CRIME AND PUNISHMENT: IS THERE A ROLE FOR CRIMINAL LAW IN HIV PREVENTION POLICY?

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Sensational cases like that of Nushawn Williams, who exposed over one hundred women to HIV, have prompted calls for criminal laws to punish people for intentional HIV exposure.[1] This article considers what role, if any, criminal law should have in addressing the issue of intentional HIV exposure and what the scope of that role should be. In that vein, the article explores the inherent tension between public health and criminal law approaches to HIV exposure, details the criminal law approach to HIV exposure—including the history and policies that have motivated criminalization of intentional HIV exposure—and the difficulties that can arise when states attempt to prosecute HIV exposure under general criminal law. Various state statutes criminalizing intentional HIV exposure are analyzed to foster an understanding of how criminal HIV exposure laws can either

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1. Lynda Richardson, *Man Faces Felony Charge of Exposing Girl to H.I.V.*, N.Y. Times B3 (Aug. 20, 1998).

support or undermine public health's HIV prevention efforts. The types of cases tending to attract the most public attention and concern are identified by presenting and evaluating illustrative intentional HIV exposure cases prosecuted under general criminal and criminal HIV exposure statutes.

Finally, the article considers how society's public health interests can be balanced against goals advanced by criminal law, and makes specific recommendations for improving existing criminal HIV exposure statutes to minimize the risk criminal law can pose to public health's HIV prevention efforts. It concludes by urging legislators to carefully consider the implications of their policy decisions by striving to enact legislation that supports the ultimate goal of reducing HIV infection.

In 1995, a young African-American man named Nushawn Williams followed a woman to Jamestown, New York,[2] a small, rural town near Buffalo.[3] Recently released from a New York City prison, the young man quickly developed a reputation in rural Jamestown for his involvement in drug sales and his numerous sexual relationships.[4] It was not long before he also became notorious as the man who exposed dozens of women to HIV, and infected many of them.[5]

In Jamestown, Williams reportedly "traded on his charm and drugs for sex."[6] News reports emphasized Williams' image as an abusive sexual predator,[7] describing how he liked to have "rough sex,"[8] and that he never used a condom.[9] Some who knew Williams

2. *Id.* at B3.

3. Donn Esmonde et al., *Drifter Targeted Crop of Lost Teens*, Buffalo News 1A (Nov. 2, 1997).

4. *Id.*

5. Henry L. Davis, *Two Births May Bring Williams' HIV Toll to 16*, Buffalo News 4B (Jan. 29, 1998); Henry L. Davis, *Latest Tests Reveal Williams Allegedly Infected 13 Women*, Buffalo News 4B (Dec. 10, 1997).

6. Lawrence K. Altman, *The Doctor's World: Sex, Privacy and Tracking H.I.V. Infections*, N.Y. Times F1 (Nov. 4, 1997); Esmonde, *supra* n. 3, at 1A; Agnes Palazzetti, *Suspect Kept Score: Williams' Records Helped Track Infected Women*, Buffalo News 1A (Oct. 29, 1997).

7. Jennifer Frey, *Jamestown and the Story of Nushawn's Girls*, Wash. Post C1 (June 1, 1999).

8. *E.g.* Henry L. Davis, *Use of Drugs, Rough Sex Eyed for Role in Outbreak*, Buffalo News 1A (Nov. 2, 1997) (reporting on speculation that rough sex, anal sex, and sharing needles may have been to blame for the extraordinarily high rate of infection among Williams' partners).

referred to him as a "sex fiend."[10] While many of the reports attempted to portray the reasons why such an unusually high number of Williams' partners became HIV-infected, they also built upon stereotypes about race, sex, and drugs, leaving many in the region, and across the nation, in fear of a supposed new breed of sexual predator.[11]

Williams first came into contact with New York City public health officials in 1996, after being referred into treatment for a sexually transmitted disease.[12] At the recommendation of the public health officials, Williams was also tested for HIV, the result of which was positive.[13] Public health officials subsequently began contacting the twenty women Williams identified as his sexual partners to advise them that they had been exposed to HIV and should be tested for it.[14] The officials also admonished Williams to disclose his infection to future sexual partners and to use a condom; however, facts later showed that Williams did not follow that instruction.[15]

Meanwhile, in 1997, Jamestown public health officials identified ten women who were infected with HIV.[16] Jamestown previously had only fifty cases of HIV since the 1980s,[17] so the significant number of infections identified within such a short time caught officials' attention.[18] By the fifth case, officials suspected that the cases were connected and, ultimately, identified Williams as the probable source of infection.[19] Eventually, state officials pursued an unusual course of action—they sought a court order authorizing the release of Williams'

9. Ellen Goodman, *Putting a Face on Reality*, Ventura County Star (Cal.) D08 (Nov. 10, 1997).

10. Esmonde, *supra* n. 3, at 1A.

11. Scott Martelle, *A Crisis of the Community Soul*, Buffalo News 7M (Oct. 4, 1998); Sheryl McCarthy, *System Worked, but Public Suffered Anyway*, Newsday A54 (Oct. 30, 1997).

12. Altman, *supra* n. 6, at F1.

13. *Id.*

14. *Id.*; McCarthy, *supra* n. 11, at A54.

15. McCarthy, *supra* n. 11, at A54; Tom Precious, *Test Results Ease AIDS Fears in Chautauqua*, Buffalo News 1A (Nov. 12, 1997).

16. Palazzetti, *supra* n. 6, at 1A.

17. *Id.*

18. Andrew Z. Galarneau, *The Doctor Who Dared*, Buffalo News 1C (Nov. 11, 1997); Palazzetti, *supra* n. 6, at 1A; Jerry Zremsk, *AIDS Outbreak in Small Town Was Easy to Spot, Experts Say*, Buffalo News 1A (Oct. 31, 1997).

19. Galarneau, *supra* n. 18, at 1C; Agnes Palazzetti, *Chautauqua Names HIV Carrier Accused of Infecting at Least 11*, Buffalo News 1A (Oct. 28, 1997).

name, aliases, and photograph, arguing that he posed an "imminent danger" to the public health, and thus his HIV status should not be protected by confidentiality laws.[20] A judge agreed and authorized public disclosure of Williams' HIV status and identifying information.[21] As one Jamestown public health official said, "I had to go after this guy, and I had to get him off the street."[22] Williams was ultimately alleged to have exposed forty-eight young women in Jamestown, and an additional fifty to seventy-five young women in New York City.[23]

Jamestown prosecutors charged Williams with assault and statutory rape for having sexual intercourse with a thirteen-year-old child.[24] Investigators discovered that he was already incarcerated in New York City on drug and robbery charges.[25] Those charges quickly came to be the least of Williams' legal woes. New York City prosecutors charged Williams with reckless endangerment, sexual misconduct, attempted assault, and endangering the welfare of a child by having sexual intercourse with a fifteen-year-old.[26] Williams was not charged with intentional HIV exposure in either Jamestown or New York City, however, because New York did not (and does not) have a criminal HIV exposure statute.[27]

Subsequent interviews with Williams indicate that he did not fully understand his diagnosis.[28] He apparently did not believe that he was

20. Galarneau, *supra* n. 18, at 1C; Palazzetti, *supra* n. 6, at 1A.

21. Galarneau, *supra* n. 18, at 1C.

22. *Id.*

23. Ctrs. for Disease Control (CDC), *Cluster of HIV-Positive Young Women—New York 1997-1998*, 48 Morbidity & Mortality Wkly. Rep. 413, 413 (1999); Davis, *supra* n. 5, at 4B; Richardson, *supra* n. 1, at B3; Amy Waldman, *Guilty Plea in an H.I.V. Exposure Case*, N.Y. Times B3 (Feb. 19, 1999).

24. *Guilty Plea in HIV Rape Case*, Newsday A27 (Feb. 28, 1999); Waldman, *supra* n. 23, at B3.

25. Esmonde, *supra* n. 3, at 1A; Palazzetti, *supra* n. 6, at 1A; Palazzetti, *supra* n. 19, at 1A; Waldman, *supra* n. 23, at B3.

26. *Guilty Plea in HIV Rape Case*, *supra* n. 24, at A27; Richardson, *supra* n. 1, at B3; Waldman, *supra* n. 23, at B3.

27. *See infra* pt. IV (cataloging states that do and do not have criminal HIV exposure statutes).

28. *Man with HIV Says Numbers Overstated*, Dallas Morn. News 8A (Nov. 6, 1997); Michael Cooper, *Drifter Says He Had Sex with up to 300*, N.Y. Times B5 (July 29, 1999); Lou Michel, *Nushawn Pleads Guilty: Deal Expected to Result in 4-Year Term*, Buffalo News 1A (Feb. 27, 1999).

HIV-infected, and stated that he thought Jamestown public health officials were "just trying to get [him] out of town."[29] Williams was diagnosed with schizophrenia in proceedings related to the New York City reckless endangerment case, further suggesting that he may not have fully understood his diagnosis.[30] Almost two years after his case became public, Williams still questioned whether he had HIV, stating "I still don't even know if I got it now."[31]

Williams' case prompted calls for criminal laws to punish those who knowingly expose others to HIV.[32] Representative of the public's mood is a 1999 statement of an Ohio lawmaker upon introducing a bill to make it a felony for an HIV-infected person to fail to inform a prospective sexual partner of his HIV status: "It is wrong for society to simply look the other way and not offer reasonable protection to those who are unknowingly being exposed to this lethal disease."[33] According to one survey, more than three-quarters of Americans agreed that those who knowingly infect another person with HIV should face criminal charges.[34] Although this sentiment has been fueled by publicity surrounding sensational cases like that of Williams, it also reflects the changing nature of the AIDS epidemic in this country—people with HIV/AIDS are living longer, remaining healthier, and, potentially, having more sexual partners.[35]

Proponents for laws criminalizing the failure to disclose one's HIV status to a potential partner argue that it will deter HIV-infected individuals from high-risk behavior, as well as punish individuals who place others at risk of infection.[36] Opponents to criminalization argue that criminal exposure laws will discourage high-risk people from being tested for HIV and undermine public health services and prevention efforts, thereby creating the potential for increased

29. *Man with HIV Says Numbers Overstated*, *supra* n. 28, at 8A.

30. Lou Michel & Gene Warner, *Williams Is Found Mentally Ill*, Buffalo News 1A (Nov. 4, 1997).

31. Cooper, *supra* n. 28, at B5.

32. Richardson, *supra* n. 1, at B3.

33. Mark Tatge, *Bill Would Require HIV Disclosure*, Plain Dealer (Cleveland, Ohio) 5B (Feb. 10, 1999).

34. 142 Cong. Rec. E1447 (daily ed. Aug. 1, 1996).

35. *Id.* at E1446-47 (noting scientists' suggestion that it is possible to suppress HIV to the point of chronic disease with early treatment).

36. *Id.* at E1447.

transmission of HIV.[37] The inherent tension between criminal law and public health approaches to the issue is manifested in the debate over criminalization. Criminal law attempts to deter transmission or exposure deemed intentional by punishing those responsible with the belief that the threat of incarceration will operate as a deterrent.[38] In contrast, the public health approach relies on the voluntary cooperation of those who are infected in HIV testing and in contacting partners of infected individuals who have been exposed to HIV, which the threat of criminal prosecution may render such voluntary efforts ineffective if high-risk individuals view such attempts to gather evidence to use against them.[39] Accordingly, this article explores the balance between the competing goals and philosophies of public health prevention efforts and the criminal law in seeking to define the appropriate scope of criminal law in this controversial area.

Effective health policy requires an understanding of the problem at issue, thus Part I of this article begins by describing HIV, modes of transmission, and risk behaviors. Part II discusses the public health approach to HIV prevention. In this section, the traditional view of public health, which is more coercive, is distinguished from the contemporary view of public health, which primarily relies upon voluntary cooperation. Understanding the modern public health approach to HIV prevention will aid an understanding of how criminal HIV exposure statutes can affect those efforts. Part III discusses the criminal law approach to HIV transmission, beginning with a review of general criminal law principles, which leads to a discussion of the historical and policy background driving criminalization of intentional HIV exposure. That review assists an understanding of the circumstances and timing that have affected the adoption of various approaches to criminalizing HIV exposure.

Part IV analyzes various statutes criminalizing intentional HIV exposure. Four separate types of statutes are examined: (1) Those that create a separate crime of intentional HIV exposure; (2) statutes

37. Zita Lazzarini & Robert Klitzman, *HIV and the Law: Integrating Law, Policy, and Social Epidemiology*, 30 J. L. Med. & Ethics 533, 537 (2002).

38. Zita Lazzarini, Sarah Bray & Scott Burris, *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J. L. Med. & Ethics 239, 239 (2002); Lazzarini & Klitzman, *supra* n. 37, at 537.

39. *See* Lazzarini & Klitzman, *supra* n. 37, at 537 (referring to the ineffectiveness of tough sentences as deterrents, and racially motivated enforcement of laws resulting in distrust of the law).

enhancing penalties when a crime is committed by someone who is HIV-infected; (3) general STI statutes that can be applied to HIV exposure; and, (4) general criminal laws. The article studies the language and implications of the statutes to reveal how criminal HIV exposure laws support or undermine public health prevention efforts.

Part V presents and evaluates illustrative cases that have been prosecuted for intentional HIV exposure under the various types of statutes discussed in Part IV. The analysis identifies the types of cases that have attracted the most public attention and concern, while Part VI identifies serious concerns about criminalizing intentional HIV exposure and how those concerns can be balanced with criminal law goals. In particular, specific recommendations are made for improving existing criminal HIV exposure statutes to minimize the risks they pose to public health prevention efforts.

The article concludes by urging policy-makers to carefully consider the implications of their decisions and to strive to make policies that support the ultimate goal of reducing HIV infection.

I. HIV TRANSMISSION

Despite the fact that the HIV/AIDS epidemic has existed in the United States for more than twenty years, there continues to be widespread misunderstanding about how HIV is transmitted. According to a fact sheet published by the Centers for Disease Control and Prevention (CDC) in 1999:

> HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly . . . through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth.[40]

While the above statement is technically correct, its broad wording leaves significant room for confusion and misconception. For example, sexual contact that does not encompass an exchange of blood,

40. CDC, *HIV and Its Transmission* 1 (July 1999) (available at <http://www.cdc.gov/hiv/pubs/facts/transmission.pdf> (accessed Apr. 1, 2004)).

semen, or vaginal fluids, poses little to no risk for HIV transmission.[41] Moreover, some sexual behaviors present greater risks than others;[42] however, the fact sheet makes no distinction among the wide range of sexual activities that may or may not put one at risk for HIV infection. Once a person is infected, the virus remains in that person's body for the remainder of his or her life.[43] While medication can control the virus, there is presently no cure for it nor is there an effective vaccine that prevents infection if exposed.[44]

II. PUBLIC HEALTH APPROACH TO HIV TRANSMISSION

A. *TRADITIONAL PUBLIC HEALTH POWERS*

Public health is characterized by its focus on the community rather than the individual.[45] Primarily, it uses laws and regulations to promote and protect societal necessities by establishing environmental conditions that promote public health, including clean air and water, uncontaminated food and drinking water, and safe housing.[46] Thus, public health uses government action to benefit and protect the welfare of the community.[47] Public health regulations often infringe on the

41. Alix R. Rubin, *HIV Positive, Employment Negative? HIV Discrimination Among Health Care Workers in the United States and France*, 17 Comp. Lab. L. 398, 404 (1996).

42. *See* Lazzarini & Klitzman, *supra* n. 37, at 534 (referring to male-to-male sex and unprotected sex as high risk behaviors).

43. U.S. Dept. of Health & Human Resources, *HIV and Its Treatment: What You Should Know—Understanding Prevention* [1] <http://aidsinfo.nih.gov/guidelines/adult/brochure/05.html> (accessed Apr. 1, 2004).

44. U.S. Dept. of Health & Human Resources, *HIV and Its Treatment: What You Should Know* [1] <http://aidsinfo.nih.gov/guidelines/adult/brochure/01.html> (accessed Apr. 1, 2004).

45. *See* Lawrence O. Gostin, *Public Health Law in a New Century Part I: Law as a Tool to Advance the Community's Health*, 283 J. Am. Med. Assn. 2837, 2838 (2000) (explaining that the community's public health interest extends to environmental protection, sanitation, clean air and water, safe roads and products, and control of infectious diseases).

46. *See id.* at 2840 (describing public health law's concern with the community's well-being, the relationship between the community and state government, and implementation of a broad range of services designed to identify, prevent, and ameliorate health threats to the community).

47. *See id.* (noting that government can require conformance with publicly established standards of conduct so that others will not be placed at risk of harm).

interests of individuals. For example, public health regulations restrict the ability of individuals to smoke in public buildings, but do not prohibit smoking altogether.[48] In some cases, the infringement on individual liberties is more severe, as in *Jacobson v. Massachusetts*.[49] There, the United States Supreme Court upheld a Massachusetts statute authorizing compulsory smallpox vaccinations during epidemics.[50] The court stated that it was:

> [N]ot prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent, and enjoying the general protection afforded by an organized local government, may thus defy the will of its constituted authorities, acting in good faith for all, [by refusing vaccination].[51]

Compulsory vaccination is only one example of the power of public health authorities to compel certain behavior. As the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic demonstrated, public health authorities have the power to quarantine individuals who are infected with, or have been exposed to, a serious and contagious illness, for the purpose of protecting others who might come into contact with them.[52] Public health officials may also require individuals to take medications for infectious diseases, such as tuberculosis, and monitor their adherence to the appropriate medical regimen to ensure that they are no longer contagious.[53] Additionally, public health authorities may require vaccination as a requirement for school attendance.[54]

A state's police power gives it the authority to promote the community's general welfare, even at the expense of individual

48. Jeffrey L. Hall, *Secondhand Smoke as an Issue in Child Custody/Visitation Disputes*, 97 W. Va. L. Rev. 115, 125 (1994).

49. 197 U.S. 11 (1905).

50. *Id.* at 39.

51. *Id.* at 37.

52. *See* Press Release from Capitol Hill, *Harman Calls on Bush Administration to Take Additional Steps* 1 (Apr. 4, 2003) (noting that existing Presidential Order 12452 permits quarantining individuals with tuberculosis, smallpox, and ebola).

53. *E.g.* 42 U.S.C. § 264(d) (2000) (enabling the National Advisory Health Council to recommend apprehension and examination of individuals with communicable diseases).

