SUPPORT FOR HIV TESTING AND HIV CRIMINALIZATION AMONG OFFENDERS UNDER COMMUNITY SUPERVISION ☆

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ABSTRACT

Purpose – *U.S. health policy promotes HIV testing and linkage to care (test-and-treat) with an emphasis on high risk groups such as convicted offenders. We sought to identify whether or not laws for mandatory HIV disclosure to sexual partners are a barrier to HIV testing among offenders under community supervision.*

Methodology/approach – *A total of 197 probationers and parolees were surveyed in a closed/item-open-ended item methodology on two reporting days in Alabama. Three main questions were asked: (1) What do offenders know about HIV? (2) What do they know about the law? (3) Do they support mandatory disclosure and HIV testing? Data for*

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the quantitative items were analyzed with SPSS and matched with open-ended responses for explanatory purposes.

Findings – *Testing and criminalization of non-disclosure were fully supported as key elements of HIV prevention. This support was framed by conceptions of HIV as a killer disease, of people with HIV as potential murderers, and by low self-awareness of HIV risk.*

Social implications – *While the study involved only a single group of convicted offenders in a southern state, the results suggest that disclosure laws legitimize HIV stigma and undermine test-and-treat strategies among communities at risk.*

Originality/value – *The research is the first of its kind to investigate possible links between HIV criminalization and barriers to HIV prevention and care among convicted offenders.*

Keywords: Convicted offenders; support of HIV testing; HIV criminalization

In 2010, the U.S. National Office of AIDS Policy (ONAP) developed the National HIV/AIDS strategy with three major related goals: (1) to reduce HIV incidence through routine testing, (2) to decrease HIV-related disparities and stigma, and (3) to provide access to HIV care (ONAP, 2010a). For the first and third goals, the strategy focuses on outreach to vulnerable communities for HIV testing and linkage to care, an approach that is referred to as test-and-treat. Convicted offenders are included in the goal for targeted HIV outreach. The strategy acknowledges a variety of potential barriers to this goal, including state laws for mandatory HIV disclosure to sexual partners. As stated in the document, people living with HIV/AIDS (PLWHA) have little incentive to be frank with sexual partners if they face increased HIV stigma and fear of arrest after being legally framed as medically dangerous (ONAP, 2010a). HIV criminalization laws therefore appear to be at odds with scaled-up efforts for HIV testing in communities at risk (Center for HIV Law and Policy, 2010).

The origins of HIV-specific laws, such as mandatory disclosure to sexual partners are seated in legislative responses to the rapid spread of HIV in the 1980s (Jürgens et al., 2009). Although the laws are controversial (Jürgens et al., 2009; Kaplan, 2012), they are also increasingly common throughout the United States. Following one HIV-related prosecution in

1986 (Center for HIV Law and Policy, 2010), at least eight states enacted HIV disclosure laws shortly afterward (Turkewitz, 2011). By 2008, 24 states had enacted HIV-specific codes for mandatory disclosure (Galletly & Pinkerton, 2008), with 13 more states creating statutes for this purpose in 2010 (Movement Advancement Project, 2014). Despite this law enforcement approach to HIV prevention, new HIV cases have remained steady at around 50,000 per year since 2010 and infection rates among Young Black Men who have Sex with Men (YBMSM) have risen sharply in recent years (Centers for Disease Control and Prevention [CDC], 2013a).

HIV prevention strategies for former inmates involve a variety of ancillary services such as discharge planning, transitional case management, housing, mental health services, and drug treatment (Robillard, Gallito-Zaparaniuk, Braithwaite, Arriola, & Kennedy, 2009). In the current test-and-treat era, employees in AIDS service agencies and health departments provide HIV-specific services such as counseling for mandatory disclosure, testing, and referrals or treatment for HIV/AIDS. However, access to HIV care is often affected by a variety of factors that involve convicted offenders, such as stigma, mental illness, substance abuse, and distrust of authorities (Ulett et al., 2009). Since sociological perspectives can help policymakers to understand sociocultural barriers to HIV prevention, it is useful to identify whether or not offenders under community supervision, as a target population, are receptive to HIV testing, and if laws for mandatory disclosure affect their willingness to participate in test-and-treat strategies for HIV control.

