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.

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EXECUTIVE SUMMARY

Introduction

In a region known for its genuine hospitality and saccharine sweet iced tea beverages, a reality more sinister persists. Health inequities and inequalities permeate throughout the US South and continue to adversely affect the lives of millions of people of color. Through the context of HIV, antiquated laws and policies exacerbate the effect of the chronic disease including persistently alarming rates of transmission and a low percentage of PLWH linked and retained in care. This is a harrowing truth when juxtaposed against current realities where biomedical advances present the opportunity for a cure in the foreseeable future. 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.[1] As of 2013, an estimated 50,000 Georgians are living with HIV—of which 25% are women. Georgia currently ranks fifth in the nation for the number of new HIV diagnoses.[2] It is estimated that 1 in 51 Georgians are at risk of contracting HIV in their lifetime.[3]

Fulton County, one of the most densely populated counties in the state, accounts for more than half of all HIV diagnoses in the state. Approximately 64% of people in the state of Georgia living with HIV reside in the Atlanta-Sandy Springs-Marietta Metropolitan Statistical Area (MSA), including Fulton, Dekalb, and Clayton counties.[4] In addition to the high prevalence of HIV in Georgia's urban areas, the stark reality is that many affected are unaware of their status. In Georgia, the rate of persons who are aware of their HIV-positive status (73%) is substantially lower than the national average (87%).[5] ***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

[1] 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.
[2] 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
[3] 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.
[4] 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.
[5] 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.

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 one year.[6]

Black women shoulder a disproportionate burden of the HIV epidemic. **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 chances of contracting HIV is 14 times higher than a white woman's.[7] Beyond initial diagnoses, Georgia has the second highest rate of Black women and girls living with HIV who have progressed to AIDS.[8] 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. Notably, 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%[9]—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 50% globally), yet research on prevention and treatment methods specifically designed for women across the spectrum of gender identity remains lacking.[10] A concerted effort must be undertaken to reform existing policies that have proven unsuccessful in order to quell the ongoing effect of the HIV and AIDS on Black women in Georgia.

Our vision

This report reflects SisterLove's values as an intersectional[11] HIV and RJ 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. Sexual and reproductive justice is an integral pillar of social justice and individual and collective self-determination. **We see Reproductive Justice as the**

[6] 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.
[7] See Figures 2 and 3.
[8] 14.8 per 100,000 – next is Louisiana with 14.0 per 100,000. Top is DC with 47.6 per 100,000.
[9] New HIV diagnoses declined 35% among Latina women, and 30% among white women.
[10] 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
[11] 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.

conditions of liberation that will exist when all people have the power and resources necessary to make their own decisions about their bodies, health, 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, trans and gender nonconforming (TGNC) communities, and lesbian, gay, bisexual, and queer (LGBQ) 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 individual and community health, including anti-Black violence, criminalization of sexuality, racism, and rampant HIV stigma based in homophobia, transphobia, and misogyny.

SisterLove's 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. Contrary to widely held ideas about 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. **Rather, our egregious health record follows predictable historically racialized and politicized lines, and we must address these drivers in order to achieve sustainable change.**

As an organization we implore local advocates and policymakers to continue their work to end all sexual and reproductive injustices that exacerbate HIV among women and girls and all of our communities most impacted by HIV. 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.

Overview of Findings

This report applies a critical Reproductive Justice (RJ) analysis of specific structural drivers shaping the HIV epidemic in Atlanta and the surrounding metro area. Consistent with SisterLove's experience serving Black women living with HIV and facing other sexual and reproductive health issues in Atlanta, we focus on the same communities in this report—though our primary focus is to analyze the structural drivers themselves, which have impacts that cross many different communities. We will highlight the following four major thematic 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.

ECONOMIC INEQUITY AS A SOCIAL DETERMINANT OF HEALTH

In Atlanta, there is a significant overlap between neighborhoods with high poverty and income inequity, lower educational attainment, and disproportionately high HIV prevalence levels.[12] Poverty and lack of healthcare access exacerbate HIV prevalence rates in Georgia. Economically and politically marginalized neighborhoods 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.[13] Individuals with unstable financial means and who lack access to physical and mental health resources may engage in activities that increase HIV risk, such as having unprotected sex in exchange for money, drugs, shelter, or other basic needs, or using intravenous drugs without clean equipment.[14] ***The geospatial concentration of poverty within Atlanta's predominantly black communities is not a matter of accident nor a reflection of the moral and social failings of minority urban communities***. But rather, years of racialized exclusionary housing and development practices, misappropriation of resources, and diminished economic opportunity are responsible for the many of the current public health challenges.

