Ending and Defending Against HIV Criminalization

A MANUAL FOR ADVOCATES

VOLUME 2

A Legal Toolkit: Resources for Attorneys Handling HIV-Related Prosecutions

THE CENTER FOR HIV LAW & POLICY

PositiveJusticeProject

IGNORANCE IS NO DEFENSE: A TOOLKIT FOR LEGAL ADVOCATES

RESOURCES FOR DEFENSE LAWYERS HANDLING HIV-RELATED PROSECUTIONS

THE CENTER FOR HIV LAW AND POLICY IS THE ORGANIZATIONAL HOME OF THE

PositiveJusticeProject

The **Positive Justice Project** (PJP) is a national coalition of organizations and individuals, including people living with or at greatest risk of HIV, those who have been arrested or prosecuted, medical and public health professionals, community organizers, advocates, attorneys, law enforcement, sex workers, social scientists and others working to end HIV criminalization in the United States. We engage in federal and state policy advocacy, resource creation, support of local advocates and attorneys working on HIV criminal cases, and educating, organizing and mobilizing communities and policy makers in the United States.

A primary goal of the PJP is to improve advocacy for HIV-positive people targeted for criminal prosecution through improved collaboration, strategy, coordination, resource-sharing and support for local advocates.

To join the PJP or become a member of the Center for HIV Law and Policy's HIV Legal Collaborative (a network of attorneys across the country) contact: rrichardson@hivlawandpolicy.org.

The **Center for HIV Law and Policy**, provides ongoing coordination of the Positive Justice Project with the active support of PJP's seven working group chairs and the many individual and organizational members of PJP. The Center for HIV Law and Policy is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV.

To learn more about our organization and access the Resource Bank,
visit our website at www.hivlawandpolicy.org.

To contact us:
Email at info@hivlawandpolicy.org.

Or write to:
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This Legal Advocate Toolkit is a resource for lawyers representing people living with HIV (PLWH) who are facing criminal prosecution based on HIV status. The Toolkit includes charts, articles, guidances, case law, legal analysis, scientific data and empirical citations. The Toolkit provides both quick-reference resources (e.g. a Chart on the Relative Risk of HIV and other STIs) and links to longer reference materials (e.g. sample briefs) that are located, along with a summary of each document, in our online Resource Bank.

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HIV Criminalization Fact Sheet

MOST STATES HAVE TARGETED HIV-POSITIVE INDIVIDUALS FOR CRIMINAL LIABILITY BASED ON THEIR HIV STATUS

- Dozens of states explicitly criminalize HIV exposure through sex, shared needles, or in some states, exposure to "bodily fluids" that can include saliva. Many states have singled out people who have tested positive for HIV for criminal prosecution or enhanced sentences, either under HIV-specific criminal laws or under general criminal laws governing crimes such as assault, attempted murder or reckless endangerment.
- Proof or intent to transmit HIV, or actual transmission, typically are not elements of these prosecutions.
- Spitting or biting, which pose no significant risk of HIV transmission, have resulted in criminal convictions and severe sentences despite the absence of HIV transmission in these cases.
- Disclosure is often the only affirmative defense to prosecution, but typically is difficult to prove. Condom use is rarely a defense.
- The common factor in all of these cases is that the criminal defendant knew her/his HIV status.
- Also common to these cases is severe ignorance of the routes and actual risk of HIV transmission in varying circumstances, and grossly exaggerated characterizations of the risk of harm defendants pose.

CRIMINALIZATION HAS NO POSITIVE EFFECT ON BEHAVIOR & UNDERMINES PUBLIC HEALTH GOALS

- Studies show that the criminalization of HIV exposure has no effect on risk behavior.
- HIV criminalization can discourage individuals from seeking testing and treatment because a positive test result subjects a person to criminal liability for otherwise non-criminal conduct.
- Health care providers frequently are forced to disclose HIV-related medical records, including documentation of private communications, as part of a criminal investigation or trial, interfering with the physician-patient relationship and the delivery of health services and generating mistrust among patients.
- In some states, health officials actually participate in creation of evidence that can be used against individuals with HIV, by requiring them to sign forms acknowledging criminal liability if they engage in certain otherwise-legal conduct.
- Sex between two consenting adults is a shared decision; the responsibility for protection against disease should not be borne by one partner. Placing exclusive responsibility on the person living with HIV undermines public health messages that everyone should take responsibility for individual sexual health.
- Criminalization further stigmatizes an already marginalized population, and reinforces ignorance and unfounded beliefs about the routes and actual risks of HIV transmission.

HIV PROSECUTIONS DISCRIMINATE AGAINST HIV-POSITIVE PERSONS

- Charges for HIV exposure often are accompanied by sensationalist media coverage, which often includes disclosure of the HIV-positive person's identity, disclosing the person's HIV status not only to the individual's community but also, with the internet, to the world.
- Sentences for people convicted of HIV exposure are typically very harsh and grossly disproportionate to any actual or potential harm, perpetuating the misconception that people with HIV are toxic, highly infectious and dangerous.
- HIV-positive persons increasingly are forced to register as sex offenders after conviction, leading to a host of life-long problems with future employment, living conditions, and the right to privacy.
- HIV exposure laws are applied unfairly and selectively, targeting those who are socially and economically marginalized, such as sex workers, while those with other STIs or infectious diseases are not targeted.

Guidance for a Legal Advocate Representing an HIV-Positive Client in a Criminal Exposure Case

The elements of criminal HIV exposure statutes vary by jurisdiction. Most penalize defendants when they do not disclose their HIV status before having specific kinds of contact with another person. What defines disclosure, and whether or not it took place, is often at the center of criminal cases.

The risk of actual harm is also at issue in some cases, especially when the defendant is on antiretroviral therapy and has an undetectable viral load. Although it is not impossible for someone with a low viral load to transmit HIV, experts agree that a low viral load significantly reduces the risk of HIV transmission. Use of a condom during sex also greatly reduces the transmission risk. Spitting or biting pose virtually zero risk of HIV transmission, and there has never been a single documented case of HIV transmission via saliva.

After identifying the elements of the offense with which the client is charged, and determining what the prosecution will need to prove, it may be helpful to have some or all of the following information about the client:

- ❑ When was s/he diagnosed as being HIV-positive?
- ❑ After diagnosis, was s/he counseled about the modes of HIV transmission and prevention methods?
- ❑ Is s/he on antiretroviral therapy?
- ❑ Was s/he on antiretroviral therapy at the time of the alleged contact?
- ❑ Did s/he tell the other person that s/he was HIV-positive?
- ❑ If not, why not?
- ❑ Would the other person have some other way of knowing about her/his HIV status?
- ❑ What type of contact was involved (sex, spitting, biting, etc.)?
- ❑ Did the other person consent to the contact?
- ❑ Did the other person consent to the contact after knowing that s/he was HIV-positive?
- ❑ If the contact involved sex, was a condom used?
- ❑ What kind of sex was involved (vaginal, anal, oral)?
- ❑ If state law criminalizes exposing others to HIV in any way, did s/he know about the law?

It will also be helpful in most cases to prepare or obtain the following (in addition to relevant case law, statutes, and regulations):

- ❑ Information from a reliable source, such as a federal, state, or local health department, about the relative HIV transmission risks of various conduct.
- ❑ Testimony or affidavit from a medical expert about HIV transmission, including language indicating that HIV is not transmitted via casual contact, HIV is not transmitted via spitting or biting, and HIV is less likely to be transmitted when a condom is used or when a person's viral load is undetectable.

Guidance for People Living with HIV Who Are Threatened with, or Are Facing, Criminal Prosecution for HIV Nondisclosure or Exposure

Dozens of states and territories have laws that criminalize HIV exposure and/or nondisclosure of HIV status for sexual contact, needle-sharing, and/or contact with "body fluids" such as saliva. Even where there are no laws specifically addressing HIV exposure or nondisclosure of status, individuals living with HIV have been prosecuted under general criminal laws, such as assault or attempted murder. Although these laws criminalize conduct that is either consensual (both people agree to it) or involves no significant risk of HIV transmission, these laws make people with HIV vulnerable to prosecution simply for being HIV positive.

