



Winter 2021

Sex, Crime, and Serostatus

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Recommended Citation

Courtney K. Cross, *Sex, Crime, and Serostatus*, 78 Wash. & Lee L. Rev. 71 (2021).

Available at: <https://scholarlycommons.law.wlu.edu/wlulr/vol78/iss1/4>

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Sex, Crime, and Serostatus

Courtney K. Cross*

Abstract

The HIV crisis in the United States is far from over. The confluence of widespread opioid usage, high rates of HIV infection, and rapidly shrinking rural medical infrastructure has created a public health powder keg across the American South. Yet few states have responded to this grim reality by expanding social and medical services. Instead, criminalizing the behavior of people with HIV remains an overused and counterproductive tool for addressing this crisis—especially in the South, where HIV-specific criminal laws are enforced with the most frequency.

People living with HIV are subject to arrest, prosecution, and lengthy prison sentences if they fail to disclose their HIV-positive serostatus before engaging in sexual or needle-sharing activities. Passed in response to panic following the discovery of HIV, these laws have not kept pace with medical advancements regarding the transmission and treatment of the infection. As a result, they criminalize behaviors that pose little risk of transmission and punish people who cannot or do not infect others. HIV criminalization laws also contribute to the

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spread of HIV by disincentivizing HIV testing, which would otherwise connect people to prevention and treatment plans.

While other scholars have critiqued these laws, this Article is the first to argue that state legislatures should pivot away from criminalization toward a comprehensive response to HIV informed by harm reduction—a branch of public health emphasizing risk mitigation. This approach must prioritize both the expansion of preventative services and the repeal of most HIV exposure laws. Simultaneously broadening services and narrowing criminal liability would remove barriers to HIV testing and promote early medical interventions, which reduce the spread of HIV and improve health outcomes. This paradigmatic shift also introduces a framework that can be implemented in other public health contexts that currently over-rely on criminalization throughout the region and the country.

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INTRODUCTION

The past twenty years have seen major breakthroughs to prevent, treat,¹ and even cure HIV.² Stories of queer

1. See Robert W. Eisinger et al., *HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable*, 321 J. AM. MED. ASS'N 451, 451–52 (2019) (reviewing studies establishing that compliance with antiretroviral HIV medication could reduce a person with HIV's viral load to the point of it being undetectable, which both improves their health outcomes while also making them incapable of transmitting HIV to others); Alison J. Rodger et al., *Risk of HIV Transmission Through Condomless Sex in Serodifferent Gay Couples with the HIV-Positive Partner Taking Suppressive Antiretroviral Therapy*, 393 LANCET 2428, 2434 (2019) (confirming that the risk of transmitting HIV to a seronegative sexual partner is essentially zero when the seropositive partner has a suppressed viral load).

2. Over the past decade, national and international research has yielded groundbreaking and lifesaving findings regarding inhibiting transmission of the virus and even destroying HIV in previously inaccessible parts of the body. See *AIDS—An Approach for Targeting HIV Reservoirs*, INSTITUT PASTEUR (Dec. 20, 2018), <https://perma.cc/548U-J3DK> (finding that HIV could be destroyed in tissue reservoirs that had previously been unreachable); Matthew Warren, *Second Patient Free of HIV After Stem-Cell Therapy*, NATURE (Mar. 5, 2019), <https://perma.cc/EF9J-TK8F> (describing how a bone marrow transplant intended to treat cancer also resulted in long-term HIV remission).

communities decimated by the unstoppable infection³ feel like tales from a bygone era now that HIV has evolved from a death sentence into a chronic condition.⁴ Yet the benefits of these pioneering medical developments are not universally accessible, even within the United States.⁵ In fact, by multiple metrics, HIV and AIDS⁶ are gaining momentum in the American South⁷ even as their spread is slowing elsewhere.⁸ As the geography of HIV has expanded from urban centers to include rural America,⁹ the South has been particularly hard-hit.¹⁰ Compared to the West,

3. See, e.g., Jeff Leavell, *The Heartbreaking Instagram Where People Remember Loved Ones Who Died of AIDS*, VICE (Oct. 16, 2018, 6:05 PM), <https://perma.cc/GHQ8-7EDW> (showing photos and discussions on Instagram of individuals who died of AIDS); *Loss and Bravery: Intimate Snapshots from the First Decade of the AIDS Crisis*, N.Y. TIMES (Dec. 3, 2018), <https://perma.cc/ERM8-Q7UU> (showing photographs of the tragic escalation of the AIDS epidemic in the 1980s captured by Times photographers and reporters).

4. See James B. McArthur, *As the Tide Turns: The Changing HIV/AIDS Epidemic and the Criminalization of HIV Exposure*, 94 CORNELL L. REV. 707, 730 (2009).

5. See *HIV in the United States by Region*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 2020), <https://perma.cc/V9U8-45ZE> (last updated July 2, 2020) [hereinafter *HIV in the United States by Region*] (depicting data from HIV diagnoses by each state or region in the United States).

6. See *id.* Given that AIDS is the terminal stage of HIV rather than a separate illness, this Article will only distinguish between the two when specifically referring to this advanced stage of HIV. See Ann Pietrangelo, *A Comprehensive Guide to HIV and AIDS*, HEALTHLINE (Mar. 28, 2018), <https://perma.cc/E43G-87ZS>.

7. This Article is using the Centers for Disease Control and Prevention's definition of the South. See *HIV in the United States by Region*, *supra* note 5 (defining the South as Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia). This definition of the region allows for the most effective data comparisons in light of the CDC's robust research.

8. See *id.*

9. See Steven W. Thrasher, *HIV Is Coming to Rural America*, N.Y. TIMES (Dec. 1, 2019), <https://perma.cc/SV7M-CP5T> ("But while robust municipal health campaigns are creating downward HIV trends in some of America's largest cities, in much of rural America, the opposite trend is emerging.").

10. See CTRS. FOR DISEASE CONTROL & PREVENTION, *HIV IN THE SOUTHERN UNITED STATES* 1 (2019), <https://perma.cc/P2BS-LB3Y> (PDF). As is the case nationally, the majority of HIV infections in the South occur in urban areas. *Id.* However, unlike the rest of the U.S., the South also has high rates of HIV

Midwest, and Northeast, the South now has the highest rates of HIV and AIDS,¹¹ with over half of new infections in the United States occurring in the South and nearly half of all people with HIV residing in the region.¹²

An analysis of southern HIV trends is no doubt beneficial to the region and its population. At the same time, it also provides critical insights into areas with overlapping characteristics that have been the subject of far fewer large-scale statistical inquiries.¹³ From rural counties in more populous states to Appalachia and similar regions abroad, understanding the dynamics in the South that coalesced into the current HIV crisis will be instructive in developing new and innovative approaches to combating the latest phase of the disease locally, nationally, and globally.

Several factors contribute to the South becoming the new epicenter of HIV.¹⁴ First, the South has high poverty rates which are generally associated with inadequate access to health care and poorer health outcomes—particularly for racial and ethnic minorities who may be economically and politically marginalized as well.¹⁵ These access and outcome deficits are especially prevalent in those southern states that have not expanded Medicaid, where many people live without health

in suburban and rural areas as well. Laura Ungar, *Five Years After Indiana's Historic HIV Outbreak, Many Rural Places Remain at Risk*, NAT'L PUB. RADIO (Feb. 16, 2020, 7:00 AM), <https://perma.cc/3DNW-Y2WW>.

11. See *HIV in the United States by Region*, *supra* note 5.

12. See *supra* notes 8–10 and accompanying text.

13. While the CDC does not include state-level data in its yearly HIV Surveillance Reports, its categories for in-depth analysis and discussion are typically age, race/ethnicity, sex, transmission type, and region. See, e.g., CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION IN THE UNITED STATES AND DEPENDENT AREAS, 2018 (UPDATED) 8–18 (May 2020), <https://perma.cc/F4GC-CR44> (PDF) [hereinafter 2018 DIAGNOSES OF HIV IN THE U.S. (UPDATED)].

14. See Casey Leins, *Fighting HIV/AIDS Epidemic in the South*, U.S. NEWS & WORLD REP. (Dec. 5, 2017, 5:50 PM), <https://perma.cc/LYR6-9JVC>.

15. See Thurka Sangaramoorthy, *Chronicity, Crisis, and the 'End of AIDS'*, 13 GLOB. PUB. HEALTH 982, 993 (2018).

insurance.¹⁶ Health care facilities are also in short supply, with the past decade witnessing rapid closure of rural hospitals across the South.¹⁷ These deficiencies undermine HIV preventative services, testing, and treatment, all of which are crucial in stopping the spread of HIV.

The opioid epidemic further exacerbates the South's vulnerability to HIV.¹⁸ The region has extremely high rates of opioid prescription.¹⁹ A preexisting addiction to prescription pain medication is the biggest risk factor for becoming addicted to heroin and other injected opioids.²⁰ Injection drug users are more likely to engage in risky behaviors that increase their likelihood of being exposed to HIV.²¹ As a result, the top

16. See *id.* (“Many Southern states rejected Medicaid expansion under the Affordable Care Act, which extended healthcare to millions of uninsured Americans.”). The southern states that have not expanded Medicaid as of November 2020 are Texas, Mississippi, Alabama, Georgia, Tennessee, Florida, South Carolina, and North Carolina. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Oct. 16, 2020), <https://perma.cc/69HM-9U9B>.

17. See Ayla Ellison, *State-by-State Breakdown of 102 Rural Hospital Closures*, BECKER'S HOSP. REV. (Mar. 20, 2019), <https://perma.cc/6PPG-RE2S> (“Of the 27 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South . . .”).

18. See *Addressing the Infectious Disease Consequences of the U.S. Opioid Crisis*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/Q999-9CNV> (last updated Mar. 18, 2019) (stating that one in every ten new cases of HIV occurs among injection drug users).

19. See *Opioid Summaries by State*, NAT'L INST. ON DRUG ABUSE, <https://perma.cc/825L-SW43> (last updated Apr. 16, 2020) (showing that the nine states with the highest rates of opioid prescription are in the South); Lyndsey A. Rolheiser et al., *Opioid Prescribing Rates by Congressional Districts, United States, 2016*, 108 AM. J. PUB. HEALTH, 1214, 1216 (2018) (stating that congressional districts with the ten highest rates of opioid prescriptions are contained in southeastern states); Amy Yurkanin, *Despite Declines, Alabama Still Leads Nation in Opioid Prescriptions*, ADVANCE LOC. (Jan. 24, 2020), <https://perma.cc/XCU5-EH4S> (noting that states with high rates of opioid prescriptions include Alabama, Arkansas, Tennessee, and Kentucky).

20. See *Today's Heroin Epidemic: More People at Risk, Multiple Drugs Abused*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/YA4V-QGL4> (last updated July 7, 2015).

21. See *Injection Drug Use and HIV Risk*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/37L2-ZKJB> (last updated Feb. 6, 2020) (explaining that when people are under the influence of substances, they are

thirty-one counties found to be most at risk for an HIV outbreak among injection drug users are all in the South.²² Without strategic interventions targeting both opioid addiction and the larger structural inequalities promoting poorer health outcomes, the devastating impact of HIV in the South is poised to proliferate as circumstances fostering its spread remain unchecked.

These overlapping conditions render the region vulnerable to HIV and ill-equipped to respond to its spread. Instead of responding to the growing problem with public health-informed measures, many southern states continue to rely heavily on criminal law to deter HIV transmission by prohibiting potential exposure of others to the infection.²³ Specifically, people living with HIV who expose others to potential infection without first disclosing their HIV positive serostatus²⁴ can be prosecuted and incarcerated.

This approach is not limited to the South.²⁵ HIV is criminalized across the country in one of three ways: via

more likely to engage in risky sexual behaviors, such as having unprotected sex, having sex with multiple partners, or trading sex for money or drugs).

22. See Michael M. Van Handel et al., *County-Level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections Among Persons Who Inject Drugs, United States*, 73 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 323, 328 (2016) (discussing broadly the study's design, methodology, results, and conclusion, which shows U.S. counties potentially vulnerable to HIV infections in the context of the national opioid epidemic); *Persons Who Inject Drugs: Vulnerable Counties or Jurisdictions Experiencing or At Risk of Outbreaks*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/75HL-SLMG> (last updated July 19, 2018) (depicting data from 220 vulnerable counties in twenty-six states and jurisdictions determined to be experiencing or at-risk of a HIV outbreak due to injection drug use).

23. See Kim Shayo Buchanan, *When is HIV a Crime? Sexuality, Gender and Consent*, 99 MINN. L. REV. 1231, 1232–33 (2015) (stating that twenty-four states have passed statutes that criminalize sexual nondisclosure of HIV).

24. The National Institutes of Health defines serostatus as: “The state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test).” *AIDS Info: HIV/AIDS Glossary*, NAT'L INSTS. HEALTH OFF. AIDS RSCH., <https://perma.cc/4LS6-T655>.

25. See generally CTR. FOR HIV L. & POL'Y, *HIV CRIMINALIZATION IN THE UNITED STATES: A SOURCEBOOK ON STATE AND FEDERAL HIV CRIMINAL LAW AND PRACTICE* (3d ed. 2020), <https://perma.cc/324S-LTX7> (PDF) (providing an overview of each U.S. state and territory's HIV criminalization laws).

HIV-specific exposure criminalization statutes, general criminal laws, and rarely-used public health laws pertaining to communicable diseases.²⁶ Despite being passed at the height of the AIDS crisis when gay men, African immigrants, and drug users were widely maligned for its spread,²⁷ HIV exposure laws are not just relics on the books: they continue to be enforced across the country to this day.²⁸ There are, however, much higher numbers of arrests and prosecutions for HIV exposure-related crimes in the South than in the rest of the country.²⁹

In light of these sobering statistics, HIV exposure statutes must be interrogated in order to determine whether or not they meet their stated goal of combating the spread of HIV.³⁰ Especially—but not exclusively—in the South, these laws are overbroad and lag behind contemporary science on HIV transmission and treatment.³¹ For example, many HIV

26. See James Richardson, Comment, *Criminal Transmission of HIV Laws: Are They Outdated or Are They Still Useful?*, 53 HOUS. L. REV. 1179, 1182 (2016).

27. See Aziza Ahmed, *Adjudicating Risk: AIDS, Crime, and Culpability*, 2016 WIS. L. REV. 627, 636 (stating that HIV was once thought to be a disease impacting only gay men, users of heroin and other injected drugs, Haitians, and hemophiliacs).

28. See *id.* at 628. The United States has the highest rate of HIV crime convictions per capita in the world. Angela Perone, *From Punitive to Proactive: An Alternative Approach for Responding to HIV Criminalization That Departs from Penalizing Marginalized Communities*, 24 HASTINGS WOMEN'S L.J. 363, 367 (2013).

29. See CTR. FOR HIV L. & POL'Y, POSITIVE JUSTICE PROJECT: ARRESTS AND PROSECUTIONS FOR HIV EXPOSURE IN THE UNITED STATES, 2008–2019 1–61 (2019), <https://perma.cc/MH22-K7UF> (PDF) (describing a study in which the data, broken down according to date and state, counted arrests and prosecutions rather than convictions over eleven years and found 207 of the incidents (or 52.4 percent) occurred in southern states).

30. See Michael R. Ulrich, *Law and Politics, An Emerging Epidemic: A Call for Evidence-Based Public Health Law*, 42 AM. J.L. & MED. 256, 270 (2016) (“Consequently, these laws ignore much of what we know today about viral loads and the risks of transmission.”).

31. See *id.* (explaining that the prosecution of individuals lacks scientific understanding because we now know that if the virus is detected early enough, an individual can reduce the viral load to the point where it is nearly impossible for him or her to transmit the virus).

criminalization statutes prohibit behaviors by a person living with HIV that pose low-to-no risk of transmitting HIV.³² Additionally, individuals who cannot transmit the infection to others because their compliance with medical treatment has made them non-contagious,³³ can nonetheless be prosecuted under many of these laws. As a result, laws meant to slow the spread of HIV are harshly punishing people who have not and cannot transmit the infection, giving credence to the argument that these laws may be punishing serostatus rather than any actual harm being inflicted.³⁴ Moreover, studies have suggested that criminalizing HIV exposure may make people living with HIV less likely to get tested and ascertain their status in order to avoid potential criminal liability.³⁵ Given that approximately 40 percent of new HIV infections come from people who are unaware of their positive serostatus,³⁶ any disincentives to

32. See Joseph Allen Garmon, Comment, *The Laws of the Past Versus the Medicine of Today: Eradicating the Criminalization of HIV/AIDS*, 57 HOW. L.J. 665, 671 (2014) (“[T]hirteen of the states that criminalize HIV have laws that specifically target HIV-positive people for spitting or biting someone even though such behavior does not transmit the virus.”); Tony Ficarrotta, *HIV Disclosure Laws Are Unjustified*, 24 DUKE J. GENDER L. & POL’Y 143, 150 (2017) (“The fact that the sexual activities some Disclosure Laws prohibit swing completely free of actual HIV transmission risks supports an inference of improper legislative purpose.”); Ulrich, *supra* note 30, at 270 (explaining that many of the laws used for prosecutions of individuals under HIV criminalization laws do not require intent to transmit the virus or actual transmission of the virus).

33. Compliance with HIV medication can now lower someone’s HIV viral load to the point where it is no longer detectable and can no longer be transmitted to others. Savas Abadsidis, *CDC Officially Admits People with HIV Who Are Undetectable Can’t Transmit HIV*, HIV PLUS MAG. (Oct. 22, 2017), <https://perma.cc/4K7X-C7GT>.

34. See Shayo Buchanan, *supra* note 23, at 1341 (arguing that HIV criminalization constitutes a status crime).

35. See Rudolf V. Van Puymbroeck, *Beyond Sex: Legal Reform for HIV/AIDS and Poverty Reduction*, 15 GEO. J. ON POVERTY L. & POL’Y 781, 798 (2008). A 2012 study by the activist group SeroProject confirmed that individuals are indeed afraid of finding out their status because of fear of the potential for prosecution. *HIV Criminalization Discourages HIV Testing, Creates Disabling and Uncertain Legal Environment for People with HIV in U.S.*, HIV JUST. NETWORK (July 25, 2012), <https://perma.cc/YT6J-QF4A>.

36. See *HIV Testing*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/U78U-6Q3Z> (last updated June 9, 2020).

testing must be reevaluated from a public health perspective. As such, updating and limiting criminal exposure laws is a necessary first step in a campaign against new infections that also supports better health outcomes for people living with HIV.

In addition to more narrowly tailored HIV exposure laws to target intentional behavior that results in tangible harm, states struggling with HIV must look more broadly than decriminalization strategies. While HIV organizations at the grassroots level have long been advocating for adoption of public health measures like access to prevention and treatment tools and better outreach to at-risk communities,³⁷ strategies like providing sterile syringes and condoms have historically been criticized by more conservative politicians.³⁸ Yet these critiques, grounded in claims of enabling high-risk behavior, have been widely debunked; instead these measures have been found to be both life-saving and cost-saving³⁹—recently amassing broader bipartisan support.⁴⁰

Moving away from criminalization and toward approaches that promote health outcomes by reducing risk—a public health

37. See, e.g., Francis Collins, *For HIV, Treatment Is Prevention*, NAT'L INSTS. HEALTH: DIR.'S BLOG (Jan. 22, 2019), <https://perma.cc/C267-PEQZ> (discussing an international health equity initiative that aims to help end the HIV epidemic and HIV-related social stigma); *About Us*, SERO PROJECT, <https://perma.cc/MA2W-XG7Z> (describing SERO Project's mission to end inappropriate criminal prosecutions of people living with HIV); NAT'L HARM REDUCTION COAL., 2019 ANNUAL IMPACT REPORT 5–13 (2019), <https://perma.cc/ZQT4-ZXU3> (PDF) (discussing the impact of harm reduction trainings and overdose prevention); NAT'L LGBT HEALTH EDUC. CTR., BEST PRACTICES IN HIV PREVENTION: TRANSLATING INNOVATION INTO ACTION 2 (2014) <https://perma.cc/2JLQ-VULE> (PDF) (describing seven best practices to stop the spread of HIV).

38. See, e.g., Megan Twohey, *Mike Pence's Response to H.I.V. Outbreak: Prayer, Then a Change of Heart*, N.Y. TIMES (Aug. 7, 2016), <https://perma.cc/C5XM-9XPS> (“And Mr. Pence, a steadfast conservative, was morally opposed to needle exchanges on the grounds that they supported drug abuse.”).

39. See, e.g., Maia Szalavitz, *An Influential Think Tank Suggested that Harm Reduction Doesn't Work*, VICE (Dec. 13, 2018), <https://perma.cc/ZQ3U-DENZ>; Maia Szalavitz, *Why It's Not 'Enabling' to Make Drug Use Safer*, WASH. POST (March 13, 2018), <https://perma.cc/BG6Y-YA5U>.

40. See Victoria Knight, *Needle Exchanges Find New Champions Among Republicans*, KAISER HEALTH NEWS (May 9, 2019), <https://perma.cc/J7JA-TBXK> (stating that needle exchanges are now being endorsed and legalized by Republican-controlled state legislatures).

philosophy referred to as harm reduction⁴¹—would represent a fundamental shift in how vulnerable individuals are treated by the state. Although dynamic advocates and activists throughout the South have long been employing these techniques, buy-in at the municipal and state level is necessary to transform harm reduction from a grassroots approach to a widespread and mainstream strategy. Adopting a harm reduction paradigm to better address public health crises would not come a moment too soon for states struggling to get HIV rates under control, where innovative measures are needed to reduce the spread of HIV and improve the health and stability of people already living with it.

In order to best illuminate the mismatch between medical science and HIV criminalization laws, Part I provides an overview of how HIV is transmitted and how it can be both prevented and treated. Part II then explores the current face of HIV across the nation, paying particular attention to the South, where the epidemic has yet to stabilize. Part III turns to HIV criminalization laws, providing a general description of criminal exposure laws and then analyzing how these laws operate in southern states. This analysis reveals vast differences across the region in terms of who is vulnerable to prosecution and for what behaviors. Turning toward potential solutions, Part IV defines and discuss the public health concept of harm reduction, which has long been employed by HIV advocacy groups in the region yet eschewed by state governments. Adopting a harm reduction framework, Part IV first proposes the adoption of prevention strategies grounded in principles of harm reduction, namely broadening the scope and reach of syringe exchange programs, expanding sex education to include medically accurate, inclusive, and pragmatic information, and making prophylactic medication for seronegative individuals more easily accessible. Part IV then proposes a scaling back of HIV criminalization to include only actual and intentional HIV transmission. Finally, the Article concludes by arguing that a paradigm shift prioritizing public health over criminalization

41. See SUSAN E. COLLINS ET AL., HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS 6–10 (G. Alan Marlat et al. eds., 2d ed. 2012).

would be nationally applicable in the HIV context and would be especially valuable in the South, where punishment remains an overused response to public health crises.

I. THE MEDICAL EVOLUTION OF HIV

Although cases of AIDS have been documented in the United States as early as the 1960s,⁴² the infection did not begin to gain widespread attention until the early 1980s when the Centers for Disease Control and Prevention (CDC) began to publish reports on unusual health conditions affecting primarily gay men.⁴³ While the condition was initially called “gay-related immunodeficiency disease,”⁴⁴ after finding the same symptoms and infections in heterosexual injection drug users and recipients of blood transfusions, it became referred to as “acquired immune deficiency syndrome.”⁴⁵ Scientists in 1985

42. The first death from AIDS has been pinpointed to have occurred in 1969. Gina Kolata, *Boy's 1969 Death Suggests AIDS Invaded U.S.* *Several Times*, N.Y. TIMES (Oct. 28, 1987), <https://perma.cc/NV48-TMAT>; John Crewdson, *Case Shakes Theories of AIDS Origin*, CHI. TRIB. (Oct. 25, 1987), <https://perma.cc/M6NR-66DA>.

