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The Dangers of Disclosure: How HIV Laws Harm Domestic Violence Survivors

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THE DANGERS OF DISCLOSURE: HOW HIV LAWS HARM DOMESTIC VIOLENCE SURVIVORS

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Abstract: People living with HIV or AIDS must decide whether, how, and when to disclose their positive status. State laws play an outsized role in this highly personal calculus. Partner notification laws require that current and former sexual partners of individuals newly diagnosed with HIV be informed of their potential exposure to the disease. Meanwhile, people who fail to disclose their positive status prior to engaging in sexual acts—even acts that carry low to no risk of infection—can be prosecuted and incarcerated for exposing their partners to HIV. Although both partner notification laws and criminal HIV exposure laws were ostensibly created to combat the spread of the disease, they are ineffective at doing so. Instead, they threaten the safety and health of people living with HIV. This Article analyzes HIV laws through the lens of domestic violence and reveals that both compliance and failure to comply with these laws can endanger survivors of domestic violence. This previously ignored double bind is significant given the reciprocal relationship between HIV and domestic violence: people living with HIV are more likely to experience domestic violence, just as survivors of domestic violence experience higher rates of HIV. Yet nearly all state HIV laws fail to recognize this inextricable relationship and, in so doing, create additional, unwarranted dangers for many individuals living at the intersection of HIV and domestic violence. This Article exposes the pernicious shortsightedness of state HIV laws and proposes reforms that would better protect both individuals at risk of infection as well as those at risk of violence.

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INTRODUCTION

Domestic violence and HIV/AIDS gained national attention within a decade of each other. The battered women's movement transformed domestic violence from a taboo topic of conversation into material covered in the mainstream media by the mid-1970s.[1] Reports of what would come to be known as the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) were increasing in frequency in the early 1980s and were a matter of widespread concern by

1. ELIZABETH PLECK, DOMESTIC TYRANNY: THE MAKING OF SOCIAL POLICY AGAINST FAMILY VIOLENCE FROM COLONIAL TIMES TO THE PRESENT 182 (1987) (comparing the lack of any newspaper articles on domestic violence against women prior to 1974 to forty-four articles on domestic violence in the New York Times alone in 1977).

the mid-1980s.[2] While they differ in terms of their specific causes and consequences, both domestic violence and HIV[3] have been recognized as public health crises since they entered the public consciousness over thirty years ago.[4]

Similarities between HIV and domestic violence extend beyond overlapping timelines into how the general public perceives people living with HIV and survivors of domestic violence. For example, there are individuals experiencing each phenomenon who are considered victims, while others are seen as assuming or even inviting the risk; certain responses like leaving a violent relationship or complying with medical treatment are considered objectively correct, while those who fail to successfully do so are met with contempt rather than empathy; and people who risk children's exposure to either HIV or domestic violence are almost universally vilified.

In addition to often being viewed and valued by society through these Manichean heuristics, people living with both HIV and domestic violence face similarly harsh judgment from the state as well. Laws surrounding the behavior of people living with HIV—referred to here as the "HIV legal regime"—create immense dilemmas for HIV-positive people who are also being abused.[5] Whether an individual is HIV-positive or -negative is known as their serostatus.[6] Although disclosure of one's serostatus will typically prevent potential state intervention, for survivors of violence

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2. JULIA DAVIS, THE HENRY J. KAISER FAMILY FOUND., EVOLUTION OF AN EPIDEMIC: 25 YEARS OF HIV/AIDS MEDIA CAMPAIGNS IN THE U.S. 7–9 (2006) (noting that well-known actor Rock Hudson's 1985 death from AIDS marked the beginning of intensive media coverage of HIV/AIDS). *But see* James W. Curran & Harold W. Jaffe, *AIDS: The Early Years and CDC's Response*, 60 MORBIDITY & MORTALITY WKLY. REP. 64, 65 (Oct. 7, 2011) (observing how little media attention was given to the disease when it was initially understood as only impacting gay men).

3. Throughout this article, I will typically be using HIV rather than HIV/AIDS. Unless specifically noted otherwise, references to HIV are meant to encompass both HIV and AIDS, the latter of which represents an end stage of the former. *See* Mary E. Ellis, *HIV vs. AIDS: What's the Difference*, HEALTHLINE (Apr. 26, 2018), https://www.healthline.com/health/hiv-aids/hiv-vs-aids#aids [https://perma.cc/DW32-FNM3] (describing HIV as a virus and AIDS as a condition that occurs when HIV has caused significant damage to the immune system).

4. *See, e.g.,* CDC, COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN THE UNITED STATES 3 (2003) (acknowledging that violence against women is a "substantial public health problem in the United States"); THE WORLD BANK, PUBLIC HEALTH AT A GLANCE: HIV/AIDS (2003) (noting that HIV/AIDS is a global public health issue).

5. Angela Perone, *From Punitive to Proactive: An Alternative Approach for Responding to HIV Criminalization that Departs from Penalizing Marginalized Communities*, 24 HASTINGS WOMEN'S L.J. 363, 391–92 (2013) (discussing how someone in an abusive or dependent relationship "may fear violence or abandonment upon disclosure").

6. The National Institutes of Health defines serostatus as "[t]he state of either having or not having detectable antibodies against a specific antigen." *HIV/AIDS Glossary*, AIDSINFO, https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/1632/serostatus [https://perma.cc/7LF9-CTB9].

disclosure can also usher in a host of dangerous consequences in the form of abuse triggered by or targeted at their positive serostatus.

The state-level web of laws that dictate the behavior of people living with HIV and endanger the lives of survivors with HIV consists primarily of partner notification laws and criminal exposure statutes. Partner notification laws require that current and former sexual partners of individuals newly-diagnosed with HIV be informed of their potential exposure to HIV.[7] Although the ultimate goal of partner notification laws is commendable—informing potentially unaware individuals that they may be at risk and urging them to get tested[8]—the very act of telling an abusive partner that they[9] may have HIV can place a survivor of domestic violence in danger of immediate retaliation and longer-term abuse.[10] While short- and long-term abuse may consist of physical violence, it may also include tactics designed to undermine medical treatment and interfere with a survivor's health outcomes.[11] In some states, if a survivor fails to disclose their status to a current or former partner, a healthcare professional will reach out to their partners directly and inform them that they have been exposed to HIV.[12] While some partners may not know the source of their exposure, others will have no doubt who the unnamed individual is, thus creating a potential for abuse.[13]

States also criminally charge HIV-positive individuals for exposing sexual partners to the risk of becoming infected with HIV.[14] These laws typically forbid people living with HIV from even having unprotected sex

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7. Mary D. Fan, *Sex, Privacy, and Public Health in a Casual Encounters Culture*, 45 U.C. DAVIS L. REV. 531, 564–65 (2011) (describing various motivations for and types of partner notification laws).

8. *Id.* at 565.

9. "They/them" is used throughout this article as a gender-neutral, singular pronoun. "She/her" or "he/his" may be used if necessary to prevent linguistic ambiguity. This choice was made to reflect the fact that individuals of any gender or gender identity may be survivors or perpetrators of violence.

10. For examples of post-disclosure violence by intimate partners, see Susan B. Apel, *Privacy in Genetic Testing: Why Women Are Different*, 11 S. CAL. INTERDISC. L.J. 1, 18–19 (2001); Sarah Chappell, *Reducing the Risk of Domestic Violence Against HIV-Positive Women: The Application and Efficacy of New York's Partner Notification Deferral Mandate*, 22 DUKE J. GENDER L. & POL'Y 241, 242–46 (2015).

11. Jane K. Stoever, *Stories Absent from the Courtroom: Responding to Domestic Violence in the Context of HIV and AIDS*, 87 N.C. L. REV. 1157, 1173 (2009) (observing how common it is for domestic violence attorneys "to hear that a batterer destroyed medication to control a partner's health and keep her sick" and providing illuminating examples); *see also* Chappell, *supra* note 10, at 247.

12. This type of approach is known as a conditional referral, in which a patient only has so much time to confirm disclosure before a health care provider notifies the patients' partners. Fan, *supra* note 7, at 564–65.

13. Chappell, *supra* note 10, at 247.

14. *See generally* THE CTR. FOR HIV LAW & POLICY, HIV CRIMINALIZATION IN THE UNITED STATES: A SOURCEBOOK ON STATE AND FEDERAL HIV CRIMINAL LAW AND PRACTICE (3d ed. 2017) (providing an overview of each U.S. state and territory's HIV criminalization laws).

without first sharing their serostatus.[15] As with partner notification laws, at first blush these statutes seem desirable from a normative perspective: people should be able to decide whether or not they assume the risk of exposing themselves to potential HIV infection.[16] But requiring disclosure in order to avoid prosecution not only opens up a survivor to the multiple forms of abuse described above, it also cedes the power of the state to abusive partners by allowing them to make false claims about lack of disclosure to further punish survivors. An abusive partner who is informed of a survivor's serostatus now has the ability to claim that they were not told.[17] Although the survivor may be exonerated, an arrest for, or charge of, HIV exposure nonetheless generates permanent public proof of the survivor's serostatus and invites discrimination and stigma.[18] Actual failure to disclose, even when motivated by genuine fear, can also result in a survivor's arrest and prosecution if an abusive partner manages to find out about the survivor's status.

Laws surrounding the behavior of people living with HIV create a catch-22 for HIV-positive survivors of domestic violence: comply with the law and risk violent retaliation, targeted abuse, and false criminal charges or opt not to disclose and risk disclosure by a healthcare professional and criminal charges in earnest. These risks are compounded for nonwhite gay and transgender individuals, who experience both high rates of HIV infection and whose sexual orientation and gender identity may serve as a locus for control and abuse.[19]

Examining the HIV legal regime from the standpoint of HIV-positive survivors undermines the deceptively simple logic behind both notification and exposure laws. For a survivor who reasonably believes disclosure will put them in physical danger or who does not get to decide when or how they have sex, the benefits of disclosure before sex are debatable at best. Moreover, the moral clarity of these laws becomes even murkier if preventative measures are also taken to make transmission

15. While many state laws make nondisclosure itself criminal, others that criminalize exposure more broadly nonetheless provide an explicit or implied affirmative defense when status has been disclosed. For a breakdown of the types of criminalization laws across the U.S., see *HIV/AIDS: HIV and STD Criminal Laws*, CDC, https://www.cdc.gov/hiv/policies/law/states/exposure.html [https://perma.cc/B26Z-VFXU].

16. Sara Klemm, *Keeping Prevention in the Crosshairs: A Better HIV Exposure Law for Maryland*, 13 J. HEALTH CARE L. & POL'Y 495, 519–20 (2010) (exploring the logic behind different criminalization proposals).

17. Perone, *supra* note 5, at 365.

18. *Id.*

19. *See HIV: HIV and Gay and Bisexual Men*, CDC, https://www.cdc.gov/hiv/group/msm/index.html [https://perma.cc/KPU6-EYLY]; *HIV: HIV and Transgender People*, CDC, https://www.cdc.gov/hiv/group/gender/transgender/index.html [https://perma.cc/74NF-4TX8].

extremely unlikely if not impossible.[20] Yet, survivors living with HIV continue to experience physical violence, negative health outcomes, and unwarranted legal intervention due to the legal regime's focus on disclosure.

Close analysis of the HIV legal regime through the lens of domestic violence dynamics reveals that disclosure is actually a poor trigger for state intervention. While choosing not to know one's own serostatus would certainly circumvent disclosure-based laws, the law should not discourage people from obtaining critical information about their health and accessing necessary treatment.[21] Instead, the HIV legal regime should be restructured in order to both encourage testing and treatment and better reflect the realities of HIV and those who live with it. Rather than carve out particular exceptions or defenses for individuals experiencing violence or abuse, the HIV legal regime should be reshaped to promote the health and safety of not just individuals who are at risk of infection but also all people already living with HIV.

Part I of this Article begins by exploring the history of HIV as well as how it is transmitted, tested for, and treated. Without this information, it would be impossible to assess how HIV laws can be structured to reduce the spread of HIV. Against this backdrop, Part II illuminates the inextricable relationship between HIV and domestic violence, revealing how any legal response to HIV that ignores the reality of domestic violence is inherently inadequate and jeopardizes the health and safety of all people living with HIV who are at risk of experiencing domestic violence. Part III first provides a historical overview of the government's response to HIV, underscoring how the creation of the HIV legal regime was in response to public outcry rather than evolving medical science. Part III then analyzes how the HIV legal regime fails to take either basic information about HIV or HIV's relationship with domestic violence into account, thereby exposing people with HIV to poor health outcomes, physical danger, and unwarranted state intervention. Part IV provides recommendations for reform that would better serve people who are at risk of HIV infection and people living with HIV who are at risk of domestic violence.

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20. The CDC provides lengthy information on how to prevent transmission, or decrease the likelihood of, transmission during sex. *See HIV/AIDS: HIV Transmission*, CDC, https://www.cdc.gov/hiv/basics/transmission.html [https://perma.cc/84NK-8ELP].

21. *See, e.g.*, Joseph A. Garmon, Comment, *The Laws of the Past Versus the Medicine of Today: Eradicating the Criminalization of HIV/AIDS*, 57 HOW. L.J. 665, 674 (2014) (reviewing arguments that criminalization based on knowledge of serostatus may disincentivize HIV testing).

I. FROM FATAL TO CHRONIC: THE EVOLUTION OF HIV/AIDS

It would be impossible to assess the effectiveness of the HIV legal regime and its impact on the lives of survivors without first reviewing the evolution of HIV as both a social and a medical phenomenon. This examination underscores how heavily the development of the HIV legal regime was influenced by panic rather than the evolving body of scientific knowledge about HIV.

A. The Emergence of HIV/AIDS in the United States

In the United States, the first death from what would come to be known as AIDS occurred in 1969, a decade before the disease began to gain national attention.[22] Distinguished medical historian Mirko Grmek pinpoints 1978 as the beginning of the AIDS epidemic in the U.S., despite the lag in scientific recognition.[23] In June of 1981, the Centers for Disease Control (CDC) published a report describing an unusual form of pneumonia in five seemingly-healthy gay men in Los Angeles.[24] A month later, the CDC reported an increase in reports of Kaposi's sarcoma—a rare type of cancer—among gay men in New York City and California.[25]

Between June 1981 and March 1982, the CDC received nearly 300 reports of documented cases of "serious opportunistic infections" including Kaposi's sarcoma,[26] most of which were from gay or bisexual men.[27] Because of the overwhelming number of opportunistic infections occurring in gay or bisexual men with depressed immune systems, the condition was referred to even by medical professionals as "gay-related immunodeficiency disease" or "GRID."[28] A special report in the *New*

22. Gina Kolata, *Boy's 1969 Death Suggests AIDS Invaded U.S. Several Times*, N.Y. TIMES, Oct. 28, 1987; *see also* John Crewdson, *Case Shakes Theories of AIDS Origin*, CHI. TRIB., Oct. 25, 1987 (both describing the case of Robert Rayford, a teenager in St. Louis whose autopsy revealed Kaposi's sarcoma, a rare form of cancer that would later be recognized as a hallmark opportunistic infection among patients with AIDS).

23. MIRKO D. GRMEK, HISTORY OF AIDS: EMERGENCE AND ORIGIN OF A MODERN PANDEMIC 17 (Russell C. Maulitz & Jacalyn Duffin trans., 1990).

24. CDC, *Pneumocystis Pneumonia—Los Angeles*, 30 MORBIDITY & MORTALITY WKLY. REP. 250, 250–51 (June 5, 1981).

25. CDC, *Kaposi's Sarcoma and Pneumocystis among Homosexual Men—New York City and California*, 30 MORBIDITY & MORTALITY WKLY. REP. 305, 305–08 (July 3, 1981).

26. Harry W. Haverkos & James W. Curran, *The Current Outbreak of Kaposi's Sarcoma and Opportunistic Infections,* 32 CANCER J. CLINICIANS 330, 331 (1982). The study noted that the concurrence of Kaposi's Sarcoma and Pneumocystis Carinii Pneumonia "had not been reported before this outbreak." *Id.* at 331–32.

27. *Id.* at 336. Of the 290 cases, 280 were men, 85% of whom identified as gay or bisexual; all ten of the women identified as heterosexual. *Id.*

28. Lawrence K. Altman, *Clue Found on Homosexuals' Precancer Syndrome*, N.Y. TIMES, June 18, 1982.

England Journal of Medicine in 1982 cautioned that "[t]he high mortality rate among young men with these disorders indicates a serious public-health problem."[29] After discovery of the same symptoms and infections in heterosexual injection drug users and recipients of blood transfusions, the label "acquired immune deficiency syndrome" replaced GRID.[30] By 1985, the actual virus was discovered and a blood test for HIV quickly followed.[31]

While the eventual discovery of the scientific cause of HIV was an unparalleled breakthrough in the urgent search to understand and manage the disease, this critical insight did not negate the blame and stigma generated by people who viewed AIDS as punishment for deviant behavior or nonconforming identity. While African Haitian immigrants were initially accused of bringing AIDS to the U.S., it is now believed that Americans brought the disease to Haiti.[32] Gay and bisexual men, people of color, nonwhite immigrants, and injection drug users bore the brunt of this condemnation as they were blamed for spreading the disease.[33] Pat Buchanan described AIDS as "nature exacting an awful retribution" against gay men.[34] Senator Jesse Helms likewise stated his belief that those who engaged in homosexual behavior deserved to be afflicted by AIDS.[35] Televangelist Jerry Falwell explicitly claimed that AIDS was a punishment from God against the gay community.[36] But it was not merely homophobic political figures who lacked sympathy for many people living with HIV: a 1990 poll found that less than half of the participants believed that people who acquired HIV via non-heterosexual sex or injection drug use should be treated with compassion.[37] The broadly held

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29. CDC Task Force on Kaposi's Sarcoma & Opportunistic Infections, *Special Report: Epidemiological Aspects of the Current Outbreak of Kaposi's Sarcoma and Opportunistic Infections*, 306 N. ENG. J. MED. 248, 251 (1982).

30. *See 30 Years of AIDS—A Retrospective*, HIV POSITIVE! (2018), http://www.hivpositivemagazine.com/30years.html [https://perma.cc/8S9J-FS76].

31. Robert C. Gallo & Luc Montagnier, *The Discovery of HIV as the Cause of AIDS*, 349 N. ENG. J. MED. 2283, 2284 (2003).

32. W. Thomas Minahan, *Disclosure Before Exposure: A Review of Ohio's HIV Criminalization Statutes*, 35 OHIO N.U. L. REV. 83, 85 (2009).

33. *See* Aziza Ahmed, *Adjudicating Risk: AIDS, Crime, and Culpability*, 2016 WIS. L. REV. 627, 636 (2016).

34. Stephen J. Pope, *Scientific and Natural Law Analyses of Homosexuality: A Methodological Study*, *in* CHRISTIAN ETHICS: AN INTRODUCTORY READER 258, 259 (Samuel Wells ed., 2010).

35. WILLIAM A. LINK, RIGHTEOUS WARRIOR: JESSE HELMS AND THE RISE OF MODERN CONSERVATISM 350 (2008).

36. Hans Johnson & William Eskridge, *The Legacy of Falwell's Bully Pulpit*, WASH. POST (May 19, 2007), https://www.washingtonpost.com/wp-dyn/content/article/2007/05/18/AR2007051801392.html [https://perma.cc/B2AE-8AVY].

