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I. INTRODUCTION

Human immunodeficiency virus (HIV) is a diagnosis no one wants to hear from a doctor. This word invokes fear, panic, and sometimes anger. When the AIDS epidemic gripped the United States in the early 1980s, these emotions drove many of the laws addressing HIV and AIDS. States passed laws criminalizing people living with HIV for engaging in certain, loosely defined, prohibited conduct and rarely required a connection with HIV transmission. These laws served to assuage the rising anxiety of the general public by quarantining people with HIV from the general public through incarceration. Despite an immense body of scientific research since the passage of many of these laws, people with HIV continue to be prosecuted each year under these laws, and no states have repealed these outdated statutes. Some states continue to prohibit biting and spitting by someone who has HIV despite an abundance of evidence suggesting that

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HIV is not transmitted through these avenues.[1] Laws that criminalize people living with HIV through prohibited conduct relating to HIV and/or nondisclosure laws ("HIV criminalization laws") adopt varying approaches as to the intent of the person engaging in the prohibited conduct, ranging from imposing liability only if the person intended to transmit HIV to requiring no specific intent at all. Some states further criminalize individuals even though they disclose their HIV-status before engaging in any prohibited conduct.

Recent executive and legislative actions and court rulings regarding HIV criminalization laws have increased attention to these laws. From President Obama's National HIV/AIDS Strategy in 2010 recommending states to revisit their HIV-specific laws to Congresswoman Barbara Lee's introduction of the Repeal HIV Discrimination Act in 2011 and Ending the HIV/AIDS Epidemic Act of 2012, federal leaders have signaled the dawn of a new era in government thinking about HIV criminalization laws. Still, many members of the legislature and judiciary resist efforts to repeal these antiquated laws or interpret them more narrowly and have in fact introduced additional laws to criminalize people with HIV. For example, in May 2011, the Nebraska Legislature passed a bill that makes it a felony for someone with HIV to strike any public safety officer with a bodily fluid or expel any bodily fluid in the direction of a public safety officer, including saliva and vomit.[2] Additionally, in 2012 Senator Norman Stone Jr. and Representative C.T. Wilson introduced a bill that would classify knowingly transmitting HIV as a felony, as opposed to its current classification as a misdemeanor.[3] An Arizona legislator even introduced a bill in January 2013 that classifies intentional exposure of *any* sexually transmitted infection without disclosure as a felony.[4] Several Washington legislators have introduced similar legislation expanding Washington's criminal laws penalizing certain conduct by people with HIV to include a more general definition of communicable diseases.[5]

In October 2012, the Supreme Court of Canada decided two cases involving HIV criminalization laws. Through these cases, the Court upheld

1. There is no risk of HIV from a human bite when the skin is not broken; however, HIV may be transmitted (although this is very rare) with severe trauma, extensive tissue damage, and the presence of blood. *See* HIV Transmission, *Can HIV be Transmitted through a Human Bite?*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Jan. 22, 2013).

2. *See* Jordan Dulmundo, *The National HIV/AIDS Strategy and Nebraska's "Spitting Bill,"* NEBRASKA AIDS PROJECT, *available at* http://stage.nap.org/news/the-national-hivaids-strategy-and-nebraskas-spitting-bill.

3. *See* S.B. 60, 430th Sess. (Md. 2012); H.B. 622, 430th Sess. (Md. 2012); *see also*, Phil Reese, *Maryland Senator introduces bill to classify HIV transmission as a felony*, WASHINGTON BLADE (Jan. 17, 2012), http://www.washingtonblade.com/2012/01/17/maryland-senator-introduces-bill-to-classify-hiv-transmission-as-felony/.

4. *See* H.B. 2218, 51st Legis., (Ariz. 2013).

5. *See* H.B. 1018, 63d Legis., (Wash. 2013); H.B. 1262, 63d Legis., (Wash. 2013).

a 1998 decision that requires a "significant risk" of HIV transmission to trigger the duty to disclose under Canada's HIV criminalization laws.[6] The Court also created a new standard by holding that a person with HIV must disclose his status if the sexual activity carries a "realistic possibility" of HIV transmission.[7] While the Court did not provide extensive guidance on what constitutes a "realistic possibility," it did acknowledge that a person with a low viral load[8] who uses a condom would not have a realistic possibility of transmitting HIV and thus, no duty to disclose under Canada's HIV criminalization laws.[9] Nevertheless, the Court noted that even condom use alone would not necessarily shield people with HIV from prosecution.[10]

Most startling about the Court's decisions is the failure to recognize complex power dynamics that prevent individuals from disclosing HIV status. In *D.C.*, an abusive man told police that his partner failed to inform him of her HIV status the first time they engaged in sexual intercourse—four years earlier.[11] He claimed that he used no condom before she disclosed her HIV status (a claim she disputes), but he acknowledged that he continued to have sexual intercourse with her after she disclosed her status and then lived with her for four years.[12] D.C.'s partner accused her of failing to disclose only after she ended the relationship, after her partner physically assaulted her son and her.[13] The police then arrested D.C. and a trial court convicted her under Canada's HIV criminalization law, even though D.C.'s partner did not have HIV.[14] While the Supreme Court of Canada reversed her conviction, its new standard may have required her to disclose unless she had a low viral load and used a condom. Even though D.C. ultimately did disclose her status, as a survivor of abuse, she may not have been able to negotiate her abusive partner's condom usage and/or felt safe to disclose her status. Moreover, perpetrators of abuse aware of their partner's HIV status can use HIV criminalization laws as leverage in a relationship by threatening to tell police that they were unaware unless the partner agrees to stay. In D.C's case, her partner only invoked the HIV criminalization law after D.C. ended the relationship. The new standards

6. R. v. Mabior, [2012] S.C.C. 47, para. 4 (Can.); R. v. D.C., [2012] S.C.C. 48, para. 1 (Can.).

7. *Mabior*, para. 4 (Can.); *D.C.*, para. 1 (Can.).

8. Viral load is a blood test that measures the level of active HIV in one's blood. People with lower viral loads are less likely to transmit HIV. *Transmission Routes, Viral Loads and Relative Risks: The Science of HIV for Lawyers and Advocates* 5, CTR. FOR HIV LAW & POLICY (July 2011), *available at* http://www.hivlawandpolicy.org/resources/view/643.

9. *Mabior*, para. 94 (Can.).

10. *Id.*

11. *D.C.*, para. 6–7 (Can.).

12. *Id.*

13. *Id.*

14. *Id.*

developed in Canada's recent cases highlight the dangers of HIV criminalization laws for individuals facing domestic abuse and violence. While anyone facing such violence is at risk, women, particularly transgender women, are especially vulnerable to such pitfalls of HIV criminalization laws.

American courts and legislators may be tempted to look to these decisions for guidance, given the increased discussion of HIV criminalization laws in the past few years. While Canada's new legal standard would be an improvement for many HIV-specific state laws in the United States, it would nonetheless fail to solve the larger problems looming over all HIV criminalization laws. HIV criminalization laws continue to perpetuate inequality by imprisoning people living with HIV (many of whom are from marginalized communities with larger incarceration rates) while spreading misinformation about HIV transmission and failing to advance any public health agenda.

Only a month before the Supreme Court of Canada decided *Mabior* and *D.C.*, the Minnesota Court of Appeals examined whether a man could be convicted under a statute addressing medical procedures for engaging in unprotected sex with another man after disclosing his HIV status.[15] The Minnesota Court reversed the conviction only after determining that the applicable statute applied specifically to medical procedures.[16] In Iowa, Donald Bogardus currently awaits trial for allegedly violating Iowa's HIV criminalization laws.[17] Mr. Bogardus faces up to twenty-five years for engaging in consensual, unprotected sex with another man because he failed to disclose his status, even though he had an undetectable viral load and did not transmit the virus.[18] Mr. Bogardus works as a certified nurse's assistant and not only faces incarceration but also permanent unemployment in nursing if convicted.[19] Nick Rhoades—another Iowa man facing incarceration under Iowa's HIV criminalization laws—filed an appeal in June 2012 with the Iowa Supreme Court after receiving a twenty-five year sentence and lifetime registration as a sex offender after engaging in consensual protected sexual activity with another man for failing to disclose his HIV status, despite the fact that he used a condom and did not transmit HIV.[20]

The United States leads the world in convictions under its HIV criminalization laws. According to a 2012 report by the United Nations,

15. State v. Rick, 821 N.W.2d 610, 613 (Minn. 2012).

16. *Id*. at 618.

17. *Donald Bogardus*, THE SERO PROJECT, http://seroproject.com/video/donald-bogardus (last visited Jan. 22, 2013).

18. *Id*.

19. *Id*.

20. Proof Br. of Applicant, Rhoades v. Iowa, No. 12-0180, 5 (N.W.2d 2012), *available at* http://www.lambdalegal.org/in-court/legal-docs/rhoades_ia_20120613_proof-brief-of-applicant-appellant-and-request-for-oral-argument.

the United States has the highest number of convictions of HIV-related criminal offenses.[21] Even when accounting for the larger population, the United States still prosecutes more people per capita than many other countries, including France, Germany, the United Kingdom, and Italy.[22] In July 2012 the International AIDS Conference focused on a number of barriers for people living with HIV, including HIV criminalization laws.[23] The fact that the United States hosted the International AIDS Conference after over twenty years in other countries underscores the importance of this issue to the U.S., where over thirty-seven states have criminal statutes specific to HIV (and even more criminal laws that are not specific to HIV but used to prosecute people living with HIV).[24] Despite numerous HIV criminalization laws and a multitude of convictions under these laws, no research suggests that these laws increase public health and/or one's likelihood of disclosure.[25] Instead, HIV criminalization laws are more likely to increase stigma and inequality amongst communities most impacted by HIV in the United States.

While an HIV diagnosis dramatically impacts any person, HIV has affected some communities more significantly. For example, African Americans comprise only fourteen percent of the United States population but approximately forty-four percent of people living with HIV.[26] Latinos are three times more likely to live with HIV than whites.[27] The CDC reports that men who engage in sexual activity with men represent only two percent of the United States population but approximately sixty-one percent of all new HIV infections.[28] Transgender respondents to a national survey reported HIV rates at over four times the national average, with the number increasing to more than twenty-five times for transgender respondents who had engaged in sex work.[29] Another report indicated that more than one in

21. UNAIDS, CRIMINALISATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION: BACKGROUND AND CURRENT LANDSCAPE 8 (2012).

22. *Id.* at 7, fig.1.

23. AIDS 2012, XIX INTERNATIONAL AIDS CONFERENCE, GENERAL INFORMATION 35 (2012), *available at* http://www.aids2012.org/Default.aspx?pageId=369.

24. *See infra* note 73; *see also infra* Part II.C.

25. However, recent research suggests that HIV criminalization laws do not appear to be effective in HIV prevention, and awareness of the laws did not influence sexual behavior or disclosure. *See* Carol L. Galletly et al., *New Jersey's HIV Exposure Law and the HIV-Related Attitudes, Beliefs, and Sexual and Seropositive Status Disclosure Behaviors of Persons Living With HIV*, 102 AM. J. OF PUB. HEALTH 2135, 2135 (2012).

26. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS (2011), *available at* http://www.cdc.gov/hiv/topics/aa/PDF/aa.pdf.

27. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AMONG LATINOS (2011), *available at* http://www.cdc.gov/hiv/resources/factsheets/pdf/latino.pdf.

28. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AMONG GAY AND BISEXUAL MEN (2012), *available at* http://www.cdc.gov/hiv/topics/msm/pdf/msm.pdf.

29. JAIME M. GRANT ET AL., THE NAT'L GAY & LESBIAN TASK FORCE & THE NAT'L CTR. FOR TRANSGENDER EQUAL., INJUSTICE AT EVERY TURN, A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 72 (2011), *available at* http://www.thetaskforce.org/reports_and_research/ntds.

four transgender women of color has HIV/AIDS.[30] These numbers highlight the importance of recognizing how HIV affects communities of color, women, low-income people, and the gay, bisexual and transgender (GBT) communities and that many individuals living with HIV often represent multiple communities.

When the HIV epidemic first emerged in the United States, many people blamed members of marginalized communities for increasing the numbers in this country. Black men, particularly from Haiti, and gay and bisexual men were prime targets for attack.[31] Stereotypes about who was contracting HIV ultimately led to biases in the law and disparate treatment under the law for members of these communities. The American legal system continues to penalize survivors of HIV based on these misconceptions and misinformation about HIV through laws that criminalize individuals for HIV-related offenses. Communities of color, women, low-income, transgender, gay and bisexual people bear the brunt of these disparate laws.

Scientific knowledge has dramatically changed our understanding of HIV and the transmission of HIV. Recent studies further suggest that HIV criminalization laws do not prevent the spread of HIV and, if anything, increase it through misinformation about transmission. Research also suggests that disclosure of HIV status is complex and affected by varying power differentials between sexual partners, violence, and one's understanding of his or her viral load or health status. As such, this article recommends eliminating HIV criminalization laws and adopting new approaches for reducing HIV rates.

Part I provides a historical context by exploring the fear of AIDS that prompted states to pass laws criminalizing HIV-related offenses. Part II explains the various ways in which states penalize people with HIV through criminal laws. Part III discusses how these laws perpetuate inequality by (1) using broad language that can allow biases based on race, class, gender, and sexual orientation to pervade the criminal process; (2) spreading misinformation about HIV and undermining public health efforts that increase awareness and reduce fear of HIV; and (3) failing to acknowledge important power dynamics that may prompt someone not to

30. Kellan Baker & Jeff Krehely, *Changing the Game: What Health Care Reform Means for Gay, Lesbian, Bisexual, and Transgender Americans*, CTR. FOR AM. PROGRESS 4 (Mar. 2011), *available at* http://www.americanprogress.org/issues/lgbt/report/2011/03/29/9200/changing-the-game.

31. Michael Christian Belli, *The Constitutionality of the "Men Who Have Sex with Men" Blood Donor Exclusion Policy*, 4 J. L. SOC'Y 315, 338 (2003); *see generally* PAUL FARMER, AIDS AND ACCUSATION: HAITI AND THE GEOGRAPHY OF BLAME 2 (1993) (examining the cultural phenomenon of the United States to incorrectly place blame on Haitians as the source of AIDS); Steven Eisenstat, *The New AIDS Scapegoat*, 44 RUTGERS L. REV. 301, 302 & n.3 (1992) (discussing survey results showing strong antipathy towards "the two groups most at risk of HIV infection, homosexual males and intravenous drug users").

disclose his or her HIV status. Part IV explores a multi-pronged approach (the Proactive Pyramid) for responding to the criminalization and discrimination of people with HIV that includes (1) engaging communities heavily impacted by HIV by tapping into the tools developed in response to criminalization and discrimination; (2) increasing education to reduce stigma; (3) repealing and/or reforming legislation that criminalizes people with HIV; and (4) reducing structural barriers to HIV prevention and treatment.

II. FEARING THE REAPER: AN HISTORICAL CONTEXT INTO HIV CRIMINALIZATION LAWS

A. FEAR AND MISINFORMATION

When the HIV/AIDS epidemic first gripped this country's attention in the early 1980s, widespread fear followed. The public became obsessed with this newly discovered illness and grew increasingly anxious about its transmission.[32] In 1987, Randy Shilts published a best-selling book based on a 1984 study about the AIDS epidemic that linked a flight attendant ("Patient Zero") to forty of the first 248 people identified with AIDS in the United States.[33] While the author of the 1984 study has repudiated its findings as substantially flawed,[34] Shilts' myth of "Patient Zero" left a lasting impression and resulted in increased fears of the promiscuous sociopath intending to infect numerous unsuspecting victims.[35] Police wore bright yellow gloves when arresting demonstrators outside the International AIDS Conference in 1987.[36] A city in West Virginia closed its public pool after a local man with HIV swam in it.[37] In 1987, one man

32. *See* Steven Roberts, *AIDS Alert*: *Politicians Awaken to the Threat of a Global Epidemic*, N.Y. TIMES, June 7, 1987 (noting that White House polls reported AIDS as the most serious issue facing the nation, after war and peace, and the economy).

33. RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC 147 (1987).

34. Dr. William Darrow and his colleagues at the CDC compiled a likely scenario for the "spread" of HIV in North America—linking it to Patient Zero. *See* Sean C. Clark, *Never in a Vacuum: Learning from the Thai Fight Against HIV*, 13 WM. & MARY J. WOMEN & L. 593, 620 n.1 (2007). Dr. Darrow subsequently repudiated his study, admitted that his methods were flawed, and accused Shilts of misrepresenting the study's conclusions. *Id.*

35. *See* SHILTS, *supra* note 33, at 136, 165 (describing rumors that a strange blond guy at the Eighth and Howard bathhouse would have sex with men before pointing out his Kaposi's sarcoma lesions, noting he had "gay cancer" and stating that they would both die as a result).

36. *See* Roberts, *supra* note 32.

37. *Oprah Winfrey: AIDS Comes to a Small Town*, *available at* http://www.oprah.com/oprahshow/AIDS-Comes-to-a-Small-Town (last visited Feb. 2, 2013). During an interview with Oprah Winfrey, Mr. Sisco detailed how his own family ostracized him for fear of contracting HIV, and some family members forbade him from burial in the family plot. *Oprah Winfrey: AIDS in Williamson, West Virginia* (ABC television broadcast Nov. 16, 1987), *available at* http://www.oprah.com/health/Oprah-Talks-with-a-Man-Living-with-AIDS-Video.

so distraught with the possibility that he had AIDS after experiencing flu symptoms, shot his family and himself to avoid the misery and suffering he thought were inevitable.[38] An autopsy confirmed that this man indeed only suffered from the flu.[39]

The disease initially appeared in certain marginalized communities, including gay men, drug users, hemophiliacs, and African Americans—particularly immigrants from Haiti.[40] Perceptions that the disease was predominant amongst gay men led to its initial name of GRID (Gay Related Immune Deficiency).[41] A series of contradictory public health statements and media reports followed,[42] even after researchers identified the virus in 1984 and labeled it as HIV in 1986.[43] Government inaction and efforts that spread misinformation failed to address the growing public health concern[44] about this new "invariably fatal"[45] disease. Communities had little or no knowledge about HIV transmission. As a result, tens of thousands of people had contracted AIDS in the United States by early 1987.[46] Early research demonstrated that Blacks and Latinos had shorter life spans once diagnosed with HIV.[47] Recent research highlights that this trend has not changed.[48]

Despite the significant effect HIV and AIDS had in communities of color, very few community leaders were willing to address this issue and instead responded with silence.[49] The reasons for such community reticence are complex and likely intertwined with religion, politics, and the misperception that AIDS affected only white gay men.[50] As the government slashed resources for communities of color, leaders in the Black and Latino community may have been enticed to focus energies elsewhere, especially given the early association of HIV with drug users

38. VERNON COLEMAN, COLEMAN'S LAWS (2006).

39. *Id.*

40. *See* Paula A. Treichler, *AIDS Homophobia, and Biomedical Discourse: An Epidemic of Signification*, 43 AIDS: CULTURAL ANALYSIS 31, 44 (1987).

41. *Id.* at 53.

42. *See* SHILTS, *supra* note 33, at 94–95.

43. *Id.* at 593.

44. *See infra*, Parts II.B, IV.A.

45. James B. McArthur, Note, *As the Tide Turns: The Changing HIV/AIDS Epidemic and the Criminalization of HIV Exposure*, 94 CORNELL L. REV., 707, 708 (2009) (discussing research describing HIV as "invariably" or "inevitably fatal").

46. Samuel R. Friedman et al., *The AIDS Epidemic among Blacks and Hispanics*, 65 THE MILBANK Q. 455, 457 (1987).

47. *Id.* at 475.

48. *See* Ctrs. for Disease Control & Prevention, *HIV Surveillance Report: Section 2 Deaths and Survival after a Diagnosis of HIV Infection or AIDS*, Tables 11a–14b (2009), *available at* http://www.cdc.gov/hiv/surveillance/resources/reports/2009report.

49. Paula C. Johnson, *Silence Equals Death: The Response To AIDS Within Communities of Color*, 1992 U. ILL. L. REV. 1075, 1077, 1079 (1992).

50. Harv. L. Rev. Ass'n, *Name Brands: The Effects of Intrusive HIV Legislation on High-Risk Demographic Groups*, 113 HARV. L. REV. 2098, 2112–13 (2000).

and gay men.[51] While community leaders of color began to join efforts to fight HIV by the end of 1989,[52] the immense resistance left many individuals with HIV without much-needed support.

The media only worsened this problem when it began to exaggerate tensions between gay men and Blacks and Latinos living with HIV or AIDS after reports of the rising number of AIDS cases in communities of color emerged.[53] While racism undoubtedly exists within the gay community,[54] such sensationalized stories seemed to serve no other purpose but to fuel friction (as most stories made no attempt to actually address complex dynamics of race, class and sexual orientation)[55] and further perpetuate the invisibility of gay men of color. Further media reports suggesting that Black men "on the down low" were transmitting HIV to Black women by secretly sleeping with male partners[56] only heightened misinformation, bias, and animosity toward Black men—regardless of sexual orientation—living with HIV.[57]

B. THE PRESIDENTIAL COMMISSION AND THE RYAN WHITE CARE ACT

In response to the fear and sensationalized reports of people infected with HIV, President Ronald Reagan formed the Presidential Commission on the Human Immunodeficiency Virus Epidemic in 1987.[58] The Commission adopted a 200-page report with numerous recommendations to (1) prevent transmission of HIV; (2) manage care of people infected with HIV; and (3) enhance efforts to find a cure.[59] Specifically, the Report devotes an entire section to criminalizing HIV transmission for individuals "who knowingly conduct themselves in ways that pose a significant risk of transmission to others" and encourages states to adopt HIV-specific criminalization statutes.[60] The Report further criticizes prostitution laws as "too lenient" and recommends that current prostitution laws be "strictly enforced."[61]

51. Daniel M. Fox, *Chronic Disease and Disadvantage: The New Politics of HIV Infection*, 15 J. HEALTH POL. POL'Y & L. 341, 348 (1990).

52. *Id.* at 349.

53. Russell K. Robinson, *Racing the Closet*, 61 STAN. L. REV. 1463, 1511–12 (2009).

54. *See e.g.*, Thom Beame, *Racism from a Black Perspective*, BLACK MEN/WHITE MEN: A GAY ANTHOLOGY 59, 59–60 (Michael J. Smith ed., 1983).

55. *See* Robinson, *supra* note 53, at 1512–13.

56. *Id*. at 1469–78.

57. Research suggests no support for the theory that Black men on the "down low" are responsible for the higher numbers of HIV rates in the Black community compared to whites. *See* Chandra L. Ford et al., *Black Sexuality, Social Construction, and Research Targeting 'The Down Low' ('The DL')*, 17 ANNALS OF EPIDEMIOLOGY 209 (2007).

58. Exec. Order No. 12,601, 52 C.F.R. 24,129 (1987).

59. PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, at XVII (1988) [hereinafter THE REPORT].

60. THE REPORT, *supra* note 59, at 130.

61. *Id.*

The Report describes five main justifications for HIV-specific criminal laws. First, the Report states that such laws are necessary to hold people accountable for "knowingly conduct[ing] themselves in a way that pose[s] a significant risk of transmission to others."[62] This justification is based solely on a punitive policy goal. Second, the Report asserts that HIV-specific criminal statutes will deter HIV-infected individuals from engaging in "high-risk behaviors."[63] The third justification entails public health: HIV-specific statutes will protect society against the spread of HIV.[64] Fourth, the Report argues that traditional criminal laws regarding murder, attempted murder and assault are insufficient to prosecute an individual who transmits HIV.[65] The Report laments that murder and attempted murder statutes are inadequate because of the purported difficulties in proving intent to transmit HIV to cause death and proving that HIV was the actual cause of death (for homicide).[66] Finally, the Report lauds HIV-specific criminal statutes as providing notice of "socially unacceptable standards of behavior."[67]

Two years after the Commission adopted the Report, Congress passed the Ryan White Care Act in 1990, the largest federally funded program for people living with HIV/AIDS.[68] While this Act provided a much-needed source of funding for HIV and AIDS, it also threatened to eliminate funding for states unless state laws criminalized knowingly exposing someone to HIV.[69] When Congress repealed this provision of the Ryan White Care Act in 2000,[70] every state had already codified criminal laws to prosecute based upon "knowing HIV exposure."[71]

III. INVOKING HIV CRIMINALIZATION LAWS

States have prosecuted people with HIV through a number of different criminal avenues. Some states have HIV-specific criminal laws that criminalize HIV transmission. Some of these states also have specific criminal statutes targeting sex workers for HIV transmission. Other states prosecute individuals for HIV transmission through general criminal laws.

62. *Id.*
63. THE REPORT, *supra* note 59, at 130.
64. *Id.*
65. *Id.*
66. *Id.*
67. *Id.* The Report specifically praises states like Florida, Idaho, Louisiana, and Nevada who had already passed criminal statutes specific to HIV transmission.
68. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, § 2647, 104 Stat. 576 (codified at 42 U.S.C. § 300ff-47) (repealed 2000) [hereinafter Ryan White CARE Act].
69. *Id.*
70. Ryan White CARE Act Amendments of 2000, Pub. L. No. 106-345, § 301(a), 114 Stat. 1319, 1345 (2000).
71. Leslie E. Wolf & Richard Vezina, *Crime and Punishment: Is There a Role for Criminal Law in HIV Prevention Policy?*, 25 WHITTIER L. REV. 821, 841 (2004).

Additionally, individuals convicted under these laws can face enhanced penalties merely because of their HIV diagnosis. Despite a cornucopia of laws for prosecuting people living with HIV, some states have sought more severe charges with increased punitive consequences by invoking their bioterrorism laws.

A. STATUTES CRIMINALIZING HIV-RELATED OFFENSES

While several states had already passed HIV-specific criminal statutes prior to the Presidential Commission's Report and the Ryan White Care Act,[72] many more states implemented laws to criminalize HIV transmission after implementation of the Ryan White Care Act. At least thirty-seven states have criminal statutes specific to HIV.[73] Such laws vary in how broadly they define prohibited conduct, intent, and affirmative defenses.

1. Prohibited Conduct

HIV-specific criminal laws generally prohibit sexual intercourse and transmission of bodily fluids. However, various states differentiate how they define prohibited sexual activity. For example, California limits "sexual activity" to sexual intercourse, which California traditionally defines as "insertive vaginal or anal intercourse on the part of an infected male, receptive consensual vaginal intercourse on the part of an infected

72. *See* THE REPORT, *supra* note 59, at 130–31.

73. *See, e.g.*, ALA. CODE § 22-11A-21(c) (2012); ALASKA STAT. ANN § 12.55.155(c)(33) (West 2012); ARK. CODE ANN. §§ 5-14-123, 20-15-903 (West 2012); CAL. HEALTH & SAFETY CODE §§ 120291, 120290, 1621.5 (West 2012); CAL. PENAL CODE §§ 12022.85, 647(f) (West 2012); COLO. REV. STAT. §§ 18-3-415.5, 18-7-205.7, 18-7-201.7 (West 2012); FLA. STAT. ANN. §§ 384.24(2), 381.0041(11)(b), 796.08(5), 775.0866 (West 2012); GA. CODE ANN. §§ 16-5-60(c), (d) (West 2012); IDAHO CODE ANN. § 39-608 (West 2012); 720 ILL. COMP. STAT. § 5.12-16.2 (West 2012); IND. CODE ANN. §§ 35-42-1-7, 35-42-2-6(e), (f), 35-45-16-2(a), (b), (d), 16-41-7-1, 35-42-1-9, 16-41-14-17 (West 2012); IOWA CODE ANN. § 709C.1 (West 2012); KAN. STAT. ANN. §§ 21-3435, 65-6005 (West 2012); KY. REV. STAT. ANN. §§ 311.990(24)(b), 529.090(3) & (4) (West 2012); LA. REV. STAT. ANN. § 14:43.5 (2012); MD. CODE ANN., HEALTH-GEN. § 18-601.1 (West 2012); MASS. GEN. LAWS ANN. ch. 265 § 22B(f) (West 2012); MICH. COMP. LAWS ANN. § 333.5210 (West 2012); MINN. STAT. § 609.2241 (West 2012); MISS. CODE ANN. §§ 97-27-14(1), (2) (West 2012); MO. ANN. STAT. §§ 191.677, 565.085, 567.020 (West 2012); MONT. CODE ANN. §§ 50-18-112, 50-18-113 (West 2012); NEV. REV. STAT. ANN. §§ 201.205, 441A.300, 441A.180, 201.358 (West 2012); N.J. STAT. ANN. § 2C:34-5 (West 2012); N.C. GEN. STAT. ANN. § 130A-144 (West 2012); N.D. CENT. CODE ANN. § 12.1-20-17 (West 2012); OHIO REV. CODE ANN. §§ 2903.11, 2907.24, 2907.25, 2907.241, 2921.38, 2927.13 (West 2012); OKLA. STAT. tit. 21, §§ 1031, 1192.1 (West 2012); OKLA. STAT. tit. 63, § 1-519 (West 2012); 18 PA. CONS. STAT. ANN. §§ 2703, 2704, 5902 (West 2012); R.I. GEN. LAWS ANN. § 23-11-1 (West 2012); S.C. CODE ANN. §§ 44-29-145, 44-29-60, 44-29-140 (2012); S.D. CODIFIED LAWS §§ 22-18-31, 22-18-33, 22-18-34 (2012); TENN. CODE ANN. §§ 39-13-109, 39-13-516, 39-13-108, 40-35-114(21), 68-10-107, 68-10-101, 68-10-111 (West 2012); UTAH CODE ANN. §§ 76-10-1309, 76-5-102.6 (West 2012); VA. CODE ANN. §§ 18.2-67.4:1(A), (B), 32.1-289.2 (West 2012); WASH. REV. CODE ANN. § 9A.36.011 (West 2012); W.VA. CODE ANN. §§ 16-4-20, 16-4-26 (West 2012); WIS. STAT. ANN. § 973.017(4) (West 2012).

woman with a male partner, or receptive consensual anal intercourse on the part of an infected man or woman with a male partner."[74]

Iowa adopts a broader definition of "sexual activity" that includes "intimate contact with another person."[75] Similarly, Michigan prohibits "sexual penetration" that it defines as "sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required."[76]

Several states prohibit activities that are not necessarily tied to sexual intercourse. For example, Iowa prohibits transmission of "blood, tissue, semen, . . . or other potentially infectious bodily fluids . . . to another person"[77] and the use of "nonsterile drug paraphernalia."[78] Washington provides yet another example of how states define prohibited conduct by including any conduct that "exposes" another person to the virus—as opposed to enumerating specific types of conduct.[79] Indiana wraps emotion into its law by criminalizing the placement of human blood, semen, urine, or fecal matter on another person in a "rude, insolent, or angry manner."[80]

Furthermore, numerous states prohibit certain conduct despite scientific evidence that such conduct does not transmit HIV. For example, Missouri prohibits biting by a person with HIV.[81] Georgia includes the "intent to transmit HIV, using . . . saliva . . . ."[82] Utah prohibits "propel[ing] . . . saliva . . . ."[83] Mississippi and Missouri similarly prohibit a person who knows he or she has HIV from "caus[ing] or knowingly caus[ing]" contact with saliva.[84] Pennsylvania includes spitting as prohibited conduct by a person who knows or "had reason to know" he or she has HIV.[85] Idaho includes saliva as a "bodily fluid" that can expose a person to HIV.[86] The CDC has long dismissed the theory that HIV can be transmitted from saliva

74. CAL. HEALTH & SAFETY CODE 120291(a), (b) (West 2006).
75. IOWA CODE ANN. § 709C.1(1)(a) (West 2003).
76. MICH. COMP. LAWS ANN. § 333.5210(2) (West 2012). Ohio has a similar statute that defines sexual conduct as "anal intercourse, vaginal intercourse, fellatio, cunnilingus, or insertion, however slight, of any part of the body into the anal or vaginal opening of another." OHIO REV. CODE ANN. § 2903.11 (West 2012).
77. IOWA CODE ANN. § 709C.1(1)(b) (West 2012).
78. *Id.* § 709C.1(1)(c).
79. WASH. REV. CODE ANN. § 9A.36.011(1)(b) (West 2012).
80. IND. CODE ANN. § 35-42-2-6(f) (West 2012).
81. MO. ANN. STAT. § 191.677(2)(c) (West 2012).
82. GA. CODE ANN. § 16-5-60(d) (West 2012).
83. UTAH CODE ANN. § 76-5-102.6 (West 2012).
84. MISS. CODE ANN. § 97-27-14(2) (West); MO. ANN. STAT. § 565.085 (West 2012).
85. 18 PA. CONS. STAT. ANN. §§ 2703, 2704 (West 2012).
86. IDAHO CODE ANN. § 39-608 (West 2012).

and noted the absence of any reports of HIV transmission from human bites.[87]

2. Intent

HIV-specific criminal laws adopt one of three approaches to intent: (1) the California approach; (2) the Florida approach; or (3) the Iowa approach. The California approach imposes criminal liability only if the defendant intended to transmit the virus to another person.[88] The Florida approach adheres to the Presidential Commission's recommendation that the prosecution be required to prove that a defendant with HIV understood his or her conduct might expose the disease to another person at the time of the offense.[89] The Iowa approach requires no specific intent and instead only requires that a defendant know he or she engaged in the prohibited conduct.[90]

3. Affirmative Defenses

While most states provide an affirmative defense for individuals who disclose their HIV-status to their sexual partner, the HIV transmission criminalization laws in Kansas[91] and Washington[92] do not permit such defenses. Thus, a person with HIV who fully discloses his or her HIV status to his or her partner can still be sentenced to prison in these states.

