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“Notify Your Partners—It’s the Law”: HIV Providers and Mandatory Disclosure

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Abstract

HIV care providers in the United States must counsel clients about disclosure to sexual partners and report anyone who is suspected of noncompliance. This study compared provider attitudes and practices in relation to counseling clients about mandatory disclosure in North Carolina and Alabama, the 2 states with similar HIV epidemiology but different laws for HIV control. Personal interviews were conducted with 20 providers in each state ($n = 40$). The results were analyzed in a qualitative, cross-comparison method to identify patterns of convergence or difference. Providers in both states believed that clients often failed to notify sexual partners and were secretive if questioned about disclosure. Differences in counseling styles and procedures for each state were noteworthy. Compared to Alabama, North Carolina had harsher penalties for nondisclosure, stricter and more standardized procedures for counseling, and providers expressed greater support for HIV criminalization. Although most North Carolina providers viewed the stricter standards as beneficial for HIV care and control, Alabama providers were likely to view such standards as a barrier to patient care. These results indicated a direct relation between state HIV law, provider attitudes, and counseling procedures for mandatory disclosure.

Keywords

HIV law, health providers, mandatory disclosure

Introduction

A vexing question for HIV prevention is whether or not people who are living with HIV/AIDS (PLWHA) should legally be required to notify sexual partners about their HIV status. Personal disclosure was not required during the 20th century’s war on syphilis^{1,2} and is still rarely enforced for non-HIV sexually transmitted infections (STIs) in the United States. Unlike syphilis which was so common during the preantibiotic era that the 19th century French writer Gustave Flaubert proclaimed, “Everyone has it, more or less,”³ HIV/AIDS was a new and particularly deadly affliction when it emerged in the 1980s as a global pandemic. HIV/AIDS was viewed differently than other STIs, in part, because of its lethality, and the US law was quickly marshaled to ensure that PLWHA notified sexual partners, employers, health employees, and public safety officers about their HIV status. These laws were then implemented in counseling practices at clinics and agencies that provide services to PLWHA. Reporting suspected cases of nondisclosure often begins with an HIV provider who contacts a disease intervention specialist (DIS) at a local health department for further action.

This investigation examined policies and protocols for counseling about mandatory HIV disclosure in Alabama and North Carolina. The 2 states have different HIV laws but similar epidemiology for HIV/AIDS. Most clients are African

Americans, rural and urban populations are about equally affected, and both states are located in the “AIDS belt” of the Southeastern region.⁴ We compared HIV counseling practices among providers in each state as well as the perceived efficacy of these practices for clients’ decisions to notify sexual partners. Both states require counseling about mandatory disclosure as part of public health statutes for HIV control and, for this misdemeanor offense, can levy a fine and/or impose a jail sentence for failure to disclose. In Alabama’s case, the public health statute code for STI control was expanded to include mandatory HIV disclosure with penalties of a fine and up to 3 months in jail for violators. North Carolina’s public health code was similarly expanded to include mandatory disclosure, but 7 requirements for HIV control make it more far-reaching than Alabama’s single provision. Under North Carolina’s code, violators can be imprisoned for up to 2 years for nondisclosure

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and also be detained beyond the term of their sentence if they are deemed a threat to public health. Two additional vehicles for prosecution exist under general criminal law. In all the US states, clients who fail to disclose to sexual partners can alternately be charged with a felony crime. Penalties for these crimes have resulted in lengthy sentences for assault or attempted murder and lifelong registration as a sex offender.⁵ A total of 36 states also enacted HIV-specific laws that criminalize nondisclosure and other putatively dangerous acts involving PLWHA (e.g., biting and spitting).⁵ Such measures to criminalize nondisclosure are unprecedented in the US history of STI control.

Criminal laws seek to punish the offender, protect society from harm, provide justice to victims, and to deter crime. Arguments in favor of deterrence and protecting society from harm are often used to support HIV-specific laws for mandatory disclosure. However, recent studies question the value of HIV criminalization as an effective strategy for HIV control. Galletly et al⁶ and Horvath et al⁷ wrote independently that HIV-specific laws neither reduce risky sexual behavior among PLWHA nor increase the likelihood of disclosure. Civil rights and community advocates contend that 2 unintended effects of HIV laws are reluctance to be tested for HIV/AIDS in vulnerable communities and increased stigma toward PLWHA.⁸⁻¹⁰ So far, evidence that HIV criminalization is a barrier to HIV testing is sparse, although a New York study found that African American respondents were intimidated by formal procedures for HIV testing, especially when their signature was required for consent.¹¹ This outcome suggests that counseling about mandatory disclosure is a barrier to disclosure if procedures are too formal or legalistic. However, 2 studies found that HIV counseling was effective in encouraging PLWHA to notify sexual partners, particularly with repeated counseling over time.^{12,13} It is unclear whether HIV counseling was effective for its own sake or because of the threat of legal action. The primary goal of the present study was to compare HIV counseling practices in 2 states with different HIV laws. We sought information on 3 questions: how clients were counseled about mandatory disclosure, what are the levels of support for HIV disclosure law, and whether providers felt that HIV counseling was effective.