If you think you might be in danger of being arrested and charged with a crime for nondisclosure or exposing another person to HIV, there are some things you can do as "damage control:"

- **DO try to have proof that you told your partner your HIV status BEFORE SEX**– for example, a diary entry, having your partner agree to video or write an agreement that he/she knows your HIV status. Regularly document how you have complied with the law. The impact that disclosure can have on intimacy, or the "heat of the moment" may make this step unrealistic. However, it is one important way that you may be able to fight a conviction, depending on the law in your state. If you are using condoms, it also can be helpful to keep a record of that (for instance in a diary). Remember, for proof of your HIV status disclosure to be useful, it has to happen BEFORE sex. An email that confirms this, if you are comfortable with the risk that emails can be widely circulated, can also serve as proof. Be aware that even if you disclosed your status on your profile or in chats on a website such as Adam4Adam or Match there may not be a permanent record of that disclosure. Make sure that if you are disclosing your status to people online that you get a screenshot of that conversation (with the date and time) of your disclosure.

- **DO NOT EMAIL anything that ever could be used against** you or that shows a desire to keep your HIV status secret, or about any worries you have about revealing your HIV status to a partner.

- **DO discuss and confirm with your health care provider that you disclose your status to partners before sex**, and make sure that your provider documents this in your medical records. If you actually can take a potential partner to your doctor or case manager to document HIV status disclosure and counseling before sex, that is ideal, but may not be practical in most instances. Taking your partner with you to a doctor or counselor after sex will not protect you from accusations that you had sex with a partner without disclosing your HIV, or even from criminal exposure charges in states where condom use in not a defense, although it may help if the law in your state only makes it a crime to not use protection, such as condoms.

- **DO tell your doctor and other health care providers to NOT disclose or discuss your medical information to the police** without a court order (different from a subpoena), and only after you and/or your health care provider have had the opportunity to oppose the court order for your records. Let them know that they should tell you immediately if they are contacted by the police or other law enforcement

personnel, and that you expect them to defend against the disclosure of your personal records to the police or a prosecutor.

- **KNOW the law in your state.** Find out what the laws are in your state. Talk to staff at an HIV legal organization in your state that understands criminal law, or look at the information online at The Center for HIV Law and Policy, which has a guide on every state and U.S. territory's HIV-specific laws and other laws that have been used to prosecute people with HIV, as well as what has happened in each state with respect to HIV-specific prosecutions. Go to: https://www.hivlawandpolicy.org/sourcebook.

- **CONSIDER lining up a lawyer**. If you have the money, you can try to identify an experienced criminal defense lawyer. Talking to a lawyer can help you understand your rights in your state and what you can do if you think you might be in danger of being arrested. However, if you have *not* been arrested or charged and do not have money for a private attorney, you generally will not be able to get advice from a criminal defense attorney at this stage.
  You can find a lawyer by going to the resources listed below, or in some instances by asking a case manager or social worker at an AIDS Service Organization (ASO) for help.

- **DO NOT TALK** to the police or answer questions about your situation without a lawyer. If you are questioned or approached before being arrested, do not say anything other than politely asking if you are being charged with a crime.

- **DO NOT TELL** the police or detective that you are HIV positive and DO NOT consent to an HIV test. Be polite, but do not talk!

If you are arrested and charged with an HIV-related crime:

- **DO NOT TALK TO THE POLICE. DO NOT VOLUNTEER ANY INFORMATION, OR ANSWER ANY QUESTIONS**. If you are on medications that you must have, try to have a friend or relative contact your doctor to get confirmation to the jail medical staff that you have a health condition that requires regular medication, along with the needed medications. ALL YOU SHOULD SAY TO A POLICE OFFICER OR DETECTIVE WHEN ASKED QUESTIONS IS THAT YOU WOULD FIRST LIKE TO SPEAK WITH AN ATTORNEY. Do not believe anything you are told about how things will go more easily if you talk, or more harshly if you do not – this is virtually never the case. Providing information about your situation without getting a lawyer's advice first is NEVER to your advantage. It is the prosecutor's job to prove that you are guilty of a crime -- do not help them.

- **KNOW YOUR RIGHTS.** You have the right not to say anything to the police or anyone else. You also have the right to speak with a lawyer. If you cannot afford to hire a lawyer, the state must provide one for you. A lawyer can explain your rights to you and help advise you on how to defend yourself. Remember, be polite, but be quiet.

- **UNDERSTAND THE CHARGES AGAINST YOU.** If you are arrested, make sure you ask what you are being accused of doing. The best person you can ask to explain the charges against you is a lawyer, but always ask for any available written information about the complaint or charges against you. If you will be assigned a public defender, it may take several days after your arrest for a lawyer to be assigned to you.

- **TAKE THE CHARGES SERIOUSLY.** Being charged with a crime can have many negative consequences. Do not delay in finding help and support from organizations or individuals who may be able to counsel and support you without charge, such as the Center for HIV Law and Policy, www.hivlawandpolicy.org, and others (see list below for additional examples).

- **DO NOT ASSUME THAT A PRIVATE ATTORNEY IS BETTER THAN A PUBLIC DEFENDER.** One of the most frequent mistakes that people make is assuming that a private attorney is better than a public defender. The fact that you are paying for a lawyer does not mean that you are getting better representation. The best lawyer is one that has experience in the county or area where you have been arrested, who knows and has worked with the local law enforcement officials where your case is, and who is familiar with HIV and/or willing to work with other professionals who are. The most important thing here is to have a smart, EXPERIENCED CRIMINAL DEFENSE ATTORNEY who will take your case seriously.

- **AVOID PEOPLE WHO SAY THEY CAN HELP YOU BECAUSE HIV DOES NOT CAUSE AIDS**. You may be approached by people who claim they want to help you because an HIV test does not prove that you have HIV or AIDS, or because HIV is not harmful to others. AIDS "denialists" -- people who do not believe that HIV is the cause of AIDS and that all AIDS treatments are toxic -- frequently approach defendants in cases that have received press coverage, and may be interested in using your case to advance their cause. These people should be avoided because they likely will hurt rather than help your case.

- **DO NOT SPEAK TO THE PRESS.** Refer all questions to your lawyer. If you don't yet have a lawyer, say you will have your lawyer get in touch when possible. A surprising number of people in the media are not careful about getting the facts correct. It is not at all unusual to be misquoted. Many press people are more interested in a sensational story than in getting the story right. IT IS VERY RARE THAT A PERSON IN THE PRESS WILL PUT YOUR INTERESTS FIRST AND A GREAT STORY SECOND.

Resources

For lists of public defender offices, legal aid programs, and legal research resources, visit the web site of the National Legal Aid and Defender Association (NLADA) at www.nlada.org and click on "Links" at the bottom of the page. For information about HIV specific laws and prosecutions, please see the Center for HIV Law and Policy website at www.hivlawandpolicy.org.