California permits disclosure alone to nullify the criminal charge.[93] Ohio allows the defense if full disclosure occurred with an adult (not a minor) with "mental capacity to appreciate the significance of the knowledge that the offender has tested positive as a carrier of the virus."[94] In addition to full disclosure, Tennessee requires that the person "exposed to HIV. . . knew that the action could result in infection with HIV."[95] Still, most statutes do not permit an affirmative defense if HIV is not transmitted, an individual has an undetectable viral load, and/or an individual uses condoms.[96]

B. SPECIFIC LAWS FOR SEX WORKERS WITH HIV

Numerous states have enacted criminal statutes specific to sex workers. For example, Florida imposes a third degree felony on an individual who

87. CTRS. FOR DISEASE CONTROL & PREVENTION (CDC), SURGEON GENERAL'S REPORT TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS 8 (1994).
88. CAL. HEALTH & SAFETY CODE § 120291(a) (West 2012).
89. FLA. STAT. ANN. § 384.24(2) (West 2012); *see also* THE REPORT, *supra* note 59, at 131.
90. IOWA CODE ANN. § 709C.1 (West 2012).
91. KAN. STAT. ANN. § 21-3435 (West 2012).
92. WASH. REV. CODE ANN. § 9A.36.011(b) (West 2012).
93. CAL. HEALTH & SAFETY CODE § 120291(a) (West 2012).
94. OHIO REV. CODE ANN. § 2903.11 (B)(2) (West 2012).
95. TENN. CODE ANN. § 39-13-109(c) (West 2012).
96. *See supra* note 73 (listing HIV criminalization statutes).

knows he or she has HIV and who "commits or offers to commit prostitution or procures another for prostitution by engaging in sexual activity in a manner likely to transmit the human immunodeficiency virus."[97] Georgia punishes a person with up to ten years in prison who offers or consents to "sexual intercourse" or sodomy for money if the person knows he or she has HIV and fails to disclose this status.[98] Missouri and Oklahoma have similarly passed additional criminal penalties for sex workers engaging in prostitution who know that they have HIV.[99] Ohio prescribes a fifth degree felony charge for persons "loitering to engage in solicitation" if they have knowledge that they have HIV.[100] Tennessee also provides that a person may be charged with a felony if she or he knows he or she has HIV and engages in prostitution and/or "loiters in a public place . . . [to be] hired to engage in sexual activity."[101] Even though Nevada has legalized prostitution, it still punishes sex workers with up to ten years in prison for continuing to work as a prostitute after testing positive for HIV.[102] Pennsylvania equally imposes a third degree felony for people who know they have HIV and "commit prostitution," "promote prostitution," or "patronize a prostitute."[103]

C. GENERAL CRIMINAL LAWS

While HIV-specific criminal laws have resulted in a bevy of additional prosecutions regarding HIV-related offenses, some states also use general criminal laws to prosecute people with HIV. For example, a Dallas jury convicted Willie Campbell, a homeless man with HIV, to thirty-five years in prison for spitting on a police officer through charges of harassing a public servant with a deadly weapon.[104] A woman in Georgia was sentenced to eight years in prison for failing to disclose her HIV status to her sexual partners under a statute for reckless conduct.[105] In Indiana, a man with HIV was sentenced to six years imprisonment for battery by body waste for throwing his urine and feces at a nurse in his detention facility.[106]

Some critics of HIV-specific laws argue for their repeal because general criminal laws are sufficient to prosecute individuals who

97. FLA. STAT. ANN. § 796.08(5) (West 2012).

98. GA. CODE ANN. § 16-5-60(c) (West 2012). Georgia fails to define "sexual intercourse" for purposes of this statute.

99. MO. ANN.. STAT. § 567.020 (West 2012); OKLA. STAT. TIT. 21, § 1031.

100. OHIO REV. CODE ANN. § 2907.241 (West 2012).

101. TENN. CODE ANN. § 39-13-516 (West 2012).

102. NEV. REV. STAT. ANN. § 201.358 (West 2012).

103. 18 PA. CONS. STAT. ANN. § 5902 (West 2012).

104. *See* Gretel C. Kovach, *Prison for Man With H.I.V. Who Spit on a Police Officer*, N.Y. TIMES, May 16, 2008; *see also* USA Today, *Critics Assail Crime Laws Aimed at People with HIV*, USA TODAY, Jan. 2, 2012.

105. *See* Ginn v. State, 667 S.E.2d 712 (Ga. Ct. App. 2008) (noting woman's argument that her sexual partner must have known of her HIV status because it had been published on the front page of a local newspaper).

106. Nash v. State, 881 N.E.2d 1060 (Ind. Ct. App. 2008).

maliciously and knowingly transmit HIV to unsuspecting partners. However, a handful of recent prosecutions suggest instead that general criminal laws are often invoked to prosecute an individual's HIV-status more than a person's actual conduct. For example, a Florida man with HIV was sentenced to fifteen years in prison for aggravated assault after biting a police officer (even though the police officer tested negative for HIV).[107] Prosecutors in South Carolina upgraded charges for a man who bit his neighbor from simple assault to intent to kill when they learned he had HIV.[108] A New York man with HIV was convicted of "aggravated assault" for biting a police officer after state prosecutors argued that his saliva was a "dangerous instrument."[109]

D. BIOTERRORISM CHARGES

Charges relating to terrorism highlight the lingering public fear of contracting HIV and prosecutors' attempts to use new laws as vehicles for prosecuting defendants suspected of having HIV. For example, Daniel Allen, a gay Black Michigan man with HIV, was charged with bioterrorism after biting his neighbor during an argument.[110] Mr. Allen asserted that he was innocent and the victim of a brutal anti-gay (and potentially anti-Black) attack but ultimately pleaded guilty to assault charges because of his health and the failure of one of his witnesses to show up for trial.[111] The prosecutor reduced his sentence to eleven months of probation only after significant public outcry.[112]

Another Michigan man who spit on a corrections officer was not so lucky. In 2007, a Michigan appellate court upheld a prison sentence of up to fifteen years for Antoine Deshaw Odom, an incarcerated Black man with HIV who spit on a correctional officer during an altercation.[113] The assault

107. David Ovalle, *HIV-Positive Man Who Bit Officer Gets 15-Year Sentence*, MIAMI HERALD, Aug. 26, 2009.

108. Greg Suskin, *Charges Upgraded Against HIV Positive Man After Fight*, WSOCTV.COM, July 23, 2009.

109. The New York Court of Appeals ultimately dismissed Mr. Plunkett's charge of aggravated assault of a police officer after concluding that Mr. Plunkett's saliva could not be considered a "dangerous instrument" because saliva was a part of the body and thus did not constitute an "instrument" under the Penal Code. *See People v. Plunkett*, 971 N.E.2d 363, 368 (N.Y. 2012).

110. Todd A. Heywood, *Once Facing 15 Years in Prison, HIV-As-Terrorism Suspect Gets Probation*, MICHIGAN MESSENGER (Dec. 8, 2010), *available at* http://67.228.170.242/160692/once-facing-15-years-in-prison-hiv-as-terrorism-suspect-gets-probation. Daniel Allen was initially charged with one count of possession of use of a harmful device in violation of a section of Michigan's bioterrorism law, one count of assault with intent to maim and assault with intent to do great bodily harm less than murder. *Id.* His charges carried a prison sentence of up to fifteen years, but after pleading no contest to his assault charge, he ultimately received eleven months of probation. *Id.*

111. *Id.*

112. Heywood, *supra* note 110.

113. People v. Odom, 740 N.W.2d 557, 567 (Mich. Ct. App. 2007).

left Mr. Odom bleeding from the mouth.[114] The court determined that Mr. Odom's saliva consisted of a "harmful biological substance" because it appeared to contain blood that was infected with HIV.[115]

Similarly, Leo Matthews from Pennsylvania was charged with terroristic threats after punching a window and shaking his fist with blood at police, threatening to spit and bite police officers and allegedly stating that he hoped the officers would get HIV.[116] Mr. Matthews was subsequently sentenced to six months to one year in jail and three months of probation after he apologized and disclosed that he did not have AIDS.[117] While Mr. Allen's terrorism charges were eventually dropped,[118] an appellate court affirmed Mr. Odom's bioterrorist conviction for spitting, and Mr. Matthews continued to be prosecuted under his state's terrorism laws, even after he stated he did not have AIDS.[119]

E. PENALTY ENHANCEMENT STATUTES

Some states have statutes that increase the sentence for a person accused of a crime if that person has HIV. For example, Alaska imposes an enhanced sentence if a defendant with HIV is charged with a crime involving penetration and exposed the victim to a "risk or a fear that the offense could result in the transmission of HIV."[120] California has a three-year sentence enhancement statute targeted to individuals who have knowledge that they are infected with HIV when they engage in a sexual offense.[121] Colorado permits judges to enhance a defendant's sentence at least three times the upper limit if the prosecutor can prove beyond a reasonable doubt that the defendant knew he or she had HIV and committed a sexual offense.[122] Tennessee law allows judges to consider a defendant's HIV status as an "advisory factor" in determining whether to enhance his or her sentence for charges of aggravated rape, sexual battery, rape of a child, or statutory rape if the defendant knew or should have known that he or she had HIV at the time of the offense.[123] Wisconsin requires a court to consider whether a person convicted of a "serious sex

114. *Id.* at 411.
115. *Id.* at 411–12.
116. Colin McEvoy, *Leo Matthews Admits to Throwing Blood onto Easton Police Officers with Hopes They Would Contract AIDS*, THE EXPRESS-TIMES, Mar. 27, 2011; Pamela Lehman, *Man Sorry About Officers' AIDS Scare, Lawyer Says*, THE MORNING CALL, Feb. 25, 2011.
117. Lehman, *supra* note 116; Nicole Radzievich, *Easton Man Gets up to a Year in Jail for Assault on Police*, THE MORNING CALL, May 13, 2011.
118. *See* Heywood, *supra* note 110.
119. *See* Lehman, *supra* note 117; *see also* J.D Malone, *Easton Man Who Tossed AIDS-Infected Blood on Police Gets Prison Sentence*, THE EXPRESS-TIMES, May 13, 2011.
120. ALASKA STAT. ANN. § 12.55.155(c)(33) (West 2012).
121. CAL. PENAL CODE § 12022.85 (West 2012).
122. COLO. REV. STAT. § 18-3-415.5 (West 2012).
123. TENN. CODE ANN. § 40-35-114 (21) (West 2012).

crime" knew he or she had HIV and the victim was "significantly exposed to HIV" by the defendant's acts.[124]

Several states impose enhanced sentencing penalties for sex-workers with HIV. For example, California increases penalties for sex workers soliciting or engaging in prostitution who are aware that they have HIV.[125] Utah enhances the penalty for a person convicted of prostitution or sexual solicitation if he or she knew he or she has HIV or was previously convicted of prostitution, patronizing a prostitute, or sexual solicitation (regardless of whether he or she knew he or she had HIV).[126]

IV. PERPETUATING INEQUALITY THROUGH FLAWED LAWS

Despite decades of numerous legal avenues for criminalizing people with HIV, no research has demonstrated that such punitive methods work to reduce HIV transmission and/or increase education about HIV. Instead, these laws are more likely to produce contrary results and actually increase misconceptions about HIV transmission by criminalizing people with HIV regardless of a person's likelihood of transmitting HIV because of condom usage, viral load, and/or engaging in activity with a very low or nonexistent likelihood of transmission.

Laws that criminalize HIV-related offenses also carry several flaws that can further perpetuate inequality by targeting members of marginalized communities through: (1) broad language that allows for biases based on race, class, gender, and sexual orientation to pervade the criminal process; (2) misinformation about HIV that undermines public health efforts; (3) failure to acknowledge important power dynamics that may prompt someone not to disclose his or her HIV status; and (4) elimination of privacy.

A. BROAD LAWS PROMOTING UNEQUAL TREATMENT AND INFUSION OF BIASES

The broad language of many HIV-related criminal laws gives prosecutors and judges immense discretion to charge, convict, and sentence defendants with HIV. This discretion can lead to disproportionate convictions and sentencing results that are unrelated to any actual HIV transmission. When the defendant is a member of a marginalized community, congealed biases regarding race, class, gender, and sexual orientation can further exacerbate a system of inequitable punishment.[127]

124. WIS. STAT. ANN. § 973.017(4) (West 2012).
125. CAL. PENAL CODE § 647(f) (West 2012).
126. UTAH CODE ANN. § 76-10-1309 (West 2012).
127. Douglas A. Berman & Stephanos Bibas, *Making Sentencing Sensible*, 4 OHIO ST. J. CRIM. L. 37, 47 (2006) (citing studies finding a correlation between sentencing disparities and a defendant's race, sex, and class).

Previous reports documenting the number of HIV transmission convictions suggest that racial minorities experience disproportionate conviction rates.[128] Moreover, recent research suggests that, at least in Michigan, Black men have disproportionately higher conviction rates than white men under Michigan's HIV criminalization laws.[129]

Laws that include vague language that the defendant "should have known" he or she had HIV at the time of the offense provide an opportunity for such biases to saturate court decisions.[130] One particular Florida case demonstrates how judges can infuse their own prejudices and stereotypes toward gay men in determining who or why someone should know that he or she has HIV. In *Cooper v. State of Florida*, the appellate court upheld the enhanced sentence of a man with HIV even though no proof demonstrated that the defendant knew he had HIV at the time of the offense, as he tested positive only after the alleged crime occurred.[131] Mr. Cooper appealed a thirty-year sentence after the State convicted him of sexual battery upon a seventeen-year-old boy.[132] The trial court departed from the recommended sentence guideline of twelve to seventeen years, in part, because the "defendant, having been an admitted homosexual for years, knew or should have known the likelihood of his having AIDS as a result of these homosexual contacts."[133] The appellate court reinforced this reasoning by stating that "[b]ecause of his life-style, Cooper knew or should have known that he had been exposed to the AIDS virus . . . ."[134] While the State presented no evidence that Mr. Cooper was either aware he had HIV or that the seventeen-year-old boy contracted HIV (and it is highly unlikely he did, as there appears to be no evidence of any exchange of bodily fluids),[135] the Court assumed that Mr. Cooper was aware or should have been aware he had HIV because he was gay.[136] Mr. Cooper's

128. A 1992 report by the CDC indicated that fifty-eight percent of the adult and adolescent AIDS cases were among "men who have sex with men" but do not inject drugs. Of these cases, eighteen percent were among Black men and eleven percent among Latino men. Twenty-three percent of the adult and adolescent AIDS cases were among female and heterosexual male intravenous drug users. Among women with AIDS, fifty-two percent were Black and twenty-one percent were Latino. ABE M. MACHER, HIV DISEASE/AIDS: MEDICAL BACKGROUND IN AIDS AND THE LAW 1, 5 (Wiley L. Publications ed., 2d ed. 1992).