54. *E.g. Zucht v. King*, 260 U.S. 174, 177 (1922) (upholding a Texas ordinance mandating vaccinations as a prerequisite to school attendance).

liberty;[55] however, while public health has the power to compel, the Constitution constrains the extent to which the state can promulgate regulations and laws promoting public health. Specifically, the interests of the community must be balanced against the interests of the individual.[56] To justify infringement of an individual's rights, certain criteria must be met: (1) There must be a significant risk to others; (2) the proposed action must be necessary and reasonably likely to achieve the stated goal (i.e. the means chosen must fit the ends); (3) the proposed action must be the least restrictive option that can achieve the goal; (4) the costs must be reasonable compared to the projected benefits; and, (5) the burdens and benefits must be fairly distributed.[57]

Public health efforts place a priority on population-based prevention with a secondary emphasis on treatment and monitoring.[58] Prevention has taken a variety of forms, including social marketing, education, vaccination, counseling, and testing.[59] Public health's monitoring function identifies populations most affected by a particular disease, thereby allowing more focused prevention and treatment efforts that are closely tailored to an affected group. Although coercion traditionally played a significant role in public health methodology, contemporary public health approaches place greater value on voluntary cooperation as opposed to coercion.[60] This shift from coercion to voluntary cooperation reflects public health officials' recognition that even mandatory programs depend upon the trust and cooperation of individuals. For example, although most states have

55. *See* Gostin, *supra* n. 45, at 2840 (providing examples of government action to protect the general welfare of the community, and how that restricts private behavior).

56. *Id.*

57. James Childress, *AIDS & Ethics* ch. 3, 53-55 (F.G. Reamer ed., Columbia U. Press 2000); *see* Lawrence O. Gostin, *Public Health Law in a New Century Part III: Public Health Regulation: A Systematic Evaluation*, 283 J. Am. Med. Assn. 3118, 3118-20 (2000) (discussing three common justifications for public health regulations' infringement upon individual rights, and elaborating on the five criteria justifying such infringements).

58. Rene Bowser & Lawrence O. Gostin, *Managed Care and the Health of a Nation*, 72 S. Cal. L. Rev. 1209, 1291 (1999).

59. *E.g.* Sean D. Murphy ed., *Contemporary Practice of the United States Relating to International Law*, 95 Am. J. Intl. L. 132, 155 (2001) (discussing the effects of the Global AIDS and Tuberculosis Relief Act, enacted in 2000, which authorizes funding for prevention of HIV transmission).

60. Larry I. Palmer, *Patient Safety, Risk Reduction, and the Law*, 36 Houston L. Rev. 1609, 1627 (1999).

mandatory partner notification for sexually transmitted infections (STIs) such as syphilis and gonorrhea, public health officials recognize that their efforts cannot be successful unless the person before them provides complete and accurate information about his or her sexual partners.[61] It can be difficult, if not impossible, to force people to reveal the names of their sexual partners if they do not wish to do so.

The shift to voluntary measures is most evident in the public health approach to HIV prevention. Cooperative 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.[62] Messages recognizing the diverse circumstances of HIV-infected people, the difficult and imperfect prospect of changing private sexual behaviors, and the pressing needs of people living with HIV, are ultimately more effective than threats of prosecution and incarceration.

B. *PUBLIC HEALTH HIV PREVENTION EFFORTS*

While public health efforts to fight HIV/AIDS have evolved over time, the core purpose has largely remained unchanged. The public health approach to HIV prevention emphasizes individuals' voluntary participation.[63] In the early years of the epidemic, there was an extensive stigma attached to having HIV/AIDS.[64] HIV-infected people experienced housing, employment, insurance, and health care discrimination, and there were even calls for their quarantine.[65] At the same time, there were no effective treatments.

To reassure people and encourage them to seek HIV testing, states adopted special protections that emphasized the voluntary nature of HIV testing, and required specific, often written, informed consent

61. *See* Matthew Carmody, *Mandatory HIV Partner Notification: Efficacy, Legality, and Notions of Traditional Public Health*, 4 Tex. Forum Civ. Liberties & Civ. Rights 107, 119 (1999) (discussing factors affecting cooperation of HIV infected individuals).

62. Childress, *supra* n. 57, at 73.

63. Larry Gostin, *A Decade of a Maturing Epidemic: An Assessment and Directions for Future Public Policy*, 16 Am. J. L. and Med. 1, 8-9 (1990).

64. Carmody, *supra* n. 61, at 118.

65. *See* Elisabeth Van Vliet, *Law, Medicine, HIV, and Women: Constructions of Guilt and Innocence*, 1 Health L. J. 191, 196 (1993) (attributing demands for mandatory testing and quarantine to the asymptomatic nature of the disease).

to testing—a step rarely required for other blood tests.[66] Additionally, HIV information was given confidentiality protection exceeding that afforded general medical information,[67] thereby encouraging people to seek HIV testing and related medical care without fear of discrimination or misuse of personal health information. Testing was also coupled with mandatory pre-test and post-test counseling designed to provide information about the behaviors that transmit HIV and how to minimize risk of infection.[68] The counseling sessions encouraged HIV-infected people to take necessary precautions to prevent infection of others and educated uninfected individuals about ways to reduce their risk of becoming infected.[69] To further encourage voluntary testing, many states offered anonymous HIV testing that allowed individuals to receive HIV testing without revealing their names.[70] This voluntary counseling and testing approach remains the dominant approach today, and continues to emphasize education with the belief that increased knowledge empowers individuals to make healthier personal choices.[71]

Public health HIV prevention efforts typically include partner notification, which involves health officials confidentially contacting partners of HIV-infected individuals to inform them of possible exposure to the virus.[72] Partners who otherwise may not have known

66. Ronald Bayer, *Public Health Policy and the AIDS Epidemic: An End to HIV Exceptionalism?*, 324 New Eng. J. Med. 1500, 1503 (1991); Bernard Lo et al., *Voluntary Screening for Human Immunodeficiency Virus (HIV) Infection: Weighing the Benefits and Harms*, 110 Annals Internal Med. 727, 727 (1989).

67. *E.g. Powell v. Schriver*, 175 F.3d 107, 111 (2d Cir. 1999) (noting that "[i]ndividuals who are infected with the HIV virus clearly possess a constitutional right to privacy regarding their condition" (quoting *Doe v. City of N.Y.*, 15 F.3d 264, 267 (2d Cir. 1994)).

68. Gostin, *supra* n. 63, at 7-8 (explaining the CDC's objectives in recommending counseling as being "to help the patient cope with the psychological burdens of contracting a potentially lethal infection, to modify behavior, to reduce the threat of transmission, and to provide an opportunity to receive early treatment").

69. *Id.*

70. Amy L. Schwartz, Student Author, *Where Everybody Knows Your Name: Iowa's Policy of Name-Based HIV Reporting*, 7 J. Gender Race & Just. 387, 390-91 (2003).

71. Todd Summers et al., *Voluntary Counseling, Testing, and Referral for HIV: New Technologies, Research Findings Create Dynamic Opportunities*, 25 J. Acquired Immune Deficiency Syndromes S128, S131 (2000).

72. *See* James G. Hodge, Jr. & Lawrence O. Gostin, *Handling Cases of Willful Exposure Through HIV Partner Counseling and Referral Services*, 23 Women's Rights

of their exposure can then receive HIV testing and information about reducing their risk of infection. As previously discussed, partner notification efforts can only be effective if the index patient trusts that public health officials will maintain their confidences and feel secure providing relevant information; HIV-infected individuals are unlikely to provide necessary partner notification information if they believe that the information will be used against them. Although awareness and public attitudes about HIV/AIDS have improved over the past two decades, the persistence of social stigma and discrimination are the foundation for a continued public health emphasis on protecting individual rights.[73]

In July 2003, the CDC issued new recommendations to increase HIV prevention efforts among HIV-infected individuals.[74] Its outline for "prevention with positives" has three basic components:

> [S]creening for HIV transmission risk behaviors and STDs, providing brief behavioral risk-reduction interventions in the office setting and referring selected patients for additional prevention interventions and other related services, and facilitating notification and counseling of sex and needle-sharing partners of infected persons.[75]

The CDC's recommendations stem from its April 2003 statement announcing the need for new approaches to HIV prevention in the United States.[76] While the CDC's recommendations are consistent with increasing public and scientific interest in conducting prevention with HIV-infected individuals, they have also been accompanied by controversy. Some community-based HIV/AIDS service organizations worry about funding cuts for prevention among those who are not HIV-infected, while some researchers are concerned about the capacity of

L. Rep. 45, 54-56 (2001) (describing laws in California and New York providing that physicians "may notify a contact if the physician reasonably believes a significant risk of transmission exists, believes the patient will not warn the partner, and notifies the patient of the physician's intent to warn the person at risk").

73. Carmody, *supra* n. 61, at 118-19.

74. CDC, *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, 52 Morbidity & Mortality Wkly. Rep. 1, 1 (2003).

75. *Id.*

76. *See generally* R.S. Janssen et al., *Advancing HIV Prevention: New Strategies for a Changing Epidemic—United States 2003*, 52 Morbidity & Mortality Wkly. Rep. 329, 329 (2003) (reviewing testing trends and new developments and strategies aimed at HIV prevention).

already overburdened medical providers to engage in effective prevention work among their HIV-infected clients.[77] Moreover, because a large percentage of HIV-infected people do not know they are infected, the efforts of "prevention with positives" only address one component of HIV prevention.[78]

C. *PUBLIC HEALTH POLICY*

Public health policy on HIV prevention and treatment has developed in a variety of ways. At the broadest level, non-governmental organizations and other international bodies have made significant policy recommendations. For example, UNAIDS issued recommendations delineating three particular functions of public health law that will be most effective in preventing the spread of HIV:

> [To] classify transmissible diseases, specifying which legal provisions apply to which diseases; impose legal duties on certain people (e.g. physicians) to identify, report, and treat diseases; and grant powers to public health officials to be exercised in the prevention and treatment of diseases.[79]

Most funding provided by the United States government is for HIV/AIDS prevention and treatment. Restrictions imposed on the use of that money influence public health policy at every level.[80] While

77. Sabin Russell, *AIDS Prevention Groups Fear U.S. Funding Cuts*, S.F. Chron. A4 (July 26, 2003); David Wahlberg, *CDC Discuss HIV Patients' Behavior*, Atlanta J. Const. 3A (July 18, 2003).

78. *See* Kaiser Network, *HIV-Positive People Not Obtaining Test Results, Receiving Appropriate Counseling, Studies Say* [1] (July 30, 2003) <http://www.thebody.com/kaiser/2003/jul30_03/hiv_testing.html> (accessed Apr. 1, 2004) (stating that researchers at the University of California, San Francisco found that only 25% of HIV-infected individuals discussed safer sex methods with their doctors and that the Los Angeles County Department of Health Services reported that 60% of men from gay bathhouses who tested positive for HIV never returned to learn the results of their HIV tests); Richard Perez-Pena, *Study Finds Many Ignore Warnings on Sex Practices*, N.Y. Times B1 (Aug. 9, 2003) (reporting the results of a comprehensive study indicating that most New Yorkers with multiple sexual partners did not know whether they were HIV-infected, and that more than 40% did not use condoms the last time they had sex).

79. Richard Elliott, *Criminal Law, Public Health, and HIV Transmission: A Policy Options Paper* 28 (UNAIDS 2002).

80. *Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990*, 42 U.S.C. §§ 300ff–300ff-90 (2000); *see* Martha M. McKinney & Katherine Marconi, *Delivering HIV Services to Vulnerable Populations: A Review of CARE Act Funded*

several federal agencies—most notably the CDC and the Health Resources and Services Administration—offer guidelines for the array of HIV prevention, care, and research undertaken across the country, the promulgation and implementation of public health law occurs primarily at the state and local level. While this allows states and communities to tailor HIV services to the specific needs of their populations—a good and necessary flexibility—it also results in diffuse and inconsistent HIV/AIDS treatment and prevention policies across the country. For example, San Francisco has not aggressively pursued formal partner notification mechanisms, opting instead to rely on the cooperation of highly active community organizations to deliver prevention messages.[81] At the other end of the spectrum, cities lacking a strong activist or non-profit infrastructure may develop policies giving the health department greater regulating power.[82]

The relationship between public health and criminal law has often been a precarious one. Within the context of HIV/AIDS, the example of partner notification highlights the tension between the use of public health measures and criminal law to prevent the spread of the virus.[83] In situations of recent diagnosis, public health professionals must balance the goal of protecting an individual's right to privacy with that of protecting others from possible infection. When an HIV-infected person willfully behaves in a manner that puts others at risk for HIV infection, despite public health education efforts, public health's voluntary cooperation approach becomes apparent. In that context, public health professionals have a variety of tools at their disposal.

Education and counseling are among the most commonly used prevention tools, especially as an initial option. Some remedial options, such as quarantine, are inappropriate in the context of HIV

Research, 117 Pub. Health Reps. 99, 100 (Mar. 2002–Apr. 2002) (evaluating CARE funded evaluations and research studies).

81. *See* Sandra Schwarcz et al., *Partner Notification for Persons Recently Infected with HIV: Experience in San Francisco*, 28 J. Acquired Immune Deficiency Syndromes 403, 403-04 (2001) (reporting results of the implementation of partner notification and community group involvement as prevention tools).

82. *E.g.* Matthew R. Golden, *HIV Partner Notification: A Neglected Prevention Intervention*, 29 Sexually Transmitted Diseases 472, 472-75 (2002) (reporting results of a survey conducted to assess the potential need for partner notification of HIV exposure among sexually transmitted disease clinic patients in New York City).

83. *See* Hodge & Gostin, *supra* n. 72, at 54-56 (noting that partner notification recognizes the partner's right to know and the duty to disclose, and tying the duty of partner notification to the common law duty to warn).

because it has a long latency period and cannot be transmitted through casual contact. Other alternatives, such as cease and desist orders, may be (and have been) used with HIV-infected individuals who persist in behaviors that put others at risk of infection.[84] When public health measures fail, however, criminal law may be a useful tool for addressing the problem of persistent behaviors that pose a significant risk to the public health.

III. CRIMINAL LAW APPROACH TO HIV TRANSMISSION

A. *GENERAL CRIMINAL LAW APPROACH*

Criminal law is designed to force compliance with social norms by punishing offenders. Criminal statutes delineate the conduct that society deems harmful enough to warrant punishment.[85] Various social interests are reflected in criminal laws, including protecting individuals from physical harm, protecting property interests and public health, safeguarding against sexual immorality, protecting the administration of justice, and preserving peace and order.[86] Though criminal law and public health share the goal of protecting society, law enforcement pursues that goal by punishing offenders after a violation

84. *See* Ronald Bayer & Amy Fairchild-Carrino, *AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior*, 83 Am. J. Pub. Health 1471, 1473 (1993) (reporting that Arkansas, Maine, Mississippi, Texas, and Oklahoma had issued 15 cease and desist orders warning specified individuals of further legal action if behavior contravening public health counsel continued).

85. Charles E. Torcia, *Wharton's Criminal Law* vol. 1, §§ 1-5 (15th ed., Clark Boardmen Callaghan 1993) (identifying protection of the community and of its moral code, retribution and reprobation, deterrence, and reformation as the primary purposes of the criminal law).

86. Wayne R. LaFave & Austin W. Scott, Jr., *Criminal Law* ch. 1, § 1.5, 22-23 (2d ed., West 1986). LaFave and Scott observe that because criminal law is framed in terms of punishment, it is focused more on preventing undesirable conduct rather than encouraging desirable conduct. *Id.* They identify the purposes of criminal law as:

> [P]rotection from physical harm to the person; protection of property from loss, destruction, or damage; protection of reputation from injury; safeguards against sexual immorality; protection of the government from injury or destruction; protection against interference with the administration of justice; protection of the public health; protection of the public peace and order; and the protection of other interests.

Id.

occurs, whereas public health's primary focus is acting on a community-wide basis to prevent the harm before it occurs.[87] While public health may intervene in individual behavior, it generally only does so to the extent the individual presents a threat to the health of the community.[88]

In criminal law, the harm to one person resulting from a violation of the law is an act that merits social response.[89] Although practical considerations, including staffing, funding, and reporting, may prevent law enforcement from pursuing all violations, criminal law's imprimatur of social disapproval and the threat of prosecution and incarceration are intended to have a generalized deterrent effect on behavior of the population at large.[90]

Criminal statutes specify the punishment for an offense, which varies according to the severity of the offense. Punishment is used to promote several goals.[91] First, it aims to deter behaviors that society deems unacceptable.[92] Second, it seeks to educate and reform offenders to prevent recidivism.[93] Third, it removes offenders from society so that they cannot perpetrate further crimes among the population at large.[94] Finally, it exacts retribution for the offense committed, thereby allowing society to express its moral outrage.[95]

87. *Id.*; *see* Stephen F. Morin, *Early Detection of HIV: Assessing the Legislative Context*, 25 J. Acquired Immune Deficiency Syndromes S144, S145 (2000) (describing various state and federal efforts to promote public health, including criminal laws, social marketing campaigns, and programs increasing the availability of safety devices).

88. *E.g. New AIDS-Like Illness—Federal Agency Slow to React*, The Post-Standard (Syracuse, N.Y.) [Editorial sec.] (Aug. 1, 1992) (noting as a large-scale example of the CDC's failure to promptly research a rare AIDS-like illness).

89. *See* LaFave & Scott, Jr., *supra* n. 86, at § 1.5(a), 23-27 (explaining that crimes result in a harm to society as a whole and detailing various theories of punishment).

90. *Id.*

91. *Id.*; Torcia, *supra* n. 85, at § 1.

92. LaFave & Scott, Jr., *supra* n. 86, at § 1.5, 22; Kenneth L. Wainstein, *Judicially Initiated Prosecution: A Means of Preventing Continuing Victimization in the Event of Prosecutorial Inaction*, 76 Cal. L. Rev. 727, 728 (1988).

93. *See* LaFave & Scott, Jr., *supra* n. 86, at § 1.5(a)(5)-(6), 25-27 (noting that education and reformation function as methods for preventing future crimes).

94. *Id.* at § 1.5(a)(2), 23-24.

95. *Id.* at § 1.5(a)(6), 26; Torcia, *supra* n. 85, at § 2.

There is little agreement about which of these goals should take priority and how conflict among the goals should be resolved.[96] Each goal, however, is reflected in contemporary criminal statutes. For example, California's "three strikes" law, mandating life in prison upon conviction of a third felony or "strike," is intended to incapacitate habitual criminals to prevent further crimes.[97] The severe penalty was designed to serve as a deterrent,[98] and, for those who are not deterred by the penalty, it exacts retribution by prescribing a life sentence for the habitual criminal.[99] As Justice Rehnquist asked during oral argument on a challenge to the statute's constitutionality, "[w]hy can't California decide that enough is enough, that someone with a long string [of convictions] like that simply deserves to be put away?"[100] Critics unsuccessfully argued that imposition of a life sentence on the basis of a non-violent third strike violated the Eighth Amendment's prohibition against cruel and unusual punishment.[101]

In contrast, California's Proposition 36 focuses on reform by diverting non-serious drug offenders to treatment, as opposed to incarceration.[102] Proponents argue that providing treatment prevents further offenses.[103] Thus, as the foregoing legislative examples illustrate, the primary goal of criminal legislation may depend upon the circumstances for which it is used and the nature of the crime.

96. LaFave & Scott, Jr., *supra* n. 86, at § 1.5(b), 27.

97. Cal. Penal Code Ann. § 1170.12 (West Supp. 2004).

98. LaFave & Scott, *supra* n. 86, at § 1.5(a)(4), 24-25.

99. *Id.* at § 1.5(a)(6), 25-26.