DIRECT LINKS

List of state public defender offices:
http://www.nlada.org/Links/Links_Home#links_IndigentDefense

List of legal aid programs:
http://www.nlada.org/Links/Links_Home#links_LegalAidPrograms

List of legal research resources:
http://www.nlada.org/Links/Links_Home#links_LegalResearch

Manual on HIV criminal laws and prosecutions:
http://www.hivlawandpolicy.org/resources/view/564

Some other organizations that can advise you before, or when, you are charged with a criminal HIV nondisclosure or HIV exposure crime:
ACLU AIDS Project, www.aclu.org/hiv-aids (national)
AIDS Law Project of Pennsylvania, www.aidslawpa.org (Pennsylvania)
Center for HIV Law and Policy (CHLP), www.hivlawandpolicy.org
GLAD, www.glad.org (New England area)
HIV Law Project, www.hivlawproject.org (New York)
Lambda Legal, www.lambdalegal.org (national)
Whitman-Walker Legal Services Clinic, www.wwc.org/hiv_aids_services/legal_services.html (Washington, DC metropolitan area)

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- **U.S. v. Banks, 36 M.J. 1003 (A.C.M.R. 1993)**
- **U.S. v. Barrows, 48 M.J. 783 (A. Ct. Army Crim. App. 1998)**
- **U.S. v. Bygrave, 46 M.J. 491 (1997)**
- **U.S. v. Dacus, 66 M.J. 235 (C.A.A.F. 2008)**
- **U.S. v. Dumford, 30 M.J. 137 (CMA 1990)**
- **U.S. v. Ebanks, 29 M.J. 926 (A.F.C.M.R. 1989)**
- **U.S. v. Edwards, 1996 CCA Lexis 224 (A.C.M. 1996)**
- **U.S. v. Goldsmith, A.C.M 31172, 1995 WL 730266 (A.F. Ct. Crim.App. 1995)**
- **U.S. v. Hall, 34 M.J. 695 (A.C.M.R. 1991) decision set aside, 36 M.J. 80 (C.M.A. 1992)**
- **U.S. v. Heyward, 20100610, 2012 WL 346635 (A. Ct. Crim. App. Jan. 31, 2012)**
- **United States v. Hurts, 2014 CCA LEXIS 284 (2014)**
- **U.S. v. Johnson, 27 M.J. 798 (AFCMR 1988)**
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- **U.S. v. Jones, 44 M.J. 103 (C.A.A.F. 1996)**
- **U.S. v. Joseph, 37 M.J. 392 (C.M.A. 1993)**
- **U.S. v. Klauck, 47 M.J. 24 (C.A.A.F. 1997)**
- **U.S. v. Morris, 25 M.J. 579 (A.C.M.R. 1987)**
- **U.S. v. Morris, 30 M.J. 1221 (ACMR 1990)**
- **U.S. v. Napier, NMCCA 200300805, 2005 WL 1473959 (N-M. Ct. Crim. App. 2005)**
- **U.S. v. Negron, 28 M.J. 775 (ACMR 1989)**
- **U.S. v. Perez, 33 M.J. 1050 (A.C.M.R. 1991).**
- **U.S. v. Pritchard, 45 M.J. 126 (C.A.A.F 1996)**
- **U.S. v. Reister, 40 M.J. 666 (N-M. C.M.R. 1994) aff'd, 44 M.J. 409 (C.A.A.F. 1996)**
- **U.S. v. Sargeant, 29 M.J. 812 (A.C.M.R. 1989)**
- **U.S. v. Schoolfield, 40 M.J. 132 (CMA 1994)**
- **U.S. v. Sorey, NMCCA9901186, 2004 WL 49093**
- **U.S. v. Stewart, 29 M.J. 92 (C.M.A. 1989)**
- **United States v. Stevens, 2013 WL 5844657 (N.M. Ct. Crim. App. 2013)**
- **U.S. v. Tootle, NMCCA 9801945, 2005 WL 3215251 (N-M. Ct. Crim. App. 2005)**
- **U.S. v. Upham, 66 M.J. 83 (C.A.A.F. 2008), aff'g 64 M.J. 547 (C.G. Ct. Crim. App. 2006)**
- **U.S. v. Walker, ACM 29757, 1993 WL 245166 (A.C.F.M.R. 1993)**
- **U.S. v. Womack, 29 M.J. 88 (C.M.A. 1989)**
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- **United States v. Hurts, 2014 CCA LEXIS 284 (2014)**

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- **Boyer v. Belleque, 659 F.3d 957 (9th Cir. 2011)**
- **Carmona v. Connolly, 2011 WL 1748694 (S.D.N.Y., July 12, 2011)**
- **Doe, et al. v. Jindal, et al., No. 11-388 (E.D. La. Mar. 29, 2012)**

- **U.S. v. Burnett, 545 F.Supp.2d 1207 (N.D. Ala. 2008)**

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- **Brock v. State, 555 So.2d 285, 288 (Ala. Crim. App. 1989)**

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- **L.A.P. v. State, 62 So. 3d 693 (Fla. Dist. Ct. App. 2011)**
- **State v. D.C., 114 So.3d 440, (Fla. Dist. Ct. App. 2013)**
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- **Scroggins v. State, 401 S.E.2d 13 (Ga. Ct. App. 1990)**

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- **State v. Mubita, 188 P.3d 867 (Idaho 2008)**
- **State v. Thomas, 983 P.2d 245 (Idaho Ct. App. 1999)**

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- **People v. Allen, No. 2009-4960 (Macomb County Ct. Mich. Cir. Ct. June 2, 2010)**
- **People v. Dempsey, 610 N.E.2d 208 (Ill. App. 5 Dist. 1993)**
- **People v. Russell, 630 N.E. 2d 794 (Ill. 1994)**

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- **Iowa Court of Appeals decision in Rhoades v. Iowa**
- **Musser v. Mapes, 2012 U.S. Dist. LEXIS 50535 (S.D. Iowa, April 11, 2012)**
- **Rhoades v. State of Iowa (Iowa Supreme Court June 13, 2014)**
- **State v. Musser, 721 N.W.2d 734, 741 (Iowa 2006)**
- **State v. Musser, No. 04-0719 (Iowa 2006)**
- **State v. Tabor, No. 0-906 / 10-0475 (Iowa Ct. App. 2011)**

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- **State v. Richardson, 209 P.3d 696 (Kan. 2009)**

Louisiana

- **State v. Caine, 652 So.2d 611 (La. Ct. App. 1995)**
- **State v. Schmidt, 771 So.2d 131 (La. Ct. App. 2000)**
- **State v. Turner, 2012-668 (La. App. 3 Cir. 12/5/12); 103 So.3d 1258**

Maryland

- **Smallwood v. State, 680 A.2d 512 (Md. 1996)**

Michigan

- **People v. Allen, No. 2009-4960 (Macomb County Ct. Mich. Cir. Ct. June 2, 2010)**
- **People v. Odom, 276 Mich. App. 407, 740 N.W. 2d 557 (2007)**

Minnesota

- **State v. Rick, 821 N.W.2d 610 (2012)**
- **State of Minnesota v. Rick, A12-0058 (Minnesota 2013)**

Missouri

- **Sykes v. Missouri, WD7356 (W.D. Mo., Apr. 17, 2012)**
- **Doe v. Quest Diagnostics, Inc., ED96516, 2012 WL 2393684 (2012)**

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- **State of New Jersey v. C.M., 2013 N.J. Super. Unpub. LEXIS 1760 (2013)**

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- **State v. Jones, 3 P.3d 142 (N.M. Ct. App. 2000)**

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- **People v. Williams, Memorandum and Order (N.Y. App. Div. Nov. 15, 2013)**
- **State of New York v. Nushawn Williams a/k/a Shyteek Johnson, DIN 98A5318 (Decision/Order issued Feb. 26, 2014)**
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- **State v. Bird, 692 N.E.2d 1013 (Ohio 1998)**
- **State v. Branch, WL 204591 (Ohio Ct. App. 2006)**
- **State of Ohio v. Constance Reif-Hill, No. 72864, 1998 WL 787389 (Ohio Ct. App. Nov. 12, 1998)**
- **State v. Eversole, __ N.E.2d __, 2009 WL 1264295 (Ohio Ct. App. 2009)**
- **State of Ohio v. Henry Couturier, 2000 Ohio App. Lexis 2677 (Ohio Ct. App. June 22, 2000)**
- **State of Ohio v. MorRondo J. Roberts, 805 N.E.2d 594 (Ohio Ct. App. 2004)**
- **State v. Price, 162 Ohio App. 3d 677 (Ohio Ct. App. 2005)**
- **State v. Thompson, 726 N.E.2d 530 (Ohio Ct. App. 1999)**

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- **State v. Guayante, 783 P.2d 1030 (Or. Ct. App. 1989)**
- **State v. Hinkhouse, 912 P.2d 921 (Or. Ct. App. 1996)**

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- **State v. Ingram, 2012 Tenn. Crim. App. LEXIS 887 (2012)**

Texas

- **Campbell v. State, 2009 WL 2025344 (Tex. App. 2009)**

Washington

- **State v. Ferguson, 15 P.3d 1271 (Wash. 2001)**
- **State v. Whitfield, 134 P.3d 1203 (Wash. Ct. App. 2006)**

LEGAL DRAFTING RESOURCES

Sample Briefs

- **Michigan v. D.A., Amicus Brief, Michigan Circuit Court, The American Civil Liberties Union Fund of Michigan**
  This amicus brief argued that a Michigan bioterrorism statute should not be applied to an HIV-positive individual who allegedly bit another individual while the two were fighting. The case was the first time a bioterrorism statute has been used to prosecute a person living with HIV.