We argue that these historical realities must be expressly acknowledged when addressing the issues present 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 in spite of 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. Building on the strength and resilience of these communities, it is imperative that swift action is undertaken to curb and decrease the effects of HIV on the lives of those living in Atlanta and the surrounding metro area.

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[12] 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

[13] 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.

[14] Avert. *People Who Inject Drugs, HIV and AIDS*. Available at: https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/people-inject-drugs.

Advocacy Recommendations

SisterLove affirms the following policy recommendations in addressing the economic realities which perpetuate the HIV epidemic in Atlanta and disproportionately impacts the lives of PLWH, their families, and communities

1. *Create a Regulated Process for Assessing Health Impacts of Economic Development Initiatives on Existing Populations*

In order to meaningfully address the economic drivers of healthy inequity in Atlanta's urban and metro communities, a concerted effort and partnership must be garnered between local and state officials alongside grassroots organizations and policymakers. The public health ills present within our community necessitate creating and internalizing these regulated processes in administrative policy culture in order to sustain and strengthen community partnerships and communication between local individuals and organizations, state and local agencies and officials, and businesses and investors, among others.

- Policies designed to address "economic development" and "economic marginalization" should be analyzed based on the *health impacts* they will have on the communities they target, according to a regulated review protocol that requires meaningful inclusion of directly affected community members and a robust monitoring process.
- This regulated process should be encouraged in all neighborhoods throughout the city, but should be *legally required* in neighborhoods containing high HIV impact zip codes, as defined by the CDC and Georgia Department of Public Health.
- An evidence-based assessment of the manner and extent to which a proposed development initiative expects to create direct and indirect impacts on individual and community health with regard to HIV prevention, care, support, and education, and wellness resources shall be required.
- The review process must occur *prior* to development decision-making that will affect a targeted community and its inclusion in decision-making should be required in deciding whether to implement a given initiative.
- It should also be used as a mechanism to *inform and address* gaps in a development initiative that may disregard, minimize, or exacerbate existing conditions affecting HIV prevalence and other chronic health challenges facing targeted communities (e.g. investments stimulating significant rent increases in neighborhoods where PLHIV require stable and affordable rental housing).

2. *Protect Affordable Housing and Prevent Displacement*

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.[15] Unstable housing has been linked to intimate partner violence[16], formally and informally trading sex for shelter, drug use, and incarceration—all of which can intersect in the lives of WLHIV.[17] 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."[18] Current economic development projects within the City of Atlanta and in surrounding counties have facilitated gentrification and 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 and other land use changes 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 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 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.

3. *Address the disproportionate rates of unemployment in low-income communities*

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.

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[15] AIDS.gov, *Housing.* Available at: https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/taking-care-of-yourself/housing/

[16] 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/.

[17] 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.

[18] Ibid.

- ❖ The state's workforce development program should conduct a needs assessment with regard to employment opportunities and living wages, highlighting the needs of PLHIV and high HIV impact neighborhoods.
- ❖ 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.

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

Lack of community-based control over and access to local food resources is a salient social driver of health, as well as a primary indicator of place-based community economic marginalization more broadly. 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 vulnerability, which is the result of protracted political inequity, place-based racial segregation, capital flows and demographic changes facilitated by outside actors, and the concentration of poverty in Black and working class areas neighborhoods over time.[19] 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. 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,

[19] Ross, G. (2014) *Food Deserted: Race, Poverty, and Food Vulnerability in Atlanta, 1980-2010*. Ph.D. Atlanta: Georgia Institute of Technology.

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. At the same time, policymakers should 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. While the spectrum of policy options available is too voluminous to name here, we posit that a commonsense place to start would be to institute housing and land use 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 to 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 and regulation of food waste, increase community access to and participation in the production of fresh foods, and increase agricultural knowledge and cultural preservation of food practices.

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 and access to transportation, physical or mental ability, access to childcare, or discrimination based on their sexuality, gender identity or expression, race or ethnicity, health literacy, socioeconomic background, or education. The ongoing HIV epidemic, and its race, gender, and income-based disparities are driven by social and political factors that result in poorer health outcomes for the most disadvantaged. We argue that biomedical inequity and oppression is a structural driver of HIV that is under-analyzed. We seek to shift the conversation from a disproportionate focus on individual choice and behavior in order to understand how health care shapes health outcomes of people from our communities.

