV transmission, condom usage is often too inconsistent in sexual relationships to protect completely against transmission. To date, several HIV prevention options exist to replace or be used in addition to condoms—including ART to achieve viral suppression for PLHIV, pre-exposure prophylaxis, post-exposure prophylaxis, and microbicide gels and rings. While different types of biomedical tools continue to be produced to quell the impact of HIV and AIDS, access to these tools remains inequitable.

PREVENTION TECHNOLOGIES

Having options to care for one's health can be lifesaving. All people have a right to choose the method that will best fit their lifestyle, in accordance with the international human right to enjoy the benefits of scientific progress.[140] All people deserve to participate in and have access to the wide range of HIV prevention information, and technologies.

Condoms ("Male" and "Female")[141]

On average, condoms reduce risk of HIV transmission by 87%.[142] However, the efficacy of condom use can range from 60% to close to 100% depending on one's consistency and adequacy of use.[143]

Condoms are a highly effective method to prevent HIV, STIs, and unintended pregnancy. Because there is a small potential for ineffectiveness, individuals are recommended to use condoms with an additional form of HIV prevention.[144] While access to condoms may not be accessible in all contexts, they are generally more accessible than other HIV prevention tools. There is no age requirement for buying condoms in Georgia; free condoms are available from some health departments, clinics, and community organizations. While a 12-pack of condoms can be purchased for $4.00 - $12.00, this still may be cost-prohibitive for some.[145] Lack of information, stigma, and profiling are additional factors that contribute to decreased condom use within certain contexts.

Young people suffer the most from a lack of evidence-based information. **Georgia schools neither prohibit nor require education on appropriate condom usage and where to obtain condoms. Georgia schools are required to provide information on HIV prevention, but there is no requirement that the information be scientifically accurate.**[146] Thus, in many cases the prevention lesson is delivered in the form of abstinence-only education and devoid of information about how to use a condom for HIV prevention. Persistent implementation of abstinence-only education programs that use shaming, misinformation, and fear as tactics to dissuade students from anything other than heterosexual sex after marriage has resulted in many young people lacking basic knowledge of how to use condoms effectively, and what types of activities may pose a scientifically supported level of risk of HIV transmission.

In addition to access and education in schools, Georgians need access to condoms in prisons. In 2010, the rate of new HIV diagnoses among individuals in the prison system nationwide was five times the rate of new diagnoses among people who are not incarcerated,[147]—accounting for transmissions occurring via condom-less and PrEP-less sex between men, and through tattooing and injection drug use without clean instruments.[148] Sexual activity, both consensual and coerced, is a common occurrence in prisons.[149] The

140 UNESCO (2009) Venice Statement on the Right to Enjoy the benefits of Scientific Progress and its Applications.
141 We refer to the "male" condom as an "external" condom and the "female condom as an "internal condom." The gendering of these condoms is unnecessary and irrelevant, as "female" condoms may also be inserted into the anus before anal sex by people of all genders.
142 Planned Parenthood Federation of America. (2011) The Truth About Condoms, Fact Sheet. Available at: https://www.plannedparenthood.org/files/9313/9611/6384/truth_about_condoms.pdf.
143 Ibid.
144 Weller S, Davis, K. Condom effectiveness in reducing heterosexual HIV transmission. Cochrane Database Syst Rev. 2002; (1):CD003255. Available at: http://www.ncbi.nlm.nih.gov/pubmed/11869658
145 Regional distinctions may further impact price.
146 O.C.G.A. § 20-2-143; see also, National Conference of State Legislators (2016) State Policies on Sex Education in Schools. Available at: http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx#2.
147 US Centers for Disease Control and Prevention. HIV Among Incarcerated Persons. Available at: http://www.cdc.gov/hiv/group/correctional.html.
148 US Centers for Disease Control and Prevention (2006) HIV Transmission Among Male Inmates in a State Prison System – Georgia, 1992-2005. Morbidity and Mortality Weekly Report: 55(15);421-426. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5515a1.htm.
149 Human Rights Watch. (March 2007) Ensure Access to Condoms in US prisons and jails. Available at: https://www.hrw.org/sites/default/files/reports/condoms0307web.pdf.

international healthcare community has called for access to condoms and water-based lubricants that are free of charge and discreetly accessible for HIV prevention in prisons.[150] Yet, many prisons do not distribute condoms or any other HIV prevention tools.[151] Both rigid regulation of consensual sex *and* failure to protect individuals from sexual violence further impede efforts to effectively address HIV in prisons.

HIV testing upon entry into prison has been mandated since 1988 in Georgia, and HIV testing while incarcerated is required to be provided upon request. However, there is no standard for providing HIV testing upon release, and therefore no way to determine the rate of HIV status transitions for persons who have been incarcerated.

Even when accessible, condom usage may depend on a sexual partner's willingness to use condoms. It has been documented that young women are particularly vulnerable to an increased rate of HIV transmission because of a lack of agency in sexual relationships, around negotiating for condom use with their partners.[152] Sex workers often face similar limitations in condom negotiation, as do people who are exposed to violence in an intimate relationship. **To bypass the barrier of condom negotiation, women and girls require a variety of prevention options that are discreet, flexible to suit individuals' circumstances, and accessible and affordable by adults and youth in a wide variety of circumstances.**

Finally, many people simply do not enjoy using condoms. Studies have shown that people who do not use condoms tend not to because of the perceived interference of the condom with the level of intimacy in a sexual relationship. [153] Condoms may decrease sensation and sexual pleasure, exacerbate erectile dysfunction, and interrupt spontaneity.[154] General social insistence on condom usage can lead to shaming those who prefer to not use condoms, which can lead to a perceived need for secrecy and individuals potentially withholding information from a healthcare provider about past sexual experiences without a condom.

Studies on effective contraceptive use tend to have high failure rates because people over-report use of contraceptives, may use condoms incorrectly, and may answer survey questions inaccurately due to perceived societal expectations to use condoms consistently. This nuanced fear of stigma – for not enjoying or not using condoms – may mean that a person will not seek or receive the health services they need, including testing for HIV and other STIs, or obtaining information about PrEP and PEP. Furthermore, even when used consistently, the potential for condoms to break translates to ongoing risk of HIV contraction. For full bodily autonomy and determination over one's sexual and reproductive future, people need unfettered access to a variety of options for HIV, STI, and pregnancy prevention that includes, but is not limited, to condom access.

Treatment as Prevention

The medical advances made in ART since the onset of the HIV epidemic provides PLHIV with the treatment necessary to carry out long, fulfilling lives—including satisfying sex lives and reproductive self-determination. ART is a daily regimen of a combination of medications, contained in either one or multiple pills that can strengthen a PLHIV's immune system, prevent progression of the virus to AIDS, and significantly improve personal health and wellbeing.[155]

"Treatment as Prevention" is a phrase used to highlight ART for PLHIV as method of reducing further HIV transmissions. Adherence to HIV treatment has been found to lower one's risk of transmitting the virus sexually by 96%.[156] The 2016 PARTNER[157] study has indicated the effectiveness of ART may be even greater: after successfully tracking 888 couples with mixed HIV status, the results of the study found zero transmissions from condomless and PrEP-less anal and vaginal sex between the partners over a period of approximately two years.[158] The results of this study suggest ART to be, thus far, the most effective biomedical prevention strategy available. This prevention strategy is strengthened when coupled

150 An intervention suggested by the World Health organization and other international organizations. See Policy brief, HIV prevention, treatment and care in prisons and other closed settings: A comprehensive package of interventions (2013). Available at: http://www.who.int/hiv/pub/prisons/prisons_package.pdf.
151 Liebowitz, A., et.al. (2012) Condom Distribution in Jail to Prevent HIV Infection. AIDS and Behavior. Available at: http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureID=2365.
152 Advocates for Youth (2016) HIV and Young Women and Girls in the United States: Understanding the Systemic Barriers Young Women and Girls Face. Available at: http://www.advocatesforyouth.org/publications/publications-a-z/2577-hiv-and-young-women-and-girls-in-the-united-states.
153 Robert M. Grant (2015) What people want from sex and preexposure prophylaxis. Available at: http://www.gmsh.ca/aids-service-organizations/publications-and-resources/what-people-want-from-prep-sex.pdf.
154 Ibid.
155 AIDS.Gov. Overview of HIV Treatments. Available at: https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/treatment-options/overview-of-hiv-treatments/.
156 US Centers for Disease Control. Prevention Benefits of HIV Treatment. Available at: http://www.cdc.gov/hiv/research/biomedicalresearch/tap/index.html.
157 Rodger, A.J., Cambiano, V., Bruun, T., et al., The JAMA Network (2016) Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner is Using Suppressive Antiretroviral Therapy. Available at: http://jamanetwork.com/journals/jama/article-abstract/2533066.
158 Ibid.

with other prevention tools like condoms, or PrEP if one sexual partner is HIV-negative.[159]

THE ROLE OF HEALTHCARE ACCESS IN ACHIEVING BIOMEDICAL EQUITY

While the PARTNER study results show great promise, TasP requires significant support to be an effective strategy in ending the HIV epidemic. TasP is only possible when PLHIV have comprehensive access to HIV treatment and the care necessary to remain adherent to treatment. Since its enactment in March 2010, the Affordable Care Act (ACA) has made strides in ensuring access to healthcare for individuals living with HIV and other chronic health disparities. Prior to the ACA, insurers were permitted to deny coverage to people with pre-existing conditions, including HIV. Some insurers also imposed annual or lifetime benefits caps, which would be easily overdrawn by individuals living with HIV or other chronic conditions. This arrangement presented significant barriers for those individuals who required consistent access to medication. As a result, PLHIV would lose access to healthcare plans or be discouraged from enrolling. The ACA effectively outlawed these forms of discrimination.[160] The ACA also originally mandated Medicaid expansion to increase the income levels determining eligibility, and set in place non-discrimination protections on the basis of race, color, national origin, disability, age, and sex.[161] It is the first federal law to prohibit discrimination in healthcare based on sex, and employs robust protection from discrimination for women and trans people.

The Supreme Court's legal decision in *National Federation of Independent Businesses v. Sebelius* permitted states to opt out of Medicaid expansion,[162] and there are currently 19 states—including Georgia—where many people are living without Medicaid[163] despite strong incentives by the federal government.[164] The reluctance of these states to expand Medicaid frustrates the purpose of the ACA to provide healthcare coverage to underinsured and uninsured

159 The White House Office of National AIDS Policy (2015) National HIV/AIDS Strategy of the United States. Available at: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf.

160 See 42 U.S.C. s. 300gg-1, 300gg-11; AIDS.gov, The Affordable Care Act and HIV/AIDS, Available at: https://www.aids.gov/federal-resources/policies/health-care-reform/. See also, Coverage for Pre-Existing Conditions. Available at: https://www.healthcare.gov/coverage/pre-existing-conditions/.

161 45 C.F.R. s. 156.200(e).

162 132 S.Ct. 2566, 2602, 183 L.ED.2d 450 (2012). 567 U.S. ___ (2012). See also, Kaiser Family Foundation, A Guide to the Supreme Court's Affordable Care Act Decision, Kaiser Family Foundation. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8332.pdf . Pursuant to the 2012 Supreme Court decision in National Federation of Independent Business v. Sebelius162, 19 states have yet to expand Medicaid, including Georgia. Nine of these states are located in the Deep South and have the highest rates of new HIV diagnoses and AIDS-related deaths among people of color in the nation.

163 Including GA, ID, UT, WY, SD, NE, KS, OK, TX, MO, WI, TN, MS, AL, FL, SC, NC, VA, and ME.
See where states stand on Medicaid expansion decisions. Available at: https://www.statereforum.org/medicaid-expansion-deciions-map?gclid=cjwkeajw3qu5brc-0ucw8o6y5zcsjaa_wtdlcoo7ne9brmd5fu09ptbzd34btq1ja1pxbda9-zsv-xocqfjw_wcb.

164 The Federal Government will subsidize coverage for people who become newly eligible under Medicaid expansion for the first three years of expansion. Shaun Donovan, More than Halfway There: New Opportunities to Expand Medicaid and Level the Playing Field, White House Blog. Available at: https://www.whitehouse.gov/blog/2016/01/14/more-halfway-there-new-opportunities-expand-medicaid-and-level-playing-field

populations, which has particular implications for PLHIV.[165] The majority of Medicaid non-expansion states are in the South, and nine states in the Deep South have the nation's greatest share of HIV. These states make up only 28% of the US population and yet, in 2013, constituted 40% of new HIV diagnoses.[166]

HIV TRANSMISSIONS WOULD DECREASE BY 90% IF ALL PLHIV WERE LINKED & RETAINED IN CARE

Because of Medicaid non-expansion in the South and continued discriminatory tactics by insurance providers, PLHIV continue to face uncertainty around the cost of treatment within state insurance marketplaces.[167] PLHIV have reported difficulty paying the copays for HIV treatment through their insurance plans.[168] Young women of color living with HIV are more likely to be uninsured or living below the poverty line and face greater difficulty paying copay cost than white women of the same age.[169] Furthermore, out of all of the Medicaid non-expansion states, Georgia has one of the highest rates of uninsured people in the nation, with 16% of Georgia's population uninsured, which is 6% higher than the national average.[170] Georgia's legislature has yet to act affirmatively regarding Medicaid expansion despite the significant health benefits it would provide Georgians.

In the absence of Medicaid expansion in Georgia, PLHIV must rely on gap-filling Ryan White funding. The Ryan White Program is a federal funding program specifically dedicated to providing care to PLHIV. The program was initiated in 1990 to provide medical care and wrap-around services, including transportation and mental healthcare, for PLHIV who are underinsured or completely uninsured.[171] In Georgia, Ryan White funding for medications is administered through the AIDS Drug Assistance Program (ADAP) and imposes additional eligibility restrictions. To enroll, an individual must fulfill certain criteria, including living at or below 400% of the poverty line, being over the age of 18, among others.[172] Individuals are required to have a doctor's visit in order to re-enroll each year. Failure to meet these requirements within the enrollment period may disrupt access to ADAP and necessary medications. Abruptly discontinuing HIV medication can result in negative health effects, including damage to the immune system and the development of resistance to certain medications.[173]

Ryan White is intended to be a payor of last resort used when there is no other avenue for payment. Contrary to its purpose, Ryan White services across the nation were utilized by 60% of people diagnosed with HIV in 2012.[174] The great reliance on this funding is unsustainable. Ryan White services are a discretionary feature of the federal government's budget, unlike Medicaid or Medicare which enjoy relatively greater funding stability. PLHIV who are reliant on Ryan White in Medicaid non-expansion states are in a precarious situation, without the complete assurance that their lifesaving HIV and AIDS treatment will be covered in coming years.[175]

Another barrier to TasP is the low numbers of people who are rapidly linked to, and retained in care. The START (Strategic Timing of Antiretroviral Treatment) study published by The National Institutes of Health (NIH) listed early diagnoses and prompt linkage to care as key elements to reduce HIV transmission rates, in combination with

165 Southern HIV/AIDS Strategy Initiative (2016) HIV/AIDS in the U.S. Deep South: Trends from 2008-2013 https://southernaids.files.wordpress.com/2011/10/hiv-aids-in-the-us-deep-south-trends-from-2008-2013.pdf.
166 Ibid.
167 Kennedy, K. (2014) AIDS patients fear discrimination in ACA exchange. Available at: http://bigstory.ap.org/article/aids-patients-fear-discrimination-aca-exchange-0 ("The Affordable Care Act bans insurers from charging an individual more than $6,350 in out-of pocket costs a year and no more than $12,700 for a family policy. But patient advocates warn those with serious illnesses could pay their entire out-of-pocket cap before their insurance kicks in any money. Money paid toward premiums doesn't count toward the caps.").
168 NHeLP (2013) Addressing the Needs of Low Income Women Living with HIV: The Role of Medicaid and the ACA. Available at: http://www.healthlaw.org/issues/health-care-reform/addressing-the-needs-of-low-income-women-living-with-hiv-the-role-of-medicaid-and-the-aca#.V4gfkCN95cw.
169 Advocates for Youth. (2016) HIV and Young Women and Girls in the United States: Understanding the Systemic Barriers Young Women and Girls Face. Available at: http://www.advocatesforyouth.org/publications/publications-a-z/2577-hiv-and-young-women-and-girls-in-the-united-states. Sixty-four percent of women living with HIV who are currently receiving medical care reported an annual income of $10,000. See Fields, J. Earlier Access to Care for Uninsured Women Living with HIV: The Affordable Care Act's Medicaid Expansion and 1115 Demonstration Projects. Available at: http://www.healthlaw.org/issues/reproductive-health/Earlier-Access-to-Care-for-Uninsured-Women-Living-with-HIV-and-the-ACA#.V3_XvyMrJcw. See also, US Centers for Disease Control and Prevention, HIV Among Women. Available at: http://www.cdc.gov/hiv/group/gender/women/.
170 Ibid. At the time of writing, Georgia is second only to Texas and tied with Oklahoma.
171 National Women's Health Network, SisterLove, Positive Women's Network-USA (2014) Ryan White and the Affordable Care Act; Advocating for Public Healthcare for Women Living With HIV. Available at: https://pwnusa.files.wordpress.com/2015/03/nwhn_pwn_sl_rw_brief_final.pdf .
172 Georgia Department of Public Health. AIDS Drug Assistance Program. Available at: https://dph.georgia.gov/aids-drug-assistance-program-adap-0.
173 Changing or Stopping Treatment (2015) Available at: https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/treatment-options/changing-stopping-treatment/.
174 US Department of Health and Human Services; Health Resources and Services Administration (2014) (2014) The Ryan White HIV/AIDS Program Progress Report 2014: Striving for an AIDS Free Generation. Available at: http://hab.hrsa.gov/data/files/2015report.pdf.
175 US Department of Health and Human Services (2016) About the Ryan White HIV/AIDS Program. Available at: http://hab.hrsa.gov/abouthab/aboutprogram.html.

