Decriminalizing HIV in Nevada

Timothy K. Taycher

University of Nevada, Reno

HIV is not the same disease as it was in the 1980s and early 1990s, but while this is true, there is still a vestige of AIDS Hysteria in Nevada law that is bad public health policy and empowers prosecutors to use someone's knowledge of their HIV status against them in court. The legislature should repeal Title 15, Chapter 201, Section 205 of the Nevada Revised Statues a "crime against public decency and good morals - the intentional transmission of HIV." The criminalization of HIV transmission is the only disease-specific criminal statute that exists in Nevada and many jurisdictions worldwide. Several of these laws were enacted before the advent of effective treatment for HIV and when rumor, stigma, and hysteria drove public perception of the disease. The year 1996 marked the publication of research that determined HIV could be controlled with combination antiretroviral therapy (ART) and in 2011, evidence was presented related to treatment as prevention, that people living with HIV and on treatment had a much-reduced chance of transmitting the virus to a seronegative partner (Hammer et al., 1996; Cohen, 2011). In 2012, pre-exposure prophylaxis (PrEP) was approved by the U.S. Food and Drug Administration (FDA) as a biomedical intervention that is near universally effective in preventing seroconversion (e.g. transmission). With these advancements in the HIV prevention and care and because criminal law should not be used as a method to discriminate against any class of people it is time to repeal the criminalization of HIV.

The Centers for Disease Control and Prevention's (CDC) *HIV Surveillance Report for 2015* reminds us that the HIV epidemic is far from over, while incidence rates have decreased over recent years the prevalence, because of longer lifespans, have remained stable (2016). In the Southern United States and among gay and bisexual men, HIV remains as it did in the beginning of the epidemic. We live in a country where every other gay or bisexual black man and one out of every four gay or bisexual Latinx men will be diagnosed with HIV in their lifetime (National

Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, 2016). The cohort of teens through young men represent the fastest growing population of new diagnoses in Nevada (Office of Public Health Informatics and Epidemiology, 2017). HIV stigma is the current contagion where the vector agent is fear and the symptoms are structural discrimination and active and passive bias (Lee, Kochman, & Sikkema, 2002). The stigma that people living with HIV face translates into anxiety related to disclosing one's status and internalizing that stigma leads to decreased ARV adherence, increased risk-taking behaviors, and other health complications (Smith, Rossetto, & Peterson, 2008; Rao, Kekewaletsw, Hosek, Martinez, & Rodriguez, 2007; Logie & Gadalla, 2009). While there is medication that people can take to control HIV and live lives comparable with their HIV-negative peers, the stigma associated with the virus has no medication except for social justice.

Nevada is one of many jurisdictions that actively contributes to the promotion of HIV stigma. Nevada has a law that contributes to the United States being the world leader of prosecutions of people living with HIV. These laws disproportionally prosecute those who are in highest risk groups of living with the virus (Hasenbush, Miyashita, & Wilson, 2016). The racial disparities in crime prosecution compounded by the racial disparities in how HIV affects the U.S. population is reason to abandon the morally unjust and scientifically ineffective policy.

FEDERAL LEGISLATIVE BACKGROUND – OUR NATIONAL PROBLEM

In August 1990, President George H.W. Bush signed into law the Ryan White Comprehensive AIDS Resources Emergency Act (Ryan White CARE Act) creating a federally-funded, community-based support system for low income people living with HIV/AIDS (PLWH). This bipartisan piece of legislation was ushered through the approval process by Senators Edward Kennedy, a Democrat from Massachusetts, and Orrin Hatch, a Republican from

Utah. While this law created the largest federal investment for communities to fight the epidemic of HIV/AIDS it unfortunately contained an amendment introduced by Senators Kennedy and Hatch that made it a federal priority for states to adopt criminal transmission of HIV statutes.