43. See *Pneumocystis Pneumonia—Los Angeles*, CTRS. FOR DISEASE CONTROL & PREVENTION (1981), <https://perma.cc/GRC6-NUP2> (discussing case reports of five gay men who were treated for pneumonia from the period of October 1980 to May 1981); *A Cluster of Kaposi's Sarcoma and Pneumocystis Carinii Pneumonia Among Homosexual Male Residents of Los Angeles and Orange Counties, California*, CTRS. FOR DISEASE CONTROL & PREVENTION (1981), <https://perma.cc/FD7M-C4LW> (discussing CDC reports from 1981 to 1982 of nineteen cases of pneumonia among previously healthy gay male residents of Los Angeles); Harry W. Haverkos & James W. Curran, *The Current Outbreak of Kaposi's Sarcoma and Opportunistic Infections*, 32 CANCER J. FOR CLINICIANS 330, 331 (1982) (“In 1981, 55 requests for pentamidine were filled for adults without known underlying disease, accounting for 37 percent of all the requests for pentamidine for adults that year.”); Ctrs. for Disease Control & Prevention Task Force on Kaposi's Sarcoma & Opportunistic Infections, *Epidemiological Aspects of the Current Outbreak of Kaposi's Sarcoma and Opportunistic Infections*, 306 NEW ENG. J. MED. 248, 251 (1982) (offering data from an outbreak among gay men and drug abusers in 1982).

44. Lawrence K. Altman, *Clue Found on Homosexuals' Precancer Syndrome*, N.Y. TIMES (June 18, 1982), <https://perma.cc/6Z9K-NNNH>.

45. *Id.*; *30 Years of AIDS—A Retrospective*, POSITIVE HEALTH PUBL'NS (2018), <https://perma.cc/9AVH-RD2D>.

isolated the precursor to AIDS, the human immunodeficiency virus, and developed a blood test to test for it.⁴⁶ Despite these early developments in the quest to understand HIV/AIDS and manage its spread, stigma and discrimination still dominated popular discourse as the infection was seen as punishment for gay men and other socially disenfranchised groups breaking social norms.⁴⁷ Many of these attitudes have continued to prevail despite thirty years of significant scientific and medical breakthroughs regarding both prevention and treatment.

A. *HIV Transmission*

HIV is a virus that attacks T cells, which are a critical part of the immune system's ability to fight infections.⁴⁸ When someone first becomes infected, their T cell count initially drops before increasing and typically remaining stable for a number of years.⁴⁹ Over time, someone living with untreated HIV often experiences a decrease in their T cell count.⁵⁰ AIDS occurs when a person's T cell level drops to below 200, causing the amount of virus, known as their viral load, to increase and heightening their vulnerability to opportunistic infections.⁵¹ Once HIV

46. See Robert Gallo & Luc Montagnic, *The Discovery of HIV as the Cause of AIDS*, 349 NEW ENG. J. MED. 2283, 2284 (2003) ("The growth of the putative virus in T-cell lines was an enormous step, facilitating the development of a blood test for HIV, which became available in blood-transfusion centers in 1985 and produced convincing evidence of the association between HIV infection and AIDS.").

47. See Ahmed, *supra* note 27, at 636 (stating that eventually it became clear that heterosexual women and men were at risk for contracting HIV through heterosexual sex). Homosexuality was particularly targeted by the Christian right during the early 1980s: Pat Buchanan described AIDS as "nature's revenge on gay men," and Jerry Falwell claimed it was "the wrath of God upon homosexuals." Igor Volsky, *Recalling Ronald Reagan's LGBT Legacy Ahead of the GOP Presidential Debate*, THINK PROGRESS (Sept. 7, 2011, 3:00 PM), <https://perma.cc/HRC6-CJFX>.

48. *About HIV*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/DT72-2Q8J> (last updated Sept. 28, 2020).

49. *What Are HIV and AIDS?*, HIV.GOV, <https://perma.cc/9X7E-P2YD> (last updated June 5, 2020).

50. *About HIV*, *supra* note 48.

51. *Id.*

becomes AIDS, an untreated person's life expectancy drops to just a few years.⁵²

HIV can only be transmitted when a bodily fluid containing the virus is injected beneath the skin or enters the body through a mucus membrane or damaged tissue.⁵³ Contrary to common belief, HIV cannot be transferred via sweat, urine, saliva, or tears.⁵⁴ In addition to the kinds of bodily fluid and mucus membranes involved, risk of transmission also depends on the viral load of the person with HIV, the type of activity being engaged in, and the kinds of preventative measures being taken.⁵⁵ By far the highest risk of transmission, at over 90 percent, is via a blood transfusion,⁵⁶ but rigorous screening of blood donations has made this form of transmission highly unlikely.⁵⁷ All other methods of transmission have less than a 2 percent risk of transmission per act, with receptive anal intercourse posing the highest risk followed by needle-sharing, insertive anal intercourse, receptive penile-vaginal sex, and

52. *Id.*

53. *HIV Transmission*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/948N-PBLM> (last updated Aug. 6, 2019) [hereinafter *HIV Transmission*]. Bodily fluids that can transmit HIV are blood, semen, pre-seminal fluid, rectal and vaginal fluids, and breast milk. *Id.* Mucus membranes susceptible to transmission are inside the mouth, penis, vagina, and rectum. *Id.*

54. *Id.*

55. See Margo Kaplan, *Rethinking HIV-Exposure Crimes*, 87 IND. L.J. 1517, 1527–30 (2012) (explaining that due to a multitude of factors, “transmission rates are far from fixed; even within a particular sexual activity, numerous variables influence the likelihood of transmission”); Shirley Kohsin Wang, *Violence & HIV/AIDS: Violence Against Women and Girls as a Cause and Consequence of HIV/AIDS*, 17 DUKE J. GENDER L. & POL’Y 313, 317–18 (2010) (noting that many factors influence HIV transmission to women and girls, including physiology, greater susceptibility to sexual violence, a partner’s stage of infection, pre-existing sexually transmitted infections, type of sexual exposure, and age).

56. *HIV Risk Behaviors*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/D7BZ-8YGD> (last updated Nov. 13, 2019) [hereinafter *HIV Risk Behaviors*].

57. See *HIV Transmission*, *supra* note 53 (“This was more common in the early years of HIV, but now the risk is extremely small because of rigorous testing of the U.S. blood supply and donated organs and tissues.”).

insertive penile-vaginal sex.⁵⁸ Giving or receiving oral sex has a nearly negligible risk of transmission.⁵⁹

Other factors play a role in determining the likelihood of transmission. Sexual assault or unwanted sexual activity can increase the likelihood of transmission since force or lack of arousal can lead to injuries through which HIV can enter the body.⁶⁰ Skin irritation or inflammation from a preexisting sexually transmitted infection can also increase the likelihood of becoming infected.⁶¹ On the other hand, correctly using a male or female condom or other prophylactics, engaging in lower-risk sexual activities, and using sterile needles significantly reduces transmission rates.⁶²

B. Contemporary Medical Interventions

For people living with HIV, a significant factor in both not transmitting HIV and maintaining a healthy T cell count is fully complying with medical treatment.⁶³ Contemporary HIV medication, called antiretroviral therapy (ART), can suppress someone's viral load to the point of being undetectable while also increasing their T cells.⁶⁴ While this does not mean someone no longer has HIV,⁶⁵ people with undetectable viral loads cannot

58. *HIV Risk Behaviors*, *supra* note 56.

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

60. *See* Wang, *supra* note 55, at 317–18 (“In the context of sexual violence against women and girls, the HIV virus is transmitted when the vulnerable mucous barriers inside and outside the genital tract break down.”).

61. *See HIV Transmission*, *supra* note 53 (explaining that “breaks or sores may make it easier for HIV to enter the body during sexual contact” and that inflammation “increases the number of cells that can serve as targets for HIV”).

62. *Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/Z22D-UDFT> (last updated Dec. 2, 2019).

63. *See id.*

64. *Id.* The CDC also puts the likelihood of vertical transmission through pregnancy to be at less than 1 percent when mothers are treatment compliant. *See id.* (recommending that HIV-positive mothers start treatment early during their pregnancy and avoid breastfeeding after delivery).

65. *See* Jeff Sheehy, *HIV Active in Tissues of Patients Who Received Antiretroviral Treatment, Study Shows*, U. CAL. S.F. (Oct. 20, 2016), <https://>

transmit HIV to sexual partners.⁶⁶ ARTs can extend the life expectancy of people living with HIV by delaying the onset of AIDS: treatment-compliant individuals have been found to have average lifespans nearly identical to those of their HIV-negative counterparts.⁶⁷ While older ART regimens often involved complicated cocktails of drugs, they are now significantly more streamlined and can even consist of a single pill.⁶⁸ However, determining an effective course of treatment may entail multiple medical appointments, lab tests, and changes in prescriptions that can be challenging for people whose income, insurance coverage, schedule, or instability at home are not conducive to this kind of experimentation.⁶⁹ Additionally, the

perma.cc/6QPW-F3KH (“While successful treatment of HIV with antiretroviral medications leads to undetectable levels of virus in the blood, controls the disease and leads to much longer lifespans, scientists know that HIV continues to reside in tissues.”). Scientists discovered a way to kill these HIV reservoirs in late 2018. See *AIDS—An Approach for Targeting HIV Reservoirs*, *supra* note 2 (explaining that the metabolic activity of CD4 T lymphocytes was what allowed the virus to multiply, a characteristic that scientists could exploit to find and destroy infected cells).

66. See CTRS. FOR DISEASE CONTROL & PREVENTION, EVIDENCE OF HIV TREATMENT AND VIRAL SUPPRESSION IN PREVENTING THE SEXUAL TRANSMISSION OF HIV 1 (2018), <https://perma.cc/27MK-UJ3Z> (PDF) (“[F]uture HIV transmissions are not expected when persons with HIV remain virally suppressed.”); Abadsidis, *supra* note 33 (reporting the CDC’s public statement that viral suppression prevents HIV transmission); Benjamin Ryan, *Undetectable Meant Zero HIV Transmissions After 89,000 Condomless Sex Acts*, POZ (July 24, 2018), <https://perma.cc/9R7K-ZDM5> (detailing results from studies on HIV transmission by virally suppressed individuals).

67. See Hasina Samji et al., *Closing the Gap: Increases in Life Expectancy Among Treated HIV-Positive Individuals in the United States and Canada*, 8 PLOS ONE 1, 1 (2013) (finding that a “20-year-old HIV-positive adult on ART in the U.S. or Canada” is expected to have a “life expectancy approaching that of the general population,” although “[d]ifferences by sex, race, HIV transmission risk group, and CD4 count remain”).

68. See Mario Brito, *On an Alternative to a Punitive State in Response to a Modern Understanding of the HIV/AIDS Epidemic in Florida*, 40 NOVA L. REV. 285, 303 (2017) (citing Stribild as an example of a drug that allows patients to “choose to take one pill, once a day, instead of several independent pills”).

69. See McArthur, *supra* note 4, at 726–31 (describing the complexity of traditional ART regimens and the significant cost and side effects of ART drugs); Richardson, *supra* note 26, at 1187–89 (describing ART as “cumbersome” and noting the need for patients’ strict adherence to their

cost of ARTs can be prohibitive for people without sufficient insurance coverage.⁷⁰

Correct usage of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) significantly reduces the likelihood of a seronegative individual acquiring HIV.⁷¹ PrEP is a daily medication that is extremely effective at reducing the risk of getting HIV: when taken correctly, the risk is reduced by 99 percent for individuals exposed to HIV through sexual contact and 74 percent for those exposed to it through injection drug use.⁷² Taking PEP soon after potentially being exposed to HIV can also significantly reduce the likelihood of transmission.⁷³ Like ARTs, PrEP and PEP can also be quite expensive for individuals without health insurance, although the Department of Health and Human Services' 2020 Ready, Set, PrEP program should make PrEP more easily accessible to the uninsured.⁷⁴ Even for those who are insured, the lack of a

treatment regime and the significant expense of HIV treatment and medicines).

70. See Aaron Neishlos & Michael D'Ambrosio, *The Other Pill: Expanding Access to Pre-Exposure Prophylaxis to Prevent HIV Transmission Among Minors in New York*, 44 *FORDHAM URB. L.J.* 725, 733 (2017) ("HIV treatment is complicated, intensive, and costly."); Mark Bolin, *The Affordable Care Act and People Living with HIV/AIDS: A Roadmap to Better Health Outcomes*, 23 *ANNALS HEALTH L.* 28, 28–29 (2014) (citing patients' "inability to access comprehensive and affordable health care coverage" as the biggest reason people living with HIV/AIDS do not receive regular medical care); McArthur, *supra* note 4, at 728–29 ("[A] three-drug therapy at the advent of [ART therapy] could cost \$18,000 a year.").

71. See *PrEP*, *CTRS. FOR DISEASE CONTROL & PREVENTION*, <https://perma.cc/7T4H-MTTY> (last updated Sept. 18, 2020) ("PrEP can stop HIV from taking hold and spreading throughout your body. When taken daily, PrEP is highly effective for preventing HIV from sex or injection drug use.").

72. *Id.*

73. *PEP*, *CTRS. FOR DISEASE CONTROL & PREVENTION*, <https://perma.cc/KTL2-R3RQ> (last updated Aug. 6, 2019).

74. See Trudy Ring, *PrEP to Be Available for Free Even if You're Uninsured*, *ADVOCATE* (Dec. 3, 2019, 1:19 PM), <https://perma.cc/5ECZ-R4VN> (reporting that the Ready, Set, PrEP program will allow uninsured Americans to "apply for free PrEP drugs through the federal government" if they "test negative for HIV, have a valid prescription for the medications, and [do] not have prescription drug coverage").

generic version and the more frequent lab work can create financial burdens.⁷⁵

II. HIV AND AIDS IN THE UNITED STATES

Compared to the mid-1980s, when HIV and AIDS were not well understood and were essentially untreatable, the United States has recently made huge gains in reducing the yearly number of new infections by two-thirds.⁷⁶ While the number of people living with HIV continues to rise, AIDS-related deaths are also down by over forty thousand per year since they peaked in the early 1990s before the development of ARTs.⁷⁷ Unfortunately, these significant gains have not been distributed evenly among populations or geographic regions.

A. National Trends

A closer analysis of HIV-related statistics in the U.S. reveals vast disparities within stabilizing or even decreasing nationwide trends. According to recent data by the CDC, while rates of new HIV diagnoses have remained stable, different population groups and regions have been experiencing decreases while others have seen rates increase.⁷⁸ Between 2013 and 2017, the rate of HIV diagnosis among Latinx individuals stayed stable; it decreased for White people, Black people, and people of mixed race; and it increased for American Indians and Asian/Pacific Islanders.⁷⁹ Despite the decreased rates for Black

75. See Stephen Frost, *HIV Criminalization Laws: A Poor Public Policy Choice in the New Era of PrEP*, 6 WAKE FOREST J.L. & POL'Y 319, 329–30 (2016) (discussing the challenges that still remain with the Ready, Set, PrEP program).

76. See CTRS. FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: TODAY'S HIV/AIDS EPIDEMIC 1 (2016), <https://perma.cc/BY6V-3SZL> (PDF).

77. *Id.* at 2.

78. *HIV in the United States and Dependent Areas*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/Z4MG-QL79> (last updated June 10, 2020) [hereinafter *HIV in the United States and Dependent Areas*].

79. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION IN THE UNITED STATES AND DEPENDENT

individuals, the 2018 rate of HIV among this ethnic group was more than double the group with the next highest rate, Latinx individuals.⁸⁰ While rates of new infection among gay and bisexual men—the population most affected by HIV—remained stable between 2012 and 2016, rates among White men actually decreased, while rates among Black men remained the same, and rose among Latinx men.⁸¹

In terms of HIV transitioning into AIDS, from 2013 to 2017, rates decreased for all ethnic groups except Native Hawaiians/Pacific Islanders, for which it increased: nonetheless, in 2018 the highest rate remained among Black individuals, which was more than twice that of the group with the next highest rate, individuals of mixed race.⁸² While the rate of death from AIDS decreased for all ethnic groups from 2013 to 2017, in 2018 the group with the highest rate was again Black people.⁸³

In addition to racial and ethnic groups experiencing very different rates of HIV infection and AIDS-related deaths, other marginalized groups are also faring worse than the nationwide patterns might suggest. Members of the LGBTQ community—especially queer people of color—face much higher risks of infection than their heterosexual counterparts. Among new diagnoses in 2017, the two highest categories were Black male-to-male sexual contact and Latinx male-to-male sexual contact, followed by White male-to-male sexual contact.⁸⁴ These numbers were significantly higher than transmission through heterosexual sex for men or women of any race.⁸⁵ Trans women—especially Black and Latinx trans women—also experience high rates of HIV infection and face many barriers

AREAS, 2018 (PRELIMINARY) 6 (2019), <https://perma.cc/3XNP-UNXR> (PDF) [hereinafter 2018 DIAGNOSES OF HIV IN THE U.S. (PRELIMINARY)].

80. See *id.* at 6 (“[The] highest rate [of HIV diagnoses] was 39.3 for [B]lack/African Americans, followed by 16.4 for Hispanics/Latinos.”).

81. *HIV in the United States and Dependent Areas*, *supra* note 78.

82. 2018 DIAGNOSES OF HIV IN THE U.S. (PRELIMINARY), *supra* note 79, at 6–7.

83. *Id.* at 8.

84. *HIV in the United States and Dependent Areas*, *supra* note 78.

85. *Id.*

to accessing appropriate health care services like discrimination and a lack of providers with trans-specific medical knowledge.⁸⁶

These cleavages demonstrate how necessary narrowly tailored HIV outreach and services are for members of communities most impacted by HIV and AIDS—especially given the frequency with which these identities overlap. These challenges are further compounded by geographic differences that create even more fractured health outcomes. This is especially true in the South, which remains in the throes of the HIV crisis even as other regions have gotten the epidemic under control.⁸⁷

B. *A Crisis in the South*

In order to isolate and analyze the impact that HIV has on the South, it is necessary to first determine what states are being included in this region and why. The South is by no means a monolith, and there is ample disagreement over which states are considered southern. From a historical perspective, “the South” connotes those eleven slave-owning states that seceded from the United States to form the Confederacy,⁸⁸ though there is some debate over the southern-ness of border-states that never officially seceded.⁸⁹ Geographical boundaries have been used to define the South—including the Mason-Dixon Line, U.S. Route 40, and the Rappahannock, Potomac, and Ohio

86. See *HIV Prevention and Care for the Transgender Population*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/2JB6-TCWA> (last updated Apr. 1, 2020) (noting that about one in seven transgender women have HIV, with the rate rising to 44 percent among Black or African American transgender women and 26 percent among Hispanic or Latina transgender women).

87. See 2018 DIAGNOSES OF HIV IN THE U.S. (PRELIMINARY), *supra* note 79, at 6–7 (noting that in 2018 the rate of HIV infection in the South was 15.7, compared to 10.0 in the Northeast, 9.3 in the West, and 7.2 in the Midwest).

88. South Carolina, Mississippi, Florida, Alabama, Georgia, Louisiana, Texas, Virginia, Arkansas, Tennessee, and North Carolina. *The Civil War: Facts*, NAT'L PARK SERV., <https://perma.cc/FZL6-BE2A> (last updated May 6, 2015).

89. Missouri, Kentucky, Maryland, Delaware, and West Virginia. *Id.*

Rivers—as have cultural divides like religion and dialect.⁹⁰ Contemporary surveys bear out these uncertainties, with self-proclaimed southerners and non-southerners alike struggling to find consensus over a taxonomy of the South.⁹¹ Even food items have formed the basis of proposed borders, with Virginia being bisected by a Sweet Tea Line above which McDonald’s no longer serves sweet tea⁹² and the Mason-Biscuit Line demarcating those states with the highest Chick-fil-A to population density.⁹³

This Article uses the concrete list of states identified as southern by the CDC and the U.S. Census Bureau: Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.⁹⁴ This definition is beneficial because the CDC

90. See Patrick Ottenhoff, *Where Does the South Begin?*, ATLANTIC (Jan. 28, 2011), <https://perma.cc/V3U4-EJVS> (arguing that censuses, rivers, religion, language, food, and politics can all be used to clarify the “obviously hazy” border between the North and South).

91. See, e.g., Soo Oh, *Which States Count as the South, According to More Than 40,000 Readers*, VOX (Sept. 30, 2019, 9:10 AM), <https://perma.cc/EJ3H-UZAH>; Walt Hickey, *Which States Are in the South?*, FIVETHIRTYEIGHT (Apr. 30, 2014, 9:20 AM), <https://perma.cc/4RD6-FR6P>; see also Matt Shipman, *Where Exactly Is the South?*, BITTER SOUTHERNER (June 6, 2018), <https://perma.cc/U6HN-EUC9> (“[N]atives of every Southern state think the state immediately north of them on the map is not far enough south to be part of the South.”).

92. See Ottenhoff, *supra* note 90 (“[Before] McDonald’s went national with sweet tea in 2008 . . . one of the best ways to measure a location’s southernness was whether or not Mickey D’s served sweet tea.”); Frank Jacobs, *The Sweet Tea Line—the Real Border Between North and South*, BIG THINK (July 23, 2010), <https://perma.cc/DPK8-A3UU> (suggesting that the South begins below the Mason-Dixon Line at a “Sweet Tea Line” that bisects Virginia).

93. See Harry Shukman, *We Figured Out Exactly Where the South is by Plotting Every Chick-fil-A Location on a Map*, TAB (Oct. 17, 2017), <https://perma.cc/448Q-5DS3> (observing that using this metric Maryland, Delaware, Washington D.C., Utah, and Colorado are part of the South).

94. *HIV in the United States by Region*, *supra* note 5; U.S. CENSUS BUREAU, CENSUS BUREAU REGIONS AND DIVISIONS WITH STATE FIPS CODES, <https://perma.cc/KFF3-GE6R> (PDF); see also *History: Regions and Divisions*, U.S. CENSUS BUREAU, <https://perma.cc/8KX9-2TR3> (last updated Dec. 17, 2019) (describing the development of the Census Bureau’s modern regional

and other agencies have gathered and organized HIV-related data by region for the past several decades.

Within this large swath of land are two more concentrated regions that also merit attention: the Deep South and Appalachia. The Deep South is typically thought to be composed of all of Louisiana, Mississippi, Alabama, Georgia, and the Carolinas as well as portions of neighboring states.⁹⁵ While the larger southern region encompasses all of the Deep South, this is not the case with Appalachia. Although the South contains much of Appalachia, the two are not coterminous as Appalachia includes all of West Virginia as well as parts of Alabama, Georgia, Kentucky, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, New York, Ohio, and Pennsylvania that include the Appalachian Mountains.⁹⁶ These regions have much in common with the South but have generated far less HIV-related data.⁹⁷ Given their many overlapping characteristics, an analysis of the South will also illuminate discussions of HIV and policy change within these regions, as well as similar areas nationwide.

1. HIV and AIDS Trends in the South

Recent data from the CDC paint a bleak picture of HIV and its impact on the South: as of 2017, compared to the West, Midwest, and Northeast, the South had by far the highest rates

designations). While this definition offers clarity, some may argue that it is too broad in its inclusion of Delaware, Maryland, and Washington, D.C. and too narrow in its exclusion of Missouri. *See* Oh, *supra* note 91 (finding Missouri received far more votes as being part of the South than Delaware, Maryland, and D.C.).

