

# Pushing HIV Legislation into the 21<sup>st</sup> Century

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*WRITER'S COMMENT: Although 40 years have passed since the HIV epidemic first shook the United States, our laws have evolved at a much slower rate than antiretroviral therapies or HIV education. A quick scroll through Reddit in late 2017 only reinforced this fact: California had just repealed many of its HIV laws, and residents were loudly voicing their disapproval. As a Global Disease Biology major, I've had the unique opportunity to combine my scientific knowledge of HIV with the political, financial, and cultural implications of the virus. Thus, I chose to address the revision of California's laws for my Disease Policy and Intervention course, aiming to quell media sensationalism with statistics and logic. We still have a long way to go in the fight against HIV/AIDS and disease stigma, but I'm happy to see the tides finally turning.*

*INSTRUCTOR'S COMMENT: GDB 102, "Disease Intervention and Policy," is the capstone class of the Global Disease Biology major. A significant part of this class is to write a policy paper and give a presentation on any topic related to health. I encourage students to choose a topic they are passionate about. Students in this class are incredibly open-minded and tolerant. They want to do the right thing. This passion spills over into excellent writing. Stephanie's paper and presentation were the embodiment of this ideal. Stephanie chose to write on the modernization of California's HIV Statutes: decriminalize and destigmatize HIV, prevent unnecessary persecution and address the inequalities perpetuated by HIV-exposure laws. Her paper takes a multiscale approach to the issue from the development of policy at the*

*state government level to how this new policy affects people in the real world. Stephanie was able to take a new law and distill into understandable language. As the health field moves forward, the ability to accurately and passionately communicate the issues is needed now more than ever. Stephanie is off to a great start.*

—David Rizzo, Department of Plant Pathology

The first cases of human immunodeficiency virus (HIV) in the United States emerged in the early 1980s, primarily targeting men who had sex with men, as well as patients receiving frequent blood transfusions. The progression of HIV into acquired immunodeficiency syndrome (AIDS)—as well as a public health epidemic—peaked in 1993, when AIDS became the leading cause of death in adults aged 25 to 44 years old and was responsible for 2% of all deaths in the United States (Hariri 2007). To combat this, Congress passed the Ryan White Care Act of 1990, which required U.S. states to establish laws that punished HIV-infected individuals for exposing others to the virus. Not willing to lose federal funding, many states—33, as of today—adopted laws that criminalized undisclosed exposure to HIV. Many of these laws do not require intent to transmit HIV, since that is difficult to prove in court and may also be prosecuted under other communicable disease laws. Instead, these statutes are often valid whenever a person living with HIV is aware of their status and engages in certain activities without disclosure (Harsono 2017).

From a public health standpoint, these HIV laws have been problematic. Most were enacted after the initial epidemic in the 1980s, when scientific understanding of HIV and its modes of transmission were severely lacking. Ignorance regarding HIV transmission has resulted in over 20% of HIV-exposure arrests being due to spitting, biting, or other external means that pose virtually zero risk to susceptible individuals (Lazzarini 2013). While the goal of health officials is to prevent the spread of HIV, laws that specifically target infected persons have not proven to be successful. Unfortunately, by not considering antiviral treatments or distinguishing between “high-risk” and “low-risk” activities, these laws may further stigmatize HIV and decrease the public’s willingness to get tested (Harsono 2017).

California is paving the way toward decriminalizing and

destigmatizing people with HIV. Signed by Governor Jerry Brown in late 2017, Senate Bill 239 repeals most of the state's HIV laws and drops the felony charge for exposing others to HIV (Center for HIV Law and Policy 2017). The new law, titled "Intentional transmission of an infectious or communicable disease," took effect on January 1st, 2018. Certainly the news headline "California lowers penalty for knowingly exposing someone to HIV" did not play well with the public. However, a closer look at this legislation is both necessary and important for understanding its role in the decades-long fight against HIV stigma.

Under the new law, HIV is treated just like any other infectious or communicable disease, such as tuberculosis, measles, and influenza. Similarly, the maximum punishment for "willful exposure" *or* transmission is six months in jail, and several conditions must be met before presenting a valid case (Cal. Health & Safety Code 120290). Prior to the appeal, "specific intent" to transmit HIV could be demonstrated even if an infected individual took precautionary measures. Many HIV-positive people voiced their concerns about this, stating that the previous law increased their stress of being falsely accused and also made them vulnerable to implicit court biases (Galletly 2008). Under section one of the new law, "specific intent" is more difficult to prove and requires actual transmission of the virus. In addition, condom use, antiretroviral therapy, and low-risk behaviors (as determined by scientific evidence) will nullify any attempt at prosecution (Center for HIV Law and Policy 2017). Antiretroviral therapy (ART) certainly deserves to be accounted for in modern laws, as regular adherence to ART has been shown to decrease HIV transmission by 96% (Lehman 2014). Thus, California's revised law provides many protections for HIV-positive individuals and strives to eliminate excessive and unnecessary prosecution.