129. Jared Wadley, *Michigan Courts Use HIV Disclosure Laws To Punish Poor, Marginalized Individuals*, U. OF MICH. NEWS SERV. (July 27, 2012), *available at* http://ns.umich.edu/new/releases/20656-michigan-courts-use-hiv-disclosure-laws-to-punish-poor-marginalized-individuals.

130. *See e.g.*, TENN. CODE ANN. § 40-35-114(21) (West 2012) (imposing sentence enhancement if "the defendant knew or should have known that, at the time of the offense, the defendant was HIV positive").

131. Cooper v. State, 539 So. 2d 508, 510, 512 (Fla. Dist. Ct. App. 1989).

132. *Id.* at 510.

133. *Id.* at 512.

134. *Id.* at 511.

135. *Cooper*, 539 So. 2d at 509–10 (noting that Mr. Cooper allegedly sexually molested the victim, and the victim cut himself on a chain link fence while fleeing from Mr. Cooper).

136. *Id.* at 511.

sexual orientation likely played a key role in the Court's decision to significantly depart from the sentencing guidelines.[137] Similarly, an Iowa court recently sentenced Nick Rhoades to twenty-five years in prison—the maximum sentence under Iowa's HIV criminalization law—and a lifetime sentence as a sex offender for a one-time sexual encounter with another man, even though he used a condom and the other man did not contract HIV.[138]

A California appellate court also upheld enhanced sentencing of a Latino man who engaged in unprotected consensual sex with a minor even though there was no evidence that the minor contracted HIV and her consent arguably vitiated an inference of force necessary for assault convictions.[139] An African American Ohio wrestler faced up to 112 years in prison and was ultimately convicted of thirty-two years imprisonment after engaging in sexual activity without disclosing his HIV status even though none of his sexual partners had tested positive for HIV at the time of his trial.[140] An African American Idaho man was sentenced to thirty years in prison for failing to disclose his HIV status, even though he used condoms, had an undetectable viral load, and did not transmit HIV.[141] An Illinois prosecutor charged a Latino man with criminal transmission of HIV and aggravated battery for biting a police officer, even though the police department acknowledged that they expected the police officer to be safe from any actual transmission.[142] A Texas court sentenced a homeless man to thirty-five years in prison because he spit on an officer arresting him for disorderly conduct.[143] Michigan went so far as to charge two Black men with HIV with crimes of bioterrorism for biting or spitting.[144]

A judge in Washington also doubled a man's second degree assault sentence from six to twelve years after finding "deliberate cruelty" because

137. *See* Arianne Stein, *Should HIV Be Jailed? HIV Criminal Exposure Statutes and Their Effects in the United States and South Africa*, 3 WASH. U. GLOB. STUD. L. REV. 177, 198 (2004) (noting that seventy-two percent of Missouri's HIV transmission cases comprised same-sex conduct).

138. Proof Br. of Applicant, Rhoades v. Iowa, No. 12-0180, at 5, 8, 9 (June 2012), *available at* http://www.lambdalegal.org/in-court/legal-docs/rhoades_ia_20120613_proof-brief-of-applicant-appellant-and-request-for-oral-argument.

139. Guevara v. Superior Court, 62 Cal. App. 4th 864, 867–69 (1998).

140. Kimberly Perry, *Ohio Wrestler Gets Prison for Failure To Share HIV Status*, THE CINCINNATI ENQUIRER (Jan. 24, 2012), *available at* http://usatoday30.usatoday.com/news/nation/story/2012-01-24/ohio-wrestler-hiv/52768272/1.

141. *Kerry Thomas*, THE SERO PROJECT (Nov. 7, 2012), http://seroproject.com/video/kerry-thomas/#tabs1 (last visited Nov. 7, 2012).

142. Jim Jaworski, *Man Accused of Biting Cop, Charged with Transmission of HIV*, TRIBLOCAL (Nov. 23, 2011), http://triblocal.com/oak-park-river-forest/2011/11/23/man-accused-of-biting-cop-charged-with-transmitting-hiv.

143. *See* Gretel C. Kovach, *Prison for Man With H.I.V. Who Spit on a Police Officer*, N.Y. TIMES (May 16, 2008), http://www.nytimes.com/2008/05/16/us/16spit.html (reporting that the court found him guilty of harassing a police officer with a deadly weapon—his saliva).

144. *See supra* Part II.D.

the man "intentionally expos[ed]" his sexual partner to HIV.[145] The man, Mr. Randall Ferguson, had a long history of intravenous drug use.[146] While the Washington Supreme Court ultimately reversed this enhanced sentence, the lower courts seemed perfectly content with imposing such a large sentence on Mr. Ferguson even though the only basis for such an enhanced sentence was that he exposed his sexual partner to HIV, an element that the prosecutor was already required to prove (and did) for his conviction.[147] While the court did not identify Mr. Ferguson's race, any bias toward intravenous drug users could have a disproportionate affect on communities of color.[148]

Repugnant views toward prostitution can also create harsh penalties for sex workers with HIV, who are often members of marginalized communities. For example, without considering violence or unequal power dynamics that can exist between sex workers, brothel owners, and clients,[149] Nevada imposes prison sentences of up to ten years if sex workers continue to work after receiving written notice that they have HIV.[150] In 1994, the Nevada Supreme Court upheld a fifteen year prison sentence of a sex worker with HIV for soliciting an undercover police officer even though no conduct actually occurred.[151] Such harsh rulings also demonstrate how sex workers are often dehumanized and vilified by courts.

Another appellate court took great pains to find that a sex worker with HIV was not entitled to confidentiality in her identity, despite state law protecting the confidentiality of individuals who test positive for HIV.[152] During this case, a television station argued that the Illinois AIDS Confidentiality Act did not preclude disclosure of the woman's identity because (1) the government and media had already disclosed her identity;

145. State v. Ferguson, 15 P.3d 1271, 1279 (Wash. 2001).

146. *Id.* at 1272.

147. *Ferguson*, 15 P.3d at 1282.

148. *See* MONROE E. PRICE, SHATTERED MIRRORS: OUR SEARCH FOR IDENTITY AND COMMUNITY IN THE AIDS ERA 65 (Harvard University Press ed., 1989) (noting that persons who use drugs intravenously are often Black or Hispanic).

149. *See* Susan E. Thompson, *Prostitution—A Choice Ignored*, 21 WOMEN'S RTS. L. REP. 217, 242 (2000) (noting that sex workers who work the streets in Nevada are more vulnerable to violence than in brothels); *see also* Ann C. McGinley, *Harassment of Sex(y) Workers: Applying Title VII to Sexualized Industries*, 18 YALE J.L. & FEMINISM 65, 106 (2006) (arguing that Nevada sex workers' dangers, risks, and fears of disease from clients can constitute violence).

150. NEV. REV. STAT. ANN. § 201.358 (West 2012).

151. Glegola v. State, 871 P.2d 950, 953 (Nev. 1994) (citing prosecution's argument that defendant's "crime" was "much more serious and obviously much more deadly than an ordinary crime of mere solicitation" and refusing to find a fifteen year sentence cruel and unusual despite the absence of any evidence that her alleged conduct could have transmitted HIV and the likelihood Ms. Glegola would die in prison with such a lengthy sentence).

152. *In re* Application of Multimedia KSDK, Inc., 581 N.E.2d 911, 912 (Ill. App. Ct. 1991) (vacating lower court's decision to refuse a television station's request to release a sex worker's identity).

and (2) her occupation as a sex worker created a compelling need to release her name to the public in the interest of public health and welfare.[153] The trial court noted that the improper disclosure of her identity by prosecutors and the media did not justify further disclosure by this television station and that no compelling need existed to disclose her identity.[154] The appellate court disagreed and found that the AIDS Confidentiality Act did not apply because the prosecutor had already inadvertently revealed her identity and, thus, her identity was a matter of public record.[155] While the Court did not address the television station's argument that the public had a "compelling need" to know this sex worker's identity, the Court's reasoning appears to be infected with disparaging views of sex workers as "criminals" whose "morally wrong" conduct precludes application of confidentiality provisions to persons with HIV who are convicted of crimes.[156]

Criticisms that courts dispense unequal justice on people of color and poor people[157] suggest that sex workers may suffer unique injustices as they are often poor white women and women of color.[158] Transgender sex workers also face unique biases in the courts based on conflated biases regarding gender, gender identity, and sexual orientation.[159]

B. HIV-RELATED CRIMINAL LAWS SPREADING MISINFORMATION AND UNDERMINING PUBLIC HEALTH INITIATIVES

HIV-specific criminal laws can further perpetuate inequality by spreading misinformation about HIV and potentially undermining public health efforts. By spreading inaccurate information about HIV transmission, particularly as it relates to marginalized communities, these laws increase stigmatization about certain behaviors that may be more prevalent in marginalized communities. By prohibiting certain conduct that is unlikely to transmit HIV, these laws may also impair important public health initiatives.

Various commentators have criticized HIV criminalization laws as posing public health concerns by discouraging people from getting tested

153. *Id.* at 911–12.
154. *Id.*
155. *In re Application of Multimedia KSDK*, 581 N.E.2d at 913.
156. *Id.* (distinguishing "disclosure of the public allegation of criminal activity" from "disclosure of the identity of a person upon whom an HIV test has been performed or the results of such a test").
157. *See* Suskin, *supra* note 108 (noting criticisms from scholars and criminal justice professionals about sentence disparities based on race, sex and class).
158. *See* Tracy M. Clements, *Prostitution and the American Health Care System: Denying Access to a Group of Women in Need*, 11 BERKELEY WOMEN'S L.J. 49, 65 (1996) (noting that many prostitutes are poor white women and women of color).
159. *See* K.L. Broad, *Critical Borderlands & Interdisciplinary, Intersectional Coalitions*, 78 DENV. U. L. REV. 1141, 1151 (2001) (suggesting that binary gender constraints "pathologize transgender expression" in the law).

for HIV because most laws only punish conduct when the person knows he or she has HIV.[160] One study of gay men in Los Angeles found that more than half of the people who tested positive for HIV did not return to receive their test results.[161] While this research did not evaluate whether HIV-related laws deterred people from returning, it suggests that such laws could at least exacerbate an already existing public health problem.[162] A similar study in Canada, however, reported that a significant minority of men who have sex with men stated that nondisclosure criminal prosecutions either affected their willingness to get tested for HIV or made them afraid to speak with medical professionals about their sexual practices.[163] The study's lead author noted that the research showed "a significant relationship between nondisclosure prosecutions, avoidance of

160. *See* ALA. CODE § 22-11A-21(c) (West 2012); ARK. CODE ANN. §§ 5-14-123 (West 2012); CAL. HEALTH & SAFETY CODE §§ 120291, 1621.5 (West 2012); CAL. PENAL CODE §§ 12022.85, 647f (West 2012); COLO. REV. STAT. §§ 18-3-415.5, 18-7-205.7, 18-7-201.7 (West 2012); FLA. STAT. ANN. §§ 384.24(2), 381.0041(11)(b), 796.08(5), 775.0866 (West 2012); GA. CODE ANN. §§ 16-5-60(c), (d) (West 2012); IDAHO CODE ANN. § 39-608 (West 2012); 720 ILL. COMP. STAT. ANN. § 5/12-16.2 (West 2012); IND. CODE ANN. § 16-41-7-1, 35-42-1-9 (West 2012); IOWA CODE ANN. § 709C.1 (West 2012); KAN. STAT. ANN. §§ 21-3435, 65-6005 (West 2012); KY. REV. STAT. ANN. §§ 311.990(24)(b), 529.090(3) & (4) (West 2012); MD. CODE ANN., HEALTH-GEN. § 18-601.1 (West 2012); MICH. COMP. LAWS ANN. § 333.5210 (West 2012); MINN. STAT. § 609.2241 (West 2012); MISS. CODE ANN. §§ 97-27-14(1), (2) (West 2012); MO. ANN. STAT. §§ 191.677, 565.085, 567.020 (West 2012); MONT. CODE ANN. §§ 50-18-112, 50-18-113 (West 2012); NEV. REV. STAT. ANN. §§ 201.205, 201.358 (West 2012); N.J. STAT. ANN. § 2C:34-5 (West 2012); N.D. CENT. CODE ANN. § 12.1-20-17 (West 2012); OHIO REV. CODE ANN. §§ 2903.11, 2907.24, 2907.25, 2907.241, 2921.38, 2927.13 (West 2012); OKLA. STAT. tit. 21, §§ 1031, 1192.1 (West 2012); 18 PA. CONS. STAT. ANN. § 5902 (West 2012); R.I. GEN. LAWS ANN. 1956 § 23-11-1 (West 2012); S.C. CODE ANN. §§ 44-29-145, 44-29-60, 44-29-140 (2012); S.D. CODIFIED LAWS §§ 22-18-31, 22-18-33, 22-18-34 (2012); TENN. CODE ANN. §§ 39-13-109, 39-13-516 (West 2012); UTAH CODE ANN. §§ 76-10-1309, 76-5-102.6 (West 2012); VA. CODE ANN. §§ 18.2-67.4:1(A), (B), 32.1-289.2 (West 2012); WIS. STAT. § 973.017(4) (West 2012).

161. *See* Kaiser Health News, *HIV-Positive People Not Obtaining Test Results, Receiving Appropriate Counseling, Studies Say*, KAISER NETWORK (July 30, 2003), http://www.kaiserhealthnews.org/Daily-Reports/2003/July/30/dr00019093.aspx?p=1 (reporting findings from the Los Angeles County Department of Health Services that sixty percent of men who tested positive for HIV failed to return to obtain their test results); *cf.* Scott Burris et al., *Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial*, 39 ARIZ. ST. L.J. 467, 472 (2007) (suggesting that people without HIV do not necessarily take more chances with people with HIV based on an assumption that they are adhering to laws regarding nondisclosure). While the Burris study suggests that sexual behavior may not be dictated by nondisclosure and condom laws, the study itself did not directly test whether HIV-related criminal laws themselves deterred individuals from obtaining HIV tests.

162. *See also* Leslie E. Wolf et al., *Crime & Punishment: Is There a Role for Criminal Law In HIV Prevention Policy*, 25 WHITTIER L. REV. 821, 869 (2004); Zita Lazzarini et al., *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J.L. MED. & ETHICS 239, 250 (2002); RICHARD ELLIOT, JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], CRIMINAL LAW, PUBLIC HEALTH AND HIV TRANSMISSION: A POLICY OPTIONS PAPER 23 (2002).

163. Todd Heywood, *HIV Criminalization May Discourage Testing, Study Shows*, THE ADVOC. (July 18, 2012), *available at* http://www.advocate.com/health/2012/07/18/study-shows-hiv-criminalization-may-discourage-testing.

testing, and higher-risk sexual practices."[164] While the study has some limitations, as it is based in Canada and involved a nonrandom sample,[165] it provides the first empirical evidence to suggest that HIV criminalization laws negatively impact HIV testing.

In addition to potentially preventing HIV testing, HIV criminal laws impede public health initiatives by spreading misinformation about HIV transmission.[166] For example, several states criminalize biting and spitting, despite scientific evidence suggesting that HIV cannot be transmitted through this conduct.[167] Some statutes even criminalize insertion of outside objects,[168] suggesting that a sex toy can transmit HIV/AIDS even if it is not contaminated.[169] Such laws are often enforced against altercations with police officers, and frequently by individuals who are homeless or in prison.[170]

Furthermore, the laws do not recognize that advances in antiretroviral drugs[171] allow most individuals living with HIV to survive with this chronic disease. HIV is a complex virus that responds differently to various medicines and individuals. However, early and consistent treatment dramatically increases one's survival and ability to live with HIV

164. *Id.*

165. *Id.*

166. *See* Michael L. Closen et al., Discussion, *Criminalization of an Epidemic: HIV-AIDS and Criminal Exposure Laws*, 46 ARK. L. REV. 921, 934 (1994).