- **People v. Allen - Amicus Brief, Macomb County Circuit Court, Lambda Legal, Community AIDS Resource and Education Services, Michigan Positive Action Coalition and Michigan Protection and Advocacy Service, Inc.**
  This amicus curiae brief was submitted on behalf of an HIV-positive man in Michigan charged with bioterrorism after biting his neighbor.

- **Rhoades v. State of Iowa, Amicus Brief, Supreme Court of Iowa, National Alliance of State and Territorial AIDS Directors, The Center for HIV Law and Policy, HIV Law Project**
  National Alliance of State and Territorial AIDS Directors, The Center for HIV Law and Policy, and HIV Law Project submitted this amicus brief in support of Nick Rhoades in his appeal of the denial of his petition for post-conviction relief. Rhoades was convicted of criminal transmission of HIV under Iowa Code § 701C.1 after a one-time consensual sexual encounter that occurred prior to disclosure of his HIV status.

- **Rhoades v. State of Iowa, Opening Brief of Applicant/ Appellant and Request for Oral Argument, Supreme Court of Iowa, Glazebrook & Moe, LLP; Lambda Legal**
  This is an opening brief and request for oral argument to the Supreme Court of Iowa in a 2012 appeal of the denial of an application for post-conviction relief. The defendant was convicted of criminal transmission of HIV under Iowa Code § 701C.1 after a one-time consensual sexual encounter that occurred prior to disclosure of his HIV status.

- **Rhoades v. State of Iowa, Reply Brief of Appellant Nick Rhoades, Supreme Court of Iowa, Glazebrook & Moe, LLP; Lambda Legal**
  This is a reply brief to a 2012 appeal of the denial of an application for post-conviction relief. The defendant was convicted of criminal transmission of HIV under Iowa Code § 701C.1 after a one-time consensual sexual encounter that occurred prior to disclosure of his HIV status.

- **Rhoades v. State of Iowa, Appellee's Brief and Conditional Notice of Oral Argument, Supreme Court of Iowa, State of Iowa**
  The State of Iowa's response brief to the Supreme Court of Iowa in Nick Rhoades's 2012 appeal of the denial of his application for post-conviction relief. In 2008, Rhoades was convicted of criminal transmission of HIV under Iowa Code § 701C.1 after a one-time consensual sexual encounter that occurred prior to disclosure of his HIV status.

- **State v. Bird, Amicus Brief, Supreme Court of Ohio, Lambda Legal**
  This amicus brief was submitted on behalf of an HIV-positive defendant in an appeal of a criminal conviction for assault with a deadly weapon for spitting in a police officer's face.

- **State v. Rick, Amicus Brief, Minnesota Supreme Court, American Civil Liberties Union, The Center for HIV Law and Policy, Lambda Legal, OutFront Minnesota**
  This amicus brief was submitted on behalf of an HIV-positive defendant in an appeal of a criminal conviction under subsection 2 of Minnesota Statute Sec. 609.2241, which prohibits the "transfer of bodily fluids" of those with HIV and other contagious diseases, and another section of the law prohibiting sexual penetration without prior disclosure of one's disease status.

- **United States v. Ms. T (anonym), Amicus Brief, U.S. District Court for the District of Maine, National Advocates for Pregnant Women, Center for HIV Law and Policy, Verrill Dana, LLP on behalf of Medical, Public Health and HIV Experts and Advocates**
  This amicus brief argued that a federal judge improperly relied on a woman's HIV positive status and pregnancy to determine the length of her jail sentence.

- **X v. The People of New York State (N.Y. App. Div.) - Amicus Brief, New York Court of Appeals, Lambda Legal, American Academy of HIV Medicine, Association of Nurses in AIDS Care and HIV Medicine Association**
  This amicus curiae brief supports the dismissal of an aggravated assault criminal charge against an HIV-positive man who allegedly bit a police officer.

SECONDARY RESOURCES

- **HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice, The Center for HIV Law and Policy (2017)**
  A resource for lawyers and community advocates on the laws, cases, and trends that define HIV criminalization in the United States.

- **Transmission Routes, Viral Loads and Relative Risks: The Science of HIV for Lawyers and Advocates, Center for HIV Law and Policy (2011)**
  This document summarizes key scientific sources and selected quotations on the nature of HIV in ways that are accessible and useful for legal briefs and other advocacy work. The publication includes sections on HIV as a chronic disease, HIV as an impairment of the immune system and a covered disability under the ADA/ADAAA, the routes and risk of HIV transmission, and the use and limits of phylogenetic analysis in proving the source of an individual's HIV infection.

- **Selected Policy Statements and Support for Decriminalization in the United States, Center for HIV Law and Policy (updated 2015)**
  This document, a supplement to *Transmission Routes, Viral Loads and Relative Risks: The Science of HIV for Lawyers and Advocates* identifies select policy statements and law journal articles that support arguments against HIV criminalization.

- **Criminalization of HIV Non-Disclosure, Exposure, and Transmission: Working Annotated Bibliography, Center for Interdisciplinary Research on AIDS, Yale University (2012)**
  This annotated bibliography is a compilation of select literature focusing on the ethical, public health, and legal issues related to criminalization of HIV non-disclosure, exposure, and transmission published in the last decade (2000-present).

- **Chart: State-by-State Criminal Laws Used to Prosecute People with HIV, Center for HIV Law and Policy (2017)**
  This chart catalogues by state the laws used to prosecute individuals with HIV. The chart includes which states and territories have HIV-specific criminal statutes, what type of behavior is criminalized, whether there are general STI criminal statutes, whether there is sex offender registration, and whether general felony statutes have been used to prosecute individuals with HIV.

SAMPLE MEDICAL EXPERT AFFIDAVIT ON HIV TRANSMISSION

STATE OF _____

COUNTY OF _____

_____ personally came and appeared before me, the undersigned Notary, who is a resident of _____ County, State of _____, and makes this his/her statement upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge.

Affidavit of _____

1. *[Include one-two paragraphs on the training, credentials, clinical experience, research experience, employment experience, publications that establish the person as qualified to offer an opinion on the mechanics of HIV transmission. Make reference to CV/resume' as attached to this statement.]*

2. HIV is spread through sexual contact with an infected person, primarily receptive anal or vaginal intercourse; by sharing needles and/or syringes (primarily for drug injection) with someone who is infected; or, less commonly (very rarely in countries that screen the blood supply) through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth, although this is rare when the mother is on effective antiretroviral therapy. However, the HIV virus is not easily transmitted.

3. People with HIV who are taking antiretroviral therapy are significantly less likely to transmit HIV to another person. The goal of antiretroviral therapy is to reduce the amount of HIV virus in a person's system to undetectable levels using commercially available viral load tests. People who have undetectable viral loads because of effective antiretroviral therapy are extremely unlikely to transmit HIV; the risk of transmission is close to zero.