37. Richard A. Knox, *Most Favor Bigger US Role in AIDS Fight, Poll Shows*, BOS. GLOBE, June 17, 1990.

perception of HIV as "a fearsome and deadly disease that was perceived to be spread largely through taboo sex acts among an abhorred sexual minority,"[38] created a climate in which the implementation of a draconian HIV legal regime would not receive widespread pushback.[39]

Not all historically marginalized populations were immediately treated with heightened suspicion at the onset of the AIDS crisis. To the contrary, women exhibiting symptoms of HIV were all but ignored. Although early medical studies and reports had identified women presenting the same AIDS-related symptoms as male patients,[40] the CDC did not initiate a natural history study of HIV in women until 1992.[41] Moreover, the CDC did not acknowledge HIV-related symptoms found only in women until 1993.[42] Women battled HIV/AIDS for over a decade, receiving vastly insufficient medical care and social services, poor health outcomes, and little to no access to clinical trials.[43] Despite this paucity of recognition and subsequent dearth of knowledge, treatment, and care, the discovery that pregnant women with HIV could infect their unborn children nevertheless became a flashpoint in the legal and moral debates over culpable behavior by people living with HIV.[44]

This combination of panic and lack of understanding pervades the political and legal response to HIV and stands in stark contrast to the body of medical science around HIV, which has continued to evolve and expand since the disease's discovery.

B. The Medical Transformation of HIV/AIDS

Understanding HIV from a physiological standpoint underscores the extent to which the initial frenzied response to the emergence of AIDS was unfounded: the ensuing and long-lasting panic, stigmatization, and regulation around HIV does not map onto the medical science behind its causes, transmission, and treatment.

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38. Dustin J. Lee, Note, *Injections, Infections, Condoms, and Care: Thoughts on Negligence and HIV Exposure*, 25 CORNELL J.L. & PUB. POL'Y 245, 248 (2015).

39. *Id.* at 249.

40. Haverkos & Curran, *supra* note 26, at 336; *see also* CDC, *Immunodeficiency among Female Sexual Partners of Males with Acquired Immune Deficiency Syndrome (AIDS)—New York,* 31 MORBIDITY & MORTALITY WKLY. REP. 697, 698 (1983).

41. Elizabeth B. Cooper, *Why Mandatory HIV Testing of Pregnant Women & Newborns Must Fail: A Legal, Historical, & Public Policy Analysis,* 3 CARDOZO WOMEN'S L.J. 13, 14 (1996); Stoever, *supra* note 11, at 1164–65.

42. Cooper, *supra* note 41, at 14.

43. *Id*. at 14–15.

44. *See, e.g.*, Shahabudeen K. Khan, *The Threat Lives On: How to Exclude Expectant Mothers from Prosecution for Mere Exposure of HIV to Their Fetuses and Infants*, 63 CLEV. ST. L. REV. 429, 431–32 (2015) (noting that laws broadly aimed at criminalizing the exposure and transmission of HIV could result in criminal prosecution of HIV-positive women for exposing their fetuses and babies to HIV).

HIV is a virus that attacks the body's immune system—specifically its T cells, which are critical in fighting infections.[45] When a person initially becomes infected, they are extremely contagious yet may not suspect that they are unwell.[46] Because the body lacks antibodies to fight the infection, it is likely that an early HIV antibody test will come back negative.[47] While a person's T cell count initially drops upon infection, their amount of T cells then usually increases and can remain stable for years.[48] If untreated, a person in this stage is infectious, but their health can remain stable otherwise.[49] This balance often shifts over time and the number of T cells fighting the infection decreases.[50] AIDS is the condition that occurs when a person's viral load increases significantly and their T cell level becomes precipitously low, rendering the body extremely vulnerable to opportunistic infections.[51] Once HIV becomes AIDS, an untreated person's life expectancy drops to only a few years.[52]

HIV can only be transmitted when a bodily fluid containing the virus enters the body via a mucus membrane or damaged tissue or is injected directly beneath the skin.[53] Bodily fluids that can transmit HIV include blood, semen, pre-seminal fluid, rectal and vaginal fluids, and breast milk.[54] Mucus membranes that are susceptible to transmission are inside the mouth, penis, vagina, and rectum.[55] HIV cannot be transferred via sweat, tears, or saliva.[56] A person's risk of acquiring HIV depends on several factors, including what kind of bodily fluid is introduced and what mucus membrane the fluid encounters, the type of activity being engaged in and what kinds of preventative measures are taken, and the viral load of the person with HIV.[57] According to the CDC, receiving a blood transfusion with infected blood has by far the highest likelihood of

45. *HIV/AIDS: About HIV/AIDS*, CDC, https://www.cdc.gov/hiv/basics/whatishiv.html [https://perma.cc/HND9-PRUL].

46. *Id.*

47. *Id.*

48. *Id.*; *The Science of HIV & AIDS–Overview*, AVERT (Oct. 10, 2019), https://www.avert.org/professionals/hiv-science/overview [https://perma.cc/DB7J-CMCB].

49. *HIV/AIDS: About HIV/AIDS, supra* note 45.

50. *Id.*

51. *Id.*

52. *Id.*

53. *HIV/AIDS: Transmission*, CDC, https://www.cdc.gov/hiv/basics/transmission.html [https://perma.cc/HE9B-46ED].

54. *Id.*

55. *Id.*

56. *Id.*

57. *See* Margo Kaplan, *Rethinking HIV-Exposure Crimes*, 87 IND. L.J. 1517, 1527–30 (2012); Shirley K. Wang, Comment, *Violence & HIV/AIDS: Violence against Women and Girls as a Cause and Consequence of HIV/AIDS*, 17 DUKE J. GENDER L. & POL'Y 313, 317–18 (2010).

transmitting HIV at over 90%[58]; luckily, intensive testing has rendered this risk extremely unlikely.[59] All other unprotected methods of transmitting HIV carry less than 2% risk of transmission per act, with receptive anal intercourse posing the highest risk followed by needle-sharing, needlestick wounds, insertive anal intercourse, receptive penile-vaginal sex, and insertive penile-vaginal sex.[60] Giving or receiving oral sex has a nearly negligible risk of transmission.[61] While these probabilities are low, the CDC is quick to caution that the likelihood of infection increases with repeated acts over time.[62]

These probabilities are not absolute. For example, any kind of violent sexual assault or unwanted sexual act may increase the likelihood of transmission because force or lack of arousal can lead to wounds or tears in the vagina, anus, or mouth through which HIV can enter the body.[63] For an HIV-negative individual, having a preexisting sexually transmitted infection can also increase the likelihood of getting HIV due to skin irritation or inflammation.[64]

There are also factors that can decrease the likelihood of transmission like using a condom correctly, engaging in lower-risk sexual activities, and using clean needles.[65] For people living with HIV, a significant factor in not transmitting HIV is fully complying with a medical treatment regimen.[66] Current HIV medication, known as antiretroviral therapy (ART) can suppress someone's viral load to the point of being undetectable.[67] While this does not mean someone is cured,[68] recent

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58. *HIV/AIDS: HIV Risk Behaviors*, CDC, https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html [https://perma.cc/R4FW-CK7Q] (placing the risk of transmission at 92.5%).

59. *HIV/AIDS: Transmission*, *supra* note 53.

60. *HIV/AIDS: HIV Risk Behaviors*, *supra* note 58 (providing likelihoods of transmission for each act as 1.38%, .63%, .23%, .11%, .08%, and .04%, respectively).

61. *Id.* The CDC also identifies the risk of transmission from spitting, biting, sharing sex toys, or throwing bodily fluids as "negligible." *Id.*

62. *Id.*

63. *See* Janet E. Moon, Comment, *Violence, Culture, & HIV/AIDS: Can Domestic Violence Laws Reduce African Women's Risk of HIV Infection?*, 35 SYRACUSE J. INT'L. L. & COM. 123, 129–31 (2007); Kim T. Seelinger, *Violence against Women and HIV Control in Uganda: A Paradox of Protection?*, 33 HASTINGS INT'L & COMP. L. REV. 345, 350 (2010); Wang, *supra* note 57, at 318.

64. HIV/AIDS: TRANSMISSION, *supra* note 53.

65. *Id.*

66. *Id.*

67. *Id.* The CDC also says that the likelihood of vertical transmission through pregnancy can be 1% or less when mothers are treatment compliant. *HIV and Pregnant Women, Infants, and Children*, CDC, https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html [https://perma.cc/VJ6S-M36A].

68. Jeff Sheehy, *HIV Active in Tissues of Patients Who Received Antiretroviral Treatment, Study Shows*, U.C.S.F. NEWS & MEDIA (Oct. 20, 2016), https://www.ucsf.edu/news/2016/10/404651/hiv-active-tissues-patients-who-received-antiretroviral-treatment-study-shows [https://perma.cc/QM4H-UCNM] (discussing findings that HIV remains in organ tissues even when undetectable in blood). It

studies have found that individuals with undetectable viral loads cannot transmit HIV to sexual partners.[69] In addition to preventing the spread of HIV, ARTs can vastly extend the lives of people living with HIV by delaying the onset of AIDS: people who are treatment-compliant have been found to have average lifespans similar to their HIV-negative counterparts.[70]

For HIV-negative individuals, the availability of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) significantly reduces the likelihood of acquiring HIV during unprotected sex.[71] If PrEP is taken at the same time daily, it can reduce the risk of acquiring HIV through unprotected sex by over 90% and through needle sharing by over 70%.[72] Taking PEP after an un- or under-protected encounter can also significantly reduce the chance of transmission.[73]

Major advances in HIV treatment and prevention have changed the perception of HIV from a fatal disease to a chronic one.[74] Yet neither access to medical care nor the stability necessary to comply with potentially complicated treatment regimens is universal. Individuals who cannot or do not receive regular medical care due to lack of insurance coverage, discrimination, or stigma do not benefit from these advances.[75] Although contemporary ARTs are often significantly less complicated than their predecessors and can consist of just a single pill, finding a successful medication or medications may require multiple doctor visits,

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is worth noting, however, that scientists discovered a way to kill these HIV reservoirs ex vivo in late 2018. Institut Pasteur, *AIDS—An Approach for Targeting HIV Reservoirs*, EUREKALERT! SCI. NEWS, (Dec. 20, 2018), https://www.pasteur.fr/en/press-area/press-documents/aids-approach-targeting-hiv-reservoirs [https://perma.cc/P2GP-YLBE].

69. CDC, EVIDENCE OF HIV TREATMENT AND VIRAL SUPPRESSION IN PREVENTING THE SEXUAL TRANSMISSION OF HIV (2018); Savas Abadsidis, *CDC Officially Admits People With HIV Who Are Undetectable Can't Transmit HIV*, HIV PLUS MAG., (Oct. 22, 2017), https://www.hivplusmag.com/undetectable/2017/9/27/breaking-cdc-officially-recognizes-undetectableuntransmittable-hiv-prevention [https://perma.cc/4KBL-YUL3]; Benjamin Ryan, *Undetectable Meant Zero HIV Transmissions After 89,000 Condomless Sex Acts*, POZ MAG. (July 22, 2018), https://www.poz.com/article/undetectable-meant-zero-hiv-transmissions-87000-condomless-sex-acts [https://perma.cc/JYC9-8Q9D].

70. Hasina Samji et al., *Closing the Gap: Increases in Life Expectancy Among Treated Individuals in the United States and Canada*, 8 PLOS ONE 1, 2 (2013).

71. *HIV/AIDS: PrEP*, CDC, https://www.cdc.gov/hiv/basics/prep.html [https://perma.cc/NCA7-9MDD].

72. *Id.*

73. *Id.*

74. James B. McArthur, Comment, *As the Tide Turns: The Changing HIV/AIDS Epidemic and the Criminalization of HIV Exposure*, 94 CORNELL L. REV. 707, 730 (2009); Aaron Neishlos & Michael D'Ambrosio, *The Other Pill: Expanding Access to Pre-Exposure Prophylaxis to Prevent HIV Transmission Among Minors in New York*, 44 FORDHAM URB. L.J. 725, 732 (2017).

75. Mark Bolin, Comment, *The Affordable Care Act and People Living with HIV/AIDS: A Roadmap to Better Health Outcomes*, 23 ANNALS HEALTH L. 28, 28–30 (2014).

lab work, and changes in prescriptions and medication routines that can be challenging for individuals whose finances, insurance coverage, schedules, or home life will not allow for this level of experimentation.[76]

The cost of ARTs can be prohibitive for people without sufficient insurance coverage.[77] PrEP and PEP can also be quite expensive and hard to access for individuals without health insurance; even for those who are insured, the lack of a generic version and the frequently required lab work can create financial burdens.[78]

Considerations of treatment and care cannot be made in a vacuum; in addition to cost, other factors impede a person living with HIV's ability to both access and comply with an often-complicated medical regimen. By undermining someone's safety and stability, domestic violence can create significant barriers to achieving and maintaining favorable health outcomes.

II. THE RELATIONSHIP BETWEEN DOMESTIC VIOLENCE AND HIV

It is no coincidence that individuals find themselves navigating both HIV and domestic violence. While neither HIV nor domestic violence causes the other, each poses a "series of risks" that increases the likelihood of the other.[79] Dynamics often found in abusive relationships can increase the risk of HIV, just as HIV diagnosis and treatment can lead to mistreatment by abusive partners.[80] Moreover, there is a significant overlap in the populations most at risk for experiencing both HIV and domestic violence.[81]

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76. *See* McArthur, *supra* note 74, at 726–31 (2009); Mario Brito, Comment, *On an Alternative to a Punitive State in Response to a Modern Understanding of the HIV/AIDS Epidemic in Florida*, 40 NOVA L. REV. 285, 304–05 (2016); James Richardson, Comment, *Criminal Transmission of HIV Laws: Are They Outdated or Are They Still Useful?*, 53 HOUS. L. REV. 1179, 1186–89 (2016).

77. Bolin, *supra* note 75, at 29–30; McArthur, *supra* note 74, at 728–29; Neishlos & D'Ambrosio, *supra* note 74, at 733.

78. Stephen Frost, *HIV Criminalization Laws: A Poor Public Policy Choice in the New Era of PrEP*, 6 WAKE FOREST J.L. & POL'Y 319, 329–30 (2016). In response to barriers preventing access to PrEP, California recently passed legislation to make the drug more easily accessible. *See, e.g.*, Karen Zraick & Sandra E. Garcia, *California Makes H.I.V.-Prevention Drugs Available Without a Prescription*, N.Y. TIMES (Oct. 9, 2019), https://www.nytimes.com/2019/10/09/us/california-hiv-drugs-prep.html [https://perma.cc/9379-6L8C] (describing California's law enabling pharmacies to distribute both pre- and post-exposure prophylaxis without a prescription).

79. Chappell, *supra* note 10, at 246.

80. *Id.* at 245–46.

81. *See infra* section II.B.

A. The Reciprocal Relationship Between Domestic Violence and HIV

Individuals with HIV, especially women, have a high prevalence of experiencing domestic violence throughout their lifetimes—much higher than the general population.[82] While indicative of the frequent co-occurrence of these two public health phenomena, this information fails to distinguish between violence prior to diagnosis, violence after the diagnosis, and violence that is directly related to the diagnosis. Analyzing how domestic violence and HIV can implicate and even catalyze the other provides more nuanced insight into the inextricable and influential relationship between domestic violence and HIV.

1. Domestic Violence as a Risk Factor for HIV

While domestic violence cannot be considered a cause of HIV, there are dynamics within many abusive relationships that can explain why domestic violence survivors face an increased risk of HIV.[83] The first of such factors is sexual abuse, which often occurs alongside physical and emotional abuse in violent relationships.[84] Exposure to HIV during a violent sexual assault increases the risk of transmission due to the creation of injuries through which HIV may enter the body.[85] HIV may also be transmitted through coerced sex, in which a survivor either does not want to have sex but does not feel safe saying no or does not want to have unprotected sex but cannot negotiate condom use.[86] Additionally, there are also accounts of abusive partners intentionally attempting to infect their intimate partners: for example, an HIV-infected woman reported that her partner confessed to infecting her deliberately, explaining to her, "I only did it because I love you so much."[87]

Survivors in abusive relationships may also have partners who have multiple sex partners at the same time.[88] Because having more sexual

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82. *See* CDC, INTERSECTION OF INTIMATE PARTNER VIOLENCE AND HIV IN WOMEN (2014), https://www.cdc.gov/violenceprevention/pdf/ipv/13_243567_Green_AAG-a.pdf [https://perma.cc/DML5-4MDN]; E.L. Machtinger et al., *Psychological Trauma and PTSD in HIV-Positive Women: A Meta-Analysis*, 16 AIDS & BEHAV. 2091, 2091 (2012).

83. Stoever, *supra* note 11, at 1177–78.

84. *Id.* (providing compelling data on female survivors in abusive relationships experiencing sexual violence).

85. Wang, *supra* note 57, at 318.

86. *Id.* at 319–21; Stoever, *supra* note 11, at 1178. For an analysis of studies exploring whether survivors are less or more likely to ask a partner to use a condom, see Moon, *supra* note 63, at 131–33.

87. Stoever, *supra* note 11, at 1179.

88. Linda J. Koenig & Jan Moore, *Women, Violence, and HIV: A Critical Evaluation with Implications for HIV Service*s, 4 MATERNAL & CHILD HEALTH J. 103, 106 (2000) (also noting that

partners creates a greater risk for HIV,[89] these dynamics can also result in a survivor being exposed to a sexual partner who is HIV-positive.

In addition to survivors being exposed to HIV directly via sex with an HIV-positive partner, survivors are also at risk of getting HIV when forced or coerced into high-risk acts like sex work or drug use.[90] Abusive partners often rely on economic abuse to exert control over survivors, creating financial barriers to leaving or asserting independence.[91] A survivor may also choose to engage in high-risk behavior like survival sex work as a means of acquiring independent income.[92] They may also sell and use injection drugs due to addiction related to their trauma-induced need to self-medicate or self-harm.[93] These decisions are also shaped by the abuse survivors are experiencing and cannot be viewed as independent from their relationships; nor should these decisions be viewed solely as functions of abusive relationships given that they constitute high-risk behavior for HIV infection.

2. HIV as a Risk Factor for Domestic Violence

Just as domestic violence and sexual assault can be risk factors for HIV infection, so too can having HIV create a vulnerability for an abusive partner to exploit. An initial diagnosis or notification of one's status can open the door to a host of physical and emotional forms of retaliation.[94]

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survivors themselves may be more likely than people who have not experienced domestic violence to have multiple sex partners).

89. *HIV/AIDS & STDS: STDs and HIV—CDC Fact Sheet*, CDC, https://www.cdc.gov/std/hiv/stdfact-std-hiv.htm [https://perma.cc/FUF9-USY5].

90. Stoever, *supra* note 11, at 1179–80.

91. *See, e.g.*, *Quick Guide: Economic and Financial Abuse*, THE NAT'L COAL. AGAINST DOMESTIC VIOLENCE (Apr. 12, 2017), https://ncadv.org/blog/posts/quick-guide-economic-and-financial-abuse [https://perma.cc/S5PE-NENL] (observing that "[u]p to 99% of domestic violence victims experience economic abuse during an abusive relationship, and finances are often cited as the biggest barrier to leaving an abusive relationship").