95. Susan S. Reif et al., *HIV Infections and AIDS in the Deep South*, 96 AM. J. PUB. HEALTH 970, 970 (2006) (using the definition of “Deep South” from MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY (10th ed. 2003)).

96. *About the Appalachian Region*, APPALACHIAN REG. COMM’N, <https://perma.cc/7YED-DQUS>. For a county-by-county analysis of Appalachia and its sub-regions, see Lyman Stone, *Where Is Appalachia?*, MEDIUM, <https://perma.cc/W9J7-FKEJ> (Jan. 13, 2017).

97. *See, e.g., HIV in the United States by Region, supra* note 5 (disaggregating data by regions, including the Midwest, Northeast, South, and West but failing to distinguish Appalachia as a region).

of HIV infection and infections classified as AIDS.⁹⁸ In fact, this 2017 data on HIV diagnosis revealed that the five states or territories with the highest rates of diagnosis were all in the South, as were twelve out of the top fifteen states or territories.⁹⁹ Of the metropolitan statistical areas with the highest rates of HIV diagnosis in 2017, fourteen out of the top fifteen were in the South.¹⁰⁰ Similarly, the seven states or territories with the highest rate of AIDS were all in the South, as were eleven out of the top fifteen states or territories.¹⁰¹ Of the metropolitan statistical areas with the highest rates of AIDS diagnosis in 2017, the top fourteen were in the South, with the New York–Newark–Jersey City conglomerate taking the fifteenth spot.¹⁰² The South's rate of death from HIV and AIDS were only

98. See CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION IN THE UNITED STATES AND DEPENDENT AREAS, 2017 6–7 (2018), <https://perma.cc/9D9G-6LXL> (PDF) (stating that the rates of HIV infection and infections classified as AIDS in the South were 16.1 and 7.6, respectively, compared to 9.4 and 3.9 in the West, 7.4 and 3.3 in the Midwest, and 10.6 and 5.3 in the Northeast).

99. *Id.* at 114. In descending order, the fifteen states or territories with the highest HIV diagnosis rates were: the District of Columbia, Georgia, Florida, Louisiana, Maryland, Nevada, Texas, South Carolina, Mississippi, New York, Alabama, Puerto Rico, Delaware, North Carolina, and New Jersey. *Id.*

100. *Id.* at 121–23. In descending order, the fifteen metropolitan statistical areas with the highest rates of HIV diagnosis in 2017 were: Miami–Fort Lauderdale–West Palm Beach, FL; Orlando–Kissimmee–Sanford, FL; Atlanta–Sandy Springs–Roswell, GA; New Orleans–Metairie, LA; Baton Rouge, LA; Jackson, MS; Jacksonville, FL; Memphis, TN–MS–AR; Columbia, SC; Las Vegas–Henderson–Paradise, NV; Houston–The Woodlands–Sugar Land, TX; Greensboro–High Point, NC; Little Rock–North Little Rock–Conway, AR; Tampa–St. Petersburg–Clearwater, FL; and El Paso, TX. *Id.*

101. *Id.* at 115–16. In descending order, the fifteen states or territories with the highest rates of people living with AIDS were: the District of Columbia, Georgia, Louisiana, Florida, Maryland, South Carolina, Mississippi, New York, Texas, Nevada, Alabama, Delaware, North Carolina, Puerto Rico, and New Jersey. *Id.*

102. *Id.* at 124–28. In descending order, the fifteen metropolitan statistical areas with the highest rates of AIDS diagnosis in 2017 were Augusta–Richmond County, GA–SC; Baton Rouge, LA; Miami–Fort Lauderdale–West Palm Beach, FL; Jackson, MS; Columbia, SC; New Orleans–Metairie, LA; Orlando–Kissimmee–Sanford, FL; Jacksonville, FL;

slightly less than that of the Northeast.¹⁰³ State-by-state data from the CDC indicates that the death rate from HIV is highest among states in the Deep South.¹⁰⁴

As of 2019, the South includes 38 percent of the U.S. population but is home to 45 percent of people living with HIV in the country and accounts for 51 percent of annual HIV infections.¹⁰⁵ As in the rest of the country, the majority of HIV diagnoses in the South are in urban areas.¹⁰⁶ Unlike elsewhere, however, the South also has high rates of HIV diagnoses in rural and suburban areas as well.¹⁰⁷ In addition to high diagnosis rates, the CDC estimates that 82,000 people in the South are living with HIV but are unaware of their serostatus.¹⁰⁸ More people living with HIV are unaware of their status in the South than in any other region: as a function of this lack of knowledge, these individuals are not receiving medical care to keep them healthy and minimize or eliminate their ability to infect others.¹⁰⁹

Memphis, TN–MS–AR; Atlanta–Sandy Springs–Roswell, GA; Baltimore–Columbia–Towson, MD; Little Rock–North Little Rock–Conway, AR; Tampa–St. Petersburg–Clearwater, FL; Houston–The Woodlands–Sugar Land, TX; New York–Newark–Jersey City, NY–NJ–PA. *Id.*

103. *See id.* at 7–8 (placing the rates of death from HIV and AIDS in the South at 6.1 and 4.9, respectively, compared to 6.4 and 5.1 in the Northeast).

104. *See* Susan S. Reif, Carolyn McAllaster & Elena Wilson, *HIV in the US Deep South*, PUB. HEALTH POST (Apr. 12, 2017), <https://perma.cc/98CB-4G2M> (noting that factors contributing to this disproportionate HIV burden include “pervasive and multi-layered HIV-related stigma, poverty, high levels of sexually-transmitted infections, racial inequality and bias, barriers to medical and social services, and laws that further HIV-related stigma and fear”). More than ten years previously, Reif documented the rapid spread of HIV across the Deep South and warned of the now-realized consequences of inadequate intervention. Reif et al., *supra* note 95, at 972–73.

105. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV PREVENTION IN THE SOUTH 1 (2019), <https://perma.cc/G55T-KQJW> (PDF).

106. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV IN THE SOUTHERN UNITED STATES 1 (2016), <https://perma.cc/X7LG-8PCL> (PDF).

107. *See* HIV PREVENTION IN THE SOUTH, *supra* note 105, at 2 (“[Twenty-four percent] of new HIV diagnoses in the South are in suburban and rural areas—*more than any other region.*”).

108. *Id.*

109. *See* HIV IN THE SOUTHERN UNITED STATES, *supra* note 106, at 2.

Within these already alarming numbers hides an even more urgent story: the dangerous relationship between marginalized communities in the South and HIV. Black people, for example, are “severely affected by HIV in the South.”¹¹⁰ Because the South is home to over half of Black individuals living in the United States, these disparities in health outcomes must not be overlooked.¹¹¹ Among women being diagnosed with HIV in the South, 69 percent are Black.¹¹² Black men who have sex with men account for 59 percent of all Black HIV diagnoses in the South: moreover, more than 60 percent of Black men who have sex with men that were diagnosed with HIV in 2014 live in the South.¹¹³ In 2017, 47 percent of all new HIV diagnoses in the South were among Black and Latinx men who have sex with men and an additional 16 percent were among White men who have sex with men.¹¹⁴ Heterosexual Black people made up another 19 percent of new diagnoses.¹¹⁵ Racial and sexual minorities thus made up 82 percent of new diagnoses, with non-White members of the LGBTQ community being disproportionately exposed to HIV.¹¹⁶ Additionally,

110. *Id.* at 1 (noting that, in 2014, Black people accounted for 54 percent of new diagnoses in the South).

111. According to the U.S. Census, 54 percent of people identifying as Black lived in the South, which is 35 percent more than any other region. *Majority of African Americans Live in 10 States; New York City and Chicago Are Cities with Largest Black Populations*, U.S. CENSUS BUREAU (Aug. 13, 2001, 12:01 AM), <https://perma.cc/CD5P-YRUM>.

112. HIV IN THE SOUTHERN UNITED STATES, *supra* note 106, at 1.

113. *Id.*

114. HIV PREVENTION IN THE SOUTH, *supra* note 105, at 2.

115. *Id.*

116. *Id.* At least one study has found that elevated HIV rates among Black men who have sex with men compared to their White counterparts are not due to behavior risk factors, which Black men were found to engage in less than White men. See Gregorio A. Millett et al., *Explaining Disparities in HIV Infection Among Black and White Men Who Have Sex with Men: A Meta-Analysis of HIV Risk Behaviors*, 21 AIDS 2083, 2085–86 (2007) (finding that Black men who have sex with men reported less substance use, fewer sex partners, less “gay identity” and less “disclosure of same sex behavior”).

approximately half of transgender people who were diagnosed with HIV between 2009 and 2014 were living in the South.¹¹⁷

2. The Confluence of HIV-Related Challenges in the South

The numerous overlapping conditions and characteristics that have resulted in the aggressive spread of HIV throughout the region have been described as a hurricane and “the perfect storm.”¹¹⁸ Many but not all of these factors have existed in the South long before HIV capitalized on them.¹¹⁹ “Disproportionate rates of concentrated poverty,” for example, have plagued rural, suburban, and urban communities across the South.¹²⁰ With poverty comes a host of other challenges that create barriers for HIV prevention and treatment, including unstable housing and transportation, lack of access to health care and health insurance generally, and lack of access to regular HIV education, testing, and medication specifically.¹²¹ Additionally, about half of the southern states’ failures to expand Medicaid has also compounded challenges faced by low income southerners when attempting to obtain adequate health care.¹²²

117. *HIV and Transgender People*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/P8JC-TFGW> (last updated Nov. 12, 2019).

118. See Leins, *supra* note 14 (stating that “high rates of opioid use, stigma around HIV, high poverty levels and poor health care infrastructure” are the conditions contributing to “the perfect storm”).

119. See Thurka Sangaramoorthy & Joseph B. Richardson, *Why the South Still Has Such High HIV Rates*, CONVERSATION (June 13, 2017, 10:23 PM) <https://perma.cc/V5HA-QBA3>.

120. *Id.*; see Drew DeSilver, *Who’s Poor in America? 50 Years into the ‘War on Poverty,’ A Data Portrait*, PEW RSCH. CTR. (Jan. 13, 2014), <https://perma.cc/KFE9-XFBR> (explaining that although poverty has become more evenly distributed since President Lyndon B. Johnson declared the “war on poverty,” the percentages are still highest in the South).

121. Reif et al., *supra* note 95, at 972; see Teresa Wiltz, *Fighting AIDS in the Deep South: Glimmers of Hope*, PEW RSCH. CTR. (June 13, 2017), <https://perma.cc/MN4Q-ZNED> (“The high rates of HIV/AIDS in the South stems from a confluence of social factors including poverty, racism, persistent anti-gay attitudes, unstable housing, a lack of transportation in rural areas and a lack of access to medical care . . .”).

122. See Leins, *supra* note 14. Within the South, Texas, Mississippi, Tennessee, Alabama, Florida, Georgia, South Carolina, and North Carolina

For people living in rural poverty, accessing health care is even more challenging given the frequency with which rural hospitals have been closing across the South over the past decade.¹²³

Poverty in the South impacts White people and people of color differently: while all racial and ethnic demographics experience poverty in the South, they do not do so at equal rates. According to the Kaiser Foundation, in nearly every southern state, Black people experience at least twice the poverty rate of White people.¹²⁴ Latinx individuals experience higher poverty rates than White people that, in some but not all southern states, are similar to, if not slightly higher than, the poverty rate among Black people.¹²⁵ Studies have also found that Black individuals are not afforded the same access to medical care, even when controlling for poverty and health insurance status,¹²⁶ nor is the care they receive the same quality.¹²⁷ Multiple forms of discrimination are seen as contributing to an environment of shame, stigma, and subpar health outcomes. According to Nic Carlisle, the executive director of the Southern AIDS Coalition, “HIV here lives in the intersection of racism, classism and homophobia.”¹²⁸

have yet to pass Medicaid expansion. *Status of State Action of the Medicaid Expansion Decision*, *supra* note 16.

123. See, e.g., Ellison, *supra* note 17 (“Of the 27 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South.”). Rural hospitals have been closing due to a combination of revenue issues, challenging patient populations, and struggles to get and keep health care providers. See *Why Rural Hospitals Are Closing*, BECKER’S HOSP. REV. (Aug. 28, 2019), <https://perma.cc/JET9-C3NB>; see also Eli Saslow, ‘Urgent Needs from Head to Toe’: This Clinic Had Two Days to Fix a Lifetime of Needs, WASH. POST (June 22, 2019, 7:09 PM), <https://perma.cc/V8GC-P9P6>.

124. *Poverty Rate by Race/Ethnicity*, KAISER FAM. FOUND., <https://perma.cc/N2CP-VWTE>.

125. *Id.*

126. See Reif et al., *supra* note 95, at 972.

127. See, e.g., Michael O. Schroeder, *Racial Bias in Medicine Leads to Worse Care for Minorities*, U.S. NEWS & WORLD REP. (Feb. 11, 2016, 10:13 AM), <https://perma.cc/TB8Q-5JNB> (explaining that, for example, Black people receive less than the recommended amount of analgesics in the emergency room, have delayed kidney transplant rates, and receive worse cardiac care).

128. Wiltz, *supra* note 121.

There are two specific health problems that layer on top of these more entrenched dynamics to yield an environment conducive to the spread of HIV. The first is the prevalence of sexually transmitted infections (STIs), which make people more likely to contract HIV.¹²⁹ STI rates are notably high across the South: in 2017, the CDC found the South to have the highest rates of chlamydia and gonorrhea and the second highest rate of syphilis.¹³⁰ The CDC posits three related explanations for the relationship between HIV and other STIs: first, the behaviors likely to result in an STI like having unprotected sex or sex with multiple partners are also risk factors for HIV; second, HIV and other STIs are often linked, so a partner with an STI is more likely to have HIV; and third, STI symptoms like sores and inflammation create a pathway for HIV to enter the bloodstream or mucus membrane that would not exist but for the STI.¹³¹ Unsurprisingly, the same barriers to education, prevention, and treatment related to poverty and stigma impact both HIV and other STIs, creating a vacuum for the two to play off of each other.¹³²

Opioid addiction in the form of injection drug use is also related to the likelihood of HIV infection.¹³³ Nationally, one in ten new HIV diagnoses is among injection drug users.¹³⁴ This is

129. See *STDs and HIV—CDC Fact Sheet*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/5NPM-TUN3> (last updated Mar. 30, 2020).

130. DIV. OF STD PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, *SEXUALLY TRANSMITTED DISEASE SURVEILLANCE 2017*, at 3, 11, 23 (2018), <https://perma.cc/7NPQ-WKES> (PDF).

131. *STDs and HIV—CDC Fact Sheet*, *supra* note 129.

132. See Reif et al., *supra* note 95, at 972

The high levels of STDs in the Deep South offer some explanation for the higher incidence of AIDS in this region, as STDs have been consistently found to facilitate HIV transmission. Health experts cite characteristics of the South, including high levels of poverty and inconsistent availability and quality of health care services, as factors contributing to the higher rates of STDs.

133. CTRS. FOR DISEASE CONTROL & PREVENTION, *ADDRESSING THE INFECTIOUS DISEASE CONSEQUENCES OF THE U.S. OPIOID CRISIS: CDC'S WORK IMPROVES HEALTH & SAVES MONEY 1* (2019), <https://perma.cc/QTC2-RDPW> (PDF).

134. *Id.*

due to injection drug users being more prone to engaging in risky sexual behavior like unprotected sex or sex work with someone with HIV or another STI¹³⁵ or using needles or drug paraphernalia infected with HIV.¹³⁶ While many people who are addicted to prescription opioids begin injecting heroin because it is cheaper and can be easier to acquire,¹³⁷ others grind and inject the pain pills for faster and more intense absorption.¹³⁸ In both cases, individuals who are addicted to opioids may find themselves engaging in dangerous behaviors that increase their risk of acquiring HIV.¹³⁹

According to the CDC, the “strongest risk factor” for becoming addicted to heroin, which is typically injected, is becoming addicted to prescription opioid pain medication.¹⁴⁰ The South has dangerously high levels of opioid prescription, which creates a high risk for addiction and transition to injection drugs.¹⁴¹ It follows, then, that the top thirty-one counties that

135. *Id.*

136. See *Injection Drug Use and HIV Risk*, *supra* note 21 (explaining that previously used needles or other injection equipment may still have blood in them that can carry HIV for up to forty-two days, depending on temperature and other factors).

137. See NAT'L INST. ON DRUG ABUSE, HEROIN RESEARCH REPORT 8 (2018), <https://perma.cc/QG4Y-BRSW> (PDF).

138. See *What are the Effects of Shooting Oxycodone?*, AM. ADDICTION CTRS., <https://perma.cc/6A8X-6CFU> (last updated June 10, 2019) (describing the process of crushing the painkiller into a fine powder, adding it to water, and then either “cooking” it or injecting it “cold” in order to take oxycodone intravenously); *Dangers of Snorting or Injecting Oxycontin*, AM. ADDICTION CTRS., <https://perma.cc/J3BT-UGKE> (last updated Sept. 3, 2019) (explaining that when OxyContin is crushed, it can be snorted like cocaine, allowing the drug to be quickly absorbed into the bloodstream).

139. See *HIV and People Who Inject Drugs*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/58AL-C8HN> (last updated Feb. 6, 2020) (outlining challenges in preventing people from sharing drug injection equipment and engaging in risky sexual behavior).

140. See *Today's Heroin Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/GW6C-W39E> (last updated July 7, 2015) (“[Forty-five percent] of people who used heroin were also addicted to prescription opioid painkillers.”).

141. See *Opioid Summaries by State*, NAT'L INST. ON DRUG ABUSE (Apr. 16, 2020), <https://perma.cc/J4WD-3BPH> (revealing that the nine states with the highest rates of opioid prescription were in the South). In descending order,

the CDC has found to be most at-risk for an outbreak of HIV and hepatitis C among injection drug users are located in the South.¹⁴² Cabell County in West Virginia provides an illuminating example of this phenomenon: although the state historically had a low rate of new HIV diagnoses, a community hard-hit by the opioid crisis became an HIV cluster, documenting more than forty-nine cases of HIV among injection drug users in less than eighteen months and creating concerns over how many injection drug users may be unaware of their positive serostatus.¹⁴³

Despite the prevalence of conditions contributing to the spread of HIV and augmenting its impact in the South, many southern states' laws have not been updated to effectively stop the spread of HIV and support positive health outcomes for those already living with it. Instead, the proliferation of HIV criminal laws punishes people living with HIV for behavior that will not spread the infection while also potentially discouraging people from getting tested and beginning treatment.

III. CRIMINALIZING HIV

The specific criminal laws being used to arrest, prosecute, and punish people living with HIV differ across the states but typically include combinations of general criminal laws like

the ten states with the highest rates of opioid prescription were found to be: Alabama, Arkansas, Tennessee, Kentucky, Louisiana, Oklahoma, Mississippi, West Virginia, South Carolina, and Indiana. *Id.* The top ten congressional districts with the highest rates of opioid prescription are also in the South. Rolheiser et al., *supra* note 19, at 1215–16.

142. See Van Handel et al., *supra* note 22, at 328; *Persons Who Inject Drugs: Vulnerable Counties or Jurisdictions Experiencing or at Risk of Outbreaks*, *supra* note 22. In fact, the top ten at-risk counties are located within Central Appalachia, which falls entirely within the South. Jessica Lily & Roxy Todd, *Appalachia Has Highest Risk of HIV & Hepatitis in Nation. The Proposed Solutions Are Controversial*, W. VA. PUB. BROAD. (May 18, 2018), <https://perma.cc/84JB-ZDTZ>.

143. See Bishop Nash, *In Addiction's Wake, HIV Now Popping Up in Appalachia*, 100 DAYS IN APPALACHIA (May 28, 2019), <https://perma.cc/N7ZG-QG6J> (underscoring the fact that all of these cases “were contracted by intravenous drug use through the sharing of contaminated syringes” in a county with “an estimated 1,800 active IV drug users”).

aggravated assault and attempted murder, criminal violations of state health laws targeting the spread of communicable diseases, and criminal laws specifically prohibiting HIV exposure.¹⁴⁴ While every state has long had both general criminal statutes and public health laws addressing communicable disease intervention, HIV exposure laws have been springing up across the country over the past forty years.¹⁴⁵

When the HIV/AIDS epidemic first gained attention in the early 1980s,¹⁴⁶ the initial widespread response was not to use criminal law to contain the disease but instead to rely on harsh isolationist mechanisms like quarantines.¹⁴⁷ In 1987, with panic around HIV rising, President Reagan signed an executive order that formed the Presidential Commission on the Human Immunodeficiency Virus Epidemic.¹⁴⁸ Shortly thereafter, the Commission issued a report that advocated for HIV-specific criminal laws prohibiting knowing transmission of HIV¹⁴⁹ and

144. See Richardson, *supra* note 26, at 1182 (describing how states without HIV or STD-specific criminal transmission laws “use statutes such as attempted murder or aggravated assault to convict individuals who engage in behavior that may or may not result in HIV transmission”); Leslie E. Wolf & Richard Vezina, *Crime and Punishment: Is There A Role for Criminal Law in HIV Prevention Policy?*, 25 WHITTIER L. REV. 821, 844–45 (2004) (outlining the “three general options” states have for criminalizing intentional HIV exposure).

145. See Brian Cox, *Turning the Tide: The Future of HIV Criminalization After Rhoades v. State and Legislative Reform in Iowa*, 11 NW. J.L. & SOC. POL’Y 28, 32–33, 53 (2016) (“The majority of states criminalize consensual sex acts for people living with HIV if they do not disclose their HIV status to their HIV-negative partner before having sex . . .”).

146. MIRKO D. GRMEK, HISTORY OF AIDS: EMERGENCE AND ORIGIN OF A MODERN PANDEMIC 3–12 (Russell C. Maulitz & Jacalyn Duffin, trans., Princeton Univ. Press 1990).

147. See Shayo Buchanan, *supra* note 23, at 1297 (discussing the conservative push for quarantine laws); see also Wendy E. Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53, 53–54 (1985) (discussing legal issues related to the imposition of quarantine).

148. Exec. Order No. 12,601, 52 Fed. Reg. 24,129 (June 24, 1987), *revoked* by Exec. Order No. 12,692, 54 Fed. Reg. 40,627 (Sept. 29, 1989).

149. See PRESIDENTIAL COMM’N ON HUM. IMMUNODEFICIENCY VIRUS EPIDEMIC, REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC 130 (1988), <https://perma.cc/JR43-MAAE> (PDF).

argued that states needed to adopt HIV-specific criminal legislation rather than rely on general criminal statutes.¹⁵⁰

The 1990 passage of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act¹⁵¹ catalyzed this movement in favor of HIV-specific criminal laws.¹⁵² The CARE Act required every state seeking federal grant funding for AIDS to certify that its criminal laws were adequate to prosecute individuals infected with HIV who intentionally or knowingly infected or exposed others to HIV.¹⁵³ Many states that had not yet passed HIV exposure laws quickly did so after the passage of the CARE Act, while others relied on their already existing general criminal statutes or communicable disease laws to qualify for CARE Act funding.¹⁵⁴

In the late 1990s, more states created or updated their criminal exposure laws after the high-profile Nushawn Williams case, in which a Black man from New York City was alleged to have exposed dozens of women to HIV after being told that he was HIV positive.¹⁵⁵ In both the first and the second

150. See *id.* (noting that prosecuting HIV-related offenses under existing criminal codes may lead to challenges). The Commission then went on to say that “[a]n HIV-specific statute, on the other hand . . . would tailor punishment to the specific crime of HIV transmission.” *Id.*

151. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, § 2647, 104 Stat. 603 (codified as amended at 42 U.S.C. § 300ff-47), repealed by Pub. L. No. 106-345, § 301(a), 114 Stat. 1345 (2000).