167. *See e.g.*, MO. ANN. STAT. § 191.677(2)(c) (West 2012); GA. CODE ANN. § 16-5-60(d) (West 2012); UTAH CODE ANN. § 76-5-102.6 (West 2012); MISS. CODE ANN. § 97-27-14(2) (West 2012); MO. REV. STAT. § 565.085 (West); 18 PA. CONS. STAT. ANN. §§ 2703, 2704 (West 2012); IDAHO CODE § 39-608 (West 2012); *see also* CTRS. FOR DISEASE CONTROL & PREVENTION, SURGEON GENERAL'S REPORT TO THE AMERICAN PUBLIC ON HIV INFECTION AND AIDS 8 (1994).

168. *See e.g.*, ARK. CODE. ANN. § 5-14-123(c)(1) (West 2012) (prohibiting "any . . . intrusion, however slight, . . . of any object into a genital or anal opening of another person's body"); MICH. COMP. LAWS ANN. § 333.5210.1-2 (West 2012) (same).

169. *See* Carol L. Galletly & Steven D. Pinkerton, *Toward Rational Criminal HIV Exposure Laws*, 32 J.L. MED. & ETHICS 327, 329 (2004) (noting that the risk of transmitting HIV through insertion of a non-contaminated object is zero); *see also* Ctrs. for Disease Control & Prevention, *supra* note 1 (explaining that HIV cannot be transmitted through biting when the skin is not broken).

170. *See e.g.*, People v. Odom, 740 N.W.2d 557, 560, 567 (Mich. Ct. App. 2007) (upholding a fifteen-year sentence for an incarcerated man with HIV who spit on a correctional officer during an altercation); Gretel C. Kovach, *Prison for Man with H.I.V. Who Spit on a Police Officer*, N.Y.TIMES, May 16, 2008 (detailing a thirty-five-year sentence for a homeless man with HIV who spit on a police officer).

171. Antiretroviral drugs are medications used to treat infection by retroviruses, like HIV. *Living with HIV/AIDS*, CTRS. FOR DISEASE CONTROL & PREVENTION (2007), *available at* http://www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm. Retroviruses reverse the normal cell process—which uses RNA to synthesize DNA—and for HIV, permanently destroy the cells they change in the genetic material of the infected cell. *Retroviruses (HIV/SIV)*, S. RESEARCH INST., http://www.southernresearch.org/life-sciences/infectious-diseases/virology/retroviruses-hivsiv (last visited Oct. 31, 2012). A combination of several antiretroviral drugs is referred to as HAART, or Highly Active Anti-Retroviral Therapy. *Living with HIV/AIDS*, *supra* note 171.

for decades. One study estimated that a person who contracts HIV at age twenty can live into her early sixties if she immediately takes her combination treatment.[172] Since antiretroviral treatment emerged in the 1990s, significant advances have developed, and an effective combination of such treatment can reduce the level of HIV virus in one's blood to undetectable levels.[173] A low viral load also makes transmission extremely unlikely.[174]

Moreover, most statutes do not include condom usage as a defense,[175] and one state even explicitly states that condom usage is not a defense.[176] These laws suggest that condoms are useless in preventing HIV transmission, despite studies showing that male condoms can be ninety-five percent effective and female condoms can be ninety-seven percent effective in preventing HIV transmission when used correctly.[177] Similarly, these laws do not recognize the use of drug treatment in significantly reducing the risk of transmission.[178] For example, an Iowa court upheld a twenty-five-year prison sentence for Adam Donald Musser, a man who had unprotected sex while on treatment for HIV, despite failing to transmit HIV to his sexual partner.[179] The Court refused to consider either Mr. Musser's drug treatment as a mitigating factor in sentencing or the fact that he did not transmit HIV to his sexual partner, in reducing or eliminating his lengthy prison sentence.[180] HIV criminalization laws also detract from

172. Antiretroviral Therapy Cohort Collaboration, *Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies*, 372 THE LANCET 293, 297 (2008).

173. Isabel Grant, *The Prosecution of Non-Disclosure of HIV in Canada: Time to Rethink Cuerrier*, 5 MCGILL J.L. & HEALTH 7, 21 (2011).

174. *Id.*; *see also* CTR. FOR HIV LAW & POLICY, TRANSMISSION ROUTES, VIRAL LOADS AND RELATIVE RISKS: THE SCIENCE OF HIV FOR LAWYERS AND ADVOCATES 20 (2011), *available at* http://www.hivlawandpolicy.org/resources/view/643 (citing research demonstrating that effective antiretroviral therapy reduces the risk of transmission by ninety-six percent).

175. *See supra* note 73 (listing statutes).

176. MO. ANN. STAT. § 191.677(4) (West 2012) (expressly stating that "[t]he use of condoms is not a defense to a violation of . . . this section.").

177. *See* Kathy Shapiro & Sunanda Ray, *Sexual Health for People Living with HIV*, 15 REPROD. HEALTH MATTERS 67, 76 (2007) (noting that male latex condoms are between eighty percent and ninety-five percent effective, and female condoms are between ninety-four percent and ninety-seven percent effective in preventing HIV); Karen R. Davis & Susan C. Weller, *The Effectiveness of Condoms in Reducing Heterosexual Transmission of HIV*, 31 FAM. PLAN. PERSPS. 276 (1999) (concluding that condoms are approximately eighty-seven percent effective in preventing HIV but may be as effective as ninety-six percent); S.D. Pinkerton & P. R. Abramson, *Effectiveness of Condoms in Preventing HIV Transmission*, 44 SOC. SCI. & MED. 1303, 1303–12 (1997) (concluding that condoms are between 90–95% effective against heterosexual transmission of HIV).

178. *See* State v. Musser, 721 N.W.2d 734, 749 (Iowa 2006) (upholding prison sentence for a man with HIV who had unprotected sex while on HIV treatment); *see also* Julio S.G. Montaner et al., *The Case for Expanding Access to Highly Active Antiretroviral Therapy to Curb the Growth of the HIV Epidemic*, 368 LANCET 531, 531–32 (2006).

179. *Musser*, 721 N.W.2d at 749.

180. *Id.* at 749–50.

public health initiatives that shared responsibility for sexual health is important in curbing HIV transmission, as opposed to placing sole responsibility on the partner with HIV.[181]

Laws that perpetuate misconceptions of HIV transmission may affect communities of color more negatively, where people may have a larger distrust of the medical establishment as a result of past racial discrimination. For example, African Americans who grew up in an era of legalized "separate but equal" policies may be more hesitant to visit doctors due to past experiences or historical knowledge of inadequate hospitals for Blacks.[182] A similar history of discrimination against Asian Americans[183] and Latinos[184] may lead to similar fears and distrust.

A history of medical experimentation without full disclosure or consent by African Americans,[185] Latinos,[186] Asian Americans,[187] immigrants,[188]

181. *See* Sara Klemm, Symposium, *Keeping Prevention in the Crosshairs: A Better HIV Exposure Law for Maryland*, 13 J. HEALTH CARE L. & POL'Y 495, 512 (2010) (citing Joint U.N. Prog. HIV/AIDS Policy Brief: *Criminalization of HIV Transmission* 1, 5 (2008)).

182. *See* Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 192 (1996) (noting that the history of abuse and inequality in the healthcare system has contributed to a fear and distrust of providers and treatment within the African American community); *see also* Sharon Voas, *Aging Black Sick, Scared; Past Abuses, Tradition Keep Them From Clinic*, PITT. POST-GAZETTE (Aug. 27, 1995), at B1 (reporting failure of elderly African Americans to seek healthcare treatment due to negative memories of medical experiments lacking consent and substandard hospitals).

183. *See* Jerry Kang, *Negative Action Against Asian Americans: The Internal Instability of Dworkin's Defense of Affirmative Action*, 31 HARV. C.R.-C.L. L. REV. 1, 47 (1996) (noting that the history of "separate but equal" applied to Asian Americans); *see also* Gong Lum v. Rice, 275 U.S. 78 (1927) (approving "separate but equal" education for Asian Americans).

184. *See* Rose Cuison Villazor, *Community Lawyering: An Approach to Addressing Inequalities in Access to Health Care for Poor, of Color and Immigrant Communities*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 35, 39 (2005) (describing discrimination in healthcare, medical care, and medical facilities on communities of color and noting that language barriers have and continue to result in poor medical care).

185. Slaves in the United States were often used in medical experimentation without knowledge or consent. *See* TODD L. SAVITT, MEDICINE AND SLAVERY: THE DISEASES AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA 291 (1978) (describing how one doctor performed multiple painful surgeries without using anesthesia on twenty-six slave women who suffered from vesico-vaginal fistula); *see also* SAVITT, *supra* note 185, at 293 (describing an experiment on sunstroke in which a doctor left a slave in a makeshift open-pit oven in rural Georgia); *see also* JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT 5–9 (1981) (discussing a study conducted by the United States Public Health Services on 400 poor Black men with syphilis for over forty years in which they were never told they had the disease and denied proper medical treatment); INST. FOR URBAN AFFAIRS & RESEARCH, HOWARD UNIV., HUMAN EXPERIMENT: AN ANCIENT NOTION IN A MODERN TECHNOLOGY 9–10 (1974) [hereinafter HOWARD UNIV.: HUMAN EXPERIMENT] (describing a study in 1963 in which doctors injected live cancer cells into twenty-two chronically ill, poor African American women without their consent or knowledge); HOWARD UNIV.: HUMAN EXPERIMENT, 9–10 (describing study of twenty women who were primarily poor, young and Black on an experimental medical device used to induce abortions despite general consensus in the medical community that this device should not be used).

women[189] and members of the LGBT community[190] may further contribute to an increased distrust of doctors by members of marginalized communities.[191] When doctors and nurses have committed medical abuses against their patients, it has usually occurred on patients who are poor and lack adequate resources to seek advice or treatment by alternative medical professionals.[192] A social and cultural memory of medical abuse and discrimination that increases distrust of the medical community is significant when fighting a disease that is fatal if left untreated.[193] Individuals who have HIV fare best when armed with comprehensive, accurate medical information and support.[194]

186. *See* Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1, 11 (2001) (describing how medical experiments regarding psychiatric drugs on Latino boys may have contributed to decreased trust in the medical care profession).

187. *See generally* ANNE FADIMAN, THE SPIRIT CATCHES YOU AND YOU FALL DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES (Noonday Press 1997); *see also* Rose Cuison Villazor, *Community Lawyering: An Approach to Addressing Inequalities in Access to Health Care for Poor, of Color and Immigrant Communities*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 35, 39 (2005) (describing discrimination in healthcare, medical care and medical facilities based on race, ethnicity and language).

188. *See* DIANA SCULLY, MEN WHO CONTROL WOMEN'S HEALTH: THE MISEDUCATION OF OBSTETRICIAN-GYNECOLOGISTS 45 (Houghton Mifflin 1980) (reissued with a new introduction, Teachers College Press 1994) (describing how a New York Women's Hospital engaged in surgical experimentation on impoverished immigrant women new to New York City in the mid-1800s).

189. *See generally* DEBORAH KUHN MCGREGOR, SEXUAL SURGERY AND THE ORIGIN OF GYNECOLOGY: J. MARION SIMS, HIS HOSPITAL, AND HIS PATIENTS (Rutgers University Press 1989) (describing how doctors performed medical experiments on poor women).

190. *See* Gary D. Allison, *Sanctioning Sodomy: The Supreme Court Liberates Gay Sex and Limits State Power to Vindicate the Moral Sentiments of the People*, 39 TULSA L. REV. 95, 109 (2003) (noting medical experiments on people identified as gay).

191. *See* Irena Stepanikova et al., *Patients' Race, Ethnicity, Language, and Trust in a Physician*, 47 J. HEALTH & SOCIAL BEHAV. 390, 401 (2006) (noting that minority patients' knowledge of a history of discrimination in healthcare may decrease their confidence in doctors); *see also* William D. King, Commentary, *Examining African Americans' Mistrust of the Health Care System: Expanding the Research Question*, 118 PUB. HEALTH REPS. 366, 366 (2003); *see also* Giselle Corbie-Smith, *Distrust, Race, and Research*, 162 ARCHIVES INTERNAL MED. 2458, 2459–60 (2002) (concluding that African Americans were significantly more likely than whites to believe that their doctors would not fully disclose the risks of research participation).

192. *See* DEBORAH KUHN MCGREGOR, SEXUAL SURGERY AND THE ORIGIN OF GYNECOLOGY: J. MARION SIMS, HIS HOSPITAL, AND HIS PATIENTS (1989) (poor women); JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT 5–9 (1981) (poor African American sharecroppers).

193. *See* Harlon L. Dalton, *AIDS in Blackface*, 118(3) DAEDALUS 205, 209 (1989) (describing the response by Black leaders to needle exchange programs introduced to curb HIV transmission due to "sensitivity to doctors conducting experiments").

194. *See* Kathy Shapiro & Sunanda Ray, *Sexual Health for People Living with HIV*, 15(29) REPROD. HEALTH MATTERS 67, 69, 71 (2007) (describing research supporting link between knowledge and positive sexual health for individuals who have HIV).

As a result of past medical injustices, most nursing and medical schools require their students to take cultural competency courses.[195] Medical professionals are adopting more culturally sensitive practices.[196] To combat low numbers of doctors and nurses from underrepresented communities, schools and medical associations distribute scholarships to increase enrollment of minority students and hopefully the medical establishment.[197] As more individuals from marginalized communities become doctors and nurses and current medical professionals enhance their cultural competency, distrust within these communities will hopefully decrease. While research is needed to confirm this phenomenon, other research studying race, ethnicity and physician trust suggest a correlation may exist between increased cultural competency in the medical profession and increased trust of doctors.[198]

HIV treatment and prevention programs have remarkably changed in the past few decades. When HIV/AIDS was initially referred to as GRID, many non-gay individuals with HIV were left untreated, particularly due to a lack of testing beyond the gay male community and a perception that AIDS affected only white, gay men.[199] The immense fear of this "gay cancer"[200] resulted in delayed public health efforts to recognize that heterosexuals were not immune from this disease.[201] While Black

195. *See* Janelle S. Taylor, *The Story Catches You and You Fall Down: Tragedy, Ethnography, and "Cultural Competence,"* 17(2) MED. ANTHROPOLOGY 159, 171 (2003) (noting that medical institutions are incorporating cross-cultural issues into their education); *see also* ANNE FADIMAN, THE SPIRIT CATCHES YOU AND YOU FALL DOWN: A HMONG CHILD, HER AMERICAN DOCTORS, AND THE COLLISION OF TWO CULTURES 269–72 (Noonday Press 1997) (describing how medical school curricula changed throughout the 1990s to incorporate cross-cultural issues).

196. *See* FADIMAN *supra* note 187, at 48, 264–66, 269–72 (describing ways in which hospitals are conducting culturally sensitive training seminars and hiring interpreters as permanent staff members).

197. For example, the American Medical Association offers tuition scholarships through its Minority Scholars Awards in the hopes of "increasing the number of minority physicians to better reflect the needs of our increasingly diverse society." *Minority Scholars Award*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/medical-education/minority-scholars-award.page (last visited Nov. 1, 2012).

198. *See* Irena Stepanikova et al., *Patients' Race, Ethnicity, Language, and Trust in a Physician*, 47 J. HEALTH & SOC. BEHAV. 390, 401 (2006) (noting that minority patients with negative experiences with their doctors and/or knowledge of a history of discrimination in healthcare may have less trust in their doctors).

199. *See* Paula C. Johnson, *Silence Equals Death: The Response to AIDS within Communities of Color*, 1992 U. ILL. L. REV. 1075, 1077 (1992) (noting that while AIDS disproportionately affected people of color "from the beginning of the epidemic," the face of AIDS was that of the white gay man).