The amendment required that if any state wanted to receive money granted by the Ryan White CARE Act, the Department of Health and Human Services had to certify that the criminal laws in the jurisdiction are "adequate to prosecute any individual who knowingly and intentionally donates, or knowingly and intentionally attempts to donate, blood, blood products, semen, tissues, organs, or other bodily fluids (Kennedy & Hatch, 1990)." While this amendment was better than the rejected amendment of Senator Jesse Helms, a Republican from North Carolina, which would have created a federal crime of HIV transmission punishable by 10 years in prison, it did set the precedent for nationwide adoption of like laws (1990). At the time of the signing of the Ryan White CARE Act, 19 states had laws that criminalized the transmission of HIV. At the time of this proposed health policy paper, 32 states have laws specific to the criminalization of HIV (The Center for HIV Law and Policy, 2017). Nevada was one of those states who adopted HIV criminalization after the passage of the Ryan White CARE Act.

STATE LEGISLATIVE BACKGROUND – OUR LOCAL PROBLEM

In 1993, Nevada had a reported 1,537 people living with HIV. This only ranked 24th in total cumulative cases in the U.S. but ranked 9th in the HIV diagnoses rate, at 40 people per 100,000 population (Centers for Disease Control and Prevention, 1993). Nevada was a high-impact state then and remains a high priority state to this day for increased intervention due to our unique demographics. Under pressure to do something, anything to seem proactive in the HIV epidemic the Nevada Legislature felt the need to address HIV at the structural level.

For those who were not in the lower castes of American society, gay men, persons who use drugs, sex workers, and immigrants, HIV was viewed as a threat to the nation's blood supply and the heterosexual community. In an effort to stem the spread of HIV, Nevada's legislature took its first steps in 1993 since the first recorded death due to complications of AIDS 10 years prior (Russell, 1983). On June 7, 1993 the Nevada Senate's Committee on the Judiciary heard Senate Bill 514 which proposed to prohibit "certain conduct through which human immunodeficiency virus may be transmitted after testing positive for disease." While the Legislature was hearing this bill, they were also considering a repeal of the so-called *anti-sodomy law* which criminalized consensual sex between two adults of the same gender (Senate Bill 466, 1993). The first hearing of this HIV criminalization proposal was relatively tame compared to the *anti-sodomy law* repeal which brought activists for and against the issue from all corners of the State. Dr. Jerry Cade, at the time, the founding director of the HIV/AIDS unit at the University Medical Center of Southern Nevada and as of 2017, still serves the community, testified that he was hesitant about establishing a disease-specific crime within Nevada's criminal law, especially when there are ones that cause more death than HIV. The line of inquiry from the senators mainly focused on whether intent to transmit can be proved in a court, whether false allegations could be proven or disproven, and whether consensual sex would negate any allegation of transmission (Senate Committee on Judiciary Minutes for June 7, 1993). Senators and witnesses, which included representatives from the Nevada District Attorney's Association and Nevada Attorneys for Criminal Justice focused on the mechanics of implementation rather than the underlying need for such a bill.

Republican State Senator Mark James tangentially related the bill to public health in saying the law, "should protect not just the person who will get the disease but also society,

which should be protected from the spread of the disease (Senate Committee on Judiciary Minutes for June 7, 1993).” Days later at the second hearing of the bill, the Committee received testimony from Dr. Paul Cameron from the Family Research Institute, which according to their mission was founded, “to generate empirical research on issues that threaten the traditional family, particularly homosexuality, AIDS, sexual social policy, and drug abuse (2017).” Cameron shared with the committee that, “those engaging in bondage and discipline, were appreciably more apt to claim that they had deliberately attempted to sexually infect others” with HIV and that “it would be an act of kindness to prosecute these individuals (Senate Committee on Judiciary Minutes for June 11, 1993).” The Committee passed the bill and it passed the Senate and Assembly without any new or different points of discussion. The Republican-controlled Senate and the Democratic-controlled Assembly were more focused on the repeal of the *anti-sodomy law* and keeping issues of HIV separate from it. Now, what has existed in Nevada law since 1993 is the enacted language of SB 514 in the *Crimes and Punishments* Title and *Crimes Against Public Decency and Good Morals* Chapter of Nevada law:

> 1. A person who, after testing positive in a test approved by the State Board of Health for exposure to the human immunodeficiency virus and receiving actual notice of that fact, intentionally, knowingly or willfully engages in conduct in a manner that is intended or likely to transmit the disease to another person is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, or by a fine of not more than $10,000, or by both fine and imprisonment.
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> 2. It is an affirmative defense to an offense charged pursuant to subsection 1 that the person who was subject to exposure to the human immunodeficiency virus as a result of

> the prohibited conduct: (a) Knew the defendant was infected with the human immunodeficiency virus; (b) Knew the conduct could result in exposure to the human immunodeficiency virus; and (c) Consented to engage in the conduct with that knowledge (Intentional transmission of human immunodeficiency virus, 1993).