Methods

Sample

We recruited 20 HIV care providers in each state (N = 40) from a list of contacts at HIV clinics, Health Departments, Community Health Centers, and AIDS Service Organizations (ASOs). Eligibility included being employed in HIV care or support services where counseling took place and a working knowledge of counseling procedures. The providers either supervised employees who counseled PLWHA about disclosure or counseled clients themselves. Institutional review boards at the 2 universities in Alabama and North Carolina approved the sampling and methods for the study.

Methods

Providers were interviewed in an individual, face-to-face format for about 1 hour at their clinic or agency. We used a semi-structured interview guide consisting of 21 open-ended items that were grouped into 3 sections: counseling protocols and practices, provider/client communication, and support for criminalizing nondisclosure. These items were followed by questions about the size, type, and location of the clinic or agency as well as questions about the interviewee's role, gender, race/ethnicity, and length of employment. All interview notes were typed up and entered into a master file for coding that matched the topic areas of the interview guide.

Analysis

The analysis followed the Glaser and Strauss¹⁴ cross-comparison method for qualitative research. First, each protocol was reviewed for attitudes, insights, and approaches that offered thick description for analysis. Then, 2 raters compared the responses for each category of the master file in order to identify common themes or agreement. Data differences within each category were matched with the respondents' gender, race/ethnicity, role, and location for possible explanations. Finally, the summaries for each state were compared with respect to counseling styles and procedures and with the respective public health codes for mandatory HIV disclosure. Four main themes emerged from the analysis: formalism versus informalism, client nondisclosure, support versus dissent, and role conflict.

Results

Interviewees

The two samples were similar in terms of social demographics and workplace. Support services personnel such as social workers, agency directors, clinic coordinators, and educators accounted for 70% of the total, with the remainder (30%) being medical personnel such as physicians and clinical nurses. Most providers were white (65%) and female (70%), although there were more men in North Carolina (40% versus 20% in Alabama) and more African Americans in Alabama (45% versus 20% in North Carolina). The providers were employed in 4 types of venue: ASOs, hospital clinics, health departments, and community health centers. Most providers were employed in clinical settings (55% in Alabama versus 70% in North Carolina), and the remainder were located at ASOs (45% in Alabama versus 30% in North Carolina).

Formalism versus Informalism

Counseling procedures differed between the 2 states. "Formal consenting" was required in HIV counseling in North Carolina but not in Alabama, where each agency or clinic formulated their own procedures for counseling clients. North Carolina's consent forms were standardized across the state and consisted of a legal to-do list for the 7 control measures, including

Table 1. Type of Law, Counseling Procedures, and Disclosure.

Item	Alabama (N = 20)	North Carolina (N = 20)
Type of law	Code S22-11A-21(c), penalties for “knowingly” transmitting STDs and HIV/AIDS Misdemeanor, up to 3 months jail No recent prosecutions	Code 41A.0202, seven HIV-specific “Control” Measures,” including partner notification Misdemeanor, up to 2 years jail Recent prosecutions
Signed consent forms	No = 20 EX: “No, the disclosure information is included in the treatment plan. It is worked in as a goal.” EX: “There’s no form. I just have a conversation with them about telling their partner.” NU: “We just rely on the patient advocate to make sure they’re up to speed on disclosure things.” MD: “If we were legally required to force people to sign a document, no one would come.”	Yes = 20 EX: “Forms are reviewed, read aloud, and signed in person. We keep a copy in their chart.” EX: “Clients sign the form and a copy is kept on file.” CM: “The DIS require signed forms in English or Spanish, and we reinforce that by requesting their signature on the control measures.”
Do clients always disclose?	No = 20 Yes = 0 MD: “Clients fear the law and become secretive. They won’t tell us the truth.” EX: “The counseling doesn’t sink in, it’s not being taken seriously.” EX: “They ‘yes’ you to death, then they do what they want to do.” EX: “They say one thing and do another. We don’t know what they do in their private life.” EX: “People don’t disclose to their partner because of the stigma.” MD: “They feel forced to disclose, but it’s hard.”	No = 19 Yes = 1 EX: “They typically tell us what they want us to hear. We know they probably don’t follow the law.” NU: “They’re just listening to what we’re saying but they aren’t going to do it.” CM: “The reality is that lots of patients are having unprotected sex.” CM: “I know they are not always going to disclose, not because they’re bad people but because of stigma.” NU: “They’re apathetic, they don’t really care.” NU: “I know people lie. They don’t want to go to jail.”