200. Researchers interchangeably used the terms "gay pneumonia," "gay cancer," and "GRID" (gay-related immune deficiency). Russell K. Robinson, *Racing the Closet*, 61 STAN. L. REV. 1463, 1512 (2009).

201. *Id.* (describing the CDC's reluctance to reframe the disease as something other than one located in the gay community); *see also* Elizabeth A. Stull, *Confronting AIDS in the Community*, 3 N.Y.U. J. LEGIS. & PUB. POL'Y 429, 430 (2000) (reviewing JANE BALIN, A

immigrants from Haiti also displayed some of the first symptoms of HIV and AIDS in the United States in the early 1980s,[202] and by 1982 the CDC reported that Blacks and Latinos comprised just under fifty percent of the males, almost eighty percent of the females, and two-thirds of the children diagnosed with HIV in the United States,[203] the government made no significant efforts to address HIV and AIDS in communities of color until the mid- to late 1980s.[204] As early as 1987, the CDC reported that Blacks and Latinos were overrepresented among persons with AIDS.[205] By 2009, African Americans represented forty-four percent of all new HIV infections, despite comprising only fourteen percent of the U.S. population.[206] As of 2009 over 230,000 African Americans have died of AIDS (representing nearly forty percent of total deaths) and of the more than one million people living with HIV in the United States, almost half are Black.[207] As a result of the disproportionate numbers of African Americans who have HIV, and eventual recognition that the disease occurred outside the white, male, gay community,[208] the government began to affirmatively address HIV as a significant public health issue.[209] Moreover, researchers are conducting studies targeting marginalized communities,[210] states have implemented laws to incorporate culturally-sensitive education,[211] and HIV treatment programs have made efforts to

NEIGHBORHOOD DIVIDED: COMMUNITY RESISTANCE TO AN AIDS CARE FACILITY (Cornell University Press 1999)).

202. *See* Samuel R. Friedman et al., *The AIDS Epidemic among Blacks and Hispanics*, 65(2) THE MILBANK Q. 455, 455 (1987).

203. *See* Daniel M. Fox, *Chronic Disease and Disadvantage: The New Politics of HIV Infection*, 15 J. HEALTH POL. POL'Y & L. 341, 345 (1990) (describing early HIV statistics); *see also* Irene S. Vernon, *AIDS: The New Smallpox among Native Americans*, 14(1) INDIGENOUS RESISTANCE & PERSISTENCE 235, 238 (1999) (noting skepticism by Native Americans and healthcare providers of CDC figures stating that less than one percent of HIV cases include Asian/Pacific Americans and Native Americans).

204. *See* Robinson, *supra* note 200; *see also* Friedman et al., *supra* note 202, at 458–60 (describing the absence of research on race and AIDS in the mid- to late 1980s).

205. *See* Friedman et al., *supra* note 202, at 458–60 (1987) (citing 1987 CDC study); *see also* Merrill Singer et al., *SIDA: The Economic, Social, and Cultural Context of AIDS among Latinos*, 4(1) MED. ANTHROPOLOGY Q. 72, 72–73 (1990) (describing statistics showing that AIDS disproportionately affects U.S. Latinos).

206. *HIV among African Americans*, CTRS. FOR DISEASE CONTROL & PREVENTION (2011), http://www.cdc.gov/hiv/topics/aa.

207. CTRS. FOR DISEASE CONTROL & PREVENTION, *Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas*, 21 HIV SURVEILLANCE REPORT 1 (2009), *available at* http://www.cdc.gov/hiv/surveillance/resources/reports/2009report.

208. Elizabeth B. Cooper, *Social Risk and the Transformation of Public Health Law: Lessons from the Plague Years*, 86 IOWA L. REV. 869, 929 n.271 (2001).

209. *See* Daniel M. Fox, *Chronic Disease and Disadvantage: The New Politics of HIV Infection*, 15 J. HEALTH POL. POL'Y & L. 341, 349 (1990) (describing changes in government treatment of HIV, including increased spending on HIV prevention and treatment).

210. *Id.* at 350 (noting changes in research policy after recognizing that HIV disproportionately affects marginalized communities).

211. *See e.g.*, 1995 Ariz. Sess. Laws 190 (requiring Arizona Department of Health Services to develop "culturally diverse programs and strategies"); CAL. HEALTH & SAFETY

increase diversity in service providers and culturally competent services.[212] However, until such changes become more widespread and have had time to settle, communities of color affected by past racial injustice may continue to distrust the medical community and thus be less likely to trust important information about HIV prevention and treatment.

C. POWER AND NONDISCLOSURE

Laws that criminalize HIV-related offenses fail to recognize important power dynamics often embedded in social relationships. Most states criminalize HIV transmission when a defendant has failed to disclose his or her HIV status.[213] This requirement fails to recognize social realities of gender-based violence and deep economic, racial, social and political inequality that leave certain groups more vulnerable to HIV. For example, because women tend to interact with the healthcare system more than men, they are likely to learn their HIV status before male partners and as a result, may be prosecuted more often despite potential transmission from their current male partner.[214]

Nondisclosure laws, in particular, fail to consider power dynamics that may make such disclosure difficult and dangerous. Someone in an abusive relationship or dependent on his or her partner for financial support or immigration sponsorship may fear violence or abandonment upon disclosure. For example, a woman convicted under Michigan's nondisclosure statute[215] alleged that she failed to disclose her HIV status to her partner because she feared he would kill her and that he would not leave her room until they had sex.[216] The trial court refused to admit

CODE §§ 120805(a)(9), (10), 120860(b)(1) (West 2012) (requiring California Department of Health Services to "correct misinformation about AIDS" and "establish centralized translation services to facilitate the development of Multilanguage, culturally relevant educational materials on HIV infection" and provide "education appropriate to the cultural background of the clientele"); CONN. GEN. STAT. ANN. § 19a-121g(a) (West 2012) (requiring the Connecticut Commissioner of Public Health to "establish culturally-appropriate therapeutic support groups" and "family-centered culturally appropriate services").

212. *See* Seth C. Kalichman et al., *Culturally Tailored HIV/AIDS Risk-Reduction Messages Targeted to African-American Urban Women: Impact on Risk Sensitization and Risk Reduction*, 61 J. CONSULTING & CLINICAL PSYCHOL. 291, 291–95 (1993).

213. For example, Washington's HIV criminalization law is silent as to disclosure, and thus, an individual who discloses his or her HIV status prior to engaging in enumerated conduct could still be prosecuted under Washington's law. WASH. REV. CODE ANN. § 9A.36.011(1)(b) (West 2012).

214. Ashley J. Moore, *Endangered Species: Examining South Africa's National Rape Crisis and Its Legislative Attempt to Protect Its Most Vulnerable Citizens*, 38 VAND. J. TRANSNAT'L L. 1469, 1494 (2005) (noting that women are more likely than men to know their HIV status due to testing at antenatal clinics).

215. MICH. COMP. LAWS ANN. § 333.5210 (West 2012) (prohibiting an individual from failing to inform a sexual partner that he or she has AIDS or HIV).

216. People v. Jensen, 564 N.W.2d 192, 195 (Mich. Ct. App. 1997), *judgment vacated in part, appeal denied in part*, 575 N.W.2d 552 (1998).

testimony from the woman's roommate because it was "self-serving" inadmissible hearsay.[217] The appellate court disagreed but found that the court's denial of this testimony was nevertheless harmless.[218] Ms. Jensen was, thus, sentenced to two years and eight months to four years of prison under this nondisclosure statute.[219]

In addition to the hefty sentences that often accompany a conviction under various HIV criminalization laws, most people convicted under these laws will have to register as a sex offender, often for life. While sex offender registries are devastating for any individual with HIV, they are particularly destructive for single mothers—many of whom are low-income women of color merely trying to make ends meet and support their family amidst a bevy of structural obstacles they now face as a registered sex offender.[220] Such additional penalties have severe repercussions in obtaining housing and even accompanying children to school. Thus, single mothers who fail to disclose their HIV status to abusive partners and women whose abusive partners threaten to falsely accuse them of failure to disclose not only face imprisonment, but also the added ramifications of being listed on a sex offender registry.

D. ELIMINATION OF PRIVACY

HIV criminalization laws penalize people with HIV beyond incarceration. They expose personal and private information about one's health diagnosis to the general public. Because many convictions under HIV criminalization laws target marginalized communities,[221] people of color, gay, bisexual and transgender persons, and poor people are more likely to lose any privacy regarding their HIV status. For example, after Kerry Thomas, an African-American man in Idaho, was charged with nondisclosure under Idaho's HIV criminalization law, he accepted a plea that resulted in a thirty-year sentence—even though he used condoms, had an undetectable viral load, and did not transmit HIV—to shield his teenage son and ill mother from an hysterical media trial and further isolation after the local newspaper posted his identity and photo.[222] Mr. Thomas's exposure prior to his sentence highlights that any privacy disappears as soon as one is charged under HIV criminalization laws. A mere charge eviscerates any attempt to keep personal medical information private,

217. *Jensen*, 564 N.W.2d at 195.
218. *Id.* at 196.
219. *Id.* at 194.
220. *See* Jaclyn Schmitt Hermes, *The Criminal Transmission of HIV: A Proposal to Eliminate Iowa's Statute*, 6 J. GENDER RACE & JUST. 473, 487 (2002) (discussing how convictions under HIV criminalization laws may require registration as a sex offender, which require a person to disclose their crime every time they move).
221. *See supra* Section III.
222. *Kerry Thomas*, THE SERO PROJECT, http://seroproject.com/video/kerry-thomas/#tabs1 (last visited Nov. 7, 2012).

because even if someone is acquitted of any charges, the criminal process usually exposes his or her medical diagnosis through court records and/or media.

If a person is convicted of violating an HIV criminalization law, she or he may also be required to register as a sex offender, sometimes for life. This further prevents any privacy in one's diagnosis, even after she or he has served any criminal sentence. The sex offender registry sometimes contains detailed information about the sex-related conviction. But oftentimes, the registry is vague and leaves more questions than answers. Thus, a person discovered on a registry will have to explain that she was convicted under an HIV criminalization statute—thus exposing the HIV diagnosis—if she does not want to be associated with a completely different sex crime, like rape or sexual misconduct with a minor.

Moreover, facts disclosed through criminal prosecutions under HIV criminalization laws may not only "out" one's HIV status but also one's sexual orientation. For example, David Bogardus had not disclosed to his family that he was gay or had HIV until after he was charged under Iowa's HIV criminalization laws.[223] Mr. Bogardus's privacy was compromised immediately after the charges and before any conviction.[224] Mr. Bogardus's family learned that he was gay and had HIV only after charges were brought against him and published in a local newspaper.[225] The newspaper sensationalized his charge and focused solely on the accusations and not on the fact that he did not intend to transmit the virus, had an undetectable viral load at the time, and did not transmit HIV to his partner. Similarly, Robert Suttle lost any privacy in his HIV diagnosis and sexual orientation after a former spurned male partner pressed charges against him for nondisclosure.[226] After he was convicted and served six months in prison, he was forced to register as a sex offender and pay fines to notify his community members about his "sex offender" status.[227]

No other health condition requires the same invasion of privacy. For example, even though high-risk HPV (human papilloma virus) causes ninety-nine percent of cervical cancers, as well as anal and other genital cancers,[228] no criminalization laws specific to HPV require extensive court proceedings when someone fails to disclose an HPV diagnosis when thousands of women a year die from cervical cancer alone.[229] One's HIV

223. *Donald Bogardus*, THE SERO PROJECT, http://seroproject.com/video/donald-bogardus (last visited Nov. 7, 2012).
224. *Id.*
225. *Id.*
226. *Robert Suttle*, THE SERO PROJECT, http://seroproject.com/video/robert-suttle/#tabs1 (last visited Nov. 7, 2012).
227. *Id.*
228. *See* CTR. FOR HIV LAW & POLICY, HIV, STIS AND RELATIVE RISKS IN THE UNITED STATES (2011), *available at* http://www.hivlawandpolicy.org/resources/view/681.
229. *Id.*

status is very private to most people. Stigma about HIV prevents many people from disclosing their status and targets people with HIV more than any other chronic illness. HIV criminalization laws that expose private health details about an individual's HIV diagnosis and/or sexual orientation do not further any public health goals but instead create only more stigma about HIV.

V. REFORMING A BROKEN SYSTEM THROUGH A PROACTIVE PYRAMID

HIV criminalization laws do not increase public awareness about HIV or encourage disclosure. Instead, research suggests that these laws do not influence modifications in one's sexual behavior[230] but may discourage individuals from getting tested for HIV.[231] Moreover, these laws perpetuate a system of inequality by targeting some of the most marginalized members of our communities. Based on antiquated understandings of HIV transmission, these laws do not further any public health initiatives or education. Most of these laws were passed at a time when ignorance about HIV reigned and legislators adopted quarantine-like policies that placed people living with HIV in confined cells away from the general public.

Instead, there are a number of more empathetic approaches that could facilitate the goals of decreasing HIV transmission while increasing public health education about HIV. Adopting more proactive and less punitive approaches also reflect an understanding of the complexity of disclosure for many individuals, particularly from marginalized communities.

This article proposes a multi-pronged approach for responding to inequality emanating from HIV criminalization laws. First, any efforts to reduce HIV transmission and increase public education must include active participation from communities heavily affected by HIV. Communities heavily affected by HIV have developed strong tools and networks for organizing around this health issue and can not only contribute but can significantly help drive these efforts forward. Second, increased education about HIV and transmission will help eliminate fears, bias, and stigma that ultimately lead to unequal and punitive responses to a community health problem. Third, policy efforts should focus on eliminating HIV criminalization laws. Even though repealing the laws themselves would not automatically and immediately increase public health awareness or decrease HIV transmission, it will contribute to these efforts by reframing the issue from one that is punitive to one that is more proactive. It will also eliminate a system of laws that perpetuate inequality and bias in a way that

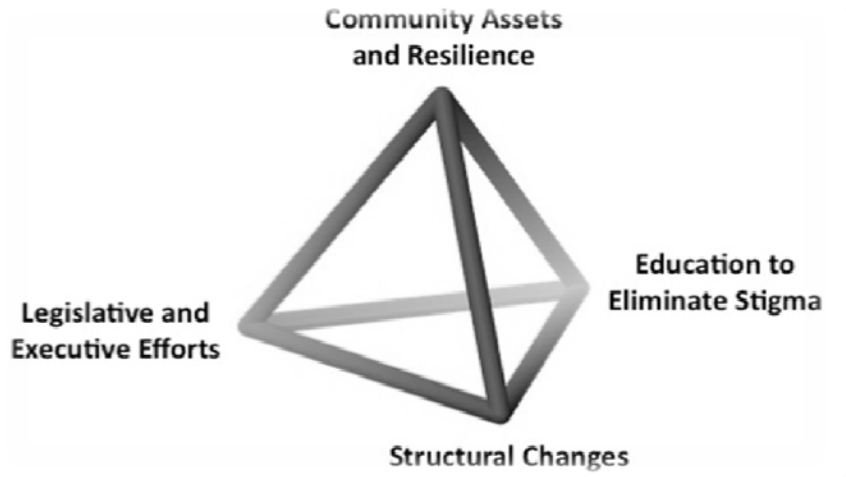
230. *See generally* Scott Burris et al., *Do criminal laws influence HIV risk behavior?*, 39 ARIZ. ST. LAW J. 467 (2007).

231. *See* Kaiser Network, *supra* note 161; *see also* Heywood, *supra* note 163.

is particularly harmful for women, people of color, and low-income, gay, bisexual, and transgender people. Finally, reform must include broad efforts to address the oppressive institutional and structural barriers that dissuade sexual partners from disclosure. Without acknowledging the complex power dynamics between sexual partners that are often informed by race, sex, sexual orientation, and class, reform efforts will be missing a critical component for effecting change.