100. Linda Greenhouse, *California's 3-Strikes Law Tested Again*, N.Y. Times A4 (Nov. 6, 2002).

101. *Lockyer v. Andrade*, 538 U.S. 63, 74-77 (2003) (upholding California's "Three Strikes" law); *see* Cal. Penal Code Ann. § 1170.12 (West Supp. 2004) (prescribing a term of life imprisonment for three-time felons).

102. Cal. Penal Code Ann. §§ 1210.1-1210.5; *see Smart Card Used to Track Proposition 36 Drug Offenders; Netsmart Technologies to Supply Technology to Monitor Drug Offenders*, 13 Alcoholism & Drug Abuse Wkly. 7, 7 (Sept. 24, 2001) (reporting that Proposition 36 mandates "treatment instead of incarceration for first- and second-time nonviolent drug offenders").

103. Ed Pope, *Proposal Mandating Treatment for Drug Offenders Wins Easily; Voters Overwhelmingly Support Measure That Targets Non-Violent*, San Jose Mercury News 8EL (Nov. 8, 2000); Daniel Vasquez, *Treatment Program Has Signs of Success*, San Jose Mercury News B1 (Apr. 17, 2002).

B. *CRIMINALIZATION OF INTENTIONAL HIV EXPOSURE*

1. *Historical Background*

Historically, states have adopted criminal laws proscribing what is perceived as sexual misconduct.[104] This has included laws against sexual activity outside of marriage, access to contraception, sodomy, and homosexuality.[105] Many of these statutes have been repealed, while others have been invalidated by Supreme Court decisions.[106] States have also adopted public health laws to address the willful or knowing transmission of STIs.[107] Most states classified willful or knowing transmission of an STI as a misdemeanor, a crime punishable by less than one year in jail.[108] With the onset of the AIDS epidemic,

104. *See* LaFave & Scott, *supra* n. 86, at § 1.5, 22 (noting that the criminal law operates to safeguard against sexual immorality).

105. *E.g. Lawrence v. Tex.*, ___ U.S. ___; 123 S. Ct. 2472, 2484 (2003) (holding unconstitutional a statute that made it a crime for two persons of the same sex to engage in certain intimate sexual conduct); *Eisenstadt v. Baird*, 405 U.S. 438, 454-55 (1972) (holding that a statute prohibiting the sale, distribution, and use of contraceptives to unmarried persons was unconstitutional); *Loving v. Va.*, 388 U.S. 1, 12 (1967) (holding that a statute prohibiting interracial marriages was unconstitutional); *Griswold v. Conn.*, 381 U.S. 479, 485 (1965) (holding unconstitutional a statute prohibiting the sale, distribution, or use of contraception to married persons).

106. *E.g. Lawrence*, 123 S. Ct. at 2481 (noting that the number of states that have statutes against homosexual conduct has been reduced from 25 to 13); *Griswold*, 381 U.S. at 485 (holding that a state statute prohibiting the sale, distribution or use of contraception to married persons was unconstitutional).

107. *E.g. Guevara v. Super. Ct. (Cal.)*, 73 Cal. Rptr. 2d 422, 426 (App. 6th Dist. 1998) (directing that aggravated assault charges for engaging in unprotected consensual sexual intercourse with a minor without disclosing HIV status be dismissed because the state failed to prove that bodily fluids of the HIV-infected defendant were likely to produce bodily injury, while upholding the constitutionality of sentencing enhancement for HIV-infected individuals); *see Florida Increases Penalty for Having Sex While Infected*, 12 AIDS Policy & L. [St. Legis. sec.] (May 30, 1997) (reporting that as of 1994, at least 27 states "had laws establishing criminal penalties for knowingly transmitting or exposing another person to HIV through sexual intercourse or other means").

108. *E.g. Berner v. Caldwell*, 543 So. 2d 686, 686 (Ala. 1989) (noting that a negligence cause of action had long been recognized in the state for transmission of disease, as reflected by the public policy making transmission of a sexually transmitted disease a class C misdemeanor); Trevor Aaronson, *Unsafe Sex*, New Times Broward-Palm Beach News [News sec.] (May 22, 2003) (noting that knowing transmission of an STI to an uninfected partner without prior consent is a misdemeanor).

some states expanded their STI statutes to include HIV/AIDS.[109] Others enacted specific statutes to address HIV/AIDS.[110] HIV/AIDS statutes differ from the "sexual misconduct" statutes of the past because they address circumstances that actually present harm to others, as opposed to consensual behaviors that may fall outside of societal norms at a given time.

Federal policy provided explicit support for criminalization of intentional exposure to HIV. From 1990 to 2000, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 provided funds to states for AIDS treatment and care, but required states to certify that their criminal laws were "adequate to prosecute any HIV infected individual" who knowingly exposed another to HIV through donation of blood, semen, breast milk, sexual activity, or needle-sharing.[111] Early in the HIV/AIDS epidemic, concerns about the safety of the blood supply appear to have been the motivating factor for making the certification requirement a condition of receiving Ryan White funds.[112] The Senate considered two amendments to the Ryan White CARE Act designed to protect the blood supply—the unsuccessful Helms Amendment, which would have made it a federal crime to donate blood when an individual knows that he or she is infected with HIV or has been an intravenous drug user or a prostitute since 1977, and the successful Kennedy-Hatch Amendment, which left the determination of how to adequately protect the blood supply to the states.[113] Twenty-one states already had statutes criminalizing knowing HIV exposure when the Ryan White CARE Act was enacted in 1990.[114] The federal certification requirement, however, was repealed in 2000, along with other sections relating to formula grants

109. *E.g. Three States Move to Adopt Criminal Exposure Statute*, 15 AIDS Policy & L. [St. Legis. sec] (Mar. 3, 2000) (reporting that Virginia, South Dakota, Wisconsin, Pennsylvania, and New York had either passed legislation or introduced legislation criminalizing HIV exposure).

110. *E.g.* Morin, *supra* n. 87, at S144 (noting legislative trends in "limiting confidentiality of HIV test results, mandating name-based HIV reporting and the partner notification, testing of newborns, and criminalizing nondisclosure in sexual and needle-sharing situations").

111. 42 U.S.C. § 300ff-47 (2000).

112. 136 Cong. Rec. S6293-S6303 (daily ed. May 16, 1990).

113. *Clean Needle Plan*, Newsday 14 (Apr. 28, 1988); Steve Gerstel, *Senate Approves Major AIDS Bill*, United Press Intl. [News sec.] (May 16, 1990).

114. *See infra* pt. IV (cataloging the development of criminal HIV exposure laws).

for early intervention services.[115] At that time, all states had certified that their criminal statutes were adequate to prosecute knowing HIV exposure, although, as detailed in Part IV, not all states adopted HIV-specific statutes.[116]

This historical and policy background explains why criminal HIV exposure laws are prevalent today. The American public has overwhelmingly supported the use of criminal law to address intentional HIV exposure;[117] however, the differences between HIV/AIDS statutes and other STI transmission statutes suggest that HIV criminal exposure statutes may be motivated, in part, by fear and misunderstanding.

2. *Justifications for Using Criminal Law*

States may turn to criminal law to address HIV transmission for several reasons. First, criminal law reflects society's interest in protecting individuals from physical harm.[118] Those who intentionally or recklessly expose others to HIV infection create a substantial but preventable harm. Their intentional behavior is similar to other actions prohibited by criminal statutes, such as assault and battery with fists or a weapon; thus, it would be inconsistent with the purpose of criminal law to exclude this behavior completely from its scope.

Second, although evidence indicates that public health approaches have been effective in reducing HIV transmission, and should be the first and primary approach to HIV prevention, they are not effective with everyone. Some HIV-infected people persist in intentional or reckless high-risk behaviors that expose others to HIV, even after being made aware of the potential harms of these behaviors.[119] When public

115. Natl. Alliance of St. & Territorial AIDS Directors, *Ryan White CARE Act Amendments of 2000* 4 (available at <http://www.nastad.org/PublicPolicyResources/Summary.pdf> (accessed Apr. 1, 2004)).

116. *See infra* pt. IV (cataloguing the development of criminal exposure laws).

117. 142 Cong. Rec. E1447 (daily ed. Aug. 1, 1996); Larry O. Gostin, *Public Health Strategies for Confronting AIDS: Legislative and Regulatory Policy in the United States*, 261 J. Am. Med. Assoc. 1621, 1627 (1989).

118. LaFave & Scott, Jr., *supra* n. 86, at § 1.5, 22.

119. *E.g.* Lazzarini, Bray & Burris, *supra* n. 38, at 246 (citing examples of publicized cases in which the defendants engaged in high-risk behaviors, including some who intentionally attempted to infect others).

health measures fail, the criminal law may be the only way to reach such persons.[120]

Other reasons have been raised to justify HIV-specific criminal statutes. Although some cases of HIV exposure or transmission have been brought under general criminal statutes for assault and attempted murder,[121] there are several difficulties with relying on general criminal statutes. As many commentators have observed, HIV exposure or transmission does not fit well within the scope of general criminal laws.[122] Traditionally, assault was defined as an unwanted touching, hence consent to contact provided a complete defense to such a charge.[123] Accordingly, assault is ill suited to the consensual nature of the behavior that can result in exposure to HIV. Attempted murder requires a showing of the specific intent to kill, an intention difficult to infer from the act of sexual intercourse or needle sharing.[124] There is anecdotal evidence that prosecutors had difficulty obtaining convictions for HIV exposure or transmission under general criminal statutes and dismissed many cases.[125] However, there have also been

120. *See id.* at 239 (explaining that criminal law can be an effective tool for HIV prevention only when it deters behavior that is responsible for new HIV cases).

121. *Id.*

122. *See* Gostin, *supra* n. 117, at 1627 (explaining that proving intent for laws criminalizing intentional HIV exposure can be very difficult); Stephen V. Kenney, *Criminalizing HIV Transmission: Lessons from History and a Model for the Future*, 8 J. Contemp. Health L. & Policy 245, 272-73 (1992) (explaining that laws criminalizing acts by a person who know of his or her HIV infection discourages participation in HIV testing and treatment programs); Kathleen M. Sullivan & Martha A. Field, *AIDS and the Coercive Power of the State*, 23 Harv. Civ. Rights-Civ. Libs. L. Rev. 139, 162-65 (1988) (noting that an examination of traditional criminal laws reveals doubtful and troubling applications to crimes of AIDS transmission).

123. Sullivan & Field, *supra* n. 122, at 168.

124. *See* Larry Gostin, *The Politics of AIDS: Compulsory State Powers, Public Health, and Civil Liberties*, 49 Ohio St. L.J. 1017, 1041-43 (1989) (explaining that to be convicted of attempted murder for transmitting HIV/AIDS, "the person must act knowing he is infected with HIV and that the particular act would almost certainly transmit the virus and kill his partner"); Kenney, *supra* n. 122, at 267 (explaining that to be convicted of attempted murder for transmitting HIV/AIDS, "a person would have to act 'with the purpose of causing' his partner to be infected and die").

125. *See* Gostin, *supra* n. 124, at 1041 (explaining that in a majority of cases, prosecutions were dropped or the defendant was acquitted due to difficulty in applying general criminal law to intentional HIV exposure).

successful prosecutions for intentional HIV exposure under such statutes.[126]

Nevertheless, serious questions have been raised about the criminal law's ability to achieve any goal but retribution in the context of intentional HIV exposure.[127] Proponents of intentional HIV exposure laws argue that by clearly condemning certain actions, the criminal law may encourage HIV-infected persons to stop engaging in behaviors that are likely to transmit HIV.[128] However, unless people are aware of the statutes, they will not affect behavior. Research regarding knowledge of HIV reporting statutes suggests that people are unaware of HIV exposure statutes.[129] Education and reform of offenders is unlikely without additional measures—such as HIV prevention, education, and drug treatment—and it remains unclear whether the penal system is committed to providing these services.[130] Finally, although criminal prosecution may be an appropriate means to protect society from HIV-infected persons who repeatedly refuse to take prevention measures, imprisonment alone is not an answer because many prisoners return to the community, and still others may be infected with HIV while in prison.[131]

126. *E.g. Burk v. Ga.*, 478 S.E.2d 416, 417 (Ga. 1996) (convicting a defendant with AIDS of reckless endangerment for attempting to bite an officer); *Weeks v. Tex.*, 834 S.W.2d 559, 561 (Tex. 1992) (convicting a defendant with HIV of attempted murder for spitting on a guard); *see Man Sentenced for Infecting 13 with HIV*, Boston Globe A14 (Apr. 6, 1999) (noting that Nushawn Williams was prosecuted for infecting at least 13 young women).

127. *E.g.* Gostin, *supra* n. 124, at 1054 (explaining that "retribution is only justified if the sufficient criminal intent can be proven").

128. *E.g.* Arianne Stein, Student Author, *Should HIV Be Jailed? HIV Criminal Exposure Statutes and Their Effects in the United States and South Africa*, 3 Wash. U. Global. Stud. L. Rev. 177, 180-82 (2004) (explaining that HIV-specific legislation promotes normative behavior to encourage people to act within the confines of the law because it is the "right thing to do," while criminal punishment discourages people from engaging in criminal activity).

129. *See* Frederick M. Hecht et al., *Does HIV Reporting by Name Deter Testing?*, 14 Acquired Immune Deficiency Syndromes 1801, 1804 (2000) (noting that the deterring effects of HIV laws are limited because of the lack of social awareness).

130. Adansi A. Amankwaa et al., *Gaps Between HIV/AIDS Policies and Treatment in Correctional Facilities*, 24 J. Health & Human Serv. Admin. 171, 171-90 (2001); Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Impact of the Correctional System on Community Health*, 78 J. Urban Health 214, 222 (2001).

131. Elizabeth Kantor, *HIV Transmission and Prevention in Prisons* [4-5] (HIV InSite 2003) (available at <http://hivinsite.ucsf.edu/InSite.jsp?page=kb-07&doc=kb-

IV. LEGISLATIVE APPROACHES TO INTENTIONAL HIV EXPOSURE

Criminal HIV exposure laws have developed in three separate stages. The first stage occurred in the early period of the HIV/AIDS epidemic. As HIV/AIDS was recognized as a new sexually transmitted infection, some states added HIV/AIDS to their existing STI transmission laws or adopted similar statutes to address HIV/AIDS.[132] A second stage followed the passage of the Ryan White CARE Act, as states complied with the Act's certification requirements to ensure their qualification to receive funds under the Act.[133] Finally, the extensive nationwide media coverage of the Nushawn Williams case in the fall of 1997 brought renewed attention to criminalization of knowing HIV exposure, prompting many states to reconsider their statutes. In response, numerous state legislators introduced bills to address intentional HIV exposure, and several states adopted new statutes or increased the penalties for existing knowing HIV exposure laws.[134]

States have three general options for criminalizing intentional HIV exposure. First, states may adopt HIV-specific statutes that create a separate crime or enhance the penalties for existing crimes.[135] Second, states may rely on existing STI statutes.[136] Finally, states may

07-04-13>) (accessed Apr. 1, 2004)) (explaining that since HIV surfaced as a sexually transmitted disease, states have encompassed the offense within their existing penal codes or made modifications to pre-existing STI laws).

132. Karen E. Lahey, *The New Line of Defense: Criminal HIV Transmission Laws*, 1 Syracuse J. Legis. & Policy 85, 86 (1995).

133. *See* Theresa M. McGovern, *Mandatory HIV Testing and Treating of Child-Bearing Women: An Unnatural, Illegal, and Unsound Approach*, 28 Colum. Hum. Rights L. Rev. 469, 471 (1997) (discussing passage of the Ryan White CARE Act and its requirement that states impose mandatory HIV testing or lose funding).

134. HIV Criminal L. & Policy Project, *HIV-Specific Criminal Transmission Laws* [1] <http://www.hivcriminallaw.org/laws/hivspec.cfm> (accessed Apr. 1, 2004); Morin, *supra* n. 87, at S144-45 (explaining that from 1996 to 1999, a trend to implement tougher "willful exposure" laws, fueled by cases like that of Nushawn Williams, developed among the states); Stein, *supra* n. 128, at 180 (explaining that Nushawn Williams' case caused a public uproar that led to many states enacting HIV specific legislation making knowledge of HIV status an element of the crime).

135. *See infra* pt. IV.A. (analyzing the 23 statutes that make HIV exposure a separate crime); *infra* pt. IV.B. (discussing the various types of enhancement statutes).

136. HIV Criminal L. & Policy Project, *STD or Communicable Disease Transmission Laws* [1] <http://www.hivcriminallaw.org/laws/std.cfm> (accessed Apr. 1, 2004); *see infra* pt. IV.C. (analyzing STI statutes in the 7 states that do not have HIV-specific statutes).

use general criminal statutes, such as assault, reckless endangerment, and the like.[137]

To evaluate how states have approached this issue, state statutes were surveyed to determine what approaches, if any, they have taken to criminalize intentional exposure to HIV. State statutes were identified through the LEXIS-NEXIS™ computerized databases by searching each state's statutes and regulations using the following search terms: (knowing! or willful! or intent!) w/5 (transmi! or expos! or infect! or communic!). If that search did not yield an HIV-specific statute, a search was then made for a statute applying more generally to sexually transmitted diseases using the following search terms: (sexual! or venereal w/5 disease). Finally, if neither search produced an HIV-specific or general STI statute, it was concluded that the state relies on general laws. The findings were then verified against other resources that have collected information about intentional HIV exposure laws, including the HIV Criminal Law and Policy Project at the University of Connecticut Health Center,[138] as well as the ACLU's State Criminal Statutes on HIV Transmission (which was last updated in 2000, but remains helpful).[139] The results differed somewhat from those sources because of recent statutory changes.

A. *HIV-SPECIFIC STATUTES: SEPARATE CRIME*

Twenty-three states have adopted HIV-specific statutes that create a separate crime of knowing HIV exposure—Arkansas, California, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Missouri, Nevada, New Jersey, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Virginia, and Washington.[140] However, there is substantial variation in the

137. Erin M. O'Toole, *HIV-Specific Crime Legislation: Targeting an Epidemic for Criminal Prosecution*, 10 J. L. & Health 183, 186 (1995-96); *see infra* pt. IV.D. (discussing the use of general criminal statutes in cases of intentional HIV exposure).

138. HIV Criminal L. & Policy Project, *supra* n. 136, at [1].

139. American Civil Liberties Union (ACLU), *State Criminal Statutes on HIV Transmission* [1-14] (June 2000) <http://archive.aclu.org/issues/aids/HIVcriminalization.html> (accessed Feb. 24, 2004).