ART. Currently, however, almost two thirds of the estimated 1.2 million people living with HIV in the United States are not in care.[176] It is estimated that HIV transmissions would decrease by 90% if every person diagnosed with HIV were linked to care and able to achieve viral loads suppression.[177]

MICROBICIDES

Microbicides are treatments that kill or neutralize a virus, and can come in the form of a gel or an insert applied vaginally for HIV prevention.[178] Rectal microbicide treatments could reduce HIV transmission rates among individuals who engage in anal sex, though they are currently still in the development stage. Vaginal microbicides are a particularly beneficial option for individuals who are seeking to prevent HIV transmission discreetly and without reliance on a partner. [179] Microbicides that can be used vaginally like the Dapivirine ring have received favorable results in recent studies.[180] Study results showed that when a silicone vaginal ring dispensing the anti-HIV drug Dapivirine remains in place, it was effective in preventing HIV transmission for a full month. The ring was most effective in women ages 22 and older. A study is currently underway to gather data on the reasons for lack of adherence among women younger than 22.[181] Despite the benefits it could provide for individuals most in need, the vaginal ring will not be available for several years due to the nature of the recent efficacy findings.

The benefits that microbicides provide as an HIV prevention mechanism are multifaceted. They provide an individual the ability to use the prevention tool as needed, rather than adhering to a more rigid prevention method, as is the case with PrEP. Moreover, microbicides allow an individual to hold their bodily autonomy and sexual health and wellbeing in their own hands, rather than relying on a partner to comply with the prevention mechanism. For individuals facing violence or fear of violence in relationships where the status of the partners is mixed or unknown, having the ability to self-administer HIV prevention treatment could be a crucial determinant in the outcome of one's health and HIV status. Microbicides are also an option for individuals who have difficulty taking pills every day, due to factors such as housing instability, lifestyle, and lack of consistent access to PrEP. Microbicides may also be a beneficial alternative for those who are concerned about the side effects of PrEP. The availability of microbicides for widespread use could have a significant impact on HIV prevention strategies, and can add another tool to the prevention method toolbox.

PRE-EXPOSURE PROPHYLAXIS (PREP)

The most effective HIV prevention treatment for people living without HIV currently available in the United States is pre-exposure prophylaxis, or PrEP. Clinically named Truvada,[182] PrEP is a daily oral pill form medication that, if properly adhered to, can reduce an HIV-negative individual's risk of HIV contraction through sexual intercourse or intravenous drug usage by 94% or more.[183] PrEP can be combined with additional barrier methods, such as condoms. PrEP offers the potential to be taken discreetly rather than relying on a partner for cooperation, and creates a unique option for couples with mixed HIV status (where one partner is HIV-positive and the other is HIV-negative), and those who wish to conceive a child without risk of HIV transmission.

The Centers for Disease Control's 2014 Clinical Practice Guidelines recommend PrEP for sexually active MSM, cisgender and trans women and men, intravenous drug users, and individuals looking to conceive without risk of HIV transmission. In 2015, it was estimated that 25% of MSM in the US (approximately 492,000 people) could benefit from Truvada to prevent the sexual transmission of HIV, and 0.4% of heterosexual cisgender men and women (approximately 624,000 people) could as well. The prevention method would

176 National Institutes of Health, NIH Study Examines Best Time for Healthy HIV-Infected People to Begin Antiretrovirals. Available at: http://www.niaid.nih.gov/news/newsreleases/Archive/2011/Pages/START.aspx.
177 UNIAIDS, 90-90-90. Available at: http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf.
178 Microbicides (2016) Available at: https://www.aids.gov/hiv-aids-basics/prevention/prevention-research/microbicides/.
179 Kaiser Family Foundation (2014) Women and HIV/AIDS in the United States. Available at: http://kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states/#footnote-cdcsurv2013.
180 ASPIRE Study, Daraprim Ring (2016) Available at: http://www.niaid.nih.gov/news/QA/Pages/ASPIRE-ring-study-qa.aspx. See also, Baeten, J.M., Palanee-Phillips, T., Brown, E.R., Schwartz, K., Soto-Torres, L.E., Govender, V., Mgodi, N.M., Matovu Kiweewa, F., Nair, G., Mhlanga, F., Siva, S., Bekker, L.-G., Jeenarain, N., Gaffoor, Z., Martinson, F., Makanani, B., Pather, A., Naidoo, L., Husnik, M., Richardson, B.A., Parikh, U.M., Mellors, J.W., Marzinke, M.A., Hendrix, C.W., van der Straten, A., Ramjee, G., Chirenje, Z.M., Nakabiito, C., Taha, T.E., Jones, J., Mayo, A., Scheckter, R., Berthiaume, J., Livant, E., Jacobson, C., Ndase, P., White, R., Patterson, K., Germuga, D., Galaska, B., Bunge, K., Singh, D., Szydlo, D.W., Montgomery, E.T., Mensch, B.S., Torjesen, K., Grossman, C.I., Chakhtoura, N., Nel, A., Rosenberg, Z., McGowan, I. and Hillier, S. (2016) 'Use of a vaginal ring containing Dapivirine for HIV-1 prevention in women', New England Journal of Medicine, . doi: 10.1056/nejmoa1506110 (where the Daraprim ring was found to be 27-37% effective).
181 National Institutes of Health. NIAID Research on Microbicides. Available at: https://www.niaid.nih.gov/topics/hivaids/research/prevention/pages/topicalmicrobicides.aspx.
182 Truvada is an antiretroviral drug that has been approved for use in HIV prevention by HIV-negative people. Truvada is a blue pill comprised of the medications Emtriva (emtricitabine) and Viread (tenofovir disoproxil fumarate).
183 US Centers for Disease Control & Prevention (2015) PrEP. Available at: http://www.cdc.gov/hiv/basics/prep.html.

likewise be useful to 18.5% of injection drug users in the US (approximately 45,000 people).[184]

Use and efficacy of PrEP for preventing sexually transmitted HIV varies depending on the types of sexual practices in which an individual engages. With respect to anal sex, a once daily PrEP regimen must be started only seven days prior to an unprotected anal sexual encounter to be effective. The iPrEX study found that individuals who took PrEP only four days a week and had condomless anal sex with a partner living with HIV or with unknown status were less likely to contract HIV.[185] Individuals engaging in vaginal sex, however, must be on PrEP for a longer period prior to condomless vaginal sex with a partner living with HIV or unknown status, for PrEP to be fully effective. While access to PrEP is important in uplifting the sexual and reproductive rights of individuals to make informed decisions about their health, the development and implementation of PrEP is complicated by the failure to adequately address the biomedical and social factors affecting the usefulness of the drug in preventing vaginal HIV transmission.

For these reasons, non-adherence decreases the effectiveness of PrEP for those engaging in vaginal sex. Furthermore, recent studies show that PrEP must be taken at the same time of the day every day to be most effective vaginally, and a specific vaginal bacteria called Gardnerella vaginalis – which is more prevalent among people of African descent – may further decrease efficacy of PrEP.[186] Cisgender women, trans men, and people of African descent that engage in vaginal sex may need to follow a different HIV prevention regimen or take special precautions if using PrEP. Healthcare providers should be aware of these disadvantages of the drug when informing patients about PrEP's reduced efficacy in preventing vaginal transmission. Continued research on different people's adherence to PrEP is critical because it relies on the efficacy of one's self-use of the treatment. PrEP should be considered a bio-behavioral, or biopsycho-social, treatment, as noted by HIV/AIDS Scholar K. Rivet Amico.[187]

Despite its current disadvantages, it is still critical for healthcare providers to recognize access to PrEP as an essential option available to women making decisions about their sexual and reproductive health. **One in three healthcare providers either do not know about PrEP or do not prescribe it.[188] Providers urgently need to be educated regarding PrEP, and PrEP prescription protocols must be developed to ensure accurate information is communicated to patients who are having vaginal sex versus anal sex, or both.**

In addition to understanding efficacy, the PrEP regimen requires strict adherence to check ups and regular testing for HIV. PrEP currently protects against the HIV-1 viral strand, which is the most widespread. There is one documented incident of an individual taking PrEP who contracted a resistant strand of HIV.[189] Regular HIV testing is critical because remaining on PrEP (i.e. Truvada alone) while one may be unknowingly living with HIV can transform that virus strain into one that is Truvada resistant. As a result, the resistant virus may be transmitted to sexual partners who are adhering to a PrEP regimen and may erroneously believe they are protected. For that reason, HIV testing must be available for individuals taking PrEP. This means that individuals must have the resources to visit a clinic every three months and receive frequent HIV testing.

It is also important to consider PrEP as one of many options, including ART treatment as prevention, condoms, and other barriers for safer sex. For the same reason, it is important to continue to engage in harm reduction initiatives such as safe injection sites for intravenous drug users who may be at risk of HIV transmission.

184 Vital Signs: Estimated Percentages and Numbers of Adults with Indications for Preexposure Prophylaxis to Prevent HIV Acquisition — United States, 2015, Morbidity and Mortality Weekly Report, November 27, 2015 / 64(46);1291-1295. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6446a4.htm?s_cid=mm6446a4_w.

185 aidsmap. The iPrEx study. Available at: http://www.aidsmap.com/The-iPrEx-study/page/1746640/.

186 Boerner, H. How Vaginal Bacteria Could Be Stoking HIV Cases and Blocking Prevention, Available at: http://www.pbs.org/newshour/updates/bacteria-stoking-hiv-cases-blocking-hiv-treatment/.

187 Amico, K.R. (2012) Adherence to preexposure chemoprophylaxis: the behavioral bridge from efficacy to effectiveness. Available at: http://casgt.org/actividades/wp-content/uploads/2014/07/AmicoPrEPuse12.pdf.

188 Flash, C. et al. Two years of Truvada for pre-exposure prophylaxis utilization in the US, Journal of the International AIDS Society 2014, 17(Suppl 3):19730. Available at: http://www.jiasociety.org/index.php/jias/article/view/19730 | http://dx.doi.org/10.7448/IAS.17.4.19730.

189 Ryan, B. (2016) PrEP Fails in Gay Man Adhering to Daily Truvada, He Contracts Drug-Resistant HIV. Available at: https://www.poz.com/article/prep-fails-gay-man-adhering-daily-truvada-contracts-drugresistant-hiv.

HEALTHCARE COVERAGE AND PREP

PrEP remains inaccessible for people who lack insurance or other financial means to obtain the drug. **While Ryan White is a critical gap-filling program for PLHIV, there is no parallel program to assist people who are not living with HIV.** [190] PrEP is covered under Medicaid and private insurance plans under the ACA's new mandates. For people on Medicaid in Georgia, PrEP treatment and routine clinic visits are now available for free through Fulton County's PrEP Clinic.[191]

In Georgia's insurance market, PrEP is available through every insurance company. However, depending on one's insurance plan, the copay for the prescription may be a significant barrier to continued access. **No non-discrimination provision applies to people without HIV seeking PrEP, and insurance companies can place Truvada on a higher tier, requiring a high copay that may result in annual out of pocket fees up to $3,000 or more.**

DATA IS NEEDED ON HOW PREP INTERACTS WITH HORMONE THERAPY

Gilead Sciences, the only pharmaceutical company currently producing Truvada as PrEP, provides two payment assistance programs: medication assistance program (MAP) and copay assistance program (CAP). MAP is intended to be used by people who do not have insurance, and who have an income less than 500% the federal poverty level (about $56,000). CAP provides assistance to a ceiling of $3,600 a year to cover copays. This is still problematic for individuals who have purchased health insurance plans on the state marketplace, who can be charged up to $6,850 in copays and other out of pocket expenses. Costs can therefore exceed $3,000 per year, which does not factor in the costs for regular clinic checkups that is an integral part of the PrEP regimen.

For individuals who have insurance, Gilead Sciences provides assistance with navigating the health insurance system and payment assistance up to $36,000 per year. This is a response to the exorbitant copay costs that some insurance companies have placed on Truvada prescriptions. However, this is still not enough for many individuals who have insurance through state exchanges. In these cases, Gilead Sciences extends assistance for people with income that is 400% of the poverty level.

The cost of PrEP is significant because it impacts adherence. High copays may deter individuals from seeking PrEP. At the Fulton County PrEP Clinic, Gilead Sciences covers all costs for individuals that earn below $58,000.[192] The clinic's opening in March 2016 was a tremendous step forward for HIV prevention in Atlanta, but it remains out of reach geographically for Georgians living throughout the rest of the state. **The creation of additional PrEP clinics throughout the state, particularly in high impact areas, is necessary to advance our prevention goals.**

In addition to cost and access barriers, people seeking PrEP still face social stigma surrounding HIV prevention tools. The stigma surrounding HIV can result in inadequate or a complete lack of education around HIV transmission and prevention techniques. This can lead to a lack of awareness of one's need to take preventative measures. While PrEP can be taken discreetly, it can still have the appearance of an antiretroviral drug. Holding the large blue PrEP pill in one's home medicine cabinet, purse, or backpack may lead to the perception that one is taking HIV treatment medication, rather than HIV prevention medication. For some, this may be a deterrent to actively seeking PrEP or continuing use. One remedy proposed by the coalition US Women and PrEP Working group is to change the appearance of PrEP to resemble a vitamin or birth control pill.[193]

YOUNG PEOPLE AND PREP

PrEP is currently only accessible to individuals over the age of 18, which is particularly troubling considering the high prevalence of HIV among 13 to 24-year-old Black and Hispanic/Latino MSM.[194] There is a lack of research on the biological effects of PrEP on youth and on the barriers to youth access and adherence to PrEP. State laws that require parental consent (or are unclear) regarding the participation of adolescents in research frustrates research efforts. Additionally, all products regulated by the FDA must have parental approval with no

190 The only state to have initiated a drug assistance program specifically targeting HIV prevention is Washington state, which began its PrEPDAP drug assistance program in April 2014. See Washington State Department of Health. What is PrEPDAP? Available at: http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/PrEPDAP. See also, Rodriguez, M. Washington State First to Assist Those Seeking HIV Prevention Pill. Available at: http://www.thebody.com/content/75057/washington-state-first-to-assist-those-seeking-hiv.html.

191 Informational interview with Cherlisa Jackson at FCPC (March 1 2016).

192 Informational interview with Cherlisa Jackson at Fulton County PrEP Clinic (2016).

193 US Women and PrEP Working Group, US Women and PrEP Working Group Statement Update. Available at: http://www.sisterlove.org/wp-content/uploads/2015/11/US-Women-and-PrEP-Updated-Statement-_Final2-1.pdf .

194 US Centers for Disease Control and Prevention (2016) HIV Among Gay and Bisexual Men. Available at: https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.

waiver option.[195] Young people most vulnerable to HIV exposure are found to be unlikely to participate if parental permission is a requirement.[196]

Doctors may prescribe PrEP off-label, meaning against the suggested use of the medication, to people under the age of 18. However, there is no research to support that the benefits of prescribing PrEP off-label outweigh the risks. Furthermore, accessing PrEP may be difficult for young adults who are over 18 but still on their parents' insurance. Insurers may accidentally send explanations of benefits to parents, and parents who are primary insurance policy holders may notice when large deductibles are being met by PrEP. FDA regulations are notoriously hard to change. Proposed rules may be influenced through the public comment process, or rules already in place may be altered by petition, but any change is unlikely without the research to support safety for adolescents to use PrEP.