92. Andrea L. Dennis & Carol E. Jordan, *Encouraging Victims: Responding to a Recent Study of Battered Women Who Commit Crimes*, 15 NEV. L.J. 1, 17–18 (2014) (providing a nonexclusive list of rationales for why victims commit crimes: "(1) coercion, (2) agency, (3) coping, and (4) revenue-raising").

93. *Id.* at 17.

94. Chappell, *supra* note 10, at 241 ("Although estimates of the prevalence of post-disclosure violence vary, women's stories suggest that post-disclosure violence is experienced and perceived as a real threat to safety."); *id.* at 246 ("Other reports confirm that '[w]omen have been shot, physically and verbally abused, rejected, and abandoned after revealing their HIV status."); Stoever, *supra* note 11, at 1170 ("Women report a range of demeaning and violent responses to partner notification. One woman described her partner's reaction: 'One day, he kicked the TV . . . and knocked up all the furniture, and took soap and wrote "AIDS bitch" on the mirror.' Another woman explained the increased violence she experienced: 'He was abusive before I told him I was HIV-positive, and afterwards, well, the beatings got worse and . . . they happened more regularly. I say that because I remember him making the statement, "I should kill you since you are trying to kill me.'" (citations omitted)).

Although some studies have found low rates of physical violence after disclosure,[95] the types of post-disclosure violence that survivors have encountered are severe, including gun and knife violence, sexual assaults, physical attacks, and threats to kill.[96]

In addition to immediate post-disclosure violence, HIV-positive individuals also experience long-term violence that is directly related to their diagnoses.[97] Because HIV constitutes a new situs for an abusive partner to exert control, many people living with HIV experience abuse. This abuse extends beyond physical violence. Abusers may take direct advantage of a survivor's HIV status by destroying or stealing medication; interfering with medical visits; threatening to tell employers, immigration officials, and loved ones about the survivor's HIV-positive status; and coercing a survivor to stay in the violent relationship by claiming no one else will love them because of their serostatus.[98]

Not only does HIV-specific abuse inflict physical and emotional injuries on survivors, it also threatens their health outcomes. A survivor who is prevented from going to the doctor or complying with their treatment plan cannot successfully keep their HIV in check and will suffer adverse health consequences,[99] just as a survivor who does not disclose for fear of abuse may struggle to comply with the many appointments and medications in secret.[100]

HIV and domestic violence cannot be fully disentangled because someone who is experiencing one is automatically at a higher risk of experiencing the other. An examination of populations with high rates of HIV further highlights this relationship.

B. Intersecting Vulnerable Populations

HIV and domestic violence are often depicted as public health concerns that affect people of all races, sexual orientations, gender identities, ages, and socioeconomic statuses.[101] While it is true that these phenomena cross social strata, viewing them as having a universal impact would be short-

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95. *See, e.g.*, Andrea C. Gielen et al., *Women's Lives after an HIV-Positive Diagnosis: Disclosure and Violence*, 4 MATERNAL & CHILD HEALTH J. 111, 116 (2000) (finding that 4% of women experienced post-disclosure violence).

96. Chappell, *supra* note 10, at 245–46; Stoever, *supra* note 11, at 1170–71.

97. Sally Zierler et al., *Violence Victimization after HIV Infection in a U.S. Probability Sample of Adult Patients in Primary Care*, 90 AM. J. PUB. HEALTH, 208, 211 (2000).

98. Stoever, *supra* note 11, at 1171–74.

99. *Id.* at 1174.

100. Chappell, *supra* note 10, at 247; Wang, *supra* note 57, at 324.

101. *Who Is at Risk for HIV?*, HIV.GOV, https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/who-is-at-risk-for-hiv [https://perma.cc/M3MG-T2JD].

sighted. Both HIV and domestic violence have particularly pernicious impacts on marginalized communities and vulnerable individuals: from the early days of HIV panic until the present, domestic violence has been a notable characteristic in the communities hardest hit by HIV.[102]

1. Historically Stigmatized Communities

Unlike domestic violence, which gained mainstream attention through claims of its universal impact,[103] HIV was initially painted as a disease only infecting marginalized individuals, specifically gay men, sex workers, and injection drug users.[104] While these overlapping populations were no doubt hugely impacted by the epidemic, they were also hardest hit by the stigma surrounding HIV. It should not come as a surprise in light of the above conversation that these groups were and are vulnerable not just to HIV but also to domestic violence.

a. Men Who Have Sex with Men

Thanks to the popularity of a salacious, highly dramatized account of the AIDS epidemic,[105] gay and bisexual men—or men who have sex with men, regardless of sexual orientation—have long been blamed for the appearance and spread of HIV in the United States.[106] While this origin story has been largely debunked,[107] men who have sex with men are indeed at high risk of infection. Receiving anal sex from an HIV-positive partner is the riskiest type of sex.[108] According to the CDC, in 2016, 70%

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102. *See, e.g.*, Fan, *supra* note 7, at 560–62 (detailing how gay men and black and Hispanic individuals are most likely to be impacted by HIV); Leigh Goodmark, *Should Domestic Violence Be Decriminalized?*, 40 HARV. J. L. & GENDER 53, 58 (2017); Tamara L. Kuennen, *Analyzing the Impact of Coercion on Domestic Violence Victims: How Much Is Too Much?*, 22 BERKELEY J. GENDER L. & JUST. 2, 18 (2007).

103. LISA A. GOODMAN & DEBORAH EPSTEIN, LISTENING TO BATTERED WOMEN: A SURVIVOR-CENTERED APPROACH TO ADVOCACY, MENTAL HEALTH, AND JUSTICE 39 (2008); Joan Meier, *Domestic Violence, Character, and Social Change in the Welfare Reform Debate*, 19 L. & POL'Y 205, 225 (1997).

104. Brigid Bone, *Whose Responsibility Is It to PrEP for Safe Sex? Archaic HIV Criminalization and Modern Medicine*, 53 WASH. U. J.L. & POL'Y 319, 321 (2017).

105. *See generally* RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC (1987) (presenting a timeline of AIDS in the United States and exploring the role of Gaetan Dugas, known in the book as "patient zero," in the disease's spread).

106. Perone, *supra* note 5, at 369 (noting that "Shilts' myth of 'Patient Zero' left a lasting impression and resulted in increased fears of the promiscuous sociopath intending to infect numerous unsuspecting victims").

107. Bethy Squires, *How One Young, Gay Man Was Wrongfully Blamed for Bringing AIDS to the U.S.*, VICE (Dec. 1, 2016), https://www.vice.com/en_us/article/vb4mz9/how-one-young-gay-man-was-wrongfully-blamed-for-bringing-aids-to-the-us [https://perma.cc/GC54-NK4X].

108. *HIV/AIDS: HIV Transmission*, *supra* note 53.

of new HIV infections in adults and adolescents of any sex involved male-to-male sexual activities.[109]

Just as the risk of HIV via receptive anal sex and the total number of HIV-positive individuals who were infected with HIV via male-to-male sex are both notably high, so too is the risk and prevalence of domestic violence in the gay community. Although data regarding violence in the gay and bisexual male communities is limited due to the relatively small size of studies focused on these populations,[110] various estimates have placed the rate of domestic violence among same-sex couples at similar to, or even greater than, rates among heterosexual couples.[111] Yet even now, compared to their heterosexual counterparts, same-sex survivors of domestic violence have fewer resources available to them and face greater stigma when coming forward to seek help. For example, there are fewer domestic violence shelters that accept gay men or trans women, and queer, trans, and gender-nonconforming individuals experience high rates of police violence and discrimination when seeking help.[112] These problems are compounded for same-sex survivors who are also HIV-positive.[113]

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109. 28 CDC, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION IN THE UNITED STATES AND DEPENDENT AREAS 2016, at 6 (2016) [hereinafter 2016 CDC SURVEILLANCE REPORT] (discussing how it is worth noting that some of these individuals engaged in both male-to-male intercourse *and* injection drugs and the actual source of transmission is unknown). Additionally, at the end of 2015, the CDC reported that, of the 738,832 men living with HIV, 71% of infections were from male-to-male sexual contact and another 7% were individuals who had engaged in both male-to-male sexual activities and injection drug use so the behavior resulting in transmission is unknown. *Id.* at 8. Similarly, at the end of 2015, 66% of men living with AIDS had gotten HIV through male-to-male sexual activity and 8% had been infected by either sex with men or injection drug use. *Id.* at 9.

110. *See, e.g.*, Gregory S. Merrill, *Understanding Domestic Violence among Gay and Bisexual Men*, *in* ISSUES IN INTIMATE VIOLENCE 129, 129–30 (Raquel Kennedy Bergen ed., 1998) (discussing four studies in the late 1980s and early 1990s that looked at gay male relationships included sample sizes ranging from 33 to 393 participants).

111. Caroline Morin, Comment, *Re-Traumatized: How Gendered Laws Exacerbate the Harm for Same-Sex Victims of Intimate Partner Violence*, 40 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 477, 478 (2014); Tara R. Pfeifer, Comment, *Out of the Shadows: The Positive Impact of Lawrence v. Texas on Victims of Same-Sex Domestic Violence*, 109 PENN ST. L. REV. 1251, 1253 (2005); Nicolas A. Suarez et al., *Dyadic Reporting of Intimate Partner Violence Among Male Couples in Three U.S. Cities*, 12 AM. J. MEN'S HEALTH 1039, 1042–43 (2018).

112.Satoko Harada, *Additional Barriers to Breaking the Silence: Issues to Consider When Representing a Victim of Same-Sex Domestic Violence*¸ 41 U. BALT. L.F. 150, 157–58 (2011); Morin, *supra* note 111, at 485; Christina Samons, Comment, *Same-Sex Domestic Violence: The Need for Affirmative Legal Protections at All Levels of Government,* 22 S. CAL. REV. L. & SOC. JUST. 417, 420 (2013).

113. Harada, *supra* note 112, at 158.

b. Sex Workers

Globally, sex workers remain one of the highest risk groups for acquiring HIV.[114] Domestically, while the CDC has confirmed that the risk of HIV is high among sex workers, it has also acknowledged that very few population-based studies have been done on rates of HIV among sex workers.[115] Sex workers, especially individuals being trafficked,[116] are also at an increased risk of HIV[117] given that their income is often dependent upon their clients' proclivities rather than their own preventative preferences.[118] If a sex worker refuses a client's request for high-risk sex or condom-less sex, they may experience violence from the customer or may not get paid and, as a result, risk violence from their manager or pimp.[119] Survivors whose work, safety, and livelihood is controlled by their intimate partners may experience not only being coerced or forced into sex work but also violence related to that work: sex workers have been found to experience high rates of domestic violence in addition to violence they experience while working.[120] One study of incarcerated women in Chicago found that the majority of women who were regularly involved in sex work were also survivors of domestic violence: within that group that had experienced domestic violence, 82% were physically attacked, 50% were sexually assaulted, 63% were threatened with a weapon, and 51% were attacked with a weapon.[121]

The private violence that sex workers experience is often compounded by violence from law enforcement.[122] As a result of this punitive climate, survival sex workers are more likely to acquiesce to unsafe demands of clients than risk violence and potential criminal sanctions by seeking help

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114. UNAIDS, MILES TO GO: CLOSING GAPS, BREAKING BARRIERS, RIGHTING INJUSTICES 47 (2018), http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf [https://perma.cc/W48H-FSKC].

115. *HIV/AIDS: HIV Risks Among Persons Who Exchange Sex for Money or Nonmonetary Items*, CDC, https://www.cdc.gov/hiv/group/sexworkers.html [https://perma.cc/9TJ5-GXTS].

116. Dorchen A. Leidholdt, *Human Trafficking and Domestic Violence: A Primer for Judges*, JUDGES' J. 16, 17–18 (2013).

117. Sienna Baskin, Aziza Ahmed & Anna Forbes, *Criminal Laws on Sex Work and HIV Transmission: Mapping the Laws, Considering the Consequences*, 93 DENV. L. REV. 355, 361 (2016).

118. Rudolf V. Van Puymbroeck, *Beyond Sex: Legal Reform for HIV/AIDS and Poverty Reaction,* 15 GEO. J. ON POVERTY L. & POL'Y 781, 782, 799 (2008).

119. *See* Kate Shannon & Joanne Csete, *Violence, Condom Negotiation, and HIV/STI Risk Among Sex Workers*, 304 J. AM. MED. ASS'N 573, 573–74 (2010).

120. Samir Goswami, *Unlocking Options for Women: A Survey of Women at Cook County Jail*, 2 U. MD. J.L. RACE, RELIGION, GENDER & CLASS 89, 106 (2002).

121. *Id.*

122. Anannya Bhattacharjee, *Whose Safety? Women of Color and the Violence of Law Enforcement* 48 (Am. Friends Serv. Committee, Working Paper, 2001), https://www.afsc.org/sites/default/files/documents/whose%20safety.pdf [https://perma.cc/KH92-YA3J].

form law enforcement. For individuals whose involvement in sex work is coerced by abusive partners or pimps,[123] failure to get paid may also result in violence after the client interaction as well.[124] Survival sex workers are thus facing a catch-22 when clients insist on dangerous and unprotected sex acts. This scenario becomes even more complicated for sex workers who are HIV-positive and potentially expose themselves to criminal sanctions and their clients to HIV.

c. Injection Drug Users

Injection drug users face a high risk of HIV because sharing needles and injection paraphernalia with someone who is HIV-positive leads to comparatively high rates of HIV transmission.[125] Moreover, HIV can survive in a used needle for well over a month, so the risk remains high for longer than one might anticipate.[126] Because needle exchange programs have only recently begun gaining momentum outside of large cities,[127] the temptation to reuse needles rather than purchase them can be high for injection drug users, especially those who are addicted.

Substance abuse, including injection drug use, is not uncommon among people experiencing domestic violence.[128] This could be due to abusive partners enabling or even exploiting the addiction, or because some survivors resort to self-medicating to cope with the abuse and trauma they experience.[129] Substance use also increases the possibility of engaging in

123. Donna Coker, *Crime Control and Feminist Law Reform in Domestic Violence Law: A Critical Review*, 4 BUFF. CRIM. L. REV. 801, 837–38 (2001).

124. Jody Raphael, *Battering Through the Lens of Class*, 11 J. GENDER, SOC. POL'Y, & L. 367, 372 (2003).

125. *HIV/AIDS: HIV Risk Behaviors*, CDC, https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html [https://perma.cc/R4FW-CK7Q].

126. *Injection Drug Use and HIV Risk*, CDC, https://www.cdc.gov/hiv/risk/idu.html [https://perma.cc/7VUV-EH9G].

127. Arian Campo-Flores & Jeanne Whalen, *Needle Exchanges Gain Currency*, WALL STREET J., March 29, 2015, https://www.wsj.com/articles/needle-exchanges-gain-currency-amid-hiv-hepatitis-infections-in-drug-users-1427673026 [https://perma.cc/Z8YR-9SWD].

128. Kristina Carbone-López et al., *Patterns of Intimate Partner Violence and Their Associations with Physical Health, Psychological Distress, and Substance Use*, 121 PUB. HEALTH. REP. 382, 390 (2006). For a discussion of domestic violence and opioid use specifically, which is more likely to involve needle drugs, see Gwendolyn Packard et. al., *Thinking about the Opioid Epidemic in the Context of Trauma and Domestic Violence: Framing the Issues*, NAT'L CTR. ON DOMESTIC VIOLENCE, TRAUMA, & MENTAL HEALTH (Jan. 25, 2016), http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/2018-trauma-opioids-and-domestic-violence/ [https://perma.cc/P3HV-44Y5] (displaying website links to webinar video).

129. CAROLE WARSHAW ET AL., MENTAL HEALTH AND SUBSTANCE USE COERCION SURVEYS: REPORT FROM THE NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH AND THE NATIONAL DOMESTIC VIOLENCE HOTLINE 17 (2014).

high-risk sexual acts or exchanging sex for money or drugs,[130] a dynamic which may already be present in abusive relationships.

While all of these groups were singled out early into the AIDS epidemic and unfairly blamed and stigmatized for its spread, they remain at risk of experiencing both HIV and domestic violence. Moreover, it is critical to note that these groups are by no means mutually exclusive and, in fact, often overlap. Men who have sex with men may engage in sex work and use needle drugs, just as female sex workers may also have unprotected anal intercourse and inject drugs. There are other, less stigmatized but equally porous communities that are also at risk of HIV infection. As these intersections mount, so too does the risk of exposure to HIV and to violence.

2. Intersecting At-Risk Populations

Over the past three decades, conceptions of risk have shifted away from blaming stigmatized communities for the spread of HIV toward the recognition that members of socially and economically marginalized groups may be more at risk for new infections.[131] Jonathan Mann, founder of the World Health Organization's Global Programme for AIDS has observed that "HIV/AIDS may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability, and premature death is linked to the status of respect for human rights and dignity."[132] This is certainly true in the United States, where race, sex, and class all factor into who is at risk of becoming HIV-positive. Unsurprisingly, members of these marginalized groups may also struggle with domestic violence, especially when it comes to finding appropriate services offering viable solutions.

a. Racial and Ethnic Minorities

Black men and women have the highest risk for HIV among all ethnic groups in the U.S.[133] Although the last decade has seen decreases in HIV

130. *Injection Drug Use*, *supra* note 126.

131. Ahmed, *supra* note 33, at 627 ("Importantly, HIV continues to disproportionately impact socially and economically marginalized communities."); Shannon Gilreath, Ex*amining Critical Race Theory: Outsider Jurisprudence and HIV/AIDS—A Perspective on Desire and Power*, 33 L. & INEQ. 371, 372 (2015) ("We know that HIV is a problem of disproportionate consequence to poor communities and communities of color.").

132. Jonathan M. Mann et al., *Health and Human Rights*, *in* HEALTH AND HUMAN RIGHTS IN A CHANGING WORLD 16, 25 (Michael Grodin et al., eds. 2013).

133. *HIV among African Americans*, CDC, https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html [https://perma.cc/RWF2-XG4G]. In 2017, 60% of African Americans diagnosed were gay or bisexual men, 26% were heterosexual women, and 14% were heterosexual men. *Id.*

and AIDS diagnoses among black individuals,[134] the risk posed to people within this group—especially heterosexual women and men who have sex with men—remains significant.[135] Moreover, HIV death rates are highest among black people,[136] who have traditionally struggled with a lack of access to health care.[137] Latinx people are also impacted by HIV: they represent a quarter of new infections despite making up one-fifth of the U.S. population: of Latinx individuals with new HIV infections, almost 90% are men and 88% of those men are gay or bisexual.[138]

While domestic violence occurs across all racial and ethnic groups, rates of domestic violence against women of color have been found to be especially high.[139] Moreover, members of communities of color can face additional challenges when it comes to accessing readily available and culturally appropriate supportive services.[140] As domestic violence shelters and advocacy groups have increasingly become staffed by young white women, nonwhite survivors and survivors from other cultures and communities have struggled to find services tailored to their specific needs.[141] Additionally, survivors of color may feel compelled to refrain from seeking intervention by the police or the criminal legal system, fearing police violence against people of color, immigration consequences, or the long-lasting effects of mass incarceration on nonwhite communities.[142]

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134. *Id.*

135. *Id.*

136. THE HENRY J. KAISER FAMILY FOUND., BLACK AMERICANS AND HIV/AIDS: THE BASICS 2 (2019).

137. Susan L. Waysdorf, *Families in the AIDS Crisis: Access, Equality, Empowerment, and the Role of Kinship Caregivers*, 3 TEX. J. WOMEN & L. 145, 169 (1994).