This chapter presents the results of a study that assessed knowledge and attitudes toward mandatory HIV disclosure and HIV testing among 197 offenders under community supervision in Alabama, the United States. The demographic characteristics of this population reflect racial disparities in the U.S. criminal justice system and regional disparities of HIV risk. For example, while African Americans comprise 26 percent of the total population of Alabama (U.S. Census Bureau, 2012), almost twice as many state-supervised probationers and parolees are Black (49 percent) (Alabama Board of Pardons and Paroles, 2013). On a broader scale, African Americans represent 13 percent of the total U.S. population (U.S. Census Bureau, 2013) and 30 percent of community supervised populations nationally (U.S. Bureau of Justice Statistics, 2011). Because HIV risk and criminal justice involvement are closely related (Epperson, El-Bassel, Gilbert, Orellana, & Chang, 2008), laws for HIV control and targeted policies for HIV testing should be examined in terms of how communities at risk perceive or respond to them. Toward this end, four main questions were asked

of our sample: (1) What did the participants know about HIV/AIDS? (2) What did they know about Alabama's disclosure law? (3) Did they consider mandatory disclosure to be a barrier to HIV testing? (4) Should offenders be tested for HIV/AIDS? Few studies have addressed these questions empirically; even fewer have been conducted among convicted offenders who are stakeholders in scaled-up efforts for HIV prevention in the United States. This study offers new information on the intersection between HIV laws and HIV testing among offenders under community supervision in a region with the highest rates of HIV/AIDS in the United States (CDC, 2013b).

HEALTH DISPARITIES, SOCIAL JUSTICE, AND HIV CONTROL

HIV disparities are the product of social difference according to intersections of gender, race/ethnicity, poverty, sexual identity, and other markers of social status. In sociological terms, HIV disparities exemplify the social-constructivist paradigm in which patterns of disease and death are shaped by history, social structure, and the lived environment (Weitz, 2012). Parker and Aggleton (2003) argued that power and domination are at the crux of the matter, with stigma being the means by which social inequality is strengthened and reinforced through moral judgments about who becomes infected or ill. This argument is in line with sociological understandings of health disparities more broadly. For example, Wilkinson and Pickett (2009) found that, despite stigmatizing tropes about poor people's bad health habits, national and cross-national variance in morbidity and mortality are closely related to income disparities, even when controlling for smoking, lack of physical exercise, and poor diet. Just as the unequal distribution of wealth is directly responsible for shorter life spans among low-income people, the unequal distribution of social power, including wealth, also produces disproportionately greater HIV rates among society's most vulnerable or least valued actors (Link and Phelan, 2002). Thus, while blame for illness is commonly attributed to lifestyle, societies create their own patterns of disease for transmissible infections such as HIV/AIDS, as well as chronic health conditions that disproportionately affect low-income groups and people of color. HIV disparities were shaped most notably by the U.S. war on drugs which created "[a] penal system so large that it is now an important part of a uniquely American system of social

stratification" (Western, 2006, p. 11). Large-scale incarceration has hollowed out communities of color, creating gender ratio disparities that promote sexual concurrency as a risk factor for HIV (Lichtenstein, Desmond, & Schwebke, 2008) and women's disempowerment in initiating condom use with male partners (Ferguson, Quinn, Eng, & Sandelowski, 2006).

Health disparities also involve barriers to health care. Sociology has identified the interplay of socioeconomic and cultural factors in these barriers, which include mistrust of medical professionals who are often socially different from the patients they treat (ONAP, 2010b). The reference to social difference is particularly relevant to this study. In writing about illness and identity, Karp (1999, p. 83) referred to chronic illness as a career in which "the person holds a position, engages in routine activities, and takes on certain perspectives." In extending this concept to AIDS-affected communities, such perspectives include historical distrust of a health system that recruited unsuspecting African American men for experimentation in the Tuskegee Syphilis Study of 1932–1972 (Jones, 1993). Because African Americans are disproportionately affected both by HIV/AIDS and criminal justice involvement, and distrust for the health system is seated in the *habitus* (collective dispositions) of black Americans (Gamble, 1997), it is important to identify how HIV testing is perceived in an era of HIV criminalization. If Karp's career trajectory holds for AIDS-affected communities that have been targeted for test-and-treat strategies, then the perspectives and positions of participants in this study could include resistance to scaled-up HIV testing on the basis of community-based distrust for U.S. public health policy.

