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# When Saliva Is a Crime: Reforming Mississippi's HIV Criminalization Law Utilizing the Center for Disease Control and Prevention's Policy Analytical Framework

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# When Saliva Is a Crime: Reforming Mississippi's HIV Criminalization Law Utilizing the Center for Disease Control and Prevention's Policy Analytical Framework

by

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**Abstract**

Mississippi is currently experiencing an HIV/AIDS crisis. The state is ranked in the top 10 for diagnoses of HIV infection, with Jackson, Mississippi ranked sixth in the nation for HIV diagnoses and fourth in the nation for AIDS diagnoses. Despite antiretroviral treatment allowing for persons with HIV to lead healthy lives, Mississippians continue to die from AIDS in large part because of stigma, misinformation, and lack of resources. This is furthered by Mississippi's HIV criminalization law. HIV criminalization laws are used to penalize HIV exposure, but HIV-specific criminal laws are considered largely ineffective public health policies because these statutes further stigmatize, do not account for lack of criminal intent, include misinformation, and do not reduce infection rates. Mississippi Code ANN. § 97-27-14 perpetuates all of these issues by including saliva, urine, and feces as a crime of endangerment by bodily substance, even though these substances have very low risk of transmitting HIV. In this study, Mississippi's existing policy was identified using the Center for Disease Control and Prevention's Policy Analytical Framework, and three possible policy options were analyzed and scored based on public health impact, feasibility, and economic and budgetary impact. Results of this analysis strongly indicate that Mississippi Code ANN. § 97-27-14 should be amended to be scientifically accurate and include a criminalization clause based on the National HIV/AIDS Strategy for the United States goals and the United States Department of Justice Civil Rights Division best practices.

Key words: HIV/AIDS, HIV-specific criminalization laws, HIV criminalization, Mississippi, crime of endangerment by bodily substance, Mississippi Code ANN. § 97-27-14

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## Table of Contents

## List of Tables

## List of Abbreviations

| | |
|---|---|
| AIDS | acquired immunodeficiency syndrome |
| ART | antiretroviral therapy |
| CDC | Center for Disease Control and Prevention |
| HIV | human immunodeficiency virus |
| PrEP | pre-exposure prophylaxis |
| PEP | post-exposure prophylaxis |

## Chapter 1: Introduction

In the United States of America, new incidences of HIV have significantly decreased in large part because of prevention efforts and drugs such as antiretroviral therapy, pre-exposure prophylaxis, and post-exposure prophylaxis that greatly reduce possible transmission. Despite tremendous progress, these trends are not seen in the Deep South where HIV rates continue to rise. From 2006 to 2015, newly diagnosed cases of HIV in Mississippi rose by 10% (Mississippi State Department of Health, STD/HIV Office, 2016). In Mississippi, almost 80% of diagnoses and mortality rates are African Americans showcasing a large health disparity (Mississippi State Department of Health, STD/HIV Office, 2016). To further this issue, Mississippi has the second highest percentage for prisoners living with HIV (Maruschak & Bronson, 2017). Mississippi is experiencing a HIV/AIDS crisis, and this crisis is further exacerbated by Mississippi HIV criminalization law.

HIV-specific criminalization laws are criminal statues used to prosecute and punish those living with HIV. These laws were created to inhibit the spread of HIV and protect others from being exposed to HIV, yet HIV criminalization is considered ineffective public health policy. These statues are stigmatizing, do not account for lack of criminal intent or transmission, include misinformation, and do not reduce infection rates. Mississippi HIV criminalization law, Mississippi Code Ann. § 97-27-14, embodies these implications as the statute includes scientifically incorrect information, a stigmatizing discrepancy between a misdemeanor and felony only based on knowing one's HIV status, and is HIV-specific. The Center for Disease Control and Prevention and the United States Department of Justice recommends that states reform HIV-specific criminal laws by repealing the statues, but, if this is not feasible, to amend the policies to be scientifically correct and include a criminal intent clause.

The purpose of this study was to prioritize the most appropriate policy option to reform Mississippi HIV criminalization law. Using Center for Disease Control and Prevention's Policy Analytical Framework, policy options were developed, analyzed, and prioritized based on public health impact, feasibility, and economic and budgetary impact. Results were analyzed, and a strategy was created to reform Mississippi HIV criminalization to be more equitable.