138. *HIV among Latinos*, CDC, https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-hiv-latinos-508.pdf [https://perma.cc/2HY3-UMMR].

139. Carimeh Townes, *How Women of Color Are Disproportionately Impacted By Domestic Violence*, THINK PROGRESS (Oct. 22, 2013), https://thinkprogress.org/how-women-of-color-are-disproportionately-impacted-by-domestic-violence-6674e93a50c5/ [https://perma.cc/CAQ2-MJWP] (summarizing multiple studies: "Shocking statistics from the Department of Justice show that almost 50 percent of Native American females 'have been raped, beaten, or stalked by an intimate partner.' Moreover, 30 percent African American women have been subjected to domestic abuse. The National Institute of Justice also found that Hispanic women 'are more likely than non-Hispanic women to be raped by a current or former intimate partner.'").

140. WOMEN OF COLOR NETWORK, NATIONAL RESOURCE CENTER ON DOMESTIC VIOLENCE, FACTS & STATS: DOMESTIC VIOLENCE IN COMMUNITIES OF COLOR 1 (2006).

141. GOODMAN & EPSTEIN, *supra* note 103, at 46–47.

142. *Id.* at 77; *see also* BHATTACHARJEE, *supra* note 122, at 20; BETH RICHIE, COMPELLED TO CRIME: THE GENDER ENTRAPMENT OF BATTERED BLACK WOMEN 96 (1996).

b. Women

The relationship between biological sex and HIV has posed problems for women since its inception: since HIV was seen as a disease primarily affecting gay men, early scientific studies were slow to include women or recognize how HIV impacted women differently from men.[143] The CDC did not include women-specific manifestations of HIV in its definition of the disease until 1991.[144] As such, women were dying of AIDS before medical science even recognized that they had the same virus.[145] Women have thus had to wait for science to catch up to their experiences with HIV despite the fact that women are twice as likely to get HIV from heterosexual sex with an HIV-positive partner than men are[146] for a host of physiological and biological reasons.[147]

Like all the communities being discussed, women are not a monolithic group and there are disparities in terms of diagnosis and treatment among women. Black women are disproportionately impacted by HIV compared to other racial and ethnic groups, especially white women.[148] HIV-positive women, especially women of color, are also even more likely than their male counterparts to struggle with poverty.[149] Black women are also "less likely to receive treatment for HIV and more likely to die early because of it."[150] Additionally, trans women—especially black and Latinx trans women—experience high rates of HIV, yet, according to the CDC, "face obstacles that make it harder to access HIV services—such as stigma and discrimination, inadequate employment or housing, and limited access to welcoming, supportive health care."[151] Finally, it must be underscored that from a public perception perspective, white women have traditionally been seen as victims of sexually transmitted diseases like HIV whereas women of color are more likely to be blamed for the disease.[152]

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143. Mary A. Bobinski, *Women and HIV: A Gender-Based Analysis of a Disease and its Legal Regulation*, 3 TEX. J. WOMEN & L. 7, 15–16 (1994).

144. Stoever, *supra* note 11, at 1164.

145. *Id.*

146. *HIV Risk Behaviors*, *supra* note 125.

147. Moon, *supra* note 63, at 130–31; Seelinger, *supra* note 63, at 350; Wang, *supra* note 57, at 317–18.

148. *HIV among Women*, CDC, https://www.cdc.gov/hiv/group/gender/women/index.html [https://perma.cc/T953-598W] (finding that in 2017, 59% of new female diagnoses were African American women, 20% were white, and 16% were Latina).

149. Waysdorf, *supra* note 137, at 168–69.

150. Fan, *supra* note 7, at 562.

151. *Transgender HIV Care*, CDC, https://www.cdc.gov/hiv/clinicians/transforming-health/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhiv%2Fclinicians%2Ftransforming-health%2Ftransgender-patients%2Fhiv.html [https://perma.cc/S4YZ-3TEJ].

152. Bobinski, *supra* note 143, at 34.

As with HIV, women's susceptibility to domestic violence is significant yet often glossed over. Despite claims that men and women experience domestic violence in similar fashions and at similar rates, women as a whole remain significantly more likely to experience severe violence and coercive control from men than vice versa.[153] Lesbian and bisexual women have been found to experience more domestic violence than heterosexual women or men of any sexual orientation, with bisexual women experiencing more abuse from an intimate partner than individuals of any other gender or sexual identity.[154] Similar to the HIV context, women of color are also less likely to be recognized or supported as victims of domestic violence than their white counterparts, despite experiencing at least as much violence.[155]

c. Economically Marginalized Individuals

Income also factors into HIV vulnerability and risk. A CDC study of urban poverty found that HIV rates and income were inversely proportional, with lower socioeconomic status resulting in high HIV prevalence.[156] As with domestic violence, poverty can both increase one's risk of HIV while also undermining one's ability to treat it effectively: "[P]overty is itself a driver of HIV and AIDS: under-nutrition, unsanitary conditions, parasite infections, inadequate primary health care, illiteracy, economic insecurity and a precarious ability to cope with the financial repercussions of illness and death all increase poor people's susceptibility to HIV and AIDS."[157] Low-income individuals with AIDS have also been found to have higher rates of mortality and AIDS-related illnesses than wealthier people living with HIV or AIDS.[158] Lack of access to adequate

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153. *See* GOODMAN & EPSTEIN, *supra* note 103, at 8–12. *See generally* LEIGH GOODMARK, A TROUBLED MARRIAGE: DOMESTIC VIOLENCE AND THE LEGAL SYSTEM 38–40 (2012) (arguing that scholars who find that men and women experience similar levels of domestic violence are measuring separate typologies of violence and thus undercounting domestic violence directed at women).

154. CDC, DIV. OF VIOLENCE PREVENTION, THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY: 2010 FINDINGS ON VICTIMIZATION BY SEXUAL ORIENTATION 2 (2013).

155. Courtney Cross, *Reentering Survivors: Invisible at the Intersection of the Criminal Legal System and the Domestic Violence Movement*, 31 BERKELEY J. GENDER L. & JUST. 60, 103–04 (2016).

156. Paul Denning & Elizabeth DiNenno, *Communities in Crisis: Is There a Generalized HIV Epidemic in Impoverished Urban Areas of the United States?*, CDC, https://www.cdc.gov/hiv/group/poverty.html [https://perma.cc/54HX-VAE4].

157. Rudolf V. Van Puymbroeck, *Beyond Sex: Legal Reform for HIV/AIDS and Poverty Reduction*, 15 GEO. J. ON POVERTY L. & POL'Y 781, 782 (2008). While this article discusses poverty in sub-Saharan Africa, its takeaways are applicable more broadly: "While HIV/AIDS impoverishes, poverty begets HIV/AIDS. Poverty and poor health conditions go hand in hand. . . , There is a strong correlation between income poverty and under-nutrition . . . ." *Id.* at 787.

158. *See* Brook Kelly, *The Modern HIV/AIDS Epidemic and Human Rights in the United States: A Lens into Lingering Gender, Race, and Health Disparities and Cutting Edge Approaches to Justice*, 41 U. BALT. L. REV. 355, 355–56 (2012).

medical care and treatment often comes hand in hand with poverty.[159] Additionally, accessing medical services in poor communities may also be accompanied by heightened surveillance and state intervention.[160] As such, poor individuals may face negative outcomes whether they do or do not access treatment.

Domestic violence and poverty share a similarly reciprocal relationship in which each makes it harder to escape from the other. Individuals in lower socioeconomic classes have been found to experience higher rates of domestic violence,[161] and experiencing violence has a demonstrably detrimental impact on survivors' attempts to gain economic mobility and success.[162] A low-income survivor has fewer options for achieving safety, as they may not be able to afford starting over and living separately from an abusive partner;[163] yet domestic violence social services often impose hard-to-meet demands on already struggling low-income survivors.[164]

Race, sex, and income do not exist separately from one another. Especially in the context of HIV, their cumulative impact on individuals possessing intersecting identities is significant. As early as 1994, it was apparent to Professor Susan Waysdorf that HIV/AIDS posed an existential threat to the most vulnerable members of society:

> [T]he stark reality is this—the future of the next generation of those whose lives are already deeply affected by the racism, sexism, poverty, and violence of this society is at stake in this epidemic. The already shredded social fabric of our society is ripping further apart, as AIDS tightens its grip on those who are the most defenseless and who have the least resources to fight the epidemic—the African-American and Hispanic communities, poor people, women, and their children.[165]

Inherent in this assessment is the recognition that people living with HIV are rarely affected by only one of the aforementioned risk factors. Many

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159. NAT'L CTR. FOR HEALTH STATISTICS, CDC, HEALTH, UNITED STATES, 2016: WITH CHARTBOOK ON LONG-TERM TRENDS IN HEALTH 251–53 (2016) (depicting, on table 63, delay or nonreceipt of needed medical care, nonreceipt of needed prescription drugs, or nonreceipt of needed dental care during the past twelve months due to cost).

160. Fan, *supra* note 7 at 562.

161. Susan L. Staggs & Stephanie Riger, *Effects of Intimate Partner Violence on Low-Income Women's Health and Employment*, 36 AM. J. COMMUNITY PSYCHOL. 133, 134–35 (2005).

162. *See, e.g.*, Jody Raphael, *Battering Through the Lens of Class*, 11 AM. U. J. GENDER SOC. POL'Y & L. 367, 367–70 (2003) (reviewing and providing examples of the reciprocal interactions between domestic violence and poverty).

163. *Id.* at 372.

164. *Id.* at 374; GOODMAN & EPSTEIN, *supra* note 103, at 46-47.

165. Waysdorf, *supra* note 137, at 171.

are instead "intersectionally marginalized"[166] and are exposed to higher risk of HIV and increased negative health outcomes by belonging to multiple vulnerable and underserved groups. This same phenomenon impacts survivors of domestic violence whose intersectional marginalization exposes them to higher risk of abuse and undermines their ability to access services and resources to navigate their abusive relationships. Just as members of marginalized communities have fewer options for adequate and prolonged treatment, so too do many marginalized survivors face barriers in accessing culturally appropriate social and legal domestic violence services.[167]

Intersectionally marginalized individuals with HIV and intersectionally marginalized survivors experience similar obstacles to health, safety, and recognition—these challenges are only compounded for survivors living with HIV. Understanding the relationship between domestic violence and HIV underscores the fact that neither can be viewed nor treated as wholly distinct from the other. Although the public health and medical fields have recognized this connection since the 1990s,[168] state-level policies regarding HIV have yet to effectively incorporate these insights. Public health or legal responses that ignore this relationship are bound to be shortsighted, ineffective, and—given the impact both are likely to have on physical and mental health—dangerous.

III. WHEN LAW AND HEALTH COLLIDE: THE HIV LEGAL REGIME

Examining the origins of the HIV legal regime underscores that the laws governing the lives of people living with HIV were passed in response to widespread fear and stigma and are not grounded in principles of public health or science. An in-depth analysis of partner notification and criminalization laws reveals that they may not only be ineffective at combatting the spread of HIV, but may also expose people living with HIV to unjustifiable threats to their health, safety, and liberty.[169]

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166. Fan, *supra* note 7, at 560.

167. Adele M. Morrison, *Changing the Domestic Violence (Dis)Course: Moving from White Victim to Multi-Cultural Survivor*, 39 U.C. DAVIS L. REV. 1061, 1082 (2006); *see also* Leigh Goodmark, *When is a Battered Woman Not a Battered Woman? When She Fights Back*, 20 YALE J.L. & FEMINISM 75, 96–97, 110–11 (2008).

168. Stoever, *supra* note 11, at 1162.

169. Aziza Ahmed & Beri Hull, *Sex and HIV Disclosure*, 38 HUM. RTS. 11, 13 (2011) ("The legal regime currently surrounding disclosure of HIV status is not able to consider the nuance of each circumstance in the manner necessary, and, in fact, the consequences of these laws may be undermining larger public health goals.").

A. The Rise of the HIV Legal Regime

The HIV legal regime in the United States has sprung up piecemeal following the discovery of AIDS in the early 1980s.[170] The vast majority of these laws exist at the state level, though federal law does make it a felony to donate or sell blood, bodily fluids, or tissue by a person who has received a positive HIV diagnosis.[171] At the state level, the HIV legal regime primarily takes on two forms: first, partner notification laws that require specific individuals get notified after a patient's HIV diagnosis[172] and, second, criminal transmission laws that make it illegal for people living with HIV to engage in certain behaviors without first disclosing their serostatus.[173]

Despite the recognition of AIDS as a deadly epidemic in the early 1980s, President Ronald Reagan did not mention AIDS publicly until 1985.[174] In 1987, with panic around HIV continuing to rise, President Reagan established the Presidential Commission on the Human Immunodeficiency Virus Epidemic via executive order.[175] One year later, the Commission issued a report that strongly opposed discrimination against people living with HIV while also advocating for increased partner

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170. The term "HIV legal regime" appears to have only been used once before, in a 2014 review of sexual orientation and gender identity legal developments. *Developments in the Law—Sexual Orientation & Gender Identity*, *Animus and Sexual Regulation*, 127 HARV. L. REV. 1680, 1785 (2014) ("The burdens and disadvantages imposed by the HIV legal regime may be so extreme, or the fit between aims and effects so poor, that neutral governmental interests cannot adequately explain the statutes' full scope."). When I use the term, I intend it to refer to the laws and regulations that have sprung up at the state and federal level in the United States since the early 1980s.

171. 18 U.S.C. § 1122(a) (2012).

172. In many states, health care professionals have discretion regarding whether to notify individuals about potentially having been exposed to HIV. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-664(I) (2019) ("If a person in possession of HIV-related information reasonably believes that an identifiable third party is at risk of HIV infection, that person may report that risk to the department."). On opposite ends of the spectrum, however, are New York, in which reporting must nearly always take place, N.Y. COMP. CODES R. & REGS. tit. 10, § 63.4(b) (2017), and Massachusetts, where medical professionals are prohibited from sharing this information without a patient's written consent, MASS. GEN. LAWS ch. 111, § 70F (2012).

173. For example, in Arkansas, it is illegal for a person who knows they have HIV/AIDS to share injection drug paraphernalia or engage in sexual penetration without first revealing their serostatus to a partner. ARK. CODE ANN. § 5-14-123(b) (2019). Like Arkansas, many states enumerate prohibited conduct Mississippi, on the other hand, makes it unlawful to "knowingly expose another person" to HIV or Hepatitis B and C without including what specific activities are criminalized. MISS. CODE ANN. § 97-27-14(1) (2019).

174. Phillip Boffey, *Reagan Defends Financing for AIDS*, N.Y. TIMES (Sept. 18, 1985), https://www.nytimes.com/1985/09/18/us/reagan-defends-financing-for-aids.html [https://perma.cc/NJT3-TB36].

175. Exec. Order No. 12,601, 52 Fed. Reg. 24, 129 (June 24, 1987).

notification[176] and HIV-specific criminal laws prohibiting knowing transmission of HIV.[177] The report went so far as to state that general criminal statutes would not sufficiently deter HIV and that states would need to explore HIV-specific criminal legislation.[178] Rather than focusing on structural risk factors and systemic reform, the report emphasized personal responsibility.[179]

Three years later, President George H. W. Bush signed the Ryan White Care Comprehensive AIDS Resources Emergency (CARE) Act, which, among other things, provided grant funding only to those states that required the creation of partner notification programs[180] and certified that their criminal laws were "adequate to prosecute any HIV infected individual" who knowingly and intentionally exposes a sexual partner to HIV.[181] Many states responded by quickly passing laws that made them eligible for the federal funding.[182] Law professor and AIDS scholar Aziza Ahmed aptly notes that this emphasis on criminalization to fight HIV was part of a "broader carceral shift" at the time in which criminal law was increasingly being seen as tools for social control.[183]

A few years later, more states created or updated their criminal exposure laws after the high-profile Nushawn Williams case in the late 1990s reignited a familiar panic over sexual deviants (this time perceived as straight black men as opposed to gay men) spreading HIV.[184] In the Williams case, a black man from New York City was alleged to have exposed dozens of women to HIV after being told that he was HIV-positive.[185] Even after serving over twelve years in prison, Williams was

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176. PRESIDENTIAL COMM'N ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC, THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC REPORT at 75–77 (June 24, 1988).

177. *Id.* at 130–31.

178. *Id.* at 130.

179. *Id.* at 81, 83, 90, 91, and 95. This may be the result of contributions from Commission Member Richard DeVos, who quickly expressed concern over members of the LGBTQ community "captur[ing] the agenda" of the Commission. Associated Press, *Head of AIDS Commission Pledges Quick Reorganization of the Panel*, N.Y. TIMES (Oct. 11, 1987), https://www.nytimes.com/1987/10/11/us/head-of-aids-commission-pledges-quick-reorganization-of-panel.html [https://perma.cc/PX4Q-GECH].

180. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, § 2646(b), 104 Stat. 602, 602–03 (1990) [hereinafter CARE Act].

181. CARE Act, *supra* note 180, § 2647(a), 104 Stat. 603, 603.

182. Sarah J. Newman, *Prevention, Not Prejudice: The Role of Federal Guidelines in HIV-Criminalization Reform*, 107 NW. U. L. REV. 1403, 1416–17 (2013).

183. Ahmed, *supra* note 33, at 629–32.

184. *See, e.g.*, Kim S. Buchanan, *When is HIV a Crime? Sexuality, Gender and Consent*, 99 MINN. L. REV. 1231, 1297–98 (2015); *see also* Minahan, *supra* note 32, at 98 (2009) (discussing the panic that arose when a black man was accused of spreading HIV to white women through sexual contact).

185. *See* Joe Sexton, *After a Childhood of Violence, A One-Man HIV Epidemic*, N.Y. TIMES, (Oct. 30, 1997), https://www.nytimes.com/1997/10/30/nyregion/after-childhood-of-violence-a-one-man-

viewed as such a threat that he was civilly committed in 2010 and has remained committed under a New York sexual offender statute.[186] In both the first and the second waves of HIV criminalization legislation, states acted quickly in response to public outcry and demonstrated their commitment to law and order rather than health and medicine. [187]

Although Congress did repeal the CARE Act's prosecution mandate in 2000, few states have opted to revisit their HIV legal regimes,[188] despite calls from President Obama to scale back the HIV legal regime in favor of public health measures.[189] Thus far, President Trump appears to have rejected his predecessor's commitment to supporting people living with HIV and proactively combating the disease.[190]

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hiv-epidemic.html [https://perma.cc/Y53T-THF2]. For another example of mainstream media using hyperbolic medical language to describe Williams's actions, see Pam Lambert, *One Man Plague*, PEOPLE (Nov. 17, 1997), https://people.com/archive/one-man-plague-vol-48-no-20/ [https://perma.cc/LCF6-WS3R]. For more nuanced reporting on Williams during his time in the media, see JoAnn Wypijewski, *The Secret Sharer: Sex, Race, & Denial in an American Small Town*, HARPER'S MAG., July 1998, at 35.