Two related issues in terms of HIV disparities involve prosecutions for non-disclosure and a widening gap between law and medicine over prosecuting exposure to sexual partners. First, people who are poor or homeless, immigrant, or engaged in sex work have been prosecuted disproportionately on a global scale (Jürgens et al., 2009). In the United States, minority groups are more likely than Whites to be convicted under HIV laws for exposure, as well for posing a threat to public safety. To illustrate, after analyzing data on 56 criminal convictions under Michigan's HIV disclosure law, Hoppe (2012) found that African American men were more likely to be convicted than Whites or Hispanics, especially if they had not disclosed to women partners. Galletly and Lazzarini's (2013) analysis of 25 arrests for HIV exposure in Tennessee revealed a similar overrepresentation of African American men who received longer sentences than whites for the same crime.

Second, scientific knowledge about HIV/AIDS has advanced so that HIV laws appear to be outdated and punishment under such laws to be unnecessarily punitive, especially if HIV transmission does not occur.

Nevertheless, prosecutions for HIV-related crimes have escalated in recent years (Center for HIV Law and Policy, 2010). Criminal sanctions in such cases can be particularly harsh. In Texas, one PLWHA who spat on a police officer was charged with assault and sentenced to 35 years in prison (Center for HIV Law and Policy, 2010), even though saliva is not a mode of HIV transmission. In Iowa, a man with an undetectable viral load, who used a condom during intercourse, was sentenced to 25 years for non-disclosure (National Alliance of State and Territorial Directors [NASTAD], 2011). The lengthy sentence in this and other cases does not recognize that PLWHA with undetectable viral loads are unlikely to infect sexual partners (Donnell et al., 2010). Such legal approaches typically affect underserved populations who are often the locus of surveillance for sexual disease as well as for crime control in the United States.

METHODS

Recruitment and Sampling

Recruitment of probationers and parolees took place after IRB approvals were obtained from The University of Alabama and the Alabama Board of Pardons and Paroles. A total of 77 probationers and 120 parolees ($N = 197$) were recruited over two mandatory reporting days at the Probation and Parole Office in Birmingham, the largest site for offenders under community supervision in Alabama. All supervisees were eligible to participate in the research if they were 19 years or older, and all were given an opportunity to participate on a voluntary basis. The decision to recruit supervisees at one site centered on the practicality of collecting data from a central location and the need to obtain a sizeable sample so that both groups could be compared on study variables of interest. The site was a substantial distance from the authors' home institutions, which afforded the participants a measure of anonymity in addition to other protections, such as omitting names, addresses, and other identifying information from completed questionnaires.

For the purpose of comparison, offenders who had ever served time in prison were categorized as parolees, and offenders who never served time in prison were categorized as probationers. The only supervisory difference between these two groups was that the parolees were under the jurisdiction of the state Board of Pardons and Paroles and probationers were under the

jurisdiction of Alabama's Circuit Courts. Unless a special condition is ordered by the Parole Board (for the parolees) or the presiding judge (for the probationers), the terms of supervision are the same.

Instrument

The participants completed a self-administered questionnaire at the 5th grade reading level. The instrument had five sections, for a total of 34 items. Section 1 consisted of 11 true/false items about how HIV could be prevented (e.g., condom use) or transmitted (e.g., mosquitoes; shared needles for drug use). Section 2 consisted of five Likert-scaled items to assess participants' perceptions of HIV risk and who should be tested for HIV. An additional item asked if participants knew anyone with HIV/AIDS but, as stipulated by the Alabama Board of Pardons and Paroles, we could not ask about participants' own HIV status. Section 3 consisted of three yes/no items about the HIV law and one scaled item about how much participants knew about the law (a lot, some details, or nothing). Four open-ended items then assessed knowledge of the law. For example, by asking "What do you know about the Alabama HIV law?" we wanted to find out if participants knew that HIV non-disclosure to sexual partners is a misdemeanor crime punishable by a fine of $500.00 and up to three months in jail. Other items in this section asked about the source of this knowledge, what they said about the law, and opinions about whether or not the law was fair. This closed-item/open-ended item technique is often used to elicit the meaning of responses to closed items in public opinion research (Zaller & Feldman, 1992). Section 4 consisted of two yes/no items about whether or not participants had ever attended a HIV prevention class and if they were offered these classes while being supervised. Section 5 consisted of eight demographic items for gender, age, race/ethnicity, marital status, education, income levels, arrest charge, and offender status (probation or parole).