THE IMPACT OF BIOMEDICAL INEQUITY ON SEXUAL AND REPRODUCTIVE WELL-BEING

Before ART was a feasible and accessible option for women to prevent HIV transmission to a child during childbirth or breastfeeding, many WLHIV were sterilized by choice, or upon suggestion or coercion by a healthcare provider. The coerced sterilization of WLHIV still occurs globally, and while the practice has been replaced by provision of ART in the United States, many healthcare providers and policymakers continue to disregard WLHIV as sexual beings with the ability and right to safely start a family if, when, and how they choose to. The lack of attention to women's unique needs, and the lack of women-centered care is another iteration of the biomedical oppression that Black women have faced throughout this nation's history.

A nationwide, women-centered urgent response to the epidemic is possible, which is what occurred after the1994 determination that ART could prevent perinatal transmission. The nationwide response placed pregnant women on highly active anti-retroviral therapy (HAART) which resulted in a sharp decline of perinatal transmissions nationally.[197] As a result, currently all pregnant women in the US are tested for HIV and provided treatment if the test is positive, though disparities exist in Georgia. Women are currently more likely to access testing and treatment services while they are pregnant than at any other time.[198] A decisive strategy to prevent HIV transmission among non-pregnant women should be instituted with as much fervor. Reproductive health should be seen as prime location to increase HIV prevention services.

There remains a lack of substantial research on PrEP's biological effects on women and trans men, including when they are taking birth control pills, hormones, or are pregnant. There is likewise not enough information on whether taking PrEP while pregnant or breastfeeding has any harmful impact on a fetus or baby. A condition of the FDA approval of Truvada required Gilead Sciences to collect data on pregnancy outcomes for pregnant women taking Truvada. There has not yet been any definitive indication that PrEP usage by a person who is pregnant or breastfeeding causes harm to a fetus or child, but more research on this is needed.

Trans women are by some estimates 50 times more likely to contract HIV.[199] **Critical data is needed on how PrEP interacts with hormone therapy that some trans people may be using at the same time as PrEP.** There has been no evidence of any negative interaction in the limited research that does exist, but the question remains under-researched. Past research efforts previously grouped trans women in the same category as MSM. The impact of doing so impaired data on adherence, failing to recognize the distinct needs and experiences of trans people. Likewise, trans men have yet to be included in any studies on PrEP to date,[200] despite the majority of trans men having reported engaging in anal sex with a cisgender male partner.[201] Many trans individuals cite fear of adverse reaction when using PrEP and hormones as a reason for poor adherence to PrEP.[202]

In response to the need for data on PrEP use by trans people, three demonstrations examining adherence to PrEP by trans women and

195 Culp, L., State Adolescent Consent Laws and Implications for HIV Pre-Exposure Prophylaxis, American Journal of Preventive Medicine, January 2013, Volume 44 (1 Suppl 2): S119–24. Available at: http://www.cdc.gov/phlp/docs/prephiv-wb.pdf.
196 Ibid.
197 US Centers for Disease Control and Prevention (2006) Achievements in public health: Reduction in Perinatal Transmission of HIV Infection-United States, 1985--2005. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a3.htm
198 US Women and PrEP Working Group, US Women and PrEP Working Group Statement Update, page 3. Available at: http://www.sisterlove.org/wp-content/uploads/2015/11/US-Women-and-PrEP-Updated-Statement-_Final2-1.pdf.
199 World Health Organization (2015) People most at risk of HIV are not getting the health services they need. Available at: http://www.who.int/mediacentre/news/releases/2014/key-populations-to-hiv/en/
200 Gallagher, B. (2015) Where do I fit in? PrEP and Transgender men. Available at: http://betablog.org/where-do-i-fit-in-prep-and-transgender-men/
201 Rowniak S, Chesla C, Rose CD, Holzemer WL. (2011) Transmen: The HIV risk of gay identity. AIDS Education and Prevention, 23(6), pp.508-20. Available at: http://repository.usfca.edu/cgi/viewcontent.cgi?article=1078&context=nursing_fac.
202 Clements-Nolle, K., Marx, R., Guzman, R. and Katz, M. (2001) context=nursing_fac=nursing_fac" l2-1.pdfFinal2-1.pdf" Face,ad. ,h status of transgender persons: Implications for public health intervention_fa American Journal of Public Health., 91(6), pp. 915.

men were announced in April 2016 in California. Funded by the California HIV/AIDS Research Program of the University of California, these unprecedented studies aim to directly address the barriers to effective PrEP access that trans people, and particularly trans women of color, are still facing.[203] The research will include an examination of adherence patterns by trans men and women to PrEP.

203 LaFee, S. and Stanga, L.L. (2015) An HIV Prevention Pill For Transgender Persons: UC Launches First in the Nation Demonstration Project. Available at: http://health.ucsd.edu/news/releases/Pages/2016-04-26-HIV-prevention-pill-for-transgender-persons.aspx.

ADVOCACY RECOMMENDATIONS

Achieving biomedical equity begins by providing communities affected by HIV with affirming, comprehensive information and holistic access to preventative measures, care, and treatment. Linking these efforts to services already being received (for example, at family planning clinics, schools, and other social service centers) meets people where they are and can facilitate easier access to HIV prevention and care services.

Ensuring that PLHIV have access to treatment and the ability to remain on treatment to maintain a suppressed viral load is a critical part of ending the HIV epidemic. However**, the lack of access to affordable HIV treatment and care facing thousands of PLHIV in the South compromises the ability to control one's sexual and reproductive wellbeing and future.** It perpetuates the stigma associated with HIV transmission and the expectation that PLHIV should be stripped of their sexual identity. It also fails to interrupt the stigmatizing myth that WLHIV cannot or should not be mothers, despite the fact that all the necessary prevention, treatment and care tools exist for WLHIV to lead full sexual and reproductive lives without fear of HIV transmission to their partners or children.[204] These barriers have a profound impact on the prevalence of HIV in the United States. It is imperative to focus further on innovative preventative options, and particularly ones that can be used discreetly, act long-term, and offer easy adherence.

Improving Biomedical Research

Although great strides have been made in HIV research in the past four decades, researches, medical professionals, and policymakers must be held accountable to all communities affected by the HIV public health crisis. The disparate impact of HIV on women, trans individuals, and people color demands that the heath needs of these communities are no longer ignored. Researchers must prioritize research design that is inclusive of the spectrum of gender identity and sexual practices, and allow research subjects to self-identify gender identity. Researchers must dedicate attention to collecting data on identity groups previously stigmatized and made invisible by being categorized as "statistically insignificant" or "difficult to assess." Research methods should reflect a heightened effort to increase data on trans men and trans women, and other de-prioritized groups, such as immigrant communities.

Access to a Full Range of Biomedical Options

All people deserve to have access to myriad preventative options that meet their lifestyle needs. **Pharmaceutical companies must be invested in creating medications that are as diverse as the individuals who rely on them to live and thrive.** Recognizing the importance of both HIV prevention methods and contraceptive methods, a dual prevention device would greatly improve the ability of individuals to protect their sexual and reproductive freedoms.

The effectiveness of PrEP brings us one step closer to ending the HIV epidemic. While its effectiveness (when used properly) is significant, understanding adherence to PrEP as bio-behavioral or biopsycho-social is integral to understanding how the benefits of access and adherence to PrEP expand beyond health to include emotional and sexual wellbeing. For these reasons, PrEP may not fit all people's lifestyles, and different communities and populations may have different adherence patterns. **Thus, additional prevention methods must be developed that are responsive to the different adherence pattern of different communities.**

Where PrEP falls short, microbicides continue to be a viable prevention method. While the development of anal and vaginal microbicides remains delayed and underfunded due to the de-prioritization of women and the lack of recognition of trans people in the HIV epidemic, there is great potential to expand current prevention and treatment efforts. Scientific innovation invites an opportunity to develop a wide array of forms of prevention including changes to the aesthetic design of the prevention pill, reducing pill size, adjusting color, and similar changes—which would increase the ability of women, TGNC people, and LGBQ people to take PrEP discreetly when necessary for safety, social, and cultural reasons. As HIV prevention options increase beyond PrEP, research on the behavior associated with taking preventative treatment— whether in pill, gel or shot form, and measures that can be taken to ensure adherence—is as critical to HIV prevention strategies as knowledge of the efficacy of the treatment when taken consistently.

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204 30 for 30 Campaign, Integrating HIV and Sexual and Reproductive Health Service Provision: A proven strategy for providing more and better healthcare to women living with and at risk of HIV/AIDS. Available at: http://30for30campaign.org/wp-content/uploads/2016/01/30-for-30-report_Integraton_HIVrepro_FINAL_Jan21_2016.pdf.

MAKING THE CASE FOR COMPREHENSIVE SEX EDUCATION

SisterLove's work in HIV, sexual health, and Reproductive Justice has demonstrated that **having access to medically accurate information about one's body, relationships, gender, sexuality, and sexual and reproductive health is necessary to meaningfully take control of those areas in one's life.**

In Georgia, young people across the spectrum of gender identity and sexuality must navigate poor access to affordable sexual and reproductive health services and support, and staggeringly high rates of STIs and HIV, among other challenges. In this hostile environment—where service providers have been documented to stigmatize trans and gender non-conforming people[205] and discriminate against Black women and girls[206]—is incumbent upon Georgia's schools, policymakers, clinical and service providers, parents and caregivers, and community organizations to ensure greater access to sexuality education. This section will explore how access to sexuality education, as one of many intersectional factors, relates to the struggle to end the HIV epidemic and provide youth with the information they need to take control of their own health and futures.

The right to information about sexual and reproductive health is a fundamental human right. International human rights standards require governments to ensure that information regarding sexual health is placed in the public domain without withholding, censoring, or otherwise intentionally misrepresenting information related to sex, sexuality, and other health-related information.[207] When young people are misinformed or denied access to relevant sexual health information, they are deprived of the fundamental right to be healthy and make informed choices about their sexual and reproductive lives.[208] Under international legal norms, governments have a duty to ensure that every person – and particularly young people—have access to comprehensive, non-discriminatory and scientifically accurate information about sex and sexuality, pursuant to the human rights to health, life, non-discrimination, education, and information.[209]

COMPREHENSIVE SEX EDUCATION OVERVIEW

Comprehensive sex education (CSE) is a means of offering evidence-based sexual health information that is age-appropriate, culturally competent, and medically accurate. CSE can encompass a range of sexual and reproductive health related topics such as reproduction, contraceptives, abortion, information on the transmission of STIs and HIV, relationship safety skills, family planning, and information on the diversity of sexuality and gender identity and expression. Research shows that CSE and access to sexual and reproductive health services can help young people safeguard their health and wellbeing.[210]

In public deliberation about sexuality education, opponents who disfavor CSE or other forms of progressive sexuality education often argue that access to information about sex will lead to youth having sex earlier and cause increased rates of STI transmission and unintended pregnancy. This unfounded rhetoric has a twofold effect. One is that teen pregnancy and STIs are stigmatized, which increases the level of shame involved in discussing and seeking resources and care around these issues. The second is that any potential progressive change to our systems is stifled, and youth end up suffering the effects. Data shows that a majority of high school students are sexually active by the time they turn 16.[211] The position that youth cannot handle information about their bodies and sexuality is paternalistic and irrational—particularly when we know that youth are thinking about sex, choosing to have sex, have been forced to have sex, and are experiencing high rates of STIs and unintended pregnancy in an environment where evidence-based sex education is inaccessible.

The discourse on pregnancy among teens has traditionally espoused the goal of "preventing teen pregnancy" which has the effect of

205 Chung, C., et al. (2016) Some Kind of Strength: Findings on healthcare and economic wellbeing from a national needs assessment of transgender and gender non-conforming people living with HIV. Transgender Law Center.
206 Center for Reproductive Rights, National Latina Institute for Reproductive Health, SisterSong Women of Color Reproductive Justice Collective (2014) Reproductive Injustice. Available at: http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CERD_Shadow_US_6.30.14_Web.pdf.
207 Center for Reproductive Rights (2001) Bringing Rights to Bear: The Human Right to Information on Sexual and Reproductive Health: Government Duties to Ensure Comprehensive Sexuality Education. Available at:, http://www.reproductiverights.org/sites/default/files/documents/BRB_SexEd.pdf. Center for Reproductive Rights.
208 World Health Organization, Sexual Health, Human Rights, and the Law (2015) Available at: http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf.
209 Center for Reproductive Rights (2008) An International Human Right: Sexuality Education for Adolescents in Schools. Available at: http://reproductiverights.org/sites/default/files/documents/SexualityEducationforAdolescents.pdf.
210 Downey, M. (2015) Sex education in Georgia: Failing the grade and students. Available at: http://getschooled.blog.myajc.com/2015/12/19/sex-education-in-georgia-failing-the-grade-and-students/
211 Kann, L., et al. (2013) 'Youth Risk Behavior Surveillance — United States', Morbidity and Mortality Wkly. Rep, 63, pp. 1–168.

stigmatizing teen pregnancy and can be paired unfairly and inaccurately with arguments that young parenthood is the moral failing of youth and a drain on community resources. In addition to shaming young parents, this distracts attention from the structural arrangements in which youth are having sex and becoming pregnant, and frustrates efforts to develop necessary support for young people who have made the choice to become a parent.[212] Many of Georgia's current policies and practices disempower young people's sexual and reproductive self-determination. Youth deserve support around this issue from schools and multiple other sources in their interpersonal and institutional interactions in order to enjoy freedom from stigma and discrimination in accessing their right to sexuality education.

Photo from SisterLove's Healthy Love Youth Leaders' sex- positive CSE video, "YourLife. YourPower. YourDecision"[213]

Furthermore, youth in metro Atlanta face high levels of stigma and discrimination based on their sexuality and gender identity and expression,[214] and youth under the age of 18 are not spared from our national epidemic of sexual [215] and partner violence.[216] Youth need and deserve frank, honest, medically accurate, and culturally competent information on sexual and reproductive health in order to navigate this fraught landscape to the best of their ability. Failing to address these realities is an indefensible position.

In the context of HIV, medical, public health, and HIV advocacy communities are becoming increasingly aware that rates among the most impacted groups—such as Black gay and bisexual men—are attributable to structural and social factors like lack of access to healthcare and a racially concentrated sexual network, rather than individual "high risk" behavior.[217] Greater access to evidence-based sexual health information can play a critical role in equipping our young people with information necessary to care for themselves and each other in an inequitable system that imposes structural health risks upon them through no fault of their own.

We seek to make the case that access to CSE is a critical factor in addressing our HIV epidemic *and* fulfilling the human rights of youth, regardless of age, to be provided with the information necessary to choose if, when, and how to have sex, whether to have a child or not have a child, and to do so free from stigma, discrimination, or fear of violence.

ACCESS TO SEXUALITY EDUCATION AS A SOCIAL DETERMINANT OF HEALTH

Access to sexuality education is a social determinant of sexual and reproductive health that impacts young people on several levels. While much of HIV is driven by structural inequities (discussed in other sections of this report), the CDC has also identified several factors that present barriers to HIV prevention among youth at the individual and interpersonal level, which could be addressed by access to a structural-level intervention such as CSE. The factors include: a low perception of risk among younger women, low rates of testing and condom usage among youth, engaging in sex with older partners, having sex while intoxicated, and feelings of isolation.[218]

212 Young Women United (2016) Dismantling Teen Pregnancy Prevention. Available at: http://www.youngwomenunited.org/wp-content/uploads/2016/05/ywu-dismantlingtpp-may2016-digital.pdf.
213 SisterLove, Inc. Healthy Love Youth Leaders Network (2016). Available at: https://youtu.be/szmd3mvQBPA.
214 Wright, E. (2016) Atlanta Youth Count!: 2015 Atlanta Youth Count and Needs Assessment. Available at: http://issuu.com/gavoice/docs/aycna_final_report_may_2016_final/3?e=3167111/35350541. (finding that among homeless youth (who had been homeless for one month in metro Atlanta): over one-quarter identified as LGBT, 6.5% identify as trans, over half of homeless trans youth survived sexual violence, and 93.1% of homeless trans youth traded sex for money).
215 National Center for Injury Prevention and Control, US Centers for Disease Control and Prevention (2012) Sexual Violence: Facts at a Glance. Available at: http://www.cdc.gov/ViolencePrevention/pdf/SV-DataSheet-a.pdf (stating that 42.2% of "female rape victims were first raped before age 18" and that "27.8% of male rape victims were first raped when they were age 10 or younger.").
216 Sexual Violence (2012). Available at: http://www.cdc.gov/ViolencePrevention/pdf/SV-DataSheet-a.pdf (stating that "22% of women and 15% of men first experienced some form of partner violence between 11 and 17 years of age.").
217 Sullivan, P., et al. (2015). Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: A prospective observational cohort study. Annals of epidemiology., 25(6), 445f epidemiology.015). Available at: http://www.ncbi.nlm.nih.gov/pubmed/25911980.
218 US Centers for Disease Control and Prevention (2014) 2013 National Data for Chlamydia, Gonorrhea, And Syphilis. Available at: http://www.cdc.gov/std/stats13/std-trends-508.pdf.