186. Melinda Miller, *Nushawn Williams Loses Bid to be Released from Civil Confinement*, BUFFALO NEWS (May 7, 2016), https://buffalonews.com/2016/05/07/nushawn-williams-loses-bid-to-be-released-from-civil-confinement/ [https://perma.cc/PN6Z-PML3].

187. *See* Buchanan, *supra* note 184, at 1299–1300 (discussing how "criminalization of HIV has often followed intensive media coverage of allegations of heterosexual transmission" and providing examples of state legislation being tied to highly publicized stories of HIV exposure).

188. Newman, *supra* note 182, at 1416. By contrast, Iowa is one of only a few states to have significantly amended its HIV exposure laws in recent years. Brian Cox, *Turning the Tide: The Future of HIV Criminalization After* Rhoades v. State *and Legislative Reform in Iowa*, 11 NW. J.L. & SOC. POL'Y 28, 28–30 (2016).

189. *See, e.g.*, WHITE HOUSE OFFICE OF NAT'L AIDS POLICY, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES 37 (2010), https://obamawhitehouse.archives.gov/sites/default/files/uploads/NHAS.pdf [https://perma.cc/E2X9-ZHJT] (promoting a public health approach to HIV prevention and care, engaging communities to affirm support for those living with HIV, promoting public leadership of those living with HIV, and strengthening civil rights law enforcement); *see also* THE WHITE HOUSE OFFICE OF NAT'L AIDS POLICY, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES: UPDATED TO 2020, at 6 (2015), https://obamawhitehouse.archives.gov/sites/default/files/docs/national_hiv_aids_strategy_update_2020.pdf [https://perma.cc/LRT3-UD5B].

190. For example, on his first day in office, Trump took all references to the National HIV/AIDS Strategy off of the White House website. Melanie Thompson, *The Trump Administration Is Dropping the Ball on HIV/AIDS*, HUFFINGTON POST (Jan. 29, 2018), https://www.huffpost.com/entry/opinion-thompson-trump-hiv-aids_n_5a68a5eee4b0e56300757efb [https://perma.cc/Y37M-94DB]. Less than six months into his term, six members of the President's Advisory Council on HIV/AIDS resigned due to concerns over the administration's lack of interest in supporting individuals with HIV/AIDS and promotion of legislation that would negatively impact these same individuals. Scott A. Schoettes, *Trump Doesn't Care About HIV. We're Outta Here*, NEWSWEEK (June 16, 2017), https://www.newsweek.com/trump-I-care-about-hiv-were-outta-here-626285 [https://perma.cc/U2BC-CWPY]. Rather than recruit new members to sit on the council, Trump dismissed all of the remaining councilmembers in December 2017. Ben Guarino, *Trump Administration Fires All Members of HIV/AIDS Advisory Council*, WASH. POST (Dec. 29, 2017), https://www.washingtonpost.com/news/to-your-health/wp/2017/12/29/trump-administration-fires-all-members-of-hivaids-advisory-council/ [https://perma.cc/4XP7-XBXF]. Additionally, a ban on fetal tissue acquisition has halted HIV experimentation at the National Institutes of Health. Amy Goldstein & Lenny Bernstein, *Trump Administration Halts Study That Would Use Fetal Tissue 'To Discover a Cure for HIV*, WASH. POST (Dec. 9, 2018), https://www.washingtonpost.com/national/h

B. Partner Notification Laws

States have broad police power to pass and enforce laws aimed at combating threats to public health.[191] Partner notification laws fall within this ambit and have been relied on for nearly a century: they were initially used in the fight against syphilis in the 1920s.[192] Since then, partner notification, also known as contact tracing, has been a cornerstone of the state response to sexually transmitted infections (STIs), including HIV.[193] Over forty states have some form of partner notification law in place.[194] The stated goal of partner notification in the context of any STI is to make the patient's partner aware of the risk, get that person tested, and, if necessary, begin a course of treatment and alter their behavior to prevent transmission.[195] The consequences of doing so, however, are not contemplated by most state notification laws.

1. The Statutory Scheme

Most states use one of three methods of partner notification: patient referral, provider referral, or conditional referral.[196] With patient referral, an individual who tests positive for HIV, known as the index patient, is told to inform their sexual or needle-sharing partners that they may have been exposed to HIV; while index patients receive counseling and resources to assist them with this process, there is no confidentiality regarding the source of the exposure, no control over what information is actually relayed, and no way to verify with certainty that the communication took place.[197] Provider referral programs place the obligation to contact partners onto medical and healthcare personnel so

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ealth-science/trump-administration-halts-study-that-was-using-fetal-tissue-to-discover-a-cure-for-hiv/2018/12/09/954fec2a-fbcd-11e8-83c0-b06139e540e5_story.html [https://perma.cc/DF2N-ZHWT]. Despite President Trump's claims in his 2019 State of the Union Address that he is committed to ending HIV, many of his social and healthcare policies undermine the likelihood of achieving this outcome. Robert Pear, *Trump Pledged to End H.I.V. But His Policies Veer the Other Way*, N.Y. TIMES (Feb. 12, 2019), https://www.nytimes.com/2019/02/12/us/politics/trump-hiv-plan.html [https://perma.cc/L6CD-CWG4].

191. Leslie E. Wolf & Richard Vezina, *Crime and Punishment: Is There A Role for Criminal Law in HIV Prevention Policy?*, 25 WHITTIER L. REV. 821, 829–30 (2004).

192. Mary D. Fan, *Decentralizing STD Surveillance: Toward Better Informed Sexual Consent*, 12 YALE J. HEALTH POL'Y, L. & ETHICS 1, 6 (2012).

193. Fan, *supra* note 7, at 564.

194. Lawrence O. Gostin & James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. GENDER L. & POL'Y 9, 28–32 tbl.A (1998).

195. Chappell, *supra* note 10, at 243–44.

196. Gostin & Hodge, *supra* note 194, at 26.

197. *Id.* at 26–27.

there is more control over the information shared and the index patient remains technically confidential, although some contacts may be able to determine the source of their exposure.[198] Provider referral programs are expensive to administer since professionals must be paid to locate and counsel all the partners provided by the index patient.[199] Conditional referrals blend these two processes by allowing the index patient a specific amount of time to inform their partners before the healthcare professional steps in to provide notification.[200] State laws differ in terms of not just who engages in contact tracing, but also who qualifies as a partner requiring notification, how much investigation has to go into finding a partner's current whereabouts, and whether partners' names get reported to state health departments.[201]

Due to the sensitive and stigmatized nature of HIV, partner notification in this context is grounded in the notion that "[c]ooperative approaches to preventing transmission are far more successful than coercive approaches when dealing with a disease characterized by social stigma, misunderstanding, fear, and personal shame."[202] That said, states and health care providers vary in terms of how they articulate "whether infected persons are obligated, or told they are obligated, to comply" with the notification process.[203] While index patients may not be required to provide an accurate and complete list of sexual or needle sharing partners, they are certainly encouraged to comply with "purportedly voluntary"[204] programs in ways that can feel coercive,[205] especially given that public health measures have traditionally relied on admittedly coercive measures to achieve desired outcomes.[206]

The voluntariness of partner notification is further undermined by those states that have created a duty or a privilege for health care providers to

198. *Id.* at 27.

199. *Id.*

200. *Id.*

201. *See also* Carrie G. Pottker-Fishel, *Improper Bedside Manner: Why State Partner Notification Laws Are Ineffective in Controlling the Proliferation of HIV*, 17 HEALTH MATRIX 147, 165–66 (2007). It is worth noting that all cases of HIV and AIDS get reported to state health departments either by name or, less commonly, by encoded identification numbers. *Id.* at 155–56.

202. Wolf & Vezina, *supra* note 191, at 831.

203. Chappell, *supra* note 10, at 242.

204. *Id.* at 241.

205. In fact, not one but two proposals for partner notification policies include instructing health care professionals to encourage disclosure. *See, e.g.*, Rahul Rajkumar, *A Human Rights Approach to Routine Provider-Initiated HIV Testing*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 319, 384 (2007) ("A medical practitioner has a duty to encourage the patient to disclose his or her HIV status . . . ."); *see also* Pottker-Fishel, *supra* note 201, at 179.

206. Wolf & Vezina, *supra* note 191, at 830 (asserting that "coercion traditionally played a significant role in public health methodology").

warn potentially exposed individuals.[207] A majority of states permit but do not require disclosure to at-risk partners by healthcare professionals,[208] which can negate a patient's ability to decide whether and how to participate in contact tracing. There is a strong tension between an index patient's right to privacy and a partner's right to know that they may have been exposed to HIV and other STIs.[209] Additionally, there is a societal interest in promoting pre- and post-exposure notification in order to promote swift preventative and treatment-based measures. Notwithstanding the very real interest in protecting private and stigmatized information, these programs have consistently been justified and upheld in legal challenges.[210]

2. Critiques and Impact

Studies of general STI partner notification programs have found that these programs have "low yield rates" when looking at the number of people tested and diagnosed compared to the number of people potentially exposed.[211] Despite supporting partner notification as a primary public health tool to combat the spread of HIV, the CDC itself has acknowledged that published data on the efficacy of these programs is limited.[212] The CDC's own literature review found low rates in terms of the number of named partners actually notified and the number of notified individuals who came in for HIV testing.[213] Additionally, it cannot be assumed that an index patient provides a comprehensive list of all her sexual partners

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207. For a lengthy discussion on the duty to warn or disclose, see Gostin & Hodge, *supra* note 194, at 41–51 (exploring the duty to warn as well as the privilege of healthcare workers to warn when no such duty exists). *But see* Jacquelyn Burke, *Discretion to Warn: Balancing Privacy Rights with the Need to Warn Unaware Partners of Likely HIV/AIDS Exposure*, 35 B.C. J.L. & SOC. JUST. 89, 90–91 (2015) (analyzing Massachusetts's unique law prohibiting health care providers from warning those potentially at risk of exposure).

208. *See* Pottker-Fishel, *supra* note 201, at 166–68.

209. *See* Chappell, *supra* note 10, at 243.

210. *See, e.g.*, Guevara v. Superior Court, 73 Cal. Rptr. 2d 421, 425–27 (Cal. Ct. App. 1998) (holding a California statute imposing three-year sentence enhancements on individuals who, knowing they are HIV-positive, have unlawful sexual intercourse with minor females not to be unconstitutional on its face); State v. Musser, 721 N.W.2d 734, 757 (Iowa 2006) (finding the Iowa criminal transmission of HIV statute constitutional against defendant's free speech, substantive due process, and cruel and unusual punishment challenges); State v. Turner, 927 So. 2d 438, 441 (La. Ct. App. 2005) (finding no abuse of discretion by the district court sentencing the defendant to five years of hard labor).

211. Fan, *supra* note 7, at 565–66 (reviewing studies from Florida and New Jersey and arguing that the cost per person tested is staggeringly high, at well over $1,000 per person before inflation).

212. CDC, *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*, 57 MORBIDITY & MORTALITY WKLY. REP. 1, 2 (2008).

213. *Id.* at 4–6 (finding in a systemic review of nine studies, a mean of 67% of partners were notified, a mean of 63% of those notified were tested, and a mean of 20% of those tested were newly diagnosed with HIV).

to begin with: index patients have been found to resist complying with partner notification services for reasons including fear of domestic violence.[214] As such, partner notification programs have been assessed by scholars as not necessarily worth the financial and relational costs.[215]

Another key cost of partner notification laws is the safety and health of index patients. Although there is no definitive estimate of the prevalence of abuse caused by notification, studies and qualitative reports confirm that it is a legitimate threat faced by people living with HIV, whether or not they have experienced domestic violence prior to disclosure.[216] While quantitative studies on experiencing post-disclosure violence vary significantly,[217] studies reporting fear of experiencing violence returned high percentages of respondents.[218] From a qualitative standpoint, the violence experienced by survivors post-disclosure has been quite severe, up to and including murder.[219] One study found that:

> Patients were kicked, beaten, shot, and raped and suffered knife wounds to the face. One patient broke both legs after jumping from a third-floor window to escape being shot. The incidents of emotional abuse ranged from partners spitting on patients to threats of violence and death against both the women and their children. Some of these incidents occurred in the presence of [health care] providers.[220]

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214. Karen H. Rothenberg & Stephen J. Paskey, *The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy and the Law,* 85 AM. J. PUB. HEALTH 1569, 1571 (1995).

215. *See, e.g.*, Chappell, supra note 10, at 244 (noting that studies have specifically found partner notification programs to have compliance issues and high costs); *see also* Pottker-Fishel, *supra* note 201, at 148; Wolf & Vezina, *supra* note 191, at 833.

216. Chappell, *supra* note 10, at 241.

217. *See, e.g.*, *id.* at 245 (providing a range based on studies of 0.5–4% of women experiencing violence). *But see* Apel, *supra* note 10, at 18–21 (2001) (reviewing studies that reported more than 20% of female respondents experiencing "physical harm" or "negative consequences of disclosure" including physical assault).

218. *See, e.g.*, Rothenberg & Paskey, *supra* note 214, at 1570 (citing a study of medical and mental health professionals who indicated that 45% of respondents had at least one female patient who had expressed fear of physical violence, and 56% had a patient who had expressed fear of emotional abuse).

219. *See, e.g.*, Jennifer Emily, *Man Who Admitted Killing HIV-Positive Girlfriend: 'I Wanted to Make Her Pay*, DALL. MORNING NEWS (Oct. 29, 2013), https://www.dallasnews.com/news/crime/2013/10/30/man-who-admitted-killing-hiv-positive-girlfriend-i-wanted-to-make-her-pay/ [https://perma.cc/GML5-Q4W7] (detailing the murder of an HIV-positive woman by her sexual partner a week after she disclosed her status and underscoring the vengeful nature of the act); *see also* Alia Malik, *Man Arrested in San Antonio Suspected of Killing Woman Because She Had HIV*, SAN ANTONIO EXPRESS-NEWS (June 17, 2014), https://www.mysanantonio.com/news/local/article/Deputies-Man-caught-in-San-Antonio-killed-woman-5558852.php [https://perma.cc/5VKR-N922] (discussing a man who strangled an HIV-positive woman to death after she had given him oral sex and he overheard her talking to someone else about her "sickness").

220. Rothenberg & Paskey, *supra* note 214, at 1570.

Survivors may rationally fear retaliation after disclosing their status from current and past partners who are able to determine the source of their exposure.[221] Moreover, individuals who may not have experienced physical violence in their relationships may nonetheless be victimized after disclosing their status—thus it is not simply those who have already experienced abuse from a partner who are at risk or afraid.

In addition to experiencing violence, partner notification laws can negatively impact survivors' health in multiple ways. First, a survivor who is concerned about notification laws or policies may not get tested out of fear of the consequences.[222] Yet without an HIV diagnosis, they will not receive treatment that could improve their health outcomes and suppress their viral load and contagiousness. If a survivor does take the test and tests positively, an abusive partner, made aware of a survivor's status via disclosure, may intentionally retaliate or undermine their treatment plan as part of a larger campaign of abuse.[223] Examples of medical treatment interference experienced by survivors living with HIV include abusive partners hiding or destroying a survivor's medication, taking the medication themselves, preventing survivors from attending doctor visits, and deleting voicemails and emails or throwing away letters from medical professionals.[224] In these situations, survivors have less access to treatment and services that would otherwise minimize their symptoms, lower their contagiousness, and extend their lives.

Because "heavier intervention and surveillance continues to be advocated for the most vulnerable groups,"[225] partner notification specifically endangers the safety and welfare of marginalized individuals living with HIV. This is especially true for low-income and economically disadvantaged individuals who are most likely to encounter routine HIV testing and notification when seeking healthcare from publicly funded clinics.[226] Within these communities, subgroups including pregnant women and immigrants are most likely to encounter routine testing due to increased state involvement in their lives[227]; it is no coincidence that these

221. Chappell, *supra* note 10, at 247.

222. *Id.* at 248.

223. *Id.* at 245–46.

224. These examples are taken from Stoever, *supra* note 11, at 1173, as well as from my own practice.

225. Fan, *Decentralizing STD Surveillance*, *supra* note 192, at 10.

226. *Id.* at 13. As Fan and others discuss, routine and especially mandatory testing of pregnant women is a hotly debated policy and has been for decades. *See, e.g.*, Karen L. Goldstein, *Balancing Risks & Rights: HIV Testing Regimes for Pregnant Women*, 4 CORNELL J.L. & PUB. POL'Y 609, 610–11 (1995) (noting the increase in consideration by state legislatures of mandatory HIV testing programs for pregnant women, and their adoption by a few states).

227. Fan, *Decentralizing STD Surveillance*, *supra* note 192, at 13.

groups also experience domestic violence specifically targeting these vulnerabilities.[228]

Analysis of partner notification laws and policies not only illuminates the inextricable relationship between domestic violence and HIV, it also reveals the ways in which laws targeted at combating HIV may actually increase exposure to violence while also decreasing a survivor's ability to access critically important HIV treatment and services, thus undermining the public health goals of reducing the spread of HIV and bringing those already infected into care.

C. Criminal Exposure Laws

Partner notification laws are not alone in their ineffective and dangerous impact on survivors living with HIV. Laws that criminalize exposing others to HIV can create equally pernicious barriers for survivors with HIV. HIV exposure is criminalized at the state level in one of three ways: through (1) communicable and sexually transmitted disease laws; (2) already-existing general criminal statutes; or (3) HIV-specific legislation prohibiting exposure to the HIV.[229] Prosecution in one of these manners is not an idle threat—the United States leads the world in HIV exposure convictions[230] and per capita prosecutions.[231] Hundreds of individuals have been prosecuted and convicted of HIV exposure in the twenty-first century.[232] While this may seem like a relatively low number overall, it is critical to recognize the "immense social cost" of these proceedings.[233]

Most HIV-specific laws were passed before scientific breakthroughs were made regarding the prevention, spread, and treatment of HIV.[234] Prosecutions for HIV exposure therefore represent not merely societal

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228. *See* Leslye E. Orloff et al., *Battered Immigrant Women's Willingness to Call for Help and Police Response*, 13 UCLA WOMEN'S L.J. 43, 44 (2003). *See generally* A. Rachel Camp, *Coercing Pregnancy*, 21 WM. & MARY J. WOMEN & L. 275 (2015).

229. Richardson, *supra* note 76, at 1182; Wolf & Vezina, *supra* note 191, at 844–45.

230. Perone, *supra* note 5, at 366–67.

231. Norman L. Reimer, *Inside NACDL: A Lamentable Example of Overcriminalization: HIV Criminalization*, CHAMPION 7, 8 (2013). *But see* Perone, *supra* note 5, at 366–67 (suggesting that the United States engages in high numbers of prosecutions per capita but does not necessarily prosecute the most globally).

232. Bone, *supra* note 104, at 320 ("With his conviction, Johnson joins the approximately 541 people who have been convicted or pled guilty to having sex while HIV positive since 2003."); Frost, *supra* note 78, at 339 ("From 2008 to 2014, there were at least 210 prosecutions in various states for HIV related crimes, and prior to that, there were at least 316 prosecutions between 1986 and 2001."); Gilreath, *supra* note 131, at 375 ("[T]here have been hundreds of prosecutions under HIV-specific laws. Forty-five states have HIV-specific laws.").