Procedures

Recruitment and data collection occurred simultaneously on the two mandatory reporting days. Procedures involved setting up a table in a corner of the central waiting area of the Probation and Parole Office with a signboard and university insignia in order to avoid any appearance of being affiliated with the office or supervisees' conditions for probation or parole. Recruitment

consisted of asking each individual who attended the office if he or she wished to participate in the study. About 85 percent of attendees agreed to participate, with refusals citing lack of interest or being pressed for time. After participants were formally consented and allotted a questionnaire to complete, we helped to interpret items if asked (some participants had minimal literacy), checked each protocol for any missing responses, and stored the protocols in a lock-box. Each participant received a $5.00 Wal-Mart gift card and a copy of the consent form to take home. On both days, the target sample of 100 surveys was administered and collected before the office closed at 5:00 p.m. Three surveys were discarded because they lacked an identification number for coding purposes for a total sample of 197 participants.

Characteristics

The participants were similar demographically to the overall population of offenders in Alabama. Most participants were African Americans (73 percent), male (65 percent), aged between 26 and 50 years old (65 percent) and unmarried (58 percent). More than two-thirds had a 12th grade education or lower (67 percent), and 80 percent of the sample had earned $20,000 or less in the past year. However, probationers and parolees differed significantly by gender, age, income, and the offense for which they were being supervised. Parolees were more likely than probationers to be male (73 percent vs. 56 percent), older than 35 years (64 percent vs. 37 percent), and to have earned less than $10,000 in the past year (69 percent vs. 46 percent). They were also more likely to have been convicted of violent or sex-related crimes (35 percent vs. 13 percent). Table 1 compares the sociodemographic characteristics of the two groups.

Analysis

The quantitative data were coded for SPSS analysis. First, we scored responses in the knowledge section of the survey instrument by dividing the number of correct responses by the 11 items for percentages of the total. Then, we organized these percentages into low, medium, and high scores. Next, chi-square tests were performed to identify relationships between sociodemographic characteristics, ordinal scores for HIV knowledge, and responses for Likert-scaled items relating to knowledge of the HIV law and attitudes toward HIV testing and mandatory disclosure. We also used

Table 1. Demographic Characteristics by Offender Status ($N = 197$).[a]

Variable	Probationers ($N = 77$)	Parolees ($N = 120$)	p
Gender			*.016*
% Male	56	73	
% Female	44	28	
Race/ethnicity			NS[a]
% African American	66	79	
% White	34	20	
% Hispanic	0	1	
Age			*.001*
% 19–25	29	10	
% 26–35	33	27	
% 36–50	20	46	
% Over 50	17	18	
Marital status			NS
% Unmarried	58	59	
% Married	27	18	
% Divorced/widowed	14	22	
Education			NS
% HS or less	58	75	
% Some college	29	20	
% College degree	13	6	
Income			*.015*
% Below $10,000	46	69	
% $10,001–$20,000	27	16	
% $20,001–$30,000	19	11	
% Over $30,000	8	4	
Arrest charge			*.007*
% Drugs	48	33	
% Theft	23	23	
% Violent	10	30	
% Sex	3	5	
% Other	16	10	

NS = not significant at $p < .05$.
[a]Totals may not sum to 100% due to rounding.

chi-square tests in order to compare responses on HIV knowledge and attitudes towards mandatory disclosure and HIV testing by offender status (probation or parole). Finally, we compared responses to yes/no or scaled items on HIV law and HIV testing to open-ended items on these topics for explanatory purposes. For example, scaled responses to "How much do you know about Alabama's HIV law?" were linked to narrative details about knowledge of the law prior to taking the survey, and yes/no

responses to the item "Do you think the law is fair?" were linked to details about why the law was fair or unfair. These responses were organized according to themes that emerged from perspectives on HIV testing and the law. As reported by Reja, Manfreda, Hlebec, and Vehovar (2003, p. 169), the "richness of responses" in linking closed- and open-ended items for designated topics helps to explain the participants' rationale or frame of reference according to sociodemographic characteristics or circumstances. This mixed analytical technique was used to inform the results that are discussed next.