PUBLIC HEALTH HINDERANCE – THE BIG PICTURE

Laws like intentional transmission, transmission without intent, acts or behaviors that are likely to lead to transmission regardless of whether transmission occurs, affirmative defenses based non-closure of HIV status, and sentencing enhancements for violent crimes when the accused is living with HIV can all be categorized under an umbrella term of the *criminalization of HIV* (Burris and Cameron, 2008). This means that where laws exist like this knowing your HIV status makes you more susceptible to criminal prosecution than the untested and untreated. Combined with remnants of AIDS Hysteria and the stigmatic media portrayals of arrested individuals, these accused individuals are judged guilty before any hearing of the facts. The legal justification for the criminalization of HIV is for deterrence and incapacitation of those who do transmit the virus. The actual effect of these laws are punitive measures that disproportionately affects those with mental health or substance use disorders, gay men, sex workers, and immigrants which only drives these populations underground and away from effective HIV treatment (Human Rights Watch, 2009).

Galletly, Lazzarini, Sanders, and Pinkerton (2014) identify the unintended consequences of these laws to include, “deterring testing and reinforcing hostility toward persons with HIV… exacerbating HIV-related stigma, and paradoxically, deterring seropositive status disclosure.” Researchers also note that virtually all prosecutions of criminal transmission of HIV did not include actual seroconversion. Organizations and researchers in the field of HIV have witnessed

the negative consequences of HIV criminalization laws since their inception but there has been virtually no repeal or lessening of the legal consequences in the United States.

The Patient Protection and Affordable Care Act (2010) emphasizes preventive health in its design of Essential Health Benefits and the U.S. Preventive Services Task Force identifies HIV testing as a medical necessity thus requiring private health insurance plans to cover routine HIV testing without cost-sharing. Medicaid programs that expanded under the ACA also had to include routine HIV testing without cost-sharing. This allowance of free, routine HIV testing within a major health care reform policy endorses the idea that everybody has an HIV status, whether negative or positive, and it is incumbent upon any sexually active individual to know their status. HIV criminal transmission laws make those who take advantage of HIV tests and who receive a positive diagnosis more of a potential criminal than people who might have other infectious diseases like Hepatitis C, MRSA, Ebola, meningitis, or even influenza.

In context of the PARTNER study (Rodger, Brunn, Cambiano, Vernazza, Strada, & Van Lunzen, 2014) and HPTN-052 (Cohen, McCauley, & Gamble, 2012), which are studies of serodiscordant couples (e.g. one HIV positive, one HIV negative), it was found no transmission of HIV occurred with condomless sexual activity if the positive partner was undetectable (e.g. that is a HIV quantitative viral load of less than 20 copies). HIV criminalization laws must be repealed as a matter of public health. The CDC estimates that one out of every seven people living with HIV are untested and untreated, making it a hidden epidemic (2017). Skarbinski et al. (2015) used a “multistep, static, deterministic [mathematical] model” with data from the National HIV Surveillance System (NHSS) and the Medical Monitoring Project (MMP) to estimate the rates of HIV transmission along each step in the HIV care continuum. The HIV care continuum or cascade developed by Gardner crafted distinct stages of progression towards viral suppression

(2011). Using the Skarbinski et al. model it was found that 91% of transmissions occur among those who do not know their status and those who do know but not linked to medical care (2015). Testing and knowing your HIV status ought to be treated solely as a health measure – not one that predisposes you for legal consequences.