## Chapter 2: Literature Review

### *HIV/AIDS Basics*

HIV stands for human immunodeficiency virus, and if the virus if left untreated leads to AIDS, which is acquired immunodeficiency syndrome. HIV attacks the body's immune system by targeting CD4 T lymphocytes , commonly known as CD4 cells or T cells (HIV.gov, 2017). CD4 T lymphocytes "help coordinate the immune response by stimulating other immune cells… to fight off infection;" through the destruction of these white blood cells, HIV weakens the immune system leaving the individual more susceptible to infections (AIDSinfo, n.d.). HIV is spread from a person who has HIV through certain bodily fluids including "blood, semen (cum), pre-seminal fluid (pre-cum), rectal fluids, vaginal fluids, and breast milk" (Center for Disease Control and Prevention, 2018b). This transmission is done via certain behaviors with the most common modes of transmission in the United States being unprotected sex and re-use of needles from intravenous drugs, yet transmission can occur if the virus comes in contact with a mucous membrane, damaged tissue, or bloodstream (Center for Disease Control and Prevention, 2018b). There is currently no cure for HIV/AIDS, but antiretroviral treatments allow for the prevention and management of HIV/AIDS. If left untreated, HIV progresses to three stages: the acute HIV infection stage, the chronic HIV infection stage, and then finally AIDS (HIV.gov, 2017).

Acute HIV infection occurs 2-4 weeks after HIV infection and is the first stage of HIV. This stage is often characterized by flu-like symptoms including headaches, rashes, and fever (AIDSinfo, 2018). Despite this characterization, many people do not experience these symptoms and "are often unaware that they're infected because they may not feel sick right away or at all" (Center for Disease Control and Prevention, 2019a). During the acute HIV infection stage, the virus is extensively produced causing CD4 T lymphocytes counts to fall rapidly. Because of the high levels of virus production, individuals "are at very high risk of transmitting HIV to… sexual

or needle-sharing partners" (HIV.gov, 2017). Eventually, the immune system responds to the HIV infection, and the "rapid replication of HIV declines and the person's viral load drops to its set point" meaning that the HIV viral load stabilizes (AIDSinfo, 2019). Once the viral load reaches the set point, CD4 T lymphocytes counts begin to rise, but the levels "may not return to pre-infection levels" (HIV.gov, 2017).

The acute HIV stage eventually progresses to the chronic HIV infection stage commonly called "clinical latency." This second stage is characterized by individuals experiencing little or no HIV related symptoms. The virus reproduces at extremely low levels and "cannot be detected with standard laboratory tests" (HIV.gov, 2017). Despite the low viral load, HIV can still be spread to others during the chronic infection stage (Center for Disease Control and Prevention, 2019a). Without any treatment, this stage can last approximately 10 years and eventually advances to AIDS (AIDSinfo, 2018).

AIDS is the final stage of HIV infection. This is the most severe stage of HIV and is characterized by opportunistic infections, very low numbers of CD4 T lymphocytes, and common symptoms including: "chills, fever, sweats, swollen lymph glands, weakness, and weight loss" (Center for Disease Control and Prevention, 2019a). For diagnosis, one is considered to have progressed to AIDS if CD4 T lymphocytes fall below 200 cells per cubic millimeter of blood or if the individual develops an opportunistic illness (AIDSinfo, 2018). Concerning cell counts, a normal number of CD4 T lymphocytes ranges from 500 to 1,500 meaning that persons living with AIDS have less than 50% to less than 10% of the normal cell count (U.S. Department of Veterans Affairs, 2018). Concerning opportunistic infections, these are infections that take advantage of a weakened immune system and include diseases such as cryptococcal meningitis, toxoplasmosis, esophageal candidiasis, and other infections (Avert,

2018). Without treatment, those with AIDS live for approximately 3 years, but this is often shortened if exposed to an opportunistic illness (AIDSinfo, 2018).