233. Frost, *supra* note 78, at 339.

234. Cox, *supra* note 188, at 28.

condemnation of certain intimate behaviors but also stigmatization of acts that do not pose similarly high risks of transmission.[235] The over-inclusiveness of HIV exposure criminalization has negative repercussions in the fight against HIV generally and in the lives of survivors living with HIV specifically. Moreover, living in the shadow of potential prosecutions can impede someone's decision to get tested and willingness to live openly with HIV: instead they are dogged by stigma and fear that sharing their status could expose them to claims of non-disclosure. Finally, as the opioid crisis worsens across the United States, there is a potential that the increased use of shared needles could result in increased prosecution under these statutes.[236]

1. The Statutory Scheme

Communicable disease laws make it a low-level crime to knowingly expose someone else to an enumerated illness or infection.[237] Most of these laws were initially passed before 1930[238] and are rarely used in the HIV criminalization context, even though HIV has typically been included in the lists of illnesses covered by the law.[239]

While general criminal statutes also predate the AIDS crisis, they have consistently been used against people living with HIV.[240] Since the 1980s,[241] charges including murder and attempted murder, bioterrorism,

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235. *Id.*; Lee, *supra* note 38, at 249.

236. States are currently contemplating whether to charge even low-level drug dealers with murder for selling opioids that result in overdose deaths. Dave Collins, *Should Drug Dealers Be Charged with Murder? States Ponder*, ASSOCIATED PRESS (Feb. 25, 2019), https://apnews.com/a5deb83c79974ff3a40188043e5a6931 [https://perma.cc/AEB3-NJZS]. Some states have already implemented these laws. *See generally* Blake Farmer, *More Accused Fentanyl Dealers Charged With Murder As Tennessee Threatens Death Penalty*, NASHVILLE PUB. RADIO (July 11, 2019), https://wpln.org/post/more-accused-fentanyl-dealers-charged-with-murder-as-tennessee-threatens-death-penalty/ [https://perma.cc/ND5B-E637]; Michelle Lou, *Under New North Carolina Law, Drug Dealers Could Be Charged with Second-Degree Murder*, CNN (July 9, 2019), https://www.cnn.com/2019/07/09/us/north-carolina-hb-474-death-by-distribution-trnd/index.html [https://perma.cc/EZ2V-RZLS]. Given the expanded use of other criminal sanctions to target the opioid epidemic, it is not unreasonable to suggest that HIV criminalization laws that already apply in the needle-sharing context could be used as well—especially given the fact that neither actual transmission nor a fatal overdose must occur in order to prosecute.

237. Joshua D. Talicska, *Criminal Charges with Too Much Bite: Why Charging and Convicting HIV-Positive Biters and Spitters of Attempted Murder Is Unjustifiable*, 12 CONN. PUB. INT. L.J. 461, 467–68 (2013).

238. Zita Lazzarini et al., *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J. L. MED. & ETHICS, 239, 241 (2002).

239. J. Stan Lehman et al., *Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States*, 18 AIDS BEHAV. 997, 1002–03 (2014).

240. *See* Brito, *supra* note 76, at 315.

241. An early example of using general criminal laws to prosecute crimes related to HIV is Alabama's *Brock v. State*, 555 So. 2d 285, (Ala. Crim. App. 1989), in which an HIV-positive prisoner bit a prison guard and was charged with attempted murder and multiple assault counts: the jury

various forms of aggravated and non-aggravated assault, assault with a deadly weapon, and reckless endangerment have been brought against people living with HIV for acts ranging from having unprotected sex without disclosing serostatus to spitting on a police officer.[242] In addition to using harsh criminal statutes to prosecute commonplace acts committed by someone with HIV, these prosecutions may be accompanied by sentence enhancements that are triggered when a defendant is HIV-positive.[243] For example, several states provide significantly harsher punishments for individuals who know they are HIV-positive and engage in sex work—regardless of whether they disclosed their serostatus and received consent.[244]

In addition to using pre-existing general criminal statutes to prosecute exposure to HIV, many states have enacted specific HIV exposure laws.[245] Scholars differ over the number of states with HIV-specific legislation but the number is consistently found to be over thirty.[246] While these statutes "vary in breadth, specificity, and severity,"[247] they typically make it illegal for people who know that they are HIV-positive to engage in certain activities—usually various sex acts—without first disclosing their serostatus.[248] Several states also prohibit people with HIV from spitting,

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convicted him of first-degree assault but the appeals court downgraded the conviction to third degree assault since it found that Brock's teeth could not be considered a deadly weapon as required by the first-degree assault statute. *Id*. at 286–88.

242. Lazzarini, *supra* note 238, at 240; Perone, *supra* note 5, at 376–78; Richardson, *supra* note 76, at 1182; Talicska, *supra* note 237, at 469–70; Ari E. Waldman, *Exceptions: The Criminal Law's Illogical Approach to HIV-Related Aggravated Assaults*, 18 VA. J. SOC. POL'Y & L. 550, 574 (2011) (listing the typical elements in an HIV aggravated assault charge as the "(1) use of a dangerous weapon (2) in a physical attack (3) in a manner that is likely (4) to cause serious harm or death").

243. *See* Perone, *supra* note 5, at 378; Talicska, *supra* note 237, at 468–69.

244. *See, e.g.*, FLA. STAT. ANN. § 796.08(5) (2019) (providing that "[a] person may be convicted and sentenced separately for a violation of this subsection and for the underlying crime of prostitution or procurement of prostitution"); NEV. REV. STAT. ANN. § 201.358 (1995); OKLA. STAT. ANN. tit. 21, § 1031(b) (2014); OHIO REV. CODE ANN. § 2907.241(d)(2) (1996); 18 PA. STAT. AND CONS. STAT. ANN. § 5902(a.1)(4) (2011); TENN. CODE ANN. § 39-13-516 (2010). Missouri's sentence enhancement goes further by noting that the use of a condom is also not a defense. MO. ANN. STAT. § 567.020(2) (2011). *But see* GA. CODE ANN. § 16-5-60(c)(3) (2017) (requiring a sex worker to disclose their positive serostatus "prior to offering or consenting to perform that act of sexual intercourse").

245. Recent publications differ on the exact number of states that enacted HIV-specific statutes, but even the lowest estimates are quite high. *See, e.g.*, Bone, *supra* note 104, at 327 (stating that thirty-five states have HIV-exposure statutes); Perone, *supra* note 5, at 373 (finding that "[a]t least thirty-seven states have criminal statutes specific to HIV"); Talicska, *supra* note 237, at 469 (estimating that the number is "at least thirty-two states and territories"). Ultimately, what is particularly relevant is that at least two-thirds of states have HIV-specific language in their criminal codes while the remaining states have certified via the Ryan White CARE Act that their existing criminal codes can be used to prosecute HIV exposure.

246. *See* Brito, *supra* note 76, at 307.

247. *See* Lazzarini, *supra* note 238, at 244.

248. *See* Bone, *supra* note 104, at 325; Wolf & Vezina, *supra* note 191, at 847.

biting, or exposing others to bodily fluids like saliva or urine even though these behaviors pose nearly no risk of transmission because these fluids contain little to no HIV unless combined with blood.[249] A few states criminalize transmission of HIV without specifying a transmission method.[250]

Within the large subset of laws that prevent transmission through sexual activities, there are substantial differences between the laws in terms of what sexual activities are prohibited, what intent is required, what defenses are explicitly provided, and what sentences may be imposed on convicted defendants.[251] In most states with HIV-specific criminal laws, sexual penetration is prohibited without prior disclosure of positive serostatus. Several states also prohibit oral sex without disclosure despite the significant difference in risk of transmission.[252] While some states specifically exempt vertical transmission from mother to infant from their exposure statutes, others have no exemption, allowing for the potential prosecution of said mothers.[253]

Only a few states distinguish between illegal and legal behavior based on risks despite significant differences in the likelihood of transmission depending factors including type of behavior, viral load, and protection used.[254] Only California requires actual transmission for an act to be

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249. *See* Tony Ficarrotta, *HIV Disclosure Laws Are Unjustified*, 24 DUKE J. GENDER L. & POL'Y 143, 143 (2017); Garmon, *supra* note 21, at 671–72; Klemm, *supra* note 16, at 510.

250. *See, e.g.*, MD. CODE ANN., Health-Gen. § 18-601.1 (2019) ("An individual who has the human immunodeficiency virus may not knowingly transfer or attempt to transfer the human immunodeficiency virus to another individual."); NEV. REV. STAT. ANN. § 201.205 (2019) (making it illegal for a person to "intentionally, knowingly or willfully engage[] in conduct in a manner that is intended or likely to transmit the disease to another person"); OKLA. STAT. ANN. tit. 21, § 1192.1 (2019) (prohibiting a person who is aware that they have HIV "with intent to infect another, to engage in conduct reasonably likely to result in the transfer of the person's own blood, bodily fluids containing visible blood, semen, or vaginal secretions into the bloodstream of another, or through the skin or other membranes of another person ").

251. *See* Khan, *supra* note 44, 438–39; Klemm, *supra* note 16, at 500.

252. *See* Bone, *supra* note 104, at 325–26; Cox, *supra* note 188, at 33.

253. *See* Khan, *supra* note 44, at 431. For example, Tennessee's statute could include transmission via breastfeeding as it prohibits a person who knows they are HIV-positive from knowingly engaging in "intimate contact" with another, which is defined as "the exposure of the body of one person to a bodily fluid of another person in any manner that presents a significant risk of HIV." TENN. CODE ANN. § 39-13-109 (2019). While HIV transmission laws are not typically used in this context, Khan further points out that criminal child welfare laws have been used to punish mothers with HIV for transmitting it to their children. Khan, *supra* note 44, at 444–45. For example, a mother has been prosecuted for felony child neglect when her child was born with HIV. Priscilla A. Ocen, *Birthing Injustice: Pregnancy as a Status Offense*, 85 GEO. WASH. L. REV. 1163, 1179 (2017).

254. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 120290 (2019) (making it an element of intentional transmission of an infectious or communicable disease to "engage[] in conduct that poses a substantial risk of transmission"); NEV. REV. STAT. ANN. § 201.205 (1995) (prohibiting "intentionally, knowingly or willfully engag[ing] in conduct in a manner that is intended or likely to transmit the disease to another person"); OKLA. STAT. ANN. tit. 21, § 1192.1 (2014); *see also* Chelsey Heindel, *Medical Advances, Criminal Disadvantages: The Tension Between Contemporary Antiretroviral*

illegal[255]; while Iowa punishes actual transmission more harshly than potential transmission.[256] Many states do not take actual transmission of HIV—or lack thereof—into account at all. Intent is similarly varied, with a small number of states, including California, requiring specific intent to transmit,[257] Iowa distinguishing intent and reckless disregard,[258] and most other states only requiring a general intent to engage in the sexual act itself without disclosure.[259] In light of these patterns, it is worth noting that the California and Iowa statutes were amended within the past six years.[260]

While many states provide an affirmative defense to individuals who disclose their status and obtain consent,[261] Maryland, Kansas, and Washington do not explicitly provide this defense in their statutes, potentially rendering even informed and consensual sex illegal.[262] Use of a condom is also not a common affirmative defense, although a few states do explicitly provide for it.[263] No statute specifically provides an explicit affirmative defense for the use of medical prevention like antiretrovirals, PrEP, or PEP, though use of these methods could be relevant in a risk or intent analysis.[264] Finally, while HIV exposure is overwhelmingly a felony,[265] punishment varies from state to state, with sentencing in some states being determined by whether or not HIV was actually

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Therapy and Criminal HIV Exposure Laws in the Workplace, 9 WASH. J.L. TECH. & ARTS 35, 43 (2013) ("[A]n HIV-positive individual commits a felony under the criminal exposure law when he or she theoretically exposes another to HIV, regardless of whether the actual transmission risk is 1 in 1 million or virtually impossible.").

255. CAL. HEALTH & SAFETY CODE § 120290 (2018).

256. IOWA CODE ANN. § 709D.3 (West 2020).

257. CAL. HEALTH & SAFETY CODE § 120290 (2018); *see also* Khan, *supra* note 44, at 439 ("A small minority of the states require a specific intent to infect, while the others require some form of general intent.").

258. IOWA CODE ANN. § 709D.3.

259. *See* Klemm, *supra* note 16, at 501.

260. LAMDA LEGAL, GOVERNOR SIGNS BILL MODERNIZING CALIFORNIA HIV LAWS (Oct. 6, 2017), https://www.lambdalegal.org/news/ca_20171006_governor-signs-bill-modernizing-hiv-laws [https://perma.cc/VLM7-7J85]; William Widmer, *Iowa Scraps Harsh Criminalization Law in Historic Vote*, NBC NEWS (May 1, 2014), https://www.nbcnews.com/news/us-news/iowa-scraps-harsh-hiv-criminalization-law-historic-vote-n94946 [https://perma.cc/DZ4Q-GEPY].

261. Alexandra McCallum, *Criminalizing the Transmission of HIV: Consent, Disclosure, and Online Dating*, 2014 UTAH L. REV. 677, 677 (2014); Perone, *supra* note 5, at 375.

262. MD. CODE ANN., Health-Gen. § 18-601.1 (2016); KAN. STAT. ANN. § 21-5424 (2019). In Washington, the statute does not include a consent defense but case law suggests it may be available nonetheless. *See* WASH. REV. CODE ANN. § 9A.36.011(b) (2019) (lacking an explicit consent defense); State v. Whitfield, 132 Wash. App. 878, 134 P.3d 1203 (2006) (suggesting that fully informed consent may be an available defense).

263. *See* Bone, *supra* note 104, at 328–29; Cox, *supra* note 188, at 33; Klemm, *supra* note 16, at 500.

264. *See* Cox, *supra* note 188, at 33–34.

265. *See* Talicska, *supra* note 237, at 470. It is a misdemeanor in Maryland, but it can nonetheless result in a sentence of up to three years. MD. CODE ANN., Health-Gen. § 18-601.1 (2016).

transmitted.[266] While most state courts impose sentences of between one and ten years, some have the authority to sentence a convicted defendant to over twenty-five years[267] while others require them to register as a sex offender.[268] Many HIV criminalization statutes reflect the panic that catalyzed their becoming law; few accurately reflect contemporary society norms or medical advancements.

2. Critiques and Impact

Although the constitutionality of HIV criminalization has been challenged,[269] it has consistently been upheld by the courts.[270] The laws are nevertheless overinclusive, implicating people living with HIV who not only do not transmit the infection to others but who posed a very low risk of doing so by virtue of using protection, having an undetectable viral load, or engaging in low- to no-risk sexual activities.[271] Exposure laws also "amplify and exacerbate the stigma, prejudice, and discrimination that already result from widely held stereotypes about HIV-positive people"[272] by linking HIV with criminality and perpetuating false information about transmission.[273] These effects can be especially harsh given that an arrest publicizes an individual's HIV status even if they are ultimately found not guilty of any crime.[274]

These laws fail to further public health goals and, in fact, may undermine them by incentivizing some individuals to not get tested.[275] Since all HIV criminalization laws require that the potential defendant be aware of their status, opting not to get tested would render one beyond the

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266. *See* Bone, *supra* note 104, at 329.

267. *See* Klemm, *supra* note 16, at 501.

268. *See* Bone, *supra* note 104, at 329.

269. *See, e.g.*, Gilreath, *supra* note 131, at 373–74 (arguing that HIV criminalization laws have replaced sodomy as a tool for singling out and punishing homosexuality and should therefore be found unconstitutional under *Lawrence*); Joseph F. Lawless, *The Deceptive Fermata of HIV-Criminalization Law: Rereading the Case of "Tiger Mandingo" Through the Juridico-Affective*, 35 COLUM. J. GENDER & L. 117, 157 (2017) (arguing that Missouri's exposure law is only arbitrarily related to the stated goal of reducing new HIV infections and is therefore violating the Fourteenth Amendment).

270. *See* Gilreath, *supra* note 131, at 380.

271. Norman L. Reimer, *NACDL's Relentless Efforts to End Overcriminalization*, CHAMPION 9 (June 2016); Graham White, *Pre-Exposure Prophylaxis (PrEP) and Criminal Liability under State HIV Laws*, 126 YALE L.J.F. 77, 79 (2016–2017).

272. *See* Klemm, *supra* note 16, at 511.

273. *See* Perone, *supra* note 5, at 383; Kaplan, *supra* note 57, at 1535–36.

274. Hayley H. Fritchie, *Burning the Family Silver: A Plea to Reform Louisiana's Antiquated HIV-Exposure Law*, 90 TUL. L. REV. 209, 223–24 (2015).

275. *See* Ficarrotta, *supra* note 249, at 146; Garmon, *supra* note 21, at 695; Newman, *supra* note 182, at 1419; Perone, *supra* note 5, at 383; Reimer, *NADCL, supra* note 271, at 9.

scope of these laws.[276] Activist group SeroProject's 2012 study confirmed that individuals are indeed afraid of finding out their status because of fear of potential for prosecution.[277] A 2014 study demonstrated that states with HIV criminal laws in the media experience lower testing rates: while the existence of the laws themselves did not have an impact on testing, their publicity through high-profile cases in the news did actually result in fewer at-risk individuals seeking testing.[278] People who may be HIV-positive but decline to get tested out of fear of prosecution risk both infecting others and experiencing their own negative health outcomes. HIV criminalization laws also disincentivize post-sex disclosure for fear of prosecution even though doing so would enable a sexual partner to acquire medication that would reduce the risk of transmission even after exposure.[279]

Many of the critiques of criminalization laws are especially apt when considered in the lives of survivors living with HIV. The very fact that "[o]ver half of HIV-exposure statutes require no mens rea other than a defendant's knowledge of her status and intent to engage in the prohibited activity"[280] implicates survivors who may know their status but are too afraid of retaliation to disclose it to their abusive partner—with whom they may continue to have sex post-diagnosis.[281] Even if a survivor with HIV in this situation takes precautions, be it the use of an external or internal condom or maintaining an undetectable viral load, they would still be violating the law in the many states. If a survivor does eventually disclose their status to an abusive partner—as many people with HIV feel they have the obligation to do[282]—their abusive partner can nonetheless report the survivor to the police for engaging in sexual acts prior to disclosure. This is not mere speculation; survivors of abuse have been prosecuted under these exact circumstances even when their abusive

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276. *See* Puymbroeck, *supra* note 157, at 782, 798.

277. A 2012 study by the activist group SeroProject confirmed that individuals are indeed afraid of finding out their status for fear of potential for prosecution. Edwin J. Bernard, *HIV Criminalisation Discourages HIV Testing, Creates Disabling and Uncertain Legal Environment for People with HIV in U.S.* (July 25, 2012), http://www.hivjustice.net/news/hiv-criminalisation-discourages-hiv-testing-creates-disabling-and-uncertain-legal-environment-for-people-with-hiv-in-u-s-press-release/ [https://perma.cc/T8KX-VDTU].

278. Sun Goo Lee, *Criminal Law and HIV Testing: Empirical Analysis of How at-Risk Individuals Respond to the Law*, 14 YALE J. HEALTH POL'Y, L. & ETHICS 194, 194 (2014) (finding that "the number of people who reported that they had been tested for HIV is inversely correlated with the frequency of newspaper coverage of criminalization of HIV-exposing behavior").