EVIDENCE FROM SOCIALPSYCHOLOGICAL THEORY

Viewing HIV criminalization and the effects thereof through various theoretical lenses can provide the framework to contextualize a single issue within a larger perspective. Specifically, Ecosocial Theory (Krieger, 1994) is useful to understand the range of factors that might lead to health inequities among certain populations. This structure is appropriate for intervention development in HIV which emphasizes the interrelationships and dependencies of the individual within their community across time. Because of the well-documented HIV health inequities among social groups, racism, sexism, homophobia, economic stratification as well as HIV criminalization fit into the macro- or society level of Krieger's Theory.

Researcher J. Craig Phillips and a team of 25 contributors formed an international effort applying Ecosocial Theory to the effects of HIV criminalization and antiretroviral therapy (ART) adherence (2013). Phillips et al. also utilized theories of social capital to identify the ways in which PLWH navigate the health care system and use established relationships and resources acquired in life to achieve optimal health. In the early years of the epidemic gay men and ethnoracial minority groups used their collective social capital to push for reforms in the drug trial and approval process, social justice improvements in the health care field, and public health insurance programs to provide access to medical care and treatments. Over time, as the intersections of race, gender identity, and class became more salient within the early

communities struck with HIV/AIDS – the social capital of the minorities within the community began to diminish.

Knowing that interventions at the various stages of influence are necessary to confront a disease and the disparate impact of that disease, the path of a structural realignment of priorities away from punitive and ineffective legal tools must be taken. HIV criminalization laws, in this era of mass incarceration, have not shown to stem the tide of HIV infections and have only contributed to media-sponsored stigma and increased racial animus. One only need to look at the case of Michael Johnson, a gay black college student from Missouri, whose racially charged trial and conviction for 30 years in prison because he was deemed a HIV predator was overturned due to prosecutorial misconduct (Schreiber, 2017).

The behavioral concept of moral hazard as described in Shi and Singh of increased consumer utilization of health care services when someone is insured (2017). More broadly it means that someone is protected against losses for any risk they might take knowing that a different party bears the effect of that risk. This concept can be applied to HIV criminalization laws where one partner is HIV positive and the other partner is HIV negative, if disclosure happened or not, the HIV negative partner is taking the moral hazard that if there was transmission or any unpleasant interaction then it will always be the positive partner's fault. The cognitive bias of a false sense of security is created when the HIV negative partner believes that they are free from risk because there are laws in place that prevent any negative outcomes (Jürgens et al., 2009). As with health insurance, one can believe that they are protected from losses because of an existing structural intervention– but if that intervention (i.e. health insurance or HIV criminalization laws) is imperfect then the person will be due for a shock. Balancing individual rights with population health, especially those of sexual expression, ought to rely on a

thorough review of evidence. The social ethic of mutual responsibility rather than placing blame on a viral underclass needs to be accepted by the legal system as it exists in the health care system.

EVIDENCE FROM LEGAL THEORY

Viewing HIV Criminalization through a legal context is an important task to understand why the government believes that they have the duty to curtail individual liberty to protect society. The compulsory quarantine of individuals who have a highly contagious disease is seen as tool to public health officials for containment but as we saw recently with the quarantine of nurse Kaci Hickox who served with Doctors Without Borders during the 2014-16 Ebola Outbreak in West Africa in 2015, the government can be too quick to ignore science in order to satiate public perception (Associated Press, 2015). Legal scholars Burris and Cameron (2008) point out some of the predicaments that criminal transmission laws have created in the fight against HIV. Legislating the sexual behavior of individuals has not historically been effective and coercive public health measures have seen to have a contradictory effect in negatively influencing the behavior, that is HIV testing is seen to decrease during times of increased coverage about individuals prosecuted under these laws (Kenney, 1992).