RESULTS

Knowledge about HIV/AIDS and Mandatory Disclosure HIV Law

Most participants answered the 11 true/false items on the HIV knowledge section correctly, with an average test score of 80 percent. Nevertheless, more than one-third of the sample (38 percent) believed incorrectly that mosquitoes transmitted HIV and more than half (59 percent) did not know that bleach could be used to sterilize needles for injection drug use. When converted to high/medium/low scores, two-thirds (65 percent) of participants earned a high score (9–11 knowledge items answered correctly). Most participants (69 percent) had also heard about Alabama's HIV law for mandatory disclosure, but only 19 percent overall knew any details beyond the threat of being arrested or jailed for non-disclosure. Little variation existed in terms of offender status or demographic characteristics such as gender, race/ethnicity, level of education, and HIV knowledge. However, parolees were more likely than probationers to know someone with HIV (45 percent vs. 22 percent), perhaps because they were older, more socially disadvantaged, and had served time in prison. Although the relationship between knowing someone with HIV and offender status was significant at the $p < .01$ level, personal acquaintance did not influence test scores for knowledge about HIV/AIDS ($p = .116$), or Alabama's HIV law ($p = .639$). Table 2 compares the results on knowledge about HIV, mandatory disclosure, and knowing someone with HIV/AIDS by offender status.

Narrative comments about Alabama's HIV law indicated that participants' knowledge related mostly to hearsay about people in the community being arrested for non-disclosure. The source of this information involved church, friends, or the workplace for probationers (83 percent) and jail,

Table 2. Knowledge of HIV/AIDS, Mandatory Disclosure, and PLWHA by Offender Status.

Item	Score	Probationers ($n = 77$) %	Parolees ($n = 120$) %	Total ($n = 197$) %	p
a. Knowledge of HIV/AIDS[a]	High	61	68	65	NS
	Medium	35	27	30	
	Low	4	5	5	
b. Knowledge of disclosure law[b]	High	17	20	19	NS
	Medium	53	49	50	
	Low	30	31	31	
c. Knows someone with HIV/AIDS	Yes	22	45	37	*.001*
	No	78	55	63	

NS = not significant at $p < .05$.
[a]HIV/AIDS scores: Out of a maximum of 11 items, high scorers were correct on 9–11 items, medium scorers were correct on 6–8 items, and low scorers were correct on 1–5 items.
[b]HIV law scale: "a lot" = high; "some details" = medium, "none" = low.

prison or family and friends for parolees (78 percent). Several misconceptions about the law were apparent after taking the narrative responses into account. Of the 53 participants who described what they knew about Alabama's HIV law (e.g., "You can go to jail" "You can be arrested"), nine were under the impression that the law falls under a murder charge and 17 thought that having HIV was a crime. Only one participant provided detailed information about the law (e.g., it is a misdemeanor crime; it is rarely prosecuted in Alabama), stating that he had learned these details from a case worker at a county health department. In sum, participants' knowledge about mandatory disclosure was perfunctory and obtained primarily from anecdotal sources.

Mandatory Disclosure as a Barrier to HIV Testing

Two-thirds of participants (66 percent) stated that mandatory disclosure was a barrier to HIV testing. The level of belief did not vary significantly by offender status or sociodemographic characteristics. In terms of why the law was a barrier to testing, a few participants again cited "fear of arrest" and "fear of arrest/going to jail" or, tangentially, "they don't want to be told they have HIV/AIDS, so they don't get tested." One participant believed that "The law does not reduce the spread of HIV/AIDS because

so many people conceal their HIV status from their partners." Twelve percent of the sample was acquainted with someone who had been arrested for non-disclosure. While this percentage is relatively low, it helps to explain participants' beliefs about the consequences of HIV testing for someone who receives a positive diagnosis.

Participants were also asked if they thought the law was fair or unfair. Paradoxically, despite believing that criminalization was a barrier to HIV testing, 85 percent of the 109 participants who responded to this item believed that the law was fair, and that prosecuting violators was warranted. Once again, this agreement did not vary significantly by offender status or sociodemographic characteristics, with the law receiving broad support from all quarters. Explanations for this result centered on a collectivist perspective and moral certitude about the necessity of protecting sexual partners from infection. Five themes were identified in narrative responses to this item:

(1) People have a right to know their partners' HIV status ($n = 39$)
(2) Not disclosing harms/kills others ($n = 25$)
(3) The law protects the public/reduces the spread of HIV ($n = 17$)
(4) It is morally wrong not to disclose ($n = 7$)
(5) The law provides justice ($n = 5$).

As evident from summary comments in Table 3, beliefs about fairness were sometimes expressed in moral outrage for non-disclosure as an act of murder. The intensity of these expressions helps to explain why such laws have gained traction in the United States, including among people with a criminal record themselves. Only nine participants, all African Americans, questioned the fairness of the law in terms of the burden of responsibility for PLWHA and communities at risk.