4. Only certain bodily fluids carrying a sufficient level of HIV virus, known as "viral load" (almost always blood and/or semen) can cause HIV transmission.

5. The risk that a person with HIV will transmit the virus to another individual also is affected by numerous biological factors, such as the person's overall health and the amount of HIV virus in each person's blood, semen, or vaginal fluid.

6. Over more than three decades, only 57 health care workers have been infected in the workplace through significant exposure to the blood of HIV-infected patients, typically through needlestick injuries. The fact that most patient care staff typically experienced hundreds of needlestick injuries during the early years of the HIV epidemic, before disposable needles were commonly used, yet fewer than 60 workplace transmissions are believed to have occurred further demonstrates the low transmission risk that HIV poses in most settings.

7. Fears that HIV might be transmitted in other ways are unfounded. If HIV were transmitted through other routes (e.g. household contact, touching, sharing food or water, kissing, insect bites), the epidemiology of HIV infection would be much different from what has been observed. For example, if mosquitoes could transmit HIV infection, or if parents and children could easily transmit HIV to other family members, many more young children and preadolescents would be infected. Instead, the number of young children with HIV has dropped dramatically with the routine use of drugs to prevent transmission during pregnancy and childbirth.

8. All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with the assistance, guidance, and laboratory support from CDC. *No additional routes of transmission have been identified,* despite a national sentinel system designed to detect just such an occurrence.

9. A large number of families in the United States have been affected by the HIV epidemic. Many people living with HIV are raising children. Hundreds of thousands of children in the United States have at least one HIV-positive parent, and these families are found in all regions of the country.

10. HIV cannot be transmitted between family members in the normal household setting unless there is contact between an open wound or the mucous membranes of one person and the HIV-infected blood of another. Taking simple precautions in the home can eliminate this extraordinarily low risk of transmission.

11. A parent with HIV poses no real risk of transmission to children in his or her care. HIV transmission is not associated with casual household contact. No one has ever transmitted HIV to a child by changing the child's diaper or clothes, feeding or caring for the child, kissing or hugging the child, or through any of the other typical interaction between a parent and a child.

12. There is no medical or public health need to separate otherwise healthy HIV-positive children from those who are not infected in the home, in schools, or in other activities. U.S. studies examining families with an HIV-positive member and in which toothbrushes were shared and fights and biting occurred have confirmed the

lack of transmission in such settings and, again, the fact that HIV is not easily transmitted.

13. Patients often ask their clinicians about the degree of HIV transmission risk associated with specific sexual activities. Because HIV cannot be transmitted sexually if the uninfected partner does not receive blood or semen containing a detectable level of HIV virus through intercourse, the use of a condom during sex is a highly effective way to reduce the chances of transmission... However, even without the use of condoms, studies examining the risk of HIV transmission associated with various sexual acts indicate that even with receptive unprotected anal sex, the per-act risk of transmission is 2% or less.

14. Receptive oral sex has poses an even lower per-act risk of HIV transmission than anal or vaginal intercourse. In fact, oral sex has not been a primary means of HIV transmission because a person with HIV who gives oral sex poses a near-zero transmission risk, and giving oral sex to someone with HIV poses a risk that is only slightly higher. Engaging in low-risk behavior such as oral sex reduces the risk that HIV transmission will occur.

15. In the United States, the risk of HIV transmission from an HIV-infected woman to a man is far lower than the risk of transmission from an HIV-infected man to a woman. HIV transmission from women to men is not a major cause of HIV transmission in the United States.

DATED this the _____day of _____, 20_____

_____
Signature of Affiant

SWORN to subscribe before me, this _____day of _____, 20____

_____
NOTARY PUBLIC

My Commission Expires:

_____

The source of some of these statements can be found in the following resources:

- Boily et al., *Heterosexual risk of HIV-1 infection per sexual-act: systematic review and meta-analysis of observational studies,* 9 Lancet Infect. Dis. 118 (2009).

- Cohen, Myron S., et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New Eng. J. Med. 493 (2011).

- Ctr. for Disease Control & Prevention, *HIV Transmission: Can HIV be transmitted by being spit on by an HIV infected person?* (March 25, 2010), available at: http://www.cdc.gov/hiv/resources/qa/transmission.htm.

- Ctr. for Disease Control & Prevention, *Occupational HIV Transmission and Prevention among Health Care Workers* (August 23, 2011), available at: http://www.cdc.gov/hiv/resources/factsheets/hcwprev.htm.

- Ctr. for HIV Law and Policy, *HIV and Pregnancy: Medical and Legal Considerations for Women and Their Advocates* (2009), available at: http://hivlawandpolicy.org/resources/view/474.

- Ctr. for HIV Law and Policy, Transmission Routes, *Viral Loads and Relative Risks: The Science of HIV for Lawyers and Advocates* (2011), available at: http://hivlawandpolicy.org/resources/view/643.

- David Wilson, et al., *Relation Between HIV Viral Load and Infectiousness: a Model-Based Analysis*, 372 Lancet 314 (2008).

- Eric Vittinghoff et al., *Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners*, 150 AM. J. EPI. 306 (1999).

- Quinn et al., Abstract, *Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1*, 342 New Eng. J. Med. 921, 921 (2000).

- Weller & Davis-Beaty, *Condom Effectiveness in Reducing Heterosexual HIV Transmission (Review)*, The Cochrane Library (2007).

Chart: Comparative Sentencing on HIV Criminalization in the United States

MAY 2012

The following chart compares the sentencing schemes for representative HIV exposure, non-disclosure, and/or transmission laws in the United States with laws punishing drinking and driving, reckless endangerment of others, and vehicular homicide. In comparison with HIV exposure, which often carries minimal risk,[i] the danger posed by these crimes is similar if not greater.[ii] However, as the chart shows, the punishment for HIV exposure can be much more severe than those for the other crimes listed below.

Jurisdiction	HIV Exposure Laws & Prosecutions	Drinking & Driving Laws	Reckless Endangerment Laws	Vehicular Homicide Laws
United States – General Trends	**Statutes**: Sentences range from 5 to 25 years imprisonment[iii]; some states have mandatory sex offender registration[iv]	**First offense**: <1 year imprisonment[v] **Subsequent offense**s: <3 years[vi]	**Misdemeanor**: ~2 years imprisonment[vii] **Felony**: ~10 years imprisonment[viii]	**Statutes**: range from <1-99 years imprisonment[ix]
California	**Statute**: 3-8 years imprisonment[x] **Actual prosecution**: 3 years imprisonment[xi]	**First offense**: 96 hours-6 months imprisonment; and fine of $390-$1,000[xii] **Second offense**: 90 days-1 year imprisonment; fine of $390-$1,000[xiii] **Third offense**: 120 days-1	N/A	**Gross vehicular manslaughter while intoxicated**: 4-10 years imprisonment[xvi] **Vehicular manslaughter while intoxicated**: up to 1 year imprisonment[xvii]

		year imprisonment; and fine of $390-$1,000[xiv] **Fourth and subsequent offenses**: 180 days-1 year imprisonment; and fine of $390-$1,000[xv]		
Georgia	**Statute**: 5-20 years imprisonment[xviii] **Actual prosecution**: 8 years imprisonment plus 2 years probation[xix]	**First offense**: 10 days-1 year (mandatory minimum of 24 hours) imprisonment; and fine of $300-$1,000[xx] **Second offense**: 90 days-12 months (mandatory minimum of 72 hours) imprisonment; and fine of $600-$1,000[xxi] **Third and subsequent offenses**: 120 days-1 year (mandatory minimum of 15 days) imprisonment; and fine of $1,000-$5,000[xxii]	N/A	**Homicide by vehicle in the first degree**: 3-15 years imprisonment[xxiii] **Homicide by vehicle in the second degree**: Up to 1 year imprisonment; and/or fine of up to $1,000[xxiv]
New Jersey	**Statute**: 3-5 years imprisonment; and/or fine of up to $15,000[xxv] **Actual prosecution**: 4 years imprisonment[xxvi]	**First offense**: 12-48 hours in Intoxicated Driver Resource Center; up to 30 days imprisonment; and a fine of $250-$500[xxvii] **Second offense**: 48 hours-90 days imprisonment; and a fine of $500-$1,000[xxviii]	**Reckless endangerment**: 6 months-5 years; and possible fine of $10,000-$15,000[xxx]	**Death by auto or vessel**: 5-10 years imprisonment; and possible fine of up to $150,000[xxxi]