Criminal behavior must be predicated on criminal intent. The state of mind where an individual knowingly does an action that it could reasonably be assumed they know is wrong is known by its Latin phrase *mens rea* (Lee, 2015). For a prosecutor to know that a defendant intended to transmit HIV to another person without their knowledge, there needs to be a clear investigation on if the defendant is fully educated about sexual risk behavior and if the plaintiff had any role in not asking or not understanding a potential disclosure. If a guilty mind is needed for a successful criminal conviction, then how is a person who is undetectable, uses condoms,

but does not make a disclosure guilty of intentional transmission or attempt to transmit? In the cases that have been prosecuted where complaints stem around biting, spitting, bioterrism, attempted murder, or even sexual contact without exchange of fluids – where the likelihood of transmission is close to null – is there a guilty mind? Prosecutors devoted to the truth would say no. But as the United States ranks first in the world for persons tried under HIV criminalization laws, prosecutors rely on retribution rather than being partners to the public health community in the fight against HIV (Global Network of People Living with HIV, 2013).

REJECTING THE HYPOTHESIS THAT CRIMINALIZATION IS BENEFICIAL

The only way that mathematical models show that a community can stem the tide of HIV infection is by getting at least 90% of those living with HIV diagnosed, by getting 90% of those diagnosed with HIV connected to medical care, and by getting 90% of those individuals retained in care having achieved viral suppression. Translated, if 73% of all people living with HIV are virally suppressed then there will be significantly less people in the pre-ART category that is most at-risk to transmit the virus (Joint United Nations Programme on HIV/AIDS, 2014). The United States health care system needs more people who are living with HIV to be virally suppressed as not only a health and social justice issue, but also a cost-containment method. Testing and early treatment of HIV is cheaper than delayed testing and an emergency room diagnosis (Paltiel et al., 2005; Freedberg et al., 2001).

Sweeney and colleagues (2017) conducted a longitudinal analysis of reported HIV transmissions in the United States among two distinct groups, U.S. states with HIV criminalization laws and U.S. states without those laws. Using CDC National HIV Surveillance System data from all states paired with social and economic data of these states, the research not only achieves the stated objective of, “assess[ing] whether state criminal exposure laws are

associated with HIV" but also elegantly provides further evidence that social determinants of health related to education, employment, urbanicity, and ethnocultural demographics are tied to various degrees of HIV transmission rates.

The researchers noted that there have been studies that investigated the relationship between structural HIV prevention interventions and success in the reduction of HIV transmission – but the tangible effects of HIV criminalization laws have received relatively little academic study. One robust study by Lee (2015) however produced a "difference-in-difference regression analysis" to determine if criminalization laws had any effect on testing or transmission. Results indicated that when demographic data was held constant media-fueled outrage against *HIV predators* resulted in demonstrably less HIV tests in a community. Generally, researchers agree that HIV prevention and issues related to transmission is multifactorial. The social determinants of health have more to do with someone's risk for acquiring HIV than any one intervention program. Said another way – lack of a steady job and income, living in a safe neighborhood, having a high school degree, or individual or systematic racism has more to do with whether someone will contract HIV than access to condoms or PrEP alone.

Phillips et al. (2013) found that there was a correlation between jurisdictions that had strict HIV criminalization statutes and reported ART adherence. While this might indicate that these laws could be improving population health through threat of prosecution, what is more likely is that study participants were already connected to medical care due to greater social capital and were attempting to be a good "therapeutic citizen" as Nguyen (2005) describes, to be accepted in your social circle you must be ART adherent. Because of the correlation between social capital, presence of HIV criminalization laws, and ART adherence – there is further

evidence of the need to extend beyond biomedical interventions for HIV care. These structural interventions to combat racism, misogyny, transphobia, homophobia must also include increased protections for those living with HIV through empowerment rather than social control.

POLICY APPROVAL PROCESS

Meeting every other year for only 120 days, the legislature in Nevada is one of the smallest in number and shortest in length in the United States. From January to June in odd-numbered years, this compact body of 63 individuals has a constitutionally finite amount of time to have hearings, debates, and votes on all sorts of policy and budgetary bills. The real work of effective policy, though, is completed during the interim between legislative sessions. There are dozens of interim commissions and committees across various policies areas that meet and craft legislation prior to each session. The Nevada Legislature also has a team of lawyers that are the drafters of the legislation – so it is imperative that each member of the Senate and Assembly work with their staff to assure that their bill or resolution says what they want it to say, does what they want it to do, and avoids as many unintended consequences as possible.