152. The Act passed during the heyday of the tough-on-crime movement in which criminal laws were often relied upon as a form of social control. Ahmed, *supra* note 27, at 629–32.

153. CARE Act § 2647. In order to access the funding, states also had to create partner notification programs. *Id.*

154. See Sarah J. Newman, Note, *Prevention, Not Prejudice: The Role of Federal Guidelines in HIV-Criminalization Reform*, 107 NW. U. L. REV. 1403, 1417 (2013) (describing how, in just three years after the passage of the CARE Act, nearly half the states had HIV-specific statutes).

155. See W. Thomas Minahan, *Disclosure Before Exposure: A Review of Ohio’s HIV Criminalization Statutes*, 35 OHIO N.U. L. REV. 83, 98 (2009) (discussing the Williams case and its effect on criminal exposure laws). After serving a dozen years in prison, Williams has remained committed under a New York sexual offender statute. Melinda Miller, *Nushawn Williams Loses Bid to be Released from Civil Commitment*, BUFFALO NEWS (May 7, 2016), <https://perma.cc/7PKR-DVAY>.

wave of HIV criminalization legislation, states acted quickly in the wake of salacious headlines in order to demonstrate their commitment to law and order rather than health and medicine.¹⁵⁶ Despite Congress's repeal of the CARE Act's prosecution mandate in 2000¹⁵⁷ and President Obama's repeated calls to scale back HIV criminalization,¹⁵⁸ only a few states have ratcheted down their HIV exposure statutes while many others have continued to enforce these laws.¹⁵⁹

156. See Jane Gross, *Trail of Arrests, H.I.V. Fears, and a Woman's Tale of Love*, N.Y. TIMES (Oct. 29, 1997), <https://perma.cc/5N3K-XDQ5> (describing the reaction of various public officials to the Williams case, including then-Mayor Rudolph Giuliani who said, "There's no question he should be prosecuted for attempted murder, or worse").

157. Pub. L. No. 106-345, § 301(a), 114 Stat. 1345 (2000); see Newman, *supra* note 154, at 1417.

158. See, e.g., OFF. OF NAT'L AIDS POL'Y, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES: UPDATED TO 2020, at 42 (2015), <https://perma.cc/YWP7-9M6U> (PDF) ("HIV-specific laws do not influence the behavior of people living with HIV in those States where these laws exist . . . legislators should reconsider whether existing laws continue to further the public interest and public health.").

159. See, e.g., *Iowa Scraps Harsh HIV Criminalization Law in Historic Vote*, NBC NEWS (May 1, 2014, 3:40 PM), <https://perma.cc/D2NS-W9UU> ("Iowa lawmakers voted early Thursday to repeal one of the nation's toughest laws punishing perceived exposure to HIV and replace it with one that reflects the latest scientific understanding of how the disease is transmitted."); Julie Moreau, *New California Law Reduces Penalty for Knowingly Exposing Someone to HIV*, NBC NEWS (Oct. 13, 2017, 9:53 AM), <https://perma.cc/QBB7-B48P> (indicating that the new law changed knowing exposure of a partner to HIV from a felony to a misdemeanor carrying a six-month prison term—the same as other communicable diseases); Sean Bland, *The Modernization of North Carolina's HIV Criminal Laws and Its Consequences*, O'NEIL INST. (June 29, 2018), <https://perma.cc/4ZEE-GBD3> ("As of January 2018 in North Carolina, if a person living with HIV is virally suppressed for six months or longer, they do not have to disclose their status to sexual partners or use a condom."); Sudhin Thanawala, *Sex with HIV Still A Crime? Updated Laws Divide Activists; Louisiana Law Changed Last Year*, ADVOCATE (July 23, 2019, 2:45 PM), <https://perma.cc/Z2TG-SVYP> ("A Louisiana law that took effect in August 2018 allows defendants to challenge a charge of exposing someone to HIV by presenting evidence that a doctor advised them they weren't infectious.").

A. National Trends

While general criminal statutes predate HIV, they have frequently been used in the HIV exposure context.¹⁶⁰ Since the rise of AIDS in the 1980s,¹⁶¹ people living with HIV have been charged with murder, attempted murder, bioterrorism, various forms of aggravated and non-aggravated assault, assault with a deadly weapon, and reckless endangerment for acts ranging from having unprotected sex without prior disclosure to spitting on a police officer.¹⁶² Additionally, positive serostatus can trigger sentence enhancements on charges unrelated to HIV exposure,¹⁶³ like solicitation: several states provide significantly

160. See Brito, *supra* note 68, at 315.

161. GRMEK, *supra* note 146, at 3. An early example of using general criminal laws to prosecute crimes related to HIV is Alabama's *Brock v. State*, in which an HIV-positive prisoner bit a prison guard and was charged with attempted murder and multiple assault counts. 555 So. 2d 285, 286 (Ala. Crim. App. 1989).

162. See, e.g., Richardson, *supra* note 26, at 1182 ("As it stands, states without statutes dealing specifically with HIV transmission use statutes such as attempted murder or aggravated assault to convict individuals who engage in behavior that may or may not result in HIV transmission."); Perone, *supra* note 28, at 376–78 (describing the case of Daniel Allen, who was charged with bioterrorism after biting his neighbor during an argument); Zita Lazzarini et al., *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J.L. MED. & ETHICS 239, 240 (2002) (discussing the importance of intent in the severity of the offense—a person who carelessly transmits HIV when they fail to take appropriate precautions has, legally, committed a less serious crime than someone who spits at another with the goal of transmitting HIV); Joshua D. Talicska, *Criminal Charges with Too Much Bite: Why Charging and Convicting HIV-Positive Biters and Spitters of Attempted Murder Is Unjustifiable*, 12 CONN. PUB. INT. L.J. 461, 469–70 (2013) (explaining that HIV-specific penalized acts can include sexual contact, sharing injection equipment, and donating blood or bodily tissue); Ari Ezra Waldman, *Exceptions: The Criminal Law's Illogical Approach to HIV-Related Aggravated Assaults*, 18 VA. J. SOC. POL'Y & L. 550, 574 (2011) (listing the typical elements in an HIV aggravated assault charge as: "(1) use of a dangerous weapon (2) in a physical attack (3) in a manner that is likely (4) to cause serious harm or death").

163. Talicska, *supra* note 162, at 468–69; Perone, *supra* note 28, at 378.

harsher punishments for people living with HIV who engage in sex work.¹⁶⁴

Communicable disease laws have been in existence for nearly a century¹⁶⁵ and have been modernized to include HIV.¹⁶⁶ These laws make it a low-level crime to knowingly expose someone else to HIV or another enumerated illness or infection but are rarely invoked in the HIV exposure context.¹⁶⁷

Many states have also enacted specific HIV exposure laws. Scholars differ over the number of states with some type of HIV-specific criminal statute, but the number is consistently

164. See, e.g., FLA. STAT. ANN. § 796.08(5) (West 2020) (providing that a person who “[p]rocur[es] another for prostitution by engaging in sexual activity in a manner likely to transmit the human immunodeficiency virus” is subject to prosecution and punishment); OKLA. STAT. ANN. tit. 21, § 1031(b) (West 2020) (“Any person who engages in an act of prostitution with knowledge that they are infected with the human immunodeficiency virus shall be guilty of a felony”); OHIO REV. CODE ANN. § 2907.241 (West 2020) (“No person, with knowledge that the person has tested positive as a carrier of a virus that causes acquired immunodeficiency syndrome, shall engage in conduct in violation of division (A) of this section.”); TENN. CODE ANN. § 39-13-516 (2020) (“A person commits aggravated prostitution when, knowing that such person is infected with HIV, the person engages in sexual activity as a business”); NEV. REV. STAT. ANN. § 201.358 (West 2020) (stating that it is a felony to work in a licensed house of prostitution after testing for and receiving notice of a positive HIV test); 18 PA. STAT. AND CONS. STAT. § 5902 (West 2020) (“Felony of the third degree if the person who committed the offense [of prostitution] knew that he or she was human immunodeficiency virus (HIV) positive or manifesting acquired immune deficiency syndrome (AIDS).”). Missouri’s sentence enhancement goes further by noting that the use of a condom is also not a defense. MO. ANN. STAT. § 567.020 (West 2020). *But see* GA. CODE ANN. § 16-5-60(c) (West 2020) (requiring a sex worker to disclose their positive serostatus “prior to offering or consenting to perform that act of sexual intercourse”).

165. See Lazzarini et al., *supra* note 162, at 241 (explaining that as early as the 1930s some states made it a misdemeanor to expose another person to a communicable or sexually transmitted disease).

166. See J. Stan Lehman et al., *Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States*, 18 AIDS BEHAV. 997, 999–1000 (2014).

167. See Talicska, *supra* note 162, at 468 (explaining that many generalized communicable disease laws are narrowly written to prohibit exposure to STDs, and because HIV, although sexually transmitted, is not generally considered to be a STD, it does not always fall under the low-level communicable disease statute).

found to be over thirty.¹⁶⁸ While these state laws differ,¹⁶⁹ most make it illegal for people living with HIV to engage in enumerated activities—like certain sex acts, needle sharing, and spitting or biting—without first disclosing their status.¹⁷⁰ Nationally, most states require only specific intent to perform the act in question rather than any intent to transmit HIV.¹⁷¹ Few states require actual transmission of the virus through the prohibited act.¹⁷² In fact, many states criminalize conduct that has a very low likelihood of transmitting HIV.¹⁷³ Some states

168. See Brito, *supra* note 68 (“The number of states with HIV-specific criminal laws fluctuates, but it is consistently reported to be slightly above thirty.”); Perone, *supra* note 28, at 373 (“At least thirty-seven states have criminal statutes specific to HIV.”); Shahabudeen K. Khan, *The Threat Lives On: How to Exclude Expectant Mothers from Prosecution for Mere Exposure of HIV to Their Fetuses and Infants*, 63 CLEV. ST. L. REV. 429, 439 (2015) (“About two-thirds of the states have enacted HIV-specific criminal transmission statutes.”); Senna Baskin et al., *Criminal Laws on Sex Work and HIV Transmission: Mapping the Laws, Considering the Consequences*, 93 DENV. L. REV. 355, 363 (2016) (“Over time, approximately thirty-three states have criminalized HIV transmission and exposure with varied rates of prosecution.”).

169. See Lazzarini et al., *supra* note 162, at 244 (“As these data [from states] indicate, statutes that create a specific new offense vary in breadth, specificity, and severity.”).

170. See Brigid Bone, Note, *Whose Responsibility is it to PrEP for Safe Sex? Archaic HIV Criminalization and Modern Medicine*, 53 WASH. U. J.L. & POL’Y 319, 325 (2017) (explaining that violations of HIV-specific exposure statutes are typically triggered by two types of action—parenteral activities, such as intravenous needle sharing, and sexual behavior by those with HIV-positive status); Wolf & Vezina, *supra* note 144, at 847 (“Most statutes apply to exposure through sexual activity and donation of blood and other tissue, whereas less than one-half apply to needle-sharing.”).

171. Amanda Weiss, Comment, *Criminalizing Consensual Transmission of HIV*, 2006 U. CHI. LEGAL F. 389, 390.

172. Dustin J. Lee, Note, *Injections, Infections, Condoms, and Care: Thoughts on Negligence and HIV Exposure*, 25 CORNELL J.L. & PUB. POL’Y 245, 249 (2015).

173. See Bone, *supra* note 170, at 325–26 (noting that although most statutes criminalize activities such as vaginal, anal, and oral sex, as well as other forms of exposure like spitting and biting between a carrier of HIV/AIDS and an uninformed second individual, the probability of transmission for any of these actions is very low).

criminalize exposing another to HIV without specifying a transmission method.¹⁷⁴

The threat of HIV exposure criminalization via one of these mechanisms is not an idle one: the United States has the highest rates of HIV exposure prosecutions¹⁷⁵ and convictions¹⁷⁶ per capita. Despite challenges in obtaining arrest and court records, one study was able to document at least 316 HIV-related prosecutions between 1986 and 2001,¹⁷⁷ while another study found at least 541 criminal convictions for HIV-related charges between 2003 and mid-2013.¹⁷⁸ The Center for HIV Law and Policy, an advocacy group for people living with HIV, released a report documenting 411 HIV exposure arrests and prosecutions between January 2008 and June 2019.¹⁷⁹ While outcomes were not included for these arrests or prosecutions, the data was broken down according to date and state: 207 of the incidents (or 52.4 percent) occurred in southern states.¹⁸⁰ Florida, Georgia, South Carolina, and Tennessee alone accounted for 129

174. See, e.g., MD. CODE ANN., HEALTH-GEN. § 18-601.1 (West 2020) (“An individual who has the human immunodeficiency virus may not knowingly transfer or attempt to transfer the human immunodeficiency virus to another individual.”); NEV. REV. STAT. ANN. § 201.205 (West 2020) (making it illegal for a person to “intentionally, knowingly or willfully engage[] in conduct in a manner that is intended or likely to transmit the disease to another person”); OKLA. STAT. ANN. tit. 21, § 1192.1 (West 2020) (prohibiting a person with HIV “with intent to infect another, to engage in conduct reasonably likely to result in the transfer of the person’s own blood, bodily fluids containing visible blood, semen, or vaginal secretions into the bloodstream of another, or through the skin . . . of another person”).

175. Norman L. Reimer, *A Lamentable Example of Overcriminalization: HIV Criminalization*, 37 CHAMPION 7, 7 (2013).

176. Perone, *supra* note 28, at 366.

177. Adeline Delavande et. al., *Criminal Prosecution and Human Immunodeficiency Virus-Related Risky Behavior*, 53 J.L. & ECON. 741, 750 (2010).

178. Sergio Hernandez, *How We Built Our HIV Crime Data Set*, PROPUBLICA (Dec. 1, 2013, 11:55 PM), <https://perma.cc/29UL-6E6Z>.

179. CTR. FOR HIV L. & POL’Y, POSITIVE JUSTICE PROJECT: ARRESTS AND PROSECUTIONS FOR HIV EXPOSURE IN THE UNITED STATES, 2008–2019 (2019), <https://perma.cc/S8YW-YR8K> (PDF).

180. *Id.*

of these arrests, or 32.7 percent of the national total.¹⁸¹ These high rates of enforcement in combination with the region's high rates of new infection create a legal minefield for southerners living with HIV. An analysis of the criminal HIV exposure landscape in the region reveals a patchwork of state laws that differ in terms of scope and applicability but, by and large, are similar in terms of their severity.

B. *Spotlight on HIV Criminalization Laws in the South*

Many southern states have criminal laws specifically impacting people living with HIV: Arkansas, Florida, Georgia, Louisiana, Maryland, Mississippi, Oklahoma, South Carolina, Tennessee, and Virginia all have specific statutes criminalizing HIV exposure.¹⁸² Of the southern states without broad criminalization statutes, Alabama and Kentucky both have sentence enhancements for assault with bodily fluids when a defendant is HIV-positive.¹⁸³ Kentucky also has a separate statutory violation regarding sex work performed by people living with HIV.¹⁸⁴ North Carolina's public health code provides many specific regulations for people living with HIV, a violation

181. *Id.*

182. *See* ARK. CODE ANN. § 5-14-123 (2020); FLA. STAT. ANN. § 384.24(2) (2020); GA. CODE ANN. § 16-5-60 (2020); LA. STAT. ANN. § 14:43.5 (2020); MD. CODE ANN., HEALTH-GEN. § 18-601.1 (West 2020); MISS. CODE ANN. § 97-27-14 (2020); OKLA. STAT. ANN. tit. 21, § 1192.1 (West 2020); S.C. CODE ANN. § 44-29-145 (2020); TENN. CODE ANN. § 39-13-109 (2020); VA. CODE ANN. § 18.2-67.4:1 (2020).

183. *See* ALA. CODE § 13A-6-242(c) (2020) ("Assault with bodily fluids is a Class A misdemeanor; provided, however, a violation of this section is a Class C felony if the person commits the crime of assault with bodily fluids knowing that he or she has a communicable disease."); KY. REV. STAT. ANN. § 508.025(2)(b) (West 2020) (elevating to a Class A misdemeanor assault with saliva, vomit, mucus, blood, seminal fluid, or feces by an adult who knows he or she has a serious communicable disease and is aware the contact "is likely to cause transmission of the disease or condition").

184. *See* KY. REV. STAT. ANN. § 529.090 (West 2020) (criminalizing the act of prostitution or procuring prostitution with knowledge of sexually transmitted diseases or HIV).

of which can be charged criminally.¹⁸⁵ While Texas does not have any criminal codes related to HIV transmission, it is notorious in its usage of harsh general criminal codes to punish potential HIV exposure.¹⁸⁶

The convergence of high rates of HIV in the South with the outsized enforcement of HIV-related criminal laws across the region necessitates a close examination of the substance and utility of laws that punish people living with HIV for potentially exposing others to the virus. While these laws differ across the South and across the country, an analysis of southern states' prohibited behaviors, statutorily provided affirmative defenses, and sentencing schemes reveal laws that are overbroad, inconsistent, and draconian, especially in light of the evolving medical science on both transmission and treatment.

1. Prohibited Conduct

Several southern states have versions of the “knowing exposure” statute that is common throughout the country.¹⁸⁷ These laws typically prohibit individuals who are aware that they have HIV or AIDS from engaging in certain acts without first revealing their status to their sexual or drug sharing partners.¹⁸⁸ Many of these acts, however, pose a low likelihood

185. See N.C. GEN. STAT. § 130A-25 (2020) (detailing the various punishments prescribed for different violations of North Carolina's public health code); *id.* § 130A-25(a) (providing that a person who violates these specific regulations “or the rules adopted by . . . a local board of health shall be guilty of a misdemeanor”).

186. See, e.g., Cox, *supra* note 145, at 7 (noting that a Texas court sentenced an HIV-positive man to prison for thirty-five years for merely spitting on a police officer to demonstrate how the state harshly applies general criminal statutes to people living with HIV); Richardson, *supra* note 26, at 1190–91 (observing that because Texas does not have a specific HIV transmission statute, prosecutors in Texas have successfully used general criminal statutes such as attempted murder to prosecute individuals living with HIV in Texas).

187. See Leslie Pickering Francis & John G. Francis, *Criminalizing Health-Related Behaviors Dangerous to Others? Disease Transmission, Transmission-Facilitation, and the Importance of Trust*, 6 CRIM. L. & PHIL. 47, 51 (2012).

188. See *id.*

of HIV transmission.¹⁸⁹ A few state HIV exposure laws are grounded not in specific activities but in likelihood of transmission: while these laws may be more flexible, they give a great deal of discretion to juries to determine medical and scientific risk.¹⁹⁰ Throughout the South, there are a great deal of differences among what kind of behaviors can result in criminal prosecution and incarceration, making the illegality of one's intimate behavior highly dependent on geography.

a. Prohibiting Behaviors Regardless of Risk

Several southern states have HIV exposure statutes that prohibit people living with HIV from engaging in specific conduct without first disclosing their serostatus—regardless of whether HIV is actually transmitted.¹⁹¹ Two additional

189. See Bone, *supra* note 170, at 325–26 (referring to acts such as oral sex, biting, spitting, or throwing bodily fluids).

190. See Chelsey Heindel, *Medical Advances, Criminal Disadvantages: The Tension Between Contemporary Antiretroviral Therapy and Criminal HIV Exposure Laws in the Workplace*, 9 WASH. J.L. TECH. & ARTS, 35, 43 (2013) (“Yet, an HIV-positive individual commits a felony under criminal exposure law when he or she theoretically exposes another to HIV, regardless of whether the actual transmission risk is 1 in 1 million or virtually impossible.”); *id.* at 44 (articulating that criminal HIV exposure laws “prioritize per se and theoretical exposure” as the primary dangers which necessitate the assignment of criminal liability); Graham White, *Pre-Exposure Prophylaxis (PrEP) and Criminal Liability Under State HIV Laws*, 126 YALE L.J.F. 77, 84 (2016) (arguing that exposure laws “impose draconian punishments for behaviors that pose little to no risk of transmitting the virus, and create an undue source of stigma for carriers of a virus that is increasingly preventable and treatable”).

191. For example, in Arkansas, it is illegal for a person who knows they have HIV/AIDS to share injection drug paraphernalia or engage in broadly defined “sexual penetration” without first revealing their HIV+ serostatus to their partner. ARK. CODE ANN. § 5-14-123(b) (2020). Sexual penetration is defined broadly to include “sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person’s body or of any object into a genital or anal opening of another person’s body.” *Id.* § 5-14-123(c). In Georgia, someone aware of their serostatus may not share injection drug paraphernalia or engage in sexual intercourse or sex acts “involving the sex organs of one person and the mouth or anus of another person” without first disclosing their status to a partner. GA. CODE ANN. § 16-5-60(c)(1)–(2) (2020). In South Carolina, it is illegal for a person living with HIV to knowingly engage in consensual or forced vaginal, anal, or oral

southern states' exposure laws apply to individuals with HIV as well as hepatitis B and C.¹⁹² Conduct proscribed by these statutes generally includes combinations of sexual penetration, oral sex, and needle sharing.¹⁹³ While some of these behaviors do pose a low (less than 2 percent per act) but real risk of transmission,¹⁹⁴ other criminalized behaviors like oral sex pose only a negligible risk of transmission.¹⁹⁵ Nonetheless, all these acts are outlawed and can expose a person living with HIV to the same serious consequences regardless of risk of transmission or whether transmission actually took place.

In addition to proscribing sexual and needle-sharing activities, some southern states also punish people living with HIV for engaging in additional behaviors typically targeted at specific classes of victims—specifically causing law enforcement, correctional officers, and first responders to come

sex or needle sharing without first informing their partner of their status. S.C. CODE ANN. § 44-29-145 (2020). Louisiana's intentional exposure to HIV law prohibits an individual aware of their serostatus from intentionally infecting another through sexual contact or "any means or contact" without the "knowing and lawful consent of the victim." LA. STAT. ANN. § 14:43.5(A)–(B) (2020). Maryland's broad exposure law can be found in its public health code and provides a criminal penalty for any knowing transfers or attempts to transfer HIV to another. MD. CODE ANN., HEALTH–GEN. § 18-601.1 (West 2020). Florida does not specifically proscribe needle sharing but makes it illegal for someone who knows they have HIV and has been informed about their ability to infect others to have sexual intercourse without first informing their partner of their serostatus and obtaining their partner's consent to have sex. FLA. STAT. ANN. § 384.24(2) (West 2020).

192. See MISS. CODE ANN. § 97-27-14(1) (2020) (criminalizing knowing exposure to these diseases without providing any prohibited activities or definitions); VA. CODE ANN. § 18.2-67.4:1 (2020) (making it illegal for anyone aware of their status to have "sexual intercourse, cunnilingus, fellatio, anilingus or anal intercourse" either with the intent to transmit the infection or merely without first disclosing it to their partner).

193. See statutes cited *supra* note 192.

194. Of the prohibited behaviors, receptive anal intercourse poses the highest risk followed by needle sharing, insertive anal intercourse, receptive penile-vaginal sex, and insertive penile-vaginal sex. *HIV Risk Behaviors*, *supra* note 56 (providing likelihoods of transmission per act as 1.38 percent, .63 percent, .11 percent, .08 percent, and .04 percent, respectively).