140. *See* Ark. Code Ann. § 5-14-123 (LEXIS L. Publg. 1987) (exposing another to the HIV virus after testing positive is a class A felony); Cal. Health & Safety Code Ann. § 120291 (West 1996 & Supp. 2004) (acting with an intent to expose another to HIV is a felony); Fla. Stat. Ann. § 384.24 (West 2002 & Supp. 2004) (communicating HIV to another through sexual intercourse is unlawful); Ga. Code Ann. § 16-5-60

(Harrison 1998) (knowing exposure of HIV through sexual intercourse, sexual acts, use of hypodermic needles or syringes, prostitution, or donation of bodily fluid or blood is a felony); Idaho Code § 39-608 (1998 & Supp. 2001) (exposing another with intent to infect that person with HIV is a felony); 720 Ill. Comp. Stat. Ann. § 5/12-16.2 (West 1993) (engaging in intimate contact with another by one who knows he or she is infected with HIV is a felony); Ind. Code Ann. § 35-42-1-7 (LEXIS L. Publg. 1998) (criminalizing reckless, knowing, or intentional transfer of HIV to another as a class C felony); Iowa Code Ann. § 709C.1 (West 2003) (engaging in intimate contact with another by one who knows he or she is infected with HIV is a felony); Ky. Rev. Stat. Ann. § 214.454 (LEXIS L. Publg. 1998) (making it unlawful for a person to donate blood or give false information to the staff of a blood establishment if that person is at high risk for infection with HIV, or has HIV or AIDS); La. Stat. Ann. § 14:43.5 (1997) (proscribing intentionally exposing another to AIDS without knowing and lawful consent); Md. Health-Gen. Code Ann. § 18-601.1 (2000) (making it a misdemeanor to knowingly transfer or attempt to transfer HIV to another); Mich. Comp. Laws Ann. § 333.5210 (West 2001) (deeming it a felony for a person who knows he or she is infected with HIV or AIDS to engage in sexual penetration with another without first informing that person of his or her HIV/AIDS infection); Mo. Rev. Stat. Ann. § 191.677 (West 1996 & Supp. 2004) (deeming the acts of an individual, knowingly infected with HIV, of donating or attempting to donate bodily fluids or organs, or exposing another to HIV without the knowledge and consent of that person through oral, anal or vaginal intercourse, sharing needles, biting or acting in any other manner that causes the HIV infected person's semen, vaginal secretions or blood to come into contact with the mucous membranes of another a class B felony, unless the person contracts HIV from the contact, in which case it becomes a class A felony); Nev. Rev. Stat. Ann. § 201.205 (LEXIS L. Publg. 2000) (criminalizing intentional, knowing, or willful engagement in an act that could transfer HIV as a category B felony); N.J. Stat. Ann. § 2C:34-5 (Supp. 2003) (committing an act of sexual penetration by one who knows that he or she is HIV-positive without the informed consent of the other person is a crime of the third degree); N.D. Cent. Code § 12.1-20-17 (1997) (criminalizing willful transfer of HIV by one who knows he or she is HIV-positive as a class A felony); Ohio Rev. Code Ann. § 2903.11 (Anderson 2002) (engaging in sexual contact with another who does not give informed consent, or who lacks the ability to understand the significance of having sexual contact with a person who has HIV, or who is under 18 by a person knowingly infected with HIV, is a felony of the second degree, unless the victim is a peace officer, in which case it is a felony of the first degree); Okla. Stat. Ann. tit. 21, § 1192.1 (West 2002) (criminalizing knowingly infecting another with HIV by intending to infect another and engaging in conduct reasonably likely to result in infection without the other person's informed consent as a felony); S.C. Code Ann. § 44-29-145 (2002) (transmitting HIV by one who knows he or she is HIV-positive is a felony); S.D. Codified Laws § 22-18-31 (Supp. 2003) (making it a class 3 felony for a person, knowing he or she is infected with HIV or AIDS, to intentionally expose another person to infection by engaging in sexual intercourse, transferring or donating bodily fluids or organs, transferring any non-sterile intravenous or intramuscular drug paraphernalia that has been contaminated to another, or causing blood or semen to come in contact with another for the purpose of exposing that person to HIV); Tenn. Code Ann. § 39-13-109 (2003) (criminalizing knowing exposure of HIV to another as a class C felony); Va. Code Ann. § 18.2-67.4:1

approaches these states have taken. Most statutes apply to exposure through sexual activity and donation of blood and other tissue,[141] whereas less than one-half apply to needle sharing.[142] A few statutes

(1996 & Supp. 2003) (criminalizing knowing and intentional transmission of HIV to another as a class 6 felony); Wash. Rev. Code Ann. § 9A.36.011 (West 2000) (criminalizing exposing or transmitting HIV to another with the intent to inflict great bodily harm as assault in the first degree, a class A felony).

141. *See* Ark. Code Ann. § 5-14-123 (exposing another to HIV through sexual intercourse and transfer of blood or blood products is a class A felony); Cal. Health & Safety Code Ann. § 120291 (exposing another to HIV through sexual activity is a felony); Cal. Health & Safety Code § 1621.5 (2004) (donating blood or other tissue is a felony when the donor knows he or she has AIDS or has received a positive test for HIV); Fla. Stat. Ann. § 384.24 (deeming it unlawful for a person knowingly infected with HIV to have sexual intercourse with another); Fla. Stat. § 381.0041 (2004) (donating blood or other tissue when the donor knows he or she is infected with HIV is a felony of the third degree); Ga. Code Ann. § 16-5-60 (deeming it unlawful for a person knowingly infected with HIV to have sexual intercourse with another or to donate bodily fluids or organs without first disclosing their infection); Idaho Code § 39-608 (deeming it a felony for a person knowingly infected with HIV to transfer or attempt to transfer bodily fluids or organs through donation or sexual activity); 720 Ill. Comp. Stat. Ann. § 5/12-16.2 (deeming it a class 2 felony for a person knowingly infected with HIV to engage in intimate contact with another or to transfer, donate, or provide his or her bodily fluids or organs); Ind. Code Ann. § 35-42-1-7 (deeming it a class C felony for a person to recklessly, knowingly, or intentionally donate blood or other bodily fluids); Iowa Code Ann. § 709C.1 (criminalizing transmission of HIV by persons knowingly infected who engage in intimate contact and transfer bodily fluids or donate organs); La. Stat. Ann. § 14:43.5 (criminalizing intentional exposure of HIV through sexual contact without knowing and lawful consent); Mich. Comp. Laws Ann. § 333.5210 (making it illegal for an HIV-infected individual to engage in sexual penetration without informing the other party); Mo. Rev. Stat. Ann. § 191.677 (criminalizing sexual intercourse and blood and organ donation by a person knowingly infected by HIV); N.J. Stat. Ann. § 2C:34-5 (Supp. 2003) (criminalizing any form of sexual penetration by a person knowingly infected with HIV without informing the other person as a felony); N.D. Cent. Code § 12.1-20-17 (criminalizing sexual activity by a person knowingly infected with HIV); Ohio Rev. Code Ann. § 2903.11 (criminalizing acts of sexual conduct by a person knowingly infected with HIV without prior disclosure of that person's HIV status); S.C. Code Ann. § 44-29-145 (criminalizing acts of sexual intercourse and bodily fluid or organ donation by a person knowingly infected with HIV); S.D. Codified Laws § 22-18-31 (criminalizing acts of sexual intercourse and bodily fluid and organ donation by a person knowingly infected with HIV); Tenn. Code Ann. § 39-13-109 (criminalizing acts of intimate contact and donation by a person knowingly infected with HIV); Va. Code Ann. § 18.2-67.4:1 (criminalizing the act of sexual intercourse by a person knowingly infected with HIV).

142. *See* Ga. Code Ann. § 16-5-60 (criminalizing the act of allowing another to use a hypodermic needle and/or syringe when that person knows he or she is infected with HIV); Idaho Code § 39-608 (criminalizing the act of allowing another use of hypodermic syringe, needle, or similar device when that person knows he or she is

do not specify the types of activities to which they apply.[143] Similarly, the vast majority of statutes do not require intent to harm, only intent to engage in the activity that creates the exposure.[144] Finally, few statutes address prevention measures.[145]

This variation illustrates the struggle policy makers and legislators face in finding the optimal balance between highly specific laws and more broadly worded laws. While broadly framed laws allow for more flexibility, specific laws provide for protection against misuse. The task is even more difficult in an area such as HIV/AIDS, where scientific and medical knowledge may change rapidly. We highlight this difficulty with specific examples throughout our analysis.

1. *Activities Included*

a. Sexual Activity

Seventy percent (16/23) of states with HIV-specific statutes specifically apply to sexual activity.[146] There is substantial variation in

infected with HIV); 720 Ill. Comp. Stat. § 5/12-16.2 (criminalizing the transfer of non-sterile intravenous drug paraphernalia by a person knowingly infected with HIV); Iowa Code Ann. § 709C.1 (criminalizing the transfer of HIV to another person with non-sterile intravenous drug paraphernalia); Mo. Rev. Stat. Ann. § 191.677 (criminalizing the sharing of needles by a person knowingly infected with HIV); N.D. Cent. Code § 12.1-20-17 (criminalizing the act of allowing another to reuse a hypodermic syringe or needle when that person is knowingly infected with HIV); S.C. Code Ann. § 44-29-145 (criminalizing the sharing of hypodermic needles and/or syringes by a person knowingly infected with HIV); S.D. Codified Laws § 22-18-31 (criminalizing transfer of non-sterile intravenous drug paraphernalia by a person knowingly infected with HIV); Tenn. Code Ann. § 39-13-109 (criminalizing knowing transfer of non-sterile intravenous drug paraphernalia by a person knowingly infected with HIV).

143. Ky. Rev. Stat. Ann. § 214.454; Md. Health-Gen. Code Ann. § 18-601.1; Nev. Rev. Stat. Ann. § 201.205 (LEXIS L. Publg. 2000); Okla. Stat. Ann. tit. 21, § 1192.1.

144. Ark. Code Ann. § 5-14-123; Fla. Stat. Ann. § 384.24; 720 Ill. Comp. Stat. Ann. § 5/12-16.2; Iowa Code Ann. § 709C.1; La. Stat. Ann. § 14:43.5; Mich. Comp. Laws Ann. § 333.5210; Mo. Rev. Stat. Ann. § 191.67; N.J. Stat. Ann. § 2C:34-5; N.D. Cent. Code § 12.1-20-17; Ohio Rev. Code Ann. § 2903.11; S.C. Code Ann. § 44-29-145; Tenn. Code Ann. § 39-13-109.

145. *Compare* Cal. Health & Safety Code Ann. § 120291 (defining proscribed "unprotected sexual activity" as being sexual activity without use of a condom) *with* Mo. Rev. Stat. Ann. § 191.677 (disallowing the use of a condom as a defense).

146. *See* Ark. Code Ann. § 5-4-123 (criminalizing the exchange of bodily fluids during "sexual intercourse, cunnilingus, felatio, anal intercourse, or any other intrusion" by a person knowingly infected with HIV as a class A felony); Cal. Health &

the definitions of activities that are criminalized under the statutes. California's definition is among the most specific and is narrowly crafted to limit its scope to behaviors that are most likely to transmit HIV.[147] Only unprotected sexual activity without disclosure of HIV-infection is criminalized.[148] "Unprotected sexual activity" is defined as "insertive vaginal or anal intercourse on the part of an infected male, receptive consensual vaginal intercourse on the part of an infected woman with a male partner, or receptive consensual anal intercourse on the part of an infected man or woman with a male partner" without the

Safety Code Ann. § 120291 (criminalizing "insertive vaginal or anal intercourse on the part of an infected male, receptive consensual vaginal intercourse on the part of an infected woman with a male partner, or receptive consensual anal intercourse"); Fla. Stat. Ann. § 384.24 (criminalizing sexual intercourse by a person knowingly infected with HIV); Ga. Code Ann. § 16-5-60 (criminalizing engaging in sexual activity or submitting "to any sexual act involving the sex organs or one person and the mouth or anus of another person" by a person knowingly infected with HIV); Idaho Code § 39-608 (criminalizing exposing another to HIV through sexual activity by "genital-genital contact, oral-genital contact, anal-genital contact"); 720 Ill. Comp. Stat. Ann. § 5/12-16.2 (criminalizing intimate contact with another by a person knowingly infected with HIV); La. Stat. Ann. § 14.43.5 (criminalizing intentionally exposing another to HIV through sexual contact); Mich. Comp. Laws Ann. § 333.5210 (criminalizing engaging in "sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion . . . of any part of a person's body or of any object into the genital or anal openings of another person's body" by a person knowingly infected with HIV); Mo. Rev. Stat. Ann. § 191.677 (criminalizing oral, anal or vaginal intercourse that results in the contact of blood, semen, or vaginal secretions by a person knowingly infected with HIV); N.J. Stat. Ann. § 2C:34-5 (criminalizing sexual penetration without informed consent by a person knowingly infected with HIV); N.D. Cent. Code § 12.1-20-17 (criminalizing sexual activity defined as "genital-genital contact, oral-genital contact, [or] anal-genital contact" by a person knowingly infected with HIV); Ohio Rev. Code Ann. § 2903.11 (criminalizing sexual conduct by a person knowingly infected with HIV without the informed consent of the other person); S.C. Code Ann. § 44-29-145 (criminalizing sexual intercourse—vaginal, anal, or oral—by a person knowingly infected with HIV without the other person's informed consent); S.D. Codified Laws § 22-18-31 (criminalizing sexual intercourse or other intimate physical contact by a person knowingly infected with HIV without the other person's informed consent); Tenn. Code Ann. § 39-13-109 (criminalizing exposing "the body of one person to a bodily fluid of another person in any manner that presents a significant risk of HIV transmission" by a person knowingly infected with HIV without the informed consent of the other person); Va. Code Ann. § 18.2-67.4:1 (criminalizing sexual intercourse, fellatio, cunnilingus, anallingus, or anal intercourse with the intent to transmit HIV to another by a person knowingly infected with HIV).

147. Cal. Health & Safety Code Ann. § 120291.

148. *Id.*

use of a condom.[149] However, such specific definitions are rare in criminal HIV exposure statutes.

Several other states prohibit only those activities that are likely to transmit the virus.[150] For example, Georgia's statute is limited to "sexual intercourse or . . . any sexual act involving the sex organs of one person and the mouth or anus of another person."[151] Idaho and North Dakota both require transfer of body fluid during "sexual activity by genital-genital contact, oral-genital contact, anal-genital contact."[152] South Dakota and Tennessee require sexual intercourse or "intimate contact," which both states define as "bodily contact which exposes a person to the *body fluid* of the infected person *in any manner that presents a significant risk* of HIV transmission."[153] Oklahoma does not specify certain activities, but rather prohibits "*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 *except during in utero transmission of blood or bodily fluids*."[154] These examples demonstrate that there are many effective ways to achieve the legislative goals.

On the other hand, a few states prohibit activities that are unlikely to transmit HIV, along with activities that are likely to transmit HIV. For example, Missouri, South Carolina, and Virginia include oral intercourse, along with anal or vaginal intercourse, in their definitions of the acts for which an HIV-infected person can be held criminally liable.[155] Others, like Florida, prohibit sexual intercourse for people who know they have HIV, without defining sexual intercourse.[156] This approach allows for broad interpretation that may include both riskier and less risky activities.

149. *Id*.

150. Ga. Code Ann. § 16-5-60; Idaho Code § 39-608; N.D. Cent. Code § 12.1-20-17; Okla. Stat. Ann. tit. 21, § 1192.1 (West 2002); S.D. Codified Laws § 22-18-31; Tenn. Code Ann. § 39-13-109.

151. Ga. Code Ann. § 16-5-60.

152. Idaho Code § 39-608; N.D. Cent. Code § 12.1-20-17.

153. S.D. Codified Laws § 22-18-32; Tenn. Code Ann. § 39-13-109 (emphasis added).

154. Okla. Stat. Ann. tit. 21, § 1192.1 (emphasis added).

155. Mo. Rev. Stat. Ann. § 191.677 (West 1996 & Supp. 2004); S.C. Code Ann. § 44-29-145 (2002); Va. Code Ann. § 18.2-67.4:1 (1996 & Supp. 2003).

156. Fla. Stat. Ann. § 384.24 (West 2002 & Supp. 2004).

Arkansas and Michigan have two of the broadest definitions of sexual activity, with both states prohibiting "sexual penetration" by an infected person without disclosure when "sexual penetration" is defined as "*any other intrusion, however slight, of any part of a person's body or of any object* into the genital or anal openings of another person's body."[157] Similarly, New Jersey criminalizes the "act of sexual penetration without the informed consent of the other person,"[158] which is defined elsewhere to include "*insertion of the hand, finger or object* into the anus or vagina."[159] These statutes criminalize behaviors that pose *no risk* of HIV transmission and, as such, are the safest types of sexual behaviors in which HIV-infected individuals can engage.[160] It seems likely that this result is the unintentional effect of adopting definitions from sexual assault or rape statutes. In contrast, Ohio adopts the definition for "sexual conduct" used in other sex crime statutes, but explicitly excepts "the insertion of an instrument, apparatus, or other object that is not a part of the body into the vaginal or anal cavity of another, unless the offender knew at the time of the insertion that the instrument, apparatus, or other object carried the offender's bodily fluid."[161] In so doing, Ohio demonstrates how to exclude low or no risk sexual behaviors from the definition of prohibited activities.

b. Needle-Sharing

Although needle-sharing accounts for about half of all HIV-infections,[162] less than half (10/23) of the states with HIV-specific statutes include needle sharing in their statutes. These are Arkansas,

157. Ark. Code Ann. § 5-14-123 (LEXIS L. Publg. 2003); Mich. Comp. Laws Ann. § 333.5210 (West 2001) (emphasis added).

158. N.J. Stat § 2C:34-5 (Supp. 2003).

159. *Id.* § 2C:14-1 (emphasis added).

160. Christina M. Shriver, *State Approaches to Criminalizing the Exposure of HIV: Problems in Statutory Construction, Constitutionality, and Implications*, 21 N. Ill. U. L. Rev. 319, 342 (2001).

161. Ohio Rev. Code Ann. § 2903.11(e)(3) (Anderson 2002).

162. David R. Gibson, *HIV Prevention in Injection Drug Users* [1] (Nov. 1998) (available at <http://hivinsite.ucsf.edu/InSite.jsp?page=kb-07&doc=kb-07-04-01-01> (accessed Apr. 1, 2004)).

Georgia, Idaho, Illinois, Iowa, Missouri, North Dakota, South Carolina, South Dakota, and Tennessee.[163]

c. Blood, Tissue Donation

Fourteen of the twenty-three states with HIV-specific criminal statutes also make it a crime for someone who knows that he is infected with HIV to donate blood, plasma, organs, skin, or other human tissue. These states are California, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Missouri, Ohio, South Carolina, South Dakota, Tennessee, and Virginia.[164] In Kentucky, this is the only type of intentional HIV exposure that is criminalized.[165]

d. Other

Several states, including Missouri, Louisiana, and South Dakota, also criminalize behaviors such as spitting, biting, throwing, or smearing bodily fluids onto another person.[166] Although numerous other states have similar statutes that apply only to emergency response persons (police officers, firefighters, emergency medical technicians) and/or corrections officers, these states are the only ones that extend their statutes regarding this type of behavior to the general public.[167] The additional protections afforded to emergency responders and corrections officers were intended to encourage their intervention, especially early in the AIDS epidemic when little was known about

163. Ark. Code Ann. § 5-14-123 (LEXIS L. Publg. 1997); Ga. Code Ann. § 16-5-60 (1998); Idaho Code § 39-608 (1998); Iowa Code Ann. § 709C.1 (West 2003); Mo. Rev. Stat. Ann. § 191.677 (West 1996 & Supp. 2004); N.D. Cent. Code § 12.1-20-17 (1997); S.C. Code Ann. § 44-29-145 (2002); S.D. Codified Laws § 22-18-31 (Supp. 2003); Tenn. Code Ann. § 39-13-109 (2003).