Educational interventions and policies crafted to reduce STI and HIV rates among young people must simultaneously shift from an imbalanced focus on young people's individual and interpersonal behavior and take into consideration how social determinants of health create the parameters within which such behavior occurs. For example, homophobia and transphobia in the home, clinical settings, and community institutions like churches can lead to displacement of young people and unstable housing linked to survival sex, and physical harassment and violence by police and other individuals.[219] Similarly, childhood physical and sexual trauma is directly linked to HIV susceptibility and poorer HIV-related health outcomes for cisgender and trans women.[220] These realities make access to sexuality education and non-discriminatory and affordable health services a heightened priority for lawmakers, community members, and advocates.

Local revenue and inequitable disbursement of state funding for schools in lower income areas is directly linked with poorer quality of education[221] in general, which likely affects access to quality sexuality education and the sexual health of students in under-resourced schools specifically. Prevailing systemic realities that organize young people's worlds—such as racism, unstable housing, gender- and sexuality-based stigma and violence inside and outside the home, generational poverty, and difficulty accessing consistent physical and mental healthcare—are all social determinants of health that impact young people's ability to meaningfully access sexual and reproductive health information and resources. Sexuality education must reflect the lived experience of young people, and engage students with health information in a way that is non-judgmental, non-shaming, frank, and does not exacerbate existing conditions of discrimination, stigma, and violence.

Schools and school boards play a critical role in educating young people about sex and sexuality. On average, school aged children will spend approximately 1, 195 hours at school each year.[222] The sexual health information relayed to students in school sponsored sexuality education programs can significantly influence young people's ability to make autonomous, well-informed, and healthy decisions as they navigate sexuality, gender, and relationships. Denying access to relevant sexual and reproductive health information deprives young people of their fundamental human right to health and by compromising their ability to make informed choices about their sexual and reproductive lives.[223]

SEXUALITY EDUCATION MUST REFLECT THE LIVED EXPERIENCES OF YOUNG PEOPLE

The Impact of HIV and STIs on Youth and the Importance of Access to CSE

Nationally, the rate of new diagnosis among young people is on the rise—creating a heightened incentive to ensure that youth are provided access to CSE. At the end of 2012, an estimated 62,400 youth were living with HIV in the US. Of these, 32,000 were living with undiagnosed HIV.[224] In 2013, an estimated 47,165 people in the United States were diagnosed with HIV – and almost a quarter of these new HIV diagnoses were among adolescents and young adults. [225] Over 50% of youth living with HIV in the United States do not know they are positive.[226] PLHIV who do not know their status enter care later in the progression of the virus, which can seriously compromise health outcomes and can increase the likelihood of their sexual partners contracting HIV.

As with other populations disproportionately impacted by HIV, race-based disparities characterize HIV figures among youth. The national incidence rate for new HIV diagnoses in 2012 was ten times higher among Black youth when compared to whites.[227] In 2010, Black youth accounted for an estimated 57% of all new HIV infections among youth in the United States, followed by Hispanic/Latino youth

219 Wright, E. (2016) Atlanta Youth Count!: 2015 Atlanta Youth Count and Needs Assessment. Available at: http://issuu.com/gavoice/docs/aycna_final_report_may_2016_final/3?e=3167111/35350541.
220 Machtinger, E.L., Wilson, T.C., Haberer, J.E. and Weiss, D.S. (2012) 'Psychological trauma and PTSD in HIV-Positive women: A Meta-Analysis', AIDS and Behavior, 16(8), pp. 2091–2100. doi: 10.1007/s10461-011-0127-4.
221 Baker, B, Corcoran, S. (2012) The Stealth Inequities of School Funding: How State and Local School Finance Systems Perpetuate Inequitable Student Spending," (2012) Available at: https://cdn.americanprogress.org/wp-content/uploads/2012/09/StealthInequities.pdf.
222 National Center for Education Statistics (2007) School and Staffing Survey. Available at: https://nces.ed.gov/surveys/sass/tables/sass0708_035_s1s.asp (indicating that the national average for a school year consists of 180 days, made up of 6.64 hours per day).
223 Sexual Health, Human Rights, and the Law (2015) Available at: http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf (stating that human rights standards require States to ensure information regarding sexual health is placed in the public domain and is accessible. States must also refrain from "censoring, withholding or intentionally misrepresenting health-related information, including sexuality education.").
224 Burda, J. (2016) 'PrEP and Our Youth: Implications for Law and Policy', University of Massachusetts School of Law. Available at: http://scholarship.law.umassd.edu/cgi/viewcontent.cgi?article=1139&context=fac_pubs.
US Centers for Disease Control and Prevention (2016) HIV Among Youth. Available at: http://www.cdc.gov/hiv/group/age/youth/.
225 Ibid.
226 Ibid.
227 Ibid.

(20%) and white youth (20%).[228] In the same year, gay and bisexual youth accounted for an estimated 19% of all new HIV cases in the US and made up 72% of new HIV infections among youth as a whole.[229] In Atlanta, young Black gay men who are at least 18 years of age and sexually active have a 60% chance of contracting HIV by the age of 30.[230] With an HIV prevalence rate of 12.1%, this is the only population for which HIV rates are actually increasing.[231]

Nationally, the number of adolescents newly diagnosed with an STI is also on the rise. Youth between 15-24 years of age account for half of the 20 million new sexually transmitted infections that occur in the United States each year. One in four sexually active adolescent young cisgender women have an STI[232] and face the additional concern of long term health consequences of comorbidity conditions such as cervical cancer and infertility.[233] STI rates for Georgia are appreciably higher than national averages. Georgia ranks first in primary and secondary syphilis[234] and ninth in chlamydial infections among all 50 states.[235] Our chlamydia and gonorrhea rates create serious implications for further sexual and reproductive health concerns, as both can lead to pelvic inflammatory disease, infertility, chronic pelvic pain, increased HIV transmission risk, and cancer. Fulton, DeKalb, Cobb, Gwinnett, and Clayton Counties have the highest *number* of reported cases of STIs among adolescents and young adults between 10-24 years of age. However, rural counties such as Terrell, Hancock, Bibb, Dougherty, and Early, with significantly smaller populations, have higher reportable *rates* of new cases compared to densely populated counties in Georgia.[236]

Access for Youth Who Choose to Parent and Youth Who Choose Not to Parent

The provision of evidence-based sexual and reproductive health education and resources can increase the agency of young people by equipping them with information on the full range of sexual and reproductive health options available to them, including the use of contraceptives, access to abortion, knowledge about prevention tools, methods to negotiate safer sex, and waiting to have sex. Youth need frank discussions and scientifically accurate information in order to take control of their health in terms of sex, sexuality, pregnancy, and whether or not they wish to parent.

The US has among the highest rates of teen pregnancy, teen births, and abortion among industrialized countries.[237] In 2014, the national average teen birth rate was 24.2 births for every 1,000 adolescent females ages 15-19.[238] Almost two-thirds of those births occurred in 18 to 19-year-olds.[239] Southern states tend to have higher teen birth rates in comparison with the rest of the country.[240] For example, the Georgia teen birth rate for 2014 was 28.4 births per 1,000 teen girls (age 15-19).[241] Stark racial and ethnic disparities in birth rates also exist in Georgia. The teen birth rate was 42 per 1,000, 34 per 1,000, 22 per 1,000 and 16 per, 1000 for Hispanic/Latina, Black, White, and American Indian teens respectively.[242] At the county level, the highest pregnancy rates are in predominately rural counties with small populations (Terrell, Chattahoochee, Hancock, Stewart and Emanuel County). The highest number of reported cases occurred in highly populated areas (Fulton, DeKalb, Gwinnett, Cobb and Clayton Counties).[243] In 2010, public spending on teen childbearing in Georgia totaled $395 million.

228 Ibid.
229 Ibid.
230 Cairns, G. (2014) HIV incidence at record high in young gay black men in Southern USA. Available at: http://www.aidsmap.com/HIV-incidence-at-record-high-in-young-gay-black-men-in-southern-USA/page/2833285/ (based on research findings by Emory University presented at the 2014 Conference on Retroviruses and Opportunistic Infections).
231 Ibid.
232 US Centers for Disease Control and Prevention (2015) STDs in adolescents and young adults. Available at: http://www.cdc.gov/std/stats14/adol.htm; US Centers for Disease Control and Prevention (2015) Reportable STDs in young people 15-24 years of age, by state. Available at: http://www.cdc.gov/std/stats/by-age/15-24-all-stds/default.htm (stating that in 2012, gonorrhea rates in women were highest among those aged 15–24 years with the highest rate being in women 19 years of age (761 cases per 100,000 population)).
233 Georgia Department of Public Health, Office of Health Indicators For Planning OASIS (2003) Available at: https://oasis.state.ga.us/oasis/oasis/qryMorbMort.aspx.
234 Georgia Department of Public Health (2016) STD Data Summary 2009-2013. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/MCH/STD/data_summary_2009_2013.pdf.
235 HHS/CDC/OID/NCHHSTP (2015) Georgia 2015 State Health Profile. Available at: http://www.cdc.gov/nchhstp/stateprofiles/pdf/georgia_profile.pdf.
236 HHS/CDC/NCHHSTP (2014) STDs in the United States 2013 National Data for Chlamydia, Gonorrhea, and Syphilis. Available at: http://www.cdc.gov/std/stats13/std-trends-508.pdf.
237 Teen Childbearing in the United States, Preliminary 2012 Birth Data (2013). The National Campaign to Prevent Teen and Unplanned Pregnancy.
238 Hamilton, B. et al., Births: Final Data for 2014 (Hamilton, B. E., Martin, J. A., Osterman, M. J. K., & Curtin, S. C. (2015). Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12.pdf.
239 Ibid.
240 Kost, K. and Henshaw, S. (2014) U.S. Teenage Prengancies, births and abortions, 2010: National and state trends by age, race and ethnicity. Available at: https://www.guttmacher.org/sites/default/files/report_pdf/ustptrends10.pdf.
241 Teen Childbearing in the United States, Preliminary 2012 Birth Data (2013) The National Campaign to Prevent Teen and Unplanned Pregnancy.
242 Teen Births By Race and Ethnicity (2016) Available at: http://datacenter.kidscount.org/data/tables/3-teen-births-by-race-andethnicity?loc=12&loct=2#detailed/2/12/false/869,36,868,867,133/10,11,9,12,1,13/250,249. KIDS COUNT Data Center.
243 Georgia Department of Public Health, Office of Health Indicators for Planning OASIS, 2013 Pregnancies & Pregnancy Rate, 10-24 Years of Age by

Rather than shaming young people for their sexual and reproductive choices and circumstances, it is critical that we increase optimal access to sexual and reproductive health information for young people who have sex and choose to parent, and for young people who have sex and choose not to parent. **Ultimately, it is the decision of every human being to decide whether, when, and how they wish to have sex and reproduce. Just as all people deserve the right to evidence-based information on HIV and STIs, the right to information about reproduction is an integral aspect of self-determination that should not be precluded merely based on age.** Instead, it is incumbent upon governments, schools, families, neighborhoods, communities, and civil society organizations to ensure that young people have access to the resources and information they need to make their own decisions.

COMMONSENSE POLICY SHIFTS IN GEORGIA SCHOOLS

Medical and public health authorities—such as the American Academy of Pediatrics and American Public Health Association—have emphasized that youth need accurate and comprehensive sexual education to prepare them to make responsible decisions on their own.[244] In addition, a majority of parents in the US support teaching CSE in schools. Data show that CSE programs can empower young people to make healthy sexual choices.[245] Youth who receive CSE as opposed to abstinence-only curricula are 50% less likely to have an unintended pregnancy.[246] Given the fact that school-aged children in the United States spend approximately 1,195 hours at school each year, exposure to quality sexual health information in school-sponsored programs can increase young people's ability to make autonomous and well-informed decisions about their bodies and relationships.[247]

Weighing the Merits of CSE Versus Abstinence Education

Evidence suggests that CSE programs can include lessons on abstinence while *also* providing age-appropriate and *complete* information about how to prevent STIs and use contraceptives effectively.[248] Sex education programs should provide skills-building information and information about bodily development, sexuality, gender, and relationships.[249] Providing such information can help youth understand their development, communicate effectively and make informed choices.[250] Information in sex education courses should include information about puberty and reproduction, abstinence, contraception and condoms, healthy and safe relationships, sexual violence prevention, body image, gender identity and sexual orientation.[251] The environment in which these topics are taught is also extremely important. **Instead of shaming students, sex education "should treat sexual development as a normal, natural part of human development."**[252] In this way, teachers can have open, informative, and meaningful discussions with students in a classroom setting.

It is important that young people are equipped with the information and tools necessary to make healthy sexual decisions *before and during* the time they are exploring sexuality, gender, and relationships. This is particularly vital in the context of the HIV epidemic, considering the majority of HIV transmissions in the United States occur through sex without condoms or PrEP.[253] Because many young people are engaging in sex by age 16, it is logical to provide comprehensive sex education in an age-appropriate manner throughout a student's primary and secondary education to ensure that necessary information is available at the relevant stages in a young person's life.[254]

In contrast, data has shown that abstinence-only programs do not result in delays in the first sexual encounter among youth, nor do they result in young people making healthier sexual choices.[255] In addition, data suggests that abstinence-only education presents potential harms, such as deterring sexually active youth from using contraceptives.[256] A study on sex education laws using the most recent national data showed that an increased emphasis on abstinence education correlates with *increased* teenage pregnancy

Residence (2003) Available at: https://oasis.state.ga.us/oasis/oasis/qryMCH.aspx

244 Sexuality Information and Education Council of the United States (2009) What the Research Says-Comprehensive Sex Education (2009) Available at: http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1193.

245 Ibid.

246 Kohler, P.K., Manhart, L.E. and Lafferty, W.E. (2008) Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. Available at: https://www.ncbi.nlm.nih.gov/pubmed/18346659.

247 School and Staffing Survey. Available at: https://nces.ed.gov/surveys/sass/tables/sass0708_035_s1s.asp.

248 Sexuality Information and Education Council of the United States (2009) What the Research Says-Comprehensive Sex Education (2009) Available at: http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1193.

249 Advocates for Youth. Sexuality Education. Available at: http://www.advocatesforyouth.org/publications/publications-a-z/2390-sexuality-education.

250 Ibid.

251 Ibid.

252 Ibid.

253 HIV Transmission and Risks (2016) Available at: https://www.poz.com/basics/hiv-basics/hiv-transmission-risks#Sexual%20Transmission

254 Kann, L., et al. (2013) 'Youth Risk Behavior Surveillance — United States', Morbidity and Mortality Wkly. Rep, 63, pp. 1–168.

255 Advocates for Youth. Comprehensive Sex Education Research and Results. Available at: http://www.advocatesforyouth.org/publications/1487.

256 Advocates for Youth. The Truth About Abstinence-Only Programs, Available at: http://www.advocatesforyouth.org/publications/publications-a-z/409-the-truth-about-abstinence-only-programs.

and birth rates.[257] Conversely, the study showed that states using comprehensive sex and/or HIV education programs had the lowest teen pregnancy rates. These programs covered both abstinence and contraceptive use.[258]

Georgia's Sex Education Law as a Double-Edged Sword

In 1988, during a time of fear-based stigma associated with the relatively new HIV and AIDS epidemic, Georgia enacted a law placing a broad mandate on its public-school system to provide students with sex education.[259] **Unfortunately, Georgia's law excludes any requirement that the information provided to students be scientifically accurate or comprehensive.** Rather, the law requires each local board of education to prescribe its own specific course of study[260], so long as the curriculum includes the merits of "abstinence from sexual activity as an effective method of prevention of pregnancy, sexually transmitted diseases, and acquired immune deficiency syndrome."[261] The curriculum must also include

DEKALB COUNTY SCHOOLS USE A CSE CURRICULUM DESIGNED TO SUPPORT STUDENTS

"instruction relating to the handling of peer pressure, the promotion of high self-esteem, local community values, [and] the legal consequences of parenthood."[262] Essentially, the law requires board-sanctioned curriculum to praise abstinence and instill "community values," but fails to require the curriculum to be scientifically accurate. Apparently, evidence-based information was not a community value identified by the 1988 state legislature.

