

RESEARCH THAT MATTERS

HIV CRIMINALIZATION IN GEORGIA

Evaluation of
Transmission Risk

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EXECUTIVE SUMMARY

HIV Criminalization is a term used to describe laws that criminalize otherwise legal conduct or increase penalties for criminal conduct based on a person's HIV status. Currently, Georgia has seven different types of HIV-specific criminal laws. The laws fall under two separate categories based on the nature of the risk: 1) Reckless Conduct and 2) Assault by a Person Living with HIV. None of the laws require actual transmission of HIV. All of these laws are broad enough to cover conduct that cannot, in fact, lead to transmission of the virus. From 1988, when the reckless conduct statute was passed, and 2003, when the assault with intent statutes were added, through the third quarter of 2017, only 74 people living with HIV had been convicted of these crimes. None of these 74 people were convicted of a crime requiring the intent to transmit HIV.¹

This report applies what we know today about the transmission and treatment of HIV to the specific types of conduct criminalized by Georgia's HIV criminal laws. It also considers some ways in which research suggests that HIV criminal laws may undermine efforts to prevent the transmission of HIV. Rather than considering all aspects of these laws, this report focuses on their public health implications, specifically their impact in the prevention and treatment of HIV.

KEY FINDINGS

- From 1988 until September 2017, only 74 people living with HIV had been convicted of these crimes; on average 2 to 3 people per year.
 - 100% of these convictions required no actual transmission of HIV.
 - 100% of these convictions required no intent to transmit the virus.
 - 100% were pursuant to statutes that are broad enough to cover conduct that cannot, in fact, lead to the transmission of HIV.

Further, the state's HIV criminal laws may undermine the state's public health efforts by deterring people from seeking HIV testing and treatment, stigmatizing those with HIV, and disproportionately affecting the communities most impacted by HIV, including people of color, women, LGBTQ people, and the formerly incarcerated.

- Some studies suggest that laws criminalizing the conduct of people with HIV (PWH) may create a disincentive for those most at risk for HIV from getting tested, from disclosing their HIV-status to potential partners and health care providers, and from consistently accessing medical care.
- HIV criminal laws further stigmatize Georgians with HIV. Research has shown that when people with HIV experience stigma, they have poorer health outcomes and are less likely to consistently engage in their own medical care and in public health efforts.

¹ One additional person was convicted of § 16-5-60(d) during this time period. However, we have no indication from their criminal record that this person had HIV (they could have had hepatitis or HIV). Accordingly, we do not count this as a person convicted of an HIV crime, or a crime that required the intent to transmit HIV.

- Georgia's HIV criminal laws impact the very populations that Georgia is trying to engage to combat HIV in the state, including people of color, women, youth, and LGBTQ people. Prior research has shown that HIV-related sex work prosecutions disproportionately impact women and people of color. In addition, youth, transgender people, and other LGBTQ people are disproportionately represented among sex workers. These are precisely the groups that Georgia currently seeks to engage in its statewide strategic plan to combat HIV.

There have been significant medical advances related to HIV since Georgia's HIV criminal laws were first passed. Modernizing these laws would support Georgia's current efforts to prevent HIV in the state.

INTRODUCTION

HIV criminalization is a term used to describe laws that criminalize otherwise legal conduct, or increase penalties for criminal conduct, based on a person's HIV-positive status. Georgia has HIV-specific criminal laws that criminalize seven specific types of behaviors (See Table 1). After providing a summary of what is known about HIV and its treatment and prevention today, this report will analyze each of these laws to determine the risk of transmission posed by the specific conduct covered by each statute.

Table 1. HIV Criminalization Laws in Georgia (2019)

CODE SECTION	CRIMINALIZED CONDUCT	FELONY/MISDEMEANOR AND STATUTORY SENTENCE
Reckless Conduct: Ga. Code Ann. § 16-5-60(c)(1)	Engaging in sexual intercourse or sexual acts without prior disclosure of one's HIV-positive status	Felony punishable by imprisonment for not more than 10 years
Reckless Conduct: Ga. Code Ann. § 16-5-60(c)(2)	Sharing needles or syringes without prior disclosure of one's HIV-positive status	Felony punishable by imprisonment for not more than 10 years
Reckless Conduct: Ga. Code Ann. § 16-5-60(c)(3)	Offering or agreeing to engage in sexual intercourse in exchange for money without first disclosing one's HIV-positive status	Felony punishable by imprisonment for not more than 10 years
Reckless Conduct: Ga. Code Ann. § 16-5-60(c)(4)	Soliciting another person for sodomy (defined as oral or anal sex ²) in exchange for money without first disclosing one's HIV-positive status	Felony punishable by imprisonment for not more than 10 years
Reckless Conduct: Ga. Code Ann. § 16-5-60(c)(5)	Donating blood, blood products, other bodily fluids, or any body organ or body part without first disclosing one's HIV-positive status	Felony punishable by imprisonment for not more than 10 years
Assault: Ga. Code Ann. § 16-5-60(d)(1)	Committing an assault with the intent to transmit HIV or hepatitis upon a peace officer while performing their duties (or because they are a peace officer), using blood, semen, vaginal secretions, saliva, urine, or feces	Felony punishable by imprisonment for not less than 5 years and no more than 20 years
Assault: Ga. Code Ann. § 16-5-60(d)(2)	Committing an assault with the intent to transmit HIV or hepatitis upon a correctional officer while performing their duties (or because they are a correctional officer), using blood, semen, vaginal secretions, saliva, urine, or feces	Felony punishable by imprisonment for not less than 5 years and no more than 20 years

² GA. CODE ANN. § 16-6-2 (2017).

In addition, this report provides estimates of the number of convictions for Georgia's HIV crimes through the third quarter of 2017. Enforcement data come from the Georgia Crime Information Center at the Georgia Bureau of Investigation, which provided the Williams Institute with anonymized criminal history record information (CHRI) data. All of the data related to Ga. Code Ann. § 16-5-60(c) were specific to PWH. However, Williams Institute researchers were not able, with the data provided, to differentiate between the people arrested under different subsections for different forms of reckless conduct. In addition, Ga. Code Ann. § 16-5-60(d) applies to both PWH and people with hepatitis and the offense codes for that section do not distinguish between the underlying disease involved. However, only one person was convicted for Ga. Code Ann. § 16-5-60(d) during the time period covered by the data provided by the state, and there is no indication that person had HIV.

HIV TRANSMISSION, TREATMENT, AND PREVENTION

Georgia's HIV criminal statutes were enacted at a time when little was known about HIV and there was widespread fear of the disease. Georgia's Reckless Conduct statute, the only statute under which charges resulted in convictions, according to the data we obtained, was initially enacted in 1988. This was just four years after the virus itself was identified as the cause of AIDS and three years after the first effective HIV test was developed.³ At that time, almost everyone known to have HIV was dying. During this period, widespread stigma and fear led to the implementation of policies and practices that excluded PWH from public life. For example, in the mid-1980s, there was still an open question about whether HIV could be transmitted through saliva, a majority of Americans favored quarantining PWH, three young brothers were banned from attending school in Florida and then their family home was burned down, and a municipal pool in West Virginia was closed after a PWH swam in it.⁴

Today, after three decades of experience with and research on HIV, we have a greater understanding of how hard it is to transmit HIV, even without medical or other precautions to prevent transmission. We now have effective treatments that allow PWH to lead full, healthy lives, with little risk of transmitting the virus to others. Further, advances such as PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis) can dramatically reduce the risk of contracting HIV among those who do not have HIV.

Based on these advances, in 2017 the Georgia House of Representatives Committee on Georgians' Barriers to Access to Adequate Health Care concluded: "Scientific advances in both understanding and treating HIV infection should be accounted for in the way intentional HIV transmission is criminalized and in mitigating alleged intent...[t]he best practice would be to reform and modernize laws so that they accurately reflect the current science of risk and modes of transmission."⁵

TRANSMISSION

Today, we know much more about how HIV is and is not transmitted than was understood in the 1980s and early 1990s.⁶ HIV is not spread through saliva, tears, or sweat or by shaking hands, sharing toilets, sharing dishes, or kissing; it does not survive long outside the human body; it cannot reproduce outside a human host; and it decays upon exposure to air.⁷ The possibility of HIV

³ A *Timeline of HIV and AIDS*, HIV.GOV (2019), <https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline>.

⁴ See *Id.*; AP, *City Closed after Swim by AIDS Victim*, APNEWS.COM (July 14, 1987), <https://apnews.com/0419dc3f67a7354b1fd22e490a67ed7f>; Billy Cox, *Remembering the Rays: A Story of Intolerance, Acceptance and Dignity*, HERALD-TRIBUNE (Sarasota, Fla.) (Sep. 4, 2007, 4:33 AM), <https://www.heraldtribune.com/article/LK/20070909/News/605231058/SH/>.

⁵ REPORT OF THE GA. HOUSE COMM. ON GEORGIANS' BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, 2017 SESS., at 9, 10 (2017), http://www.house.ga.gov/Documents/CommitteeDocuments/2017/Barriers_To_Adequate_Healthcare/FINAL_REPORT.pdf.

⁶ Y. Tony Yang & Kristen Underhill, *Rethinking Criminalization of HIV Exposure - Lessons from California's New Legislation*, 378 NEW ENG. J. MED. 1174 (2018), available at <https://doi.org/10.1056/NEJMp1716981>.

⁷ U.S. CENTERS FOR DISEASE CONTROL & PREVENTION, OCCUPATIONAL HIV TRANSMISSION AND PREVENTION AMONG HEALTH CARE WORKERS 1 (2015), <https://www.cdc.gov/hiv/pdf/workplace/cdc-hiv-healthcareworkers.pdf> ("Health care workers who are exposed to a needlestick involving HIV-infected blood at work have a 0.23% risk of becoming infected," and the "[r]isk of exposure due

transmission between adults outside the context of sexual activity, contaminated needles, and blood transfusion is essentially zero.⁸

HIV can be spread only if blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a PWH comes into direct contact with the mucous membranes or bloodstream of a person without HIV—and even if such contact occurs, transmission is usually quite rare.⁹ Even without viral suppression (achieved through treatment) or the use of medication by people who do not have HIV to prevent infection, the riskiest sexual exposure, receptive anal intercourse, carries an average HIV transmission efficiency in the range of 1 per 100 sex acts. Insertive anal intercourse carries an approximately 0.11% risk, and vaginal intercourse is less risky still. Needle sharing to inject drugs carries a 0.63% risk, and needlestick a 0.23% risk. For other exposures, the risk is so low that—according to the CDC—it is not possible to put a precise number on it.¹⁰ For example, as the CDC explains, the actual risk of acquiring HIV via blood transfusion is “extremely small because of rigorous testing of the US blood supply.”¹¹ Further, when a PWH has an undetectable viral load, the risk of transmission to an HIV-negative person decreases even more.¹² There have been *no* reported cases of transmission of the virus through sex with a PWH who has a consistently undetectable viral load.¹³

TREATMENT

Georgia’s HIV criminal law that has resulted in convictions was passed when HIV was an untreatable, and almost always fatal, disease. The first drug used to treat HIV, AZT (zidovudine), did not receive FDA approval until 1987—one year before enactment of Georgia’s Reckless Conduct statute.¹⁴ AZT had very limited long-term effectiveness and caused significant side effects.¹⁵ By 1993 AIDS was the

to splashes with bodily fluids is thought to be near zero even if the fluids are overtly bloody”).

⁸ U.S. Centers for Disease Control & Prevention, *HIV Transmission*, CDC.GOV (Aug. 6, 2019), <https://www.cdc.gov/hiv/basics/transmission.html>.

⁹ See *id.*; U.S. Centers for Disease Control & Prevention, *HIV Risk Behaviors*, CDC.GOV (Nov. 13, 2019), <https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html>.

¹⁰ *Id.*

¹¹ *HIV Transmission*, *supra* note 7.

¹² U.S. CENTERS FOR DISEASE CONTROL & PREVENTION, *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV*, CDC.GOV <https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html> (last visited Feb. 14, 2020) (ART is 100% effective for preventing sexual transmission of HIV). See also Robert W. Eisinger, Carl W. Dieffenbach, & Anthony S. Fauci, *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 JAMA 451 (2019), available at <https://doi.org/10.1001/jama.2018.21167>; Pietro Vernazza & Edwin J. Bernard, *HIV is not transmitted under fully suppressive therapy: The Swiss Statement—eight years later*, 14246 SWISS MED. WEEKLY 1 (2016), available at <https://doi.org/10.4414/smw.2016.14246>.

¹³ Myron S. Cohen et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, 375 NEW ENG. J. MED. 830, 830 (Sep. 1, 2016), available at <https://doi.org/10.1056/NEJMoa1600693>.

¹⁴ Nat’l Inst. of Allergy & Infectious Diseases, *Antiretroviral Drug Discovery and Development*, NIAID.NIH.GOV (Nov. 26, 2018), <https://www.niaid.nih.gov/diseases-conditions/antiretroviral-drug-development>.