This multi-pronged approach should not be systematically followed like a step-by-step process. Instead, it is a dynamic model in which each piece should be pursued simultaneously with the other three pieces. By concurrently engaging all pieces, each aspect will inform each other. For example, by engaging communities who have developed strong systems of support and resilience after years of stigma and discrimination, policymakers will have more compelling stories and a deeper understanding of the issue for any legislative and executive reforms. Similarly, any education to eliminate stigma or structural changes will be further enhanced through community participation. Moreover, community resilience becomes stronger with efforts to employ legislative and executive reform, education to eliminate stigma, and structural changes. Like a tetrahedron, or pyramid with four triangular faces, each piece provides support to the other pieces and strengthens the integrity of the larger structure. Here, each aspect of reform strengthens and informs the other aspects of reform, thus making the overall Proactive Pyramid Approach stronger and more effective at responding to HIV transmission and HIV criminalization laws.

FIGURE 1: THE PROACTIVE PYRAMID APPROACH



By engaging in such a multi-faceted approach, each piece of the pyramid will invariably inform the other and result in a more enriching and

comprehensive strategy for eliminating the criminalization of people living with HIV.

A. COMMUNITY ASSETS AND RESILIENCE

A critical component for any of these approaches is to recognize the importance of engaging individuals living with HIV and communities heavily impacted by HIV, particularly communities of color and the LGBT community. Legislators cannot pass or repeal laws without the strength of their community voices. These community voices represent essential assets to a movement aimed at decriminalizing HIV. Before researchers, social workers, and policy and legal scholars began examining the efficacy of HIV criminalization laws, people living with HIV were forming a community of support to combat fear, prejudice and discrimination and to support one another through the immense physical and emotional roller coaster inevitable with an HIV/AIDS diagnosis.[232] People living with HIV also encountered not only public fear and a desire to effectively quarantine people who tested positive for HIV, but also increased legislation, criminal prosecutions, and imprisonment of people with HIV.[233] HIV-specific laws became a vehicle to further criminalize and target the HIV community. Particularly in marginalized communities where prosecution rates are higher,[234] people witnessed their friends, family, and neighbors maneuver criminal prosecutions emanating from these laws and practices. Criminal laws that uniquely targeted sex workers[235] also left some poor women, gay men, and transgender women jobless.[236]

It is through such turbulent times that communities heavily affected by HIV began to strengthen the power of their voice and develop broader support networks within the larger community.[237] Extensive support networks are particularly important because of the unique needs of individuals living with HIV.[238] Support networks have helped people

232. *See infra* notes 237–58 (describing the significance of support networks for individuals with HIV).

233. *See supra* Parts II, III (describing public responses and court decisions regarding individuals with HIV).

234. *See* Berman, *supra* note 127, at 47; MACHER, *supra* note 128, at § 1.4.

235. *See supra* Section II.B.

236. *See generally* Ronald Weitzer, *New directions in Research on Prostitution*, 43 CRIME L. & SOC. CHANGE 211 (2005) (discussing prostitution by male and transgender sex workers).

237. *See* Frenk Guni, *HIV/AIDS Health Care: Research & Policy*, 17 EMORY INT'L L. REV. 673, 676–77 (2003) (noting the "resolve and undying will to live" and collectively organize into movements, support groups, and networks of people living with HIV/AIDS).

238. James Monroe Smith, *When Knowing the Law Is Not Enough: Confronting Denial and Considering Sociocultural Issues Affecting HIV Positive People*, 17 HAMLINE J. PUB. L. & POL'Y 1, 8 (1995); *see also* Connie M. Mayer, *Unique Mental Health Needs of HIV-Infected Women Inmates: What Services Are Required Under the Constitution and the Americans with Disabilities Act?,* 6 WM. & MARY J. WOMEN & L. 215, 229–30 (1999)

living with HIV heal from social wounds inflicted by stigma, discrimination and isolation.[239] People living with HIV have created communities of similarly interested, nonrelated individuals[240] to support each other through their process of emotional, physical, and in some cases, cultural survival.[241] National networks like the National Minority AIDS Counsel and NORA (National Organizations Responding to AIDS) and local community support groups have helped form strong bonds between persons with HIV/AIDS.[242] With strong support, maintaining and monitoring one's health becomes easier[243] and provides more time and energy for community mobilization and political participation.

As a result, HIV communities have not only developed strong mechanisms for survival but transformed the social landscape to ameliorate conditions of inequity.[244] This resilient community has tapped into its human and social capital to increase awareness, services, and funding for HIV-related issues.[245] Frustrations with inadequate healthcare, discrimination and a desire to change have prompted community groups to mobilize and demand reform.[246] More recently, HIV communities have begun mobilizing to challenge HIV criminalization laws that disproportionately affect the most marginalized members of the HIV

(describing research suggesting the importance of group therapy and support networks for women with HIV).

239. Smith, *supra* note 238, at 8.

240. *See* Angela Kelly, *Making Community: Individuals and Families Living with and Affected by Haemophilia, HIV/AIDS and other Blood-Borne Viruses*, 4(4) CULTURE, HEALTH & SEXUALITY 443, 449 (2002) (describing nontraditional familial ties).

241. The initial refusal of community leaders in the Black and Latino communities, despite disproportionate numbers of cases of Blacks and Latinos with HIV, resulted in Blacks and Latinos living with HIV to seek out specific community and support networks within HIV-positive communities of color. *See supra* notes 232–36; *see also* Laurence J. Kirmayer et al., *Community Resilience: Models, Metaphors and Measures*, J. ABORIGINAL HEALTH 62, 86 (2009) (describing the importance of cultural continuity).

242. *See* Raechel Anglin, *The Path of "Easy Legislation:" A Case Study of the U.S. Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003*, 34 OHIO N.U. L. REV. 567, 588 n.121 (2008) (noting the presence of the National Minority AIDS Counsel in lobbying for HIV prevention and treatment programs); *see also* Chai Rachel Feldblum, *The Art of Legislative Lawyering and the Six Circles Theory of Advocacy*, 34 MCGEORGE L. REV. 785, 788 (2003) (describing lobbying efforts of NORA).

243. Smith, *supra* note 238, at 8; Mayer, *supra* note 238, at 229–30.

244. *Id.*

245. *Id.*

246. *See* George W. Smith, *Political Activist as Ethnographer*, 37(4) SOC. PROBS. 629, 639 (1990) (describing how frustration amongst people living with AIDS of inadequate healthcare prompted community action and reform); *see also* Judy Clark & Kathy Boudin, *Community of Women Organize Themselves to Cope with the AIDS Crisis: A Case Study from Bedford Hills Correctional Facility*, 17 SOC. JUST. 90, 94 (1990) (describing the emergence of a peer counseling and education program by women with HIV in a New York maximum security prison).

community.[247] Such collective action has produced tangible results for people living with HIV. For example, a group of community individuals in San Francisco responded to the dearth of culturally competent services by forming organizations like the Black Coalition on AIDS (BCA).[248] As a response to efforts by groups like the BCA, San Francisco hospitals and clinics began incorporating more cultural sensitivity into their services.[249]

Similarly, in response to government inaction to the AIDS epidemic and intense social stigma of HIV,[250] AIDS activist Cleve Jones created the NAMES Project Memorial Quilt.[251] While initially starting in San Francisco, the Quilt Project grew to a national effort gathering almost 46,000 individual panels representing more than 91,000 people.[252] The Project's massive display on the National Mall made it much more difficult for legislators to ignore this growing epidemic.[253] Less than a year later, the United States government conducted a national AIDS education campaign.[254]

Collective action need not take the form of massive mobilization. Action by a small group of six women incarcerated in New York demonstrates the power of a small but vibrant group capable of creating change. Despite facing numerous obstacles—including race, gender, past

247. For example, over seventy organizations and community leaders in the HIV community have endorsed the Repeal HIV Discrimination Act. *Fact Sheet on H.R. 3053, REPEAL HIV Discrimination Act*, CTR. FOR HIV L. & POL'Y, http://hivlawandpolicy.org/resources/view/663 (last visited Nov. 1, 2012).

248. *See Black Coalition on AIDS: History of BCA*, BLACK COALITION ON AIDS, http://www.bcoa.org/history.html (last visited Nov. 1, 2012).

249. *See* THE CAL. ENDOWMENT, CAL. PAN-ETHNIC HEALTH NETWORK, BUILDING CULTURALLY COMPETENT HEALTH SYSTEMS IN CALIFORNIA 1, 12, 24–25 (2007), *available at* http://www.cpehn.org/pdfs/CL%20Hospital%20Brief.pdf; *see also* FADIMAN, *supra* note 187; Taylor, *supra* note 195.

250. The Quilt often provided the only opportunity for survivors to remember and celebrate the people they lost due to immense social stigma and fear of AIDS, including refusal of many funeral homes and crematories to handle the remains. *See* GARY LADERMAN, REST IN PEACE: A CULTURAL HISTORY OF DEATH AND THE FUNERAL HOME IN TWENTIETH CENTURY AMERICA 198 (2003).

251. *See* Peter S. Hawkins, *Naming Names: The Art of Memory and the NAMES Project AIDS Quilt*, 19(4) CRITICAL INQUIRY 752, 757 (1993) (discussing the Quilt's origins and quoting Cleve Jones as stating that "quilts represent coziness, humanity and warmth" and speak of "family loyalty").

252. *The AIDS Memorial Quilt*, AIDS QUILT, http://www.aidsquilt.org (last visited Feb. 6, 2013).

253. *See* Hawkins, *supra* note 251, at 760 n.13 (describing a speech by Cleve Jones at the Lincoln Memorial in which he criticized the government's apathy to the crisis).

254. Alan J. Bush & Gregory W. Boller, *Rethinking the Role of Television Advertising during Health Crises: A Rhetorical Analysis of the Federal AIDS Campaign*, 20 J. ADVERTISING 28 (1991); CHARLES F. TURNER ET AL., AIDS: SEXUAL BEHAVIOR AND INTRAVENOUS DRUG USE, ch. 4 (1989); MICHAEL QUAM & NANCY FORD, AIDS POLICIES AND PRACTICES IN THE UNITED STATES, IN ACTION ON AIDS: NATIONAL POLICIES in COMPARATIVE PERSPECTIVE 25, 38–44 (Barbara A. Misztal & David Moss eds. 1990).

drug use, incarceration, and no funding[255]—a group of six women incarcerated in a maximum security prison in New York submitted a proposal to the Superintendent to create a peer counseling and education program.[256] The women wanted a space to discuss feelings about how AIDS affected their families, communities, and themselves.[257] After several months, the Superintendent agreed to implement AIDS Counseling and Education (ACE).[258]

These examples highlight the importance of engaging communities and individuals who are directly and heavily impacted by HIV and AIDS. People living with HIV who have battled discrimination, exclusion, and misinformation can contribute significantly to the dialogue and any public policy efforts to eliminate HIV criminalization laws and increase public education about HIV transmission.

B. EDUCATION TO ELIMINATE STIGMA

One of the biggest barriers to HIV prevention and treatment is stigma.[259] HIV criminalization laws only increase stigma, especially when they have no connection to transmission.[260] Education provides a powerful tool for reducing stigma.[261] By increasing awareness and understanding about HIV and transmission, fear is less likely to drive decisions by prosecutors, lawmakers, and judges.

Stigma continues to plague the lives of people with HIV.[262] HIV criminalization laws reflect this stigma toward HIV and a lack of awareness about HIV treatment. In addition to serving sometimes hefty sentences, individuals prosecuted under HIV criminalization laws must also register as sex offenders. Furthermore, any criminal conviction remains in the public

255. This New York prison also had a history of medical abuse and segregation of women with HIV. *See* Clark & Boudin, *supra* note 246, at 92.

256. *See* Clark & Boudin, *supra* note 246 at 94–95 (describing the emergence of a peer counseling and education program by women with HIV in a New York maximum security prison).

257. *Id.*

258. *Id.* at 95.

259. *See* Gregory M. Herek, *Illness, Stigma, and AIDS*, PSYCHOL. ASPECTS OF SERIOUS ILLNESS: CHRONIC CONDITIONS, FATAL DISEASES, & CLINICAL CARE 131 (Paul T. Costa, Jr. & Gary R. VandenBos eds. 1990) (asserting that "[f]ears of harassment, job discrimination, and loss of insurance coverage may deter [people at risk for HIV] from being tested [or treated]"); *see also* Ronda B. Goldfein & Sarah R. Schalman-Bergen, *From the Streets of Philadelphia: The AIDS Law Project of Pennsylvania's How-to Primer on Mitigating Health Disparities*, 82 TEMP. L. REV. 1205, 1213 (2010) (citing studies showing that the existence of AIDS stigma creates a barrier for HIV testing and treatment).

260. *See supra* note 73 (listing statutes).

261. *See* Karen E. Zuck, *HIV and Medical Privacy: Government Infringement on Prisoners' Constitutional Rights*, 9 U. PA. J. CONST. L. 1277, 1296 (2007) (advocating for education to reduce stigma against people with HIV in prison).

262. *Stigma*, CTR. FOR HIV LAW & POLICY, http://www.hivlawandpolicy.org/resource Categories/view/36 (last visited Nov. 1, 2012).

record and sometimes even in an easily accessible published case.[263] For example, even though a Minnesota appellate court reversed Daniel James Rick's conviction of first-degree assault under Minnesota's HIV criminalization law, a published case about his HIV diagnosis and sexual history with men remains public for all to see.[264]

Stigma has continued despite numerous medical advances in HIV treatment over the past few decades. Whereas in the 1980s, people diagnosed with HIV faced a more uncertain future, today, people taking consistent antiretroviral treatment can live a full adult life.[265] Nevertheless, HIV criminalization laws still treat HIV as if it is a death sentence. While many other sexually transmitted infections can lead to potentially fatal cancers,[266] no other health diagnosis requires mandatory disclosure to avoid criminalization.

Stigma toward people with HIV also leads to a system of disparate sentencing that does not correlate with the alleged crime or take into account any prophylactic measures a person with HIV may have taken prior to engaging in sexual activity and/or whether any actual HIV transmission occurred. Most HIV criminalization laws do not provide an affirmative defense for condom usage, viral load, or lack of transmission.[267] Thus, a person with minimal or zero viral load who uses condoms and fails to transmit HIV can face the same penalties under most HIV criminalization laws as someone who actually intends to transmit HIV to his or her sexual partner.[268]

The harsh sentences people with HIV receive also reflect current stigma against people with HIV. For example, HIV criminalization laws generally carry sentences ranging between five and twenty-five years of incarceration, and some states require mandatory sex offender registration.[269] In comparison, a first offense under many states' drinking

263. *See* Rick, *supra* note 15.

264. *Id.*

265. *See* Antiretroviral Therapy Cohort Collaboration, *Life Expectancy of Individuals on Combination Antiretroviral Therapy in High-Income Countries: A Collaborative Analysis of 14 Cohort Studies*, 372:9635 THE LANCET 293, 297 (2008).

266. For example, high risk HPV causes ninety-nine percent of cervical cancer cases, as well as anal and other genital cancers. *HIV, STIs and Relative Risks in the United States*, CTR. FOR HIV LAW & POLICY, *available at* http://www.hivlawandpolicy.org/resources/view/681 (last visited Jan. 31, 2013). In 2007, over 4000 women died of cervical cancer in the United States. *Id.*

267. *See supra* note 73 (listing statutes).

268. For example, Donald Bogardus faces up to twenty-five years in prison after a former partner pressed charges under Iowa's HIV criminalization laws even though he had an undetectable viral load and did not transmit the virus. *See Donald Bogardus*, *supra* note 17.