Because of this legal framework, the content of curriculum is left to the wide discretion of school boards, equating to an enormous amount of power over the messages students receive about sex and HIV. **The law specifically authorizes each local school board to develop a tailored approach with specific curriculum standards as the board "deems appropriate."[263] Thus, local school boards can permit any form of sex education – from comprehensive and scientifically accurate to abstinence-only and myth-based.** All would conform to the law, so long as the school board were to deem such curriculum appropriate. A secondary consequence is that the quality and quantity of sex education across the state can vary per the cultural perceptions and understanding of sexual and reproductive health of the members of each local school board. The law also provides a parent or guardian the option to remove their children from all or part of any sexuality and HIV education provided by sending a written notice to the school.[264]

Furthermore, while the law theoretically permits a discussion of prevention technologies (which could encompass information on condoms, contraceptives and PrEP), such discussions are not required. Unsurprisingly, only one-third of schools surveyed by the CDC in 2014 taught students how to use condoms.[265] Nearly all the schools surveyed by the CDC included the benefits of abstinence in their curriculum and reported teaching students about the transmission of STIs and HIV. However, as young members of SisterLove have pointed out based on their lived experiences, "teaching" about HIV and STIs can be as marginal as merely stating the words "HIV" or "gonorrhea" – for example – and explaining that one can contract these by having sex. Those schools that applied abstinence-only education and emphasized abstinence as a method of HIV, STI, and pregnancy prevention to the exclusion of other necessary tools for safer sex were comfortably in conformance with the law.

Georgia's law calls for local boards of education to establish a committee to periodically review sex and HIV education instructional materials.[266] The committee is encouraged, but not required, to include one "male" and one "female" student currently attending the eleventh or twelfth grade in the public school system.[267] Similarly, the law encourages, but does not require, that the remainder of the committee be comprised primarily of nonteaching parents who have children enrolled in the local public schools and who represent the diversity of the student body, augmented by others such as educators, health professionals, and other community representatives.[268] The committee is encouraged to make recommendations concerning age and grade level appropriateness of curriculum. Any recommendations made by the committee must be approved by the local board of education before they are

257 Stanger-Hall, K.F. and Hall, D.W. (2011) Abstinence-only education and teen pregnancy rates: why we need comprehensive sex education in the U.S. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22022362.
258 Ibid.
259 1988 was the same year in which the Georgia General Assembly passed its HIV-specific criminalization statute, making it a felony for a PLHIV who knows their status to engage in specific acts without disclosing their positive status. See O.C.G.A. 16-5-60.
260 O.C.G.A. § 20-2-143.
261 Ibid.
262 Ibid.
263 Ibid.
264 Ibid.
265 Eloy, M. (2015) CDC: Most Ga. Schools donuth.org/publications/publications-. Available at: http://news.wabe.org/post/cdc-most-ga-schools-dont-teach-recommended-sex-ed-topics
266 Ga. Board of Ed. Rule 160-4-2-.12.
267 Ibid.
268 Ibid.

implemented.[269] Consequently, the review committee is ultimately restricted by the local school board members' opinions regarding what constitutes "appropriate" sex education for its jurisdiction.

Even though many of Georgia's local school boards have chosen to implement narrow and conservative curricula thus far, the breadth Georgia's sex education law leaves much room for progressive change that could significantly improve the sexual and reproductive wellbeing of Georgia's youth, as there are no legal barriers prohibiting local boards of education from prescribing comprehensive sex education programs. And while an overhaul of the law mandating medically accurate CSE would be ideal, improving local level curriculum would be well worth the effort short of a legislative fix. In a time of high HIV and STI incidence among young people, heightened abortion restrictions, and inexcusable rates of maternal death – it is imperative that local policymakers and community leaders work towards empowering Georgia's young people with the comprehensive information necessary to make healthy and safe decisions on their own.

Georgia Performance Standards for Health Education

In 2002, the Georgia Department of Education established the *Georgia Performance Standards for Health Education* for grades K–12.[270] These standards may be used as a framework to be used by local schools as they create instruction programs addressing sex and HIV education. They are based on the eight National Health Education Standards developed by the Joint Committee on National Health Education Standards.[271] The health education standards recommend teaching eighth graders that abstinence is the "most effective and healthy means of preventing" STIs.[272]

The standards also recommend that information on sexual violence prevention be included in curriculum for youth in the ninth through twelfth grades. Specifically, the standards call for students to be empowered to utilize resources from their school and community that provide valid health information.[273] For example, per the standards, students should be able to access resources, such as rape crisis centers, that can provide accurate information about sexual assault and sexual violence. The standards also provide that students should be empowered to prevent, manage, or resolve conflicts by being able to identify the warning signs of unhealthy relationships. However, there is no formal mechanism monitoring whether schools are implementing the standards, and no data exists demonstrating the progress or effectiveness of the Georgia Performance Standards when applied.

Interpreting and Implementing "Sex Education" in Georgia Counties

In Georgia, many counties have chosen a strict abstinence-only program. Up until 2010, only programs that met a strict abstinence-only definition were eligible for federal funding.[274] The Obama administration's proposed budget for FY 2010 changed financial incentives by removing the rigid abstinence-only requirement, and expanded streams for sex education programs that have been proven to reduce teen pregnancy, delay sexual activity, or increase contraceptive use.[275] Under this framework, funding recipients may still decide to provide abstinence-only curriculum, without precluding other funding recipients from implementing comprehensive sex education programs in their jurisdictions. President Obama's proposed budget for FY2017 maintains the funding for comprehensive sex education programs.[276] The budget also removes the funding for abstinence-only-until-marriage programs.[277]

As a result, some Georgia counties have begun to adopt more comprehensive sex education curricula. **DeKalb County Schools, for example, uses an age-appropriate, comprehensive sexual education curriculum that is designed to "support students to make healthy decisions: abstain from sex, use protection when they do have sex, seek healthcare when they need it, communicate effectively with their families, and respect others' decisions not to have sex."[278]**

Approximately half of Georgia school systems, however, still use the "Choosing the Best" sex education curriculum.[279] This

269 Ibid.
270 Georgia Performance Standards for Health Education (2009) Available at: https://www.georgiastandards.org/standards/GPS%20Support%20Docs/Health_Education_2-11-2010.pdf
271 Georgia Department of Education. Health Education (2015) Available at: https://www.georgiastandards.org/standards/pages/browsestandards/healthed.aspx (The Committee consisted of representatives from the American Association for Health Education, American School Health Association, American Public Health Association, and the Society of State Directors of Health, Physical Education, and Recreation and sponsored by the American Cancer Society.).
272 Ibid.
273 Georgia Performance Standards: Health Education (2009) Available at: https://www.georgiastandards.org/Standards/Georgia%20Performance%20Standards/9-12_Health_Education.pdf.
274 Advocates for Youth. Comprehensive Sex Education Research and Results. Available at: http://www.advocatesforyouth.org/publications/1487.
275 Ibid.
276 Advocates for Youth. President's Budget Supports Key Sexual Health Issues. Available at: http://www.advocatesforyouth.org/blogs-main/advocates-blog/2561-presidents-budget-supports-key-sexual-health-issues.
277 Ibid.
278 Downey, M. (2015) Sex education in Georgia: Failing the grade and students. Available at: http://getschooled.blog.myajc.com/2015/12/19/sex-education-in-georgia-failing-the-grade-and-students/.
279 Ibid.

program does not teach students about the evidence-based benefits of using condoms or how to use condoms correctly. Rather, the curriculum only imparts information about the risks associated with condom use. For example, Bartow County uses the program, which specifically bans educators from disseminating information to students about where they can obtain condoms and family planning counseling and services.

Fulton County adopted its abstinence-based "Choosing the Best" program in 2001.[280] The program covers contraception, but does not advocate the use of contraceptives nor demonstrate how to use them.[281] The program focuses primarily on the reasons why a student should choose not to have sex. The "Choosing the Best" programs provide sex and relationship education content in a number of areas, including: risk, risk reduction versus risk elimination (including a discussion of abstinence as the healthiest choice), rewards, relationship education, (including a discussion about preventing sexual abuse and date rape and the dangers of "sexting"), the dangers of mixing alcohol and sex, refusal skills, freedom pledges (a commitment to delay sexual initiation), character development, parent involvement, and building self-esteem.[282] **"Choosing the Best" programs are not open to discussions about the general concerns and questions raised by youth participating in the program.**[283] The Leader's Guide Teaching instruction manual for the Choosing the Best program explicitly instructs teachers not to meaningfully address student questions whose subject matter is not contained in the curriculum. The guide states to educators: "In these situations, please refer students to a school counselor or nurse, per your district guidelines."[284]

In 2015, Fulton County voted to maintain its abstinence-based curriculum[285],despite Fulton County's status as the epicenter of the HIV epidemic and the evidence that CSE can help prevent HIV transmission. The decision was met with opposition from several sexual and reproductive health, rights, and justice groups, including Georgia Equality, Feminist Women's Health Center, Planned Parenthood Southeast, and opposition from some parents in Fulton County.

The Ongoing Struggle to Pass Legislation in Georgia's House and Senate

The unsuccessful "Prevention First" Act was introduced in Georgia in March 2007 and was intended to help reduce unintended pregnancies, prevent the spread of STIs, and support healthy families by improving women's health.[286] If it had passed, the law would have expanded access to preventative healthcare services and education programs by implementing comprehensive, medically accurate sex education programs.[287] Specifically, the resolution urged Congress to require that federally-funded sex education programs provide information on the use of contraceptives to ensure that the information is medically accurate and includes health benefits and failure rates.[288] As a result, all state programs receiving federal funding would have had to teach about not only abstinence, but also contraception in a medically accurate way.[289] The resolution progressed to the Senate Committee on Health and Human Services in March 2007, but failed to move out of committee and eventually died without being passed into law.[290]

How Georgia's Sex Education Record Compares to Other States

Only 22 states and the District of Columbia require that public schools teach sex education.[291] *Only 19 states require that sex education, where provided, must be "medically, factually, or technically accurate."*[292] Georgia does not require medical accuracy in sex education. The definition of "medically accurate" varies from state to state, but often includes criteria such as requiring information to be "verified or supported by the weight of research conducted in compliance with accepted scientific methods and published in peer-reviewed journals, if applicable, or comprising information recognized as accurate, objective, and complete."[293] In 2004, the US House of Representative's Committee on Government Reform found that **80% of the most popular and federally funded abstinence-only programs contained incorrect or misleading educational**

280 Fulton County Department of Health and Wellness High Impact Prevention Program: Jurisdictional HIV Prevention Plan, November 14, 2012-December 31, 2016 (2012).
281 Ibid.
282 Choosing the Best, Frequently Asked Questions. Available at: http://www.choosingthebest.com/faq#questionA6.
283 Ibid.
284 Ibid.
285 WSB-TV, Health Advocates Upset by Update to Fulton County Sex-Ed. (2015) Available at: http://www.wsbtv.com/news/local/health-advocates-upset-update-fulton-county-sex-ed/27043803.
286 Sexuality Information and Education Council of the United States (2007) Georgia State Profile Fiscal Year 2007. Available at: http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1111.
287 Ibid.
288 Georgia Senate Resolution 388 (2011) Available at: http://www.legis.ga.gov/Legislation/20072008/70427.pdf.
289 Sexuality Information and Education Council of the United States, Georgia State Profile Fiscal Year 2007 (2007) Available at: http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1111.
290 Ibid.
291 Guttmacher Institute (2016) Sex and HIV education. Available at: http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf.
292 Ibid.
293 Blackman, K., Scotti, S. and Heller, E. (2016) State Policies on Sex Education in Schools. Available at: http://www.ncsl.org/research/health/state-policies-on-sex-education-in-schools.aspx.

materials and information.[294] This misleading information included scientific errors, incorrect information about the accuracy of contraceptives and their use, misrepresentations about the risks of having an abortion, inclusion of religious content when material covered was supposedly scientifically based, and the promotion of stereotypical binary gender roles.[295]

Georgia's Resource-Based Barriers to Providing CSE

Well-informed teachers and access to resources are fundamental to providing effective sex education to youth. Health and physical education teachers are often tasked with providing sex education to students and are not always specifically trained in sex education.[296] A 2006 Georgia School Health Profile indicated **that more than 60% of health instructors desired more professional education in human sexuality.**[297] These instructors may lack training on the legal, ethical, and classroom management concerns that will likely arise in discussions about sex and other intimate topics. This reality is not dissimilar from the national picture, as only 61% of colleges and universities require sex education courses for health education certification, and **close to one-third of sex education teachers report having had no additional training in the subject prior to providing instruction to youth.**[298] As Debra Hauser, executive director of Advocates for Youth explains, when a teacher is uncomfortable or not prepared to teach sex education, "that sends a message almost as strong as giving the wrong information."[299]

Educators also need quality curriculum to effectively provide students with information on the complicated and personal topics involved in sex education. Most school districts often fail to design an effective curriculum, and many rely on the inadequate information contained relayed through integrated Health and Physical Education. Georgia's one commonly used health textbook for Health and Physical Education classes has been edited over the past ten years in such a way that the sexuality education content is now practically non-existent.

Access to Sex Education for Georgia's Youth Outside of the Public School System

It is crucial to recognize that public schools are not the only venue for providing CSE, and that a singular focus on Georgia's public school system would exclude the many youth not currently attending school. For several reasons – including poverty, unstable housing, under-resourced schools, poor quality of education, stigma, violence, and displacement based on sexuality and gender identity[300], unintended pregnancies, and encounters with the juvenile court system – not all youth are interested in or able to prioritize consistently attending school and participating in sex education programs. In the 2010-2011 school year, the dropout rate in Georgia for students in the ninth through twelfth grades was 3.7%.[301]

Some counties in Georgia have innovated community-based initiatives that offer more comprehensive and frank sex education, operating without the content-based regulatory constraints placed on public schools. For example, the Columbus Wellness Center Outreach and Prevention Project, Inc. is a community resource that serves youth. Located in Columbus, Georgia, the center provides family planning, birth control, and HIV prevention services to residents.[302] The center implemented the "Becoming a Responsible Teen" program, which is an "evidence-based HIV/AIDS-prevention education curriculum."[303] The program is designed for Black youth between the ages of 14 and 18 and serves young people from 13 to 19 in three Georgia counties, reaching approximately 90 youth annually. This program consists of eight 1.5 to 2 hour sessions. The sessions include interactive group discussions, including role play created by teens. Throughout the sessions, teens learn to convey what they have learned about the risks of HIV to their friends. The curriculum consists of not only HIV prevention tools, but also topics that are relevant to teen pregnancy. Specifically, the program teaches youth to "clarify their own values about sexual decisions and pressures as well as practice skills to

294 Planned Parenthood (2015) Fighting for Real Sex Ed - Planned Parenthood Illinois Action. Available at: http://www.plannedparenthoodactionillinois.org/issues/sex_ed_issues.php.
295 Ibid.
296 Georgia Department of Public Health (2014) Georgia Middle and High School Health Education Data Summary: HIV/STD Prevention. Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/2014_HIVSTD_Prevention_Education_DataSummary_final.pdf.
297 School Health Profiles Report Georgia School Health Profiles Report School Health Profiles Report School Health Profiles Report (2007) Available at: https://dph.georgia.gov/sites/dph.georgia.gov/files/2006_School_Health_Profiles_FINAL.pdf.
298 Blad, E. (2016) New Teacher-Preparation Standards Focus on Sex Education. Available at: http://www.edweek.org/ew/articles/2014/05/07/30sexed.h33.html.
299 Ibid.
300 Wright, E. (2016, May). 2015 Atlanta homeless youth count! : 2015 Atlanta Youth Count and Needs Assessment. Available at: https://issuu.com/gavoice/docs/aycna_final_report_may_2016_final/3?e=3167111/35350541(May (finding that among homeless youth (who had been homeless for one month in metro Atlanta): over one-quarter identified as LGBT, 6.5% identify as trans, over half of homeless trans youth survived sexual violence, and 93.1% of homeless trans youth traded sex for money).
301 Clayton County Board of Education. Clayton Can Soar to the Top. Available at: http://www.claytoncountypublichealth.org/media/23597-CCST_Program_Inserts_05062013.pdf.
302 Resource Center For Adolescent Pregnancy Prevention, Evidence-Based Programs: Becoming A Responsible Teen (BART), Available at: http://recapp.etr.org/recapp/index.cfm?fuseaction=pages.ebpDetail&PageID=2.
303 Ibid.

reduce sexual risk-taking."[304] Among the topics discussed are how to use a condom correctly, how to use assertive communication, effective refusal techniques, self-management, and problem solving. Abstinence is also a topic that is included in the curriculum and is discussed as the "best way to prevent HIV infection and pregnancy."[305]

Progressive parents, guardians, and other caregivers who support greater access to medically accurate sex education for young people are another largely untapped resource that can help to generate a sea change in the approach to young people's ability to receive sexual and reproductive health information, at schools, in homes, and in other community institutions. Advocates and other proponents of CSE should initiate discussions with parents to gauge the potential for them to take a more active role in advocating for CSE in schools and for incorporating CSE information and principles in age-appropriate discussions **in the home and other community spaces, such as places of worship and community organizations.** Overall, studies have shown that parents are supportive of CSE in schools and that parental involvement in advocacy can help to influence improvements in access to sex education.[306] However, such initiatives should be undertaken with the caveat that not all parents, caregivers, and youth may be supportive of the involvement of authority figures, and that not all parents' and caregivers' views align with CSE best practices. Ultimately, any involvement of parents and caregivers should not compromise the integrity of medically accurate information, interfere with students' feelings of safety, or make them feel judged, shamed, silenced, or discriminated against in any way.