¹⁵ Keith Alcom, *Zidovudine (AZY, Retrovir)*, NAM AIDSMAP (2011), <http://www.aidsmap.com/about-hiv/arv-background-information/zidovudine-azt-retrovir> (last visited Aug. 27, 2019); Paul L. Boyer et al., *Analysis of the Zidovudine Resistance Mutations T215Y, M41L, and L210W in HIV-1 Reverse Transcriptase*, 59 ANTIMICROB. AGENTS CHEMOTHER. 7184-7196, 7184-86

leading cause of death in the US for men aged 25 to 44; by 1994 it would go on to be the leading cause of death for all Americans in that age group.¹⁶

Fortunately, the difference between HIV treatment then and now could not be more stark. In 1995, researchers discovered that using multiple antiretroviral drugs in tandem prevents HIV from both reproducing and acquiring resistance to the drugs.¹⁷ This treatment is known as antiretroviral therapy (ART). Recent studies have found that initiating modern ART medication as soon as HIV infection is diagnosed is of great benefit for the patient, resulting in decreased morbidity and mortality.¹⁸ Soon after starting ART, the vast majority of PWH reach an “undetectable” viral load.¹⁹ ART usually involves only once-daily pills²⁰ and relatively infrequent checkups.²¹ For most people, ART causes few side

(2015), available at <https://doi.org/10.1128/AAC.05069-14>.

¹⁶ *Id.*

¹⁷ Nat'l Inst. of Allergy & Infectious Diseases, *Antiretroviral Drug Discovery and Development*, *supra* note 13; U.S. Dep't of Health and Human Svcs., *HIV Overview: FDA-Approved HIV Medicines*, AIDSINFO.NIH.GOV, <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/58/fda-approved-hiv-medicines>; Nat'l Inst. of Allergy & Infectious Diseases, *Starting and Staying on Antiretroviral Treatment*, NIAID.NIH.GOV (Nov. 27, 2018), <https://www.niaid.nih.gov/diseases-conditions/starting-antiretroviral-treatment>.

¹⁸ The Insight Start Group, *Initiation of Antiretroviral Therapy in Early Asymptomatic HIV Infection*, 373 N. ENGL. J. MED. 795 (2015).

¹⁹ Nat'l Inst. of Allergy & Infectious Diseases, *10 Things to Know About HIV Suppression*, NIAID.NIH.GOV (Nov. 14, 2017), <https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression>. Suppression of HIV to undetectable levels means that, while a person will retain latent HIV virus in the body, the virus is controlled. U.S. Dep't of Health and Human Svcs., *HIV Overview: What is a Latent HIV Reservoir?*, AIDSINFO.NIH.GOV (Jul. 3, 2019), <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/93/what-is-a-latent-hiv-reservoir>; Nat'l Inst. of Allergy & Infectious Diseases, *HIV Treatment, the Viral Reservoir, and HIV DNA*, NIAID.NIH.GOV (Nov. 27, 2018), <https://www.niaid.nih.gov/diseases-conditions/hiv-treatment-viral-reservoir-hiv-dna>; U.S. Dep't of Health and Human Svcs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Limitations to Treatment Safety and Efficacy*, AIDSINFO.NIH.GOV (Oct. 17, 2017), <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/30/adherence>.

²⁰ U.S. Dep't of Health and Human Svcs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Limitations to Treatment Safety and Efficacy*, *supra* note 18; Nat'l Inst. of Allergy & Infectious Diseases, *Starting and Staying on Antiretroviral Treatment*, *supra* note 16. Each pill contains all three or four of the antiretroviral medications that person needs. These pills have no special storage or handling requirements. Such once-daily treatment regimens are associated with higher levels of adherence.

²¹ U.S. Dep't of Health and Human Svcs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Tests for Initial Assessment and Follow-up*, AIDSINFO.NIH.GOV (Dec. 18, 2019), <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/3/tests-for-initial-assessment-and-follow-up> (see Table 3); U.S. Dep't of Health and Human Svcs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring*, AIDSINFO.NIH.GOV (May 1, 2014), <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/458/plasma-hiv-1-rna--viral-load--and-cd4-count-monitoring> (hereinafter “HHS, *Viral Load and CD4 Count Monitoring*”); U.S. Dep't of Health and Human Svcs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Limitations to Treatment Safety and Efficacy*, *supra* note 18; U.S. Dep't of Health and Human Svcs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Laboratory Testing for Initial Assessment and Monitoring of Patients with HIV Receiving Antiretroviral Therapy*, AIDSINFO.NIH.GOV (Dec. 18, 2019), <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/3/testsfor-initial-assessment-and-follow-up>.

effects, if any, and those are generally well tolerated.²² Developing resistance to ART is rare,²³ and switching to a different combination can once again suppress the virus to undetectable levels.²⁴ Those who sustain undetectable HIV levels because of ART can live a healthy life with a normal life expectancy.²⁵

PREVENTION

An undetectable viral load has significant implications for the risk of transmission: those with an undetectable viral load have virtually no risk of transmitting HIV to an uninfected partner during sex.²⁶ Research conclusively demonstrates that those who maintain an undetectable viral load have effectively zero chance of transmitting HIV to an uninfected partner, even if no other form of prevention is used.²⁷ The US federal government has recognized this principle as “firmly established” by “an overwhelming body of clinical evidence.”²⁸ Today, over half (52%) of all PWH in Georgia currently have an undetectable viral load and cannot transmit the virus through sex.²⁹

²² HIV Treatment Overview, HIV.GOV (Mar. 29, 2019), <https://www.hiv.gov/hiv-basics/staying-in-hiv-care/hiv-treatment/hiv-treatment-overview>; U.S. Dep’t of Health and Human Scvs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Adverse Effects of Antiretroviral Agents*, AIDSINFO.NIH.GOV (Dec. 18, 2019), <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/31/adverse-effects-of-arv>.

²³ In almost all cases, resistance to a particular ART regimen develops only if the patient is unable to adhere to the prescribed medications. See, e.g., U.S. Dep’t of Health and Human Scvs., *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV: Limitations to Treatment Safety and Efficacy*, *supra* note 18. Resistance is rare in people who achieve an undetectable viral load and continue taking ART as directed.; Eric J. Arts & Daria J. Hazuda, *HIV-1 Antiretroviral Drug Therapy*, 2 Cold Spring Harbor Perspectives in Med. a007161 (2012), available at <https://doi.org/10.1101/cshperspect.a007161>.

²⁴ U.S. Dep’t of Health and Human Svcs., *HIV Overview: FDA-Approved HIV Medicines*, *supra* note 16. Resistance to multiple drugs is increasingly uncommon, thus it is unlikely that a PWH would be unable to find an alternate therapeutic option and be unable to retain/maintain viral suppression. See U.S. Dep’t of Health and Human Svcs., *Guidelines: Drug-Resistance Testing*, AIDSINFO.NIH.GOV, <https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/6/drug-resistance-testing>; Alison F. Feder et al., *More Effective Drugs Lead to Harder Selective Sweeps in the Evolution of Drug Resistance in HIV-1*, eLife 2016; 5: e10670 (2016), available at <https://doi.org/10.7554/eLife.10670>.

²⁵ U.S. Centers for Disease Control & Prevention, *About HIV/AIDS*, CDC.GOV (Dec. 2, 2019), <https://www.cdc.gov/hiv/basics/whatishiv.html>.

²⁶ U.S. Centers for Disease Control & Prevention, *HIV Treatment Can Prevent Sexual Transmission*, CDC.GOV (Jul. 2019), <https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-tasp-101.pdf>; Nat’l Institute of Allergy and Infectious Diseases, *HIV Undetectable = Untransmittable (U=U), or Treatment as Prevention*, NIAID.NIH.GOV (May 21, 2019), <https://www.niaid.nih.gov/diseases-conditions/treatment-prevention>; U.S. Centers for Disease Control & Prevention, *HIV Treatment as Prevention*, CDC.GOV (Nov. 12, 2019), <https://www.cdc.gov/hiv/risk/art/index.html>

²⁷ *Id.*; *U=U Taking Off in 2017*, 4 LANCET HIV e475 (2017), available at [https://doi.org/10.1016/S2352-3018\(17\)30183-2](https://doi.org/10.1016/S2352-3018(17)30183-2).

²⁸ U.S. Dep’t of Health and Human Scvs., *The Science is Clear: With HIV, Undetectable Equals Untransmittable* (Jan. 10, 2019), <https://www.nih.gov/news-events/news-releases/scienceclear-hiv-undetectable-equals-untransmittable>. See also Nat’l Institute of Allergy and Infectious Diseases, *HIV Undetectable = Untransmittable (U=U), or Treatment as Prevention*, *supra* note 26.

²⁹ PowerPoint Presentation by Ga. Dep’t of Public Health HIV/AIDS Epidemiology, *HIV Care Continuum*, 2017, Georgia-Slides, slide 3 (Jan 28, 2019), <https://dph.georgia.gov/hiv-care-continuum>.

Based on these advances, in 2017 the Georgia House of Representatives Committee on Georgians' Barriers to Access to Adequate Health Care concluded: "HIV treatment is more powerful than ever, both for the health of people with HIV and as a prevention tool for sexual transmission. Recent studies found zero linked HIV infections from sexual behavior while the person with HIV was virally suppressed/undetectable...it would be most appropriate to acknowledge these scientific advances by allowing an accused to rely on them in defense of the charge of intentionally transmitting or intentionally exposing another to HIV. Such a defense, if proven, would then negate the necessary intent to transmit HIV."³⁰

PREP

ART has also had direct benefits for those who are HIV-negative. For those at risk of contracting HIV, the use of Pre-Exposure Prophylaxis, or PrEP, has provided an extremely effective barrier to becoming infected with HIV. PrEP is a daily, single-pill medication that has been found to reduce the risk of contracting HIV when exposed via sexual contact by approximately 99%— essentially 'blocking' a person from acquiring HIV.³¹ In June 2019, based on a thorough review of the data, the US Preventive Services Task Force granted PrEP a Grade A rating for its effectiveness in preventing HIV.³² In other words, PrEP is standardized recommended medical practice. PrEP is a critical component of the state of Georgia's integrated HIV strategic plan for 2017-2021 in general, and in particular in reducing the high concentration of new infections among men who have sex with men (MSMs) and among people of color.³³

PEP

HIV negative individuals who are exposed to HIV may take ART following the exposure, known as post-exposure prophylaxis (PEP), to decrease the risk of acquiring HIV. Giving someone PEP just after exposure can prevent them from contracting HIV.³⁴ In one study of 100 individuals who took

³⁰ REPORT OF THE GA. HOUSE COMM. ON GEORGIANS' BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, *supra* note 4 at 10, 11.

³¹ U.S. Centers for Disease Control & Prevention, *Pre-Exposure Prophylaxis (PrEP)*, CDC.gov (Dec. 13, 2019), <https://www.cdc.gov/hiv/risk/prep/index.html>; U.S. Dep't of Health and Human Svcs., *Pre-Exposure Prophylaxis (PrEP)* (Jan. 6, 2020) <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/20/85/pre-exposure-prophylaxis--prep->.

³² U.S. Preventive Services Task Force, *Final Recommendation Statement: Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis* (Jun. 2019), <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis>.

³³ GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021 51, 126-27, 146 (2016) ("2017-2021 SMART Objective 2: By December 2021, reduce the number of new diagnosis by at least 25%. Strategy 1: Expand access to effective prevention services and intensify efforts, including pre-exposure prophylaxis (PrEP)"; "2017-2021 SMART Objective 4: By 2021, reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black/African American gay and bisexual men, and Black/African American women. Strategy 1: By 2021, reduce HIV-related disparities in communities at high risk. Activity: Utilize PrEP clinics to reduce new HIV infections and provide high risk negatives (HRN) access to HIV prevention education services."; "4. Increase the percentage of at risk MSM taking PrEP to 50% (with an emphasis on the 18-24 age group) by December 31, 2020.")

³⁴ U.S. Centers for Disease Control & Prevention, *PEP*, CDC.gov (Aug. 6, 2019), <https://www.cdc.gov/hiv/basics/pep.html>.

a PEP regimen following a higher-risk sexual exposure, no participant became infected with HIV.³⁵ And in a study of individuals who reported needlestick injuries, PEP using AZT was shown to reduce the risk of HIV infection by 81%.³⁶ It is anticipated that the current protocol, the use of three drugs contemporaneously, would result in even greater protective efficacy.

E.g., UC Davis Student Health & Counseling Svcs., Post-exposure Prophylaxis (PEP) for HIV, UC DAVIS.EDU, <https://shcs.ucdavis.edu/topics/post-exposureprophylaxis-pep-hiv> (last visited Feb. 14, 2020). See also U.S. CENTERS FOR DISEASE CONTROL & PREVENTION, UPDATED GUIDELINES FOR ANTIRETROVIRAL POSTEXPOSURE PROPHYLAXIS AFTER SEXUAL, INJECTION DRUG USE, OR OTHER NONOCCUPATIONAL EXPOSURE TO HIV—UNITED STATES, 2016 30, <https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf> <https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf> (2016). E.g., Anthony S. Fauci et al., *Ending the HIV Epidemic: A Plan for the United States*, 321 JAMA 844 (2019), available at <https://doi.org/10.1001/jama.2019.1343>.

³⁵ Kenneth H. Mayer et al., *Optimal HIV Postexposure Prophylaxis Regimen Completion With Single Tablet Daily Elvitegravir/Cobicistat/Tenofovir Disoproxil Fumarate/Emtricitabine Compared With More Frequent Dosing Regimens*, 75 J. ACQUIR. IMMUNE DEFIC. SYNDR. 535 (2017), available at <https://doi.org/10.1097/QAI.0000000000001440>.

³⁶ Myron S. Cohen et al., *Narrative Review: Antiretroviral Therapy to Prevent the Sexual Transmission of HIV-1*, 146 ANNALS OF INTERNAL MED. 591, n.63 (2007), available at <https://doi.org/10.7326/0003-4819-146-8-200704170-00010>.