If an individual contracts HIV, the virus can be managed through antiretroviral therapy, commonly known as ART. ART consist of various medications that treat HIV by preventing the growth of the virus. Antiretroviral drugs, commonly referred to as ARV, are not cures for HIV/AIDS, but when used in combination (combination therapy) allow for reduced viral load (The AIDS InfoNet, 2014). When using ART, the person living with HIV's viral load can be undetectable meaning that if they were to test for HIV, they would test negative and would not be able to transmit the virus. These drugs should begin to be taken once tested positive for HIV and allows for persons living with HIV/AIDS to live long, healthy lives.

HIV/AIDS can be prevented through certain behaviors and drugs. The only methods that absolutely prevent the spread of HIV/AIDS are abstinence and not sharing needles from intravenous drugs, but there are numerous other very effective methods. Other prevention methods include limiting number of sexual partners, using condoms correctly every time the individual has sex, and taking "advantage of newer HIV prevention medicines such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)" (Center for Disease Control and Prevention, 2019c)

PrEP and PEP are antiretroviral drugs used to reduce one's susceptibility of contracting HIV. PEP is a HIV prevention drug used in emergency situations where the individual could have been potentially exposed to HIV (Center for Disease Control and Prevention, 2018d). PEP is a pill taken "once or twice daily for 28 days" and must be administered within 72 hours after being possibly exposed (HIV.gov, 2018). PrEP is "a new HIV prevention approach where HIV-negative individuals use anti-HIV medications to reduce their risk of becoming infected if they

are exposed to the virus" (San Francisco AIDS Foundation, 2018). Essentially, this is a pill taken by those who do not have HIV and it greatly reduces chances of contracting HIV by blocking the virus from reproducing. Studies have shown that when taken daily, "PrEP reduces the risk of getting HIV from sex by more than 90%" and "reduces the risk of getting HIV by more than 70%" (Center for Disease Control and Prevention, 2019b). These drugs greatly reduce one's risk of contracting HIV if properly taken.

*HIV/AIDS in the United States*

Currently, there are approximately 1.1 million people living in the United States with HIV and half of these people are virally suppressed (HIV.gov, 2019). Nationally, annual rates of HIV infections and diagnoses are declining, which is attributed to HIV prevention initiatives such as education, resources, and drugs (Center for Disease Control and Prevention, 2018a).

Despite the nationally decreasing trend, the Deep South region of the United States consisting of Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, and Texas "has been disproportionately affected by HIV, as this region has consistently experienced the highest HIV diagnosis rates and death rates of any US region" (Reif et al., 2017). This alarming HIV/AIDS trend in the Deep South continues as almost 50% of those living with HIV/AIDS are in the Southern United States despite this area making up less than 40% of the nation's population (McAllaster, 2014). Minority populations are especially impacted by HIV/AIDS diagnoses and deaths as African Americans represent the majority of new incidences and prevalence of HIV/AIDS in the Deep South. This is especially prevalent in "new diagnoses among African American men who have sex with men" (Reif et al., 2017).

Another important population that is disproportionately impacted by HIV/AIDS in the United States are those incarcerated. According to the Bureau of Justice Statistics, there are

approximately 2,162, 400 incarcerated people in the United States (Kaeble & Cowhig, 2018). This mass incarceration in the United States has a "high concentration of HIV infection within correctional facilities;" this in part of because of imprisonment of those for "illicit drug use" and drug laws leading "to substantial increase in incarceration rates for African American men," which are both populations that have higher rates of HIV (Whol, 2016). In 2015, there were approximately 17,000 prisoners with HIV (Maruschak & Bronson, 2017). This translates to approximately 1.3% of "prisoners who had HIV as a percent of custody population" (Maruschak & Bronson, 2017). To further elaborate, "an estimated 14% of all persons living with HIV infection in the United States, and 20% of African American HIV-Infected individuals, pass through a jail or prison each year" further showing the HIV prevalence in prisons (Wohl, 2016). HIV disproportionately impacts African American males in the prison system even with the fact that national HIV trends in the incarcerated are falling (Maruschak & Bronson, 2017).