Who Should Be Tested?

The question of whether or not offenders should be tested for HIV (testing is mandatory in Alabama prisons) met with similar approval. Almost all participants (98 percent) agreed that inmates in jail and prison should be tested for HIV. Although less likely to agree that probationers or parolees should be tested for HIV, most participants supported testing as a public health measure for offenders under community supervision (68 percent). This result did not vary significantly by race, gender, or offender status. However, despite a history of drug use and other risk factors, only

Table 3. Support for Alabama's HIV Law for Mandatory Disclosure ($N = 109$).[a]

a. The Law is Fair ($n = 93$, 85%)	b. The Law is Unfair ($n = 9$, 8%)
"Your ass needs to go to jail for that."	"The law protects those who are not infected but violates the privacy of those who are."
"They should be required to put their HIV status on drivers' licenses."	"Some laws don't make sense."
"The law helps them to stop and think."	"People shouldn't have to go to jail for having sex with HIV."
"Yes, because people want to spread AIDS."	"It's unfair because everyone don't know about the law."
"I don't want them around, so it's fair."	"Only poor people are being prosecuted for it."
"It's fair because it's the law."	"It should be a personal choice to disclose your status to a partner."
"The law is fair because it stops the killing."	"We are living in times when [partners] don't listen to you."
"HIV is deadly and to conceal is criminal."	
"If you have AIDS and don't tell your partner, that's murder."	
"The law will help to save the next generation."	

[a]Seven participants (6%) who answered this question were undecided about whether or not they supported the law; they are not included here.

17 percent of participants realized or admitted that probationers and parolees were at greater risk of HIV than members of the general public. Further, only 16 percent agreed that parolees, who generally are older and have served time in prison, were at greater risk than probationers whose criminal justice involvement is often minimal. These results are summarized in Table 4.

One result was more encouraging in terms of realistic appraisals of individual HIV risk. Risk awareness was highest among participants who had attended HIV classes (46 percent of parolees vs. 15 percent of probationers). These participants were significantly more likely than nonattendees to agree that offenders under community supervision are at greater risk than the general public ($p = .03$), suggesting that HIV programs in correctional settings, drug treatment programs and other points of contact are useful for HIV risk awareness and prevention. Further, more than one-third of participants (38 percent) who were offered HIV prevention classes had taken them compared to only 14 percent of people who were never offered classes ($p = .001$). Providing HIV education classes to offenders could be the key to participation rather than expecting offenders to

Table 4. HIV Testing, Risk, and Education ($N = 197$).[a]

Item	Agree %	Disagree %	Undecided %
a. Who should be tested for HIV?			
Probationers/parolees	68	15	18
Inmates in jail	98	1	1
Inmates in prison	98	1	1
b. Who is at greater risk of HIV?			
Probationers over general public[a]	17	68	17
Parolees over general public	20	68	14
Parolees over probationers	16	69	17

[a]Totals may not total 100% because of rounding.

volunteer on their own accord. Most attendees had taken HIV classes in prison rather than in community settings, which suggests greater availability to such programs when incarcerated, but also fewer opportunities for offenders under community supervision. Only 21 percent of the entire sample had been offered HIV classes while on probation or parole.

DISCUSSION

The study revealed strong support for HIV testing and mandatory HIV disclosure among a sample of offenders under community supervision in Alabama. By focusing on these two elements of HIV control, we were able to identify if target groups, which include convicted offenders, were receptive to HIV testing in an era of criminalization for non-disclosure. As noted in the introduction, policymakers, health providers, and community activists are increasingly concerned about HIV laws for mandatory disclosure because, as reported by Turkewitz (2011): "Who wants to know their status if they can be arrested?" We will discuss the findings of our study within this dialectical framework, with a particular focus on results that could inform test-and-treat strategies for HIV control among convicted offenders.