APPLICATION OF HIV SCIENCE TO GEORGIA'S HIV CRIMES

RECKLESS CONDUCT CRIMES

This section applies what is now known about HIV and its prevention and treatment to each of Georgia's five HIV Reckless Conduct crimes (consensual sex, sharing needles, prostitution, solicitation of sodomy, and blood or organ donation). Only 74 people were convicted of these crimes from 1988 through the third quarter of 2017; or on average two to three people per year. As explained above, however, Williams Institute researchers were not able to differentiate between these five crimes using the available data in order to determine how many people were convicted of each.³⁷

As discussed above, since Georgia passed its Reckless Conduct crimes in 1988, HIV has moved from a nearly always fatal disease to a manageable, chronic condition. Further, we know that HIV is much more difficult to transmit than initially thought in the early years of the epidemic, and people who are on ART and achieve an undetectable viral load cannot sexually transmit the virus.

Sexual Intercourse and Sex Acts

Offense

Pursuant to Ga. Code Ann. § 16-5-60(c)(1), a PWH who knows that they have HIV and “[k]nowingly engages in sexual intercourse or performs or submits to any sexual act involving the sex organs of one person and the mouth or anus of another person” and does not disclose their HIV-status is guilty of a felony punishable by up to ten years of imprisonment.³⁸

Notably, by its terms this statute includes oral sex and other forms of sex that have little risk of transmitting HIV. While “sexual intercourse” is not defined in this section of the statute, and has not been defined in any court cases, “sexual intercourse” is defined elsewhere in the Georgia criminal code for another sex offense as “genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex.”³⁹ In addition, the definition of “sexual act” in the statute (“any sexual act involving the sex organs of one person and the mouth or anus of another person”) also clearly includes oral sex.⁴⁰

³⁷ However, when considering all arrests, we were able to determine that approximately 1 in 4 people with Reckless Conduct incidents had concurrent charges relevant to one of the subsections of § 16-5-60(c). This includes 13% of all those with Reckless Conduct incidents who had concurrent drug charges; 8% that had concurrent prostitution or other charges related to commercial sex work; and 7% that had concurrent charges for other sex offenses.

³⁸ GA. CODE ANN., § 16-5-60(c)(1).

³⁹ GA. CODE ANN. § 16-12-100. Under Georgia law “sexual intercourse” requires actual penile penetration (penetration with a sex object does not count). *Propes v. State*, 815 S.E.2d 571 (Ga. Ct. App. 2018); *Rodriguez v. State*, 806 S.E.3d 916 (Ga. Ct. App. 2017); *Ginn v. State*, 667 S.E.3d 712 (Ga. Ct. App. 2008); *Stulb v. State*, 631 S.E.2d 765 (Ga. Ct. App. 2006).

⁴⁰ GA. CODE ANN. § 16-5-60(c)(1).

This HIV crime does not require transmission of HIV or intent to transmit HIV. In addition, the statute criminalizes behavior with very low risk of transmitting the virus, including oral sex.

Transmission Risk

In 1988, when this statute was passed, the first HIV test had been approved three years earlier⁴¹ and the first of the effective medications to treat HIV were still seven years away.⁴² At that time, there was also a lack of knowledge about rates of transmission through “sexual intercourse” and the effect of condom use and ART on reducing the risk of transmission.

In the last 30 years, we have learned that consistent use of condoms reduces the risk of transmission by 63%-80%.⁴³ Further, as described more fully above, since 1995, antiretroviral therapy (ART) has enabled people living with HIV to suppress their viral loads to undetectable levels, allowing the vast majority to lead long and healthy lives and effectively eliminating the risk of transmitting HIV.⁴⁴ Today, 52% of all PWH in Georgia have an undetectable viral load and cannot transmit the virus through sex.⁴⁵ However, Georgia law has not been updated to account for these medical advances.

Further, recent research shows that the risk of HIV transmission through “sexual intercourse” is low even if people are not using condoms or taking medications that reduce risk. The CDC estimates that the per-act risk of transmission varies from close to 0% to a maximum average of 1.38%, depending on the type of “intercourse” (Table 2).⁴⁶ Table 2 does not include acts that carry even less risk of transmission, such as sharing sex toys.⁴⁷

⁴¹ U.S. Food & Drug Admin, *HIV/AIDS Historical Time Line 1981-1990*, FDA.GOV (Jan 5, 2018), <https://www.fda.gov/patients/hiv-timeline-and-history-approvals/hivaids-historical-time-line-1981-1990>.

⁴² U.S. Food & Drug Admin, *HIV/AIDS Historical Time Line 1991-1999*, FDA.GOV (Aug. 14, 2018), <https://www.fda.gov/patients/hiv-timeline-and-history-approvals/hivaids-historical-time-line-1991-1999>.

⁴³ U.S. Centers for Disease Control & Prevention, *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV*, *supra* note 11.

⁴⁴ Myron S. Cohen, et al., *Antiretroviral Therapy for the Prevention of HIV-1 Transmission*, 375 *NEW ENG. J. MED.* 830, 831 (2016), <https://doi.org/10.1056/NEJMoa1600693>; U.S. Centers for Disease Control & Prevention, *HIV Treatment as Prevention*, *supra* note 26.

⁴⁵ PowerPoint Presentation by Ga. Dep’t of Public Health HIV/AIDS Epidemiology, *supra* note 29 at slide 3.

⁴⁶ U.S. Centers for Disease Control & Prevention, *HIV Risk Behaviors*, *supra* note 8.

⁴⁷ *Id.*

Table 2. Average Per-Act Transmission Risk Per Sex Act (without Condom Use and without Treatment)⁴⁸

SEX ACT	AVERAGE PER ACT TRANSMISSION RISK
Receptive anal intercourse	1.38%
Insertive anal intercourse	0.11%
Receptive penile-vaginal intercourse	0.08%
Insertive penile-vaginal intercourse	0.04%
Receptive oral intercourse	Low
Insertive oral intercourse	Low

Based on medical developments and research over the past thirty years, Georgia law criminalizes conduct that is extremely unlikely to transmit the virus.

Sharing Needles

Offense

Pursuant to Ga. Code Ann. § 16-5-60(c)(2), a PWH who knows they have HIV and who “[k]nowingly allows another person to use a hypodermic needle, syringe, or both” that they have used for drugs or any other reason without first disclosing that they are HIV-positive is guilty of a felony punishable by up to ten years of imprisonment.⁴⁹ This HIV crime does not require transmission of HIV or intent to transmit HIV. In addition, the statute criminalizes behavior with lower risk of transmitting the virus than originally understood or for those taking ART.

Transmission Risk

Sharing needles during injection drug use with no other precautions carries an HIV transmission risk of 0.63%. This does not take into consideration consistent use of pre-exposure prophylaxis (approximately 74-84% reduction in risk for people who inject drugs)⁵⁰ or antiretroviral therapy.⁵¹

⁴⁸ *Id.*

⁴⁹ GA. CODE ANN. § 16-5-60(c)(2).

⁵⁰ U.S. Centers for Disease Control & Prevention, *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV*, *supra* note 11; Kachit Choopanya et al., *Antiretroviral Prophylaxis for HIV Infection in Injecting Drug Users in Bangkok, Thailand* (the Bangkok Tenofovir Study): a Randomized, Double-Blind, Placebo-Controlled Phase 3 Trial, 381 *LANCET* 2083 (2013) (finding that PrEP can reduce HIV transmission in injecting drug users; “an adherence-based analysis, limited to participants coming daily who met adherence criteria (i.e., took study drug 71% of days with no more than 2 consecutive days off study drug) during a 2–3 month period before incident HIV infections occurred, showed a 55.9% (95% CI, 18.8 to 86.0; P ¼ 0.11) reduction in HIV risk associated with PrEP. Thus, using Cox regression to analyze adherence data from all participants, we found that as adherence improved, the effectiveness of PrEP increased; from 48.9% overall to 58.0% for participants with at least 75% adherence, and to 83.5% for those with at least 97.5% adherence.”).

⁵¹ U.S. Centers for Disease Control & Prevention, *HIV Risk Behaviors*, *supra* note 8. See also France Lert and Michel D. Kazatchkine, *Antiretroviral HIV Treatment and Care for Injecting Drug Users: An Evidence-Based Overview*, 18 *INT. J. DRUG POL.*

While the reduction in risk for those who are on ART and have achieved undetectable viral loads has not been quantified, “based on the available indirect data, the risk of HIV transmission between intravenous drug users is thought to be markedly reduced if the HIV-infected person is on effective ART.”⁵² Three recent studies, published since 2017, show even more promising evidence that adherence to ART and achieving viral suppression reduces the risk of HIV transmission for intravenous drug users.⁵³

5 (2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020510/> (describing the benefits injection drug users can gain from antiretroviral treatment and discussing factors that decrease efficacy).

⁵² Jan Albert et al., *Risk of HIV Transmission from Patients on Antiretroviral Therapy: A Position Statement from the Public Health Agency of Sweden and the Swedish Reference Group for Antiretroviral Therapy*, 46 *Scand. J. Infect. Dis.* 673 (2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4196576/> (“it is reasonable to assume that it provides some risk reduction”). U.S. Centers for Disease Control and Prevention, *Protecting Others*, CDC.gov (Aug. 9, 2019), <https://www.cdc.gov/hiv/basics/livingwithhiv/protecting-others.html> (“We don’t know whether getting and keeping an undetectable viral load prevents HIV transmission through sharing needles or other injection drug equipment. It very likely reduces the risk, but we don’t know by how much.”); U.S. Centers for Disease Control & Prevention, *HIV Treatment as Prevention*, *supra* note 26 (In their estimation of risk of transmission w/undetectable viral load, CDC further quantifies risk for those who share syringes/other drug equipment as “unknown, but likely reduced risk”).

⁵³ Daniel J. Escudero et al., *The Risk of HIV Transmission at Each Step of the HIV Care Continuum among People Who Inject Drugs: A Modeling Study*, 17 *BWC Public Health* 614 (2017) (Estimated that those with suppressed viral load contributed the lowest amount of transmission among new cases among PWID in 2012: “Despite accounting for only 33% of the HIV-infected PWID population, the Undiagnosed were associated with 52.6% (95% simulation interval [95% SI]: 47.1–57.0%) of total transmission events. The Diagnosed – not on ART population contributed the second-largest proportion of HIV transmissions, with 36.6% (95% SI: 32.2–41.5%). The Unsuppressed population contributed 8.7% (95% SI: 5.6–11.8%), and Suppressed 2.1% (95% SI: 1.1–3.9%), relatively little of overall transmission.”); Bodhan Nosyk et al., *The Relative Impacts of Antiretroviral Therapy and Harm Reduction Initiatives on HIV Incidence in British Columbia, Canada, 1996-2013: A Modeling Study*, 4 *Lancet HIV* e303 (Finding that ART, in conjunction with harm reduction, averted 3204 HIV incident cases over study period, with simulation estimates finding that ~1,409 were averted due to ART: “ART alone would have reduced HIV incidence by 44% (10% – 67%) as a result of prevention of HIV transmission through needle sharing;” and “we emphasize that our results were based on an assumed, and likely conservative estimate of 50% efficacy of ART in reducing HIV transmission through needle sharing. If the true efficacy of ART in preventing HIV transmission through needle sharing is closer to its efficacy in sexual transmission, ART’s impact on incident cases averted may be greater than that of harm reduction services.”); Press Release, Nat’l Inst. of Health, *Novel Intervention Halves Rate of Death among People Living with HIV Who Inject Drugs* (Aug. 31, 2018), available at <https://www.nih.gov/news-events/news-releases/novel-intervention-halves-rate-death-among-people-living-hiv-who-inject-drugs> (“The HPTN 074 study was not designed to determine whether the intervention would reduce the rate of HIV infection among injection partners of the participants living with HIV, but rather to determine the feasibility of a larger study that could measure this effect. In HPTN 074, seven injection partners of participants living with HIV who received only the standard of care became infected, while no injection partners of participants living with HIV who received the study intervention became infected. This result is promising, according to the investigators, but because the overall HIV incidence among injection partners was so low, a larger clinical trial to test the effect of the study intervention on HIV transmission among injection drug users would not be feasible.”)

Prostitution and Other Related Crimes

Offense

Two subsections of Ga. Code Ann. § 16-5-60(c) increase penalties for PWH who engage in commercial sex work. Pursuant to Ga. Code Ann. § 16-5-60(c)(3), a PWH who knows they have HIV and “offers or consents to perform with another person an act of sexual intercourse for money” without disclosing that they have HIV is guilty of a felony punishable for up to ten years.⁵⁴ Pursuant to Ga. Code Ann. § 16-5-60(c)(4), a PWH who knows they have HIV and “solicits another person to perform or submit to an act of sodomy for money” without disclosing that they have HIV is also guilty of a felony punishable by up to ten years of imprisonment.⁵⁵ Where a person is charged with prostitution⁵⁶ under the code sections unrelated to HIV, the crime is a misdemeanor rather than a felony.⁵⁷

Notably, these subsections of the statute include oral sex and other forms of sex that have little risk of transmitting HIV. As explained above, while “sexual intercourse” is not defined in this section of the statute, and has not been defined in any court cases, sexual intercourse is defined elsewhere in the Georgia criminal code for another sex offense as “genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex.”⁵⁸ Further, a person commits the offense of sodomy when he or she performs or submits to any sexual act involving the sex organs of one person and the mouth or anus of another.⁵⁹

This crime does not require an intent to transmit HIV, actual transmission, or even behavior that could result in transmission of the virus. Further, the statute does not take into account disclosure of one’s HIV status or any efforts by the defendant to reduce the risk of transmitting the virus, including the use of condoms or ART.