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 WLHIV have access to the full range of treatment options available, 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 desire. It also fails to interrupt the stigmatizing myth that WLHIV cannot or should not be mothers, despite the fact all of 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.[20] 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 are easily adhered to.

1. Improve 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

[20] 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.

impact of HIV on women, trans individuals, and people color demands that the heath needs of these communities are no longer ignored.

- ❖ Promote and 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 invisiblized 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.

2. Increase Access to a Full Range of Biomedical Options

All people deserve to have access to a myriad of 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 in order to live and thrive. Recognizing the importance of 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. Increasing our understanding of adherence to PrEP as bio-behavioral or biopsycho-social is integral to fully realizing the benefits of access expanding beyond physical 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.
- ❖ Prioritize the funding of microbicides, a viable alternative prevention method to PrEP. 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 enormous potential to expand current prevention and treatment efforts.
- ❖ Encourage diversity in science. 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.

MAKING THE CASE FOR COMPREHENSIVE SEXUAL EDUCATION

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[21] and discriminate against Black women and girls[22]—it is incumbent upon Georgia's schools, policymakers, clinical and service providers, parents and caregivers, and community organizations to ensure greater access to sexuality education. 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.*** 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. Failing to do so is unjust, leaving young people without the education and skills they need to protect and empower themselves as they navigate through an epicenter of the HIV epidemic and other public health crises.

Advocacy Recommendations

1. *Reform the Legal Framework Governing Sex Education*

- 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.[23] The broad deference currently afforded to local school boards has resulted in inconsistencies in the quality and content of sexuality education in Georgia that varies among and within school districts.[24] 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.[25] For these reasons, Georgia's current sex education law should be modernized and

[21] 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.
[22] 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.
[23] See O.C.G.A. § 20-2-143.
[24] 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/.
[25] 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.

mandate that all schools implement medically accurate CSE standards that are relevant to the realities that youth face in Georgia.

- ❖ Sexuality education should be required to be sequential, administered throughout elementary, middle, and high school grade levels, 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 sex and human sexuality.
- ❖ 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.

2. 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 how to receive 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 will help to maximize the number of youth who are aware of their health status. Opt out routine HIV and STI testing in schools will give students the ability to know their status and in turn the ability to make better informed sexual health decisions.
- ❖ Funding must be allocated for community based programs operating outside of schools, in order for parents, caregivers, service providers, advocates and other proponents of CSE to initiate trainings and discussions with providers, parents, caregivers, and community members.
- ❖ 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 never compromised, and to ensure that youth are not judged, shamed, silenced, violated, or discriminated against in any way.

RESTRICTION OF SEXUAL AUTONOMY AND THE CRIMINALIZATION OF HIV

Despite our advances in treatment, prevention, and HIV science – 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. ***Criminalization and restriction of sexual autonomy 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.*** 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."[26]

Advocacy Recommendations

HIV criminalization dehumanizes people living with HIV, and feeds the violence of stigma that has been with us since the beginning of our epidemic. HIV criminalization arbitrarily discriminates against people based on their health status and invasively regulates and controls the sexual lives and reproductive autonomy of WLHIV. 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.

1. *Cease Disproportionate Profiling and Policing of LGBTQ Folks and Trans Women of Color*

- 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, LGBQ and/or TGNC identity, and/or involvement in street-based economies.[27]

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[26] 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.

[27] 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*

- 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 anti-TGNC discrimination and violence.[28] In the context of HIV criminalization, stigma and the impact of certain social determinants of health – such as racial disparities in HIV based criminal prosecutions – are all forces that can and do inevitably intersect in populations affected by over-policing and mass incarceration.

2. *Prioritize Focus on the Systemic Drivers of the Epidemic*

- 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, than with individual behavior.[29] Responding to the HIV epidemic by criminalizing 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 fails to hold local and state officials accountable.

3. *Adopt Harm-Reduction Strategies that are Less Punitive*

- SisterLove opposes punitive responses to HIV as a public health issue. We believe that 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 to harm reduction 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.
- Adjust our focus and efforts 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.

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.

[28] Ibid.

[29] 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.

4. *Affirmative Steps Must Be Taken to Modernize and Reform Georgia's HIV-Specific Criminal Law*

- Advocacy efforts to modernize our laws should take into account Department of Justice[30] 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.
- 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.[31]

[30] 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.

[31] 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.