164. Cal. Health & Safety Code Ann. § 1621.5 (West 1999 & Supp. 2004); Fla. Stat. Ann. § 381.0041(11)(b) (West 2002); Ga. Code Ann. § 16-5-60; Idaho Code § 39-608; 720 Ill. Comp. Stat. Ann. § 5/12-16.2 (West 1993); Ind. Code Ann. § 35-42-1-7 (LEXIS L. Publg. 1998); Iowa Code Ann. § 709C.1 (West 2003); Ky. Rev. Stat. Ann. § 311.990(25)(b) (LEXIS L. Publg. 2001); Mo. Rev. Stat. Ann. § 191.677; Ohio Rev. Code Ann. § 2927.13; S.C. Code Ann. § 44-29-145; S.D. Codified Laws § 22-18-31; Tenn. Code Ann. § 39-13-109; Va. Code Ann. § 32.1-289.2 (2001).

165. Ky. Rev. Stat. Ann. § 311.990.

166. Ind. Code Ann. § 35-42-2-6; La. Stat. Ann. § 14:43.5 (1997); Mo. Rev. Stat. Ann. § 191.677; S.D. Codified Laws § 22-18-31.

167. Ariz. Rev. Stat. Ann. § 13-1210 (West 2001 & Supp. 2003); 410 Ill. Comp. Stat. Ann. § 305/7; Ind. Code Ann. § 35-42-2-6; La. Stat. Ann. § 14:43.5; Mo. Rev. Stat. Ann. § 191.677; S.D. Codified Laws § 22-18-31.

transmission, as well as to establish standards of respect for these professionals.[168] Other states, such as Nevada and Washington, do not specifically define the type of conduct that is covered by their statutes.[169] For Nevada, the prohibited activity is that which "is intended or likely to transmit the disease."[170] Washington refers only to the "administ[ration], expos[ure], or transmi[ssion]" of HIV.[171] Presumably, these definitions could include any of the types of exposures discussed above. Finally, Oklahoma is the only state that explicitly discusses perinatal transmission. It excludes in utero transmission of blood or bodily fluids from its definition of prohibited conduct.[172]

2. *Required Intent*

The vast majority of these states only require that HIV-infected persons have intended to engage in the act that exposed another to HIV (e.g. sexual activity, needle-sharing).[173] They do not require that the person intended to transmit the virus. In contrast, California requires that the HIV-infected person engaged in unprotected sexual activity "with the specific intent to infect the other person with HIV," in addition to knowing she is infected with HIV and without disclosing her HIV status to her partner. The statute makes explicit that the fact the person knew she was HIV infected is not enough to prove specific intent.[174] Similarly, Oklahoma and Virginia require that the HIV infected person act with the intent to infect.[175] Washington requires the "intent to inflict great bodily harm."[176]

168. *See* James E. DeLine, Student Author, *Compulsory AIDS Testing of Individuals Who Assault Public Safety Officers: Protecting the Police or the Fourth Amendment?*, 38 Wayne L. Rev. 461, 480, 482-83 (1991) (noting that special statutes specifically regarding public safety officers protect the state's special interest in the health and safety of those who protect the general public).

169. Nev. Rev. Stat. Ann. § 201.205 (LEXIS L. Publg. 2001); Wash. Rev. Code Ann. § 9A.36.011 (West 2000).

170. Nev. Rev. Stat. Ann. § 201.205.

171. Wash. Rev. Code Ann. § 9A.36.011.

172. Okla. Stat. Ann. tit. 21, § 1192.1 (West 2002).

173. *E.g.* Ga. Code Ann. § 16-5-60(c); N.D. Cent. Code § 12.1-20-17 (1997); Tenn. Code Ann. § 39-13-109 (2003).

174. Cal. Health & Safety Code Ann. § 120291 (West Supp. 2004).

175. Okla. Stat. Ann. tit. 21, § 1192.1; Va. Code Ann. § 18.2-67.4:1 (1996 & Supp. 2003).

176. Wash. Rev. Code Ann. § 9A.36.011.

3. *Defenses*

a. Prevention Measures

Only three states take prevention measures into account in their statutes. California does so by limiting the scope of its statute to specified sexual acts without a condom.[177] North Dakota provides that condom use is an affirmative defense to the charge of intentional HIV exposure, but only if the sexual activity is consensual and "after full disclosure of the risk of such activity."[178] In contrast, Missouri's statute explicitly states, "use of condoms is not a defense."[179] No statute discusses prevention measures with respect to needle sharing, which may reflect the lack of evidence that there are effective means of reducing the risk when sharing needles.

b. Disclosure/Consent

Ten of the states that criminalize intentional HIV exposure through sexual activity include failure to disclose HIV infection as an element of the crime. These states are Arkansas, California, Georgia, Louisiana, Michigan, Missouri, New Jersey, Ohio, Oklahoma, and South Carolina.[180] Accordingly, evidence of consent would prevent prosecution. Eight of the states include consent as an affirmative defense to the crime, but require not only that the victim understood that the accused was HIV-infected but also that the activity could transmit HIV. These states are Florida, Idaho, Illinois, Iowa, Nevada, North Dakota, South Dakota, and Tennessee.[181] Three states, Maryland, Virginia, and Washington, fail to mention consent, which

177. Cal. Health & Safety Code Ann. § 120291.

178. N.D. Cent. Code § 12.1-20-17.

179. Mo. Rev. Stat. Ann. § 191.677 (West Supp. 2004).

180. Ark. Code Ann. § 5-14-123 (LEXIS L. Publg. 1987); Cal. Health & Safety Code Ann. § 120291; Ga. Code Ann. § 16-5-60 (Harrison 1998); La. Stat. Ann. § 14:43.5 (1997); Mich. Comp. Laws Ann. § 333.5210; Mo. Rev. Stat. Ann. § 191.677; N.J. Stat. Ann § 2C:34-5 (Supp. 2003); Ohio Rev. Code Ann. § 2903.11 (Anderson 2002); Okla. Stat. Ann. tit. 21, § 1192.1; S.C. Code Ann. § 44-29-145 (2002).

181. Fla. Stat. Ann. § 384.24 (West 2002); Idaho Code § 39-608 (1998 & Supp. 2001); 720 Ill. Comp. Stat. Ann. § 5/12-16.2 (West 1993); Iowa Code Ann. § 709C.1 (West 1993); Nev. Rev. Stat. Ann. § 201.205 (LEXIS L. Publg. 2000); N.D. Cent. Code § 12.1-20-17; S.D. Codified Laws § 22-18-33 (Supp. 2003); Tenn. Code Ann. § 39-13-109 (2003).

may leave HIV-infected individuals vulnerable to prosecution for consensual acts.[182]

c. Penalties

The vast majority of states that have made intentional HIV exposure a separate crime have made that crime a felony;[183] however, states have classified it differently, resulting in different ranges of penalties.[184] Penalties range from a minimum of one year to a maximum of life in prison.[185]

B. *HIV-SPECIFIC STATUTES: ENHANCEMENT STATUTES*

In some states, committing a sex crime while known to be HIV-infected may increase the penalties for the crime (we refer to these additional penalties as "enhancements"). In some states, this is the only instance in which knowing exposure is criminalized. Other states, however, have adopted enhancements in addition to an HIV-specific crime.

1. *Sex Crimes*

Colorado requires imposition of a "mandatory term of incarceration of at least three times the upper limit of the presumptive range for the level of offense committed, up to the remainder of the person's natural life," for persons convicted of a sexual offense that consists of sexual penetration and who were notified prior to the

182. Md. Health-Gen. Code Ann. § 18-601.1 (2000); Va. Code Ann. § 18.2-67.4:1 (1996 & Supp. 2003); Wash Rev. Code Ann. § 9A.36.011 (West 2000).

183. Ark. Code Ann. § 5-14-123; Cal. Health & Safety Code Ann. § 120291; Ga. Code Ann. § 16-5-60; Idaho Code Ann. § 39-608; 720 Ill. Comp. Stat. Ann. § 5/12-16.2; Ind. Code Ann. § 35-42-1-7 (LEXIS L. Publg. 1998); Iowa Code Ann. § 709C.1; La. Stat. Ann. § 14:43.5; Mich. Comp. Laws Ann. § 333.5210; Mo. Rev. Stat. Ann. §191.677; Nev. Rev. Stat. Ann. § 201.205; N.D. Cent. Code § 12.1-20-17; Ohio Rev. Code Ann. § 2903.11; Okla. Stat. Ann. tit. 21, § 1192.1; S.C. Code Ann. § 44-29-145; S.D. Codified Laws § 22-18-31; Tenn. Code Ann. § 39-13-109; Va. Code Ann. § 18.2-67.4:1; Wash. Rev. Code Ann. § 9A.36.011.

184. Md. Health-Gen. Code Ann. § 18-601.1.

185. *Compare* Colo. Rev. Stat. Ann. § 18-3-415.5 (West. Supp. 2003) (establishing a maximum penalty of life in prison) *with* Va. Code Ann. §§ 18.2(f), 18.2-67.4:1 (1996 & Supp. 2003) (stating that violating the Virginia HIV transmission statute is a class 6 felony, which is punishable by at least 1 year in prison).

offense that they were HIV-infected.[186] Wisconsin increases the penalties for conviction of a serious sex crime if the person knew he had a sexually transmitted disease or HIV at the time of the crime.[187] California and Florida also have an enhancement for persons previously convicted of listed sex offenses (including rape, statutory rape, sexual penetration, and sexual assault) if they are convicted of a second sex offense and previously tested positive for HIV.[188] In California, the enhancement can add three years imprisonment to the sentence.[189] Ohio specifically criminalizes sexual conduct:

> [W]ith a person whom the offender knows or has reasonable cause to believe lacks the mental capacity to appreciate the significance of the knowledge that the offender has tested positive as a carrier of a virus that causes acquired immunodeficiency syndrome or with a person under eighteen years of age who is not the spouse of the offender.[190]

Tennessee allows the court to consider HIV infection as an enhancement factor at the time of sentencing.[191]

2. *Prostitution*

California, Colorado, Kentucky, Florida, Nevada, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Utah impose enhancements for HIV-infected individuals who engage in prostitution.[192] Several of these laws also apply to those who solicit prostitutes when HIV-infected or procure the services of prostitutes who are known to be HIV-infected. Georgia makes it a felony to offer

186. Colo. Rev. Stat. Ann. §§ 18-3-415.5, 18-7-205.7.

187. Wis. Stat. Ann. § 973.017 (West Supp. 2003).

188. Cal. Penal Code Ann. § 647f (West 1999); Fla. Stat. Ann. § 775.0877 (West 2000 & Supp. 2004).

189. Cal. Penal Code Ann. §§ 666.7(h)(12), 12022.85 (West 2000 & Supp. 2004).

190. Ohio Rev. Code Ann. § 2903.11 (Anderson 2002).

191. Tenn. Code Ann. § 39-13-521 (2003).

192. Cal. Penal Code Ann. § 1202.6; Colo. Rev. Stat. Ann. § 18.7-201.5 (West Supp. 2003); Fla. Stat. Ann. § 796.08; Ky. Rev. Stat. Ann. § 529.090 (LEXIS L. Publg. 1999); Nev. Rev. Stat. Ann. § 201.358 (LEXIS L. Publg. 2001); Ohio Rev. Code Ann. §§ 2907.24-2907.241; Okla. Stat. Ann. tit. 21, § 1031(B) (West 2002); 18 Pa. Consol. Stat. Ann. § 5902 (West 2000 & Supp. 2003); S.C. Code Ann. § 44-29-145 (2003); Tenn. Code Ann. § 39-13-521 (2003); Utah Code Ann. § 76-10-1309 (1999).

or consent to perform sexual intercourse for money while HIV-infected.[193]

C. *GENERAL STI STATUTES*

If states did not have an HIV-specific statute, we looked for state STI statutes.[194] Several states have statutes that criminalize knowing transmission of STIs or other infectious diseases, which could be read to include HIV. Alabama, Montana, New York, and Rhode Island classify this crime as a misdemeanor,[195] Kansas classifies it as a felony,[196] and West Virginia indicates that the exposure to an STI is "unlawful," but does not specify whether the crime is a misdemeanor or a felony.[197] In contrast, all of the HIV-specific statutes classified the crime as a felony.[198]

Like the HIV-specific statutes, there is variation in how these statutes define prohibited acts. Only Kansas requires that the prohibited acts be conducted "with the intent to expose that individual to that life threatening communicable disease."[199] This law and the one in Minnesota apply to sexual activity, needle sharing and blood or other tissue donation.[200] The remaining states refer only to sexual activity. Alabama's statute is limited to "any act which will *probably or likely transmit* such disease to another person."[201] In contrast, Minnesota, like the Arkansas and Michigan HIV-specific statutes, includes low or no risk activity by including "any intrusion however slight into the genital or anal openings of the complainant's body by any part of the actor's body or any object used by the actor for this purpose" in its definition.[202] Like Ohio, Kansas excludes the low or no risk activity by defining "sexual intercourse" and "sodomy" "not [to]

193. Ga. Code Ann. § 16-5-60 (Harrison 1998).

194. States with HIV-specific statutes may also have STI statutes that include HIV, but that are not listed here.

195. Ala. Code § 22-11A-21 (1997); Mont. Code Ann. § 50-18-113 (2003); N.Y. Pub. Health Laws § 2307 (McKinney 2003); R.I. Gen. Laws § 23-11-1 (1996).

196. Kan. Stat. Ann. § 21-3435 (West Supp. 2003).

197. W. Va. Code § 16-4-20 (2003).

198. *See supra* pt. IV.A.

199. Kan. Stat. Ann. § 21-3435.

200. *Id.*; Minn. Stat. Ann. § 609.2241 (West 2002).

201. Ala. Code § 22-11A-21 (1997) (emphasis added).

202. Minn. Stat. Ann. § 609.341.

include penetration by any object other than the male sex organ."[203] Montana, Rhode Island, and West Virginia prohibit "exposure" to the disease without defining what that is.[204] New York leaves "sexual intercourse" undefined.[205]

Only Minnesota discusses defenses to these crimes. It provides that it is an affirmative defense to prosecution if the person took means to prevent transmission as advised by a physician.[206] In addition, failure to inform of the infection is part of the definition of the crime.[207] The other statutes are silent on the issue of consent and prevention measures.

D. *GENERAL CRIMINAL LAWS*

The remaining states, Alaska, Arizona, Connecticut, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, Texas, Vermont, and Wyoming, have neither HIV-specific laws nor more general STI laws that apply to HIV. We therefore assume that these states relied on general criminal law statutes to meet the former Ryan White CARE Act requirement. We also note that, although a state may have a more specific statute that applies, that does not preclude it from charging a defendant under more general laws. For example, although New York has an STI statute that criminalizes (as a misdemeanor) sexual intercourse when a person has a known infectious sexually transmitted disease.[208] It relied on general criminal laws (e.g. statutory rape and reckless endangerment) in its prosecution of Nushawn Williams.[209] Indeed, some of the states' HIV-specific laws make explicit that other laws may still be applied.[210] For these states,

203. Kan. Stat. Ann. § 21-3435.

204. Mont. Code Ann. § 50-18-113 (2002); R.I. Gen. Laws § 23-11-1 (1996); W. Va. Code § 16-4-20.

205. N.Y. Pub. Health Law § 2307 (McKinney 2003).

206. Minn. Stat. Ann. § 609.2241.

207. *Id.*

208. N.Y. Pub. Health Law § 2307.

209. *See* Waldman, *supra* n. 23, at B3 (reporting that Nushawn Williams pleaded guilty to reckless endangerment).

210. Ala. Code § 22-11A-21 (1997); Minn. Stat. Ann. § 609.2241; N.Y. Pub. Health Law § 2307.

it is often necessary to look at the case law in order to understand how states are actually dealing with the issue.[211]

E. *SUMMARY ANALYSIS*

Our review of statutes that may be applied to intentional HIV exposure demonstrates that legislators may take a wide variety of approaches to this issue. HIV-specific criminal exposure laws have been the most popular approach, but there are significant differences among the state statutes. Most state HIV-specific exposure statutes focus on sexual activity.[212] Many of these have the potential to undermine public health HIV prevention efforts because they criminalize low-risk behaviors and do not account for prevention measures such as condom use. The failure to account for safer sex prevention efforts suggests an underlying message that HIV-infected people should not engage in sexual relations. There is no research that indicates this message is either practical or sustainable.

This moral connotation is also revealed in the penalties for HIV exposure under HIV-specific statutes. HIV exposure is a felony in every state with such a statute and carries with it an average maximum penalty of eleven years in prison.[213] These penalties are often more severe than those for comparable crimes such as assault.[214] Moreover, the overwhelming majority of general STI statutes make the crime a misdemeanor punishable by less than one year in jail.[215] Stiff penalties for HIV exposure may actually reduce the number of successful prosecutions because public health authorities may be reluctant to turn to criminal sanctions and exposure victims may be reluctant to cooperate with prosecutors. Even in the notorious Nushawn Williams case, prosecutors' ability to prosecute Williams was limited because

211. Amy M. Decker, Student Author, *Criminalizing the Intentional or Reckless Exposure to HIV: A Wake-Up Call to Kansas*, 46 Kan. L. Rev. 333, 349-50, 355-56 (1998).

212. Ga. Code Ann. § 16-5-60 (Harrison 1998); Kan. Stat. Ann. § 21-3435 (West Supp. 2003); N.Y. Pub. Health Law § 2307; R.I. Gen. Laws § 23-11-1 (1996).

213. Ga. Code Ann. § 16-5-60; Kan. Stat. Ann. § 21-3435.

214. *Compare* Kan. Stat. Ann. § 21-3435 (making intentional exposure to a life threatening disease a severity level 7 felony) *with id.* § 21-3408 (making assault a class C misdemeanor).

215. Ala. Code § 22-11A-21; Minn. Stat. Ann. § 609.2241 (West 2002); Mont. Code Ann. § 50-18-113 (2002); N.Y. Pub. Health Law § 2307; R.I. Gen. Laws § 23-11-1.

few of his victims were willing to testify against him.[216] On the other hand, STI laws covering a wide range of possible infections—many of which are easily curable—may not be well suited to HIV.[217] The failure of almost all of STI statutes to address issues of consent and prevention may leave HIV-infected individuals vulnerable to prosecution for consensual activities or activities that comply with recommended prevention measures.