The 2017 Legislative Session wrapped up on June 5th and it was a session unlike many in the recent past. There was a huge partisan change from 2015 to 2017, a 20% or 12 seat change from Republican to Democrat. This altered the leadership of the Assembly and the Senate as well from Republican-controlled to Democratic-controlled. Because of this – the Democratic party controlled the chairmanships of all the committees as well as the ability to appoint individuals to the interim committees that will start working and preparing for the next legislative session in 2019. Nevada has long been considered a *purple* state where moderate Democrats and moderate Republicans join to craft policy. But this past legislative session saw 41 vetoes by Governor Brian Sandoval, the most since assuming office in 2011. While in office, he had to work with

three Democratically-controlled legislatures out of his four legislative sessions. This high number of vetoes could either be from more liberal proposed laws coming to his desk for signature or for the Governor becoming more conservative in his political leanings in his last year in office. The former is more than likely true according to political analysts (Ryan, 2017; Sebelius, 2017).

The 2018 elections will be a turning point for Nevada during these years of the Donald Trump White House Administration. Nevada will elect its Governor, all members of the Assembly, and half of the members of the Senate – the balance of power will be decided and the agenda for the 2019 legislative session will be dependent upon that balance. Remembering that the *anti-sodomy law* was repealed in 1993 with a Republican majority in the Nevada State Senate and that politically conservative Orrin Hatch of Utah was instrumental to the passage of the Ryan White Care Act in 1990 – one can only guess, until the new legislators are sworn in, what the ideological makeup of each chamber will be, regardless of party.

Health policy bills, like all other policy bills, are referred to their committee of jurisdiction but if there is any fiscal impact then it is also referred to the appropriate finance committee once the policy has been vetted. Some bills that have impact on public health policy might not get referred to the Committees on Health and Human Services; for example, seat-belt, helmet, and speed-limit laws would be referred the Transportation Committees; sex trafficking is referred to the Judiciary Committees; sexual health education is referred to the Education Committees; and issues relating to health insurance are usually heard in the Committees on Commerce and Labor. In the end, the decision on where a bill is referred to is at the discretion of the Majority Leader of each body – therefore the decisions on sending bills to committees does signal where that Majority Leader thinks the bill has a better chance of surviving or dying.

Because this proposed policy is more simple than it is complex in terms of the actual legal language, amending the law by deletion, the Legislative Counsel Bureau will have little involvement in the drafting of the legislation. In Nevada, there are a variety of pathways for an idea to be introduced as legislation. While any legislator can introduce bills for consideration, each executive branch department is able to submit requests, as well as the various interim committee. Finding a suitable sponsor is the first step in any policy proposal to be considered by the legislature.

INTEREST GROUPS

Interest groups and issue advocates are an important part of the legislative process. Their main job is to educate legislators about the pros and cons of the issues. While these people and groups have their own agenda, it is not to say that their information is biased. The legislative process depends upon effective legislators who can hear the various opinions and evidence and make their best judgement on passage or rejection of a proposal.

In reviewing the legislative process participation of the approving of NRS 201.205 there are still some of the same legislators, lobbyists, and activists that can be found around the halls in Carson City. Using the learned lessons of the recent passage of California Senate Bill 239, which reduced from a felony to a misdemeanor the criminalization of HIV, building a coalition of diverse interest groups is important for passage. The American Psychological Association in March 2017 released a statement in support of the repeal of HIV criminalization laws saying that psychologists must, “discuss the public health implications and the role that psychological research and practice can play in helping to address the individual and social impact of these laws.” Additionally, the American Civil Liberties Union is an important partner in the repeal of this law, the national organization sponsored an editorial by lawyer Chase Strangio saying that

these laws are used in "combination of racism, homophobia, and a gross misunderstanding (or perhaps deliberate rejection) of science … [leading to] inhumane conviction[s] and sentence[s] (2015)." These two organizations as well as other civil rights and public health groups will form the core professional support of the repeal of HIV criminalization laws.