Transmission Risk

There are a number of ways in which this statute, by the breadth of the conduct that it covers, criminalizes behavior that cannot actually transmit HIV:

- **Offers or consents.** To “offer or consent to perform an act of sexual intercourse” requires no sexual contact; rather, it is an agreement or request to engage in sex work. Due to the challenge of arresting people while they are actually engaged in sex acts, the vast majority of people arrested for solicitation are arrested while having a conversation, stepping into a car, or exchanging money—in other words, at a time when no physical contact has occurred and when it

⁵⁴ GA. CODE ANN. § 16-5-60(c)(3), (4).

⁵⁵ GA. CODE ANN. § 16-5-60(c)(3), (4).

⁵⁶ GA. CODE ANN. § 16-6-9 (“A person commits the offense of prostitution when he or she performs or offers or consents to perform a sexual act, including but not limited to sexual intercourse or sodomy, for money or other items of value.”).

⁵⁷ GA. CODE ANN. § 16-6-13(2).

⁵⁸ GA. CODE ANN. § 16-12-100. Under Georgia law “sexual intercourse” requires actual penile penetration (penetration with a sex object does not count). *Propes v. State*, 815 S.E.2d 571 (Ga. Ct. App. 2018); *Rodriguez v. State*, 806 S.E.3d 916 (Ga. Ct. App. 2017); *Ginn v. State*, 667 S.E.3d 712 (Ga. Ct. App. 2008); *Stulb v. State*, 631 S.E.2d 765 (Ga. Ct. App. 2006).

⁵⁹ GA. CODE ANN. § 16-6-2(a)(1). See also *Melton v. State*, 639 S.E.2d 411 (Ga. Ct. App. 2006).

is often unknown whether safer sex practices will be used. It would be an unusual circumstance where a law enforcement officer directly observed sexual conduct in making an arrest for prostitution.

- **Solicits.** Similarly, the crime of “soliciting another person to perform or submit to an act of sodomy” just requires the solicitation; no sexual act in fact is required. Solicitation, does not require any sexual contact to have occurred and it would often be unknown whether safer sex practices would have been used if such sex acts were to take place.
- **Sex acts that have negligible risks of transmission of the virus.** The statute criminalizes oral sex which is highly unlikely to transmit HIV. In fact, oral sex is recommended by the CDC as safer sex practice.⁶⁰

Assuming the relatively rarer circumstance in which a person is arrested for prostitution while in the middle of sexual contact, the type of sex act would determine the risk of transmission. As explained above, sexual conduct carries a low to negligible risk of transmission, and the risk is further reduced by the use of ART and/or condoms.⁶¹

Like the statute described above that criminalizes PWH who engage in sexual conduct outside of prostitution, these two subsections of Georgia’s Reckless Conduct statute were passed in 1988 and do not reflect medical advances that have occurred over the past 30 years or current knowledge about the impact of safer sex practices on transmission rates. Moreover, the statute criminalizes conversations, such as “offering,” “consenting to” or “solicitating” sex acts, that involve no sexual conduct and could not transmit the virus.

Based on this, in 2017, the Georgia House of Representatives Committee on Georgians’ Barriers to Access to Adequate Health Care concluded: “Consider that both prostitution and solicitation of sodomy are misdemeanors under Georgia law when the accused is not infected with HIV. These crimes only become felonies when the accused merely knows they are infected with HIV and fails to disclose their status. Thus, the current language in O.C.G.A. § 16-5-60(c) falls short by penalizing behavior that does not require the type of *intentional behavior* for which an enhanced penalty is typically reserved or the federal government has consistently highlighted for prosecution.”⁶²

⁶⁰ U.S. Centers for Disease Control & Prevention, *HIV Risk Reduction Tool: Oral Sex*, CDC.GOV https://wwwn.cdc.gov/hivrisk/transmit/activities/oral_sex.html (last visited Feb. 14, 2020) (“There’s little to no risk of transmitting HIV through oral sex. What you can do: Choosing activities with little to no risk like oral sex instead of higher-risk activities like anal sex can lower your chances of transmitting HIV.”); U.S. Centers for Disease Control & Prevention, *HIV Risk Reduction Tool: Touching*, CDC.GOV, <https://wwwn.cdc.gov/hivrisk/transmit/activities/touching.html> (last visited Feb. 14, 2020) (“There’s little to no risk for getting or transmitting HIV from touching...What you can do: Choosing activities with little to no risk like touching instead of higher-risk activities like anal or vaginal sex can lower your chances of getting or transmitting HIV. If you use sex toys, do not share them with your partner, or if you do, always cover it with a new condom, and wash it carefully after each use.”).

⁶¹ U.S. CENTERS FOR DISEASE CONTROL & PREVENTION, *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV*, *supra* note 11.

⁶² REPORT OF THE GA. HOUSE COMM. ON GEORGIANS’ BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, *supra* note 4 at 10.

Organ and Tissue Donation

Offense

Pursuant to Ga. Code Ann. § 16-5-60(c)(5), a PWH who knows they have HIV and “donates blood, blood products, other body fluids, or any body organ or body part without” disclosing their HIV-status in advance is guilty of a felony punishable by up to ten years of imprisonment.⁶³ This crime does not require actual transmission of HIV, the actual exposure of another person to HIV (or even, for that matter, actual exposure to the donated blood, blood products, or organ), or the intent to transmit HIV to another person.

Transmission Risk

This subsection of Georgia law was also passed in 1988, at a very different time than today. At that time, legislators would have been aware that a number of hemophiliacs in the US were infected with HIV from blood transfusions during the initial years of the epidemic.⁶⁴ However, in the last twenty years there have been only two known cases of HIV infection through blood, tissue, or organ donation. Testing of blood donors for HIV began in 1985 and was required by the FDA in 1987; even more effective screening procedures were put in place in 1992 and in 1999.⁶⁵

Today, the FDA requires that all blood that is donated in the US be screened for HIV.⁶⁶ HIV screening procedures include serologic testing and mini-pool nucleic acid testing (MP-NAT), which pools six to sixteen samples and screens them together to detect HIV antibodies.⁶⁷ The accuracy of current tests leaves almost no room for error. Current tests are able to screen out virtually all HIV-positive blood donations. There is a short period of time, referred to as the “window period,” when a newly infected person’s level of antigens produced by the virus is not yet detectable; however, this window period is rather narrow (10 - 14 days from onset of infection to first detection using nucleic acid testing). Consequently, there is a very small risk of an HIV-positive donation entering the blood supply.⁶⁸

⁶³ GA. CODE ANN. § 16-5-60(C)(5) (2017).

⁶⁴ Mark Cichocki, *What Is the Risk of HIV in Hemophiliacs?*, VERYWELLHEALTH.COM (Sep. 7, 2019), <https://www.verywellhealth.com/hemophilia-and-hiv-48852>.

⁶⁵ U.S. Food & Drug Admin., *HIV/AIDS Historical Time Line 1981-1990*, FDA.GOV (Jan. 5, 2018), <https://www.fda.gov/patients/hiv-timeline-and-history-approvals/hivaids-historical-time-line-1981-1990>

⁶⁶ U.S. Food & Drug Admin., *Complete List of Donor Screening Assays for Infectious Agents and HIV Diagnostic Assays, Vaccines, Blood & Biologics*, FDA.GOV, http://www.fda.gov/BiologicsBloodVaccines/BloodBloodProducts/ApprovedProducts/LicensedProductsBLAs/BloodDonorScreening/InfectiousDisease/ucm080466.htm#HBsAg_Assays (Apr. 11, 2019) (In addition blood is screened for Hepatitis B and C, Human T-Lymphotropic Virus (HTLV), syphilis, West Nile virus, *Trypanosoma cruzi* (Chagas disease), and cytomegalovirus (CMV)).

⁶⁷ Steven Kleinman, *Risk of HIV from Blood Transfusion*, UPToDATE.COM (Sep. 6, 2019), <https://www.uptodate.com/contents/risk-of-hiv-from-blood-transfusion>.

⁶⁸ U.S. Centers for Disease Control & Prevention, *Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations*, CDC.GOV (June 27, 2014), <https://stacks.cdc.gov/view/cdc/23447>.

Current scientific assessments estimate the risk of an HIV-positive blood transfusion in the US blood supply at about one in 1.4 million to one in 2.3 million.⁶⁹ Since 2002, there has been only one person in the United States who tested positive for HIV due to a blood transfusion.⁷⁰ Health investigators determined that the blood donor in that case did not know he had HIV at the time of the donation and, in fact, could not have known because he donated the blood during the 10-14 day window of time before HIV infection can be detected through screening.⁷¹ Since this one incident in 2008, there have been no reports of such transmissions for blood transfusions;⁷² there have been no reports of transmission through organ donations since 2009.⁷³

In terms of the application of Georgia's HIV criminal law, a donor must know that they have HIV to commit the crime. For a person to know that they have HIV, they must receive positive test results. To receive positive test results, a PWH must obtain an HIV test after the 10-14 day "window period." Since all HIV-positive blood donations that are outside of the window period will be detected and screened out by standard FDA screening tests at the time of donation, any person who knowingly donates HIV-positive blood poses negligible risk to the blood supply, as their blood will be detected and removed by standard screening tools before entering the blood supply. Therefore, a felony law against knowingly donating HIV-positive blood does little to protect the blood supply.

Additionally, like blood donations, all tissue donors must be screened and tested for HIV prior to transplantation.⁷⁴ While there is a risk of HIV-positive tissue donation during the window period as described above, it is exceedingly small.⁷⁵ Even if tissue is received from a donor with HIV, risk of

⁶⁹ See Michael P. Busch et al., *A New Strategy for Estimating Risks of Transfusion-Transmitted Viral Infections Based on Rates of Detection of Recently Infected Donors*, 45 *TRANSFUSION* 254 (2005), available at <https://doi.org/10.1111/j.1537-2995.2004.04215.x>; R.Y. Dodd, E.P. Notari IV, and S.L. Stramer, *Current Prevalence and Incidence of Infectious Disease Markers and Estimated Window-Period Risk in the American Red Cross Blood Donor Population*, 42 *TRANSFUSION* 975 (2002), available at <https://doi.org/10.1046/j.1537-2995.2002.00174.x>; D. Michael Strong & Louis Katz, *Blood-Bank Testing for Infectious Diseases: How Safe is Blood Transfusion?*, 8 *TRENDS IN MOLECULAR MED.* 355, 356 (2002), available at [https://doi.org/10.1016/S1471-4914\(02\)02361-4](https://doi.org/10.1016/S1471-4914(02)02361-4); Shimian Zou, et al., *Prevalence, Incidence, and Residual Risk of Human Immunodeficiency Virus and Hepatitis C Virus Infections Among United States Blood Donors Since the Introduction of Nucleic Acid Testing*, 50 *TRANSFUSION* 1495 (2010), available at <https://doi.org/10.1111/j.1537-2995.2010.02622.x>.

⁷⁰ U.S. Centers for Disease Control & Prevention, *HIV Transmission Through Transfusion—Missouri and Colorado, 2008*, 59 *MMWR* 1335 (2010), available at [HTTPS://WWW.CDC.GOV/MMWR/PREVIEW/MMWRHTML/MM5941A3.HTM](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5941a3.htm).

⁷¹ *Id.* See also Blythe Bernhard, *First Case of HIV from Blood Transfusion Traced to Missouri Donor*, *ST. LOUIS POST-DISPATCH* (Oct. 22, 2010), https://www.stltoday.com/news/local/metro/first-case-of-hiv-from-blood-transfusion-traced-to-missouri/article_318e226b-e782-5fc2-8394-28ca274b46ce.html.

⁷² U.S. Centers for Disease Control & Prevention, *HIV Transmission Through Transfusion—Missouri and Colorado, 2008*, *supra* note 70..

⁷³ U.S. Centers for Disease Control & Prevention, *HIV Transmitted from a Living Organ Donor—New York City, 2009*, 60 *MMWR* 297, 300 (Mar. 18, 2011), available at <https://www.cdc.gov/mmwr/pdf/wk/mm6010.pdf>.

⁷⁴ ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, MEMBER EVALUATION PLAN 9, 38 (2020), https://optn.transplant.hrsa.gov/media/1202/evaluation_plan.pdf.

⁷⁵ Additionally, the Organ Procurement and Transplantation Network policy requires informed consent and that prophylaxis be offered (if available) to recipients from donors who are at increased risk for transmission of blood-borne pathogens. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, POLICIES 295 (2020), <https://optn.transplant.hrsa.gov/>

transmission from transplant varies based on the type of tissue donated. Avascular or relatively avascular tissue donations—donations of tissue that contains limited or no blood vessels or lymphatics, such as the corneas, musculoskeletal tissue and dura matter—have not resulted in HIV transmission.⁷⁶ This may be due, in part, to their avascularity, and in part to tissue processing, which can inactivate HIV.⁷⁷ The few transmission events from tissue donations outside of large organs have been in “vascular tissues, including large marrow containing bone pieces and skin.”⁷⁸ Nevertheless, since the advent of nucleic acid testing (NAT) in 1999, a 20 year period, no HIV transmissions have occurred in musculoskeletal or skin allografts, also known as bone and connective or skin tissue donations.⁷⁹

The highest risk of HIV-positive tissue donations is among donors who are deceased, because such individuals cannot directly answer questions about risk behaviors and profiles.⁸⁰ Further, it is unclear whether HIV tests have the same effectiveness on cadavers.⁸¹ Nonetheless, Georgia’s law criminalizing tissue donors with HIV does not further efforts to combat the disease in the context of deceased donors since the law cannot be enforced against them.