269. *See Comparative Sentencing Chart on HIV Criminalization in the United States*, CTR. FOR HIV LAW & POLICY (May 2012), *available at* http://hivlawandpolicy.org/resources/view/743.

and driving laws carries only up to one year of imprisonment[270]—even though approximately 10,228 people died in alcohol-related crashes in 2010,[271] accounting for approximately thirty-one percent of all traffic deaths in 2010.[272] Patrice Michelle Ginn's conviction in Georgia highlights how stigma infuses the sentencing process. Ms. Ginn was charged under Georgia's HIV criminalization statute for engaging in unprotected sexual intercourse without disclosing her HIV status, even though a local newspaper had disclosed her status prior to her relationship.[273] The appellate court affirmed her conviction of eight years imprisonment plus two years probation, despite no evidence of HIV transmission.[274] Under Georgia's HIV criminalization statute, a person can face up to twenty years imprisonment, regardless of HIV transmission.[275] In contrast, drunk driving and second-degree vehicular homicide carry only a maximum sentence of one-year imprisonment.[276] Thus, Ms. Ginn could have accidentally killed her sexual partner with a car and faced less (or no) prison time, instead of the eight year-sentence for engaging in unprotected sex without necessarily transmitting the virus. Even if she had transmitted the virus, her sexual partner would not necessarily have died from it but faced a chronic health condition with consistent medical treatment.[277]

By shedding light on how stigma affects public opinion, and legislative and judicial decision-making, the negative ramifications of such stigma should dissipate. Further education about HIV transmission, treatment, and prevention will also help reduce stigma and help refocus energies on supporting people with HIV and increasing health education about HIV. Efforts to reduce stigma and increase awareness and education should include communities impacted by HIV. Many organizations are currently engaging in this important work, including the Sero Project[278] and Positive

270. *Id.* A subsequent offense still only subjects one to a maximum of three years imprisonment in most states.

271. U.S. DEPT. OF TRANSP., NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS 2010 DATA: ALCOHOL IMPAIRED DRIVING 1 (April 2012), *available at* http://www.nhtsa.gov [hereinafter DOT 2010 DATA].

272. *Id.* at 1.

273. *See* Ginn v. State, 667 S.E.2d 712 (Ga. Ct. App. 2008).

274. *Id.*

275. GA. CODE. ANN. § 16-5-60(c), (d) (West 2010) (engaging in anal, oral, or penile-vaginal intercourse, sharing a hypodermic needle or syringe, offering or consenting to sexual intercourse or an act of sodomy for money, or donating blood or other body parts without first disclosing status is a felony punishable by up to ten years imprisonment; assault using blood, semen, vaginal secretions, saliva, urine, or feces upon a peace or correctional officer with intent to transmit HIV is a felony punishable by five to twenty years imprisonment).

276. *See* GA. CODE. ANN. § 40-6-391(a), (c)(3)(A)-(B) (West 2010); GA. CODE. ANN. §§ 40-6-393(b), 17-10-3(a)(1) (West 2010).

277. *HIV, STIs and Relative Risks in the United States*, CTR. FOR HIV LAW & POLICY (Oct. 2011), *available at* http://www.hivlawandpolicy.org/resources/view/681.

278. The Sero Project works with individuals and communities heavily impacted by HIV to "combat[] HIV-related stigma and advocat[e] for sound public health and HIV prevention

Justice Project.[279] The media can also be a powerful tool for reducing stigma. Several recent articles by national news outlets demonstrate that the national media has expressed a growing interest in covering stigma toward people with HIV, particularly those sentenced under HIV criminalization laws.[280] Education efforts should be combined with continued outreach to local and national media to ensure that efforts to decrease stigma reach a wide audience.

C. LEGISLATIVE AND EXECUTIVE EFFORTS TO DECRIMINALIZE HIV

One of the easiest ways to eliminate the inequality and misinformation that flows from HIV criminalization laws is to repeal the laws themselves.[281] States unwilling to completely repeal their laws should at the very least amend them to accurately reflect current understandings of HIV transmission.[282]

In 2010, President Barack Obama outlined the National HIV/AIDS Strategy, which outlined three goals: (1) reducing the number of people who become infected with HIV; (2) increasing access to care and optimizing health outcomes for people living with HIV; and (3) reducing HIV-related health disparities.[283] One of his recommendations for reducing health disparities included reducing stigma and discrimination for people living with HIV by revisiting HIV criminalization laws to ensure that they reflect our current understanding of the "best public health practices for

policies based on science and epidemiology rather than ignorance and fear." *See* SERO PROJECT, http://seroproject.com (last visited Nov. 4, 2012).

279. The Positive Justice Project is a "national movement of people living with HIV, medical and public health professionals, community organizers, advocates, attorneys, ex-offenders, sex workers, social scientists and others working to end HIV criminalization in the United States." *See* CTR. FOR HIV LAW & POLICY, http://www.hivlawandpolicy.org/public/initiatives/positivejusticeproject (last visited Nov. 4, 2012).

280. *See e.g.* Saundra Young, *Imprisoned Over HIV: One Man's Story*, CNN, http://www.cnn.com/2012/08/02/health/criminalizing-hiv/index.html (last updated Nov. 9, 2012) (discussing how Iowa's HIV criminalization laws affected Nick Rhoades after a former partner pressed charges even though Mr. Rhoades had an undetectable viral load and did not transmit the virus to his sexual partner); Rod McCullom, *The Criminalization of HIV (and Why You Should Be Concerned)*, EBONY MAGAZINE, Aug. 16, 2012, *available at* http://www.ebony.com/news-views/exclusive-the-criminalization-of-hiv-and-why-you-should-be-concerned-877 (interviewing Congresswoman Barbara Lee about her Repeal HIV Discrimination bill and discussing the problems with HIV criminalization laws).

281. *See e.g.*, James B. McArthur, Note, *As the Tide Turns: The Changing HIV/AIDS Epidemic and the Criminalization of HIV Exposure*, 94 CORNELL L. REV. 707, 740 (2009) (suggesting that traditional criminal law is sufficient to criminalize HIV transmission); *see generally* Michael L. Closen et al., Discussion, *Criminalization of an Epidemic: HIV-AIDS and Criminal Exposure Laws*, 46 ARK. L. REV. 921 (documenting discussion amongst several legal scholars as to the problems with HIV-specific statutes).

282. Sara Klemm, Symposium, *Keeping Prevention in the Crosshairs: A Better HIV Exposure Law for Maryland*, 13 J. HEALTH CARE L. & POL'Y 495, 518–20 (2010); *contra* McArthur, *supra* note 281, at 737.

283. OFFICE OF THE PRESIDENT, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES, at vii (2010), *available at* http://www.whitehouse.gov/administration/eop/onap/nhas.

preventing and treating HIV."[284] More recently, in July 2012, the Global Commission on HIV and the Law recommended that states repeal HIV-specific laws.[285]

Legislative efforts to repeal HIV criminalization laws began in late 2011 when on September 23, 2011, Congresswoman Barbara Lee introduced legislation to repeal various criminal laws regarding people who test positive for HIV.[286] The Repeal HIV Discrimination Act requires federal and state officials to review federal and state laws, policies, and regulations regarding the criminal prosecution of individuals for HIV-related offenses.[287] This bill provides incentives for states to repeal or reform such HIV criminalization laws and practices that unfairly target people with HIV for consensual sex and conduct that poses no measurable risk of HIV transmission.[288] The Repeal HIV Discrimination Act is the first bill in the United States to address HIV criminalization. In an interview with Ebony magazine, Representative Lee explained that "[m]any of these laws were enacted before people understood how HIV was transmitted," and that "[t]hey are archaic and they don't reflect current scientific research."[289] She further noted the impact of these laws on African Americans by acknowledging that under these laws African Americans "could be prosecuted for something we didn't know we have" because "[b]lack men and women tend to be 'late testers' for HIV/AIDS."[290] In June 2012, Representative Lee encouraged the Congressional Black Caucus to support efforts to "change laws that specifically criminalize people with HIV and end the persecution of individuals for actions that pose no risk of transmission."[291] In July 2012, Congresswoman Lee introduced a similar bill in preparation for the International AIDS Conference,[292] called "Ending the HIV/AIDS Epidemic Act of 2012" that while not explicitly addressing HIV criminalization laws, includes provisions about "best practice recommendations regarding

284. *Id.* at 36.

285. GLOBAL COMMISSION ON HIV AND THE LAW, RISKS, RIGHTS AND HEALTH 97 (2012), *available at* http://www.hivlawcommission.org/index.php/report.

286. Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act, H.R. 3053, 112th Cong. (2011).

287. *Id.*

288. *Id.*

289. *The Criminalization of HIV (and Why You Should Be Concerned): Rep. Barbara Lee Explains the Danger of the U.S.'s Increasing Prosecution of Persons Accused of Transmitting the Virus*, EBONY MAGAZINE (Aug. 16, 2012), *available at* http://www.ebony.com/news-views/exclusive-the-criminalization-of-hiv-and-why-you-should-be-concerned-877 [hereinafter EBONY].

290. EBONY, *supra* note 289.

291. Barbara Lee, *AIDS 2012: International AIDS Conference Comes to Washington D.C.*, CONG. BLACK CAUCUS: THIS WEEK IN CONGRESS 2:8 (2012).

292. XIX International AIDS Conference, *Conference Overview*, AIDS 2012, *available at* http://www.aids2012.org/Default.aspx?pageId=369 (last visited Feb. 6, 2013).

criminal and related civil commitment cases involving people living with HIV/AIDS."[293]

The Repeal HIV Discrimination Act (and arguably the Ending the HIV/AIDS Epidemic Act of 2012) reflects the growing understanding of HIV transmission. They also reflect the vibrant and perseverant efforts amongst communities uniquely affected by HIV to create a strong support network and fight for change. While these bills alone will not eradicate misinformation or discrimination against people living with HIV, they have increased awareness about how HIV criminalization laws perpetuate inequality and spread misinformation about HIV transmission.

In July 2012, thirty-six members of Congress signed a letter to Attorney General Eric Holder requesting that the U.S. Department of Justice review state and federal laws, policies, regulations, and judicial proceedings involving criminal cases against people living with HIV/AIDS.[294] The legislators further requested that the Department of Justice "examine the reliance on HIV status to initiate, or increase punishment related to, charges against members of the armed forces and inmates in federally-operated or supported prisons and jails."[295] Finally, the letter recommends that the Department of Justice "collaborate with domestic experts and civil society organizations that have already reviewed and continue to monitor these laws and ways to modernize them to more accurately reflect current scientific knowledge."[296] While this letter does not reflect specific legislation, it underscores the importance of advocacy by communities and organizations heavily impacted by HIV and highlights how legislative advocacy can include efforts beyond repealing current state laws.

D. STRUCTURAL CHANGES

Because the circumstances around disclosure are often complex and intertwined with complicated power dynamics between sexual partners and larger institutional and structural issues, any approach discussing eliminating discrimination and criminalization of people living with HIV must include a discussion about structural changes. Such structural changes include eliminating disparity in housing, education, and healthcare while fighting racism, sexism, heterosexism, and classism.

Research repeatedly reiterates that HIV disparately affects communities of color, women, low-income people, and bisexual, transgender, and gay people who develop HIV at higher rates than the larger community and often face greater structural barriers for obtaining

293. H.R. 6138, 112th Cong., (2012).
294. Letter from Barbard Lee et al. to the Honorable Eric H. Holder, Jr. (July 17, 2012), *available at* http://hivlawandpolicy.org/resources/view/767.
295. *Id.*
296. *Id.*

adequate treatment.[297] Research further suggests that social determinants—the conditions in which people are born, grow, live, work, and age—have a larger impact on HIV health outcomes than certain behaviors.[298] For example, inadequate access to housing, healthcare, and education can affect one's ability to obtain the necessary resources to arm oneself with accurate health information and prevent and/or treat HIV. Similarly, structural barriers such as poverty, racism, sexism, and heterosexism can increase stress and reduce positive health outcomes.[299]

Thus, a comprehensive approach that includes efforts to end disparities in housing, education, and healthcare are essential for reducing inequality and criminalization of people living with HIV. Similarly, efforts to eliminate interlocking oppressions such as racism, sexism, heterosexism, and classism should accompany legislative advocacy efforts to repeal or amend HIV criminalization laws.

Various groups and scholars also emphasize a broader need to ensure human rights by passing laws protecting equal rights, removing legal barriers to condoms and sex education, reforming police practices, and including community representatives in lawmaking.[300] This human rights approach is credited with "captur[ing a] positive vision of HIV prevention."[301] In 2011, the U.N. Secretary-General encouraged a shift in approaching HIV from punitive to human-rights based.[302] He advocated shifting priorities and resource allocation to addressing the human rights of people living with HIV.[303] These approaches demonstrate a more

297. *See supra* notes 26–29 and accompanying text.

298. RUSSELL ROBINSON ET AL., HIV/AIDS INEQUALITY: STRUCTURAL BARRIERS TO PREVENTION, TREATMENT AND CARE IN COMMUNITIES OF COLOR: WHY WE NEED A HOLISTIC APPROACH TO ELIMINATE RACIAL DISPARITIES IN HIV/AIDS, CTR. FOR AM. PROGRESS 2 (2012) (citing World Health Organization, *Social Determinants of Health Key Concepts*, *available at* http://www.who.int/social_determinants/final_report/key_concepts_en.pdf).

299. *Id*.

300. *See e.g.*, OPEN SOCIETY INSTITUTE, 10 REASONS TO OPPOSE THE CRIMINALIZATION OF HIV EXPOSURE OR TRANSMISSION 22–23 (2008), *available at* http://www.opensocietyfoundations.org/publications/ten-reasons-oppose-criminalization-hiv-exposure-or-transmission; *see generally* Aziza Ahmed, *Alternatives to Criminalization of HIV Transmission and Exposure*, Testimony for the American Bar Association AIDS Coordinating Committee on Criminal HIV Exposure and Transmission Laws (Jan. 2011), *available at* http://works.bepress.com/aziza_ahmed/4/; *see also* Kim M. Blankenship & Stephen Koester, *Criminal Law, Policing Policy, and HIV Risk in Female Street Sex Workers and Injection Drug Users*, 30 J.L. MED. & ETHICS 548, 556–57 (2002) (describing conversations with sex workers about how alternative approaches by police to sex workers with HIV could result in better protection and less fear of abuse, harassment, stigmatization and oppression).

301. Edwin Cameron et al., *HIV Is a Virus, Not a Crime: Ten Reasons Against Criminal Statutes and Criminal Prosecutions*, Debate, 11:7 J. INTERNAT'L AIDS SOC'Y 1, 6 (2008).

302. U.N. GEN. ASSEMBLY, THE PROTECTION OF HUMAN RIGHTS IN THE CONTEXT OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): REPORT OF THE SECRETARY-GENERAL, HUMAN RIGHTS COUNSEL, 16TH SESSION, U.N. DOC. A/HRC16/69 (2010), *available at* http://www2.ohchr.org/english/bodies/hrcouncil/16session/resolutions.htm.

303. *Id.*

comprehensive understanding of HIV, HIV transmission, and the social determinants that can impact HIV outcomes.

Ultimately, implementing comprehensive structural changes will help buttress efforts to reduce stigma through education and legislative and executive reforms. Moreover, by including communities impacted by HIV in these processes, these efforts will become much richer with the stories and experiences of people whose lives have been directly affected by HIV. By interweaving community support, education, executive and legislative reforms, and structural changes through a multi-pronged approach like the Proactive Pyramid, efforts to address HIV transmission can move from a punitive model to one that is proactive and ultimately much more likely to be effective in reducing HIV transmission.

VI. CONCLUSION

Since the initial years of the HIV epidemic in the early 1980s, researchers have contributed significantly to advances in prevention and treatment methods for HIV and an understanding of its transmission. Laws passed during this early era that targeted people with HIV now serve as vestiges of fear and misinformation about HIV transmission. While increased health education has eliminated some of this fear and misinformation, antiquated HIV criminalization laws only perpetuate them. These laws also perpetuate systems of inequality by enabling bias and misinformation to permeate the courts. As such, new approaches to HIV transmission should move from a punitive model and more toward a proactive transformative model. Despite decades of discrimination under HIV criminalization laws, communities heavily impacted by HIV have developed a strong resilience for support and survival, and any approaches to eradicate discrimination under HIV-specific laws must engage these communities. By employing a multi-pronged approach, like the Proactive Pyramid, that simultaneously acknowledges the importance of engaging (1) community assets and resilience, (2) education to eliminate stigma, (3) legislative and executive efforts to decriminalize HIV, and (4) structural changes, the lens for addressing HIV can move from one that is more punitive to one that is more proactive. Through such a multi-faceted approach involving community support, education, executive and legislative repeal efforts, and structural changes, people living with HIV can thrive without the shackles of discrimination flowing from such oppressive HIV criminalization laws that disproportionately affect marginalized communities and increase fear, misinformation, and stigma about HIV and people living with this chronic illness.