Participants were asked what they knew about HIV/AIDS in segue to our primary focus on attitudes and beliefs toward HIV testing and mandatory disclosure. We found that awareness of how HIV is acquired and prevented was reasonably good. The average score of 80 percent was similar to 82 percent correct answers on HIV risk behavior knowledge among

1,050 students at historically Black colleges and universities (Sutton et al., 2011), and 84 percent correct responses among 800 felony probationers in rural states (Oser, Leukefeld, Cosentino-Boehm & Havens, 2006). By contrast, knowledge of Alabama's HIV disclosure law was only fair, although most participants knew that non-disclosure was a crime. Other statements about the law, including that people who do not disclose could be charged with murder under Alabama's HIV code, were more vengeful than true. Some participants believed that HIV itself was crime, which raises the question of whether or not HIV criminalization helps to promote such beliefs at a time when policymakers seek to end stigma and discrimination toward PLWHA and to build stronger rapport with health providers, including by revisiting laws for HIV exposure that are not supported by medical evidence (ONAP, 2010b).

The results were mixed on fairness of the law versus the law as a barrier to testing. Although most participants cited fear of arrest and going to jail as barriers to testing, an even larger majority believed that the law was fair, referring to non-disclosure as an act of murder or death sentence. These responses are likely to reflect ideas about HIV transmissibility that are rooted in the panics of the 1980s, before the advent of antiretroviral medicines made HIV treatable and reduced the likelihood of transmission to sexual partners (Donnell et al. 2010). Such views might be common in constituencies that are being targeted for HIV testing, as suggested by Horvath, Weinmeyer, and Rosser's (2010) finding that 65 percent of 1,725 MSM supported the criminalization of non-disclosure. The idea that PLWHA carry a death sentence exists among other publics as well. For example, Djokic et al. (2009, p. 27) reported that 75 percent of 500 U.S. housing authority residents believed that PLWHA die within a year of being diagnosed, a result that the authors attributed to "serious adverse stigmata." Educational efforts are clearly needed in order to counter the perception that HIV is a certain death sentence for anyone who receives a positive diagnosis.

HIV testing was supported as a public health measure for HIV control. Participants' beliefs that inmates, in particular, should be tested might reflect Alabama's policy of mandatory testing prisoners as required by state law, or the idea that prisoners are more likely to have HIV/AIDS. While approval of HIV testing was unequivocal, participants were more likely to believe that inmates should be tested rather than community-based offenders like themselves. This high level of support for testing could be interpreted as receptiveness to test-and-treat programs among offenders under community supervision; however, additional findings of this study suggest

otherwise. For example, most participants did not believe that probationers and parolees were at greater HIV risk than the U.S. general population, a misconception that could reduce voluntary HIV testing (see "Implications"). Participants also held stigmatizing ideas about PLWHA and supported HIV criminalization by a wide margin, both of which could deter voluntary testing in order to avoid being stigmatized. On this point, Levy et al. (2014) found that stigma was a barrier to HIV prevention self-efficacy among BMSM and that HIV testing itself was stigmatized in their social networks.

An unexpected finding of the study relates to the importance of HIV classes in achieving goals for HIV prevention. One-third of participants had taken HIV classes in prison or drug treatment programs, a higher proportion than in other correctional settings in the United States (see Belenko, Langley, Crimmins, & Chaple, 2004; Collica, 2007; Oser et al., 2006). Participants in the current study were significantly more aware that offenders under community supervision were at greater risk of HIV/AIDS than the general public, although they were also older than the 15–29 years at which people are typically diagnosed with HIV/AIDS (CDC, 2013c). This age discrepancy affirms the urgency of implementing HIV prevention programs for young people at risk, particularly offenders under community supervision who were never incarcerated or enrolled in drug treatment programs.

As a final point, participants' beliefs that structural interventions (HIV laws, HIV testing) were beneficial for HIV control raises the question of support for laws that are deemed to be a barrier to testing. Other researchers have identified stigma as a bridging factor between the two domains. For example, Mahajan et al. (2008), NASTAD (2011), Block (2014), and Jürgens et al. (2009), to name a few, identified stigma as an obstacle in testing for HIV, and as noted earlier, policymakers have framed HIV criminalization in terms of prejudice toward PLWHA (ONAP, 2010a). In the present case, stigma was expressed in views about HIV/AIDS as a deadly disease and non-disclosure as an act of murder. This response helps to solve a riddle: the law was supported because of a basic premise ("non-disclosure is murder"), and was a barrier to testing for the same reason – PLWHA are "murderers in the making." This logic is likely to reflect attitudes toward PLWHA in the community at large.