*HIV/AIDS in Mississippi*

Mississippi follows trends seen in the Deep South. From 2006 to 2015, "there was a 10% increase in the number of newly reported HIV diagnoses in the state of Mississippi" juxtaposing national decreases (Mississippi State Department of Health, STD/HIV Office, 2016). In 2015, there were approximately 10,000 people living with HIV/AIDS, and of this population, almost 80% were African American; this translates to "the rate of Black males living with an HIV diagnosis is 5.4 times that of White males" and "the rate of Black females living with an HIV diagnosis is 9.6 times that of White females" (AIDSVu, 2018). This health disparity that African Americans make up approximately 40% of Mississippi's population yet make up 80% of incidences, prevalence, and deaths among those living with HIV (Mississippi State Department of Health, STD/HIV Office, 2016). Mississippi also followed regional trends in that the primary

transmission rate of HIV was through men having sex with men (AIDSVu, 2018). In relation to other states in the nation, Mississippi is the ninth in the nation for new diagnoses of HIV rate and sixth in the nation for the rate of AIDS diagnoses; Jackson, Mississippi ranked sixth highest for diagnoses of HIV and fourth highest for AIDS diagnoses (Center for Disease Control and Prevention, 2018a). These numbers showcase that despite effective treatment, HIV transmission and death by AIDS continue to remain prevalent in Mississippi.

HIV/AIDS in Mississippi's prison population also show alarming trends. There are approximately 29,000 people incarcerated in Mississippi; Hispanics make up the majority of the population followed by African Americans, Native Americans, and lastly Caucasians (Prison Policy Initiative, n.d.). There are approximately 2.1% of "prisoners who had HIV as a percent of custody population," which is the second highest percentage in the nation (Maruschak & Bronson, 2017). Mississippi's alarming rates of HIV/AIDS are also prevalent in the prison system.

*HIV Criminalization Nationally*

HIV criminalization is defined as "use of criminal law to penalize alleged, perceived, or potential HIV exposure; alleged nondisclosure of a known HIV-positive status prior to sexual contact (including acts that do not risk HIV transmission); or non-intentional HIV transmission" (The Elizabeth Taylor AIDS Foundation, 2018). This is the "application of criminal law to people living with HIV based solely on their HIV status," and many of these statutes "allow prosecution for acts that constitute no or very little risk by failing to recognize condom use or low viral load or by criminalizing spitting, biting, scratching or oral sex" (Bernard & Cameron, 2016). HIV criminalization laws were first enacted in 1986 (Lehman et al., 2014). Prosecution of these laws first emerged in the United States in 1987, five years after the United States

recognized AIDS as a medical disorder and one year after the virus became known as HIV; this was a time of widespread panic exacerbated by "inaccurate and contradictory public health statements and media reports regarding transmission of the agent" (Bernard, 2010). Justifications of these laws are public health measures "to inhibit the spread of HIV" and "protect persons from exposure to infection with HIV" (Cameron, 2009).

From a 2014 review cosponsored by the Centers for Disease Control and Prevention and the U.S. Department of Justice, in the United States there are currently "33 states that have one or more HIV-specific criminal laws" making up 67 laws (Lehman et al., 2014). Of these states, "24 require persons who are aware that they have HIV to disclose their status to sexual partners," 14 states "require disclosure to needle-sharing partners," 13 states "criminalize prostitution/solicitation," 11 states "criminalize behaviors such as biting, spitting, and throwing bodily fluids, most often in the context of prisons and correctional facilities," 19 states "criminalize donating blood," and "HIV-specific criminal laws are classified as felonies in 28 states" (Lehman et al., 2014). Most of these laws "were passed before studies showed that antiretroviral therapy (ART) reduces HIV transmission risk and most laws do not account for HIV prevention measures that reduce transmission risk, such as condom use, ART, or pre-exposure prophylaxis" (Lehman et al., 2014).

Using HIV criminalization law, there have been at least 104 convictions and/or prosecutions between 2013 and 2015 (Bernard & Cameron, 2016). Since being enacted in 1987, "a reported national total of at least 350 prosecutions" have occurred (UNAIDS, 2012). This data is difficult to assess on a national level "because state-level prosecution and arrest data are not readily available in any national legal database," so "the number of prosecutions, arrests, and

instances where HIV-specific criminal laws are used to induce plea agreements is unknown" (Lehman et al., 2014).