		Third and subsequent offenses: 90-120 days imprisonment; and a fine of $1,000[xxix]		
Ohio	*Prostitution-related offenses:* **Statute**: 6 months-3 years imprisonment; and possible fine of up to $10,000[xxxii] **Actual prosecution**: 4 years imprisonment[xxxiii] *Felonious assault:* **Statute:** 2-8 years imprisonment; and possible fine of up to $15,000[xxxiv] **Actual prosecution**: 16 years imprisonment; and mandatory sex offender registration[xxxv]	**First offense**: 3 days-6 months imprisonment; and a fine of $375-$1,075[xxxvi] **Second offense**: 10 days-6 months imprisonment; and fine of $525-$1,625[xxxvii] **Third offense**: 30 days-1 year imprisonment; and fine of $850-$2,750[xxxviii] **Fourth and fifth offenses**: 1-5 years imprisonment; and fine of $1,350-$10,500[xxxix]	N/A	**Vehicular manslaughter**: 15 days-90 days imprisonment[xl] **Vehicular homicide**: 15 days-180 days imprisonment[xli] **Aggravated vehicular homicide**: 1-5 years imprisonment[xlii]
Oklahoma	**Statute**: Up to 5 years imprisonment[xliii] **Actual prosecution**: None on record, but as of the date of this report, a 23-year-old man is accused of engaging in unprotected sexual intercourse with several women without first disclosing his status. He faces 3 felony counts of 2nd	*Driving while impaired by alcohol or other substances (0.05-0.08 BAC):* **First offense**: Up to 6 months imprisonment; and/or fine of $100-$500[xlv] *Driving while under the*	N/A	**Negligent homicide**: Up to 1 year imprisonment; and/or fine of at least $1,000[l]

	degree rape, 2 felony counts of assault & battery with a deadly weapon, and 2 felony counts of knowing intent to transfer HIV. He is currently in prison on a $2 million bond awaiting trial.[xliv]	*influence of alcohol or other substances (0.08+ BAC):* **First offense**: 10 days-1 year imprisonment; and fine of up to $1,000[xlvi] **Second offense**: 1 year-5 years imprisonment; and fine of up to $2,500[xlvii] **Third offense**: 1 year-10 years imprisonment; and fine of up to $5,000[xlviii] **Fourth offense**: 1 year-20 years imprisonment; and fine of up to $5,000[xlix]		
Tennessee	**Statute**: 3-15 years imprisonment; and possible fine of up to $10,000; and mandatory sex offender registration[li] **Actual prosecution**: 26 years and six months imprisonment; and mandatory sex offender registration[lii]	**First offense**: 48 hours-11 months, 29 days imprisonment; and fine of $350-$1,500[liii] **Second offense**: 45 days-11 months, 29 days imprisonment; and fine of $600-$3,500[liv] **Third offense**: 120 days-11 months, 29 days imprisonment; and fine of $1,100-$10,000[lv] **Fourth and subsequent offenses**: at least 150 days imprisonment; and fine of	**Reckless endangerment**: Up to 11 months, 29 days imprisonment; and/or fine of up to $2,500[lvii] **Reckless endangerment with a deadly weapon**: 1-6 years imprisonment; and possible fine of up to $3,000[lviii]	**Vehicular homicide**: 3-15 years imprisonment; and possible fine up to $10,000[lix]

		$3,000-$15,000[lvi]		

[i] The risk of transmission for a single act of unprotected sex between a man and a woman is less than 0.1%. Julie Fox et al*., Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm*, 25 AIDS 1065 (2011).
[ii] For example, a person with a .08 BAC is almost 3 times more likely to get into an accident compared to a person with no alcohol in his or her system. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., NATIONAL SURVEY OF DRINKING AND DRIVING ATTITUDES AND BEHAVIORS 5 (2008), *available at* http://www.nhtsa.gov/staticfiles/nti/pdf/811342.pdf.
[iii] POSITIVE JUSTICE PROJECT, THE CTR. FOR HIV L. & POL'Y, ENDING AND DEFENDING AGAINST HIV CRIMINALIZATION: A MANUAL FOR ADVOCATES (2010), *available at* http://www.hivlawandpolicy.org/resources/view/564.
[iv] *See, e.g.*, Arkansas, ARK. CODE ANN. § 12-12-903(12)(A)(i)(p); Iowa, IOWA CODE ANN. § 692A.102(1)(c)(22); Ohio, OHIO REV. CODE ANN. § 2950.01(G)(1)(c) (West 2010); Louisiana, LA. REV. STAT. § 541(24) (2005) (modified with minor changes by 2010 La. Sess. Law Serv. Act. 387 (H.B. 825)); South Dakota, S.D. CODIFIED LAWS § 22-24B-2 (West 2010); Tennessee, TENN. CODE ANN. § 40-39-202(28) (2004); Washington, WASH. REV. CODE ANN. § 9.94A.507 (2011).
[v] *See, e.g.*, CONN. GEN. STAT. § 14-227a(g) (2011). (first offense: 48 hours-6 months imprisonment; and a fine of $500-$1000); 75 PA. CONS. STAT. §§ 3802(a), 3804(a)(1). (first offense: at least 6 months probation; and a fine of $300). *See also* NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., A STATE-BY-STATE ANALYSIS OF LAWS DEALING WITH DRIVING UNDER THE INFLUENCE OF DRUGS (2008), *available at* www.nhtsa.gov/staticfiles/nti/pdf/811236.pdf.
[vi] *See, e.g.*, CONN. GEN. STAT. § 14-227a(g) (2011). (second offense: 120 days-2 years imprisonment; and a fine of $1000-$4000); 75 PA. CONS. STAT. §§ 3802(a), 3804(a)(2) (2011). (second offense: 5 days-6 months imprisonment; and a fine of $300-$2,500). *See also* NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., A STATE-BY-STATE ANALYSIS OF LAWS DEALING WITH DRIVING UNDER THE INFLUENCE OF DRUGS (2008), *available at* www.nhtsa.gov/staticfiles/nti/pdf/811236.pdf.
[vii] *See, e.g.*, COLO. REV. STAT. § 18-3-208 (2012) (class 3 misdemeanor: up to 6 months imprisonment; and/or a fine of $50-$750); 18 PA. CONS. STAT. § 2705, 106(b) (2011). (class 2 misdemeanor: up to 2 years imprisonment).