195. See *id.*

into contact with a seropositive person's bodily fluids.¹⁹⁶ These laws were ostensibly designed to protect law enforcement from being exposed to HIV. Given that the risk of transmission via these activities is negligible,¹⁹⁷ they serve merely as an additional mechanism by which to punish people living with HIV. Several southern states also explicitly ban and provide enhanced punishments for people living with HIV who engage in sex work—charges which can be applied on top of solicitation or prostitution charges.¹⁹⁸ In several of these states, even a sex

196. See GA. CODE ANN. § 16-5-60(d)(1)–(2) (2020) (classifying peace and correctional officers engaging in the performance of their official duties as distinct protected classes from an assault by an individual who knows he or she has HIV, and intends to transmit the virus to the officer); MISS. CODE ANN. § 97-27-14(2)(a) (2020) (“A person commits the crime of endangerment by bodily substance if the person attempts to cause or knowingly cause a corrections employee, a visitor to a correctional facility or another prisoner or offender to come into contact with blood, seminal fluid, urine, feces, or saliva.”); LA. STAT. ANN. § 14:43.5(C) (2020) (criminalizing the intentional exposure of a first responder acting pursuant to the performance of his or her duty to HIV). While Kentucky doesn't have an HIV exposure law, its third-degree assault statute includes causing a non-consenting on-duty peace officer to come into contact with bodily fluids “from an adult who knows that he or she has a serious communicable disease and competent medical or epidemiological evidence demonstrates that the specific type of contact caused by the actor is likely to cause transmission of the disease or condition.” KY. REV. STAT. ANN. § 508.025(2)(b) (West 2020). Alabama does not have an HIV exposure statute, yet its legislature recently passed an assault with bodily fluids statute that punishes people with communicable diseases (including HIV) for causing anyone to come into contact with their bodily fluids. ALA. CODE § 13A-6-242 (2020).

197. See *HIV Risk Behaviors*, *supra* note 56 (labeling the risk of HIV transmission from biting, spitting, and throwing of body fluids, which include semen or saliva, as “negligible”).

198. See GA. CODE ANN. § 16-5-60(c)(1)–(2) (2020) (prohibiting performing sexual intercourse for money or soliciting sodomy for money without disclosure of one's positive serostatus); TENN. CODE ANN. § 39-13-516 (2020) (defining aggravated prostitution as occurring “when, knowing that such person is infected with HIV, the person engages in sexual activity as a business or is an inmate in a house of prostitution or loiters in a public place for the purpose of being hired to engage in sexual activity”); FLA. STAT. ANN. § 796.08(5) (West 2020) (criminalizing engaging in or procuring sex work “in a manner likely to transmit [HIV]” by someone aware of their status and ability to infect others regardless of serostatus disclosure); KY. REV. STAT. ANN. § 529.090(3)–(4) (West 2020) (outlawing sex work by a person living with HIV in language that

worker who has obtained informed consent or who is incapable of transmitting HIV due to risk mitigation could nonetheless be prosecuted.¹⁹⁹ Furthermore, in some southern states without specific HIV exposure laws, individuals are being arrested and prosecuted for the same activities under general criminal statutes.²⁰⁰

Many southern state HIV exposure laws either explicitly or implicitly ban behaviors that pose little to no risk of transmission and make no distinction between these behaviors and higher risk activities.²⁰¹ While they provide bright-line rules as to what behaviors are illegal, these laws neither accurately map onto high-risk activities nor take into account the potential for risk mitigation.

b. Prohibiting Behaviors in Light of Risk

While three states in the region do attempt to incorporate risk into their HIV criminalization schemes, they do so differently, and in ways that do not provide people living with HIV with a clear understanding of whether their behavior may result in criminal liability. For example, although North

mirrors that of the Florida law); S.C. CODE ANN. § 44-29-145 (2020) (banning prostitution regardless of knowledge or consent).

199. See FLA. STAT. ANN. § 796.08 (West 2020) (providing no defense for having obtained informed consent before committing the sexual act); KY. REV. STAT. ANN. § 529.090 (West 2020) (mentioning no defense for informed consent or low risk of transmission available to a person who committed prostitution by engaging in sexual activity that could transmit HIV); S.C. CODE ANN. § 44-29-145(2) (2020) (criminalizing prostitution regardless of consent).

200. See Tim Martin, *Judging HIV Criminalization: Failures of Judges and Commentators to Engage with Public Health Knowledge and HIV-Positive Perspectives*, 4 U.C. IRVINE L. REV. 493, 498–99 (2014) (writing that twenty states which have enacted HIV-specific criminal statutes have continued to prosecute individuals for “HIV exposure under general criminal law”); CTR. FOR HIV L. & POL’Y, *supra* note 25, at 2008–19 (finding arrests and prosecutions under general criminal statutes for HIV exposure in Alabama and Texas, but not in Delaware, the District of Columbia, or West Virginia).

201. See Talicska, *supra* note 162, at 476 (“Given that the punishments imposed on HIV-positive biters and spitters often exceed the punishment the individuals would have received for engaging in higher-risk behaviors, there is sufficient reason to conclude that such punishments are not proportionate to the offense in question.”).

Carolina does not have an exposure statute, it is a crime to violate any public health-related administrative regulation.²⁰² The state passed new regulations regarding people living with HIV that went into effect in 2018.²⁰³ These regulations require people living with HIV to use a condom during sex unless 1) their HIV viral load is low enough to be untransmittable, 2) their sexual partner also has HIV, 3) their sexual partner is complying with pre-exposure prophylactic medication, or 4) the sex occurred in the context of being sexually assaulted.²⁰⁴ The regulations also include a prohibition against sharing used injection drug paraphernalia that may be contaminated with blood.²⁰⁵ People living with HIV must notify both past sex and needle sharing partners of their serostatus and future partners when their viral load is detectable.²⁰⁶ A person living with HIV who is aware of these regulations and has consulted them closely would be aware of what kinds of high-risk behaviors would expose them to potential prosecution. Individuals who have not examined the regulations but who are engaging in risk-mitigating behavior are also less likely to experience criminal sanctions. Yet there is still the possibility that someone who has engaged in riskier activities without ever transmitting HIV to another could still find themselves being punished.

Oklahoma's statute does not include the same level of scientific insight contained in the recent North Carolina regulations but it does reflect an understanding about how transmission risks can vary.²⁰⁷ It prohibits a person aware of their positive serostatus from engaging in behavior "reasonably likely to result in the transfer" of their bodily fluids into the bloodstream or through the membranes of another person, while explicitly excluding in utero transmission.²⁰⁸ There, the defendant has to have the intent to infect a victim who has not

202. N.C. GEN. STAT. § 130A-25(a) (2020).

203. 10A N.C. ADMIN. CODE § 41A.0202 (2020).

204. *Id.* § 41A.0202(1)(a).

205. *Id.* § 41A.0202(1)(b).

206. *Id.* § 41A.0202(1)(d)–(g).

207. OKLA. STAT. ANN. tit. 21, § 1192.1 (West 2020).

208. *Id.* § 1192.1(A).

given informed consent to being exposed to HIV.²⁰⁹ Tennessee's exposure statute applies to individuals aware of the fact that they have HIV or hepatitis B or C and prohibits them from knowingly engaging in intimate contact that presents a high risk of transmission and sharing nonsterile injection drug paraphernalia.²¹⁰ Because these two statutes are fairly vague, much discretion must be given to experts to properly convey information on risk and risk-mitigation and to juries to understand and synthesize this information into their verdicts.²¹¹ Additionally, it is unclear whether or how use of medication or prophylactics would be factored into the risk assessment. Finally, in neither state would lack of actual transmission be an explicitly provided defense.²¹²

Outside of these three states, prohibited conduct is not typically determined by either risk or actual harm. The way the majority of these laws criminalize broad swaths of behavior creates danger for people with and without HIV and entrenches stigma around people living with HIV being inherently dangerous.

2. Exemptions from Prosecution and Affirmative Defenses

In the same way that the criminalization of certain behaviors reflects outdated panic around HIV transmission, so too do the lack of medically sound exemptions and affirmative defenses reveal an inaccurate understanding of how HIV can be successfully prevented and treated. The most common means of circumventing criminal HIV exposure statutes is disclosure and/or partner consent.²¹³ While several southern states make

209. *Id.*

210. TENN. CODE ANN. § 39-13-109(a) (2020).

211. See Martin, *supra* note 200, at 505–06 (noting how easily expert testimony on transmission can be misunderstood).

212. See OKLA. STAT. ANN. tit. 21, § 1192.1 (West 2020) (providing no defense for lack of actual transmission); TENN. CODE ANN. § 39-13-109 (2020) (same).

213. See Bone, *supra* note 170, at 328 (recording that in sixteen out of the twenty-four states with an HIV exposure law, the prosecution holds the burden of proof to show a lack of disclosure of serostatus, while “in the

nondisclosure or lack of consent an element of the crime itself,²¹⁴ others require the defendant to prove disclosure in order to avoid conviction²¹⁵—a fact that that can be challenging to prove given the intimate nature of such interactions.²¹⁶ Louisiana’s recently updated law makes lack of consent both an element of the crime and an affirmative defense.²¹⁷ In Virginia, where specific intent to transmit HIV is required, disclosure is the difference between a felony exposure charge and a misdemeanor charge.²¹⁸ Maryland’s law makes no mention of either disclosure or consent—meaning that neither would definitively prevent a defendant from being charged or convicted.²¹⁹

remaining states, disclosure is an affirmative defense to a charge of HIV exposure”).

214. ARK. CODE ANN. § 5-14-123(B) (2020) (specifying only disclosure); FLA. STAT. ANN. § 384.24(2) (West 2020) (requiring disclosure and consent); GA. CODE ANN. § 16-5-60(c)(1)–(2) (2020) (requiring disclosure); LA. STAT. ANN. § 14:43.5(A) (2020) (requiring the “knowing and lawful consent of the victim”); OKLA. STAT. ANN. tit. 21, § 1192.1(A)(1)–(2) (West 2020) (making lack of consent an element of the crime); S.C. CODE ANN. § 44-29-145(1), (4) (2020) (requiring disclosure of serostatus).

215. See MISS. CODE ANN. § 97-27-14(1) (2020) (providing a defense of “prior knowledge and willing consent”); TENN. CODE ANN. § 39-13-109(c) (2020) (providing an affirmative defense when “the person exposed to HIV knew that the infected person was infected with HIV, knew that the action could result in infection with HIV, and gave advance consent to the action with that knowledge”).

216. See Bone, *supra* note 170, at 327–28 (“Proving disclosure of HIV status between two otherwise consenting adults can be incredibly difficult and may also be dangerous for the HIV positive partner.”).

217. LA. STAT. ANN. § 14:43.5(F)(1) (2020).

218. VA. CODE ANN. § 18.2-67.4:1(A)–(B) (2020). This statute would allow the conviction of individuals who intentionally expose partners to HIV with their partners’ consent—which includes a small but extant population within the gay community known as “bug chasers.” See Weiss, *supra* note 171, at 389 (explaining that “bug-chasers” are “HIV-negative gay men who actively seek out infection, arranging to have unprotected sexual intercourse with infected partners”).

219. MD. CODE ANN., HEALTH–GEN. § 18-601.1 (West 2020); see Sara Klemm, *Keeping Prevention in the Crosshairs: A Better HIV Exposure Law for Maryland*, 13 J. HEALTH CARE L. & POL’Y 495, 513 (2010) (writing that Maryland’s criminal HIV exposure law is unique because it is one of the “broadest facial articulations of what conduct is prohibited” because it covers any action by an individual who knowingly transfers or “attempts to transfer”

North Carolina's law is contingent upon condom usage instead of disclosure or consent: there, people living with HIV must refrain from having sex without a condom unless enumerated measures are taken to prevent new exposure—if these measures are not taken, consent to the transmission without a condom is immaterial.²²⁰ Of all the southern states, these exemptions from prosecution are by far the most reflective of evolving medical science regarding HIV transmission and treatment, although Louisiana provides affirmative defenses that gesture in this direction.²²¹ The Louisiana legislature recently revised its affirmative defenses for HIV exposure to include not just consent to potential infection but also 1) disclosure of serostatus combined with being advised by a doctor that a person living with HIV was no longer infectious or 2) disclosure as well as “practical [and professionally accepted] means to prevent transmission as advised by a physician.”²²² Unlike in North Carolina, however, people living with HIV in Louisiana must still disclose their status even if they cannot transmit the virus.²²³

Because of major advancements made in treating HIV and preventing its transmission, more state legislatures intent on keeping their HIV exposure statutes in their current form must consider updating them to include medically accurate exemptions from prosecution or, at the very least, affirmative defenses. Not only do many of the prohibited acts in HIV exposure laws pose very low or no risk of transmission, few statutes have sufficient protections for individuals who are themselves taking precautions to make transmission unlikely if

HIV). Here too serodiscordant individuals having consensual, unprotected sex or needle-sharing could be exposed to criminal liability.

220. 10A N.C. ADMIN. CODE § 41A.0202(a)–(b) (2020). Specifically, these protective measures beyond condom usage include: the seropositive individual being in and compliant with medical treatment for the past six months with a suppressed HIV viral load; both sexual partners already having HIV; or the seronegative partner being on pre-exposure prophylaxis medication as directed by a doctor. *Id.* § 41A.0202(a)(i)–(iv).

221. *See* LA. STAT. ANN. § 14:43.5 (2020).

222. *Id.* § 14:43.5(F).

223. *Id.* § 14:43.5(A)–(C).

not impossible. Failure to make these changes will result in the continued arrest, prosecution, and conviction of individuals who did not or could not transmit HIV. While even an arrest for HIV exposure can have a hugely detrimental impact on the life of a person living with HIV, those convicted of the crime face steep punishment in terms of jail time as well as formal and informal collateral consequences.²²⁴

3. Sentencing and the Cost of a Conviction

At the national level,²²⁵ the vast majority of HIV exposure statutes are felonies that come with significant prison time.²²⁶ This pattern remains in place in the South as well, where most HIV exposure laws are punishable as felonies with sentencing ranges in some states of up to thirty years.²²⁷ HIV exposure is

224. See Kaplan, *supra* note 55, at 1554 (recognizing that HIV-positive individuals face harsh punishments because of the “proliferation of numerous statutes prohibiting different specific activities,” which results in “arbitrary differences in punishment level and grossly disproportionate punishment”); *id.* at 1555 (“HIV-exposure laws are nearly universally graded as felonies, with an average maximum sentence of eleven years.”).

225. See Talicska, *supra* note 162, at 470 (writing that at “least thirty-two states and territories have enacted HIV-specific criminal statutes,” which vary in “breadth, specificity, and severity,” and are all “aimed at reducing HIV transmission by penalizing certain conduct”).

226. See Delavande, *supra* note 177, at 749 (“HIV exposure is a felony . . . and is punishable by an average maximum penalty of 11 years of prison” (citation omitted)).

227. In Arkansas, a violation of the exposure statute is a Class A felony, which has a sentencing range of six to thirty years. ARK. CODE ANN. §§ 5-14-123(d), 5-4-401(2) (2020). In Florida, a first-time violator commits a third-degree felony and can be sentenced to up to five years of incarceration while a repeat offense is considered a first-degree felony with a sentence of up to thirty years. FLA. STAT. ANN. §§ 384.34(5), 775.082(3) (West 2020). In Georgia, a conviction of exposure is a felony that can result in a sentence of up to twenty years while a conviction for HIV exposure via assault with bodily fluids can yield up to a thirty-year sentence. GA. CODE ANN. § 16-5-60(c)–(d) (2020). In Louisiana, intentionally exposing another to HIV can result in a sentence of up to ten years or eleven years of the victim is a first responder. LA. STAT. ANN. § 14:43.5(E) (2020). A violation of Mississippi’s exposure statute is a felony that can yield a sentence of between three and ten years. MISS. CODE ANN. § 97-27-14(2)(c)–(3) (2020). It is worth noting that the same violation of this statute by an individual with a contagious disease that is not HIV or hepatitis B or C would be a misdemeanor. *Id.* In Oklahoma, a

only a misdemeanor in two southern states—one of which nonetheless provides a punishment of up to three years.²²⁸ States that either don't have specific HIV exposure statutes or that do not rely exclusively on their exposure statutes have prosecuted similar acts under general criminal laws, including reckless endangerment, aggravated assault, assault with a deadly weapon, and attempted murder—depending on the severity of the statute invoked, sentences in these prosecutions can mirror the higher end of the exposure sentencing ranges.²²⁹ Additionally, those states with statutes criminalizing sex work performed by people living with HIV provide significantly heightened sentences compared to prostitution or solicitation generally.²³⁰

On top of lengthy sentences for behavior that may not involve actual transmission of HIV, defendants found guilty of HIV transmission may be required to register as sex

defendant found guilty of HIV exposure can be sentenced for a felony of up to five years. OKLA. STAT. ANN. tit. 21, § 1192.1(B) (West 2020). The potential sentence in South Carolina is up to ten years. S.C. CODE ANN. § 44-29-145 (2020). HIV exposure in Tennessee is a Class C felony with a sentencing range of three to fifteen years. TENN. CODE ANN. §§ 39-13-109(e), 40-35-111(e)(1) (2020) (categorizing exposure to hepatitis as a Class A misdemeanor).

228. See MD. CODE ANN., HEALTH-GEN. § 18-601.1(b) (West 2020) (carrying a punishment of up to three years). Meanwhile, a violation of North Carolina's health code is a misdemeanor resulting in a sentence of up to 150 days. N.C. GEN. STAT. §§ 130A-25, 15A-1340.23 (2020).

229. See Cox, *supra* note 145, at 22; Richardson, *supra* note 26, at 1182; Talicska, *supra* note 162, at 470.

230. See FLA. STAT. ANN. § 796.08(5) (West 2020) (elevating the criminal act committed by a sex worker to a third-degree felony, increasing the punishment); KY. REV. STAT. ANN. § 529.090(4) (West 2020) (making the act of procuring another to commit prostitution in a manner likely to transmit HIV a Class D felony); OKLA. STAT. ANN. tit. 21, § 1031(B) (West 2020) (raising the act of prostitution by an individual who knows that he or she has HIV to a felony punishable by imprisonment of up to five years); TENN. CODE ANN. § 39-13-516(a)–(d) (2020) (categorizing the act of “aggravated prostitution” by a person who knows he or she is infected with HIV as a Class C felony); S.C. CODE ANN. § 44-29-145(2) (2020) (making it a felony punishable by imprisonment for up to ten years for a person who knows that he is infected with HIV to “knowingly commit an act of prostitution with another person”).

offenders.²³¹ Registration as a sex offender can make it extremely difficult for a person living with HIV to meet their basic needs post-incarceration like finding housing or work, especially given the public nature of sex offender registries.²³²

In addition to these formal punishments, a conviction or even an arrest for an HIV-exposure related activity can have far-reaching consequences for people living with HIV. Like all returning citizens, people living with HIV will experience informal collateral consequences during their lifelong reentry experience, including finding and keeping public or private housing, denials of professional licensure applications, voter disenfranchisement, and even deportation of non-citizens.²³³ Moreover, a conviction—or even an arrest—will put someone’s serostatus and, potentially, their sexual orientation on display and may serve to out them to family, friends, neighbors, employers, colleagues and others without their consent: even if the defendant is exonerated, an arrest for or charge of HIV exposure exposes them to the potential for discrimination and stigma in their personal and professional lives.²³⁴ Additionally, the challenges created by both a diagnosis of HIV and the

231. ARK. CODE ANN. § 12-12-903 (2020); LA. STAT. ANN. § 15:541(24)(a) (2020); TENN. CODE ANN. § 40-39-202 (2020). Tennessee does allow defendants to petition the court for termination of sex offender registration if they were convicted of aggravated prostitution but can demonstrate that they were victims of human trafficking, domestic violence, or sexual assault. TENN. CODE ANN. § 40-39-218 (2020).

232. See Bone, *supra* note 170, at 330 (“Registering as a sex offender not only marks a defendant for life, but also will reduce their chances of obtaining a job, housing, or ability to start a family.”); Perone, *supra* note 28, at 392 (noting that registering as a sex offender results in severe collateral repercussions such as “in obtaining housing and even accompanying children to school”).

233. See Michael Pinard, *An Integrated Perspective on the Collateral Consequences of Criminal Convictions and Reentry Issues Faced by Formerly Incarcerated Individuals*, 86 B.U. L. REV. 623, 634–36 (2006) (outlining the notable collateral consequences including “temporary or permanent ineligibility for public benefits, public or government-assisted housing, and federal student aid; various employment-related restrictions; disqualification from military service; civic disqualifications such as felon disenfranchisement and ineligibility for jury service; and, for non-citizens, deportation”).

234. See Perone, *supra* note 28, at 392 (examining how HIV criminalization laws penalize people with HIV beyond incarceration).

barriers of having a criminal record may also expose a person living with HIV to domestic violence by an abusive partner seeking to exert control and exploit their partner's vulnerabilities.²³⁵

Depending on what state they are in, people living with HIV may be exposed to lengthy prison sentences followed by long-lasting or permanent formal and informal collateral consequences for engaging in behavior that—but for their seropositive status—would come with little to no criminal penalty.²³⁶ Individuals who do not or cannot transmit HIV due to compliance with a medical treatment regime may spend years in prison in several southern states when they could not even be arrested for HIV exposure in North Carolina or Louisiana. These discrepancies create real disparities in the well-being and liberty of people living with HIV. In light of scientific and medical advancements regarding the treatment and transmission of HIV, it is time to reevaluate the utility of these laws as a means of ending the spread of HIV. Rather than relying on outdated stereotypes or obsolete science, lawmakers should follow HIV advocates' lead and turn to public health policies as a way of reshaping both the legal and social services' response to HIV. While relevant nationwide, this paradigm shift is particularly crucial in southern states where HIV remains an urgent—and growing—problem.

235. See Courtney K. Cross, *The Dangers of Disclosure: How HIV Laws Harm Domestic Violence Survivors*, 95 WASH. L. REV. 83, 98 (2020) (“Abusers may take direct advantage of a survivor’s HIV status by destroying or stealing medication; interfering with medical visits; threatening to tell employers, immigration officials, and loved ones about the survivor’s HIV-positive status . . .”).

236. See, e.g., Shayo Buchanan, *supra* note 23, at 1341 (arguing that HIV criminalization constitutes a status crime); *Robinson v. California*, 370 U.S. 660, 666 (1962) (discussing criminalization based on immutable characteristics). For a discussion of the fractured evolution of the status crime doctrine since *Robinson*, see Stephen Rushin & Jenny Carroll, *Bathroom Laws as Status Crimes*, 86 FORDHAM L. REV. 1, 35 (2017).

IV. MITIGATING THE RISK OF HIV THROUGH HARM REDUCTION

The benefits of pivoting away from criminalization toward a health outcome-oriented approach include a renewed focus on scientific empiricism and an increased commitment to prevention and treatment instead of punishments. Broadly, public health is an interdisciplinary field dedicated to applying contemporary knowledge and information to achieve “the maximum impact on the health status of a population.”²³⁷ Public health encapsulates numerous strategies and approaches to improving health outcomes including harm reduction, which employs practical and nonjudgmental strategies to ameliorate harms created by both high-risk behaviors themselves and attempts to legislate them.²³⁸ Harm reduction is particularly well-suited for the HIV context because the activities that can put people at risk of infection are highly stigmatized and heavily legislated.²³⁹

A. *Harm Reduction Generally*

Harm reduction is a pragmatic public health strategy that shares the primary tenets of public health—“improving health, social well-being, and quality of life.”²⁴⁰ Rather than consisting of specific rules or mechanisms, harm reduction more closely resembles a set of principles based in dignity and empathy.²⁴¹ These amorphous boundaries make concisely defining harm

237. BERNARD J. TURNOCK, PUBLIC HEALTH: WHAT IT IS AND HOW IT WORKS 13 (6th ed. 2016).

238. See COLLINS ET AL., *supra* note 41, at 25 (observing that the harm reduction theory is predicated on advancing the basic human rights of affected individuals who have been marginalized and/or disenfranchised because of their high-risk behaviors and the associate consequences).