*HIV Criminalization in Mississippi*

Mississippi Code also reflects HIV criminalization. Mississippi Code ANN. § 97-27-14 criminalizes "causing exposure to human immunodeficiency virus (HIV)" and the "crime of endangerment by bodily substance." Mississippi Code ANN. § 97-27-14 states:

> "(1) It shall be unlawful for any person to knowingly expose another person to human immunodeficiency virus (HIV), hepatitis B or hepatitis C. Prior knowledge and willing consent to the exposure is a defense to a charge brought under this paragraph. A violation of this subsection shall be a felony.
>
> (2)
>
> (a) A person commits the crime of endangerment by bodily substance if the person attempts to cause or knowingly causes a corrections employee, a visitor to a correctional facility or another prisoner or offender to come into contact with blood, seminal fluid, urine, feces or saliva.
>
> (b) As used in this subsection, the following definitions shall apply unless the context clearly requires otherwise:
>
> (i) "Corrections employee" means a person who is an employee or contracted employee of a subcontractor of a department or agency responsible for operating a jail, prison, correctional facility or a person who is assigned to work in a jail, prison or correctional facility.
>
> (ii) "Offender" means a person who is in the custody of the Department of Corrections.
>
> (iii) "Prisoner" means a person confined in a county or city jail.

(c) A violation of this subsection is a misdemeanor unless the person violating this section knows that he is infected with human immunodeficiency virus (HIV), hepatitis B or hepatitis C, in which case it is a felony.

(3) Any person convicted of a felony violation of this section shall be imprisoned for not less than three (3) years nor more than ten (10) years and a fine of not more than Ten Thousand Dollars ($10,000.00), or both.

(4) Any person guilty of a misdemeanor violation of this section shall be punished by imprisonment in the county jail for up to one (1) year and may be fined One Thousand Dollars ($1,000.00), or both.

(5) The provisions of this section shall be in addition to any other provisions of law for which the actions described in this section may be prosecuted."

This law was enacted in 2004, almost 20 years after first HIV laws emerged. Only three states have enacted HIV criminalization laws after Mississippi (Lehman et al., 2014). Since 2004, there have been two prosecutions and two convictions under this code (Sero, n.d.).

*Implications of HIV Criminalization*

HIV criminalization is considered ineffective public health public health policy as advocated by countless HIV/AIDS organizations and research. The four primary arguments against HIV criminalization are that these statues further stigma, unnecessarily criminalize those who do not have criminal intent, do not reflect current scientific information, and are ineffective at reducing prevalence.

Stigma plays a central role in HIV criminalization. "Overall, two-thirds (22 of 33) of states enacted their first [HIV criminalization] law" before 1990 meaning that most states that have HIV criminalization statutes passed in the midst of the AIDS epidemic, a time in American

history filled with fear, confusion, and misinformation surrounding the disease (Lehman et al., 2014). HIV/AIDS has been stigmatized for two primary reasons: "the fact that HIV is sexually transmitted and the fact that it is predominantly found in groups that are already socially disfavored or marginalized: gay men, the poor, black Africans, women, those who use drugs, sex workers;" the stigma often contributed to the enactment of these laws (Cameron, 2009). In the publication by the HIV Justice Network and the Global Network of People Living with HIV (GNP+) entitled *Advancing HIV Justice 2*, Edwin Cameron, Constitutional Court of South Africa and HIV activist, states:

> "The enactment and enforcement of HIV-specific criminal laws – or even the threat of their enforcement – fuels the fires of stigma. It reinforces the idea that HIV is shameful, that it is a disgraceful contamination. And by reinforcing stigma, HIV criminalization makes it more difficult for those at risk of HIV to access testing and prevention. It also makes it more difficult for those living with the virus to talk openly about it, and to be tested, treated and supported" (Bernard & Cameron, 2016).

In the criminalization of HIV/AIDS, shame and fear are reinforced, which can discourage individuals from accessing needed testing and resources. Ultimately, these laws are enacted because of stigma associated with HIV/AIDS, and these laws further foster stigma associated with HIV/AIDS.

Another reason that HIV criminalization is considered poor public health methodology is that these laws punish those without criminal intent. HIV-specific criminal law "fails to uphold the legal and judicial fairness (including key criminal law principles of legality, foreseeability, intent, causality, proportionality, and proof)" (Bernard & Cameron, 2016). HIV criminality allows for prosecution of those who did not transmit the disease and had no criminal intent.

Edwin Cameron states “defendants have been punished less for what they did than for the virus they carried” meaning that the crime is more associated with HIV than the specified act (Cameron, 2009).