**A significant byproduct** of HIV laws is that historically marginalized groups, such as sex workers and ethnic minorities, make up the bulk of prosecuted individuals (UNAIDS 2008). Over 95% of all HIV criminalization cases in California involve sex workers (Hasenbush 2017). Under the prior law, individuals who were caught soliciting and found to be HIV-positive could be convicted of a felony and jailed for three years—even in the absence of physical contact (Cal. Penal Code 647f). As California criminal justice data suggests, two-thirds of

prostitution arrests target women, and black women in particular are overrepresented in HIV felony cases. As a group, women comprise 43% of all HIV criminalization cases—but make up just 13% of California’s HIV-positive population (Hasenbush 2017).

In the State of California, a felony may be punishable by death or imprisonment for 16 months or longer. Recurring felonies fall under the “Three Strikes Law,” which increases the punishment for repeat offenders and allows the state to dole out 25-year sentences with no parole. In addition, state felons lose their immediate right to vote, sit on a jury, own a firearm, and face many obstacles when applying for jobs (California Courts). California Health & Safety Code 120290 serves to address the previous law’s discrimination by repealing its HIV felony clause.

To further protect the rights of HIV-positive individuals, the new legislation includes a protection clause for individuals with an infectious or communicable disease that become or intend to become pregnant. A survey administered by the U.S. Positive Women’s Network between 2010-2011 found that a quarter of respondents had negative experiences with health care professionals after disclosing that they were pregnant and HIV-positive. Inaccurate information, stigma, and unsupportive medical providers were commonly listed as influencing a respondent’s decision to carry a pregnancy to term (Diagnosis, Sexuality and Choice 2011). Fortunately, the advent of antiretroviral therapy has significantly decreased the likelihood that an HIV-positive person will give birth to an HIV-positive child. Compared to the 1990s, perinatal transmission rates have dropped by 90%, and the chance of a baby being infected with HIV when both mother and child are taking ART is less than 1%. In riskier cases, a Cesarean delivery can be performed to further avoid transmission (CDC 2018). The updated California law reflects these statistics, reiterating that HIV-positive individuals have full autonomy over their body and reproductive choices, even if they cannot receive ART (Cal. Health & Safety Code 120290(d)).

**Planned and deliberate transmission** of HIV/AIDS is rare; unfortunately, media sensationalism is not. Perhaps one of the most memorable cases of HIV transmission was that of Nushawn Williams in 1995. A proclaimed “sex fiend” and known drug abuser, Williams exposed over 100 New Yorkers to HIV after testing positive for the

virus in 1996. At the time, public health officials released his name and photograph, hoping that someone in the region would recognize him and turn him in. Upon retrospective analysis, these public health officials clearly evaded privacy laws, and schizophrenia likely played a major role in Williams' situation. However, this case has forever haunted the law books. Ohio made it a felony for HIV-positive individuals to protect their serostatus, and many states were quick to implement stricter HIV laws following the case's completion (Wolf 2003).

When Governor Brown signed the California Health & Safety Code 120290 in 2017, Republican lawmakers, media outlets, and those among the general population voiced their concerns—many of which were reminiscent of fears regarding cases like Nushawn Williams. What is critical to understand is that this law's intent is not to lessen the punishment of perceived "biological warfare," but to modernize how California approaches and prevents transmission of HIV. When first examining HIV exposure laws in 2008, California researchers predicted that the greatest compliance would occur when a law allowed for "multiple options of lawful sexual expression." To test this hypothesis, researchers created a mathematical model comparing HIV transmission rates with their respective state exposure laws. "Strict" laws were those that completely forbid sexual activity without prior serostatus disclosure, while "flexible" laws were those that only required disclosure for high-risk activities. During analysis, flexible exposure laws were found to be equal to or more effective than strict laws at preventing HIV transmission, likely because individuals could opt for low-risk activities in lieu of disclosing their status. These results were valid when "high-risk" sex (typically penetrative sex) was riskier than "low-risk" sex (Galletly 2008).

In the current era of highly successful antiretroviral therapies, "high-risk" sex is no longer synonymous with unprotected intercourse. An individual regularly receiving ART may pose a lower risk during all sexual encounters than an individual engaging in "low-risk" activities with no treatment. As such, even the most flexible laws must evolve with the advancement of modern medicine, and that is precisely what California Health & Safety Code 120290 has set out to do. To further justify the repeal of strict HIV laws, it has been documented that individuals living in states that require disclosure before all sexual encounters behave similarly to those living in less strict states. Thus, people's behaviors seem to remain relatively static regardless of their knowledge of state HIV laws

(Harsono 2017). Results from another study found that among 1,421 people living with HIV, those registered in states with higher-than-median HIV prosecution rates were *less* likely to disclose their status to partners than those living elsewhere (Harsono 2017). Thus, it is possible that strict HIV laws may actually hinder public health efforts to reduce transmission (Burris 2007).