279. *See* Cox, *supra* note 188, at 9–10.

280. Kaplan, *supra* note 57, at 1532.

281. *See* Buchanan, *supra* note 184, at 1257.

282. Daniel H. Ciccarone et al., *Sex Without Disclosure of Positive HIV Serostatus in a US Probability Sample of Persons Receiving Medical Care for HIV Infection*, 93 AM. J. PUB. HEALTH 949, 952 tbl.2 (2003); Andrea C. Gielen et al., *Women's Lives After an HIV-Positive Diagnosis: Disclosure and Violence*, 4 MATERNAL & CHILD HEALTH J. 111, 112 (2000).

partners continued to have sex with them after they disclosed their status. Brook Kelly, an HIV human rights attorney for the U.S. Positive Women's Network, describes one such situation:

> Shannon was diagnosed with HIV in the 1990s. She was in a relationship for many years with an abusive man. In that relationship, she became pregnant and had a child. He knew her HIV status and had accompanied her on visits to her HIV specialist as well as to her OB/GYN. When Shannon was finally ready to leave him, . . . [h]e began disclosing Shannon's HIV status to her family, people at her work, and to anyone who would listen until a temporary restraining order was filed against him to stop the harassment. However, this only escalated his behavior, and he filed charges against Shannon under South Carolina's HIV-specific criminalization law. Shannon, who had never had significant brushes with the law, was sentenced to six years in prison.[283]

Kelly goes on to note a fact that is by no means unique to Shannon's experience, that "[a]fter her release, she found re-entry quite difficult."[284] Shannon struggled to get custody of her children, access public benefits and adequate medical care, and find a job—especially in light of her felony conviction for HIV transmission.[285]

Individuals coming home from jail or prison often face these and other collateral consequences, including difficulty obtaining public or private housing, denials of applications for professional licenses, voter disenfranchisement, and deportation of non-citizens.[286] Survivors of domestic violence returning to the community after incarceration encounter these challenges while also being especially vulnerable to domestic violence targeting their status as returning citizens.[287] Reentering survivors with HIV present multiple vulnerabilities that could be exploited by abusive partners. Additionally, their conviction or arrest has made their serostatus public information—an invasion of privacy potentially against the defendant's wishes.[288] Moreover, adding major

283. Kelly, *supra* note 158, at 365.

284. *Id.*

285. *Id.*

286. Michael Pinard, *An Integrated Perspective on the Collateral Consequences of Criminal Convictions and Reentry Issues Faced by Formerly Incarcerated Individuals*, 86 B.U. L. REV. 623, 634–36 (2006).

287. *See* Cross, *supra* note 155, at 83–87.

288. This involuntary disclosure also implicates questions of privacy rights under the due process clause that exceed the scope of this Article but merit further attention. For a discussion of privacy rights geared toward individuals living with HIV, see LAMDA LEGAL, KNOW YOUR RIGHTS:

healthcare management to reentering survivor's already long list of appointments and obligations creates even more stress, stigma, and instability. HIV criminalization laws, including sentence enhancements for sex workers, thus have a particularly severe impact on HIV-positive survivors who do not immediately disclose their status to their abusive partners or former partners.

As is the case with partner notification laws, criminal HIV exposure statutes have negative consequences in the lives of already-marginalized individuals,[289] who may also be survivors with HIV. These laws are able to specifically target and harm marginalized individuals 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 [their] HIV status; and (4) elimination of privacy."[290] While they by no means exclusively impact members of underserved or underrepresented communities, HIV exposure laws are overwhelmingly constructed in ways that ignore the lived experiences of marginalized people.

Many of these laws were born out of the gendered, racist, and heteronormative motivation to protect white women from men—especially black men—and are also used to reinforce traditional social, racial, and gender norms rather than to protect at-risk individuals.[291] Rather than protecting at-risk individuals, these laws are used to punish racial and sexual minorities.[292] Additionally, survival sex workers, notably women of color and trans women, are also likely to experience "unique injustices" when facing exposure charges or enhancements given the confluence of stigma and gender nonconformity that their cases present.[293]

PRIVACY, CONFIDENTIALITY, AND DISCLOSURE (2017), https://www.lambdalegal.org/know-your-rights/article/hiv-privacy-and-confidentiality [https://perma.cc/P879-QJ88].

289. *See* Lee, *supra* note 38, at 251; Kaplan, *supra* note 57, at 1563.

290. Perone, *supra* note 5, at 379.

291. *See* Buchanan, *supra* note 184, at 1301–06; Gilreath, *supra* note 131, at 372.

292. *See* Bone, *supra* note 104, at 335; Gilreath, *supra* note 131, at 373. A study of exposure prosecutions in Michigan between 1992 and 2010 found that black men with female partners faced comparatively high conviction rates and that men with male partners generally faced a relatively low conviction rate. Trevor Alexander Hoppe, *Disparate Risks of Conviction under Michigan's Felony HIV Disclosure Law: An Observational Analysis of Convictions and HIV Diagnoses, 1992–2010*, 17 PUNISHMENT & SOC. 73, 81–85 (2015). An examination of exposure prosecutions in Oklahoma posited that the total lack of prosecutions against men with male partners reflect the state's lack of interest in protecting men who have sex with men. Sara Potts, *A Double-Edged Sword: Oklahoma's Transmission Statute and the Lack of Prosecutions for Intentional HIV Transmissions Against Homosexual Males*, 38 OKLA. CITY U. L. REV. 433, 433–34 (2013).

293. Perone, *supra* note 5, at 383.

Like partner notification laws, laws criminalizing exposure to HIV fail to meet their intended goals—here, punishing blameworthy individuals who cause harm to others. At best, they prosecute individuals arbitrarily; at worst, they undermine incentives to test and punish marginalized individuals more often and more harshly than their privileged counterparts. For survivors living with HIV who do comply, these laws hand their partners another tool for abuse or retaliation, this time by invoking the power of the state.[294]

IV. RECOMMENDATIONS

The foregoing discussion illuminates both the inextricable relationship between domestic violence and HIV and also the many ways by which the HIV legal regime disserves and endangers the health and safety of HIV-positive survivors and potential survivors of domestic violence. Given the reciprocal nature of HIV and domestic violence, it is not hyperbole to view all people living with HIV as either survivors or potential survivors of violence. There are myriad ways the HIV legal regime could be restructured to reduce the threat of violence against people living with HIV while also protecting those without HIV from infection. Restructuring notification and exposure laws is a necessary but insufficient improvement; instead, the domestic violence movement should also incorporate HIV prevention, testing, and counseling into the mainstream services offered to survivors.

A. Reforming Partner Notification to Encourage Testing

1. Improving Outcomes in the Medical Community

In designing partner notification laws and programs, states must always grapple with the tension between privacy and health—typically conceived of as the privacy of the index patient versus the health of their current and former sexual partners.[295] In light of their increased risk of domestic violence post-disclosure, the HIV-positive patient's health and safety must factor into this analysis as well. There are multiple ways to balance these factors. One is to make anonymous testing—in which patients are assigned ID numbers and the results are never a part of their medical records—more readily available so that individuals who might not otherwise get tested out of fear of notification and its consequences can

294. *See* Buchanan, *supra* note 184, at 1259.

295. *See* Ronen Avraham & Joachim Meyer, *The Optimal Scope of Physicians' Duty to Protect Patients' Privacy*, 100 MINN. L. REV. HEADNOTES 30, 31–32 (2016).

do so without concern.[296] Anonymous testing is typically available at specific testing sites but not in most hospitals or medical centers.[297] Anonymous testing allows individuals to find out their status without triggering other obligations typically associated with a positive HIV test.[298]

Downsides of anonymous testing include the inability for medical professionals to both follow up with someone who has tested positive and to contact their partners if doing so would not endanger them.[299] That said, anonymous testing must be more widely available so those individuals who would otherwise be too afraid to find out their status will feel more comfortable doing so. Although individuals who can afford it are able to purchase anonymous at-home HIV and STI testing kits,[300] the ability to test anonymously should be available to individuals who cannot afford the several-hundred-dollar kits or who need immediate medical counseling after testing positive. Given the many ways that an in-home test could provide inaccurate or confusing results,[301] the same benefits should be available through supportive health clinics that accept health insurance and Medicare.

While anonymous testing should be available to individuals who may be hesitant to test otherwise, confidential (but not anonymous) testing should also be improved to reflect the lived experiences of survivors of domestic violence living with HIV. Some domestic violence activists have advocated in favor of emulating New York's mandatory partner notification laws. In New York, a positive test triggers a mandatory report by the healthcare provider to the state including the index patient's information as well as names and addresses of the index patient's sexual partners.[302] The healthcare provider must note whether a domestic violence screening has been conducted; if it has not, it will be undertaken

296. *See* Chappell, *supra* note 10, at 257 ("[I]nterviews with HIV test counselors reveal that anonymous testing is seen as something of a cure for fears surrounding partner notification.").

297. *Id.*

298. *See* Chappell, *supra* note 10, at 256; Pottker-Fishel, *supra* note 201, at 151–52.

299. *See* Chappell, *supra* note 10, at 257.

300. People are now able to buy at-home cheek swab tests that allow them to take an HIV test and get the results without leaving home. *See, e.g.*, *Taking the Test*, ORAQUICK, http://www.oraquick.com/Taking-the-Test/How-To-Video [https://perma.cc/29UB-HS4Z].

301. *See, e.g.*, Carrie Arnold, *At-Home HIV Test Poses Dilemmas and Opportunities*, 380 LANCET 1045 (2012) (discussing the potential for false positives and false negatives as well as the lack of immediate counseling). For a more recent assessment, see Danielle Dresden, *Home HIV Test Kits: Uses, What to Expect, and Benefits*, MED. NEWS TODAY (Mar. 13, 2017) [https://perma.cc/FB4E-A536] (discussing one brand's 91.7% accuracy rate as well as the existence of several non-FDA approved kits).

302. N.Y. COMP. CODES R. & REGS. tit. 10, § 63.4(b) (2017).

by a county public health official.[303] If the screening indicates the risk of domestic violence, "the authorized public health official, in consultation with the reporting physician, must be satisfied in his/her professional judgment that reasonable arrangements, efforts or referrals to address the safety of affected persons have been made if and when the notification is to proceed."[304] While notification of some abusive partners may be postponed, others may be notified of their exposure to HIV even if the index patient has reported indicia of domestic violence. In the case of domestic violence, physicians are instructed to:

> Defer partner notification any time a risk of behavior toward the HIV-infected individual may have a severe negative effect on the physical health and safety of the HIV-infected individual, his/her children, or someone who is close to them, or to a contact if identified. In all other cases partner notification should go forward.[305]

If the notification of a specific partner is deferred, then the physician is instructed to give domestic violence referrals to the patient, get a release signed for follow-up communication, and consult with the health department in order to determine how to proceed.[306]

New York's domestic violence screening, resource referrals, and safety-based deferrals go further than other partner notification processes and represent a synthesis of information regarding the intertwined nature of domestic violence and HIV. These aspects of the partner notification law are laudable and should be replicated broadly. Yet New York's policy is ultimately undermined by its requirement of severe physical impact. Domestic violence takes many forms and can be extremely detrimental to the safety and welfare of survivors even if it would not consistently be classified as severe physical abuse.[307] Moreover, making physicians the arbiters of when to grant deferrals and for how long ignores the well-established reality that medical professionals are highly reluctant to

303. *Id.* § 63.8(f).

304. *Id.* § 63.8(c).

305. *NYSDOH Protocol - Domestic Violence Screening in Relation to HIV Counseling, Testing, Referral & Partner Notification*, N.Y. ST. DEP'T HEALTH, https://www.health.ny.gov/diseases/aids/providers/regulations/domesticviolence/protocol.htm [https://perma.cc/66S6-XK3M].

306. *Id.*

307. *See, e.g.*, Steven Sosny, *Effects of Emotional Abuse: It Hurts When I Love*, PSYCHOL. TODAY (Aug. 26, 2008), https://www.psychologytoday.com/us/blog/anger-in-the-age-entitlement/200808/effects-emotional-abuse-it-hurts-when-i-love [https://perma.cc/3J94-V5CY] (noting that emotional abuse can be more psychologically damaging than physical abuse).

engage with patients around issues of domestic violence and partner notification more broadly.[308]

Rather than require healthcare professionals to navigate series of undefined and labyrinthine balancing tests, people living with HIV themselves should be able to opt out of notifying any individual they think might interfere with their safety or health. Patients should receive domestic violence screening and counseling when testing and receiving their results. Although they should be encouraged to have at-risk individuals notified in order to bring them into care, the impact of notifying each contact should be discussed and the patient should ultimately be able to determine which of their partners can safely be notified. Additionally, patients should be able to choose between notifying partners directly and having healthcare professionals notify partners anonymously, depending on what the patient thinks would be more likely to promote both their own safety and their partners' willingness to test. Prioritizing patients' discretion to determine whose notification would adversely affect their lives will reduce fear of testing.

Establishing routine provider-initiated testing in which asymptomatic patients are offered HIV tests regularly when seeking any kind of medical services would be an effective way of ensuring that all individuals—including those who may have been screened out of partner notification due to domestic violence—would encounter offers for testing and treatment somewhat regularly.[309] If all individuals were asked non-coercively if they would like to be tested for HIV and informed of the benefits of doing so every time they saw their primary care doctor, went to urgent care, or attended any number of fairly routine physical or behavioral health appointments, the idea of an HIV test would become less stigmatized and more people might be inclined to test more often—especially if the testing was anonymous or patients were informed in advance of their ability to screen abusive partners out of notification.

Increasing the availability of truly anonymous testing, incorporating domestic violence screening and counseling into the testing process, allowing patients to determine which partners were safe to notify, and implementing frequent and widespread invitations to test would all enable people concerned about testing to do so with greatly diminished fear of retaliation and stigma. Of course, improving the front-end of the HIV

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308. Chappell, *supra* note 10, at 252–53; *see also* Pottker-Fishel, *supra* note 201, at 171–74 (discussing the pitfalls of having healthcare providers on the front lines of partner notification); Rajkumar, *supra* note 205, at 366 (noting that "partner notification is an extremely sensitive task that requires the skill of highly trained social workers and health care providers. As one social worker in San Francisco put it, 'it takes a special kind of person to do this job'").

309. *See* Rajkumar, *supra* note 205, at 325–26 (describing routine provider-initiated testing as regularly offered HIV testing by a medical professional that remains fully optional for patients).

legal regime must be accompanied by back-end reform of criminal exposure laws.

2. *Incorporating HIV Testing, Counseling, and Safety Planning into Domestic Violence Services*

While it is critical that the HIV legal regime be reformed to better reflect the realities of survivors living with HIV, domestic violence organizations, institutions, and systems cannot wait for legislative action and must instead take the lead on proactively addressing this intersection. In light of the inextricable relationship between domestic violence and HIV, it is surprising that many domestic violence organizations do not also offer HIV counseling and services.[310]

Domestic violence shelter residents and staff have expressed enthusiasm about the possibility of offering HIV testing and counseling at domestic violence shelters.[311] Other beneficial services for survivors in domestic violence shelters include programming and counseling around HIV prevention and safer sex for survivors who are HIV-positive and negative. Conversations, especially those that are peer-led,[312] around coercion, condom negotiation, and different methods of prevention—including external and internal condoms, and PrEP—would benefit individuals in abusive relationships regardless of their serostatus.

Moreover, while shelters are a critical locus for intervention, many survivors of domestic violence do not seek assistance from shelters. As such, other intervention points should be encouraged to offer non-coercive HIV screening and counseling into their services, including local advocacy groups, government agencies, and behavioral healthcare services. This way survivors could learn about their heightened risk of HIV exposure and be able to immediately opt into onsite services regarding risk and harm reduction practices. Where offering testing onsite is unwise or impractical, interested survivors could be assisted with making testing appointments at facilities with domestic violence counseling and safety planning services. This synergy would help survivors prevent infection and spread of HIV and provide more holistic treatment to those who may be or become HIV-positive. Counseling and resources concerning local partner notification laws would be critical

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310. *See, e.g.*, Michele A. Rountree, Elizabeth C. Pomeroy & Flavio F. Marsiglia, *Domestic Violence Shelters as Prevention Agents for HIV/AIDS?*, 33 H. & SOC. WORK 221, 226 (2008) (surveying domestic violence shelters and finding that they "lack HIV/AIDS programming to meet the needs of the women they serve who are at increased risk of HIV/AIDS infection").

311. Claire B. Draucker et al., *Rapid HIV Testing and Counseling for Residents in Domestic Violence Shelters*, 55 WOMEN & HEALTH 334, 345 (2015).

312. *See* Baskin et al., *supra* note 117, at 387–88 (discussing the effectiveness of peer-to-peer counseling in reducing HIV among sex workers).

prior to testing just as information on what any given state's transmission laws consist of is an important aspect of post-test counseling.

The adoption of new services may well be more expensive than what many domestic violence non-profits can afford. When this is the case, domestic violence advocates, activists, and attorneys should seek out free or low-cost training on how HIV is transmitted and impacts health, how it intersects with domestic violence, and where to refer clients in order to get testing, counseling, or treatment. Survivors seeking assistance or intervention should be asked about HIV and safe sex practices regularly and without judgment. Even if services cannot be coordinated on-site, people experiencing domestic violence should be given an opportunity to share their concerns and experiences around HIV and explore how the reciprocal relationship between HIV and domestic violence might impact them personally.

B. Vastly Reducing the Scope of Criminal Exposure Laws

Scholarly suggestions for reforming HIV exposure laws are plentiful and range from explicitly prohibiting even more intimate behaviors[313] to doing away entirely with all HIV-specific criminal laws.[314] Many who wish to repeal HIV exposure laws are advocating not for total decriminalization but for reliance instead on general criminal statutes to mitigate the overbreadth of exposure laws.[315] Between these two poles of expansion and elimination lie calls for reforming HIV exposure statutes to better reflect the realities of the current fight against HIV. Prime among these calls for change are recommendations prioritizing risk as the defining feature of prohibited conduct.[316] Law professor Margo Kaplan has suggested statutory language that incorporates risk in multiple elements, by both requiring a finding that a defendant engaged in behavior

313. *See, e.g.*, Carmen M. Cusack, *Nonconsensual Insemination: Seminally Transmitted Diseases as Intimate Partner Violence*, 49 CRIM. L. BULL. 691, 707 (2013) (arguing in favor of creating a new crime of nonconsensual insemination in which it is illegal to transmit a disease to someone else unless that person both consented to being inseminated and assumed the risks thereof); Leslie P. Francis & John G. Francis, *Criminalizing Health-Related Behaviors Dangerous to Others? Disease Transmission, Transmission-Facilitation, and the Importance of Trust*, 6 CRIM. L. & PHIL. 47, 57–58 (2012) (considering but ultimately ruling against the creation of a new class of crimes that facilitate transmission like failure to report disease outbreaks, deliberate prevention of treatment, and discouraging or preventing vaccination).

314. *See, e.g.*, Scott Burris, et al., *Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial*, 39 ARIZ. ST. L.J. 467 (2007); McArthur, *supra* note 74, at 711.

315. *See, e.g.*, McArthur, *supra* note 74, at 711 (all authors arguing for the usage of general criminal statutes rather than HIV-specific exposure laws); Pickering et al., *supra* note 314, at 408 (same); Puymbroeck, *supra* note 157, at 798 (same); Talicska, *supra* note 237, at 491 (same).