PARENTS, GUARDIANS, AND CAREGIVERS ARE AN UNTAPPED RESOURCE THAT CAN HELP GENERATE A SEA CHANGE IN SEXUALITY EDUCATION

One program successfully used with parents, caregivers, and youth in Oakland, California, involved an approach that integrated the resources of a Reproductive Justice organization – Asian Communities for Reproductive Justice (ACRJ) – with the unique role of parents to engage in discussions about sexuality education with their own children, and mobilize other parents around the importance of sexuality education, and to advocate for access to sexuality education in their children's schools.[307] Based on studies showing that an overwhelming majority of parents and caregivers in their communities supported access to sexuality education, ACRJ created a toolkit that could support safe, culturally-competent spaces for parents and caregivers to become more knowledgeable about how to engage in discussions on these subjects with their children, other parents, and school officials.

Clinicians and providers of community based social and health services – such as case managers and community health educators – also have a role in ensuring that sexuality education is widely accessible, non-shaming, and culturally competent. The American Academy of Pediatrics (AAP) – which supports CSE and rejects abstinence-only education as ineffective – released a report in July 2016 recommending pediatricians to incorporate sexuality education during progressive conversations with patients.[308] The AAP recommended the inclusion of medically accurate, age appropriate, and developmentally appropriate information that gives a comprehensive picture of sexual and reproductive health to young people, inclusive of gender identity, diverse sexualities, sexual health, body image, and healthy relationships. In addition to providers, the report emphasized the significant role of schools, households, churches, and other community entities in shoring up sexuality education access gaps.

It is incumbent upon school officials, state and local policymakers, clinicians, service providers, parents and caregivers, and community institutions and organizations to hold themselves accountable to the needs of their young people. This interconnected interpersonal and institutional web constitutes many of the overlapping sources from which young people could gain meaningful access to critical health information that has a significant impact on shaping their futures. Thus, these entities and individuals should continue to strategize and innovate methods to reach youth where they are and to provide the information they need to take control of their health. The significant barriers to implementing CSE in public schools should incentivize non-school based community entities and other individuals to take up this call with even more urgency.

304 Ibid.
305 Ibid.
306 Huberman, B., Advocates for Youth, Parents as Advocates for Comprehensive Sex Education in Schools. Available at: http://www.advocatesforyouth.org/storage/advfy/documents/advocate.pdf.
307 Asian Communities for Reproductive Justice, Transforming API Communities: Tools for Sexuality Education. Available at: http://strongfamiliesmovement.org/assets/docs/ACRJ-Transforming-API-Communities.pdf.
308 Brenner,C., et al., American Academy of Pediatrics, Sexuality Education for Children and Adolescents. Available at: http://pediatrics.aappublications.org/content/pediatrics/early/2016/07/14/peds.2016-1348.full.pdf.

ADVOCACY RECOMMENDATIONS

The multiple sexual health crises facing youth in Georgia require urgent action by the state and various community stakeholders. Withholding access to critical sexual and reproductive health information is a direct form of oppression that denies young people's human rights to physical and mental health, self-determination, and bodily autonomy. Young people's access to uniform and effective models of comprehensive sex education is a core issue Reproductive Justice.

Reform the Legal Framework Governing Sex Education and Improve Local Curriculum

The discretion afforded to local school officials under Georgia law in the interpretation and implementation of sexuality education programs must be reined in so that educators are required to provide a baseline of medically accurate sexual and reproductive health information to students.[309] The broad deference currently afforded to local school boards has resulted in inconsistencies in the quality and content of sexuality education in Georgia, which varies among and within school districts.[310] It has been well established that CSE programs afford youth the information they need to make informed decisions related to health, including STIs and pregnancy.[311]

For these reasons, **Georgia's current sex education law should be modernized and mandate to require that all school boards to implement medically accurate CSE standards that are relevant to the realities that youth face in Georgia.** Sexuality education curriculum should be sequential, administered throughout elementary, middle, and high school, and provide age-appropriate curriculum addressing the physical, mental, emotional, and social dimensions of human sexuality. Curriculum should be medically accurate and reflect the best medical and scientific understanding of human sexuality. Furthermore, the law should be amended to require, rather than merely encourage, the inclusion of young people and a diversity of parents to serve on review committees tasked with reviewing sexuality education curriculum used in schools prior to such a legislative overhaul, local boards must work to diversify committees and monitor the efficacy of current curricula.

Ensure Adequate Resources for Community-Wide CSE Availability

In addition to modernizing the legal framework governing the content requirements for curriculum, our legislature must also allocate funding adequate to ensure that youth are provided with the information *and* resources necessary to live in their power by protecting their health, engaging in healthy explorations and expressions of identity, utilizing tools to foster safe and affirming relationships, and ensuring youth are knowledgeable about how to access preventive services, and appropriate and affordable care when necessary. Adequate funding and resources are needed to ensure that programs provide students with quality instructional materials and well trained, culturally competent, and non-shaming teachers. Sex education instructors should receive legal, ethical, and classroom management training to be adequately prepared to engage with students. **Moreover, increased access to sexual and reproductive health education should be coupled with commonsense sexual health resources—such as opt out routine HIV and STI testing in schools (which can help to maximize the number of youth who are aware of their health status) and flexible leave policies for young people who choose to parent while still in school.**

Funding must be allocated for community based programs operating outside of schools, for youth services, and for parents, caregivers, service providers, advocates and other proponents of CSE to initiate trainings and discussions with other providers, parents, caregivers, and community members. Overall, national and state based studies have shown that parents and caregivers are supportive of CSE in schools and that parental involvement in advocacy can help to influence improvements in access to sex education.[312] Initiatives involving parents, caregivers, and other authority figures should take potential power imbalances between adults and youth into account, and implement safeguards so that students' feelings of safety and ownership over advocacy are not compromised.

Access to medically accurate sexual health education has the potential to serve as a primary tool to improve Georgia's sexual and reproductive health record. Investing in CSE and better access to sexual and reproductive health services is an investment in the collective future of all Georgians, and especially those most severely impacted by sexual and reproductive health disparities.

309 See O.C.G.A. § 20-2-143.
310 Downey, M. (2015) Sex education in Georgia: Failing the grade and students. Available at: http://getschooled.blog.myajc.com/2015/12/19/sex-education-in-georgia-failing-the-grade-and-students/.
311 Stanger-Hall, K.F. and Hall, D.W. (2011) Abstinence-only education and teen pregnancy rates: why we need comprehensive sex education in the U.S. Available at: https://www.ncbi.nlm.nih.gov/pubmed/22022362.
312 Huberman, B., Advocates for Youth, Parents as Advocates for Comprehensive Sex Education in Schools. Available at: http://www.advocatesforyouth.org/storage/advfy/documents/advocate.pdf.

RESTRICTION OF SEXUAL AUTONOMY AND THE CRIMINALIZATION OF HIV

BACKGROUND

The criminalization of people based on their HIV status is a form of state-sanctioned sexual regulation and control. It interferes with the self-determination of individuals, exploits pre-existing conditions of socioeconomic and political inequity, and disrupts the health and stability of individuals, families, and communities. Criminalization and regulation of sexuality impacts people's everyday lives by restricting the ability to fully express one's sexuality due to fear of HIV stigma and prosecution, and by erecting barriers to taking full control of one's health and relationships in healthy, safe, and supported ways. Criminalization disproportionately affects people of color, LGBQ, and GNC people. HIV-specific criminalization mirrors this dynamic.

Despite our advances in treatment, prevention, and HIV science – HIV-specific criminalization laws persist and continue to be seen by many as an appropriate measure to use against PLHIV. This is due in part to deeply entrenched stigma about HIV, stereotypical characterizations of PLHIV, and a failure of our public and private institutions to convey accurate, evidence-based information about HIV transmission, treatment, and prevention that could chip away at the damaging myth that HIV is a death sentence. Science is on the side of HIV decriminalization advocates, yet continued ignorance about HIV science and deep stigma associated with the sexuality and sexual behavior of PLHIV creates a formidable barrier to change. As noted by one HIV advocate: "Despite the description…by legislators and prosecutors, in fact, it is not intentional transmission but intentional sex while HIV-positive that is the focus of these state laws."[313] This section will focus on the law, policy, and cultural factors at play in the ongoing battle to end HIV criminalization in the US, in the specific context of criminalization for non-disclosure and HIV "exposure" and transmission through sex.

HIV-specific criminal laws single out and punish PLHIV for non-disclosure of HIV status, HIV exposure, HIV transmission, or some combination of these acts. Currently, over 30 US states and 2 US territories (i.e. the US Virgin Islands and Guam) have such laws.[314] In addition to HIV criminalization laws, PLHIV have been prosecuted under generally applicable criminal laws for perceived "exposure" and transmission, such as aggravated assault, terroristic threats, reckless endangerment, and attempted murder. These laws are discriminatory, outdated, and do not align with HIV science – often criminalizing behaviors that pose little to no risk of transmitting HIV and prohibiting defendants from demonstrating the efficacy of risk reduction measures taken. **In many states, including Georgia, PLHIV can be prosecuted even if they had no intent to harm and caused no actual harm.**

Many of these state laws were enacted in the late 1980s and early 1990s before antiretroviral therapy existed, scientific knowledge regarding HIV transmission routes, prevention, and treatment was in its incipient stages, fear-based misinformation about the virus proliferated, and homophobia and transphobia were widespread. Concerned with driving down transmissions in this public health environment, the Presidential Commission on the Human Immunodeficiency Virus Epidemic – created under the Reagan Administration in 1987 – encouraged state governments to enact HIV-specific statutes to criminalize "socially unacceptable standards of behavior specific to the HIV epidemic and tailor punishment to the specific crime of HIV transmission."[315] The commission recommended that states utilize public health methods for reducing transmissions, and identified criminalization as an appropriate method to employ if other civil methods failed to drive down transmissions. The commission did acknowledge that spending excessive state resources on criminalization could take important funds away from public health efforts, and that HIV-specific

313 Hanssens, C., High Income Countries Dialogue (16-17 September 2011) (quoted in Global Commission on HIV and the Law report: Risks, Rights & Health (2012). Available at: http://www.hivlawcommission.org/resources/report/FinalReport-Risks,Rights&Health-EN.pdf.

314 Center for HIV Law and Policy, Positive Justice Project (2015) Ending & Defending Against HIV Criminalization: A Manual for Advocates, Vol. 1. Available at: http://www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/HIV%20Crim%20Manual%20%28updated%205.4.15%29.pdf.

315 Newman, S.J., (2013) ainst HIV Criminalization: A Manual for Advocates, Vol. 1th-EN.pdfealth-EN.pdf" IV and the LAvailable at: http://www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/PREVENTION%20NOT%20PREJUDICE%20THE%20ROLE%20OF%20FEDERAL%20GUIDELINES%20IN%20HIV-CRIMINALIZATION%20R.pdf. See also, Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic (1988). Available at: http://ia700402.us.archive.org/14/items/reportofpresiden00pres/reportofpresident00pres.pdf.

criminalization could drive people away from getting tested. It also encouraged states to make such laws applicable only to those who were aware of their status, failed to disclose and obtain their partner's consent, and engaged in behavior that could likely result in transmission.

Following in this policy direction, the Ryan White Comprehensive AIDS Resources Emergency Act was authorized in 1990, containing a requirement that state recipients of federal funding demonstrate that their state criminal laws were adequate to prosecute PLHIV for exposing others to HIV.[316] This requirement remained intact until the Act was reauthorized a decade later in 2000. Conditioning funding on such a requirement led to a proliferation of state HIV criminalization laws in the 1990s. States that did not pass HIV-specific criminal statutes were required to prove that other general criminal provisions (under existing state law) would be sufficient to prosecute individuals for HIV exposure, transmission, and non-disclosure.

HIV CRIMINAL LAWS SHOULD BE REFORMED TO ELIMINATE ALL DISCRIMINATION AGAINST PLHIV

Fortunately, in recent years there has been a growing progressive effort to overhaul the criminalization of HIV. **The Department of Justice and Centers for Disease Control have spoken with one voice on this issue, recommending all states to re-examine their HIV-specific criminal laws and reform them to reflect HIV science around transmission routes and risk, and to remove provisions that discriminate against PLHIV.**[317] The US Department of Justice also released best practices to guide states in the process of reform, urging states to repeal HIV-specific criminal laws in all but two circumstances: when the person living with HIV is aware of their status and commits a sex crime involving a risk of transmission; and when a person living with HIV is aware of their status and evidence clearly demonstrates that the individual had the intent to transmit the virus and took action that carried a significant risk of transmission.[318] In May of 2016, the National Association of Criminal Defense Lawyers passed a resolution "opposing all laws that base criminal liability and/or penalty enhancements on one's HIV status rather than on the intent to harm another individual."[319] The American Psychological Association[320] and the American Medical Association[321] have both passed resolutions opposing any law that discriminates against anyone based on their real or imagined disease. While these are positive steps, more must be done to dismantle the deeply entrenched cultural notions that HIV is a "death sentence" and that PLHIV with HIV are "deadly weapons" – powerful myths that drive continued HIV stigma and the false perception that HIV criminalization laws are necessary.

GEORGIA'S HIV-SPECIFIC CRIMINAL LAWS

The Georgia Code divides HIV-specific criminal offenses into two major parts.[322] In 1988, within the first decade of the HIV epidemic in the US, Georgia enacted the first portion of its HIV criminalization statute, which established felony-level liability that explicitly discriminates against PLHIV for nondisclosure of HIV-positive status before engaging in certain acts. This portion of the law can be used to punish a PLHIV, even if they do not transmit HIV or intend to transmit HIV. These acts include commercial and non-commercial sex acts, exchanging or sharing hypodermic needles or syringes, and donating blood, bodily fluids, or organs. For PLHIV who know their status, the penalty under the Georgia Code for committing these acts

316 Id; see also, Pub. L. No. 101-381, 104. Stat. 576 (codified at 42 U.S.C. § 300ff (2006).
317 US Department of Justice and US Centers for Disease Control and Prevention. Prevalence and Public Health Implications of State Laws That Criminalize Potential HIV Exposure in The United States (2013). Available at: https://www.ada.gov/hiv/HIV-criminalization-paper.htm.
318 US Department of Justice, Civil Rights Division (2014) Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically Supported Factors. Available at: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/doj-hiv-criminal-law-best-practices-guide.pdf.
319 National Association of Criminal Defense Lawyers (2016) Nation's Criminal Defense Bar Decries HIV Criminalization (2016). Available at: https://www.nacdl.org/hiv_crim_resolution/; National Association of Criminal Defense Lawyers (2016), Resolution of the Board of Directors of the National Association of Criminal Defense Lawyers Concerning HIV Criminalization. Available at: https://www.nacdl.org/resolutions/2016sm01/.
320 American Psychological Association (2016) Resolution Opposing HIV Criminalization. Available at: http://www.apa.org/about/policy/hiv-criminalization.aspx.
321 American Medical Association (2014) H-20.914 Discrimination and Criminalization Based on HIV Seropositivity. Available at: http://www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/AMA%20Resolution.pdf.
322 O.C.G.A. § 16-5-60(c) establishes felony criminal penalties, punishable by imprisonment up to ten years, for specific behavior by a knowingly HIV-positive person, including: (i) Non-disclosure of HIV-positive status prior to sexual intercourse or other sex act. O.C.G.A. § 16-5-60(c)(1); (ii) HIV-positive person knowingly shares a hypodermic needle or syringe with another person previously used HIV-positive person; or non-disclosure of HIV-positive status prior to HIV-positive person knowingly sharing a hypodermic needle or syringe previously used by the HIV-positive person. O.C.G.A. § 16-5-60(c)(2); (iii) Non-disclosure of HIV-positive status prior to offering or consenting to perform a commercial sex act (including "sexual intercourse" and "sodomy"). O.C.G.A. § 16-5-60(c)(3)-(4); Non-disclosure of HIV-positive status prior to collection and storage of the HIV-positive person's bodily fluids or body organs intended for donation. O.C.G.A. § 16-5-60(c)(5). O.C.G.A. § 16-5-60(d)(1)-(2) establishes felony criminal penalties, punishable by imprisonment for five to 20 years, when a knowingly HIV-positive person or a knowingly hepatitis-positive person uses their blood, semen, vaginal fluid, urine, feces, or saliva in an assault against a police officer or correctional officer while in the performance of their professional duties.

without prior disclosure can result in a ten-year imprisonment sentence.[323]

The law was expanded in 2003, making it a felony for an HIV-positive or hepatitis-positive person who knows their status and intentionally uses their blood, semen, vaginal fluid, urine, feces, or saliva in an assault against a peace officer (i.e. police officer) or correctional officer while in the performance of the officer's professional duties. Even though many of these bodily fluids carry little to no scientifically supported risk of transmission, the offense is punishable by imprisonment sentences up to 20 years.[324]

THERE IS NO EVIDENCE DEMONSTRATING THAT HIV CRIMINALIZATION DECREASES HIV TRANSMISSIONS

IMPLICATIONS OF HIV CRIMINALIZATION LAWS[325]

HIV criminalization laws result in extremely damaging legal, social, and public health impacts which disproportionately affect PLHIV, those communities with high HIV prevalence, and groups disproportionately subjected to criminalization includes people of color and LGBQ and TGNC people.