[viii] *See, e.g.*, N.Y. PENAL LAW §§ 120.25, 70(2)(d) (2011). (1st degree reckless endangerment, class D felony: up to 7 years imprisonment); TENN. CODE ANN. §§ 39-13-101, 40-35-11(b)(5) (class E felony: up to 6 years imprisonment; and possible fine of $5,000).
[ix] *See* MADD, PENALTIES FOR DRUNK DRIVING VEHICULAR HOMICIDE (2011), *available at* http://www.madd.org/laws/law-overview/Vehicular_Homicide_Overview.pdf.
[x] CAL. HEALTH & SAFETY CODE § 120291 (2011). (engaging in unprotected anal or vaginal intercourse without first disclosing status and with specific intent to transmit HIV is a felony punishable by three, five, or eight years imprisonment).
[xi] Beatriz E. Valenzuela, *Gang member gets 3 years in HIV exposure case*, HIGH DESERT DAILY PRESS, Oct. 22, 2010, http://www.vvdailypress.com/news/gets-22531-hiv-member.html. (defendant convicted of intent to expose another person to AIDS through sexual activity after engaging in unprotected sexual intercourse without first disclosing his status).
[xii] CAL. VEH. CODE §§ 23152, 23536(a) (2011).
[xiii] CAL. VEH. CODE §§ 23152, 23540(a) (2011).
[xiv] CAL. VEH. CODE §§ 23152, 23546(a) (2011).
[xv] CAL. VEH. CODE §§ 23152, 23550(a) (2011).
[xvi] CAL. PEN. CODE § 191.5(a), (c)(1) (2011).
[xvii] CAL. PEN. CODE § 191.5(b), (c)(2) (2011).
[xviii] GA. CODE. ANN. § 16-5-60(c), (d) (2010). (engaging in anal, oral, or penile-vaginal intercourse, sharing a hypodermic needle or syringe, offering or consenting to sexual intercourse or an act of sodomy for money, or donating blood or other body parts without first disclosing status is a felony punishable by up to 10 years imprisonment; assault using blood, semen, vaginal secretions, saliva, urine, or feces upon a peace or correctional officer with intent to transmit HIV is a felony punishable by 5-20 years imprisonment).
[xix] Ginn v. State, 667 S.E.2d 712, 713 (Ga. Ct. App. 2008). (defendant was convicted of reckless conduct after engaging in unprotected sexual intercourse without first disclosing her status, even though two witnesses testified that the "victim" was aware of the defendant's status after it was published on the front page of a local newspaper).
[xx] GA. CODE. ANN. § 40-6-391(a), (c)(1)(A)-(B) (2010).
[xxi] GA. CODE. ANN. § 40-6-391(a), (c)(2)(A)-(B) (2010).
[xxii] GA. CODE. ANN. § 40-6-391(a), (c)(3)(A)-(B) (2010).
[xxiii] GA. CODE. ANN. § 40-6-393(a) (2010).
[xxiv] GA. CODE. ANN. §§ 40-6-393(b), 17-10-3(a)(1) (2010).

[xxv] N.J. STAT. ANN § 2C: 34-5, :43-6(a)(3), :43-3(b)(1) (2010). (engaging in sexual penetration without first disclosing status is a 3rd degree crime punishable by 3-5 years imprisonment and/or a fine of up to $15,000).
[xxvi] Jennifer Golson, *N.J. man gets 4 years in prison for not telling two sexual partners he had HIV*, NJ.COM, Oct. 29, 2010, http://www.nj.com/news/index.ssf/2010/10/nj_man_gets_4_years_in_prison.html. (defendant was convicted of the 3rd degree crime of diseased person committing an act of sexual penetration after engaging in sexual relations with two women without first disclosing his status).
[xxvii] N.J. STAT. ANN § 39:4-50(a)(1) (2010).
[xxviii] N.J. STAT. ANN § 39:4-50(a)(2) (2010).
[xxix] N.J. STAT. ANN § 39:4-50(a)(3) (2010).
[xxx] N.J. STAT. ANN § 2C:12-2(a)-(b), :43-6(a)(3)-(4), :43:3(b)(1)-(2) (2010).
[xxxi] N.J. STAT. ANN § 2C:11-5(a)-(b), :43-6(a)(2), :43-3(a)(2) (2010).
[xxxii] OHIO REV. CODE ANN. §§ 2907.25(A)-(C), 2907.24 (A)-(C), 2907.241 (A)-(D), 2929.14(A), 2929.18(A)(3) (2011). (prostitution by an HIV-positive person is a 3rd degree felony punishable by 9 months-3 years imprisonment and possible fine of up to $10,000; solicitation of prostitution by an HIV-positive person is a 3rd degree felony punishable by 9 months-3 years imprisonment and a possible fine of up to $10,000; loitering for the purpose of solicitation by an HIV-positive person is a 5th degree felony punishable by 6 months-1 year imprisonment and a possible fine of up to $2,500; solicitation and prostitution by HIV-negative persons are both 3rd degree misdemeanors).
[xxxiii] State v. West, No. 22966, 2009 WL 4268554 (Ohio Ct. App. Nov. 25, 2009). (defendant convicted of two counts of soliciting another to engage in sexual activity for hire after a positive HIV test).
[xxxiv] OHIO REV. CODE ANN. §§ 2903.11 (B)-(E) (2011). (engaging in anal, oral, or vaginal intercourse or the insertion, however slight, of any body part or instrument that carries the bodily fluids of an HIV-positive person into another's vagina or anus without first disclosing status is a 2nd degree felony punishable by 2-8 years imprisonment and a possible fine of up to $15,000).
[xxxv] State v. Gonzalez, 796 N.E.2d 12 (Ohio Ct. App. 2003). (defendant was convicted of two counts of felonious assault after engaging in unprotected sexual intercourse without first disclosing his status).
[xxxvi] OHIO REV. CODE ANN. § 4511.19(A)(1), (G)(1)(a) (2011).
[xxxvii] OHIO REV. CODE ANN. § 4511.19(A)(1), (G)(1)(b) (2011).
[xxxviii] OHIO REV. CODE ANN. § 4511.19(A)(1), (G)(1)(c) (2011).
[xxxix] OHIO REV. CODE ANN. § 4511.19(A)(1), (G)(1)(d) (2011).
[xl] OHIO REV. CODE ANN. §§ 2903.06(A), (D), (E), 2929.24(A)(2) (2011).
[xli] OHIO REV. CODE ANN. §§ 2903.06(A), (C), (E), 2929.24(A)(1) (2011).
[xlii] OHIO REV. CODE ANN. §§ 2903.06(A), (B), (E), 2929.14(A)(3)(a) (2011).
[xliii] OKLA. STAT. TIT. 21, § 1192.1(A)-(B) (2011). (engaging in conduct that carries a reasonable likelihood of transfer of blood and other bodily fluids without first disclosing status or obtaining the other person's consent, and with the intent to infect the other person is a felony punishable by up to 5 years imprisonment).
[xliv] On Demand Court Records, http://www1.odcr.com/detail.php?Case=026-CF%20%201200123&County=026- (last visited Apr. 18, 2012).
[xlv] OKLA. STAT. TIT. 47, § 761(A) (2012).
[xlvi] OKLA. STAT. TIT. 47, § 11-902V1(A)-(C)(1) (2011).
[xlvii] OKLA. STAT. TIT. 47, § 11-902V1(A)-(C)(2) (2011).
[xlviii] OKLA. STAT. TIT. 47, § 11-902V1(A)-(C)(3) (2011).
[xlix] OKLA. STAT. TIT. 47, § 11-902V1(A)-(C)(4) (2011).
[l] OKLA. STAT. TIT. 47, § 11-903(A)-(B) (2011).
[li] TENN. CODE ANN. §§ 39-13-109, 40-35-111(b)(3), 40-39-201 to -202 (2012). (engaging in intimate contact – here, any contact that exposes one body to a bodily fluid of another in any manner that presents significant risk of HIV transmission – without first disclosing status is a class C misdemeanor punishable by 3-15 years in prison and possible fine of up to $10,000).
[lii] State v. Wiser, No. M1999-02500-CCA-R3-CD, 2000 WL 1612363 at *2 (Tenn. Crim. App. Oct. 30, 2000). (defendant was convicted of 22 counts of criminal exposure of another to HIV after engaging in unprotected sexual relations with several men without first disclosing her status).
[liii] TENN. CODE ANN. § 55-10-401 to -403(a)(1)(A)(i), (s)(1) (2012).
[liv] TENN. CODE ANN. § 55-10-401 to -403 (a)(1)(A)(iv) (2012).
[lv] TENN. CODE ANN. § 55-10-401 to -403 (a)(1)(A)(v) (2012).
[lvi] TENN. CODE ANN. § 55-10-401 to -403 (a)(1)(A)(vi) (2010).
[lvii] TENN. CODE ANN. §§ 40-35-111(e)(1) (2010).