HIV-specific criminalization laws are also ineffective because the statues often do not reflect current scientific information. These policies are filled with “persistent misinformation about routes of HIV transmission,” which showcase that the policies are based on ignorance and/or stigma (Kelly, 2012). Saliva, urine, feces, and biting are commonly included in HIV-specific criminalization laws, yet these bodily fluids and actions pose negligible risk for viral transmission. Scientifically incorrect information misleads individuals in how HIV is transmitted and criminalizes those living with HIV for exposing others to HIV even though their actions and bodily fluids cannot transmit HIV. Ultimately. HIV-specific criminalization laws that include incorrect scientific information spread misinformation encouraging stigma and criminalize those living with HIV for no harm committed.

Despite being enacted to inhibit the spread of HIV and protect others from getting HIV, HIV-specific criminalization laws do not work. There is a “general lack of evidence that HIV-specific criminal laws have reduced transmission” (Lehman et.al., 2014). Numerous studies have shown limited impact of HIV-specific criminal laws on reducing HIV rates, even though the primary reason these laws exist are to reduce transmission rates.

Ultimately, HIV-specific criminal laws undermine HIV prevention, treatment, and care efforts. Studies have exhibited that “there is no good public health reason to treat sexual behavior involving HIV exposure as a crime, and… it is very difficult or impossible to do so fairly” (Burris, Beletsky, Burleson, Case, and Lazzarini, 2007). These laws are HIV-specific meaning that “the laws only apply to people who know their status” causing the statues to have the

potential to be "powerful disincentives for voluntary testing" (Burris et. al., 2007). These HIV-specific statues further stigma while singling out those living with HIV, which can discourage testing, further transmission of the virus by those who do not test, and discourage those living with HIV to access needed resources. HIV-specific criminal statues hinder prevention, treatment, and care efforts, whose efforts significantly reduce the spread of HIV and decrease the chances of HIV progressing to AIDS.

*Best Practices*

In a study published by both the Center for Disease Control and Prevention and the United States Department of Justice, HIV-specific criminal state laws were analyzed to conclude that states should "assess the laws' alignment with current evidence regarding transmission risk, and consider whether the laws are the best vehicle to achieve their intended purposes" (Lehman et.al., 2014). This suggestion was furthered by the United States Department of Justice Civil Rights Division's publication entitled *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors* (2014). The publication states:

> "Generally, the best practice would be for states to reform these laws to eliminate HIV-specific criminal penalties except in two distinct circumstances. First, states may wish to retain criminal liability when a person who knows he/she is HIV positive commits a (non-HIV specific) sex crime where there is a risk of transmission (e.g., rape or other sexual assault). The second circumstance is where the individual knows he/she is HIV positive and the evidence clearly demonstrates that individual's intent was to transmit the virus and that the behavior engaged in had a significant risk of transmission, whether or not transmission actually occurred." (U.S. Department of Justice Civil Right Division, 2014).

These findings are further validated by the *National HIV/AIDS Strategy for the United States: Updated to 2020*. This strategy includes the United States Department of Justice Civil Rights Division best practices to reform HIV-specific criminal laws in their list of achievements and include in their recommended actions for state governments to ensure their "criminal laws reflect current scientific information regarding HIV transmission and prevention" and that "anti-stigma civil rights messages" are in Federal documents (The White House Washington, 2015).

These studies and governmental publications show that the ideal public health solution for HIV-specific criminal laws is to repeal these statues to alleviate stigma related to these policies. If repeal is not possible, then these statutes should be reexamined and amended to be scientifically accurate, include a clause for criminal intent, and reduce stigma.