The HIV-specific intentional exposure criminal laws may also reflect a misperception of risk by the public and its elected officials. Survey data suggests that anywhere from fifty to ninety-five percent of the public believes that the probability of transmitting HIV from a single sexual encounter is quite high.[218] However, the scientific data suggests that the probability of transmission in a single sexual encounter is quite low—for each vaginal sexual act among heterosexual couples in which the male partner is HIV-infected, the risk of infection is less than one in one thousand.[219] The risk of transmission when the female partner is HIV-infected is even lower.[220] Given the public's misperception of the risk, it is no wonder that it considers knowing exposure to HIV reprehensible. In the public's mind, the harm is almost certain, comparable to firing a gun at someone. The evidence, however, indicates that is not the case.[221]

Enhancement statutes also demonstrate the public's moral condemnation of intentional HIV exposure. HIV enhancement statutes reflect the view that a sex crime is more serious when the victim is also exposed to HIV. Enhancement statutes are common in criminal law. An assault is generally considered more serious and the punishment increases when a weapon is used, as opposed to when the "weapon" is an assailant's fists.[222] In contrast, enhancements for prostitution

216. Michel, *supra* n. 28, at 1A.

217. Ga. Code Ann. § 16-5-60; W. Va. Code § 16-4-20 (2003).

218. Personal communication with Daniel Halperin (referring to unpublished data collected by Daniel Halperin, Ina Roy & David Campt).

219. Nancy S. Padian et al., *Heterosexual Transmission of Human Immunodeficiency Virus (HIV) in Northern California: Results from a Ten-Year Study*, 146 Am. J. Epidemiology 350, 352 (1997).

220. *Id.* at 354.

221. *Id.*

222. *E.g.* 34 N.Y. Jur. 2d, *Criminal Law Part Three: Specific Offenses and Defenses Thereto* § 3701 (2003) (explaining that simple assault is elevated to felony aggravated

appear to be directed more at condemning the behavior than at recognizing a separate harm. Unlike serious sex crimes, prostitution is, for the most part, consensual. Like needle-sharing, criminal exposure laws related to prostitution are unlikely to deter HIV-infected prostitutes unless the underlying social issues are addressed. This might include providing safe housing, means of support other than prostitution, protection against violence (from pimps and others), drug treatment, and counseling and education to develop social and coping skills. Some enhancements, however, may not reflect a qualitative difference in the severity of the crime, but rather serve other policy goals. For example, enhancements for alleged gang activity may reflect political efforts at curtailing gang activity, rather than punishment for some additional harm in the crime committed.[223]

Enhancements for serious sex crimes are the most appropriate enhancements for intentional HIV exposure, as opposed to enhancements for aggravated assault, because the additional harm posed by HIV exposure is not analogous to the greater harm posed by assault with a deadly weapon. Public sentiment reflected in relevant statutes reveals support for strong condemnation of at least some behaviors that expose others to HIV. The question that arises, then, is what behaviors should be subject to the statutes? To answer that question, this article will consider the cases prosecuted under intentional exposure statutes.

V. PROSECUTED CASES FOR INTENTIONAL HIV EXPOSURE

An examination of cases that have been filed or have gone to trial provides several important avenues to understanding the approaches legislatures have taken to criminal intentional HIV exposure. Perhaps most importantly, these cases can provide us with a sense of what people find troubling or concerning about possible intentional HIV infection by illustrating both what is actually brought to trial and what receives greater or lesser attention in the popular press. Furthermore,

assault when there is serious physical injury and a deadly weapon or dangerous instrument was used).

223. *E.g.* M. Scott Smith, Student Author, *Utah's Gang Enhancement Statute: Did the Legislature Create a Sentencing Factor as It Intended or Did It Unwittingly Create an Element of the Offense?*, 2000 Utah L. Rev. 671, 675 (2000) (noting that Utah's gang enhancement statute was enacted with the hope of curbing gang-related criminal activity).

by examining the actions of the accused, we can begin to understand how the statutes have been used.

There are several challenges to conducting a comprehensive review of criminal HIV infection cases. First, unless they are appealed, most cases that go to court are not reported, and even some appeals may not result in a written opinion. Thus, to identify all such cases, one would have to search court records at all trial courts in each state. Because court records often are not available electronically, that alone would be a monumental task. Accordingly, we must rely on accounts within the popular press, where all such cases may not be reported. Even if we were able to identify all court cases, however, it would be extraordinarily difficult to identify cases in which charges are made but then dropped before being brought to court. Several sources have done excellent work in documenting both the trends in legislation and case law on this issue.[224] Rather than duplicate their work, this section of the article has been written with the hope of providing several representative cases illuminating some of the more pressing policies underlying this issue.

Following the approach states have taken in their statutes, cases that have gone to court generally fall into one of four categories. First, many of these charges are specifically for HIV infection; depending on the state, an HIV-specific or general statue may be applied to a given case.[225] Second, numerous HIV-related charges are attached to charges for additional crimes such as assault or prostitution.[226] In these "enhancement" or "add-on" cases, the penalty for a crime is increased if the accused is HIV-infected and knew of her status prior to the commission of the act.[227] Third, numerous cases regarding HIV infection, have been tried under general criminal laws.[228] Fourth, there have been a small number of civil cases brought about by individuals seeking damages after becoming HIV-infected, which we do not

224. *See generally e.g.* ACLU, *supra* n. 139, at [1-14]; HIV Criminal L. & Policy Project, *supra* n. 136, at [1]; Lazzarini, Bray & Burris, *supra* n. 38, at 239-46.

225. HIV Criminal L. & Policy Project, *supra* n. 136, at [1].

226. *E.g.* Cal. Penal Code Ann. § 647f (West 2004) (noting that an additional penalty can be added for the transmission of HIV).

227. *Id.*

228. *See* Decker, *supra* n. 211, at 349-50 (analyzing HIV-exposure cases prosecuted under general criminal laws); Gostin, *supra* n. 124, at 1042.

discuss.[229] In addition, we do not discuss the cases that have been tried in military courts, as they function separately from the civilian courts.[230]

According to the HIV Criminal Law and Policy Project, "316 unique prosecutions of persons for exposure or transmission of HIV [occurred in the United States] during the period 1986-2001."[231] The several cases below represent some of the more common scenarios in which HIV infection cases go to court. In some instances, an individual is brought to court solely to be tried for intentional HIV exposure.[232] More commonly, the individual is charged with intentional HIV exposure in addition to other crimes.[233]

A. *CASES PROSECUTED UNDER HIV-SPECIFIC STATUTES*

One of the most well known HIV exposure cases of the past several years was that of Nikko Briteramos in South Dakota.[234] In 2001, Briteramos began his first year as a student at SiTanka Huron University in the small town of Huron, South Dakota.[235] Later that school year, in February 2002, he was informed that he was infected with HIV after attempting to donate blood.[236] In subsequent contact with local health department officials, he revealed that in the weeks following his diagnosis he had unprotected sex with several female college classmates.[237] The health department officials contacted law

229. *E.g. Marcussen v. Brandstat*, 836 F. Supp. 624, 626 (N.D. Iowa 1993) (reporting a civil suit brought by a prisoner against prison officials for being assigned to a cell with an HIV-positive inmate, and thereby exposing him to the risk of HIV infection); Kevin Dobbs, *Renewed Threat of HIV Spread Stuns Region*, Argus Leader (Sioux Falls, S.D.) 1A (2002) (reporting two civil cases for HIV exposure with multi-million dollar verdicts).

230. *See* Elizabeth Beard McLaughlin, *A "Society Apart?" The Military's Response to the Threat of AIDS*, 1993 Army Law. 3, 6-7 (1993) (discussing HIV transmission cases in military courts).

231. HIV Criminal L. & Policy Project, *supra* n. 136, at [1].

232. *Id.* at tbl. 2.

233. *Id.*

234. Dobbs, *supra* n. 229, at 1A.

235. John W. Fountain, *After Arrest, Campus Queues for H.I.V. Tests*, N.Y. Times A16 (May 1, 2002).

236. *Id.*

237. *Id.*

enforcement authorities, who arrested and charged Briteramos with a felony for intentionally exposing his sexual partners to HIV.[238]

After pleading guilty to the charges against him, Briteramos was sentenced in August 2002 to a suspended five-year prison term, 120 days in jail, several hundred hours of community service, and to continue as a student at the university.[239] However, several months later, a judge determined that Briteramos had violated this sentence by failing to return to jail on time after class ended, and thus sent him to prison for a four-year term.[240] The popular press coverage of this case has been extensive,[241] with several key themes coming to light. Much of the press has emphasized the rarity of HIV cases in South Dakota and the town of Huron, creating a picture of a small town that has been shaken by the actions of an outsider.[242] Briteramos himself is generally represented in a positive light, frequently portrayed as both successful and well liked;[243] however, his actions have been portrayed as reckless, and likened by some (including South Dakota's then-Governor Bill Janklow) as tantamount to murder.[244]

To date, several defendants have challenged the constitutionality of their HIV exposure convictions under intentional HIV exposure statutes; however, as of the date of this article, no published cases report that any has been successful.[245]

238. *Id.*

239. John-John Williams, *2 S. Dakotans Sentenced for Spreading HIV*, Argus Leader (Sioux Falls, S.D.) 1B (2003).

240. *Id.*

241. *HIV Positive College Student Sentenced for Having Unprotected Sex with His Girlfriend*, Jet [¶ 1] (Sept. 23, 2002); Dobbs, *supra* n. 229, at 1A (May 12, 2002); John W. Fountain, *supra* n. 235, at A16; Maura Lerner, *HIV Arrest Catches S. Dakota off Guard*, Star Tribune 8A (Apr. 27, 2002); Stephanie Simon, *AIDS Scare at Tiny College Shakes Town*, L.A. Times pt. 1, 12 (Apr. 30, 2002).

242. Dobbs, *supra* n. 229, at 1A; Fountain, *supra* n. 235, at A16.

243. Fountain, *supra* n. 235, at A16.

244. *Id.*

245. *See generally e.g. Ill. v. Russell*, 630 N.E.2d 794 (Ill. 1994); *Iowa v. Keene*, 629 N.W.2d 360 (Iowa 2001); *Mo. v. Mahan*, 971 S.W.2d 307 (Mo. 1998); *Guevara v. Super. Ct. (Cal.)*, 73 Cal. Rptr. 2d 121 (App. 6th Dist. 1998); *La. v. Gamberella*, 633 So. 2d 595 (La. App. 1st Cir. 1993); *Wash. v. Stark*, 832 P.2d 109 (Wash. App. 1992).

B. *CASES PROSECUTED UNDER ENHANCEMENT STATUTES*

Although cases like that of Nikko Briteramos attract media attention, they do not represent the majority of HIV exposure cases that have been prosecuted. It is estimated that seventy percent of charges brought for intentional HIV exposure relate to acts that are already illegal.[246] Either the crime carries higher penalties when HIV is involved (e.g. prostitution, sexual assault or other sex crimes while HIV-infected) or the HIV exposure is added to a list of other charges, such as sexual assault or rape.[247] The multiple charges and high penalties associated with intentional HIV exposure can increase the likelihood that the perpetrator will be punished. The underlying premise to both approaches is that the crime victim suffers a separate harm when he or she is also exposed to risk of HIV infection.

1. *Sex Work*

In 2002, Panchita Hall was arraigned in Los Angeles for felony prostitution under a 1988 California law that "requires prostitutes who are HIV-positive and who have been informed of their blood test results to be charged with a felony upon their second arrest."[248] Hall had a record of arrests prior to this one, having been convicted of prostitution six times since she became aware of her HIV status in 1995.[249] While the conviction carried a three-year prison term, the prosecutor in the case sought an enhanced sentence of up to nine years.[250] However, at the last minute, a plea bargain was struck, and Hall was sentenced to four years for a probation violation on a prior prostitution charge.[251]

While California has a specific statute addressing intentional HIV exposure, this additional law addresses the legal and public health concerns about specific behaviors that create a high risk of HIV infection. Sex workers obviously tend to have a high number of sexual partners, thus increasing their risk both for becoming infected and

246. Lazzarini, Bray & Burris, *supra* n. 38, at 244.

247. *Id*. at 244-45.

248. John L. Mitchell, *Prostitute's HIV-Related Charge Dropped in Plea Bargain*, L.A. Times pt. 2, 3 (Sept. 13, 2002).

249. *Id.*

250. *Id.*

251. *Id.*

infecting others with HIV. Cases involving prostitution have comprised about thirteen percent of the total sexual exposure cases.[252] According to the Los Angeles Times, more than two hundred prostitutes in California have been convicted on felony charges under this law since 1995.[253] As described above, some states also have additional laws that specifically punish someone who knows he or she is HIV-infected for soliciting a prostitute.[254]

2. *Sexual Assault*

The case of Robert Morrow illustrates how HIV exposure can be used to enhance sentences for sexual assault and other violent crimes. In 2001, Morrow was tried and convicted in a Tennessee court for the abduction and rape of a sixteen-year-old girl, whom he had threatened with a firearm and forced from her workplace.[255] The victim escaped from the cabin in which Morrow was keeping her and reported the crimes.[256] Morrow was later arrested and determined to be HIV-infected.[257] Morrow pleaded guilty to two charges of aggravated rape, one charge of especially aggravated kidnapping, and criminal exposure to HIV.[258] The stiff penalties for the first three convictions were augmented by the inclusion of the HIV enhancement.[259] Morrow, who had known he was HIV-infected since 1988, was a repeat offender of sex crimes, with additional convictions in Louisiana.[260] In this and many other sexual assault cases, the HIV exposure law serves as an enhancement to convictions for crimes that are already considered morally unacceptable by society and worthy of significant punishment.

252. Lazzarini, Bray & Burris, *supra* n. 38, at 245.

253. Mitchell, *supra* n. 248, at 3.

254. Cal. Penal Code Ann. § 666.7(12) (West 1998); Fla. Stat. Ann. § 79608(4) (West 1993).

255. *Tenn. v. Morrow*, 2001 WL 1105371 at *1 (Tenn. Crim. App. 2001).

256. *Id.* at *2.

257. *Id.*

258. *Id.*

259. *Id.* at **2, 4.

260. *Rapes in Tennessee and Louisiana Bring Sentences of 68 Years, Life* [1] (Mar. 27, 2002).

3. *Statutory Rape*

A number of cases have been brought for exposing a minor to HIV through sexual contact.[261] In 1998, California prosecuted Dennis Guevara using its HIV-enhancement law for sex with a minor while knowingly HIV-infected.[262] Very few states, however, have specific enhancement laws that allow for increased penalties when HIV exposure is coupled with statutory rape. Most states have opted to bring the charge of HIV exposure in addition to charges of statutory rape or other sexual misconduct. For example, in 1999, Robert Branfield was charged in Iowa for second-degree sexual abuse, lascivious acts with a child, and transmission of HIV through sexual contact.[263] In such cases, adding the charge of intentional HIV exposure usually increases the penalties that would be possible under the statutory rape charge alone.[264]

C. *CASES PROSECUTED UNDER GENERAL CRIMINAL STATUTES*

While the public attention to the Nushawn Williams case inspired a new wave of HIV-specific legislation, his case was prosecuted under general criminal statutes.[265] Jamestown prosecutors charged him with statutory rape for his sexual relationship with a thirteen-year-old Jamestown girl.[266] New York City prosecutors charged him with reckless endangerment, sexual misconduct, attempted assault, and endangering the welfare of a child for his sexual relationship with a fifteen-year-old girl there.[267] Like the Briteramos case in Huron, South Dakota, the press directed significant attention to the fact that the crimes were committed, at least in part, in a small, rural town.[268]

261. *See generally e.g. Mo. v. Mahan*, 971 S.W.2d 307, 310 (Mo. 1998); *Guevara v. Super. Ct. (Cal)*, 73 Cal. Rptr. 2d 421, 423 (App. 6th Dist. 1998).

262. *Guevara*, 73 Cal. Rptr. 2d at 426.

263. *Man Imprisoned for 25 Years under New Iowa Exposure Law*, 14 AIDS Policy & Law 3 (Feb. 19, 1999).

264. *Guevara*, 73 Cal. Rptr. 2d at 426 (noting that "Penal Code section 12022.85 is aimed solely at enhancing the punishment for a sex crime where the perpetrator has knowingly exposed the victim to transmission of an inevitably deadly disease").

265. *See* Richardson, *supra* n. 1, at B3.

266. *Guilty Plea in HIV Rape Case*, *supra* n. 24, at A27.

267. Richardson, *supra* n. 1, at B3.

268. *Compare* James Janega, *Prairie Town Reeling from HIV Scare: South Dakota's Huron Tries to Cope with the Fallout after a College Student from Chicago Is Charged with Intentionally Hiding His Diagnosis Before Having Sex*, Chi. Tribune 3C (May 5,

Williams ultimately pled guilty to a single count of reckless endangerment for having unprotected sex with the fifteen-year-old and received a six-year sentence for that charge.[269] Williams also pleaded guilty to two counts of rape in the second degree and to reckless endangerment for having unprotected sex with the thirteen-year-old girl and received four to twelve years for those charges.[270] He was denied parole in 2001.[271]

D. *SUMMARY ANALYSIS*

As the foregoing cases illustrate, most individuals who have been *prosecuted* for HIV exposure typically engaged in extreme behavior, repeatedly engaging in behaviors that were already criminal.[272] A few cases have been successfully prosecuted for behaviors that present little risk of HIV transmission,[273] and a broader range of cases may have been brought, but dropped before trial.

Overly broad statutes can undermine the public health message by perpetuating misunderstandings about HIV transmission and diverting attention from the behaviors that present the greatest risk of HIV transmission. In addition, in cases such as prostitution, prosecution fails to address the underlying problems—including drug addiction, poverty, and violence—all of which mediate against behavior change. Because prostitution is illegal in most states, cases against sex workers target the status of sex workers as criminals and perpetrators of HIV infection without recognizing the significantly greater health risks

2002) (observing that crime occurred in a "small town on the prairie" that "still looks like the innocent America of an earlier time") *with* Frey, *supra* n. 7, at F1 (describing Jamestown as a "small," "rural," "Anytown, U.S.A.," and "proof that AIDS can happen to anyone, anywhere").

269. Raphael Sugarman & Ralph R. Ortega, *HIV-Infected Man Gets 6-Year Term*, Daily News 31 (Apr. 16, 1999).

270. Michel, *supra* n. 28, at 1A; Richardson, *supra* n. 1, at B3.

271. *World: Nation Briefs*, Newsday A20 (Aug. 3, 2001).

272. *E.g. Guevara v. Super. Ct. (Cal)*, 73 Cal. Rptr. 2d 421, 423 (App. 6th Dist. 1998) (noting that the criminal involved, who knew he had HIV, was also being charged with unlawful sexual intercourse and assault with a deadly weapon); Richardson, *supra* n. 1, at B3 (noting Williams' prior criminal behavior).

273. *E.g. U.S. v. Moore*, 846 F.2d 1163, 1169 (8th Cir. 1988) (noting that the bite of an individual can be considered a deadly and dangerous weapon); *Scroggins v. Ga.*, 401 S.E.2d 13, 16 (Ga. App. 1990) (noting that although there were no documented cases of HIV being transmitted through saliva, such transmission is not impossible, and therefore a bite could result in death).

(including risk for HIV infection) that these women and men also face. It therefore is appropriate to amend intentional HIV exposure statutes to minimize the negative impact on public health prevention measures, while retaining the ability to prosecute the more serious cases.

VI. BALANCING PUBLIC HEALTH AND CRIMINAL LAW GOALS

Our analysis of state statutes that address intentional HIV exposure and the cases that have been prosecuted highlights the issues and areas of concern with criminalizing HIV exposure. It may still be possible to meet public demands for state action while supporting public health prevention efforts. To do this, it is first necessary to understand objections raised regarding the criminalization effort.