Legal Issues

Court decisions and statutes that codify HIV criminalization put an official stamp of legitimacy on persistent myths about the routes of HIV transmission. HIV criminalization statutes have the effect of situating defendants in highly discriminatory frameworks within which to argue their cases. Under the existing Georgia law, a defendant has two defenses: (1) they did not have knowledge of their own status; or (2) they did in fact disclose their status.

In the case of proving disclosure, the accused is put in the near-impossible position of proving that they disclosed their status to their partner and that their partner knew the defendant's status. This has resulted in scenarios where the testimony of one sexual partner's word is weighed against the other's. Defendants are often barred from entering evidence demonstrating that he or she took steps that effectively reduced or eliminated risk of transmission to their sexual partner – such as wearing a condom, adhering to antiretroviral treatment, and having a low viral load with a negligible risk of transmission. In other words, **the defendant's alleged failure to disclose forecloses the ability to demonstrate the risk of harm or actual harm caused to the defendant's sexual partner – even where that risk is low or non-existent.** The unspoken presumption is that the PLHIV is assumed to be guilty based on the mere fact of their HIV status and engagement in behavior perceived as socially deviant.

Advocates have advised PLHIV to prove disclosure by using various methods to document the HIV-negative sex partner's informed consent and awareness of the PLHIV's positive status prior to sexual interaction—including affidavits or formal written statements of acknowledgement, creating videos in which the HIV-negative partner acknowledges awareness of the positive partner's status, or visiting a doctor or other third party and discussing the positive partner's status in their presence so that the third party may be called to testify regarding the PLHIV's disclosure and HIV-negative person's awareness of that person's status.[326] **In reality, these methods are often unreasonably difficult to carry out in practice and they still place a discriminatory and extraordinary burden on PLHIV that is not imposed on HIV-negative persons or people with similar health conditions.**

Public Health and Medical Issues

The discriminatory impact of HIV criminalization is perhaps most damaging in public health and medical contexts. HIV stigma embedded in HIV criminalization laws may discourage individuals from getting tested to be shielded from prosecution based on known status. Without timely testing, PLHIV are not linked to care, which can ultimately increase transmissions as well as risk of criminal prosecution. Criminalization as a means of addressing HIV – a treatable, manageable, chronic health condition (with access to care) – directly counteracts public health objectives outlined in the US National HIV/AIDS Strategy (i.e. increasing testing and linkage to care, and viral suppression, especially in high-risk populations).[327]

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323 O.C.G.A. § 16-5-60(c)(1)-(5).
324 O.C.G.A. § 16-5-60(d)(1)-(2).
325 Harsono, D., Galletly, C.L., O'Keefe, E., Lazzarini, Z., et al. (2016) Criminalization of HIV Exposure: A Review of Empirical Studies in the United States. Available at: https://www.ncbi.nlm.nih.gov/pubmed/27605364 (reviewing empirical research conducted between 1990 and 2004 on HIV criminalization, and its impacts on disclosure, testing, safer sex practices, and associations between HIV criminalization laws and HIV stigma).
326 Sero Project, What You Need to Know About Laws that Prosecute People With HIV. Available at: http://seroproject.com/protection-center/; see also, HIV Disclosure Acknowledgement Statement. Available at: http://seroproject.com/wp-content/uploads/2012/07/HIV-Disclosure-Document.pdf (sample affidavit acknowledging that the person living with HIV disclosed their positive status to the person signing the affidavit, that theperson signing the affidavit t is aware of the positive partner's status, and that the signer waives all claims against their positive partner for failing to disclose their status).
327 See The White House Office of National AIDS Policy, National HIV/AIDS Strategy of the United States (2015) Available at: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf; The White House, Office of National AIDS Policy, National HIV/AIDS Strategy of the United States (2010) Available at: https://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf

There is no evidence demonstrating that HIV criminalization decreases HIV transmissions. Rather, HIV criminalization counteracts the goals and methods outlined in the National HIV/AIDS Strategy and the Fulton County Strategy to End AIDS in Fulton County.[328] Furthermore, it is SisterLove's position that sexual intimacy between two people is a mutually shared decision; both partners have a responsibility to protect themselves – and the burden to protect the health of two sex partners should not rest on one partner alone. HIV criminalization defeats education and awareness efforts to improve the everyday person's understanding of the science of HIV transmission, the effectiveness of modern HIV treatment, and the importance of regular HIV testing – as it does not take these factors into account.

Social Impact

The continued existence of HIV criminalization statutes inherently legitimizes misinformation about the risks and routes of HIV transmission and reinforces stigma. HIV stigma operates on multiple levels: it has the power to impact internalized stigma, infiltrate intimate relationship dynamics, and affect public and institutional spaces. HIV criminalization perpetuates the image that HIV affects individuals stereotyped as "sexual deviants." Stigmatizing stereotypes disproportionately burden already marginalized, over-policed, and over-criminalized populations such as sex workers, LGBQ and TGNC individuals, and people involved in informal survival economies.[329]

A legal and social culture in which a health condition can impose criminal liability reinforces the myth that PLHIV are to be treated with exceptionalism, and that HIV is an inherently dangerous and deadly disease. In some cases, this can increase interpersonal stigma in serodifferent relationships (where one partner is HIV-positive and the other HIV-negative) and can increase conditions for potential violence in intimate relationships. In the context of intimate partner violence, an HIV-negative partner may use their HIV-positive partner's status as a tool of coercion, control, isolation, or harassment. **This is particularly concerning for cisgender and trans women living with HIV, who experience PTSD and trauma at a disproportionately higher rate than HIV-negative women**.[330] For example, Cicely Bolden, an HIV-positive woman from Dallas, was killed by her intimate partner when he discovered her status. He stated: "She killed me, so I killed her."[331] **In Georgia, the state HIV criminalization statute requires disclosure without considering that disclosure may be unsafe and could lead to violent, and in some cases fatal, retaliation.**

Both traditional media and social media outlets often increase stigma around HIV by reporting HIV criminalization cases in a sensationalized fashion that inflates the "sexual deviant" defendant trope – often along racial lines – rather than offering a balanced approach to coverage that fully and humanely provides the defendant's point of view, information on the actual health science of HIV transmission, or valid arguments opposing prosecution of the defendant or HIV criminalization generally. Often, media outlets will "out" the defendant to the entire community—by making non-consensual assertions about the defendant's health status, sexual relationships, gender identity, family background, and other intimate, personal information.[332]

Criminal Restriction of Sexual Autonomy as Reproductive Injustice

Mass Incarceration

The criminalization of PLHIV has gained more attention in recent years, and it is important to place these issues in the larger frame of criminalization and systemic mass incarceration, rather than to address these issues in isolation. The United States incarcerates more people than any other nation in the world, with its total number of incarcerated people standing at 2.3 million.[333] The US constitutes 5% of the world's population, but makes up a massive 25% of the globe's entire incarcerated population.[334] One in every three adults in the US is subject to correctional incarceration or surveillance and monitoring, including those housed in prisons and jails and those under parole or probation.[335] Blacks and Hispanic/Latinos make up

328 Ibid.; Fulton County Task Force to End HIV/AIDS, Phase I Progress Report: Building the Strategy to End AIDS in Fulton County (2015) Available at: http://www.sisterlove.org/wp-content/uploads/2014/10/2015-1201-Strategy-to-End-AIDS-in-Fulton-County-Phase-I.pdf.
329 Ritchie, A., et al. (2014) A Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People Living with HIV. Available at: https://web.law.columbia.edu/sites/default/files/microsites/gender-sexuality/files/roadmap_for_change_full_report.pdf.
330 Machtinger, EL, Wilson, TC, Haberer, JE, Weiss, DS (2012), Recent Trauma is Associated with Antiretroviral Failure and HIV Transmission Risk Behavior Among HIV-Positive Women and Female-Identified Transgenders,' AIDS and Behavior, 16, 2160-2170. See also, Positive Women's Network-USA, Violence Against Women Factsheet. Available at: https://pwnusa.wordpress.com/policy-agenda/violence-against-women/factsheet/.
331 Emily, J. (2015) Man who admitted killing HIV-positive girlfriend: 'I wanted to make her pay,' Available at: http://www.dallasnews.com/news/crime/headlines/20131029-man-who-admitted-killing-girlfriend-with-hiv-i-wanted-to-make-her-pay.ece.
332 For example, see, McCullom, R. (2015) The Reckless Prosecution of 'Tiger Mandingo.' Available at: https://www.thenation.com/article/reckless-prosecution-tiger-mandingo/ (critiquing media coverage and public reactions to the 2015 Michael Johnson case in Missouri).
333 NAACP, Criminal Justice Fact Sheet. Available at: naacp.org/pages/criminal-justice-fact-sheet.
334 Ibid.
335 Ibid.

58% of all prisoners in 2008, while these populations only constitute 25% of the overall population.[336]

There are now more women being criminalized than ever, with the number of incarcerated women having increased by over 700% in the last three decades; this rate of growth has outpaced the rate of the incarcerated men by 50% over the same time period.[337] Black women are incarcerated at twice the rate of white women, and Latina women at 1.2 times the rate of white women.[338] This is highlighted even more starkly when considering that "more than 60% of women in state prisons have a child that is under 18."[339] Furthermore, law enforcement agencies, jails, and prisons are facing mounting criticism for sexual and physical violence against incarcerated cisgender women, as well as against TGNC people, and the overwhelming failure to house TGNC people according to their gender.[340]

In addition to having the world's largest incarcerated population, the US also maintains the largest immigration detention system. The detention of immigrants for immigration-related violations was formerly a rare practice, but since the late 1980s, the shift towards a capitalist-based, tough-on-crime immigration policy has caused the immigrant detainee population to skyrocket. In 2013, there were 441,000 persons detained in immigration detention centers.[341] This is the backdrop against which individuals most disproportionately impacted by the HIV epidemic must navigate potential prosecution for HIV exposure and transmission.

Mass incarceration generally, and HIV criminalization specifically, distracts attention from their structural drivers, including poverty, persistent racial segregation and violence, and poor access to affordable healthcare. Using punitive measures to respond to issues of poverty, mental health, substance dependency, and HIV is ineffective, interferes with self-determination, disrupts families and childhood development, causes individual and community trauma, and significantly hinders the ability of a community to grow and thrive in safe and healthy ways. **The use of criminal law and regulations to police and control sexuality and reproduction feeds into the system of mass incarceration and the social attitudes that stigmatize certain behaviors and identities with no legitimate basis.**

Interaction of Law, Culture, and Social Identity

United States' legal culture has long centered policing and criminalization as mechanisms of social control. Use of both the criminal and civil law to police different aspects of our self-determination – and our sexual and reproductive health and lives in particular – is a fundamental pillar of modern statecraft that disciplines our behavior and restricts cultural change. This legitimizes the message that certain people who engage in certain activities do not have self-determination over their bodies. Just as gender, sexuality, and race are social constructs that serve as organizing principles in our social order – the construction of criminality and the construction of "proper motherhood" and "proper sexuality" are also organizing principles that guide policymaking culture. The US government has repeatedly used criminal and civil laws to punish and control sex- and reproduction-related behavior, ranging from sterilizing people with developmental disabilities[342] and women of color[343], to criminalizing adult consensual homosexual sex[344], and prohibiting marriage between two people of different races.[345]

Law is a tool that often reflects the moral feelings of those with the highest levels of institutional power over political decision-making and cultural messaging in our country, and thus reflects dominant notions of which sexual and reproductive behaviors and identities are "acceptable," and those that are not and must be rooted out and punished. This is evident in the context of HIV stigma and criminalization, where the lines between law and culture are blurred, leaving little room for commonsense approaches to reforming laws that are not based on current science. Without a basis in evidence-based HIV science, HIV criminalization narratives capitalize on persistent myths that HIV is a death sentence, notions of deviant Black sexuality, compounded by a wider culture of the criminalization of Black, Hispanic/Latino, and LGBQ and TGNC communities.

Some pro-HIV criminalization commentators have argued that HIV criminalization is a positive tool for "protecting" cisgender women

336 Vera Institute for Justice, Center on Sentencing and Corrections (2015) Incarceration's Front Door: The Misuse of Jails in America. Available at: http://www.vera.org/sites/default/files/resources/downloads/incarcerations-front-door-report_02.pdf.
337 The Sentencing Project, Fact Sheet: Incarcerated Women and Girls. Available at: sentencingproject.org/wp-content/uploads/2016/02/Incarcerated-Women-and-Girls.pdf.
338 Id.
339 Id.
340 Ritchie, A. et al. (2014) A Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People Living with HIV. Available at: https://web.law.columbia.edu/sites/default/files/microsites/gender-sexuality/files/roadmap_for_change_full_report.pdf.
341 Detention Watch Network, Immigration Detention 101. Available at:, https://www.detentionwatchnetwork.org/issues/detention-101.
342 Buck v. Bell, 274 U.S. 200 (1927).
343 See, Nittle, N.K. (2016) The U.S. Government's Role in Sterilizing Women of Color. Available at: http://racerelations.about.com/od/historyofracerelations/a/The-U-s-Governments-Role-In-Sterilizing-Women-Of-Color; see also, Our Bodies Our Selves, History of Forced Sterilization and Current U.S. Abuses. Available at: http://www.ourbodiesourselves.org/health-info/forced-sterilization/.
344 Lawrence v. Texas, 539 U.S. 558 (2003).
345 Loving v. Virginia, 388 U.S. 1 (1967).

from men living with HIV, triggering the image of women as helpless and in need of "protection," HIV as a death sentence, and PLHIV as biological weapons. HIV criminalization also breeds attitudes that demonize Black bisexual men and other Black men who have sex with people of different genders, creating a "sexual panic" providing fodder for the "down-low discourse rooted in biphobia, racism, and heteropatriarchy."[346] We acknowledge the deep roots of historically entrenched misogyny and homophobia that underlie these narratives, and support ongoing conversations to unpack these complex narratives in the support of greater sexual self-determination.

346 Charles Stephens, in correspondence with authors. (November 2016)

The Power and Politics of Cultural Narratives

The interplay between law, culture, social identity, and HIV stigma was highlighted in the high profile case of Michael Johnson, a 23-year-old Black gay man and college wrestler who was sentenced to 30 years imprisonment for transmitting HIV to one sexual partner and "exposing" four other people, all of whom were white.[347] After deliberating for only two hours, the nearly all-white jury found Johnson guilty.[348] Racial caricatures were used to describe Johnson online, which demonized Johnson's sexuality in online commentaries and informal online posts about Johnson's case.[349] A professor at Georgetown Preston D. Mitchum explained the cultural logic, stating: "A black man who is muscular and attractive is accused of not disclosing his status to mostly white accusers. The trial is being heard by an almost entirely white jury. The constant repetition of the name 'Tiger Mandingo' [a name which Johnson used on his social media accounts]. It is a deliberate strategy to say, 'This is a brutal black man who did this intentionally to these precious, young, white accusers.'"[350]

> "WHILE YOU ARE BEING FRAMED AS A MONSTER, WE CONTINUOUSLY VALUE YOUR HUMANITY."