Abbreviations: CM, clinic or care manager; EX, executive director; NU, clinic nurse; MD, clinic physician.

mandatory disclosure. The client was obliged to read the list and sign the form, with the provider acting as official witness. The client’s signature was considered proof of being counseled about mandatory disclosure, and all clients were advised that their clinic records would be subpoenaed if they faced prosecution. In some cases, recalcitrant clients were “re-consented” if they appeared to be flouting the law, so that several forms were placed on the client’s file as a matter of record.

Alabama’s approach to the counseling was more informal, did not require a signed form, and consisted mainly of advice about legal disclosure. Compared to North Carolina’s emphasis on signed consent forms in all cases, only four Alabama interviewees used any type of form when they counseled clients about disclosure. Three of these forms were client centered (i.e., the client was asked to evaluate the visit for quality control purposes) and thus unrelated to formal consent procedures. The fourth form, borrowed from Mississippi, was used solely as a guide for discussion and did not require the client’s signature. Table 1 compares the type of law and counseling procedures in both states, with quotes for illustration.

Client Nondisclosure

Client nondisclosure was the only theme with consensus (Table 1). Almost all providers were skeptical that counseling led to disclosure or safer sex with all or most partners. Further,

counseling about HIV laws was inferred to invoke fear rather than honesty about sexual activity. Providers stated that the counseling often fell on deaf ears, with clients being either secretive or suspicious if asked about disclosure or adamant about their adherence to the law despite evidence to the contrary (e.g., by becoming pregnant or contracting an STI). Providers in both states asserted that they were often viewed as law enforcers who would report violators to the authorities. The main difference in counseling styles was that providers in North Carolina were more likely to tell clients that they would be jailed for violating the law and providers spent more time trying to convince clients to disclose, including through the process of re-consenting in follow-up appointments.

Support for the Law

Support for disclosure laws varied by state. Although most (90%) of the North Carolina providers supported mandatory disclosure laws, fewer than half (45%) of the Alabama interviewees did so. One-fourth (25%) of the Alabama providers rejected the idea of disclosure laws entirely. The North Carolina interviewees typically responded in terms of, “the law exists; therefore I support it.” In both states, proponents of the law espoused an ethos of individual responsibility, made a clear distinction between potential vectors (the client) and victims (sex partners), and viewed nondisclosure as a crime in all cases.

Table 2. Support for HIV Disclosure law.

Response	Alabama (N = 20)	North Carolina (N = 20)
Yes	N = 9 SW: "It's the client's responsibility. They could be putting someone at risk." PM: "The laws should be stronger. [Non-disclosure] is attempted murder." SW: "The laws empower me. I was taught — and believe in—the idea of "imminent risk." SW: "I believe in personal responsibility. Every infected person has a responsibility to protect themselves and others."	N = 18 NU: "I do agree with it. Laws are put in place for a reason. If lawmakers think this will help, I agree. I completely support the law." NU: "Absolutely. We wouldn't be in public health if we didn't believe in these laws. The control measures clearly outline what public health is all about." EX: "On a professional and personal basis, I do. This law helps prevent the spread of disease and I am going to do anything I can to support it."
Somewhat	N = 6 MD: "It's a gray area. It makes people believe they can't have a sex life. I'm torn, there's so much stigma." MD: "Patients should disclose to partners because it's best for them. But it's hard to enforce the law." PM: "It depends, there are gray areas. It's not always clear cut. We're dealing with human beings."	N = 2 CM: "I agree with the law in general, but there are tons of people who break their control measures and nothing is done about it. Personally, I believe that the law is a complete waste of time." CM: "Yes, but if you are medically compliant and undetectable, I see a little bit of wiggle room."
Not at all	N = 5 EX: "If your viral load is undetectable, you can't transmit HIV." NU: "You can't legislate behavior in the bedroom. It isn't possible to control and has no effect." MD: "The law is a barrier between us and the patient. We try to steer away from being law enforcement officers." MD: "The laws are made by people who don't understand HIV patients." EX: "The laws increase stigma. They keep people from testing and HIV care."	N = 0 No responses to report

Abbreviations: CM, clinic or care manager; EX, executive director of an AIDS service organization; NU, clinic nurse; PM, peer mentor; MD, clinic physician; SW, clinical social worker.