239. See Perone, *supra* note 28, at 383 (stating that HIV criminalization laws undermine “public health initiatives” by prohibiting “conduct that is unlikely to transmit HIV” and “increase stigmatization about certain behaviors that may be more prevalent in marginalized communities”).

240. Sharon Stancliff et al., *Harm Reduction: Front Line Public Health*, 34 J. ADDICTIVE DISEASES 206, 206 (2015).

241. See COLLINS ET AL., *supra* note 41, at 6 (describing harm reduction as a “humanitarian stance that accepts the inherent dignity of life” rather than a “fixed set of rules or regulations”).

reduction challenging: even within the public health field there are many different definitions in use.²⁴² Yet this purposeful imprecision is what enables harm reduction to translate across different contexts.²⁴³ At its core, however, harm reduction is characterized by a non-judgmental conception of high-risk behaviors as socially constructed and unlikely to be eradicated.²⁴⁴ Rather than requiring or prioritizing abstinence from risky activities, harm reduction posits that risk mitigation strategies should be paramount at both the individual and systemic levels in order to realistically promote safer and healthier outcomes.²⁴⁵ Harm reduction advocates distinguish between primary harms that flow from the risky behavior itself

242. See, e.g., Andrew Lee Ball, *HIV, Injecting Drug Use and Harm Reduction: A Public Health Response*, 102 ADDICTION 684, 686 (2007) (noting that there is still “no universally accepted definition for” harm reduction in the public health field).

243. Harm reduction strategies have proven beneficial in many contexts including but not limited to HIV/AIDS. See, e.g., *id.* at 687 (“Recent reviews of the evidence on the role of harm reduction in HIV prevention demonstrate clearly the public health benefit of a number of key interventions and their relative safety.”); Zachary Chan & Michael Siegel, *Electronic Cigarettes as a Harm Reduction Strategy for Tobacco Control: A Step Forward or a Repeat of Past Mistakes*, 32 J. PUB. HEALTH POL’Y 16, 17 (2011) (discussing harm reduction in the context of tobacco usage); Miranda W. Langendam et al., *The Impact of Harm Reduction-Methadone Treatment on Mortality Among Heroin Users*, 91 AM. J. PUB. HEALTH 774, 778 (2001) (discussing harm reduction in the context of heroin addiction); Mary E. Larimer et al., *Harm Reduction for Alcohol Problems*, in HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS 63 (G. Alan Marlatt et al. eds., 2d ed. 2012) (discussing harm reduction in the context of alcohol consumption); Michael Peake Andrasik & Ty W. Lostutter, *Harm Reduction for High Risk Sexual Behavior and HIV*, in HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS 202 (G. Alan Marlatt et al. eds., 2d ed. 2012) (discussing harm reduction in the context of risky sexual behavior).

244. See COLLINS ET AL., *supra* note 41, at 18 (“Within the harm reduction framework, it is acknowledged that our belief systems surrounding high-risk behaviors are products of a given time and culture and their associated values, norms, and beliefs.”).

245. See *id.* at 20 (explaining that harm reduction advocates “seek to educate, support and empower individuals and communities to explore and understand various options for reducing harm”).

and secondary harms which are generated by policies meant to address the high-risk activity.²⁴⁶

For example, primary harms from injecting opioids include risk of overdose and infection while secondary harms consist of not obtaining sterile needles or avoiding medical attention out of fear of arrest. Rather than require immediate and total abstinence from injection drug use, harm reduction activists seek to reduce both types of harm: in the first instance, by facilitating acquisition of clean paraphernalia and overdose reversing medication and, in the second, advocating for reduced law enforcement intervention and penalties.²⁴⁷ Because one goal of drug decriminalization is to reduce harms that spring directly from the criminal justice system, it often falls within the ambit for harm reduction policy advocacy.²⁴⁸

Critics of harm reduction philosophies and practices argue that such policies merely enable dangerous behavior and wear down public opposition to immoral actions.²⁴⁹ From a more

246. See Robert J. MacCoun, *Toward a Psychology of Harm Reduction*, 53 AM. PSYCH. 1199, 1199 (1998).

247. See Angélica Cházaro, *Beyond Respectability: Dismantling the Harms of “Illegality,”* 52 HARV. J. ON LEGIS. 355, 411 (2015) (explaining that in the illicit-drug use arena, harm reduction theory focuses on the decriminalization of selected laws and the removal of penalties for possession “inasmuch as decriminalization aims to reduce harms to drug users from the criminal justice system itself”); Cahn & Siegel, *supra* note 243, at 16 (“Harm reduction is a framework for public health policy that focuses on reducing the harmful consequences of recreational drug use without necessarily reducing or eliminating the use itself.”).

248. See Cházaro, *supra* note 247, at 410–11 (indicating that drug decriminalization and harm reduction policies shared “understanding that illicit behavior will happen whether or not the law prohibits it” such that pragmatic interventions should be “considered and weighed by their effectiveness at reducing the harmful consequences of the behavior or activity”); Joanna N. Erdman, *Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach*, 34 HARV. J.L. & GENDER 413, 459 (2011) (stating forcefully that the “evidence is so overwhelming that criminal laws generate more health-related harm than they prevent, it is exceedingly difficult not to advocate legal reform under a harm reduction rationale”).

249. See Robert J. MacCoun, *Moral Outrage and Opposition to Harm Reduction*, 7 CRIM. L. & PHIL. 83, 84 (2013) (noting that opponents of harm reduction theory argue that such policies send a bad message by “encouraging or enabling the behavior and weakening society’s moral stigma against it”); Amber A. Leary, *A Safe Harbor in the Opioid Crisis: How the Federal*

semantic perspective, opponents have argued that claims of harm have become ubiquitous and cut in too many directions to provide concrete insights into policy analysis.²⁵⁰ Despite these critiques, harm reduction has become an increasingly common approach to mitigating high-risk behaviors internationally, and more recently, domestically.²⁵¹

While harm reduction strategies have been common across Europe over the past one hundred years in the drug context,²⁵² early harm reduction efforts in the United States took shape during the AIDS crisis when grassroots groups were quickly organized by members of the gay community to educate, protect, and treat members of local affected populations.²⁵³ In 1982, the Gay Men's Health Crisis started the first AIDS hotline, distributed fifty thousand copies of its first newsletter, created a peer-to-peer program, and opened an office in San Francisco—all before the federal government provided any funding for medical research.²⁵⁴ In addition to providing direct services to people living with HIV/AIDS and at-risk communities, HIV-focused organizations also pressured the

Government Should Allow States to Legislate for Safe Injection Facilities in Light of the Opioid Public Health Emergency, 84 BROOK. L. REV. 635, 657 (2019) (“Critics of harm reduction policies argue that they imply tolerance, condonation, and promotion of drug use.”).

250. See Bernard E. Harcourt, *The Collapse of the Harm Principle*, 90 J. CRIM. L. & CRIMINOLOGY 109, 113 (1999) (“Claims of harm have become so pervasive that the harm principle has become meaningless: the harm principle no longer serves the function of a critical principal because non-trivial arguments permeate the debate.”).

251. See Leary, *supra* note 249, at 657 (observing that harm reduction “is the dominant philosophy outside of the United States, and there is evidence that the United States may be ready to more openly embrace harm reduction policies in light of the growing heroin epidemic”).

252. COLLINS ET AL., *supra* note 41, at 10–11.

253. See *id.* at 16 (noting that due to slow governmental response, grassroots organizations like the Gay Men's Health Crisis and STOP AIDS mobilized to provide education and services to those most vulnerable to HIV, including providing needle exchanges which at the time was illegal in many states).

254. *GMHC/HIV/AIDS Timeline*, GAY MEN'S HEALTH CRISIS, <https://perma.cc/6GD4-PCM2>.

government and medical agencies to take HIV/AIDS research more seriously and make treatment more widely available.²⁵⁵

More than thirty years later, harm reduction techniques have been endorsed globally for combating the spread of HIV, bringing people living with HIV into care, and improving health outcomes.²⁵⁶ Their use is encouraged by intergovernmental bodies, including the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), especially when addressing HIV among injection drug users.²⁵⁷ This is a critical population to target given the realities of needle sharing and the fact that HIV can survive in a syringe for over forty days.²⁵⁸ Support for and adoption of mainstream harm reduction strategies like needle exchange programs has been slow and piecemeal in the United States, yet continue to gain traction.²⁵⁹ More cutting-edge practices like safe injection

255. COLLINS ET AL., *supra* note 41, at 16.

256. See *Update: Harm Reduction*, JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) (Oct. 10, 2016), <https://perma.cc/H8HS-PXMY>.

257. See *Harm Reduction*, WORLD HEALTH ORGANIZATION: REGIONAL OFFICE FOR EUROPE, <https://perma.cc/UU4G-6HED> (“WHO/Europe actively promotes scaling-up comprehensive harm reduction services to effectively address the HIV epidemic among [people who inject drugs] and their sexual partners.”); *Harm Reduction for HIV Prevention*, AVERT, <https://perma.cc/5SV2-74JX> (last updated Oct. 3, 2019) (noting that the WHO, UNODC, and UNAIDS all “strongly recommend” a harm reduction approach to preventing and treating HIV among people who inject drugs).

258. See *Injection Drug Use and HIV Risk*, *supra* note 21.

259. See Richard Weinmeyer, *Needle Exchange Programs’ Status in U.S. Politics*, 18 AMA J. ETHICS 252, 253–55 (2016) (providing a history of federal policies on needle exchange programs); German Lopez, *Needle Exchanges Have Been Proved to Work Against Opioid Addiction. They’re Banned in 15 States*, VOX (June 22, 2018), <https://perma.cc/DT4E-V6YW> (providing that needle exchanges are legalized in twenty-six states, illegal in fifteen states, and are either locally permitted or are not addressed by state law in nine states); Jeffrey A. Singer, *More Evidence in Support of Needle Exchange Programs*, CATO INST. (Nov. 3, 2019), <https://perma.cc/WD4F-6233> (noting that despite strong scientific and economic support for needle exchange programs, drug paraphernalia laws in many states make them illegal).

sites,²⁶⁰ heroin maintenance therapy,²⁶¹ and providing clean needles to prison inmates²⁶² that have showed promise globally have yet to be embraced domestically.

Harm reduction strategies are not limited to addressing only transmission via injection drugs. Harm reduction efforts linked to preventing the spread of HIV through sexual activity include comprehensive sex and sexually transmitted infection education²⁶³ that includes condom distribution and education²⁶⁴ and information on less risky sexual positions.²⁶⁵ Additionally, making medication like pre-exposure prophylaxis accessible to at-risk individuals²⁶⁶ and anti-retrovirals available to people

260. See Leary, *supra* note 249, at 658–59 (explaining that safe injection sites reduce blood-borne illness and bacterial infection by providing clean needles and reduce the risk of overdoses by providing immediate medical intervention if necessary).

261. See Jessica G. Katz, Note, *Heroin Maintenance Treatment: Its Effectiveness and the Legislative Changes Necessary to Implement It in the U.S.*, 26 J. CONTEMP. HEALTH L. & POL'Y 300, 302 (2009) (recognizing that while U.S. laws would currently prohibit medical studies into the effectiveness of heroin maintenance therapy, which “provides heroin addicts with controlled doses of pure heroin . . . in a sterile and supervised setting,” studies in Canada and Europe have shown its effectiveness).

262. See Kate Abramson, Note, *Unfairly Condemned to Disease: The Argument for Needle-Exchange Programs in United States Prisons*, 16 GEO. J. ON POVERTY L. & POL'Y 695, 697 (2009) (noting the WHO's support for needle exchange programs in prisons and the success of such programs in the Switzerland and Spain).

263. See *Comprehensive Sexuality Education*, AIDS UNITED, <https://perma.cc/L5FL-ALZT> (“Comprehensive sex education programs have been shown to effectively delay sexual activity, increase condom use, and decrease the number of sexual partners. These programs are a critical tool in preventing HIV . . .”).

264. See Mahnaz R. Charania et al., *Efficacy of Structural-Level Condom Distribution Interventions: A Meta-Analysis of U.S. and International Studies, 1998–2007*, 15 AIDS BEHAV. 1283, 1295 (2011) (“[C]ondom distribution programs can significantly impact condom use behaviors among at-risk populations (e.g., youth, adults), as well as high-risk populations (e.g., commercial sex workers).”).

265. See *HIV Risk and Prevention: Anal Sex*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/E7RV-976H>.

266. See *Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/8Z8K-FXR6> (“[W]hen taking [pre-exposure prophylaxis]

living with HIV²⁶⁷ will also prevent the spread of HIV through both sex and needle sharing. These strategies require both on the ground distribution of information, prophylactics, and medication, as well as systemic change at the municipal, state, and federal level to fund and support these initiatives.

In addition to lobbying for the passage of laws that will make these programs and services more prevalent and accessible,²⁶⁸ harm reduction supporters and activists—especially those who are living with HIV—are typically opposed to overly broad HIV criminalization laws and support their ratcheting down or repeal.²⁶⁹

Neither an increase in harm reduction programming nor the scaling back of draconian HIV criminalization legislation is, alone, sufficient to reduce the spread of HIV and improve the health outcomes of people living with HIV. Instead, a comprehensive harm reduction approach to HIV mandates a response that both increases and formalizes prevention and

consistently, the risk of acquiring HIV is reduced by an estimated 74–84% among [people who inject drugs].”).

267. See *Science Validates Undetectable = Untransmittable HIV Prevention Message*, NAT'L INST. OF HEALTH (July 22, 2018), <https://perma.cc/9DBF-YKVD>.

268. See Lesly-Marie Buer, *Overdosing in Appalachia*, BOS. REV. (July 8, 2019), <https://perma.cc/2PFD-YL4S> (identifying the three pillars of overdose harm reduction as maintenance therapy, naloxone access, and safer consumption, and noting that “many harm reduction strategies are still heavily regulated, if not outright illegal”).

269. Groups that oppose these laws in the United States include the American Medical Association, the American Psychological Association, the American Academy of HIV Medicine, the Center for HIV Law & Policy, the Sero Project, and AIDS United. Edwin J. Bernard, *International Civil Society Experts Launch the Oslo Declaration on HIV Criminalization*, HIV JUST. NETWORK (Feb. 22, 2012), <https://perma.cc/DSY8-PCKZ>. Internationally there is also widespread support for amending or repealing these laws as well. *Id.*; see UNAIDS, ENDING OVERLY BROAD CRIMINALIZATION OF HIV NON-DISCLOSURE, EXPOSURE AND TRANSMISSION: CRITICAL SCIENTIFIC, MEDICAL AND LEGAL CONSIDERATIONS 2 (2013), <https://perma.cc/KK58-CZLS> (PDF) (expressing UNAIDS's concern with the criminalization of HIV non-disclosure, exposure, or transmission); WORLD HEALTH ORG., SEXUAL HEALTH, HUMAN RIGHTS AND THE LAW 8 (2015), <https://perma.cc/8QXU-BQ9Y> (PDF) (identifying the WHO's opposition to the criminalization of HIV transmission).

treatment while also contemporizing HIV criminalization statutes in light of modern scientific and medical advancements.

B. *Strategies that Increase Access to HIV Prevention*

There are myriad ways that harm reduction approaches can be used to both mitigate the transmission of HIV and provide concrete and necessary support to people already living with HIV. Harm reduction practices can and should be implemented at the individual, organizational, municipal, and state levels. This Article primarily focuses on making recommendations at the municipal and state level so as to avoid heaping additional expenses onto already struggling non-profits, churches, social groups, unions, or other nongovernmental bodies that work closely with people who are at risk of infection or already living with HIV. This focus is particularly vital in the South, where federal and private funding is especially scarce.²⁷⁰ As such, this Article recommends three harm reduction-oriented types of programming where local and state intervention would play a huge role in reducing the spread of HIV: needle exchange programs, sex education, and PrEP.

1. Broadening the Reach of Needle Exchange Programs

Along with the CDC,²⁷¹ the WHO, the UN Office on Drugs and Crime (UNODC), and the UNAIDS have long supported needle exchange programs to reduce HIV transmission via sharing infected syringes.²⁷² Despite this widespread enthusiasm, the federal government prohibited federal dollars

270. See Wiltz, *supra* note 121 (explaining that federal funding for HIV prevention lags in the South in part because organizations have been less successful in securing grant funding and that the region receives less money from private donations which tend to go towards the original epicenters of the disease).

271. *Syringe Service Programs (SSPs): Fact Sheet*, CTNS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/PUC6-W5S7>.

272. WORLD HEALTH ORG., UNITED NATIONS OFF. ON DRUGS & CRIME (UNODC), & UNAIDS, TECHNICAL GUIDE FOR COUNTRIES TO SET TARGETS FOR UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, AND CARE FOR INJECTION DRUG USERS 6 (2009), <https://perma.cc/GK9H-C62C> (PDF).

being spent on needle exchanges until late 2015 when, in light of the HIV outbreak in Indiana, Congress allowed funding for exchange programs—albeit not for needles themselves.²⁷³ Needle exchange programs were instrumental in containing and reducing the number of HIV infections in Scott County, Indiana: as a result, many previously adversarial lawmakers have warmed to the concept.²⁷⁴ Sustained expansion of needle exchange programs has nonetheless been slow, especially in the South.²⁷⁵

Kaiser Foundation data from 2018 shows that all but eleven states have some form of needle exchange program for a total of 320 nationally, but only ten of these jurisdictions have ten or more programs, while the remaining twenty-eight have between zero and three programs.²⁷⁶ The South contains just shy of 30 percent of needle exchange programs in the country with ninety-four.²⁷⁷ By contrast Australia, with a total population of about 20 percent of the South's population,²⁷⁸ has over three thousand syringe exchange programs.²⁷⁹

There is not an even distribution of these programs across the South: some states have over twenty, while nine southern states only have between one and four programs, and four have

273. Weinmeyer, *supra* note 259, at 253–55.

274. See *Syringe Exchange Program in Scott County, Indiana, Played Key Role in Controlling HIV Outbreak*, NEWS IUPUI (June 14, 2018), <https://perma.cc/SE93-4JP8>.

275. See Knight, *supra* note 40 (noting that thirteen states still have laws that make needle exchange programs illegal and even in those where it is legal some localities have worked to shut such programs down).

276. *Sterile Syringe Exchange Programs*, KAISER FAM. FOUND., <https://perma.cc/678W-JX9X>.

277. *Id.*

278. The 2010 census estimated that the South had over 114.5 million people living in the region whereas the total population of Australia was approximately 22.5 million. PAUL MACKUN & STEVEN WILSON, U.S. CENSUS BUREAU, POPULATION DISTRIBUTION AND CHANGE: 2000 TO 2010 1 (2011), <https://perma.cc/6FL9-MFVN> (PDF); AUSTRALIAN BUREAU OF STATISTICS, AUSTRALIAN DEMOGRAPHIC STATISTICS: DECEMBER QUARTER 2010 1 (2011), <https://perma.cc/6NKJ-U44Q> (PDF).

279. Josh Katz, *Why a City at the Center of the Opioid Crisis Gave Up a Tool to Fight It*, N.Y. TIMES (Apr. 27, 2018), <https://perma.cc/8XW6-PKRZ>.

none.²⁸⁰ People who inject drugs are often marginalized and may struggle to access programs outside of their community, let alone outside of their state. Additionally, some needle exchange programs have strict residency requirements, in part to prevent too many injection drug users from coming into the county.²⁸¹ This dearth of programs can pose challenges to organizations currently in operation. For example, a syringe exchange program in Charleston, West Virginia, recently closed due in part to criticisms that it was bringing too many drug users and too much crime into the city.²⁸²

Given the challenges southern non-profits and grassroots groups face in acquiring private grants and donations,²⁸³ states and municipalities should invest in these programs, recognizing the financial and health benefits that come with needle exchanges.²⁸⁴ This commitment requires disavowal of claims that needle exchange programs encourage drug use and increase negative externalities; claims that have been widely disproved.²⁸⁵ Increasing funding to existing programs and facilitating new ones would enable program patrons to access more services closer to home, especially in rural areas.²⁸⁶ Needle exchange programs are prime locations to also provide

280. *Sterile Syringe Exchange Programs*, *supra* note 276.

281. *See, e.g.*, Katz, *supra* note 279 (noting that county residency was one of several restrictions imposed in order to reduce the number of people able to access the sterile syringe services).

282. *See id.* (“In early March, the [Charleston] mayor began using his daily radio show to rally public sentiment against the [needle exchange program at the] health department, citing discarded needles and rising crime that he attributed to what he saw as a weekly influx of people using drugs.”).

283. *See supra* note 270 and accompanying text.

284. *See Access to Clean Syringes*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/W3LA-8BEU> (last updated Aug. 5, 2016) (referencing a study which found a return on investment for needle exchange programs of \$7.58 for every \$1 spent).

285. *See* Jonah Seligman, Comment, *Confronting a Crisis: An Appraisal of Legislation in Louisiana Combating the Opioid Epidemic*, 93 TUL. L. REV. 147, 169–70 (2018).

286. *See* REGINA LA BELLE, COMER FAM. FOUND., A GUIDE TO ESTABLISHING SYRINGE SERVICES PROGRAMS IN RURAL, AT-RISK AREAS 3 (2017), <https://perma.cc/CB4E-HG5H> (PDF) (noting that rural counties and predominately rural counties have fewer programs than more urban areas).

life-saving Narcan, HIV testing, condoms, hygiene products and other necessities, as well as education and information on safe sex and syringe use techniques, and referrals to medical and legal services to address longer term problems.²⁸⁷ Because needle exchanges are typically run by groups who have credibility in the community, patrons may be less skeptical of the resources they recommend.²⁸⁸

In order for this kind of expansion to be feasible, municipalities must revisit regulations put in place to decrease foot traffic, like limiting patrons to county residents, requiring valid photo ID, and placing limits on the amount of patrons that can attend in any given day.²⁸⁹ States may also need to scale

287. See Nicholas J. Golding, Note, *The Needle and the Damage Done: Indiana's Response to the 2015 HIV Epidemic and the Need to Change State and Federal Policies Regarding Needle Exchanges and Intravenous Drug Users*, 14 IND. HEALTH L. REV. 173, 176 (2017) (“These programs offer crucial services such as supplying clean needles to addicts, disposing of contaminated needles, providing on-site medical care, and testing for HIV, hepatitis C, and various other diseases commonly spread through intravenous drug use.”); Nicole Schill, Note, *The Fatal Shortcomings of Our Good Samaritan Overdose Statutes and Proposed Model Statute*, 25 CARDOZO J. EQUAL RTS. & SOC. JUST. 123, 136 (2018) (“[T]hese programs often work to reduce overall addiction rates by acting as a referral source for treatment programs and even providing drug counseling.”); Ungar, *supra* note 10 (describing how the HIV outbreak in Indiana was curbed due to places like syringe exchange program in Scotts County which “was part of a ‘one-stop shop,’ where people could also get drug treatment referrals, free HIV testing and other services”).