A. *ARGUMENTS AGAINST CRIMINALIZING INTENTIONAL HIV EXPOSURE*

There are substantial concerns that criminalizing intentional HIV exposure may interfere with public health prevention efforts.[274] Although there is little data on this issue, the threat of criminal prosecution may deter people from HIV testing, counseling, and treatment.[275] People who do not know their HIV status may be more likely to engage in high-risk behaviors, and, therefore, may increase the spread of HIV transmission.[276] Recent research found that more than

274. *E.g.* Brian Leech, Student Author, *Criminalizing Sexual Transmission of HIV: Oklahoma's Intentional Transmission Statute: Unconstitutional or Merely Unenforceable?*, 46 Okla. L. Rev. 687, 694 (1993):

> Should the state choose to abrogate one's right of confidentiality in HIV testing matters, then the criminal statute will seriously undermine the overall public policy behind the law, and in fact, could conceivably promote the spread of HIV. Lack of confidentiality may discourage people from seeking treatment and testing. This in turn could result in people unaware of their HIV-positive status engaging in activity with a high likelihood of transferring the disease.

Id. at 694; *Criminal Penalties for the Spread of AIDS*, 9 The Recorder (S.F.) 4 (May 18, 1992) (reporting the formal opposition of the Bar Association of San Francisco to proposed legislation criminalizing intentional HIV exposure because of concern that access to voluntary testing records was counter to public health tenets).

275. Lazzarini, Bray & Burris, *supra* n. 38, at 250.

276. Lawrence O. Gostin and James G. Hodge, Jr., *The Names Debate: The Case for National HIV Reporting in the United States*, 61 Albany L. Rev. 679, 714-15 (1998).

half of the people testing positive for HIV infection did not return to receive their test results.[277] The study did not evaluate the effect of criminal laws on the decision not to return, but its results suggest that criminal laws could exacerbate an existing problem. In addition, HIV-infected individuals may also be reluctant to cooperate with partner notification out of fear that the information they provide may be used against them or their partners.[278] Without patient cooperation, public health officials cannot conduct effective partner notification.[279]

Second, there are empirical questions about whether criminal laws can achieve their prevention goals of deterring high-risk behaviors. Numerous studies show that public health efforts can reduce high-risk behaviors and transmission of HIV and other STIs.[280] There are, however, no published studies demonstrating the effectiveness of the criminal approach to HIV prevention.[281]

Third, prosecution under broadly drawn criminal HIV transmission laws may place too many people at risk of prosecution. Whereas moral standards define the behaviors to which people should

277. *See* Kaiser Network, *supra* n. 78, at [1] (reporting findings of the Los Angeles County Department of Health Services that 60% of men who tested positive for HIV never returned to the clinic to learn the results of the HIV test).

278. *See* Hodge & Gostin, *supra* n. 72, at 50 (recognizing the tension resulting from the need to respect an HIV-infected individual's privacy so that he or she will participate in public health efforts and the need to warn those who are at risk of being HIV-infected after being exposed to the virus who, despite efforts to maintain confidentiality of the HIV-infected individual, may nonetheless deduce that person's identity).

279. Bayer, *supra* n. 66, at 1502; Kathleen E. Toomey & Willard Cates, Jr., *Partner Notification for the Prevention of HIV Infection*, 3 Acquired Immune Deficiency Syndromes S57, S57, S60 (1989).

280. *See generally e.g.* Judith D. Auerbach & Thomas J. Coates, *HIV Prevention Research: Accomplishments and Challenges for the Third Decade of AIDS*, 90 Am. J. Pub. Health 1029, 1029, 1031 (2000) (citing studies and exemplary HIV prevention interventions); Natl. Insts. of Health, *Interventions to Prevent HIV Risk Behaviors* 1-41 (1997) (providing a bibliography including studies finding that behavioral intervention can reduce the spread of HIV); Mary Jane Rotheram-Borus et al., *HIV Prevention Programs with Heterosexuals*, 14 Acquired Immune Deficiency Syndromes S59, S59-67 (2000) (reporting the results of 32 HIV prevention programs identifying effective prevention efforts as those based on: (1) Social cognitive theories; (2) treatment of STIs; and, (3) pre-test and post-test HIV counseling); Gina M. Wingood & Ralph J. DiClemente, *HIV Sexual Risk Reduction Interventions for Women: A Review*, 12 Am. J. Preventive Med. 209, 209-13 (1996) (reporting findings on reduction in high-risk behavior of women through behavioral interventions).

281. Lazzarini & Klitzman, *supra* n. 37, at 535.

aspire, criminal laws ideally reflect minimum standards of behavior to which most people conform.[282] However, behaviors prohibited under criminal HIV transmission statutes appear prevalent. Many people do not disclose STIs to sexual partners. In one survey, more than ninety-five percent of respondents agreed there was a responsibility to discuss STIs with sexual partners.[283] However, only a third of respondents with STIs informed their partners of the infection before they had sexual intercourse.[284] Many factors may influence a person's ability to disclose his or her HIV infection in a particular relationship.

Fourth, there may be discrimination in prosecution and sentencing. Law enforcement officials and prosecutors have broad discretion regarding who is arrested, what charges are brought, and who is prosecuted for these crimes. Overbroad statutes create opportunities for misuse, such as prosecution of cases in which the risk of HIV transmission is very low.[285] Of the many cases in which HIV is transmitted, very few are criminally prosecuted.[286] The selection of cases for prosecution may be discriminatory, as has occurred with some sodomy prosecutions.[287] For example, many have suggested that the prosecution of Nushawn Williams was fueled by the fact that he was an African-American man in a small, predominantly white community.[288] Fears and prejudices can also taint sentencing for criminal HIV exposure, which have typically been longer than those

282. LaFave & Scott, Jr. , *supra* n. 86, at § 1.5, 22; Torcia, *supra* n. 85, at 21.

283. Kaiser Family Foundation, *The 1998 Kaiser Family Foundation/Glamour Survey of Men and Women on Sexually Transmitted Diseases* 11 (Feb. 25, 1999) (available at <http://www.kff.org/mediapartnerships/leader.cfm?url=/commonspot/security/getfile.cfm> (accessed Apr. 1, 2004)).

284. *Id.* at 22.

285. David Heckelman, *AIDS Law Too Vague to Enforce*, Chi. Daily L. Bulletin 1 (Nov. 10, 1993).

286. *E.g. Nushawn Williams Indicted for Exposing Girl to HIV*, 13 AIDS Policy & L. 6 (Sept. 4, 1998) (reporting that the indictment against Williams marked "the first time in New York City that a reckless endangerment charge has been brought in an HIV exposure case, according to [the] Bronx District Attorney").

287. *Bowers v. Hardwick*, 478 U.S. 186, 201 (1986) (Blackmun, J., dissenting), *overruled by*, *Lawrence v. Tex.*, ___ U.S.___; 123 S. Ct. 2472 (2003); *see* Sullivan & Field, *supra* n. 122, at 190 (noting that education is more likely to decrease HIV transmission).

288. *E.g.* Lazzarini & Klitzman, *supra* n. 37, at 537-38 (observing that media coverage of Nushawn Williams' cases revealed "many deep-seated stereotypes related to race and sexuality").

for comparable crimes.[289] A comparison between the sentences authorized for criminal exposure to HIV and drunk driving illustrates this point. Both exposing someone to HIV and driving drunk create a risk of serious harm and may be punished regardless of whether actual harm occurs. Under drunk driving laws, maximum sentences, for first offenses, are relatively short—typically six months to a year.[290] Under criminal HIV exposure laws, sentences can be as long as ten, fifteen, or twenty-five years.[291] People prosecuted for exposing others to HIV have received long sentences (five to twenty years), even when the victim was not infected.[292]

Fifth, perinatal transmission raises particular concerns about discrimination for several reasons. Criminalization of perinatal transmission might place at risk HIV-infected women who agreed to antiretroviral therapy during pregnancy but still transmitted HIV to their child. These women may have had no intent to transmit the virus, and may have taken appropriate precautionary measures. Moreover, such statutes may also infringe on an HIV-infected woman's reproductive rights. Historically, HIV-infected women have been discouraged from becoming pregnant.[293] Finally, HIV-infected pregnant women are disproportionately women of color who also have been disproportionately targeted for prosecution for perinatal drug

289. *See* Stein, *supra* n. 128, 179 (positing that HIV-exposure criminalization statutes are more a product of a fear and panic-based moral campaign against an alleged vice).

290. *E.g.* Cal. Vehicle Code Ann. § 23536 (West 1999 & Supp. 2004) (setting the range of punishment for a first time offender at 96 hours to 6 months); Utah Code Ann. § 41-6-44 (1998 & Supp. 2003) (establishing a minimum sentence of 48 hours for the first conviction).

291. *E.g.* Ga. Code Ann. § 16-5-60 (Harriston 2002) (mandating imprisonment for not more than 10 years); Iowa Code Ann. § 915.43 (West 2003); Nev. Rev. Stat. § 201.205 (LEXIS L. Publg. 1993 & Supp. 2003) (prescribing not less than 2 years and not more than 10).

292. *Arkansas Court Affirms Conviction of Man Who Infected Sex Partner*, 13 AIDS Policy & L. 16 (Sept. 4, 1998); *Grave Risk of HIV Exists Even if Victim is Not Infected*, 13 AIDS Policy & L. 11 (Apr. 3, 1998); *In Brief: Guilty Verdict*, 13 AIDS Policy & L. 9 (May 15, 1998).

293. Nancy E. Kass, *Reproductive Decision Making in the Context of HIV: The Case for Nondirective Counseling*, in *AIDS, Women, and the Next Generation: Towards a Morally Acceptable Public Policy for HIV Testing of Pregnant Women and Newborns* 308 (Ruth R. Faden et. al., eds., Oxford U. Press 1991).

use.[294] Only one state's statute excludes perinatal transmission from criminal prosecution.[295]

B. *FINDING A BALANCE*

There is strong public support for criminal HIV exposure laws.[296] There is also strong support, however for efforts to reduce the spread of HIV. Legislators need to seriously consider the concerns that public health professionals and others have raised about criminal HIV exposure laws.[297] Although proponents of criminal HIV exposure laws state that these laws are intended, in part, to reduce HIV infection, these statutes can interfere with public health prevention efforts if not carefully drawn. Accordingly there needs to be thoughtful reconsideration of criminal HIV exposure laws to better define the goals and to adopt policies that work in concert with public health efforts.

First, legislators need to realistically consider the law's limitations. Society's experiences with other complex behaviors, such as transmission of other STIs, prostitution, and illegal drug use suggest that criminal laws alone have little impact on reducing such behaviors.[298] Addressing these behaviors often requires changes on individual, social, and environmental levels.[299] Criminal law may have a role in these efforts, but it is only one of multiple approaches and should not be the first approach.[300] For example, there is increasing support for offering drug offenders treatment rather than prison as a

294. Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 New Engl. J. Med. 1202, 1202-04 (1990); Philip H. Jos et al., *The Charleston Policy on Cocaine Use During Pregnancy: A Cautionary Tale*, 23 J. L. Med. & Ethics 120, 124 (1995).

295. Okla. Stat. Ann. tit. 21, § 1192.1 (West 2002); *HIV-Positive Mothers Risk Criminal Prosecution, Group Warns*, 13 AIDS Policy & L. 15 (1998).

296. Michel, *supra* n. 28, at 1A.

297. Lazzarini, Bray & Burris, *supra* n. 38, at 246-47, 251.

298. Kenney, *supra* n. 122, at 271-73.

299. Lazzarini, Bray & Burris, *supra* n. 38, at 249.

300. *See* Cari Cason et. al., *The Impact of Laws on HIV and STD Prevention*, 30 J. L. Med. & Ethics 139, 145 (2002) (explaining that "HIV-related laws represent one approach to integrating law and social epidemiology [but] [p]olicy makers should consider additional research, reform, or intervention as they continue to refine responses to HIV").

first approach.[301] Moreover, as described above, most people do not disclose STIs to their sexual partners. Reasons for non-disclosure are complex. In some cases, people need to learn skills to help them disclose, something that some public health prevention programs address.[302] In other cases, disclosure may place people at risk of other harm.[303] The law does not address these difficulties and, therefore, places people at risk for failing to meet a standard of behavior that most people cannot achieve. The criminal laws are intended to address behavior that falls outside social standards.[304] This application does not.

Even when the criminal law is used, incarcerating a person who has exposed others to HIV through consensual sexual activity does not necessarily reduce HIV transmission. Behaviors within a community must also change. As cases like Nushawn Williams' have revealed, many people engage in behaviors that put them at risk for HIV.[305] In Jamestown, New York, the Williams case revealed that adolescents and young adults in the area were engaging in risky activities, including unprotected sex with multiple partners.[306] In fact, after the potential HIV exposure through Williams was revealed, more than fourteen hundred people sought HIV testing, suggesting that risk behaviors were widespread.[307] Although the Williams case heightened awareness

301. *E.g.* Elizabeth P. Deschenes et al., *Drug Court or Probation?: An Experimental Evaluation of Maricopa County's Drug Court*, 18 J. Sys. J. 55, 56 (1995) (reporting that Maricopa County's drug court program resulted in the participants having fewer drug violations after released).

302. Christine J. De Rosa & Gary Marks, *Preventive Counseling of HIV-Positive Men and Self-Disclosure of Serostatus to Sex Partners: New Opportunities for Prevention*, 17 Health Psychol. 224, 227-30 (1998).

303. *See id*. at 229 (reporting that some people experience others' negative reactions, such as stigmatization and rejection).

304. Lazzarini, Bray & Burris, *supra* n. 38, at 248-49.

305. *See* Andrew Z. Galarneau, *Nushawn Williams' Legacy Finds Public Alarm Turned into Action*, Buffalo News A1 (Oct. 27, 1998) (describing how "drug dealers are still setting up shop"); Martelle, *supra* n. 11, at 7M (explaining how heroine use is a "reality" in the neighborhood); Lou Michel & Charity Vogel, *Who Is to Blame? Nushawn's Sex Partners Differ Over Fault*, Buffalo News A1 (Feb. 28, 1999) (describing the promiscuous girls who have "sex with everyone").

306. *See* Galarneau, *supra* n. 18, at 1C (questioning why so many adolescents would have careless sex with strangers, even when advised about the risk of contracting HIV); Martelle, *supra* n. 11, at 7M (describing that even with talk of "safe sex," people still resort to their old risky behaviors).

307. Galarneau, *supra* n. 305, at A1 (Oct. 27, 1998); Martelle, *supra* n. 11, at 7M.

about HIV/AIDS in the community, some contend that behaviors and attitudes have not changed in subsequent years.[308] The community, however, has amended its AIDS education programs to try to better reach the adolescents at risk.[309] Similarly, a recent New York City survey indicated that more than half the people in New York City with multiple sex partners did not know their HIV status and more than forty percent did not use a condom the last time they had sex.[310] Reducing the risk of further transmission requires that others in the community understand how HIV is transmitted and what they can do to protect themselves and their partners, have access to condoms to reduce their risk, and, perhaps, change social norms to reduce the acceptability of unprotected sex with multiple sex partners.

Second, legislators should look at how public health efforts and the criminal law can work together. Public health efforts sometimes require both a "carrot" and a "stick" to achieve their results. Criminal law can be a beneficial adjunct in such efforts, available if public health efforts fail. Experiences in tuberculosis control illustrate how public health can use detention to promote public health goals.[311] For example, New York City developed a system to deal with the dramatic increase of tuberculosis cases in the early 1990s.[312] This system combined existing public health measures (such as directly observed drug therapy) with increased legal powers to detain individuals to control the spread of the disease.[313] If a patient failed to engage in voluntary drug therapy, he could be mandated to participate in directly observed treatment; this proved extremely successful, largely because of the credible threat of detention behind the mandate.[314] The threat itself proved sufficient for most patients, with only two percent of all known tuberculosis patients being detained in New York City in both 1993 and 1997.[315] These patients tended to be repeat offenders with an extensive history of medical noncompliance.[316] By creating a program

308. Martelle, *supra* n. 11, at 7M; Michel & Vogel, *supra* n. 305, at A1 .

309. Galarneau, *supra* n. 305, at 1A.

310. Perez-Pena, *supra* n. 78, at B1.

311. M. Rose Gasner et. al., *The Use of Legal Action in New York City to Ensure Treatment of Tuberculosis*, 340 New Eng. J. Med. 359, 359 (1999).

312. *Id.*

313. *Id.* at 362.

314. *Id.*

315. *Id.* at 361, 364-65.

316. *Id.* at 363.

based on successively more restrictive means of disease control, the city balanced the rights of individuals with the health interests of the greater public. More importantly, it provided the services, such as shelter and food, to overcome potential barriers to voluntary compliance, and increase the likelihood that voluntary measures would succeed.[317] It also established a checks and balances system that prevented overly severe punishments and restrictions for individuals who did not pose a major threat to the public health.[318] Other states have used both civil and criminal detention to achieve similar goals.[319]

At least some of the prosecuted cases demonstrate this two-stage approach. For example, in two Missouri cases, the defendants were prosecuted for intentionally exposing others to HIV only after attending multiple sessions with public health counselors who had warned them against engaging in unprotected sex, explained how to use condoms, and had them sign statements saying that they were aware of the criminal HIV transmission law and would not violate it.[320] Experience in Colorado suggests that using progressively coercive measures, including cease and desist orders and restriction orders, with HIV-infected people who persist in risky behavior may be effective in stemming such behavior.[321] Although Colorado public health officials could not themselves seek criminal sanctions, prosecutors' decisions to bring an independent criminal action curtailed risky behavior in some cases.[322] The credible threat of criminal sanctions may deter risky behavior.[323] Accordingly, although there are concerns about using the criminal law to address HIV transmission, limited use of the criminal law may serve important purposes in HIV prevention.[324] These types of approaches can be effective, provided there is also a commitment to

317. *Id.* at 360.

318. *Id.* at 360, 364-65.

319. Tom Oscherwitz et al., *Detention of Persistently Nonadherent Patients with Tuberculosis*, 278 J. Am. Med. Assn. 843, 843-46 (1997).

320. *Mo. v. Mahan*, 971 S.W.2d 307, 309-12 (Mo. 1998).

321. *See* Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 9 Colum. L. Rev. 59, 109, n. 194-95 (1999) (explaining that Colorado's disease control statute authorizes compulsory control measures, such as the issuance of a cease and desist order when an individual engages in conduct that endangers others).

322. Colo. Rev Stat. Ann. § 25-4-1406 (West 1999).

323. Lazzarini, Bray & Burris, *supra* n. 38, at 250.

324. Cason et. al., *supra* n. 300, at 144-45.

providing the services needed to support voluntary compliance with public health efforts.[325] In the case of HIV prevention, this may include commitment to effective risk reduction counseling programs, drug treatment, and provision of food and shelter.[326]

C. *IMPROVING CURRENT CRIMINAL HIV EXPOSURE STATUTES*

If states choose to include criminal HIV exposure as part of their efforts to curb HIV infection, there are several ways that current criminal HIV transmission statutes could be changed to limit their potentially negative effect on prevention efforts.