Groups specific to Nevada that are expected to be in favor of this proposal can be gleaned from the minutes of Nevada Senate Bill 466 (1993). Remembering that these groups in favor of the repeal of the *anti-sodomy law* did so on civil rights grounds and for public health objectives, one could assume that when given the arguments of repealing the HIV criminalization statute they would support that as well. Dr. Jerry Cade and Dr. Trudy Larson were founding members of the Nevada State AIDS Advisory Taskforce are two of the leaders in the medical community in Nevada who would be vital partners. Other partners would include the Nevada Women's Lobby, "a statewide non-partisan coalition of organizations, and individual women and men who are committed to women and families (2017);" the Progressive Leadership Alliance of Nevada an organization founded to provide a, "cohesive force for social and environmental justice (2017);" and quite possibly the Nevada Attorneys for Criminal Justice whose mission is to provide "effective representation … [and to] … seek justice for the accused (2017)."

There are groups and individuals in Nevada that can be expected to be against the repeal of NRS 201.205 without any reservation that they would turn out to be an unsuspected ally. The National Eagle Forum, an organization founded by conservative standard-bearer Phyllis Schlafly to "enable conservative and pro-family men and women… to preserve individual liberty, respect for family integrity, public and private virtue, and private enterprise (2017)" has a charter partner organization, Nevada Families for Freedom with Janine Hansen at its helm. Hansen and her partner organization, the Independent American Party of Nevada will be opposed to the any

repeal of the criminalization of HIV. Evangelical conservative religious organizations might encourage their members to petition against this measure as they did for SB 466 (1993), they include Glory Temple Church (Senate Committee on Judiciary Minutes for May 24, 1993) in Reno, Nevada and the Valley Christian Fellowship Church in Gardnerville, Nevada (Assembly Committee on Judiciary Minutes for June 10, 1993).

Potential non-ideological groups that might be against the repeal of the criminalization of HIV would include District Attorneys individually or as a group in the Nevada District Attorney Association who might not want to appear soft on crime. And because unanimity of opinion in any organization or profession is not likely, it can be expected that some in the public health workforce would be opposed to this repeal, saying that this containing and punitive measure is needed. This opposing position was taken by the California Academy of Preventive Medicine and Beyond AIDS in California Senate Bill 239 (Assembly Committee on Appropriations Senate Bill 239 Analysis for August 23, 2017). While these groups are assessed on past behavior to be against this proposed measure, until there is a measure that is in the public domain it can only be guessed what their official position would be. People and organizations can surprise.

IMPLEMENTATION & EVALUATION

Implementation of this health policy is initially simple– prosecutors would no longer be allowed to use a person's HIV status or knowledge of their HIV status as the basis for a criminal trial. The complexity of HIV, though, will require, as it always has, dedicated resources to promote education, testing, and care for those impacted. The legal community can adopt a restorative justice framework where conflict resolution, mediation, and impact education are the tenants and where incarceration and retribution are not the end goals (Ahmed, 2010). Proactive approaches in regards to universal testing, fully implemented pre-exposure prophylaxis for

communities at high risk for HIV, anti-stigma campaigns, and structural empowerment of minority communities can also decrease the use of these laws in the first place (Perone, 2013). Lastly, investment into mental health resources, housing-first policies, and making quality and accessible preventive primary health care available to high-impact communities can prevent many health problems aside from HIV before they begin.

CONCLUSION

For the past 24 years, receiving a positive HIV test in Nevada is evidence of a crime in the making. Overzealous prosecutors, fueled by vestiges of AIDS Hysteria change the lives of hundreds of people living with HIV in this country. These individuals living with a life-altering diagnosis are arrested, tried, and convicted in courts in almost every state just because they had prior knowledge of their HIV status. In cases where non-disclosure does happen but transmission is prevented through condoms or treatment, people are still found guilty. In cases where police officers are bit or spit upon by someone living with HIV, the detained individual is charged with bioterrorism or attempted murder. A virus does not make a person a criminal, lack of education about risk behaviors does not make a person a criminal, having sex where transmission of HIV is statistically negligible does not make a person a criminal, but these people are part of our criminal justice system. This system perpetuates the hysteria and does nothing to control HIV in our society. HIV stigma is a contagion that can only be stopped with a sober discussion of scientific evidence, making human rights a priority in public health, and repealing the criminalization of HIV.

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