While this statute has no public health benefit, it puts at risk the lives of Georgia residents with HIV by unnecessarily limiting organs available to those who need transplants. This statute potentially makes Georgia out of step not only with current medical practice, but federal law. In 2013, Congress passed the Federal HIV Organ Policy Equity (HOPE) Act, which allows organ donations between donors with HIV and recipients with HIV.⁸²

[media/1200/optn_policies.pdf](#).

⁷⁶ R.J. Simonds, *AIDS Testing: A Comprehensive Guide to Technical, Medical, Social, Legal, and Management Issues*, in *AIDS TESTING* (Gerald Schochetman & J. Richard George, eds., 1994); J.P. Pirnay, et al., *HIV Transmission by Transplantation of Allograft Skin: a Review of the Literature*, 23 *BURNS* 1 (1997), available at [https://doi.org/10.1016/S0305-4179\(96\)00081-2](https://doi.org/10.1016/S0305-4179(96)00081-2).

⁷⁷ Simonds, *supra* note 76; Pirnay, et al., *supra* note 76 at 2; Ellen Heck, Allen Brown, and Dwight H. Cavanagh, *Nucleic Acid Testing and Tissue Safety: An Eye Bank’s Five-Year Review of HIV and Hepatitis Testing for Donor Corneas*, 32 *CORNEA* 503, 505 (2013), available at <https://doi.org/10.1097/ICO.0b013e3182653a7a>.

⁷⁸ Simonds, *supra* note 76.

⁷⁹ M. Hinsenkamp, et al., *Adverse Reactions and Events Related to Musculoskeletal Allografts: Reviewed by the World Health Organization Project NOTIFY*, 36 *INT’L ORTHOPAEDICS* 633 (2012), available at <https://doi.org/10.1007/s00264-011-1391-7>; A. Pruss, et al., *Tissue Donation and Virus Safety: More Nucleic Acid Amplification Testing is Needed*, 12 *Transplant Infectious Disease* 375, 380 (2010), available at <https://doi.org/10.1111/j.1399-3062.2010.00505.x>.

⁸⁰ A. Pruss, et al., *supra* note 79 at 378-79. Nevertheless, the Organ Procurement and Transplantation Network policy requires a review of a deceased donor’s medical and behavioral history and a complete physical examination. See *ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, POLICIES*, *supra* note 75 at 22.

⁸¹ I. Wilkemeyer, et al., *Comparative Infectious Serology Testing of Pre- and Post-Mortem Blood Samples from Cornea Donors*, 13 *CELL & TISSUE BANKING* 447 (2012), available at <https://doi.org/10.1007/s10561-012-9326-0>.

⁸² Under the HIV Organ Policy Equity Act, Pub. L. No. 113-51, 127 Stat. 579 (2013), an individual living with HIV can donate an organ to another individual living with HIV. As of December 2018, more than 100 such organ transplants had been performed. United Network for Organ Sharing, *100 people transplanted thanks to HOPE Act*, UNOS.ORG (Dec. 20, 2018), <https://unos.org/news/100-peopletransplanted-thanks-to-hope-act/>. Recipients must be under the care of approved research institutions that are following the criteria put forth by the Organ Procurement and Transplantation Network 42 U.S.C. § 274f-5. The federal definition of “organs” in this context includes donor tissue. 42 C.F.R. § 121.2. However, based

Despite the HOPE Act, Georgia has not repealed the prohibition against organ and tissue donations by HIV-positive donors, thereby limiting the ability to use HIV-positive organ and tissue donations for Georgia residents living with HIV. Of course, increasing the pool of available organs helps recipients who are HIV-negative as well. For example, California ended its prohibition on organ and tissue donations by HIV-positive donors at the request of surgeons so they could immediately proceed with organ transplants in order to save patients' lives.⁸³ Nationally, it has been estimated that HIV criminal laws may be preventing as many as five hundred HIV-positive organs from becoming available every year for HIV-positive recipients.⁸⁴ Of course, there is a way to interpret this subsection of Georgia's Reckless Conduct state to allow such donations as long as the organ donor "discloses" that they have HIV. But at best, the current subsection from 1988 creates confusion and does not reflect the policy goals advanced by the more recently enacted HOPE Act.

ASSAULT WITH INTENT CRIMES

Georgia also criminalizes assault upon a peace officer or a corrections officer with intent to transmit HIV. While these two crimes also do not require actual transmission, they do require the intent to transmit HIV. However, since the passage of these two subsections in 2003, only one person has been convicted of either of these crimes and we can not infer that that person had HIV.⁸⁵

Assault upon a Peace Officer or Corrections Officer with Intent to Transmit HIV

Offense

Pursuant to Ga. Code Ann. § 16-5-60(d)(1), a PWH or hepatitis who knows they have HIV and "commits an assault with the intent to transmit HIV or hepatitis, using his or her body fluids (blood, semen, or vaginal secretions), saliva, urine, or feces upon" on a peace officer is guilty of a felony punishable by up to 20 years of imprisonment.⁸⁶ Ga. Code Ann. § 16-5-60(d)(2) is the same offense but applies to correctional officers. While this statute requires an intent to transmit HIV, the actual transmission of HIV, or even behavior that could transmit the virus, is not required. Moreover, the use of ART to reduce transmission risk is not taken into account by the statute.

on current scientific advances and NIH protocol, at this time, only kidneys and livers are being used from donors who have HIV. U.S. Dep't of Health & Human Serv., *HOPE Act*, <https://optn.transplant.hrsa.gov/learn/professional-education/hope-act/> (last visited May 5, 2019).

⁸³ Alexei Koseff, *California to Allow Transplants Between HIV-infected People*, SACRAMENTO BEE CAPITOL ALERT (May 27, 2016, 11:47AM), <https://www.sacbee.com/news/politics-government/capitol-alert/article80346002.html>

⁸⁴ Nina Bai, *Moving Mountains: A Surgeons Fight to Legalize HIV-to-HIV Organ Transplants*, UCSF.EDU (Jun. 20, 2017), <https://www.ucsf.edu/news/2017/06/407411/moving-mountains-surgeons-fight-legalize-hiv-hiv-organ-transplants> (last visited Feb. 1, 2020).

⁸⁵ Only two people have ever been charged with one of these crimes where we could infer they had HIV. Neither of these people were convicted of this crime.

⁸⁶ GA. CODE ANN. § 16-5-60(d)(1).

Transmission Risk

To the extent the statute broadly includes the transmission of “body fluids,” it criminalizes the transmission of fluids such as sweat, saliva, tears, urine, and feces that cannot transmit HIV.⁸⁷ Further, HIV does not survive long outside the human body; it cannot reproduce outside a human host; and it decays upon exposure to air.⁸⁸ The possibility of HIV transmission between adults outside the context of sexual activity, contaminated needles, and blood transfusion is essentially zero.⁸⁹ As explained above, the risk is further reduced by the use of ART. Accordingly, these assault statutes cover little to no activity that actually poses a risk for transmitting HIV.

SUMMARY

From 1988 through September of 2017, there were 74 convictions under Georgia’s HIV criminal laws—approximately two to three convictions per year. Of those, none required intent to transmit HIV as an element of the crime, and none required proof of actual transmission of HIV. Further, it is possible that some of these convictions were not based on behavior that could actually transmit the virus. Georgia’s HIV criminal laws were passed in 1988 and 2003. We now know that people living with HIV can achieve viral suppression and have life expectancies similar to those who are not living with HIV. Additionally, we now know that those with undetectable viral loads cannot transmit the virus through sexual conduct.

In 2017, the Georgia House of Representatives Committee on Georgians’ Barriers to Access to Adequate Health Care concluded: “In 1988, at the first implementation of statutory measures criminalizing certain behaviors of citizens living with (HIV), the Georgia General Assembly expressed an intent to exercise the state’s police power to ‘deal with AIDS and HIV.’” It seems most appropriate to interpret this intent as a desire to strive to make policies that support a reduction of HIV infection in Georgia. Unfortunately, that initial enactment, which remains part of our overall criminal law in this context today, did not require an intent to expose or transmit HIV. Instead, it broadly condemns behaviors, some with negligible risk of transmission, irrespective of the likelihood of being a vehicle for increasing the spread of HIV among Georgia’s citizens.”⁹⁰

⁸⁷ U.S. Centers for Disease Control & Prevention, *HIV and STD Criminal Laws*, CDC.gov (Jul. 1, 2019), <https://www.cdc.gov/hiv/policies/law/states/exposure.html>; J. Stan Lehman, et al., *Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States*, 18 AIDS BEHAV. 997 (2014), available at <https://doi.org/10.1007/s10461-014-0724-0>.

⁸⁸ U.S. CENTERS FOR DISEASE CONTROL & PREVENTION, OCCUPATIONAL HIV TRANSMISSION AND PREVENTION AMONG HEALTH CARE WORKERS 1 (2015), <https://www.cdc.gov/hiv/pdf/workplace/cdc-hiv-healthcareworkers.pdf> (“Health care workers who are exposed to a needlestick involving HIV-infected blood at work have a 0.23% risk of becoming infected,” and the “[r]isk of exposure due to splashes with bodily fluids is thought to be near zero even if the fluids are overtly bloody”).

⁸⁹ U.S. Centers for Disease Control & Prevention, *HIV Transmission*, CDC.gov (Aug. 6, 2019), <https://www.cdc.gov/hiv/basics/transmission.html>.

⁹⁰ REPORT OF THE GA. HOUSE COMM. ON GEORGIANS’ BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, *supra* note 4 at 9.

THE IMPACT OF GEORGIA'S HIV CRIMINALIZATION LAWS ON PUBLIC HEALTH

While the continued enforcement of Georgia's HIV-specific criminal laws does little to prevent the spread of HIV, these laws may undermine the state's public health efforts by: 1) deterring people from seeking HIV testing and treatment, 2) stigmatizing PWH, and 3) impacting vulnerable communities who are most at risk of HIV—the very communities that Georgia seeks to engage in its fight against HIV.

HIV CRIMINAL LAWS MAY DETER TESTING, DISCLOSURE, AND OTHER HIV PREVENTION STRATEGIES

Rather than contributing to efforts to stop the spread of HIV, HIV criminalization laws may undermine HIV prevention strategies. Some research shows that HIV criminal laws have no public health benefits, while other studies suggest they have a negative impact.⁹¹ For example, some research, summarized below, suggests that HIV criminalization laws may discourage individuals from getting tested and knowing their HIV-status, since laws require knowledge of one's status in order to be convicted. This can undermine prevention efforts since those who do not know their status are more likely than those who do know to transmit the virus and are estimated to account for one-third of all new transmissions.⁹² One study found higher rates of PWH who don't know their positive status in states with laws criminalizing HIV exposure, suggesting that such laws may be disincentivizing testing among those most at risk.⁹³ Another study found that testing rates remained stable following enactment of an HIV criminal law,⁹⁴ but decreased following increased media coverage of HIV criminal exposure prosecutions.⁹⁵ While more systematic reviews have found that HIV criminalization laws have little impact on testing rates for people in general, they may lead those from the highest risk groups to avoid testing altogether, only to test anonymously, or to have more anonymous sexual encounters.⁹⁶

⁹¹ Concluding that “Criminal exposure laws had no effect on detectable HIV prevention.” REPORT OF THE GA. HOUSE COMM. ON GEORGIANS' BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, *supra* note 4 at 9.

⁹² Jacek Skarbinski et al., *Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States*, 175 JAMA INTERNAL MED. 588 (2015), available at <https://doi.org/10.1001/jamainternmed.2014.8180>.

⁹³ Pratha Sah et al., *HIV Criminalization Exacerbates Subpar Diagnosis and Treatment Across the United States: Response to the Association of HIV Diagnosis Rates and Laws Criminalizing HIV Exposure in the United States*, 31 AIDS 2437 (2017), available at <https://doi.org/10.1097/QAD.0000000000001636>.

⁹⁴ Patricia Sweeney et al., *Association of HIV Diagnosis Rates and Laws Criminalizing HIV Exposure in the United States*, 31 AIDS 1483-1488 (2017), available at <https://doi.org/10.1097/QAD.0000000000001501>.

⁹⁵ Sun Goo Lee, *Criminal Law and HIV Testing: Empirical Analysis of How At-Risk Individuals Respond to Law*, 14 YALE J. HEALTH POL'Y L. & ETHICS 194, iv (2014), available at <https://digitalcommons.law.yale.edu/yjhple/vol14/iss1/4/>.

⁹⁶ Dini Harsono et al., *Criminalization of HIV Exposure: A Review of Empirical Studies in the United States*, 21 AIDS BEHAV. 27 (2017), available at <https://doi.org/10.1007/s10461-016-1540-5>; Patrick O'Byrne, Alyssa Bryan, and Marie Roy, *HIV Criminal Prosecutions and Public Health: An Examination of the Empirical Research*, 39 MED. HUMANIT. 85 (2013), available at <https://doi.org/10.1136/medhum-2013-010366>.