In response to the public attack and legal case against Michael Johnson, 89 Black gay men penned an open letter to Johnson, voicing their solidarity and support for him.[351] The letter writers highlighted the fact that HIV criminalization laws created and continue to exacerbate a social pattern of both fetishizing and punishing Black gay sexuality, and stigmatizing people living with HIV. The letter writers stated: "These laws feed into stereotypes that assume Black gay men are irresponsible and hypersexual. For you, your accusers saw your Black and masculine body as a site of ultimate sexual pleasure, until they had to deal with you as a whole person. At that moment you became a problem and were disposable to them."[352] The letter reiterated: "While you are being framed as a monster, we continuously value your humanity and write this letter to you."

Another example of the pervasiveness of culturally entrenched HIV stigma was demonstrated in a recent Georgia case. In September 2016, a man from Gwinnett County was sentenced to the maximum sentence of 10 years imprisonment under Georgia's HIV criminalization statute. According to a news release from the Gwinnett County District Attorney's Office, the judge presiding over the case called the defendant an "evil person"[353]—revealing the culturally-based moral outrage towards the sexuality of PLHIV that underpins ongoing HIV criminalization so often seen in HIV exposure and transmission prosecutions. **This demonstrates impunity with which the legal system obfuscates the line between HIV science, conventional parameters of criminal law (requiring intent and evidence-based prosecutions), and culturally normative HIV stigma.**

HIV stigma is bolstered by HIV criminalization laws that legitimize the persistent myth that HIV is a death sentence. **In the eyes of the public, the law says that HIV causes death, and therefore those who "expose" others are engaging in lethal behavior. This attitude does not accord with science, and yet it is on our books, persists in the public imagination, and therefore sustains pervasive HIV stigma.**

The case of Cicely Bolden highlights the intersection of misogyny, violence against WLHIV, and HIV stigma. Cicely Bolden was 28 years old when her partner learned that she was living with HIV.[354] He allegedly proceeded to have unprotected sex with her (believing he had already contracted a deadly disease), and then stabbed her while she was lying in her bed. After admitting to killing Bolden, her partner stated his erroneous belief that HIV exposure is a death sentence: "In my mind, I'm already dead," and, "She killed me, so I killed her."

In addition to reiterating the power of HIV stigma, Bolden's case demonstrates the extremely complicated nature of disclosure, especially in the context of sexual relationships.

Disclosure is at the center of HIV criminalization laws, which put the onus on PLHIV to disclose their status without considering the severe retaliation and violence that may occur as a result. This is particularly salient when we consider the staggering

347 McCullom, R. (2015) The Reckless Prosecution of 'Tiger Mandingo.' Available at: https://www.thenation.com/article/reckless-prosecution-tiger-mandingo/.
348 Human Rights Campaign (2015) Picking Up the Pieces: The Sentencing of Michael Johnson. Available at: http://www.hrc.org/blog/picking-up-the-pieces-the-sentencing-of-michael-johnson.
349 McCullom, R. (2015) The Reckless Prosecution of 'Tiger Mandingo.' Available at: https://www.thenation.com/article/reckless-prosecution-tiger-mandingo/.
350 Ibid.
351 Pass, K. et al (2015) An Open Letter to Michael Johnson. Available at: https://www.poz.com/article/michael-johnson-27220-2596.
352 Id.
353 Estep, T. (2016) In Gwinnett, 'evil' HIV-positive man gets 10 years for Craigslist sex. Available at:, : http://www.ajc.com/news/news/local/hiv-positive-gwinnett-man-gets-10-years-sex-craigs/nsWtG/.
354 Emily, J. (2015) Man who admitted killing HIV-positive girlfriend: 'I wanted to make her pay,' Available at: http://www.dallasnews.com/news/crime/headlines/20131029-man-who-admitted-killing-girlfriend-with-hiv-i-wanted-to-make-her-pay.ece.

prevalence of intimate partner violence among WLHIV, including childhood and recent trauma. WLHIV are five times more likely to have PTSD and are twice as likely to have experienced intimate partner violence.[355] Furthermore, WLHIV who have experienced recent trauma are over four times more likely to fail to adhere to HIV treatment and four times less likely to be able to negotiate or engage in safe safer sex practices and drug use practices.[356] As a result, WLHIV may be heavily impacted by the unintended consequences of the law, including the risk of violence in intimate partner relationships. These are critical facts that must be built into state legal frameworks in order to protect cisgender and trans women from violence – especially where that violence is based on their HIV status – and should be used to repeal all aspects of our laws that mandate disclosure and punish nondisclosure of HIV status.

355 Machtinger, EL, Wilson, TC, Haberer, JE, Weiss, DS (2012), "Psychological Trauma and PTSD in HIV-Positive Women: A Meta-Analysis," AIDS and Behavior, 16, 2091-2100.

356 Machtinger, E.L., Wilson, T.C., Haberer, J.E. and Weiss, D.S. (2012) 'Psychological trauma and PTSD in HIV-Positive women: A Meta-Analysis', AIDS and Behavior, 16(8), pp. 2091–2100. doi: 10.1007/s10461-011-0127-4; Machtinger, EL, Wilson, TC, Haberer, JE, Weiss, DS (2012), Recent Trauma is Associated with Antiretroviral Failure and HIV Transmission Risk Behavior Among HIV-Positive Women and Female-Identified Transgenders,' AIDS and Behavior, 16, 2160-2170; See also, Positive Women's Network-USA, Violence Against Women Factsheet. Available at: https://pwnusa.wordpress.com/policy-agenda/violence-against-women/factsheet/.

ADVOCACY RECOMMENDATIONS

HIV criminalization dehumanizes PLHIV, and feeds the violence of stigma that has fueled the epidemic. HIV criminalization discriminates against people based on their health status and invasively regulates and controls the sexual lives and reproductive autonomy of PLHIV. Criminalization not only interferes with individual autonomy—it disrupts the safety and health of our families, neighborhoods, and communities—making it a clear issue of reproductive oppression.

HIV Criminalization in the Larger Context of Mass Incarceration

HIV stigma and criminalization is not only about disease-specific discrimination. HIV disproportionately impacts people of color and LGBQ and TGNC communities, as well as low-income individuals, under- and uninsured individuals, and those engaged in street-based survival sex work. **Arrests and prosecutions, by default, impact those populations already over-policed in our criminal legal system and profiled for their race, physical and mental health status, gender identity, sexuality, and/or involvement in street-based economies.**[357] Thus, those most impacted by HIV are also those most affected by this country's system of mass incarceration as well as its unaddressed and unresolved issues of racism and anti-LGBQ and TGNC discrimination and violence.[358]

HIV health outcomes and access to prevention and care are largely determined by structural inequities based on oppressive social identity hierarchies, the politics of healthcare, and poverty, more so than with individual behavior.[359] Responding to the HIV epidemic by criminalizing individual PLHIV distracts us from the systemic drivers of the epidemic, supplies the gatekeepers of criminalization laws (i.e. state legislatures, prosecutors, judges, police officers, etc.) with the power to discriminate against PLHIV, and lets state and local policy makers off the hook who are responsible for addressing the social determinants of health that fuel the ongoing HIV epidemic, and its disparate impact on people of color and LGBQ and TGNC individuals in the first place.

Conceptualizing Effective Strategies for Change

SisterLove opposes punitive responses to HIV as a public health issue. Instead, a more effective strategy would focus on improving access to comprehensive physical, mental, and emotional health services, increasing prevention education, prioritizing community power building and access to resources, and applying culturally-relevant approaches to sexual health and healthy relationships. Furthermore, we support human rights based approaches that include the elimination of discrimination in access to healthcare, especially on the basis of race, citizenship status, income level, physical health and ability status, mental health status, education level, history of trauma, socio-geographic location, gender identity, or sexual identity. We argue emphatically for greater focus on improving the social determinants of health, such as affordable access to healthcare and prevention technologies like PrEP, comprehensive sex education at all levels, prioritizing community-level power and resource building, and advancing sex-positive, trauma-informed, culturally competent approaches to sexual and reproductive health and healthy relationships. **These are civil means to advance a public health strategy that prioritizes human dignity over senseless criminalization.**

Advocacy efforts to modernize our laws should take into account Department of Justice[360] guidelines, which recommend that any reform of HIV criminalization laws should: (1) Eliminate criminal laws that are specific to HIV; (2) Require clear intent to transmit the virus and that the behavior engaged in posed a significant risk of transmission; (3) Align laws with current scientific evidence regarding HIV transmission risk; and (4) Establish criminal penalties that are proportionate to demonstrated actual harm caused. As a general matter, the Center for HIV Law and Policy points out that people should never be targeted as subjects of criminal liability based on their health condition or having a communicable disease, except in the case of the commission of a sex crime or intentional HIV exposure by behavior that has a significant risk of resulting in transmission.[361]

The state of Georgia and the City of Atlanta have some of the highest rates of HIV in the nation. Georgia legislators should act decisively to

357 A recently published Williams Institute report found that HIV criminalization laws have a severe impact on foreign born persons. The report found that 15% of individuals who interacted with the criminal legal system in California for an HIV-specific crime were foreign born, and that 94% of these immigrants came into contact with the criminal legal system for solicitation while HIV-positive. See The Williams Institute, UCLA School of Law, Hasenbush, A., Wilson, B. (2016) HIV Criminalization Against Immigrants in California. Available at: http://williamsinstitute.law.ucla.edu/wp-content/uploads/HIVCriminalizationAgainstImmigrants.2016.pdf; See also, Ritchie, A. et al. (2014) A Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People Living with HIV. Available at: https://web.law.columbia.edu/sites/default/files/microsites/gender-sexuality/files/roadmap_for_change_full_report.pdf.

358 Ibid.

359 Sullivan, P., et al. (2015). Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: A prospective observational cohort study. Annals of epidemiology., 25(6), 445f epidemiology.015). Available at: http://www.ncbi.nlm.nih.gov/pubmed/25911980.

360 US Department of Justice, Civil Rights Division (2014) Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically Supported Factors. Available at: https://www.aids.gov/federal-resources/national-hiv-aids-strategy/doj-hiv-criminal-law-best-practices-guide.pdf.

361 Center for HIV Law and Policy, Positive Justice Project, Guiding Principles for Eliminating Disease-Specific Laws. Available at: http://web.archive.org/web/20160325132150/http://hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/Positive%20Justice%20Project%20Guiding%20Principles_1.pdf.

overhaul its HIV-specific criminal statute – either by repealing it completely, or reforming it by removing all provisions that criminalize HIV specifically (broadening the statute to cover all infectious diseases), requiring proof that the defendant acted with intent to transmit an infectious disease, and took action that carried a significant likelihood of transmission, allowing defendants to offer evidence demonstrating risk reduction measures taken. Some advocates who have taken up the fight to dismantle HIV criminalization advocate for complete repeal, arguing that laws criminalizing people with infectious diseases have no place on the books whatsoever. Other advocates argue for reform of existing laws, to limit the effect of judges' potential bias by providing them with narrow parameters within which they must decide cases with HIV-positive defendants. In either case, lawmakers must face the reality that eliminating HIV criminalization is a critical and necessary step for turning the tide of the HIV epidemic in Georgia.

CONCLUSION

This report has sought to explore the interlocking nature of key structural issues impacting the HIV epidemic in Georgia. **We have attempted to demonstrate that the roots of our HIV epidemic are complex and multilayered, and that our collective responses should reflect this.**

SisterLove calls for greater attention to the social determinants of health and the longer standing forces of economic inequity that drive poverty and create our to sexual health landscape. It is only with an understanding of our history of race- and class-based segregation that we can properly contextualize overlapping realities of concentrated poverty, lack of access to health resources, and resulting health disparities in our city and state. **Land use policies directly impact individual and community health; this means we must look critically at programs that purport to advance "development" without explicitly addressing how such programs will impact our city's and state's economically marginalized and politically disenfranchised neighborhoods, which often suffer most from sexual health disparities.**

We acknowledge the burgeoning research demonstrating that structural factors—rather than individual "risky" behaviors—drive our ongoing epidemic among the most impacted groups, and we encourage further research and attention to policies that address these structural factors. This includes ensuring access to affordable healthcare for PLHIV and communities most impacted by the epidemic. **We also recognize that while structural forces are at the root of the ongoing epidemic, all people deserve the right to have access to the full range of biomedical prevention and treatment technologies to protect their individual health *and* to be free from biomedical violence, research-specific and otherwise.** We also call for increased cultural competence in HIV research that addresses severe data gaps in our understanding of how HIV impacts trans and gender non-conforming people, cisgender women and LGBQ groups of color, and immigrant communities when disaggregated by race and ethnicity.

We call for immediate action to provide young people with **access to medically accurate, evidence-based, and non-stigmatizing sexuality education and resources in the public schools,** and for the allocation of resources to provide sexuality education in other community spaces for those not currently enrolled in school. Our young people and communities need and deserve to be equipped with the information and resources they need to make their own best decisions regarding their sexual and reproductive health and lives.

Lastly, we reject the restriction of sexual autonomy and self-determination through HIV criminalization, which, in practice, equates to state-sponsored policing of gender and sexuality rooted in HIV stigma. **Legal provisions that explicitly discriminate against PLHIV have no place in our legal system, and must be overhauled with great urgency.** We acknowledge the entrenched nature of HIV stigma in the public imagination and its power to permeate our judicial system against defendants that are disproportionately people of color, women, and LGBQ and TGNC people. Therefore, we recommend that lawmakers reform our criminal code in a way that protects PLHIV from discrimination and brings the law in alignment with current HIV science and criminal law standards.

The thematic areas we have highlighted have intersectional, multidimensional effects on Georgians' lives, spanning individual, interpersonal, and institutional levels of lived experience. It **is our hope that this critical Reproductive Justice analysis has explicated some of the ways in which multiple forces of oppression intersect in the lives of those most impacted by HIV—and that this analysis will provoke further questions, research, advocacy, and action on these issues in a manner that advances the movement for social, sexual, and Reproductive Justice.**

The clarion call to "End the Epidemic" in the US is one that we have heard. We can only fully answer this call, however, when we have mapped and achieved our way to the end of all the sexual and reproductive injustices that exacerbate HIV among women and girls and all our communities most impacted by HIV. We invite you to join this journey to win sustainable protections for women and PLHIV, and to press forward with dignity, determination, and love.

- **INCREASE** HIV initiatives that explicitly address the Social Determinants of Health.
- **MONITOR AND ASSESS** local land use and economic policies, and amend or reject those that fail to address the needs and impacts upon neighborhoods that bear a disproportionate burden of HIV and other health disparities.
- **ENSURE ACCESS** to the full range of biomedical HIV prevention and treatment technologies, research, and healthcare to advance the health of women impacted by HIV.
- **PROVIDE** young people with medically accurate, evidence based, non-stigmatizing CSE and related resources, and improve leave policies and support resources for young parents.
- **END DISCRIMINATION** against PLHIV under Georgia's criminal law.

GLOSSARY

Antiretroviral therapy (ART) – a combination of antiretroviral drugs used to reduce viral load and slow the progression of HIV.

Cisgender – term to refer to a person whose gender identity is the same as their sex assigned at birth.

Gender non-conforming – term to refer to a person whose gender identity and/or gender expression is different from socially prescribed binary gender (male/man/masculine-female/woman/feminine) expectations.

Intersectionality – term to refer to the interlocking, overlapping, and compounding nature of social, political, economic, cultural, and legal oppression upon impacted groups and identities.

LGBQ – Lesbian, Gay, Bisexual, Queer

"Men who have sex with men"/ "MSM" – this term is primarily used in medical and public health research and practice and refers to men who have sex with men and who may or may not identify as gay or bisexual.

PLHIV – people or person living with HIV.

Serodifferent – term used to refer to two or people with different serostatuses (e.g. a couple in which one partner is HIV-positive and the other is HIV-negative); this term is preferred to the overly medicalized and stigmatizing term "serodiscordant."

Serostatus – the degree of antibodies to a specific antigen, such as HIV (e.g. "positive serostatus")

Social Determinant of Health (SDH) –the conditions, environment, resource availability, and social practices that impacting individual and community health risks and health outcomes.

TGNC – Trans and Gender Non-Conforming

Trans/Transgender – broad term to refer to a person whose gender identity is different from their sex assigned at birth.

Viral load – amount of HIV particles contained per milliliter in a sample of an individual's blood.

Viral suppression – refers to an individual's viral load being so low that it is not "detectable" when monitored in standard HIV blood tests.

WLHIV – women or woman living with HIV.

**A note on language used in this report:* We use the terms "women," "cisgender," "trans," and "gender non-conforming" depending upon the context of use. Where specifically relevant, we use trans, gender non-conforming, and cisgender specific language. In all other cases, we use the term "women" in a manner inclusive of all those who identify as women. To make this report accessible, we have attempted to use non-technical language, and to include explanations of any technical language when used.

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