California Health & Safety Code 120290 also repeals a law that punished HIV-positive individuals for donating blood, organs, or tissue. This law was repealed due to its infrequency of use and redundancy with policies already in place by the U.S. Food and Drug Administration (FDA). During the early years of the HIV/AIDS epidemic, men who had sex with men were permanently barred from donating blood in all fifty states due to their overrepresentation as an HIV-positive group (Hughes 2015). However, HIV testing methods and knowledge of the disease have improved considerably since the 1980s. To honor these advances, the FDA recently revised blood donor guidelines, allowing men who have not had sex with men in at least 12 months to donate blood. This deferral period allows for HIV viral counts—if applicable—to reach detectable levels prior to the blood screening process (USFDA). Since all blood donations in the United States are screened for HIV and a slew of other infectious diseases prior to being accepted, California's previous law seems more of a relic than a useful statute. Although the new law has repealed or amended most HIV-specific rulings, sentence enhancements for HIV-positive criminals have been left intact. If an HIV-positive individual commits rape and/or has sex with a minor, the law still allows for a three-year sentence enhancement for each offense (Cal. Penal Code 12022.85).

**As of today**, 1.2 million people in the United States are HIV-positive, but nearly one in seven people are ignorant of their serostatus (U.S. Statistics 2017). The “90/90/90” goal of 2015 attempts to tackle this issue, striving for a future where 90% of infected individuals are aware of their status and have access to healthcare and antiretroviral therapy by 2020 (90-90-90). Regardless of a state's position on HIV laws, punishment does not appear helpful when citizens cannot access HIV treatment, education, and counseling services. Replacing jail time with affordable and easily accessible healthcare services could go a long way

toward actually preventing HIV transmission and suppressing viral loads. San Francisco has led the way in HIV prevention strategies, offering ART and pre/post-exposure prophylaxis to all residents, regardless of their financial situation. The city boasts some of the lowest unknown infection rates in the country—only 7.5% among men who have sex with men. In addition, San Francisco aims to provide same-day care to infected individuals, further lowering the population's viral levels (Das 2013).

By focusing on preventative HIV care and not inflicting harsh punishment on those who fall through the cracks, California has set a bold precedent for the future of HIV/AIDS statutes in the United States. However, the Center for HIV Law and Policy did address some concerns regarding the new mandate. Primarily, the “willful exposure” portion of the new law could be problematic. While disease transmission and “specific intent” are *required* for conviction under the first section of the new law, this is not the case under the “willful exposure” section. To convict someone under this segment, a health officer must have issued specific instructions to an infected individual that were undermined within 96 hours (Cal. Health & Safety Code 120290(a)(2)). Examples could include recommendations to avoid air travel, or to stay home from work. Thus, HIV-positive individuals who frequently visit healthcare providers may be at higher risk of prosecution than those who do not. This might prove to be a loophole in the law that could be unfairly exploited by prosecutors. In addition, permitting a wide range of healthcare workers to satisfy this portion of the law might grant this group unfair power in HIV criminal trials. Privacy protections were also excluded from this section—a worrisome scenario, given the importance of medical confidentiality when treating HIV (Center for HIV Law and Policy 2017).

The true impact of California Health & Safety Code 120290 on HIV transmission rates has yet to be determined, but at the very least, the state can expect a significant decrease in HIV-related court cases. By reducing the disproportionate burden that prior laws had on marginalized communities, this new statute is a reminder that *anyone* can contract HIV—and doing so does not make you a public menace. This law will also dissuade prosecutors from piling on HIV-related crimes to other sentences. If an individual is taken to court for reasons unrelated to their serostatus, being HIV-positive should never influence their punishment. Incidentally, this could help free up the courts and allow judges and



jurors to tackle more pertinent matters.

Hopefully, the advent of this law will prompt additional states to revisit their HIV statutes. While the original purpose of these laws was to prevent transmission of a deadly disease, modern medicine has transformed the way we view HIV—and it is time for the law to reflect reality. While HIV laws have failed to alter transmission rates and behaviors of infected individuals, they have successfully persecuted vulnerable communities and instilled fear in seropositive persons. Perhaps instead of focusing on ways to punish those who are already infected, states should invest more time in treatment and preventative care. It has been established that antiretroviral therapy, education, accessible healthcare, and low risk of prosecution all positively correlate with a reduction in new HIV cases. Thus, preventative care, rather than criminalization, is the next logical step in tackling HIV—and California has aligned itself on the right side of history.

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