Although interviewees who were equivocal about the law supported legal disclosure on moral grounds, they also felt that disclosure was a gray area, especially when clients faced rejection, revenge seeking, or even violence after notifying sexual partners. Citing sexual privacy or social justice concerns, participants who were opposed to the law rejected the premise that nondisclosure should be criminalized or viewed the law as a barrier to HIV testing and HIV care. Table 2 summarizes these results using interview excerpts for illustration.

Role Conflict

Opinions were divided about whether counseling about mandatory disclosure should be client centered or law centered for maximum efficacy. The primary objective of the law-centered advocates was to ensure that clients understood their legal obligations for disclosure. In a client-centered approach, the provider prioritized client care over disclosure requirements, which might be addressed fleetingly or in relation to client concerns about health and safety. The large majority (90%) of North Carolina providers took a law-centered approach in which they focused on the legal aspects of disclosure as required by state law and viewed formal "consenting" as

integral to HIV care. The North Carolina providers justified this approach by stating that they had empowered clients to avoid prosecution. By contrast, over half (55%) of the Alabama interviewees took a client-centered approach in which they focused on strategies for disclosure rather than the law itself. These providers self-identified as client advocates rather than as law enforcers and were ambivalent about or frankly opposed to formal counseling procedures and the use of signed consent forms. Although in the minority, opponents of the law in both states were frank about their dislike of having to counsel clients about mandatory disclosure and felt that this function militated against building trust with clients. Physicians were particularly opposed to HIV laws for disclosure, citing problems with open communication during visits or legal requirements that placed an undue burden on clients. It is worth noting that administrators and support staff who defended the law were the least conflicted about their role. Table 3 summarizes the differences between the 2 groups in terms of role integration or conflict.

Discussion

Differences between the 2 states are systemic. North Carolina's law required more formal counseling procedures than in

Table 3. Role Conflict among Providers.

Response	Alabama (N = 20)	North Carolina (N = 20)
No	<p>N = 9</p> <p>CO: "Counselors are only providing information." EX: "It's our job to disclose names to the health dept." PM: "It's okay. It's up to the client to do the responsible thing." EX: "It's part of our role. We inform and make aware." EX: "Our ASO holds the clients accountable. Some organizations don't have a backbone with their clients."</p>	<p>N = 18</p> <p>EX: "We are obligated to report. This part of our role and the responsibility of this work." MD: "Part of my job is to inform patients. That is what I do." NU: "You have to be a law enforcer to protect the community." EX: "It's like child abuse. I have a right and duty to report." NU: "You must be an enforcer of the law and I am okay with that. You have to take the bitter with the sweet."</p>
Yes	<p>N = 11</p> <p>NU: "There's a strained dynamic between provider and patient [because of the law]." NU: "I have to report, but I do feel like an enforcer." CO: "We're caught in the middle. Bottom line—they're still our patients and we're trying to protect them." MD: "I don't like telling people about the law. I don't want to feel like a policeman." EX: "I'll inform the patient but I'm not the sex police." MD: "The whole goal is to keep them in care—that's our bias. It's incredibly difficult to get patients to disclose and we can only go so far."</p>	<p>N = 2</p> <p>MD: "That's why I avoid coming across as a law enforcer because it ends the conversation and they stop asking questions. You lose that trust. It's not good to be a cop and a doctor." CO: "I feel like a bit of a snitch more than anything. At the same time, you have to enforce the law."</p>

Abbreviations: CO, coordinator; EX, executive director; NU, clinic nurse; PM, peer mentor; MD, clinic physician.

Alabama and led to more arrests and prosecutions for nondisclosure.⁵ Since HIV care employees were the focus of this study, it is unclear from a client's perspective whether counseling about mandatory disclosure and having signed consent forms helped or hindered HIV disclosure. Published research on this topic indicates that clients are more likely to disclose to sexual partners after being counseled about safer sex^{12,13} and that HIV counseling results in fewer episodes of unprotected sex or STIs.¹⁵ However, our interviewees doubted the effectiveness of such efforts. They perceived clients to be fearful, evasive, secretive, or overly agreeable during counseling sessions. The providers were skeptical because the client or a partner had presented with an STI or became pregnant, or because the client appeared to be in denial.