Further, HIV criminalization laws may undermine HIV prevention strategies in other ways. Most studies have found that HIV criminal laws do not impact sexual risk behaviors for either PWH or people who do not have HIV;⁹⁷ a few have found that such laws *increase* sexual risk behaviors.⁹⁸ Similarly, rather than encouraging disclosure, HIV criminal laws may lead PWH to hide their status from sexual partners out of fear of criminal prosecution, including that a partner may later falsely claim they did not reveal their HIV-status.⁹⁹ Other studies suggest that such laws may also make PWH less likely to disclose their HIV status or risk behaviors to health care providers.¹⁰⁰ For HIV service providers, these laws can shift the focus from having open conversations and providing crucial prevention information toward discussions of legal, rather than health, consequences.¹⁰¹ Finally, by criminalizing sex work, in particular, with much harsher penalties, HIV criminal laws may discourage sex workers from seeking health care services including testing and treatment (for fear of criminal liability) or from negotiating safer sex practices with clients (for fear of being picked up by law enforcement while having longer conversations with clients).¹⁰²

HIV CRIMINAL LAWS UNDERMINE PUBLIC HEALTH BY INCREASING HIV STIGMA

HIV criminal laws also undermine Georgia’s ability to combat HIV by increasing stigma related to HIV. Georgia’s current five-year plan for combating HIV in the state identifies HIV stigma in general, and HIV criminalization more specifically, as key barriers to reaching the state’s goals in combatting HIV. In 2017, a state legislative report identified that modernizing the state’s HIV criminal laws was important because they create stigma that has a negative impact the state’s ability to combat HIV.

⁹⁷ O’Byrne, *supra* note 92; Scott Burris et al., *Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial*, 39 ARIZ. STATE LAW J. 467 (2007), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=977274.

⁹⁸ Keith J. Hovath et al., *Men Who have Sex with Men Who Believe that Their State has a HIV Criminal Law Report Higher Condomless Anal Sex than Those Who are Unsure of the Law in Their State*, 21 AIDS BEHAV. 51 (2017), available at <https://doi.org/10.1007/s10461-016-1286-0>.

⁹⁹ Carol L. Galletly & Stephen D. Pinkerton, *Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV*, 10 AIDS BEHAV. 451 (2006), available at <https://doi.org/10.1007/s10461-006-9117-3>.

¹⁰⁰ O’Byrne, *supra* note 92; Eric Mykhalovskiy et al., *The Public Health Implications of Criminalizing HIV, Non-Disclosure, Exposure, and Transmission: Report of an International Workshop* (2014), available at <https://www.hivlawandpolicy.org/sites/default/files/Public%20Health%20Implications%20of%20Criminalizing%20HIV%20Non-Disclosure.%20Exposure%20and%20Transmission.pdf>.

¹⁰¹ Eric Mykhalovskiy, *The Problem Of “Significant Risk”: Exploring The Public Health Impact Of Criminalizing HIV Non-Disclosure*, 73 SOC. SCI. MED. 668 (2011), available at <https://doi.org/10.1016/j.socscimed.2011.06.051>.

¹⁰² See, e.g., Sienna Baskin et al., *Criminal Laws on Sex Work and HIV Transmission: Mapping the Laws, Considering the Consequences*, 93 DENVER L. REV. 355 (2016); Margaret H. Wurth et al., *Condoms as Evidence of Prostitution in the United States and the Criminalization of Sex Work*, 16 J. INT. AIDS SOC. (2013), available at <https://doi.org/10.7448/IAS.16.1.18626>; CENTER FOR HIV LAW AND POLICY & NATIONAL LGBTQ TASK FORCE, *THE INTERSECTION OF SEX WORK AND HIV CRIMINALIZATION: AN ADVOCATE’S TOOLKIT* (2017), [https://www.hivlawandpolicy.org/sites/default/files/Sex Work HIV Toolkit FINAL R2 0.pdf](https://www.hivlawandpolicy.org/sites/default/files/Sex%20Work%20HIV%20Toolkit%20FINAL%20R2%200.pdf). In some states, possession of a condom is viewed as sufficient evidence of intent to solicit, discouraging the very behavior that would reduce HIV transmission risk. *Id.*

HIV criminalization laws contribute to the stigmatization of PWH in a number of ways. First, they perpetuate inaccurate beliefs about how HIV is transmitted by criminalizing behavior that cannot transmit the virus. Further, by carrying significant criminal penalties, they convey that the consequences of the disease are much more severe, if not fatal, despite the reality that, for most today, HIV is managed much like other chronic health conditions.¹⁰³ In addition, these laws send the message that PWH are a threat even when engaged in consensual conduct that cannot transmit the virus. This undermines an important public health message created in the earliest days of the AIDS epidemic—that specific types of conduct, not certain types of people, transmit HIV.¹⁰⁴ The negative and inaccurate messages conveyed by these laws serve to reinforce discriminatory attitudes and behavior towards PWH; contribute to PWH having a negative self-image; and lead PWH to isolate themselves because they fear discrimination and harassment.¹⁰⁵ All of these are forms of stigma.¹⁰⁶

In 2017, the Georgia House of Representatives Committee on Georgians' Barriers to Access to Adequate Health Care, specifically linked the state's current HIV criminalization laws to stigma that has a negative impact the state's ability to combat HIV. The report lists "stigma of positive status" as one of "the most common barriers to HIV/AIDS treatment."¹⁰⁷ It concludes that modernizing the state's HIV criminal laws will provide "an environment that urges personal responsibility for sexual health, reduces stigma, encourages and facilitates testing, and is important for collaboration and maintenance of care."¹⁰⁸

Moreover, Georgia's current five-year strategy for fighting HIV has as central goal of fighting stigma. Stigma is seen as hindering people's "engagement in [HIV] prevention and care services"¹⁰⁹ and combatting stigma is identified as a central strategy to reduce HIV related health disparities based on race, sexual orientation, gender, gender identity, and age.¹¹⁰ This includes fighting the "stigma and victimization" that MSM¹¹¹ and

¹⁰³ Matthew Weait, *HIV Stigma and the Criminal Law*, On Health, BIOMEDCENTRAL.COM (Dec. 1, 2016), <https://blogs.biomedcentral.com/on-health/2016/12/01/hiv-stigma-and-the-criminal-law/>; Baskin et al., *supra* note 98; Galletly & Pinkerton, *supra* note 95.

¹⁰⁴ Aziza Ahmed et al., *Criminalising Consensual Sexual Behaviour in the Context of HIV: Consequences, Evidence, and Leadership*, 6 GLOB. PUBLIC HEALTH S357 (2011), available at <https://doi.org/10.1080/17441692.2011.623136>; Weait, *supra* note 99; Galletly & Pinkerton, *supra* note 95.

¹⁰⁵ Ahmed et al., *supra* note 100; Sergio Rueda et al., *Examining the Associations Between HIV-Related Stigma and Health Outcomes in People Living With HIV/AIDS: A Series of Meta-Analyses*, 6 BMJ OPEN (2016), available at <https://doi.org/10.1136/bmjopen-2016-011453>.

¹⁰⁶ *Id.*

¹⁰⁷ REPORT OF THE GA. HOUSE COMM. ON GEORGIANS' BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, *supra* note 4 at 9.

¹⁰⁸ *Id.* at 11.

¹⁰⁹ GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017–2021, *supra* note 32 at 51, 82-83 ("HIV Prevention and Service Barriers, Social and Structural barriers: stigma related to behaviors of HIV risk for infection and discrimination").

¹¹⁰ *Id.* at 139, 140, 142 (2015-2020 NHAS Goal 3: Reduce HIV related health disparities and health inequities; 2017-2021 SMART Objective 2: By 2021, reduce disparities related to race, sexual orientation, gender, gender identity, and age to improve retention in care of targeted populations by 50%; Strategy 4: Reduce stigma and discrimination based on HIV status, gender identity and expression, sexual identity and expression, race/ethnicity, and socioeconomic status among PWH).

¹¹¹ GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017–2021, *supra* note

transgender populations face, that in part accounts for their much higher rates of HIV.¹¹²

Some of the many activities in Georgia's five-year plan for combatting stigma include a state-wide anti-stigma campaign; creating a community based advisory group and MSM/Transgender strategies as "a multi-tiered approach to mitigating stigmas attached to HIV and sexuality;"¹¹³ a "Speak Out HIV" campaign to empower young, gay and bisexual men to reduce the stigma associated with HIV, particularly the stigma around getting tested, disclosing status, and remaining engaged in care;¹¹⁴ and conducting trainings for provider staff and partner agencies in the state on a number of topics related to stigma and its negative impacts on fighting HIV in the state, including "trainings on state and federal laws on stigma, discrimination and criminalization of HIV."¹¹⁵ The plan also notes that "additional resources are needed to address stigma."¹¹⁶

Finally, the link between HIV stigma and worse health outcomes for PWH is well documented. Stigma has been described as a "fundamental cause of health inequalities," serving as a significant source of stress while imposing structural, social, material, and even economic disadvantage on those stigmatized, ultimately leading to poorer health.¹¹⁷ More specifically, higher rates of HIV stigma have been linked with depression, worse mental and physical health, more severe HIV symptomology, lower medication adherence, and lower social support.¹¹⁸ By furthering HIV stigma, HIV criminalization

32 ("Since the discovery of HIV/AIDS, MSM have been disproportionately impacted. Estimated to be two to four percent of the population, they exceed 50% of HIV prevalence (total cases) and nearly two-thirds of new diagnoses. ...Further complicating the landscape are a host of structural factors, such as stigma and victimization.").

¹¹² *Id.* at 50-51.

¹¹³ *Id.* at 51 (This initiative shall mobilize a community-based advisory group to recommend actionable steps. The MSM/Transgender strategy maps out over 30 activities to address eight NHAS goals.).

¹¹⁴ *Id.* at 64.

¹¹⁵ *Id.* at 142 (Including conducting training for provider staff and partner agencies on: "Office of Minority Subrecipients Health's National Culturally and Linguistically Appropriate Part A Standards (CLAS); providing culturally and linguistically appropriate care for LGBT, gender identity and sexual identity and expression, non-English speaking populations, African American and Hispanics, precariously housed and homeless, formerly incarcerated, substance users, individuals with mental health problems, and lower socioeconomic populations; health disparities and impact of stigma and discrimination; and state and training federal laws on stigma, documented in discrimination and criminalization of HIV").

¹¹⁶ *Id.* at 75 (Additional resources are needed to address stigma. Part A agencies are working with the Georgia DPH to coordinate with their statewide anti-stigma campaign.).

¹¹⁷ Mark L. Hatzenbuehler et al., *Stigma as a Fundamental Cause of Population Health Inequalities*, 103 AM. J. PUBLIC HEALTH 813 (2013), available at <https://doi.org/10.2105/AJPH.2012.301069>; Patrick W. Corrigan, *Structural Stigma in State Legislation*, 56 PSYCHIATR. SERV. 557 (2005), available at <https://doi.org/10.1176/appi.ps.56.5.557>; Jo C. Phelan et al., *Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications*, 51 J. HEALTH SOC. BEHAV. S28 (2010), available at <https://www.jstor.org/stable/20798314>.

¹¹⁸ Sergio Rueda et al., *Examining the Associations Between HIV-Related Stigma and Health Outcomes in People Living With HIV/AIDS: A Series of Meta-Analyses*, 6 BMJ OPEN (2016), available at <https://doi.org/10.1136/bmjopen-2016-011453>; C. Logie & T.M. Gadalla, *Meta-Analysis of Health and Demographic Correlates of Stigma Towards People Living With HIV*, 21 AIDS CARE 742 (2009), available at <https://doi.org/10.1080/09540120802511877>; Bulent Turan et al., *How Does Stigma Affect People Living with HIV? The Mediating Roles of Internalized and Anticipated HIV Stigma in the Effects of Perceived Community Stigma on Health and Psychosocial Outcomes*, 21 AIDS BEHAV. 283 (2017), available at <https://doi.org/10.1007/s10461-016-1451-5>; Peter A. Venable et al., *Impact of HIV-Related Stigma on Health Behaviors and Psychological Adjustment Among HIV-Positive*

laws increase the risk of these adverse outcomes, as well as PWH's vulnerability to discrimination, harassment, and violence.¹¹⁹

GEORGIA'S HIV CRIMINAL LAWS HAVE A DISPROPORTIONATE IMPACT ON THE POPULATIONS THE STATE MUST ENGAGE TO FIGHT THE EPIDEMIC

For Georgia's HIV prevention efforts to be successful, the state's public health and medical systems must engage people of color, women, LGBTQ communities, and sex workers. However, these are precisely the groups of people that are disproportionately impacted by the state's HIV criminal laws. The risk is that the state's criminal laws alienate these communities and individuals, as opposed to creating the cooperative environment needed to successfully combat HIV.

People of Color and Women

HIV is growing more rapidly in Georgia than almost any other state. In 2017, Georgia was the state with the highest rate of new HIV infections, only surpassed by Washington DC.¹²⁰ As of December 31, 2017, there were 58,808 people with HIV in Georgia: 75% were male, 24% were female, and 1% were transgender.¹²¹ The vast majority of new infections are among people of color. In 2017, 72% of those newly diagnosed with HIV-disease were Black and 16% were Hispanic.¹²² The rate of new infections was over ten times higher for Black people and over 2.5 times higher for Latinx people than for white people living in the state.¹²³

Due to the concentration of the HIV epidemic among people of color in the state, one of the primary objectives in Georgia's five-year plan to combat HIV is to "reduce HIV related health disparities and inequities" by reducing disparities in the rate of new diagnosis among "young Black/African American gay and bisexual men, and Black/African American women, and Hispanics."¹²⁴ Similarly, primary goals

Men and Women, 10 AIDS BEHAV. 473 (2006), available at <https://doi.org/10.1007/s10461-006-9099-1>.