288. See Bob Curley, *Rural Areas Now Supporting Needle Exchange Programs—Here's Why*, HEALTHLINE (May 29, 2019), <https://perma.cc/8TVR-TB34> (“For better or worse, the migration of injection drug use from the inner city to suburbia and small-town America has helped break down the stigma that hampers adoption of programs like needle exchange.”); Ungar, *supra* note 10 (quoting a talk given by the Surgeon General who described how “dealing with the [Indiana HIV] outbreak was more about relationships than science” and that the needle exchange program would not have been successful without the support of community leaders and advocates).

289. See, e.g., Katz, *supra* note 279 (observing how the closure of the Charleston, West Virginia needle exchange program was rooted in its popularity: as a result, the health department imposed photo ID requirements, hepatitis C testing, and a one-for-one exchange policy before ultimately closing); *West Virginia City Approves Regulations for Needle Exchange*, ASSOCIATED PRESS (Sept. 6, 2019), <https://perma.cc/C3JC-DKKB> (describing requirements for a syringe exchange program in Clarksburg, West Virginia, as including showing photo identification, taking blood tests, and limiting the

back criminal laws relating to possession of drug paraphernalia in order to ensure that individuals heading to or from these programs—even those traveling a long distance—will not be criminally charged or have their parole revoked.²⁹⁰ Expanding needle exchange in prisons would also have a positive effect on HIV prevention for incarcerated individuals.²⁹¹ Implementation of all these policies will also require police officer training and buy-in.²⁹² From a harm reduction perspective, all of these changes hinge on the acceptance of high-risk and often taboo behaviors and center the safety of individuals over punitive responses.

Although the logic opposing harm reduction measures in the South has long been that they enable and encourage people to engage in high-risk behaviors,²⁹³ these attitudes have shifted

program to county residents in order to eliminate what the city's mayor called "negativities" associated with the program).

290. See Schill, *supra* note 287, at 136 ("[T]he effectiveness of syringe programs depends on the amnesty being provided to program participants for the possession of illegal syringes."); Alia Hoss, *Many State Laws Undermine Harm Reduction Strategies in the Opioid Crisis*, BILL HEALTH (July 20, 2018), <https://perma.cc/G896-RTJ3> (observing that, in addition to lacking immunity for paraphernalia-related crimes, "only 18 states provide protection from probation and parole violations in their overdose immunity laws").

291. See Abramson, *supra* note 262, at 696–98 (noting that due to the scarcity of needles in prison, prisoners are more likely to engage in the high-risk practice of sharing needles with multiple partners).

292. See, e.g., Henri Gendreau, *Roanoke Chief Supports New Needle Exchange Plan, Officials Say*, RICHMOND TIMES-DISPATCH (Apr. 13, 2019), <https://perma.cc/UCX4-ET7R> (describing how the implementation of a needle exchange program in Roanoke, Virginia faced several roadblocks before the police chief signed a letter of support). For examples of harm reduction-informed policing to address the opioid crisis, see Barbara Fedders, *Opioid Policing*, 94 IND. L.J. 389, 395 (2019); Steve Herbert et. al., *Policing Social Marginality: Contrasting Approaches*, 43 LAW & SOC. INQUIRY 1491, 1496 (2018); Katherine Beckett, *The Uses and Abuses of Police Discretion: Toward Harm Reduction Policing*, 10 HARV. L. & POL'Y REV. 77, 77 (2016).

293. See Katz, *supra* note 279 (explaining that while the research supporting the effectiveness of needle exchanges is "unambiguous," public leaders in Charleston, West Virginia, closed their last exchange program with the mayor calling it a "mini-mall for junkies and drug dealers"); Max Blau, *Southern States Slowly Embracing Harm Reduction to Curb Opioid Epidemic*, PEW RSCH. CTR. (April 15, 2019), <https://perma.cc/R7S2-5CM5> ("[I]n the Bible Belt, many Southerners who held conservative views often criticized harm

over time with the recognition that harm reduction measures can save both lives and money.²⁹⁴ While there are admittedly too few syringe exchange programs in the South, it is telling that the ninety that do exist have sprung up since 2014.²⁹⁵ Grassroots organizations have been paving the way, providing needles, drug works, and Narcan to communities in need.²⁹⁶ While some politicians, especially in the Deep South, continue to disparage harm reduction efforts,²⁹⁷ local authorities in some southern areas hard-hit by the opioid epidemic have expressed greater willingness to explore harm reduction strategies to prevent further public health crises.²⁹⁸

2. Expanding Sex Education

There is strong evidence that comprehensive evidence-based sex education and HIV prevention decrease risky sexual behaviors without encouraging or increasing sexual behavior among young people.²⁹⁹ These programs can have an even greater impact on the reduction of high-risk sexual activity

reduction as something that encouraged—not ended—the use of drugs. Those practices, in many states, were banned outright.”).

294. See Blau, *supra* note 293.

295. See *id.*

296. See *id.*

297. See *id.* (describing how state senators in Alabama and Louisiana have expressed continuing disapproval over measures they perceive as being soft on crime and lenient on drug users).

298. As a Fayetteville, Arkansas Police Department Captain observed, “This problem is so bad that we need to consider trying anything new.” *Id.*

299. See, e.g., Douglas B. Kirby et al., *Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People Throughout the World*, 40 J. ADOLESCENT HEALTH 206, 213–14 (2007) (reporting that “two thirds of [comprehensive sex education] programs had a significant positive impact on behavior” increasing condom use and delaying or reducing sexual activity and that only one of the fifty-two studies showed that the curriculum “hastened the initiation of sex”); Virginia A. Fonner et al., *School Based Sex Education and HIV Prevention in Low and Middle-Income Countries: A Systematic Review and Meta-Analysis*, 9 PLOS ONE 1, 16 (2014) (reviewing studies that assessed sexual education as a prevention tool).

when paired with in-school condom availability programs.³⁰⁰ Given that, nationally, the vast majority of young people who become HIV positive are men exposed to the virus through male-to-male sexual contact, sex and HIV education must include information on sex, STI and HIV risk, and protection in same-sex as well as opposite-sex encounters.³⁰¹ Very few young people nationally receive informative sex education that includes same-sex relationships and some of the youth who need it the most are living in states where these topics are either ignored or restricted.³⁰² Adopting a harm reduction lens would transform sexual health and same-sex sexual health from a taboo topic into a matter of urgency. A study from 2001 confirmed the benefits of inclusive HIV instruction in school, finding that LGBTQ students in schools with inclusive sexual health curricula were less likely to engage in risky sexual behaviors whereas LGBTQ students in schools without this programming “were at greater risk than all other youths for HIV infection, pregnancy, suicide, and victimization.”³⁰³ The changing of state laws and education regulations to require this kind of inclusive, pragmatic education would therefore have a positive impact on more than just HIV rates. From a harm reduction perspective, providing accurate and comprehensive

300. See Timothy Wang et al., *The Effects of School-Based Condom Availability Programs (CAPs) on Condom Acquisition, Use, and Sexual Behavior: A Systematic Review*, 22 AIDS BEHAV. 308, 317 (2018) (reviewing studies that show the effectiveness of condom availability programs).

301. See *HIV and Youth*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/8TAQ-KZ25> (indicating 92 percent of all new HIV diagnoses in young men come from male-to-male sexual contact).

302. See HUM. RTS. CAMPAIGN, *A CALL TO ACTION: LGBTQ YOUTH NEED INCLUSIVE SEX EDUCATION 1* (2015), <https://perma.cc/Y399-HKTB> (PDF) (revealing that only 12 percent of millennials surveyed indicate that their sex education classes included material on same-sex relationships).

303. Susan M. Blake et al., *Preventing Sexual Risk Behaviors Among Gay, Lesbian, and Bisexual Adolescents: The Benefits of Gay-Sensitive HIV Instruction in Schools*, 91 AM. J. PUB. HEALTH 940, 944 (2001).

information is a necessary strategy to reduce risks that flow from sexual activity.³⁰⁴

States across the nation vary in terms of whether sex education or HIV education are required,³⁰⁵ with decisions about curricula being decided by state legislatures and local school districts.³⁰⁶ Only twenty-seven states and Washington, D.C. mandate both sex education and HIV education in public schools.³⁰⁷ Nationally, less than half of high schools and even fewer middle schools teach all of the sexual health topics that the CDC recommends.³⁰⁸ As federal funding for STI prevention has been drastically reduced, states must reevaluate how they can reduce HIV and STI transmission through better sexual health education in school.³⁰⁹

In the South, eleven states and the District of Columbia mandate both sex and HIV education, but only North Carolina and Virginia require the information to be medically accurate.³¹⁰

304. *See id.* (noting that in addition to lowering risk for HIV, providing comprehensive sexual education made LGBTQ youths less likely to experience victimization, commit suicide, or become pregnant).

305. *See Sex and HIV Education: State Laws and Policies*, GUTTMACHER INST., <https://perma.cc/F747-BLR2> (last updated Oct. 12, 2020) (explaining that thirty states mandate sex education and thirty-seven states mandate HIV education).

306. *See* Rachel Rubenstein, Note, *Sex Education: Funding Facts, Not Fear*, 27 HEALTH MATRIX 525, 543 (2017) (“In some states, local school districts are given very broad discretion in creating curricula. Though this allows communities the benefit of addressing specific community needs Allowing this sort of discretion means that the curricula’s content depend on the whims of local leaders”). For an in-depth discussion of state-by-state distinctions, see generally Melody Alemansour et al., *Sex Education in Schools*, 20 GEO. J. GENDER & L. 467 (2019).

307. *Sex and HIV Education: State Laws and Policies*, *supra* note 305.

308. *New Findings from CDC Survey Suggest Too Few Schools Teach Prevention of HIV, STDs, Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 9, 2015), <https://perma.cc/WP3M-HLLE>.

309. *See* David C. Harvey, *Our Nation’s Deadly Disregard for Sexual Health*, HILL (Oct. 21, 2019), <https://perma.cc/H9GG-T2S4> (noting that federal funding for STD prevention has effectively been cut in half and nearly half of all local programs have had to cut budgets).

310. *See Sex and HIV Education: State Laws and Policies*, *supra* note 305 (listing the eleven states as Delaware, Florida, Georgia, Kentucky, Maryland,

By contrast, Tennessee requires sex education only in areas with high teen pregnancy rates, Mississippi will only allow school districts to include topics including contraception or STIs if the state Department of Education has granted permission, and Alabama requires HIV education but not sex education.³¹¹ Louisiana requires neither HIV education nor sex education.³¹² Alabama, South Carolina, Florida and Texas all require that, if provided in school, sex education must include negative information on LGBTQ orientation.³¹³ Twelve southern states also require that, when provided, sex education must stress the importance of abstinence and most of these states also require emphasizing the importance of having sex only once married.³¹⁴ Additionally, eight states and the District of Columbia all require any HIV education provided to cover information on abstinence without requiring any information be provided about condoms.³¹⁵

From a harm reduction perspective, this lack of evidence-based education is woefully inadequate: stressing abstinence and waiting until marriage ignores the reality that

North Carolina, South Carolina, Tennessee, Texas, Virginia, West Virginia, and the District of Columbia).

311. *Id.*

312. *Id.*

313. *Id.* More broadly, Alabama, Louisiana, Mississippi, Oklahoma, South Carolina, and Texas all restrict teaching LGBTQ-related topics in schools, beyond the sex education context. See HUM. RTS. CAMPAIGN, *supra* note 302, at 3 (explaining that this ranges from Arizona which “prohibits instruction that ‘promotes a homosexual life-style’” to Alabama which “require[s] teachers to ‘emphasize [. . .] that homosexuality is not a lifestyle acceptable to the general public’” (alteration in original)); see also Tiffany Pham, Comment, *Stepping Out of the Closet: Creating More Inclusive Sexual Education Instruction for Texas Public Schools*, 17 TEX. TECH ADMIN. L.J. 347, 352 (2016) (providing the background of the movement to prohibit the teaching of pro-LGBTQ curriculum in public schools).

314. See *Sex and HIV Education: State Laws and Policies*, *supra* note 305 (listing those twelve states as Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Texas).

315. See *id.* (listing those eight states as Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina, Tennessee, and the District of Columbia).

young people are having sex and gives them too few tools to protect themselves against HIV, STIs, pregnancy, and unhealthy sexual relationships. Given that the South has the highest teen birth rates³¹⁶ and non-HIV teen STI rates³¹⁷ in the country, there is ample evidence that the South's dominant model for state-level decisions regarding sex and HIV education has not been successful.³¹⁸ Not accounting for age, the South also has higher rates of STIs than the rest of the country, with 60 percent of the twenty cities with the highest STI rates being in the South.³¹⁹

3. Making PrEP Widely Accessible

As discussed above, a seronegative individual taking pre-exposure prophylaxis medication (“PrEP”) regularly can vastly reduce their risk of HIV infection through both sex and needle sharing. Making PrEP easily accessible hinges on both the recognition that people will be engaging in high-risk sexual or injection drug use behaviors and the desire to help those people avoid getting HIV. When abstaining from these risky behaviors is the first or only line of defense against HIV, PrEP may not be seen as a vital tool in HIV prevention. AIDSvU, an interactive HIV mapping tool, released data showing the rise in PrEP use across the country between 2012 and 2016.³²⁰ During that period, the number of PrEP users increased by 880 percent but “the growth and distribution of PrEP use has been

316. *Teen Birth Rate by State*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/QB3X-ZEX7> (last updated Apr. 28, 2020).

317. *Sexually Transmitted Disease Surveillance 2017: Adolescents and Young Adults*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/D3TM-AYW7> (last updated July 24, 2018). This data does not appear to be available for youth HIV rates across the United States.

318. *See supra* notes 310–317 and accompanying text.

319. Tim Barclay, *These U.S. Cities Have the Highest STD Rates*, INNERBODY, <https://perma.cc/L3CV-QSVA> (last updated July 30, 2020).

320. *See Mapping PrEP: First Ever Data on PrEP Users Across the U.S.*, AIDSvU, <https://perma.cc/3327-QF3F> (discussing a map “visualizing a 73 percent increase year over year in persons using PrEP across the U.S. from 2012 to 2016”).

inconsistent across different sexes, age groups, and geographic regions.”³²¹

In 2016, only 30 percent of PrEP users lived in the South, despite the region accounting for over 50 percent of new HIV diagnoses.³²² Given the South’s high diagnosis rate and low PrEP usage rate, the region has the “lowest PrEP-to-need ratio” in the country.³²³ This information is not surprising since the lowest rates of PrEP use have been found in those states that have not expanded Medicaid and have high rates of uninsured individuals and individuals living in poverty.³²⁴

A study of the only PrEP clinic in Birmingham, Alabama, between 2014 and 2016 found that Black patients, especially Black men who have sex with men, were vastly underrepresented at the clinic compared to rates of HIV infection.³²⁵ Increasing access to PrEP therefore must include culturally appropriate outreach and community-based support systems.³²⁶ Some cities in the South have recognized the need to build inclusive, intersectional infrastructures in order to make PrEP accessible and better understood: Atlanta, Houston, and Charlotte have all paired with the Black AIDS Institute to create PrEP learning collaboratives that bring stakeholders together to improve systems, collaborations, and access.³²⁷

321. *Id.*

322. *Id.*

323. See *PrEP Use Growing in US, but Not Reaching All Those in Need*, NAM AIDSMAP (Mar. 7, 2018), <https://perma.cc/8BUU-DCVP> (“PrEP is only reaching a small proportion of those who could benefit from it.”).

324. *Id.*

325. See Latehsa Elopra et al., *The Right People, Right Places, and Right Practices: Disparities in PrEP Access Among African American Men, Women and MSM in the Deep South*, 74 J. AIDS 56, 58 (2017) (finding that Black men who have sex with men comprised only 18 percent of patients but 50 percent of HIV infections).

326. See *id.* (recognizing that “structural barriers and cultural factors likely play a role” in HIV health disparities for Black men who have sex with other men).

327. See *Black Treatment Advocates Network (BTAN)*, BLACK AIDS INST., <https://perma.cc/H693-L7VT> (“The Black Treatment Advocates Network (BTAN) is a national network of HIV/AIDS stakeholders including service providers, community members and leaders, educators, and people living with

These collaborations have catalyzed the creation of dedicated clinics, referral systems, and partnerships to make sure that people who need PrEP are able to obtain it and comply with the regimen.³²⁸ These efforts should be emulated in other cities as well as rural areas across the South with explicit attention being paid to the cultural demographics and access barriers of the involved communities, including young people.³²⁹

Even with community buy-in and targeted outreach, widespread PrEP access across the South cannot be achieved without also expanding access to existing health insurance programs that provide free or affordable access to PrEP, such as Medicaid, which provides health insurance coverage to eligible low-income individuals and people with disabilities.³³⁰ The South has the highest number of states that have not expanded Medicaid.³³¹ Only half of the states in the South have done so: in fact, nine out of the thirteen states that did not expand Medicaid by 2020 are in the South.³³² Medicaid is crucial for PrEP access because both enrollees and providers can be educated through initial and continuing enrollment materials and provider manuals and newsletters, respectively, as well as through targeted outreach based on extensive data collection.³³³ Moreover, coverage benefits are extremely important: PrEP is

HIV/AIDS, who mobilize Black communities across the country to confront HIV.”).

328. *Id.*

329. See Jason Potter Burda, *Prep and Our Youth: Implications in Law and Policy*, 30 COLUM. J. GENDER & L. 295, 353 (2016) (“Ensuring PrEP acceptability among youth requires eliminating the stigma that attaches to those who use it. Doing so is best achieved through education . . .”).

330. See Emma Sophia Kay & Rogério M. Pinto, *Is Insurance a Barrier to HIV Preexposure Prophylaxis? Clarifying the Issue*, 110 AM. J. PUB. HEALTH. 61, 62 (2020) (“Medicaid covers PrEP and . . . PrEP is nearly free for low-income individuals.”).

331. *Find Medicaid Coverage in Your State*, HEALTHINSURANCE.ORG (Oct. 6, 2020), <https://perma.cc/F4DG-YBZN>.

332. *Id.*

333. See NAOMI SEILER, ENHANCING MEDICAID PROVIDER AND PATIENT ENGAGEMENT AND EDUCATION TO DELIVER PREP INTERVENTION SERVICES 2–3 (2019), <https://perma.cc/H3HS-YLYY> (PDF) (detailing how Medicaid managed care organizations provide educational and outreach tools).

covered for individuals on Medicaid and most private insurance companies,³³⁴ but even for those who are insured, the lack of a generic version and the more frequent lab work can create financial burdens.³³⁵ Even so, individuals who are insured are far more likely to use PrEP than those who are not.³³⁶ For those who are uninsured, PrEP can cost over \$1,800 per month and there is not currently a generic version,³³⁷ although Gilead Sciences—the company that makes Truvada, the only version of PrEP on the market—recently agreed to donate enough medication to cover 200,000 people a year.³³⁸ While ambitious, this is not nearly enough to cover all uninsured individuals who are at risk of getting HIV.³³⁹

Medicaid expansion would enable uninsured low-income individuals who do not currently qualify for Medicaid to obtain coverage.³⁴⁰ In addition to PrEP, this would also cover HIV

334. See Stephen Hicks, *Staying on PrEP Is Significantly Different for PrEP Users with Commercial Insurance Versus Medicaid*, BODY PRO (Mar. 13, 2019), <https://perma.cc/RHW9-M5YU> (discussing differences in PrEP usage between privately insured individuals and individuals on Medicaid); Berkeley Lovelace Jr., *Free Daily HIV Prevention Pills Will Soon Be Available to Private Insurance Holders*, CNBC (June 11, 2019, 1:50 PM), <https://perma.cc/3T2S-RQ6P> (reporting on PrEP's availability to privately insured individuals).

335. See Frost, *supra* note 75, at 329–30 (lamenting both PrEP's high cost for uninsured persons and PrEP users' "responsib[ility] for more frequent doctor visits and lab tests").

336. See RUPA R. PATEL ET AL., *IMPACT OF INSURANCE COVERAGE ON UTILIZATION OF PRE-EXPOSURE PROPHYLAXIS FOR HIV PREVENTION 1* (PLOS ONE 2017), <https://perma.cc/CWQ4-S5FC> (PDF) (“[I]nsured patients were four times as likely to use PrEP services compared to the uninsured.”).

337. Frost, *supra* note 75, at 329–30.

338. Press Release, Gilead, *Gilead Sciences to Provide Free Truvada for PrEP® to Support U.S. Initiative to End the HIV Epidemic* (May 9, 2019), <https://perma.cc/3GE9-NN3X> (PDF). The Gilead Advancing Access Program has also been helping individuals whose insurance did not cover PrEP to apply for financial assistance. *How Can You Get Help Paying for TRUVADA for PrEP?*, TRUVADA, <https://perma.cc/BGD2-B5V8>.

339. Press Release, Gilead, *supra* note 338 (sharing that only “200,000 of the estimated 1.1 million Americans who are at risk for HIV currently receive Truvada for PrEP”).

340. See *The Affordable Care Act and HIV/AIDS: Improving Access to Coverage*, HIV.GOV, <https://perma.cc/HDZ6-646T> (“Under the ACA, states

treatment, which would improve health outcomes for those living with HIV and decrease their viral load, ideally to the point of being untransmittable.³⁴¹ Some southern states like North Carolina show potential for rapid Medicaid expansion.³⁴² From a political economy perspective, it may seem challenging to find coalitions in non-expansion states willing to support Medicaid expansion: it is worth noting, however, that studies continue to demonstrate that doing so actually benefits both health outcomes³⁴³ and state budgets.³⁴⁴ Until more state legislatures are willing to embrace the fiscal benefits and improved health outcomes, states and municipalities must find ways to improve access to PrEP, like the “End the Epidemic” strategies being implemented in some southern jurisdictions to expand access and care.³⁴⁵

C. *Harm Reduction as a Catalyst for Decriminalization*

While the above recommendations center on mitigating primary harms that could arise while engaging in high-risk behavior like unprotected sex or needle sharing,

have the option . . . to expand Medicaid to generally include those with incomes at or below 138% of the Federal poverty line”)

341. See *id.* (“[T]he expansion of Medicaid to low-income childless adults is particularly important for many gay, bisexual, and other men who have sex with men (MSM) who were previously ineligible for Medicaid, and yet remain the population most affected by the HIV epidemic.”).

342. See Amanda Abrams, *North Carolina Could Finally Expand Medicaid*, SCALAWAG (July 22, 2019), <https://perma.cc/5EG9-C2WH> (recognizing Medicaid expansion’s bipartisan support in North Carolina).

343. See John A. Graves et al., *Medicaid Expansion Slowed Rates of Health Decline for Low-Income Adults in Southern States*, 39 HEALTH AFFS. 67, 75 (2020) (“Medicaid expansion was associated with lower rates of self-reported health declines and a higher likelihood of maintaining baseline health status over time.”).

344. See JESSE CROSS-CALL, *MEDICAID EXPANSION CONTINUES TO BENEFIT STATE BUDGETS, CONTRARY TO CRITICS’ CLAIMS 2* (Center on Budget & Policy Priorities 2018) <https://perma.cc/A29C-NESE> (PDF) (“Many state and independent analyses have found that [Medicaid] expansion produced *net savings* for state budgets”).