[lviii] TENN. CODE ANN. § 40-35-111(b)(5) (2010).
[lix] TENN. CODE ANN. §§ 39-13-213(a)(1), 40-35-111(b)(3) (2010).

Chart: HIV, STIs and Relative Risks in the United States

The chart below presents data comparing HIV infection to other sexually transmitted infections. These data illustrate that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV. Herpes simplex virus type 2 (HSV-2) and human papilloma virus (HPV) are more prevalent than HIV. Gonorrhoea and HPV are far more easily transmissible than HIV during unprotected sexual activity. Like HIV, HSV-2 is not curable. Potential consequences of HPV, gonorrhoea, and HSV- 2 include cancer, pelvic inflammatory disease, infertility, and infant death.

Disease	Prevalence	Associated Risk of Transmission	Infection Outcomes
HIV	• United States: 0.6%[1]	• Infection rate per sexual exposure to HIV:[2] • Receptive vaginal intercourse: 0.10% • Insertive vaginal intercourse: 0.05% • Receptive oral intercourse: 0.00-0.04% • Insertive oral intercourse: ~0.00% • Receptive anal intercourse: 1.40% • Insertive anal intercourse: 0.065%	• HIV is not curable[3] • Untreated HIV infection will almost inevitably lead to illness and premature death[4] • HIV can be managed as a chronic disease through the use of HAART[5,6] • HIV-positive individuals can experience a near-normal life span with early detection and treatment [7]
Human Papilloma Virus (HPV)	• United States:[8] Low-risk and/or high-risk types: 26.8%	• Median transmission estimate for low- and high-risk types: 40% per heterosexual contact (62.5% if HPV prevalence in men and women is assumed to be equal, 30% if prevalence is assumed to be 1.5 times higher in women, and 10% if prevalence is assumed to be twice as high in women)[9] • Transmission rate of the 14 high-risk types of HPV: 43.0%–94.0% per average relationship between discordant heterosexual partners[10]	• There are more than forty types of HPV, classified as low-risk or high-risk based on strength of association with cervical cancer[11] • High-risk HPV types cause 99% of cervical cancer cases, as well as anal and other genital cancers[12] • The advent of HPV screening and prevention technology has greatly reduced the number of cervical cancer deaths in high-income countries[13] • In 2007, 4,021 women died of cervical cancer in the United States[14] • Cervical cancer ranks in the top 10 most prevalent cancers among Black, Hispanic, American Indian and Alaska Native women in the United States[15]
Gonorrhoea	• United States:[16] • 105.5 cases in women per 100,000 population • 91.9 cases in men per 100,000 population	• Estimated female to male transmission rate per sexual contact: 25.0%[17] • Estimated male to female transmission rate per sexual contact: 50.0%[18]	• Gonorrhoea is treatable with antibiotics[19] • Treating gonorrhoea continues to become more difficult as drug resistance grows – Cephalosporins, currently in use, are the fourth line of treatment for gonorrhoea infection[20] • The Centers for Disease Control (CDC) now recommends dual therapy for gonorrhoea utilizing a cephalosporin and either azithromycin or doxycycline[21] • Untreated gonorrhoea can cause pelvic inflammatory disease, ectopic pregnancy, and infertility[22] • Untreated gonorrhoea can increase susceptibility to human immunodeficiency virus (HIV) infection[23]

Herpes Simplex Virus Type 2 (HSV-2)	• United States:[24] • 16.2% overall population prevalence	• Male to female transmission rate per sexual contact: .089%[25] • Female to male transmission rate per sexual contact: .015%[26]	• HSV-2, like all other types of herpes, is not curable[27] • Can cause repeated outbreaks of genital sores and lead to infant death if acquired during pregnancy[28] • Can increase susceptibility to HIV infection and can increase infectiousness of HIV-positive individuals[29]

[1] Central Intelligence Agency. "HIV/AIDS - Adult Prevalence Rate." https://www.cia.gov/library/publications/the-world-factbook/rankorder/2155rank.html
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Chart: HIV and Chronic Disease in the United States

The chart below presents data on the risk of HIV infection in conjunction with data on chronic diseases such as cardiovascular disease, diabetes, and Hepatitis C. This chart allows for the comparison of HIV to other chronic diseases that are common in high-income countries and that require lifelong clinical management. This data is not intended to diminish the personal and societal consequences of HIV infection, but to draw awareness to the equal or greater toll of other chronic diseases.

Disease	Prevalence	Social and Economic Burden of Disease[1]	Treatment	Disease Progression
HIV	• United States: 0.6%[2]	• In 2002, annual direct and indirect costs of new HIV infections in the United States were estimated to total $36.4 billion[3]	• There is no cure for HIV infection[4] • HAART can suppress the virus, slow disease progression, and prolong life[5] • Adherence to HAART can decrease viral load and lower viral transmissibility[6]	• Untreated HIV infection will almost inevitably lead to illness and premature death[7] • HIV targets the immune system – it can begin degrading the immune system within weeks of infection, though some individuals do not experience symptoms for years[8] • Average life expectancy in the United States after diagnosis is 22.5 years[9] • HIV infection can increase vulnerability to cardiovascular disease, kidney disease, liver disease, and cancer[10]
Hepatitis C	• United States: 1.5% (overall prevalence)[11]	• Direct health care costs associated with Hepatitis C predicted to reach $10.7 billion in the United States between 2010 and 2019[12]	• Antiviral drug therapy can cure Hepatitis C[13] • Length of treatment regimens, drug side effects, and drug availability often impede curing Hepatitis C and lead to development of chronic disease[14]	• Symptoms of initial Hepatitis C infection include fever, fatigue, nausea, vomiting, decline in appetite, abdominal pain, discoloration of urine and feces, joint pain, and jaundice[15] • Symptoms in chronically-infected people may indicate advanced liver disease[16] • 60.0–70.0% of chronically-infected individuals develop chronic liver disease[17] • 5.0-20.0% of chronically-infected individuals develop cirrhosis[18] • 1.0–5.0% of chronically-infected individuals die from cirrhosis or liver cancer[19]
Cardio-vascular Disease	• United States: 33% (adult prevalence)[20]	• Accounted for 17,853,000 DALYs in high income countries in 2004[21]	• Behavior modifications, drug therapy, and operations such as bypass surgery or heart transplants may help control cardiovascular disease[22]	• Cardiovascular disease often manifests in acute events such as heart attack or stroke[23] • Behavioral risk factors, such as diet, physical inactivity, and tobacco use, are responsible for approximately 80% of CVD[24] • Elevated blood pressure, elevated blood glucose, elevated blood lipids, and obesity are all symptomatic of cardiovascular disease[25]
Diabetes	• United States: 8.3% (overall prevalence)[26]	• Diabetes was estimated cost the United States $174 billion in direct health care and lost productivity expenditures[27]	• Behavior modifications, insulin treatment, and other drug regimens are used to regulate diabetes[28]	• 50% of people with diabetes die of cardiovascular disease[29] • On average, diabetics over the age of 50 die 8 years sooner than non-diabetic peers[30] • After 15 years of diabetes, approximately 2% of people become blind, and about 10% develop severe visual impairment due to diabetic retinopathy[31] • 10-20% of people with diabetes die of kidney failure[32] • Up to 50% of people with diabetes are affected by diabetic neuropathy, which increases the chance of foot ulcers and can lead to limb amputation [33] • Overall risk of dying among people with diabetes is at least double

				the risk of their peers without diabetes[34]

[1] Social burden of disease is represented by DALYs, disability-adjusted life years, which allow for the quantification of human disease toll. The World Health Organization, defines a DALY as "a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health." http://www.who.int/healthinfo/global_burden_disease/en/
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