¹¹⁹ Aziza Ahmed et al., *Criminalising Consensual Sexual Behaviour in the Context of HIV: Consequences, Evidence, and Leadership*, 6 GLOB. PUBLIC HEALTH S357 (2011), available at <https://doi.org/10.1080/17441692.2011.623136>; Carol L. Galletly & Stephen D. Pinkerton, *Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV*, 10 AIDS BEHAV. 451 (2006), available at <https://doi.org/10.1007/s10461-006-9117-3>; Vanable et al., *supra* note 114; Matthew Weait, *HIV Stigma and the Criminal Law*, On Health, BIOMEDCENTRAL.COM (Dec. 1, 2016), <https://blogs.biomedcentral.com/on-health/2016/12/01/hiv-stigma-and-the-criminal-law/>.

¹²⁰ John Elflein, *U.S. States with the Highest Rates of HIV Diagnoses*, STATISTA.COM (Aug. 9, 2019), <https://www.statista.com/statistics/257734/us-states-with-highest-aids-diagnosis-rates/>.

¹²¹ GA. DEP'T OF PUBLIC HEALTH, HIV SURVEILLANCE FACT SHEET: GEORGIA, 2017 3 (Jan. 29, 2019), available at <https://dph.georgia.gov/georgias-hiv-aids-epidemiology-section/georgia-hiv-surveillance-data>.

¹²² *Id.*

¹²³ *Id.* at 2.

¹²⁴ GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017–2021, *supra* note 32 at 139, 146 ("2015–2020 NHAS Goal 3: Reduce HIV related health disparities and health inequities; 2017–2021 SMART Objective 4: By 2021, reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black/African American gay and bisexual men, and Black/African American women; Strategy 1: By 2021, reduce HIV-related disparities in communities at high risk. AA YMSM • MSM • Transgender Women • AA Women •

related to reducing HIV infections in the state,¹²⁵ linking and retaining PWH in HIV care, and improving health outcomes of PWH¹²⁶ focus on communities of color. In addition, efforts focused on MSMs are specifically focused on African Americans and Latino MSMs.¹²⁷ However, Georgia's HIV criminalization laws undermine these efforts by disproportionately impacting people of color.

Williams Institute research shows that Black people in particular are impacted by Georgia's HIV offenses. (The state does not keep data in its criminal records system that indicate whether defendants are Latinx or Hispanic). Six out of ten people arrested for an HIV offense (63%) in Georgia were Black: 46% of people arrested for such offense were Black males and 16% were Black Females.¹²⁸ White males made up 26% of arrests for HIV offenses and White females made up 11%.¹²⁹ Further, when White men and Black men are compared directly, Black men had conviction rates under HIV-related offenses that were nearly twice as high as white men (16% versus 9% respectively).¹³⁰ The evidence of the disproportionate impact of HIV criminal laws on people of color in Georgia is consistent with analysis of data from other states conducted by the Williams Institute, including California¹³¹ and Florida.¹³²

Hispanics”).

¹²⁵ *Id.* at 125 (“2015-2020 NHAS Goal 1: Reducing new HIV Infections. 2017-2021 SMART Objective 1: By December 2021, increase the percentage of people living with HIV (PLWH) who know their serostatus to 90%. Strategy 1: Intensify HIV testing efforts in the communities where HIV is most heavily concentrated. AA MSM • MSM • Transgender • AA Women • Hispanics).

¹²⁶ *Id.* at 129, 132 (“2015-2020 NHAS Goal 2: Increase access to care and improve health outcomes. 2017-2021 SMART Objective 1: By December 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of HIV diagnosis to at least 90% and engage individuals identified as out of care (no medical appointment in last 6 months; Strategy 7: Incorporate opportunities for client engagement into all aspects of service delivery. Transgender • Women • Hispanic • AA Women • MSM”).

¹²⁷ *Id.* at 51 (Black and Latino MSM focus).

¹²⁸ AMIRA HASENBUSH, HIV CRIMINALIZATION IN GEORGIA: PENAL IMPLICATIONS FOR PEOPLE LIVING WITH HIV/AIDS, WILLIAMS INSTITUTE 15 (2018), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-Georgia-Jan-2018-1.pdf>.

¹²⁹ *Id.* at 15.

¹³⁰ *Id.*

¹³¹ AMIRA HASENBUSH, HIV CRIMINALIZATION IN CALIFORNIA: PENAL IMPLICATIONS FOR PEOPLE LIVING WITH HIV, WILLIAMS INSTITUTE 17 (2016), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-California-Updated-June-2016.pdf>. Statistical analyses of data related to HIV crimes in California have shown that Black men were more likely to be arrested for HIV-related offenses than their White counterparts: 17% of HIV-related arrests were of White males, while 22% of HIV-related arrests were of Black males. Additionally, both Black and White women were disproportionately represented in HIV-related arrests when compared to the general population living with HIV.

¹³² AMIRA HASENBUSH, HIV CRIMINALIZATION IN FLORIDA: PENAL IMPLICATIONS FOR PEOPLE LIVING WITH HIV, WILLIAMS INSTITUTE (2018), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-Florida-Oct-2018.pdf>. While data from Florida do not allow us to measure the impact of enforcement on Latinos, in Florida, 43% of all arrests for HIV crimes were among Black people. Further, Black adults were far more likely to be convicted of an HIV offense among those charged with an HIV crime. For example, 30% of Black men v. 22% of white men were convicted under the state's HIV exposure statute. In terms of sex work, over 60% of Black women, and 42% of Black men who were arrested for an HIV sex work offense were convicted under an HIV statute, compared with 36% of White women and 18% of White men.

Women, and more specifically women of color, are also a focus of Georgia's current five-year plan to combat HIV in the state. One of the primary objectives in Georgia's five-year plan is to "reduce HIV related health disparities and inequities" by reducing disparities in the rate of new diagnosis among "Black/African American women" and women more generally.¹³³ Similarly, primary goals related to linking and retaining PWH in HIV care and improving health outcomes¹³⁴ focus on women more generally and African-American women in particular. However, Georgia's HIV criminalization laws undermine these efforts by disproportionately impacting women.

In Georgia, women are disproportionately arrested for HIV-related offenses. Women made up 27% of those arrested for HIV offenses and 75% of all HIV-related offenses that had a concurrent sex work arrest,¹³⁵ while accounting for only 24% of all PWH statewide.¹³⁶ Overall, White women account for only 3% of all PWH in Georgia, yet accounted for 11% of all HIV crime arrests and 26% of all such arrests with a concurrent sex work offense.¹³⁷ Similarly, Black women accounted for 16% of all HIV-related arrests and 49% of HIV sex work arrests, despite representing only 19% of Georgians who have HIV.¹³⁸

¹³³GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021, *supra* note 32 at 139, 146 ("2015-2020 NHAS Goal 3: Reduce HIV related health disparities and health inequities; 2017-2021 SMART Objective 4: By 2021, reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black/African American gay and bisexual men, and Black/African American women; Strategy 1: By 2021, reduce HIV-related disparities in communities at high risk. AA YMSM • MSM • Transgender Women • AA Women • Hispanics").

¹³⁴*Id.* at 129, 132 ("2015-2020 NHAS Goal 2: Increase access to care and improve health outcomes. 2017-2021 SMART Objective 1: By December 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of HIV diagnosis to at least 90% and engage individuals identified as out of care (no medical appointment in last 6 months); Strategy 7: Incorporate opportunities for client engagement into all aspects of service delivery. Transgender • Women • Hispanics • AA Women • MSM").

¹³⁵AMIRA HASENBUSH, HIV CRIMINALIZATION IN GEORGIA: PENAL IMPLICATIONS FOR PEOPLE LIVING WITH HIV/AIDS, *supra* note 124 at 9, 18.

¹³⁶GA. DEP'T OF PUBLIC HEALTH, HIV SURVEILLANCE FACT SHEET: GEORGIA, 2017, *supra* note 117 at 3.

¹³⁷AMIRA HASENBUSH, HIV CRIMINALIZATION IN GEORGIA: PENAL IMPLICATIONS FOR PEOPLE LIVING WITH HIV/AIDS, *supra* note 124 at 15, 16.

¹³⁸*Id.*

LGBTQ Communities

The HIV epidemic disproportionately impacts LGBTQ communities. As such, Georgia has recognized the importance of working closely with LGBTQ communities, and all PWH, to combat the disease. Yet, the enforcement of HIV crimes in Georgia disproportionately affects members of communities that are the most impacted by HIV in the state and undermines cooperative relationships with people of color, women, and LGBTQ communities that are needed to fight HIV.

MSMs comprise over 52% of all PWH in Georgia and 82% of new HIV diagnoses in 2017 in Georgia were attributed to MSM sexual contact.¹³⁹ While data on the prevalence of HIV among transgender people in Georgia are sparse, it is estimated that at least 1% of the PWH in Georgia are transgender.¹⁴⁰ According to Georgia's current five-year plan to fight HIV, "Although there is no systematic surveillance data for the transgender population, it has been estimated in recent studies that between 41% to 63% of Black/African American transgender women, 14% to 50% of Latina transgender women, and 4% to 13% of Asian-Pacific Islander transgender women are HIV-positive. Initial studies of transgender male youth have also estimated the HIV prevalence to be between 19% and 22%. Other studies of the overall prevalence of HIV among transgender men estimate that 2% to 3% of transgender men are HIV-positive."¹⁴¹

While there are no data that allow us to identify the sexual orientation or gender identity of those charged with Georgia's HIV related offenses, given the demographics of HIV in the state (over 53% MSM and/or transgender), it is likely that many of those arrested or convicted are LGBTQ. This may be particularly true to the extent that Georgia's HIV crimes are enforced against sex workers, and at least 8% of the HIV-related offenses had a concurrent sex work related charge.¹⁴² The scope of Georgia's prostitution and sodomy laws includes survival sex work, such as sex work in exchange for money, housing, or food. As a result, such statutes result in several vulnerable groups being directly targeted for arrest and criminal penalties, including LGBTQ people and women of color.

¹³⁹ GA. DEP'T OF PUBLIC HEALTH, HIV SURVEILLANCE FACT SHEET: GEORGIA, 2017, *supra* note 117 at 2.

¹⁴⁰ *Id.* at 1.

¹⁴¹ GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017–2021, *supra* note 32 at 13.

¹⁴² AMIRA HASENBUSH, HIV CRIMINALIZATION IN GEORGIA: PENAL IMPLICATIONS FOR PEOPLE LIVING WITH HIV/AIDS, *supra* note 124 at 13.

The criminalization of sex work is much more likely to impact LGBTQ populations, particularly LGBTQ youth and transgender adults.¹⁴³ LGBTQ youth are overrepresented in the foster care system,¹⁴⁴ more likely to be homeless,¹⁴⁵ and report high levels of subsistence and survival sex.¹⁴⁶ In one study among LGBTQ youth, young men were three times as likely as young women to have traded sex for a place to stay, and in general, LGBTQ youth were seven to eight times more likely than heterosexual youth to have done so.¹⁴⁷ Another study found that transgender youth in New York City were eight times more likely than their cisgender peers to trade sex for shelter.¹⁴⁸ Further, a national survey of youth in juvenile justice facilities found that LGB youth are much more likely than non-LGB youth to be in juvenile detention on prostitution-related offenses—about double the rate for girls and 10 times the rate for boys.¹⁴⁹

¹⁴³ See, e.g., Zack Ford, *How LGBT People Would Benefit From The Decriminalization Of Sex Work*, THINKPROGRESS.ORG (Jul. 28, 2015), <https://thinkprogress.org/how-lgbt-people-would-benefit-from-the-decriminalization-of-sex-work-fbb53b44a103/> (“Transgender people and men who have sex with men also account for a significant proportion of sex workers in many states...”). The 2011 National Transgender Discrimination Survey found that 11% of respondents had done sex work for income at some point in their lives, compared to just 1% of women nationally. Trans people were more likely to have been involved in sex work if they had lost a job due to bias.. NAT’L CENTER FOR TRANSGENDER EQUALITY, NATIONAL TRANSGENDER DISCRIMINATION SURVEY (2011). See also AMNESTY INTERNATIONAL POLICY ON STATE OBLIGATIONS TO RESPECT, PROTECT AND FULFILL THE HUMAN RIGHTS OF SEX WORKERS, AMNESTY INTERNATIONAL 5 (2016) (“Sex workers who are lesbian, gay, bisexual, transgender and/or intersex (LGBTI), or who are otherwise seen as transgressing gender or sexuality norms, face intersectional discrimination and marginalization.”).

¹⁴⁴ See BIANCA D.M. WILSON, KHUSH COOPER, ANGELIKI KASTANIS & SHELIA NEZHAD, *SEXUAL AND GENDER MINORITY YOUTH IN FOSTER CARE: ASSESSING DISPROPORTIONALITY AND DISPARITIES IN LOS ANGELES*, WILLIAMS INSTITUTE (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/LAFYS_report_final-aug-2014.pdf; Laura Baams, Bianca D.M. Wilson, Stephen T. Russell, *LGBTQ Youth in Unstable Housing and Foster Care*, 143 PEDIATRICS e20174211 (2019), available at <https://doi.org/10.1542/peds.2017-4211>.