345. Jeremiah Johnson & Kenyon Farrow, *Ending the Epidemic Without Medicaid Expansion? How U.S. States Are Moving Ahead Without Full Health Care*, 24 TAGLINE 13, 13–16 (2017).

decriminalization pivots to the secondary harms imposed by the criminal legal system—especially on already marginalized and vulnerable individuals.³⁴⁶ The cost of these laws are high, especially given that an arrest publicizes an individual’s HIV status and possibly their sexual orientation even if they are ultimately found not guilty of any crime.³⁴⁷ Moreover, arrest, prosecution, conviction, imprisonment, and ensuing collateral consequences can each have the same devastating consequences they have on other individuals involved with the criminal legal system³⁴⁸ while incarceration and reentry also jeopardizes the health of people living with HIV.³⁴⁹ These laws must be critiqued from an additional harm reduction perspective as well: that they discourage people from getting tested in order to remain outside the scope of the laws, which require knowledge of one’s status.³⁵⁰ This then exposes the individuals opting out

346. See Katherine Beckett, *The Uses and Abuses of Police Discretion: Toward Harm Reduction Policing*, 10 HARV. L. & POL’Y REV. 77, 85–86 (2016) (“[F]rom a harm reduction point of view, the active intervention of the criminal justice system is often counterproductive and a source of damage.”).

347. See Hayley H. Fritchie, *Burning the Family Silver: A Plea to Reform Louisiana’s Antiquated HIV-Exposure Law*, 90 TUL. L. REV. 209, 223–24 (2015) (criticizing newspapers’ publishing HIV-related arrests because doing so creates needless stigmatization “when no crime has been committed”).

348. See Pinard, *supra* note 233, at 634–36 (2006) (detailing how the criminal legal system deteriorates individuals’ social, economic, and political access). See generally MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* (2010).

349. See S.E. Smith, *HIV Is Still a Big Problem in Prisons*, VICE (Jan. 2, 2018, 12:00 PM), <https://perma.cc/39KC-H8DK> (noting access to care during and after incarceration is extremely varied and unpredictable); Heather Boerner, *After Prison, Many People Living with HIV Go Without Treatment*, NAT’L PUB. RADIO (Oct. 9, 2018, 6:43 PM), <https://perma.cc/S8NU-GL2G> (discussing challenges to accessing health care when prison-issued prescriptions run out after reentry).

350. SEROPROJECT, *HIV CRIMINALIZATION DISCOURAGES HIV TESTING, CREATES DISABLING AND UNCERTAIN LEGAL ENVIRONMENT FOR PEOPLE WITH HIV IN U.S.* 1, 3 (2012), <https://perma.cc/ZCH6-SS3S> (PDF). A 2015 study demonstrated that states with HIV criminal laws in the media experience lower testing rates. See Sun Goo Lee, *Criminal Law and HIV Testing: Empirical Analysis of How At-Risk Individuals Respond to the Law*, 14 YALE J. HEALTH POL’Y L. & ETHICS 194, 194 (2015) (“[T]he number of people who reported that they had been tested for HIV is inversely correlated with the

of testing to the dangers of living with untreated HIV while also exposing their sexual or needle sharing partners to an extremely contagious form of the virus.

An individual arrested for HIV exposure—whether or not they did or could transmit the virus through sexual contact or syringe sharing—will have their serostatus and possibly their sexual orientation thrust into the public domain.³⁵¹ As with most arrested individuals, the arrest itself can be disruptive and can directly or indirectly result in the loss of employment, child custody, housing, and social standing.³⁵² Any sort of pre-trial detention heightens the risk and impact of those losses.³⁵³ A trial will only further publicize the defendant's health information—even if they prevail, the public record created by the process is likely to impact their professional and personal relationships for quite some time.³⁵⁴ If they are convicted and receive prison time—since in most states HIV exposure is a felony—they could spend years far away from friends, family, and high-quality medical professionals.³⁵⁵ Once they return,

frequency of newspaper coverage of criminalization of HIV-exposing behavior.”).

351. See *supra* note 347 and accompanying text.

352. See BETH E. RICHIE, *COMPELLED TO CRIME: THE GENDER ENTRAPMENT OF BATTERED BLACK WOMEN* 6 (1996) (chronicling how arrest and detention interrupt activities of daily life and inflict trauma); Eisha Jain, *Arrests as Regulation*, 67 *STAN. L. REV.* 809, 823–25 (2015) (discussing the far-ranging consequences of arrests that do not result in convictions).

353. See RICHIE, *supra* note 352, at 6 (recounting the pre-trial process as “characterized by long periods of waiting and by having to respond to police, court, and correctional officers . . . who treat . . . inmates with disgust and contempt”).

354. See Cross, *supra* note 235, at 123 (highlighting the negative outcomes from “publicity through high-profile cases in the news”).

355. See *Prisoners, HIV, and AIDS*, AVERT, <https://perma.cc/Y7TE-7MNT> (last updated Oct. 10, 2019) (“For prisoners living with HIV, adherence to antiretroviral treatment is often difficult and the everyday stresses of living in a prison can compromise an already weakened immune system, leading to poor health and risk of co-infections.”); Beth Schwartzapfel, *Why Some Prisoners with HIV Get Better Treatment than Others*, MARSHALL PROJECT (Mar. 29, 2016, 11:01 AM), <https://perma.cc/8H7M-6G4V> (exploring differences in HIV treatment between prisoners in Louisiana jails versus prisons).

they may find themselves hampered by collateral consequences including sex offender registration that dictate whether or where they will be able to find employment and housing, access public benefits, or reunite with their family.³⁵⁶ These are incredibly high costs for anyone involved in the criminal legal system to pay. Yet people living with HIV may incur them even if they were incapable of transmitting the disease³⁵⁷ or unable to share their status without fear of violence or retaliation from an intimate partner.³⁵⁸

These laws create significant challenges for people living with HIV. By virtue of the fact that they punish people who know they have HIV but do not disclose this fact, they can create a disincentive to get tested: studies have shown that fear of criminal intervention is one reason people cite for not testing.³⁵⁹ Another study found that states with HIV criminal laws covered in the media experience lower testing rates.³⁶⁰ Failure to get tested endangers both a person unaware of their status and thus not receiving medical attention and anyone with whom they engage in activities that pose a risk of transmission.³⁶¹ HIV criminalization laws also disincentivize post-sex disclosure for fear of prosecution even though doing so would enable a sexual

356. See Pinard, *supra* note 233, at 634–36 (listing the collateral consequences “that stem from the fact of conviction rather than from the sentence of the court”); Cross, *supra* note 235, at 124 (“Individuals coming home from jail or prison often face . . . difficulty obtaining public or private housing, denials of applications for professional licenses, voter disenfranchisement, and deportation of non-citizens.”).

357. See White, *supra* note 190, at 79; Norman L. Reimer, *Inside NACDL: NACDL’s Relentless Efforts to End Overcriminalization*, CHAMPION (June 2016), <https://perma.cc/2QQK-YQ85>.

358. See Cross, *supra* note 235, at 97 (“An initial diagnosis or notification of one’s status can open the door to a host of physical and emotional forms of retaliation.”).

359. See *supra* note 35 and accompanying text.

360. See Lee, *supra* note 350, at 194 (“[A]t-risk individuals’ HIV testing is associated with media coverage of criminalizing HIV-exposing behavior.”).

361. *HIV Basics: Testing*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://perma.cc/773R-7SQH> (last updated June 25, 2020).

partner to acquire medication that would reduce the risk of transmission even after exposure.³⁶²

The severity of harm created by HIV exposure laws is unjustifiable, especially in light of how much one's geographic location dictates what behavior is illegal, how likely criminal intervention is, and what kind of access to testing and treatment is available. Criminal exposure laws should be ratcheted down to only prohibit transmission that is both actual and intentional.³⁶³ That is, criminal exposure laws should only be able to punish someone who intends to transmit HIV to another and does in fact cause that person to become infected.³⁶⁴ Individuals whose viral loads are undetectable and therefore cannot transmit the virus should not fall within the ambit of

362. See Cox, *supra* note 145, at 22 (presenting a study that “suggest[s] that the threat of criminal prosecution drove some people . . . towards ‘increased anonymity’ in sexual relationships and reduced openness about HIV status, which could be detrimental to HIV prevention”).

363. See Shayo Buchanan, *supra* note 23, at 1339 (suggesting that HIV exposure laws should be decriminalized rather than intensified).

364. See Cross, *supra* note 235, at 132–33 (arguing for laws criminalizing only intentional and actual HIV transmission to “ensure[] that survivors of domestic violence with no intent to transmit HIV will remain beyond the ambit of the law” and eliminate liability for those who seek to prevent transmission but ultimately fail to do so). Phylogenetic testing determines the similarity of strands of HIV in different people: This would allow the prosecution to prove that the defendant actually transmitted HIV to the victim or would enable the defendant to defeat this claim of causation. See Erin E. Langley & Dominic J. Nardi, Jr., *The Irony of Outlawing AIDS: A Human Rights Argument Against the Criminalization of HIV Transmission*, 11 GEO. J. GENDER & L. 743, 788–89 (2010) (noting how other countries successfully use phylogenetic testing in criminal trials); EDWIN J. BERNARD ET AL., *THE USE OF PHYLOGENETIC ANALYSIS AS EVIDENCE IN CRIMINAL INVESTIGATION OF HIV TRANSMISSION 2* (2007), <https://perma.cc/DJY7-JKNC> (PDF) (“Phylogenetic analysis can be—and has been—used to exonerate individuals and exclude the possibility that the defendant was responsible for HIV transmission.”). This testing provides useful information though it must be noted that it is not definitive in its results. See W. Thomas Minahan, *Disclosure Before Exposure: A Review of Ohio’s HIV Criminalization Statutes*, 35 OHIO N.U. L. REV. 83, 89–90 (2009) (noting the potential for the virus to mutate or for the victim to have given it to the defendant). For a discussion of both actual and proximate cause in criminal law, see Adam J. Kolber, *The Bumpiness of Criminal Law*, 67 ALA. L. REV. 855, 867–69 (2016).

these laws, nor should individuals who engage in activities with partners they know to be on PrEP or using a condom.

At first blush, this may appear to suggest that HIV exposure laws should be amended to incorporate risk of transmission into either the elements of the crime itself or as an affirmative defense. Yet to shield treatment-adherent individuals from criminal liability, and not those who share a lack of intent to infect but do not have access to the same medication, would result in only the most marginalized being punished for engaging in the same behavior as others with greater means.³⁶⁵ The same individuals and communities that are at a heightened risk of getting HIV in the first place will remain most at risk for prosecution under laws that factor in risk prevention.³⁶⁶ Moreover, criminalizing behavior when there is no actual transmission of HIV raises questions as to what injury has been caused to the seronegative partner—the answers to which further stigma around associating with people living with HIV.³⁶⁷

One critique this proposal faces is that prosecutors could simply use general criminal statutes such as assault or attempted murder to prosecute those cases that do not constitute intentional infection.³⁶⁸ This problem, however, is not limited only to this proposal since prosecutors in states with exposure statutes are already using both HIV exposure and general criminal statutes.³⁶⁹ The decriminalization of

365. See Ahmed, *supra* note 27, at 629 (recognizing HIV laws' potential "disparate effect[s] on racial minorities who have less access to [medication]").

366. See *id.* at 651 ("[I]t is racial minorities and women, largely women of color, who bear the brunt of the epidemic and are least likely to be able to access care.").

367. See Lee, *supra* note 350, at 251 ("Statutes which criminalize behavior that cannot in any real sense transmit HIV . . . are not only needlessly overbroad. They also perpetuate mistaken conceptions of HIV/AIDS and hurt those living with the disease." (citation omitted)).

368. See Richardson, *supra* note 26, at 1203–04 ("[U]sing general statutes to prosecute HIV transmission can make it difficult to obtain a conviction or can lead to incongruous punishments." (citations omitted)).

369. See Martin, *supra* note 200, at 499 ("[T]wenty states . . . have enacted HIV-specific criminal statutes [and] have continued to prosecute HIV exposure under general criminal law as well.").

unintentional infection and any associated legislative history would at least demonstrate the legislature's commitment to shrinking the pool of punishable HIV exposure offenses—which would be fully undermined by charging the same behavior as a different criminal offense.³⁷⁰ Through training and advocacy, prosecutorial discretion, while potentially problematic in the context of HIV exposure and other crimes involving marginalized populations,³⁷¹ may be a useful tool in reining in continued HIV exposure prosecutions.³⁷² Additionally, failure to scale back HIV exposure laws or their enforcement may present opportunities ripe for jury nullification as modern medicine underscores the potential for unjust outcomes.³⁷³

Critics of ratcheting down to only criminalizing intentional transmission have argued that it can be challenging to prove specific intent to transmit.³⁷⁴ While there may be cases where

370. See *id.* at 498 (advocating for “assessing whether [general criminal] laws reflect an understanding of their impact on HIV-positive people and their communities, and whether the punishments inflicted are proportional to those imposed for comparable or more serious offenses”).

371. See, e.g., McArthur, *supra* note 4, at 736 (“[R]elying on prosecutorial discretion runs the risk that prosecutors will disproportionately pursue actions against disfavored groups such as racial and sexual minorities.”); Sara Potts, *A Double-Edged Sword: Oklahoma’s Transmission Statute and the Lack of Prosecutions for Intentional HIV Transmissions Against Homosexual Males*, 38 OKLA. CITY U. L. REV. 433, 450–51 (2013) (analyzing Oklahoma prosecutors’ failure to enforce HIV transmission outside of heterosexual couples as a way of protecting women and enshrining heterosexual relationships).

372. See Lazzarini et al., *supra* note 162, at 246–49 (demonstrating that prosecutors are already selective in their decisions about when to prosecute HIV exposure).

373. See Paul Butler, *Racially Based Jury Nullification: Black Power in the Criminal Justice System*, 105 YALE L.J. 677, 700 (1995) (explaining that jurors nullify “because the jury objects to the law that the defendant violated or to the application of the law to that defendant”); Adrien Leavitt, *Queering Jury Nullification: Using Jury Nullification as a Tool to Fight Against the Criminalization of Queer and Transgender People*, 10 SEATTLE J. FOR SOC. JUST. 709, 716 (2012) (arguing that, through jury nullification, “queer jurors and their allies will begin to ameliorate the harmful effects of the criminalization of non-heteronormative sexual and gender identities and simultaneously protect members of their community from the violence of prisons”).

374. See Richardson, *supra* note 26, at 1202 (“Other than the defendant stating that he intends to infect another person, there really is not a way to

this proves difficult, there have also been others where the defendant admits their intention or where the context makes their intentions clear.³⁷⁵ Intent in criminal cases is often inferred from circumstantial evidence in addition to more direct evidence.³⁷⁶ This kind of analysis has long been ubiquitous in criminal trials, for example when jurors must determine intent in a homicide.³⁷⁷

On the other hand, some advocates may argue that continuing to criminalize even intentional transmission is unjust. While some activists argue for the complete decriminalization of undisclosed HIV exposure, limiting criminalization to only the most egregious acts falls in line with recommendations from UNAIDS and other HIV advocates.³⁷⁸ Removing criminal penalties for unintentional exposure will mitigate fear associated with HIV testing and disclosing one's status. It also does not impact the ability of a victim of reckless yet unintentional infection to pursue tort remedies.³⁷⁹ Instead, it reflects the harm reduction-informed philosophy that public

show [intent to transmit]."); Van Puymbroeck, *supra* note 35, at 797 (recognizing "thorny issues of proof" such as proving intent and "issues surrounding consent and misrepresentation").

375. See Jane K. Stoeber, *Stories Absent from the Courtroom: Responding to Domestic Violence in the Context of HIV and AIDS*, 87 N.C. L. REV. 1157, 1179 (2009) ("One HIV-infected woman reported that her partner confessed to infecting her deliberately, explaining to her, 'I only did it because I love you so much.'").

376. See, e.g., *People v. Lauria*, 59 Cal. Rptr. 628, 631–32 (Cal. Ct. App. 1967) (noting that intent in conspiracy cases can be based on either direct evidence or circumstantial evidence).

377. See, e.g., Comment, *Lying in Wait Murder*, 6 STAN. L. REV. 345, 346–47 (1954) (discussing various intent levels required for different degrees of murder).

378. See Bernard, *supra* note 269 ("[T]here may be a limited role for criminal law in rare cases in which people transmit HIV with malicious intent"); UNAIDS, *supra* note 269 (promoting legal systems that "limit any application of criminal law to truly blameworthy cases where it is needed to achieve justice").

379. See Kaplan, *supra* note 55, at 1564–65 ("[T]ort law might provide a superior means of regulation."); Lee, *supra* note 350, at 245 (same); Shayo Buchanan, *supra* note 23, at 1271–72 (discussing how civil courts handle HIV-related tort cases).

health interventions will be more effective and less damaging than criminal interventions, even if it does require a shift away from tough-on-crime politics.

As states like Alabama grapple with overcrowded jails and federal demands to reduce its prison population,³⁸⁰ there is potential for tough-on-crime states to consider repealing laws that undermine the health and safety of their populace in order to reduce both spending and prison populations—as well as improving health outcomes from eliminating barriers to HIV testing. Data on incarceration rates from the recent narrowing of exposure statutes in both California and Iowa³⁸¹ may be persuasive as well.

CONCLUSION

The above recommendations would improve the health outcomes of both people at risk of getting HIV and people already living with HIV across the United States. In their own right, the adoption of any of these recommendations would help reduce the high rate of HIV by providing access to accurate health-related information, preventative measures, and medication. The ratcheting down of criminal laws used against people living with HIV would result in fewer arrests and prosecutions and would reduce new HIV infections by removing a disincentive to test and disclose. These recommendations embody a paradigm shift in which health, autonomy, and destigmatization would take priority over abandoning, shaming, and punishing those perceived as committing moral transgressions. At the same time, these recommendations

380. See Debbie Elliot, *Justice Dept. Finds Violence in Alabama Prisons 'Common, Cruel, Pervasive'*, NAT'L PUB. RADIO (Apr. 3, 2019), <https://perma.cc/N8LA-JM6H> (sharing a U.S. Department of Justice report on Alabama's prisons following a two-year civil rights investigation).

381. See *Governor Signs Bill Modernizing California HIV Laws*, LAMBDA LEGAL (Oct. 6, 2017), <https://perma.cc/476B-CSY8> (examining California's modernized legislative approach to HIV); William Widmer, *Iowa Scraps Harsh Criminalization Law in Historic Vote*, NBC NEWS (May 1, 2014), <https://perma.cc/S7W6-UQ2K> (heralding Iowa law's shift away from mandatory felony sentences and sex offender registration for persons sentenced for HIV transmission).

present an opportunity for fiscal reform which may be appealing to conservative members of state and local governments. In addition to the cost-saving that would occur through funding prevention programs rather than prolonged medical intervention,³⁸² scaling back criminalization laws will reduce the prison population and related costs,³⁸³ which only increase as the prison population grows older serving lengthy sentences.³⁸⁴

While nationally relevant, such a sea change is particularly necessary in the South, where state legislatures remain largely committed to addressing public health issues by punishing and shaming individuals navigating unintended health outcomes rather than providing supportive social and medical services. Chemical endangerment laws are a prime example of using criminal law to address a public health crisis: these laws impose harsh criminal penalties on pregnant people and post-partum individuals whose babies test positive for illegal drugs.³⁸⁵

382. See CTRS. FOR DISEASE CONTROL & PREVENTION, REDUCING HARMS FROM INJECTION DRUG USE & OPIOID USE DISORDER WITH SYRINGE SERVICES PROGRAMS 1 (2017) (noting that it costs over \$400,000 to treat someone with HIV over their lifetime). A 2014 cost-effectiveness analysis estimated that an annual investment of \$10 million nationwide would result in a lifetime treatment savings of nearly \$76 million and a return on investment of over \$7 for every \$1 spent. T.Q. Nguyen et al., *Syringe Exchange in the United States: A National Level Economic Evaluation of Hypothetical Increases in Investment*, 18 AIDS & BEHAV. 2144, 2150 (2014). An earlier study in New York City found that a needle exchange program would result in a one-year savings of approximately \$1,000–\$3,000 per client. H.K. Belani et al., *Cost Effectiveness of Needle and Syringe Exchange for the Prevention of HIV in New York City*, 7 J. HIV/AIDS & SOC. SERVS. 229, 235 (2008).

383. See VERA INST., THE PRICE OF PRISONS: EXAMINING STATE SPENDING TRENDS, 2010–2015, at 7 (2017) (summarizing the cost per inmate for prisons across the United States). While the national average cost per inmate is about \$33,000, it has been noted that the cost per prisoner in southern states is typically less than \$25,000 with Alabama being the least expensive at nearly \$15,000 per prisoner—which is still a significant amount per person. *Id.*

384. See Matt McKillop & Alex Boucher, *Aging Prison Populations Drive Up Costs*, PEW RSCH. CTR. (Feb. 20, 2018), <https://perma.cc/MDP6-8NYG> (placing the cost of incarcerating prisoners fifty-five and older at two to three times the national average).

385. See Kathryn A. Kellett, *Miscarriage of Justice: Prenatal Substance Abusers Need Treatment, Not Confinement Under Chemical Endangerment*

Alabama, South Carolina, and Tennessee have all prosecuted people for violation of these laws relatively recently.³⁸⁶ Between 2006 and 2015, Alabama prosecuted 479 people under its chemical endangerment law, a number significantly higher than the rest of the states combined.³⁸⁷ An even more recent example of this phenomenon is the passage of laws restricting or banning abortion access in six southern states.³⁸⁸ Rather than address the crisis of unwanted pregnancies via education and prevention, these states have turned to criminalization and humiliation to limit access to health care services.³⁸⁹ While these laws, which have so far been enjoined by federal courts, seek to punish health care providers rather than pregnant individuals, how they might ensnare individuals experiencing miscarriages, stillbirths, or self-induced abortions remains a cause for concern.³⁹⁰ As with HIV criminalization, chemical endangerment laws and abortion bans push marginalized individuals with unplanned health challenges away from seeking treatment out of fear of criminal ramifications and demonstrate the need for a public health-centered paradigm shift.

Adopting a harm reduction approach to these public health issues would shift the focus onto prevention and treatment,

Laws, 40 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 455, 459 (2014) (listing the states that categorize substance abuse while pregnant as “child abuse”).

386. Myrisha S. Lewis, *Criminalizing Substance Abuse and Undermining Roe v. Wade: The Tension Between Abortion Doctrine and the Criminalization of Prenatal Substance Abuse*, 23 WM. & MARY J. WOMEN & L. 185, 190–99 (2017).

387. Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, PROPUBLICA (Sept. 23, 2015), <https://perma.cc/7NR9-Q3EQ>; Katherine Koster, *Alabama’s Chemical Endangerment Laws: Where the War on Drugs Meets the War on Women*, HUFFPOST (Sept. 25, 2015), <https://perma.cc/QC2G-GVPU>.

388. See Susan Milligan, *A Guide to Abortion Laws by State*, U.S. NEWS & WORLD REP. (June 27, 2019), <https://perma.cc/JFJ2-HGUC>.

389. See Brianna Sacks, *For Women Trying to Get an Abortion in Alabama, “This System Is Designed To Humiliate You”*, BUZZFEED NEWS (June 1, 2019), <https://perma.cc/F4M3-678S> (discussing the difficulty of getting an abortion in Alabama).

390. See Deanna Paul & Emily Wax-Thibodeaux, *Could Miscarriages Land Women in Jail? Let’s Clarify These Georgia and Alabama Abortion Bills*, WASH. POST (May 12, 2019), <https://perma.cc/MB7B-EQ83> (discussing the potential consequences of proposed Alabama and Georgia abortion bills).

promoting better health outcomes and minimizing invasive and dangerous interactions with the criminal legal system. Given the many intersecting efforts to promote these practices and policies at the grassroots level throughout the South, municipal and state level efforts to do the same will benefit tremendously from the robust networks of potential partners and collaborators already in place.