316. *See, e.g.*, Kaplan, *supra* note 57, at 1521; Klemm, *supra* note 16, at 521–22; Richardson, *supra* note 76, at 1206.

that "creates a substantial and unjustifiable risk" and that the defendant is only held liable for risk that exceeds the expectations of the victim.[317] While others have incorporated this complex proposal into their own recommendations,[318] Kaplan herself has acknowledged that the challenges in implementing a model that is both highly fact specific and requires a jury to analyze contemporary medical information about the transmission of HIV may ultimately be more unwieldy than merely repealing exposure statutes.[319]

Despite the shortcomings of the current landscape, eliminating HIV-specific criminal statutes would not be an effective solution. Doing so would result in all HIV transmission prosecutions being brought under the general criminal code, which by no means eliminates the problems posed by HIV criminalization statutes.[320] Traditional criminal statutes do not neatly map onto the behavior involved in HIV transmission, resulting in prosecutors and juries having to massage the elements of a given crime to fit the facts of HIV exposure.[321] A narrowly tailored and clearly written HIV exposure statute would circumvent this problem while also providing people with a comprehensive definition of prohibited conduct.[322] An unambiguous statute also mitigates—without being able to fully erase—bias and stereotyping by clearly delineating the elements and facts that must be proven in order to find a defendant guilty.[323]

In light of the host of critiques that plague the current manifestations of HIV criminalization laws, state legislatures should vastly scale back what behavior is illegal without simply resorting to the general criminal code. Following in the tradition of HIV-positive activists and advocates, this Article proposes to only criminalize transmission of HIV and other STIs

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317. *See* Kaplan, *supra* note 57, at 1551 (Providing sample statutory language: "[i]t is unlawful for an individual (1) [with the purpose of infecting another with HIV] (2) [who is aware of and ignores a substantial and unjustifiable risk that her actions will result in HIV infection of another] (3) [who should have been aware of a substantial and unjustifiable risk that her actions will result in HIV infection of another] to engage in conduct that creates a substantial and unjustifiable risk of infecting another with HIV. For the purposes of this statute, the word 'creates' applies only to the degree of risk that the defendant [knows/recklessly disregards a risk/should have known] the victim did not consent to").

318. *See, e.g.*, McCallum, *supra* note 261, at 699–700 (suggesting adopting Kaplan's language with additional jury instructions for clarity).

319. *See* Kaplan, *supra* note 57, at 1564 (acknowledging that, compared to the complex analysis her standard would require, it might actually make more sense to eliminate HIV-specific crimes instead).

320. *See* Newman, *supra* note 182, at 1427–28.

321. Amy L. McGuire, *AIDS as a Weapon: Criminal Prosecution of HIV Exposure*, 36 HOUS. L. REV. 1787, 1815 (1999).

322. *See Klemm*, *supra* note 16, at 522–23; Richardson, *supra* note 76, at 1201–02; *see also* Newman, *supra* note 182, at 1428 (noting that general criminal statutes "fail to give specific notice of the types of activities that could lead to criminal liability").

323. *See* Klemm, *supra* note 16, at 522.

that are intentional and actually transmitted.[324] That is, a person could only be found guilty of transmitting HIV if that person has the specific intent to transmit an STI including HIV and does, in fact, transmit it.[325] A person could not be found guilty of intentional transmission if their partner consents to actual transmission of HIV.[326] By requiring actual transmission, this proposal negates the need for a complicated analysis of what constitutes both risky behavior and adequate risk prevention in light of constantly evolving medical knowledge. Requiring both specific intent and actual transmission focuses criminalization on only the most egregious cases where actual and permanent harm results.[327] Additionally, an actual transmission requirement may also discourage false criminal claims for the purpose of stigmatizing or punishing because it necessarily means that the one bringing the claim would have to prove that they have contracted HIV as well.

Given the devastating impact of mass incarceration on many of the same communities that experience high rates of HIV, this proposal errs on the side of being potentially under- rather than over-inclusive.[328] In creating such a narrow scope, it not only ensures that survivors of domestic violence with no intent to transmit HIV will remain beyond the ambit of the law, it also excludes from liability individuals who do not intend to infect their partners but are unable to successfully mitigate the risk. Many scholars have recommended that states attribute different

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324. *See* Buchanan, *supra* note 184, at 1339; Cox, *supra* note 188, at 52. *See also* Edwin J. Bernard, *International Civil Society Experts Launch the Oslo Declaration on HIV Criminalization*, HIV JUSTICE NETWORK (Feb. 22, 2012) [https://perma.cc/FR6E-6M9F]; UNAIDS, ENDING OVERLY BROAD CRIMINALIZATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION: CRITICAL SCIENTIFIC, MEDICAL AND LEGAL CONSIDERATIONS 2 (2013).

325. Minahan, *supra* note 32, at 89–90 (while it cannot establish who gave the strain to whom, evidence regarding HIV testing as well as intent should ensure that the correct party is charged and prosecuted); Erin E. Langley & Dominic J. Nardi, Jr., *The Irony of Outlawing AIDS: A Human Rights Argument Against the Criminalization of HIV Transmission*, 11 GEO. J. GENDER & L. 743, 788–89 (2010) (explaining that phylogenic testing should be used to establish that the defendant and the victim actually share the same strain of HIV).

326. While rare, the phenomenon of seeking out HIV does exist and individuals who participate in such a relationship should not be culpable under the law. Amanda Weiss, *Criminalizing Consensual Transmission of HIV*, 2006 U. CHI. LEGAL F. 389 (2006) ("'[B]ug-chasers' are HIV-negative gay men who actively seek out infection, arranging to have unprotected sexual intercourse with infected partners [known as 'gift-givers.']").

327. *See* Lee, *supra* note 38, at 266 (labeling malicious and intentional transmission cases as "the most egregious").

328. *See generally* MICHELLE ALEXANDER, THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS (2010); Dorothy E. Roberts, *The Social and Moral Cost of Mass Incarceration in African American Communities*, 56 STAN. L. REV. 1271 (2004). For a discussion of reducing the number of federal crimes, see Marco Rubio, *A Step Toward Freedom: Reduce the Number of Crimes*, BRENNAN CTR. JUST. (Apr. 28, 2015), https://www.brennancenter.org/our-work/analysis-opinion/step-toward-freedom-reduce-number-crimes [https://perma.cc/D686-5QZD].

punishments to defendants who act intentionally versus recklessly[329] and also provide affirmative defenses to individuals who took proactive steps to mitigate transmission.[330] Adopting these strategies does not adequately take into account the social and political dynamics around who is able to successfully access HIV treatment and risk management strategies.[331] As antiretroviral therapy and PrEP become increasingly accessible to privileged communities,[332] only those individuals who cannot access or comply with treatment or whose partners cannot reliably access PrEP will be in violation of reckless transmission laws that exempt individuals mitigating risk.[333] As prominent HIV legal scholar Aziza Ahmed points out:

> the pre-existing maldistribution of access to HIV treatment means that only some of the accused will benefit legally from these scientific advancements. This could have a disparate effect on racial minorities who have less access to [treatment] and, in turn, will not have the capacity to mitigate potential culpability by arguing that they are less likely to transmit HIV.[334]

Thus, the same individuals and communities that are at a heightened risk of getting HIV in the first place—including but not limited to survivors of domestic violence—will remain most at risk for prosecution under laws that factor in risk prevention.[335] This is especially true for those survivors whose abusive partners intentionally undermine or interfere with their treatment compliance, as well as for intersectionally marginalized individuals who lack access to treatment or cannot achieve sufficient compliance with their medical regimen. As Ahmed deftly argues, risk analyses may seem neutral and scientifically based when in reality they obscure the critical truth that not everyone has equal access to treatment or equal ability to comply. As such, "[f]or many racial minorities, and others without access to ART, the benefits of scientific progress will not

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329. *See, e.g.*, Klemm, *supra* note 16, at 523; McCallum, *supra* note 261, at 685; Newman, *supra* note 182, at 1434–35.

330. *See* Klemm, *supra* note 16, at 523; Richardson, *supra* note 76, at 1204.

331. *See* Ahmed, *supra* note 33, at 640 ("[A]s it becomes clear that access to ART may have bearing on one's culpability in HIV criminal transmission and exposure cases, it becomes necessary to examine the disparities in who has access to the medicines that can decrease one's viral load and, in turn, render them innocent.").

332. *See* Frost, *supra* note 78, at 338–40; Richardson, *supra* note 76, at 1188–89.

333. *See* Ahmed, *supra* note 33, at 627–28; McArthur, *supra* note 74, at 707.

334. Ahmed, *supra* note 33, at 629.

335. *Id.* at 651 (Observing that "[u]nderstanding the potential racial effect of evaluations of 'risk of transmission' requires an examination of who actually has access to the antiretrovirals that lower viral load and lessen the likelihood of being held accountable for exposing another to HIV. In the United States, it is racial minorities and women, largely women of color, who bear the brunt of the epidemic and are least likely to be able to access care.").

have a protective effect against either HIV transmission or findings of guilt."[336]

Moreover, as methods for both prevention and treatment of HIV become more effective and, hopefully, accessible, criminalization of behavior that does not and could not actually transmit HIV begins to increasingly resemble a status crime in which an individual with HIV is punished simply for having HIV rather than for engaging in dangerous behavior.[337]

Criminalizing only intentional and actual transmission of HIV is itself not impervious to critique. In addition to individuals who face real barriers in successfully accessing preventative measures, eliminating the crime of reckless exposure may well exempt individuals who simply opt out of taking reasonable precautions and, in so doing, infect their partners, including some abusive partners who transmit HIV to survivors. There is an argument, however, that in light of this lack of criminal sanctions, sexual partners may feel a heightened responsibility to protect themselves since they cannot assume that their partner is taking steps to avoid criminal liability.[338] Given the wealth of studies that demonstrate that criminal laws themselves do not influence people's sexual risk-taking,[339] removing cause for this false confidence may encourage individuals to be more proactive about their health. Admittedly, this moral hazard-based logic provides no comfort to individuals whose partners' recklessness resulted in transmission of HIV. While there is some potential that victims of reckless exposure or transmission could seek remedies in tort,[340] the socioeconomic status of potential defendants would weigh heavily in any consideration of this approach.[341]

Critics of criminalizing only intentional transmission have noted that it can be challenging to prove the requisite intent without an overt admission.[342] While there may be cases where this proves challenging, there will also be others where the defendant does indeed admit as much

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336. *Id.* at 653.

337. *See* Robinson v. California, 370 U.S. 660, 666 (1962); Buchanan, *supra* note 184, at 1341 (arguing that HIV criminalization constitutes a status crime).

338. *See* Newman, *supra* note 182, at 1435 (exploring this moral hazard theory and arguing that only criminalizing specific intent "would place a greater emphasis on joint responsibility in sexual relationships by encouraging condom use and would help eliminate the discrimination that HIV-positive individuals face").

339. *See, e.g.*, Lee, *supra* note 278, at 198–99 ("Several empirical studies have validated the theory that criminal punishment fails to prevent risky sexual activities.").

340. *See* Buchanan, *supra* note 184, at 1271–72; Kaplan, *supra* note 57, at 1564–65; Lee, *supra* note 38, at 245.

341. *See* Waldman, *supra* note 242, at 602.

342. *See* Puymbroeck, *supra* note 157, at 797; Richardson, *supra* note 76, at 1202.

or where the context makes the defendant's intentions clear.[343] Just as survivors' HIV status can be exploited by abusive partners, so too can intentional transmission constitute a form of abuse by an HIV-positive abusive partner.[344] Individuals who use HIV to exert power over, or punish, their partners by infecting them would fall squarely into the purview of an intentional transmission statute.

A challenging critique that this statutory proposal would face is that, even if implemented, prosecutors would simply use general criminal statutes such as assault or attempted murder to prosecute those cases that did not fall within its narrow scope.[345] While this double-dipping undermines the purpose of enacting a discrete criminalization statute, the problem is not limited to only this proposal since many states with exposure statutes are already experiencing the continued use of general criminal statutes.[346] Eliminating this concern would require a specific legislative intent that general criminal statutes no longer be used to prosecute HIV exposure. Legislatures would be more likely to express this intent during the enactment of a new statute—especially one like the current proposal that would require the amendment of current statutes—than sua sponte in response to the status quo. Moreover, even the adoption of an intentional transmission statute of this nature without a robust legislative history would signal that a legislature is intending to reduce the number of individuals eligible for prosecution on transmission and exposure grounds.

In addition to amending exposure laws themselves, the legislature would need to eliminate HIV-specific crimes and sentencing enhancements used against HIV-positive sex workers. These amendments would ensure that only those with a specific intent to transmit HIV were prosecuted and punished.[347] It is important to recognize that specifically

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343. *See, e.g.*, Stoever, *supra* note 11, at 1179 (describing how "[o]ne HIV-infected woman reported that her partner confessed to infecting her deliberately, explaining to her, 'I only did it because I love you so much'").

344. *Id.*

345. *See* Richardson, *supra* note 76, at 1202 (noting that prosecutors who could not prevail under an intentional statute "would have to resort to a general statute, like assault or aggravated harassment, in order to seek a conviction").

346. Tim Martin, *Judging HIV Criminalization: Failures of Judges and Commentators to Engage with Public Health Knowledge and HIV-Positive Perspectives*, 4 U.C. IRVINE L. REV. 493, 498–99 (2014) ("LawAtlas indicates that twenty states that have enacted HIV-specific criminal statutes have continued to prosecute HIV exposure under general criminal law as well.").

347. While exploring the intersection of general sex work criminalization and the HIV legal regime is beyond the scope of this article, it is worth noting that recent research has found that the decriminalization of sex "would have the greatest effect on the course of HIV epidemics across all settings, averting 33–46% of HIV infections in the next decade." Kate Shannon et al., *Global Epidemiology of HIV Among Female Sex Workers: Influence of Structural Determinants*, 385 LANCET 55, 55 (2015). Decriminalizing sex work would also "promote HIV prevention and reduce

reforming exposure laws is necessary but not sufficient in the campaign to overhaul legislation that has a harmful effect in the lives of people living with HIV and those who are at risk.

From a political economy perspective, advocating for state criminalization laws to be significantly pared down may seem challenging, especially in light of the mainstream belief that legislatures tend to consistently expand rather than contract criminal statutes.[348] Contrary to this consensus, however, law professor Darryl Brown has found that, while criminal codes do expand to address new developments in technology and behavior, they also contract, especially when the harm of the behavior in question is "debatable."[349] Given that many HIV exposure statutes criminalize behavior where there will not or even cannot be harm beyond short-term concern or regret,[350] scaling back exposure laws may be more manageable than it seems at first blush.

In fact, some states have begun to ratchet down their exposure statutes. In Iowa, for example, the legislature amended the state's law at the same time that the state Supreme Court ruled that defendants could not be found guilty of criminal HIV exposure if the behavior they engaged in could not actually transmit the virus.[351] The legislature concurrently opted to amend its draconian statute and instead replace it with one where the seriousness of the offense depends on both the intent of the defendant as well as the actual harm to the victim.[352] The law also provides numerous affirmative defenses for, among other things, consent and the use of preventative measures.[353] While these changes are certainly admirable, they nonetheless leave open the possibility for individuals, including survivors

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HIV transmission among sex workers and their sexual partners, while promoting effective treatment and the human rights of sex workers living with HIV." Baskin*, supra* note 117, at 388.

348. Darryl K. Brown*, Democracy and Decriminalization*, 86 TEX. L. REV. 223, 223 (2007) (noting that "[t]he political process of criminal law legislation is, as several leading scholars have characterized it, a 'one-way ratchet'").

349. *Id.* at 234.

350. *See* Buchanan, *supra* note 184, at 1263–64 (arguing that "[m]ost nondisclosure complainants have not been physically harmed. They may, however, experience fear, anger, or betrayal upon learning of the nondisclosure . . . . Another harm uninformed partners might experience is the fact that they had sex that they would have refused had they known the truth").

351. Rhoades v. State, 848 N.W.2d 22, 28 (Iowa 2014) (holding that "we would not want to deprive a person of his or her liberty on the basis the defendant's actions caused something that can only theoretically occur").

352. IOWA CODE ANN. § 709D.3 (West 2020).

353. *Id.* Additionally the law specifically states that it is not a crime for a person with a contagious or infectious disease to become pregnant, continue a pregnancy, or decline treatment while pregnant. *Id.* § 709D.3(5).

of domestic violence, to be convicted of reckless exposure if they are unable to obtain preventative measures.[354]

By contrast, in 2017 California reduced the punishment for knowingly transmitting HIV without disclosure from a felony to a misdemeanor after advocates pushed for HIV transmission to be treated like other communicable diseases in the state.[355] The bill also repealed heightened penalties for people living with HIV engaging in sex work.[356] The new communicable disease law requires a defendant to be aware of their status, intend to infect another person, engage in behavior that poses substantial risk of transmission, and transmit the disease to another individual who is unaware of the defendant's status.[357] This narrowly tailored law is a prime example of the kind of statute that would only implicate individuals succeeding in intentionally spreading HIV rather than individuals who do not wish to spread HIV or other communicable diseases but are unable to access or implement preventative measures.

Iowa and California provide roadmaps for activists and advocates in different political climates who seek to update their state's archaic and overbroad HIV criminalization laws. Survivors living with HIV, however, need more than a diminished threat of abuse or prosecution in order to achieve stability, safety, and better health outcomes.

CONCLUSION

While the HIV legal regime is often justified by sensationalized stories of untoward sexual deviants, changing the frame to view these laws in light of the lived experience of survivors of domestic violence calls their stated purpose, scope, and implementation into question. Rather than seeking specific exceptions to the HIV legal regime for survivors, this Article calls for an overhaul of these structures so that all people living with HIV can be better served by a legal system that is committed to protecting them from discrimination, stigma, and violence. Domestic violence exceptionalism would not meet this goal; even exemptions from notification or prosecution would instead force already marginalized survivors to meet individual system actors' arbitrary standards and expectations. Instead, especially in light of the potential for any person

354. HIV advocates agree that this law is an improvement on the former statute but nonetheless falls short of achieving more equitable outcomes for people living with HIV. *See* Mark J. Stern, *Iowa's Reformed HIV Criminalization Law is Still Pretty Terrible*, SLATE (June 16, 2014), https://slate.com/human-interest/2014/06/iowa-reformed-its-hiv-criminalization-law-but-its-still-bad.html [https://perma.cc/U7XT-CUEP].

355. Julie Moreau, *New California Law Reduces Penalty for Knowingly Exposing Someone to HIV*, NBC NEWS (Oct. 13, 2017), https://www.nbcnews.com/feature/nbc-out/new-california-law-reduces-penalty-knowingly-exposing-someone-hiv-n809416 [https://perma.cc/A7EH-GCAA].

356. *Id.*

357. CAL. HEALTH & SAFETY CODE § 120290(a)(1) (2018).

living with HIV to experience domestic violence, partner notification and exposure laws should be reformed to better reflect the realities faced by people living with HIV, while also protecting those who may be at risk of infection. Finally, domestic violence organizations must acknowledge the link between domestic violence and HIV and incorporate HIV training and services to better serve survivors living at this intersection.