¹⁴⁵ See SOON KYU CHOI, ET AL., *SERVING OUR YOUTH 2015: THE NEEDS AND EXPERIENCES OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUESTIONING YOUTH EXPERIENCING HOMELESSNESS*, WILLIAMS INSTITUTE, TRUE COLORS FUND & THE PALETTE FUND (2015), <https://truecolorsfund.org/wp-content/uploads/2015/05/Serving-Our-Youth-June-2015.pdf>; John Ecker, *Queer, Young, and Homeless: A Review of the Literature*, 37 CHILD YOUTH SERV. 325 (2016), available at <https://doi.org/10.1080/0145935X.2016.1151781>.

¹⁴⁶ See MEREDITH DANK ET AL., *SURVIVING THE STREETS OF NEW YORK: EXPERIENCES OF LGBTQ YOUTH, YMSM, AND YWSW ENGAGED IN SURVIVAL SEX*, URBAN INSTITUTE (2015), <https://www.urban.org/sites/default/files/publication/42186/2000119-Surviving-the-Streets-of-New-York.pdf>; ANDREW CRAY, KATIE MILLER & LAURA E. DURSO, *THE EXPERIENCES AND UNMET NEEDS OF LGBT HOMELESS YOUTH*, CENTER FOR AMERICAN PROGRESS (2013), <https://www.americanprogress.org/wp-content/uploads/2013/09/LGBTHomelessYouth.pdf>; KERITH CONRON ET AL., *OUR HEALTH MATTERS: MENTAL HEALTH, RISK, AND RESILIENCE AMONG LGBTQ YOUTH OF COLOR WHO LIVE, WORK, OR PLAY IN BOSTON*, FENWAY INSTITUTE (2015), <https://fenwayhealth.org/wp-content/uploads/our-health-matters.pdf>; Robert Garofalo et al., *Overlooked, Misunderstood and At-risk: Exploring the Lives and HIV Risk of Ethnic Minority Male-to-Female Transgender Youth*, 38 J. ADOLESC. HEALTH 230 (2006), <https://doi.org/10.1016/j.jadohealth.2005.03.023>.

¹⁴⁷ LANCE FREEMAN & DARRICK HAMILTON, *A COUNT OF HOMELESS YOUTH IN NEW YORK CITY: 2007*, EMPIRE STATE COALITION OF YOUTH AND FAMILY SERVICES (2008).

¹⁴⁸ *Id.*

¹⁴⁹ WORLD HEALTH ORGANIZATION, *POLICY BRIEF: TRANSGENDER PEOPLE AND HIV* (2015), https://apps.who.int/iris/bitstream/handle/10665/179517/WHO_HIV_2015.17_eng.pdf.

In addition, transgender people, and transgender people of color in particular, are more likely to report being involved in sex work.¹⁵⁰ Transgender people face severe economic constraints due to family rejection, discrimination from educational institutions, and in the labor market, which forces some to resort to underground economies, including sex work, to survive.¹⁵¹ In a 2015 national survey, 19% of transgender people reported doing sex work for money, food, or shelter at some point in their lives, and 5% reported doing so for money in the past year. The rates for engaging in sex work in the past year were much higher for Black trans women (24%), Latina trans women (19%), and those living with HIV (32%).¹⁵²

In *Georgia's Integrated HIV Prevention and Care Plan, 2017-2021*, LGBTQ people are a focus for HIV prevention and treatment efforts given that they make up over half of PWH in the state. Due to the concentration of the HIV epidemic among LGBTQ people in the state, one of the primary objectives in Georgia's five-year plan is to "reduce HIV related health disparities and inequities" by reducing disparities in the rate of new diagnosis among "young Black/African American gay and bisexual men."¹⁵³ Similarly, primary goals related to reducing HIV infections,¹⁵⁴ linking and retaining PWH in

¹⁵⁰ SANDY E. JAMES ET AL., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY, NATIONAL CENTER FOR TRANSGENDER EQUALITY, (2016), <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>; Jeffrey H. Herbst, *Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review*, 12 AIDS BEHAV. 1 (2008), available at <https://doi.org/10.1007/s10461-007-9299-3>; Don Operario et al., *Sex Work and HIV Status Among Transgender Women: Systematic Review and Meta-Analysis*. 48 J. ACQUIR. IMMUNE DEFIC. SYNDR. 97 (2008), available at <https://doi.org/10.1097/QAI.0b013e31816e3971>. Other laws also affect HIV vulnerability among transgender people. For example, most countries criminalize some or all aspects of sex work. "Sex work is a significant source of income for many transgender women around the world, given their exclusion from other means of income generation. In settings where sex work is illegal, transgender sex workers often bear the brunt of police brutality, and, when complaints against police brutality are lodged, they are often ignored." WORLD HEALTH ORGANIZATION, UNDERSERVED. OVERPOLICED. INVISIBILIZED. LGBT SEX WORKERS DO MATTER (2015), http://www.sexworkeurope.org/sites/default/files/resource-pdfs/icrse_briefing_paper_october2015.pdf. In addition, a study about HIV and transgender people, commissioned by the World Health Organization, notes, "Sex work is a significant source of income for many transgender women around the world, given their exclusion from other means of income generation. In settings where sex work is illegal, transgender sex workers often bear the brunt of police brutality and, when complaints against police brutality are lodged, they are often ignored." AMNESTY INTERNATIONAL, *supra* note 139 at 5 ("...whilst the majority of the world's sex workers are cisgender women, when examined on a per capita basis a larger proportion of the transgender community is involved in sex work compared to the proportion of the population of who is transgender.").

¹⁵¹ JAMES ET AL., *supra* note 146.

¹⁵² *Id.* at 158.

¹⁵³ GA. DEPARTMENT OF HEALTH HIV/AIDS SECTION, GEORGIA INTEGRATED HIV PREVENTION AND CARE PLAN 2017–2021, *supra* note 32 at 139, 146 ("2015-2020 NHAS Goal 3: Reduce HIV related health disparities and health inequities; 2017-2021 SMART Objective 4: By 2021, reduce disparities in the rate of new diagnosis by at least 15% in the following groups: gay and bisexual men, young Black/African American gay and bisexual men, and Black/African American women; Strategy 1: By 2021, reduce HIV-related disparities in communities at high risk. AA YMSM • MSM • Transgender Women • AA Women • Hispanics.")

¹⁵⁴ *Id.* at 125 ("2015-2020 NHAS Goal 1: Reducing new HIV Infections. 2017-2021 SMART Objective 1: By December 2021, increase the percentage of people living with HIV (PLWH) who know their serostatus to 90%. Strategy 1: Intensify HIV testing efforts in the communities where HIV is most heavily concentrated. AA MSM • MSM • Transgender • AA

HIV care, improving health outcomes of PWH,¹⁵⁵ and increasing access to PrEP and other prevention activities,¹⁵⁶ focus on MSMs and transgender people. In addition, Georgia has a number of plans and activities specifically focused on LGBTQ communities including a Georgia Statewide MSM Strategic Plan¹⁵⁷ and a statewide MSM/Transgender Strategy.¹⁵⁸

Throughout every part of the five-year strategic plan, Georgia calls for working collaboratively with all PWH including people of color, women, and LGBTQ communities because “it has been determined that collaborative efforts work best when planning activities for populations at risk.”¹⁵⁹ As the plan further explains:

The meaningful involvement of Persons Living with HIV/AIDS is a foundational crosscutting principle which is inherent in all Goals, Strategies, Objectives, and Action Steps of this Plan. Documents of the Joint United Nations Programme on HIV/AIDS (UNAIDS) lay out principles that uphold the rights and responsibilities of PLWHIV, including the right of self-determination and participation in decision-making processes that affect their lives (UNAIDS, 2007). These documents echo the Denver Principles of

Women • Hispanics.”).

¹⁵⁵ *Id.* at 129, 132 (“2015-2020 NHAS Goal 2: Increase access to care and improve health outcomes. 2017-2021 SMART Objective 1: By December 2021, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of HIV diagnosis to at least 90% and engage individuals identified as out of care (no medical appointment in last 6 months). Strategy 7: Incorporate opportunities for client engagement into all aspects of service delivery. Transgender • Women • Hispanics • AA Women, •MSM.”).

¹⁵⁶ *Id.* at 125 (“HIV Prevention and Care Service Needs of Persons at Risk for HIV: Persons at risk for HIV are in need of HIV prevention education and the availability of resources to support the establishment of PrEP clinics and the provision of PrEP services (medication and clinical follow-up). Georgia Part B Consortia reported service needs related to prevention education, testing, and promotion in the form of advertisements (media, billboards, etc.) outside of the EMA area, with a specific focus on Black/African American, MSM and Transgender populations.”)

¹⁵⁷ *Id.* at 51 (“DPH HIV Prevention Program has created elevated strategic priorities to support our ultimate vision and direction with the Georgia Statewide MSM Strategic Plan which is to reduce new infections, improve access to care, and enhance standards of care. These priorities will guide decision making, the allocation of resources, and clarify the office’s overarching plan of action to address the needs of men who have sex with men in Georgia with a specified focus on African American and Latino MSM who carry the highest burden in the state. The Elevated Strategic Priorities are as follows: 1) Ensure that 50% of MSM are tested every year by December 31, 2018, with an emphasis on young MSM 18-24. 2) Ensure that 90% of all MSM have access to condoms by December 31, 2018. 3) Link 90% of all positive MSM found through public health testing to medical care within 14 days by December 31, 2018. 4) Increase the percentage of at risk MSM taking PrEP to 50% (with an emphasis on the 18-24 age group) by December 31, 2020.”).

¹⁵⁸ *Id.* at 50-51 (“Since the discovery of HIV/AIDS, MSM have been disproportionately impacted. Estimated to be two to four percent of the population, they exceed 50% of HIV prevalence (total cases) and nearly two-thirds of new diagnoses. ...Further complicating the landscape are a host of structural factors, such as stigma and victimization. With MSM’s HIV disparity and its broad landscape in mind, the DPH Office of HIV, led by the Coordinators for MSM/Lesbian, Gay, Bisexual, and Transgender Activities, has developed an MSM/Transgender strategy. The strategy intends to move Georgia forward in achieving, even exceeding goals of the National HIV/AIDS Strategy 2020 (NHAS). To meet these goals, bold action is necessary. The following describes some of the planned initiatives put forth in the MSM/Transgender strategy. At its core, the strategy means to shift our response systems to better attend to MSM and transgender people.”).

¹⁵⁹ *Id.* at 41.

1983 that boldly affirmed the rights of people with AIDS (Denver Principles, 1983). PLWH will be included in all aspects of planning, design, implementation, and evaluation of programs for HIV testing, prevention, and care. In all that we do in furthering the goals of the NHAS [National HIV/AIDS Strategy], we will operate through an overarching framework of cultural and linguistically appropriate services which respect the heterogeneous community of persons living with HIV.¹⁶⁰

and

The National HIV/AIDS Strategy reminds us that structural and social determinants are serious indicators that reveal an individual's perception of personal health as well as the health of a community. In order to implement interventions and activities to combat the rise in HIV/AIDS infection the G-PACC continues to provide guidance on effective ways to target populations who present indicators for HIV infection through community engagement sessions and stakeholder activities. Collaboration and participation of community representatives and other stakeholders in the research process helps to build faith, trust and gives to the acceptance in the use of intervention. Collaboration from community partners and agencies increase the opportunities to build communities and secure invested stakeholders to support engagements, activities, and strategies for alleviating the burden from populations who present high risk for HIV/AIDS. It has been determined that collaborative efforts work best when planning activities for populations at risk.¹⁶¹

While Georgia has recognized that that cooperation with all PWH—including people of color, women, and LGBTQ people—is essential to combatting the AIDS epidemic, this cooperation may be undermined by the enforcement of criminal laws that disproportionately stigmatize these very communities.

¹⁶⁰ *Id.* at 86.

¹⁶¹ *Id.* at 40-42.

CONCLUSION

HIV is treatable, preventable, and harder to transmit than was thought in the early years of the epidemic. Further, the criminalization of HIV could be undermining the state's efforts to work cooperatively with the communities most impacted by the HIV epidemic. In 2017, the Georgia legislative committee on *Barriers to Access to Adequate Health Care* concluded: "The best practice would be for states to reform their laws to eliminate HIV-specific criminal penalties except" in limited circumstances including requiring that there be a significant risk of transmission and when "the evidence clearly demonstrates that the individual's intent was to transmit the virus."¹⁶² Georgia's HIV criminal laws should be modernized to reflect what is known about HIV today and to conform to the state's current plans to combat HIV.¹⁶³

¹⁶² REPORT OF THE GA. HOUSE COMM. ON GEORGIANS' BARRIERS TO ACCESS TO ADEQUATE HEALTH CARE, *supra* note 4 at 9.

¹⁶³ See Kenneth H. Mayer et al., *Addressing HIV Criminalization: Science Confronts Ignorance and Bias*, 21 J. INT. AIDS Soc. e25163 (2018), available at <https://doi.org/10.1002/jia2.25163>; Françoise Barré-Sinoussi et al., *Expert Consensus Statement on the Science of HIV in the Context of Criminal Law*, 21 J. INT. AIDS Soc. e25161 (2018), available at <https://doi.org/10.1002/jia2.25161>; Yang & Underhill, *Rethinking Criminalization*, *supra* note 5.

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