1. *Use Enhancement Statutes for Serious Sex Crimes*

The vast majority of HIV exposure cases involve acts that are already criminal.[327] Because the exposure creates an additional harm, it is appropriate that the lack of consent to the exposure is an additional crime. Enhancement of penalties for exposure to HIV while committing another crime is also unlikely to affect public health measures negatively.

a. Sexual Assault

Victims of sexual assault do not have the opportunity to consent. In addition to the assault itself, they are subjected to the additional risk of a fatal infection. Accordingly, it is appropriate to create secondary charges or enhancement of penalties for sexual crimes in which the perpetrator knowingly exposes others to a significant risk of HIV. Wisconsin and Florida, for example, have statutes that do this.[328]

b. Sex with Minors

Sexual relations with minors have been criminalized as a way of protecting minors who are not yet capable of making informed decisions or protecting their interests. Because they may be less

325. *See* Gostin et. al., *supra* n. 321, at 65-66, 94-95, 119-20 (reasoning that health agencies need to portray an element of trustworthiness and credibility to the public to dismiss fears that they are simply an extension of the government).

326. Cason et. al., *supra* n. 300, at 144-45.

327. Lazzarini, Bray & Burris, *supra* n. 38, at 244, 251.

328. Fla. Stat. Ann. § 775.0877 (West 2002); Wis. Stat. Ann. § 973.017 (West Supp. 2003).

capable of protecting themselves against exposure to HIV, it would seem reasonable to include enhancement for statutory rape charges. There is significant variation among states, however, as to the age of consent, as well as the legal age differential between partners that may give rise to statutory rape charges. Sexually active minors already face barriers for seeking testing and treatment; they may fear parental reaction or have difficulty acknowledging their own sexuality. To avoid creating additional barriers for care, any enhancement statutes should be carefully crafted to focus on sexual relationships where minors need the most protection—e.g. younger minors with significantly older partners. Some physician reporting guidelines similarly focus on minors' sexual relationships with significantly older partners, rather than on sexual activity between minors of similar ages.[329]

Enhancements should not be used for prostitution. As discussed above, a complex set of social circumstances often leads an individual to enter into sex work, including poverty, drug addiction, immigration status, language barriers, and lack of education and/or skills.[330] A more effective approach to HIV prevention among this population is to develop programs for supporting use of safer sex measures in sex work, while also working to change the larger social factors that lead women and men to engage in sex work.[331]

2. *Target Only Harmful Behaviors*

The concern that criminalization of intentional HIV exposure may undermine public health prevention messages is exacerbated by the fact that many of the HIV exposure statutes criminalize behaviors that present low or no risk of HIV transmission. For example, statutes in Arkansas and Michigan are overly broad, including activities in their

329. Abigail English & Catherine Teare, *Statutory Rape Enforcement and Child Abuse Reporting: Effects on Health Care Access for Adolescents*, 50 DePaul L. Rev. 827, 838, 859 (2001).

330. *See* Kara Abramson, *Beyond Consent, Toward Safeguarding Human Rights: Implementing the United Nations Trafficking Protocol*, 44 Harv. Intl. L. J. 473, 478, 491 (2003) (stating that factors making people more vulnerable to prostitution include poverty, illiteracy and lack of opportunity).

331. *See* Anupama K. Menon, *Gendered Epidemic: Addressing the Specific Needs of Women Fighting HIV/AIDS in Cambodia*, 18 Berkeley Women's L. J. 254, 259-62 (2003) (explaining that increasing women's access to education about STIs and economic opportunities may provide sex workers with alternative work options).

scope in which there is no exposure to bodily fluids containing HIV, and hence no risk of HIV transmission.[332] This over-inclusion of behaviors creates a potential for abuse because it allows for arbitrary prosecutions and feeds into public fears by overstating potential health risks when there are none. Moreover, if overly restrictive laws create unrealistic standards for behavior, then HIV-infected people may give up on prevention measures.[333]

Instead, any criminal HIV transmission law should prohibit only those behaviors that pose a high risk of HIV transmission. For example, California criminalizes only *unprotected* sexual activity.[334] Moreover, low-risk activities, such as oral sex, are not included in the language of the statute.[335] Other states, such as Tennessee, include only activities that "present a *significant* risk of HIV transmission" in their criminal statute.[336]

3. *Exclude Behaviors That Comply with Prevention Guidelines*

Most statutes do not address the effect of prevention measures that are recommended by public health authorities. As a result, behaviors that present a low risk of HIV transmission are criminalized. Behaviors that comply with prevention guidelines issued by the CDC (e.g. condom usage), even without a partner's knowledge or consent, should not be criminalized under criminal HIV transmission laws. Although we believe that HIV-infected people have a moral obligation to inform their sexual and drug-sharing partners of their infection,[337] we recognize that many find this moral standard difficult to attain. In some circumstances, it may not be safe for the individual to disclose

332. Ark. Code Ann. § 5-14-123 (LEXIS L. Publg. 1997); Mich. Comp. Laws Ann. § 333.5210 (West 2001).

333. David E. Ostrow et. al., *Attitudes Towards Highly Active Antiretroviral Therapy Are Associated with Sexual Risk Taking Among HIV-Infected Homosexual Men*, 16 Acquired Immune Deficiency Syndromes 775, 775-80 (2002).

334. Cal. Health & Safety Code Ann. § 120291 (West 2003 & Supp. 2004) (emphasis added).

335. *Id.* § 120291(b)(1).

336. Tenn. Code Ann. § 39-13-109(b)(2) (2003) (emphasis added).

337. Ronald Bayer, *AIDS Prevention—Sexual Ethics and Responsibility*, 334 New Eng. J. Med. 1540, 1541 (1996) (quoting Michelangelo Signorile, *HIV-Positive and Careless*, 4 N.Y. Times 15 (Feb. 26, 1995)).

the infection status.[338] Accordingly, all statutes should explicitly account for behaviors that comply with prevention measures.

Preferably, behaviors that comply with prevention guidelines should be excluded from the law's coverage, as California does by criminalizing only unprotected sexual activity.[339] Alternatively, compliance with prevention guidelines should be a defense to the charge of criminal HIV transmission, as North Dakota allows.[340] The latter approach, however, is less preferable because it shifts the burden of proof from the prosecutor to the defendant, increasing the risks of prosecution of HIV-infected individuals who consistently follow prevention guidelines.[341]

4. *Require Intent to Harm*

Most of the criminal HIV exposure statutes do not require any intent to harm.[342] Typically, it is enough that the defendant, knowing he or she was HIV-infected, intended to engage in the behavior (e.g. unprotected sex or needle-sharing) that may have exposed his or her partner to HIV. This approach was taken in criminal HIV transmission statutes because prosecutors had difficulty proving the required intent to harm the partner under traditional criminal statutes.[343] Although the prosecutions of Nushawn Williams and others show that successful prosecutions for intentional HIV exposure can occur under existing general criminal laws, the concern about the difficulty of proving intent is understandable. On the other hand, requiring only a showing of intent to engage in the sexual or drug-sharing behavior may go too far in enlarging the scope of potentially criminal cases. Under this standard, an HIV-infected person who consistently uses condoms could be subject to prosecution for a condom failure. A better approach may

338. *See* U.S. Dept. Health & Human Servs., *Violence, Stigma HIV & AIDS* [Violence sec.] (available at <http://www.hab.hrsa.gov/publications/stigma/violence.htm> (accessed Apr. 1, 2004)) (explaining that research indicates disclosure of HIV positive status may provoke violence in intimate relationships).

339. Cal. Health & Safety Code Ann. § 120291(a).

340. N.D. Cent. Code § 12.1-20-17(3) (1997).

341. Mona Markus, *A Treatment for the Disease: Criminal HIV Transmission/Exposure Laws*, 23 Nova L. Rev. 847, 869-71 (1999).

342. *E.g.* Ga. Code Ann. § 16-5-60 (Harrison 1998); N.D. Cent Code § 12.1-20-17; Tenn. Code Ann. § 39-13-109 (2003).

343. *See* Gostin, *supra* n. 117, at 1627 (stating that the vast majority of HIV transmission cases were dropped or unsuccessful).

be to require the intent to infect the other person, an approach taken by California, Oklahoma, and Virginia.[344] A reasonable compromise between these two standards, however, would be to require a showing of recklessness (i.e. conscious disregard for the consequences of the action) supported by evidence beyond knowing about one's HIV infection. Applying this stricter standard may reduce the risk of abuse of these statutes without hindering the ability to pursue egregious cases.

5. *Target Persistent Offenders*

Many of the prosecuted cases involve defendants who have exposed multiple partners to HIV.[345] Targeting people who expose multiple partners to HIV makes sense from a public health perspective because the alleged perpetrators place the most people at risk of HIV infection. However, it is unfair to prosecute people for consensual sexual behavior when they have not been warned of the risk and have not received the information and support necessary to effect behavior change. Accordingly, such exposure should only be subject to criminal prosecution upon referral by a public health official after the offender: (1) Has been warned that additional exposures would result in criminal prosecution; and, (2) has failed less restrictive public health measures to achieve behavior change.

We acknowledge the complexity and possible difficulty of this approach when put into practice. Most importantly, it requires effective public health measures at a variety of levels. The Nushawn Williams case raises interesting issues in this regard. If Williams is

344. Cal. Health & Safety Code Ann. § 120291(a); Okla. Stat. Ann. tit. 21, § 1192.1 (West 2002); Va. Code Ann. § 18.2-67.4:1 (Supp. 2003). Few cases have been brought under the California statute, and California prosecutors contend that the specific intent requirement is too strict. John M. Glionna, *Law on HIV Infection Little Used: As a Victim Finds, State's Tough Standard Means Few Who Knowingly Pass the Virus Are Prosecuted*, L.A. Times B1 (Sept. 10, 2003). Since submission of this article, the judge has dismissed the indictment against Hill. Jaxon Van Derbeken, *HIV Transmission Case Tossed Out; Man Didn't Intentionally Infect, Judge Finds*, S.F. Chron. A25 (Dec. 10, 2003); John M. Glionna, *Former San Francisco Health Official Held in AIDS-Law Case*, L.A. Times B8 (Sept. 19, 2003). His partner underwent HIV testing after discovering the deception and learned he too was HIV-infected. *Id.* The partner had previously been awarded $5 million in damages on default judgment in a civil suit for knowing exposure and lying about HIV-status. *Id.*

345. *See* Lazzarini, Bray & Burris, *supra* n. 38, at 244 (noting that sexual exposure was the most common basis for prosecution).

believed, public health officials did not do an adequate job of counseling and educating Williams about his infection.[346] Regardless of what actually happened, his response has implications for how public health HIV counseling should proceed. It is common for individuals to have difficulty accepting their infection status immediately upon diagnosis.[347] There may be a need to have multiple sessions with the person over a period of time, as he or she comes to terms with this information. At the very least, people receiving test results should be provided with referrals for medical care and psychological support. While not everyone will want or participate in such sessions, providing them the opportunity to accept their condition and take responsibility for their behavior may not only help ensure understanding of the diagnosis and its implications but also assist potential future prosecution by establishing that an individual accused of a crime had been adequately informed about the risks.

6. *Decrease the Penalties*

As we have discussed, the penalties for intentional HIV exposure are disproportionate to crimes of similar severity.[348] Victims in consensual cases may be reluctant to give testimony when they learn the potential penalties for the crime. In addition, public health officials may not consider referring serious cases for criminal treatment if the penalties are seen as too high. If criminal HIV exposure laws are to serve as a "stick," then the penalties need to be brought in line with similar crimes, especially for first-time offenders.

346. *See* Cooper, *supra* n. 28, at B5 (reporting Williams' statement in an interview, occurring after his prosecution, that he still did not know if he was infected with HIV).

347. Sarah Chippindale & Lesley French, *HIV Counseling and the Psychological Management of Patients with HIV or AIDS*, 322 British Med. J. 1533, 1534 (2001); Peter H. Kilmarx et al., *Living with HIV: Experiences and Perspectives of HIV-Infected Sexually Transmitted Disease Clinic Patients After Posttest Counseling*, 25 Sexually Transmitted Diseases 28, 32 (1998); Peter Leiberich et al., *Longitudinal Development of Distress, Coping and Quality of Life in HIV-Positive Persons*, 66 Psychotherapy & Psychosomatics 237, 238 (1997); Karla Meursing & Flora Sibindi, *HIV Counselling—A Luxury or Necessity?*, 15 Health Policy & Plan. 17, 19 (2000).

348. *See supra* pt. IV.E. (stating that some enhancement statutes do not reflect a qualitative difference in the severity of the crime).

7. *Provide Protections*

Appropriate protections for HIV-infected persons should be incorporated into criminal HIV transmission statutes. Such laws should exempt perinatal HIV transmission to protect the rights of HIV-infected women to procreate and rear their children without fear of criminal prosecution, as is done in Oklahoma.[349] In addition, test results and disclosure of partners must be protected to ensure that people at risk of HIV infection are not deterred from seeking HIV information, testing, or treatment. For example, California law prohibits disclosure of HIV test results in a criminal case absent a court order that finds the public interest in disclosure outweighs the potential harm to the defendant.[350]

D. *POLICY IMPLICATIONS*

Additional federal policy is not required. Based on concerns that states would not act on their own, Congress used the 1990 Ryan White CARE Act to require that states have statutes to address intentional HIV transmission.[351] By 2000, all states had certified that they had statutes addressing intentional HIV exposure, and this requirement was removed from the Act.[352] A majority of states have elected to adopt HIV-specific statutes.[353] Accordingly, there is no longer a need for this federal policy to encourage them.

1. *Scope of Statutes*

States have many options of addressing intentional HIV transmission. Some states continue to rely on general criminal laws to address this issue.[354] As the Nushawn Williams case demonstrates, this approach can be used to respond to serious cases.[355] Other states rely on STI statutes, while still others have HIV-specific statutes that create a separate crime of intentional HIV transmission and/or provide

349. Okla. Stat. Ann. tit. 21, § 1192.1 (West 2002).

350. Cal. Health & Safety Code Ann. §120292(a)(2) (West Supp. 2004).

351. 42 U.S.C. § 300ff-47 (1990).

352. Natl. Alliance of St. & Territorial AIDS Directors, *supra* n. 115, at 4.

353. *Supra* pt. IV.A.

354. Lazzarini, Bray & Burris, *supra* n. 38, at 247.

355. *See* Richardson, *supra* n. 1, at B3 (stating that Williams was indicted on a felony charge of reckless endangerment).

for enhanced penalties for sexual crimes committed by HIV-infected individuals. In egregious cases, prosecutors likely can be successful, whether or not the state has an HIV-specific law.[356] Specific HIV laws that are more narrowly tailored, however, may have benefits for both prevention and criminal law.

States that choose to criminalize intentional HIV exposure should amend statutes to support prevention measures. Substantial concerns have been raised about what effect intentional HIV transmission criminal statutes may have on prevention efforts.[357] Some states, however, have drafted their statutes in ways that minimizes those risks by excluding behaviors that are unlikely to transmit HIV and by accounting for prevention measures.[358] States should understand that prevention programs designed to enlist the voluntary cooperation of HIV-infected people prevent transmission far more effectively than criminal sanctions. [359] They should take seriously the public health concerns and reevaluate their statutes to see whether they can be amended to better meet their goals.

2. *Establish Monitoring Mechanisms*

Because so little empirical data currently exists on the effect of criminal HIV exposure statutes on HIV prevention, states should establish mechanisms for monitoring the impact of criminalization on public health efforts.[360] For example, public health departments should report on changes in testing patterns or participation in partner notification efforts, as well as their perceptions regarding receptiveness to counseling efforts. Carefully designed research is needed regarding knowledge and opinions of criminalization laws within various communities, any impact on the incidence of risky behavior, and the

356. David P. Niemeier, Student Author, *The Criminal Transmission of AIDS: A Critical Examination of Missouri's HIV-Specific Statute*, 45 St. Louis U. L.J. 667, 676 (2001).

357. *See* Stein, *supra* n. 128, at 197-98 (stating that criminal HIV exposure statutes have not been effective in combating the spread of the disease, but that education and funding for medical treatment will).

358. S.D. Codified Laws § 22-18-32 (Supp. 2003); Tenn. Code Ann. § 39-13-109 (2003).

359. Stein, *supra* n. 128, at 197-98.

360. *See* Lazzarini, Bray & Burris, *supra* n. 38, at 239 (noting that "comprehensive data on the actual use of [HIV criminal laws has] not even been collected in the U.S.").

actual investigation and prosecution of cases under these laws.[361] This type of research is necessary to evaluate whether criminalization is achieving its goals and to identify any problems with implementation or unintended consequences.[362] Precedents exist for reversing public policies because they were shown to decrease adherence to public health recommendations.[363] For example, an Illinois law requiring premarital HIV testing was repealed after studies showed that after passage of the law use of HIV testing declined in Illinois and the number of marriages by Illinois residents in neighboring states increased.[364] States should be prepared to amend or revoke statutes if they adversely affect HIV prevention efforts.

VII. CONCLUSION

Federal and state legislators have an important role in shaping HIV prevention policy, both through the statutes they adopt and the funding they authorize. HIV education and other prevention efforts have proven highly effective in reducing HIV infection.[365] Sustaining these efforts, however, requires legislative support for social and environmental changes. For example, reducing HIV infection among injection drug users may require legislation to permit sale or exchange of clean needles, support for drug treatment programs, and other measures that address the social and environmental factors that influence injection drug users' ability to reduce risks. Criminal HIV exposure laws have historic precedent and potentially important symbolic value, and many legislators and their constituents support

361. HIV Criminal L. & Policy Project, *About the Project: Goals and Objectives* [1] <http://www.hivcriminallaw.org/phdata/index.cfm> (accessed Mar. 20, 2004).

362. *Id*.

363. *Cf.* Bernard J. Turnock & Chester J. Kelly, *Mandatory Premarital Testing for Human Immunodeficiency Virus*, 261 J. Am. Med. Assn. 3415, 3415 (1989) (detailing studies illustrating that both Indiana and Illinois repealed mandatory testing statutes when they were shown not to be cost-effective).

364. Edward A. Belongia et al., Letter to the Editor, *Border Hopping as a Consequence of Premarital HIV Screening: The Kenosha Diamond*, 260 J. Am. Med. Assn. 1883, 1884 (1998); Paul D. Cleary et al., *Compulsory Premarital Screening for the Human Immunodeficiency Virus: Technical and Public Health Considerations*, 258 J. Am. Med. Assn. 1757, 1761; Turnock & Kelly, *supra* n. 363, at 3416.

365. CDC, *HIV Prevention Saves Lives* [1] (Feb. 2001) <http://www.cdc.gov/hiv/pubs/brochure/prevention.htm> (accessed Mar. 5, 2004).

them.[366] However, legislators should also take into account the broader effect these statutes may have on HIV prevention efforts. We believe that, with careful consideration, legislators can make decisions that appropriately balance these two competing goals and further support efforts to reduce the incidence of HIV.

366. Lazzarini, Bray & Burris, *supra* n. 38, at 252; Stein, *supra* n. 128, at 179.