The providers' skepticism about client behavior raises the question of whether having to sign consent forms contributes to clients' reluctance to discuss prosecutable actions in HIV care settings. As noted earlier, having to sign a consent form was a barrier to HIV testing in New York because people did not want to be identified.¹¹ Requiring a consent form that describes the legal penalties for nonadherence and states that a client's signature could be used for evidentiary purposes in a court of law could have even greater deterrence to honest reporting among people who fear prosecution or who feel stigmatized by HIV/AIDS.¹⁶ The research did not clarify whether signing a consent form for HIV testing is the same as a formal discussion about mandatory disclosure (and signing forms) in relation to barriers to notifying partners. Future studies could help to answer this question and, even more usefully, could engage clients in their motivations for abiding by or ignoring the law for mandatory disclosure to sexual partners.

We found that almost all providers in North Carolina supported formal and sometimes repeated consent in order to ensure compliance with HIV control measures in the state. This finding suggests that HIV-specific codes and laws generate their own logic that meshes with (or shapes) the worldview of HIV care providers who are responsible for counseling clients about disclosure. By contrast, Alabama's less strict public health code for STI/HIV control provided greater flexibility for counseling clients about disclosure and generated a variety of counseling styles and practices across the state, none of which required written consent. Public health code requirements for mandatory disclosure were still evident in "notify your partner—it's the law" messages, but the Alabama providers were equivocal about HIV criminalization and likely to acknowledge the difficulties of disclosure to sexual partners. This ambivalence might relate to the absence of an HIV-specific public health code in Alabama, but other factors might be in play as well, such as strong local advocacy to decriminalize HIV on social justice grounds.¹⁷

A third finding was the connection between providers' roles and their support for the law. In general, administrators and designated employees who formally counseled clients about the law viewed mandatory disclosure as essential to protecting the public's health and were likely to pressure clients to follow the law. Conversely, physicians and clinical nurses who provided HIV care were more concerned about health maintenance and expressed greater skepticism about the fairness or benefits of HIV laws for HIV control. Clinical providers were also more concerned about how the HIV laws affected continuity of care. A study of quality of care at STD clinics found similar differences in attitudes toward clients, with lower level employees

expressing greater concern about client behavior and medical staff expressing greater concern about client care.¹⁸ Such findings not only reflect the division of labor in STI/HIV care but also suggest that support for HIV laws is stronger among staff members who are primarily responsible for counseling clients and referring suspected violators to DIS. The DIS, who engage in investigative activities in relation to “challeng[ing] patient denial and evasiveness” in order to expose the truth,¹⁹ are the primary means by which prosecution becomes a reality.

Conclusions

This study contributes to the knowledge about how clients are counseled about adhering to HIV laws for disclosure. By comparing 2 southern states with different public health codes, we came to 2 conclusions about the interface between law and praxis in counseling practices about mandatory disclosure. First, the public health statutes provided a legal framework for counseling protocols and practices for HIV counseling in each state. We found that the law served as a point of action; that is, North Carolina’s HIV code directed providers to counsel clients in a standardized format that included documentary proof of consent, and Alabama’s STI/HIV code allowed flexibility in how providers counseled clients about disclosing to sexual partners. We also concluded that support for HIV laws directly related to locality. One state (Alabama) had an ethos of legal leniency, informal counseling practices, and less support for enforcement. North Carolina’s ethos was toward stricter law, formal counseling practices, and greater support for enforcement, perhaps because standardized protocols and specialized training for the 7 North Carolina control measures had reduced cognitive dissonance among providers. Further research could establish whether this congruence between law and praxis occurs in other regions of the United States or internationally.

An unanswered question is whether these differences in law and praxis actually affect client disclosure. Although this question could be addressed in future research, we believe that the consensus among providers about nonadherence casts doubt on the efficacy of HIV laws for mandatory disclosure. It is telling that, regardless of the US emphasis on formal counseling for secondary prevention and the threat of prosecution for violators, HIV rates have remained stubbornly high, especially among African Americans in the South.²⁰ Both health advocates and federal policymakers have recommended changing HIV laws and codes that criminalize nondisclosure, in part because of the widespread concerns about HIV laws being a barrier to testing and treatment²¹ and also because transmission to sexual partners is unlikely if antiretroviral drugs are taken on a regular basis.²² Sayings such as “take the test, risk arrest” which have circulated among at-risk communities in recent years are the direct result of HIV laws that were institutionalized in the manner we discussed and whose intent was relayed to clients through warnings, signed consent forms, and reiterative counseling about the legal consequences of failure to disclose.^{10,23} In view of the putative cat-and-mouse activity

between providers and clients reported in this study, perhaps it is time to change the law enforcement model of HIV counseling so that the threat of prosecution no longer deters open dialog with the clients about helpful strategies for disclosure to sexual partners.

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