Limitations

The results should be interpreted with caution. Although the self-administered questionnaires were worded at a fifth grade reading level,

about 20 percent of participants needed help in order to interpret or complete some items. While every attempt was made to be as neutral and non-directive as possible, such hands-on help might have produced socially desirable answers. Future research with offenders could use "talk" methods such as focus groups or personal interviews that do not require participants to answer survey items. However, qualitative methods might not be as practical as brief surveys that can be completed at short notice on reporting days when large numbers of offenders are in attendance. While our research is novel in exploring the knowledge and attitudes of U.S. probationers and parolees on HIV control measures, the study also did not fully explore why HIV laws were a barrier to HIV testing. Further research could identify the effects of incarceration, probation, or parole on willingness to be tested, investigate the dynamics of race and gender in relation to testing and the law, and examine relations between mandatory disclosure, penalties for HIV exposure, and uptake of testing and HIV care.

IMPLICATIONS FOR THE SOCIOLOGY OF HEALTH CARE

The sociological implications of the results center on health beliefs and dispositions in relation to U.S. policy for scaled-up HIV testing among communities at risk. The participants' beliefs that convicted offenders are *not* at greater HIV risk than members of the general public suggest low rates of voluntary HIV testing in such groups, despite high levels of support for this measure. In public opinion surveys, people who believe that they are not at risk of HIV/AIDS are unlikely to be tested on a voluntary basis (Henry J. Kaiser Family Foundation, 2014). In relation to the Southeastern states, Gay, Napravnik, and Eron (2006) and Krawczyk et al. (2006) found that an alarming number of non-diagnosed PLWHA do not get tested prior to becoming symptomatic or being hospitalized with an AIDS-defining illness. Such delays in care-seeking, which are among the worst in the nation, are likely to contribute to the region's disproportionately high HIV rates as a cause of excess morbidity and mortality among African Americans. The testing-related *habitus* of the South, as shaped by low self-awareness of HIV risk, low health literacy among communities at risk (Parikh, Parker, Nurss, Baker, & Williams, 1996), and the moral geography of a socially conservative region, casts doubt on the efficacy of national strategies to reduce HIV rates through early testing and linkage to care.

A question that was raised earlier in this chapter involves barriers to scaled-up HIV testing on the basis of historical distrust for U.S. health policy among African Americans. The issue is relevant to HIV control because most participants – as well as 78 percent of Alabama's incarcerated offenders – involve people of color (Mauer & King, 2007). If distrust for public health policy is a salient factor among African Americans, then high levels of support for HIV testing and criminalization must be explained in terms of the context in which participants supported punitive sanctions for HIV non-disclosure and distanced themselves from PLWHA in them-and-us polarities. We contend that such responses reflect the power of HIV stigma to create social distance from the "other," even among convicted offenders who have a discredited identity of their own. The attitudes and beliefs that were expressed here place convicted lawbreakers in the role of defenders of the status quo and of hegemonic power in the workings of social inequality through HIV stigma (Parker & Aggleton, 2003). The harshness of these responses indicates that HIV holds a special place in the hierarchy of social stigma, and that convicted offenders represent the generalized other in terms of beliefs and attitudes toward HIV/AIDS in communities at risk. The implications of these findings are that HIV stigma may, in fact, be particularly harsh in HIV-affected communities, thereby helping to explain the discrepancy between support for HIV testing and criminalization of non-disclosure among participants, as well as delays in testing and care-seeking for HIV in southeastern states.

A conundrum for public health is how to reconcile the growing rift between law and medicine in approaches to HIV control. If HIV laws serve to legitimize prejudice and discrimination against PLWHA, then efforts should be made to synchronize HIV codes or policies with statutes for notifiable sexually transmitted infections such as syphilis or gonorrhea, and to review health care practices that appear too legalistic or alienating for people with a history of involvement with coercive authority. Since the sociology of health care looks critically at institutional goals and actions that contribute to health inequalities, the results of this study could be used to help destigmatize HIV/AIDS, advocate for reform, and make HIV testing more socially acceptable according to public health strategies that explicitly seek the voluntary participation of high risk populations. It is important to acknowledge that HIV laws for mandatory disclosure were generated by widespread fear and moral outrage after so-called "monstrous sexualities" were blamed for the HIV epidemic in the 1980s (Persson & Newman, 2008). Medical advances have since transformed HIV from a fatal disease to a manageable one, thereby creating a discursive space for

reconceptualizing HIV/AIDS in less stigmatizing terms, and also making it possible to contest outdated laws that appear to be more about punishment than prevention among communities at risk.

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