## Chapter 3: Statement of Problem

Amidst national decreasing trends, Mississippi's HIV/AIDS prevalence continues to increase. This predominantly impacts African American men who make up 74% of persons living with HIV and 68% of death by AIDS. Despite the availability of antiretroviral drugs that allow for people living with HIV to lead healthy lives, Mississippians are still dying of AIDS at alarming rates. These trends are also seen in the Mississippi prison system as Mississippi is the fourth highest in the nation for prisoners who had HIV as percent of custody population. These issues are further complicated by Mississippi's HIV-specific criminal law, Mississippi Code Ann. § 97-27-14. The statute relates to the crime of endangerment by bodily substance as applied to the prison population and includes urine, feces, and saliva, which are scientifically incorrect modes of HIV transmission. Based on national publications including the National HIV/AIDS Strategy for the United States: Updated to 2020 and the U.S. Department of Justice Civil Rights' Best Practices Guide to reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors, HIV-specific criminal laws should be reformed to reflect accurate scientific information and to prevent further stigma to persons living with HIV. Despite all these factors, the Mississippi State Department of Health's 2017-2021 Integrated HIV Prevention and Care Plan explicitly states that HIV-related criminal laws in Mississippi exist, but "before HIV decriminalization can happen, capacity building and awareness raising first occur and will be the focus of our efforts for the first year of this plan" and does not give a 5 year plan to holistically address HIV criminalization laws nor mention any plan related to the high prevalence of prisoners with HIV. Criminal laws serve as written guide for morality and justice. In having public health criminal statues based on unscientific and unrecommended information, Mississippi Code Ann. § 97-27-14 further perpetuates a culture of stigma for HIV/AIDS

furthering the Mississippi HIV/AIDS crisis. Mississippi Code Ann. § 97-27-14 must be methodologically reformed to reflect national standards.

## Chapter 4: Method

I used the CDC's Policy Analytical Framework to develop and analyze different HIV-specific policy options for Mississippi based on suggestions from the National HIV/AIDS Strategy for the United States: Updated to 2020 and the U.S. Department of Justice Civil Rights' Best Practices Guide to reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors. The CDC's Policy and Analytical Framework consists of three domains: Problem Identification, Policy Analysis, and Strategy and Policy Development.

Domain 1 is Problem Identification; this consists of "identify[ing] the problem or issue" to have a specific issue/problem that would enable a "clear policy solution" (Centers for Disease Control and Prevention, 2013). Problem Identification consists of "synthesiz[ing] data on the characteristics of the problem or issue, including the burden (how many people it affects), frequency (how often it occurs), severity (how serious the problem is), and scope (range of outcomes it affects)" (Centers for Disease Control and Prevention, 2013). Ultimately, the issue or problem is clearly identified.

Domain 2 is Policy Analysis. Policy Analysis consists of three main parts: "identify and describe policy options," "assess policy options," and "prioritize policy options" (Centers for Disease Control and Prevention, 2013). Identifying policy options consists of researching possible options related to the problem or issue. This includes conducting a literature review, looking at best practices, and performing an environmental scan to see what other states/jurisdictions have done. Describing policy options consists of elaborating on the options identified. This step includes answering framing questions "to describe the process and structure as well as the questions for each of the three interrelated criteria: health impact feasibility, and economic and budgetary impacts" (Table 1) (Centers for Disease Control and Prevention, 2013).

| Table 1: Policy Analysis: Key Questions | |
|---|---|
| **Framing Questions** | |
| What is the policy lever – is it legislative, administrative, regulatory, other? | |
| What level of government institution will implement? | |
| How does the policy work/operate? (e.g. is it mandatory? Will enforcement be necessary? How is it funded? Who is responsible for administering the policy?) | |
| What are the objectives of the policy? | |
| What is the legal landscape surrounding the policy (e.g. court rulings, constitutionality)? | |
| What is the historical context (e.g. has the policy been debated previously)? | |
| What are the experiences of other jurisdictions? | |
| What is the value-added of the policy? | |
| What are the expected short, intermediate, and long-term outcomes? | |
| What might be the unintended positive and negative consequences of the policy? | |
| **Public Health Impact: Potential for the policy to impact risk factors, quality of life, disparities, morbidity and mortality** | |
| How does the policy address the problem or issue (e.g., increase access, protect from exposure)? | |
| What are the magnitude, reach, and distribution of benefit and burden (including impact on risk factor, quality of life, morbidity and mortality? | |
| What population(s) will benefit? How much? When? | |
| What population(s) will be negatively impacted? How much? When? | |
| Will the policy impact health disparities/health equity? How? | |
| Are there gaps in the data/evidence-base? | |
| **Feasibility*: Likelihood that the policy can be successfully adopted and implemented** | |
| ***Political*** | |

| | |
|---|---|
| What are the current political forces including political history, environment, and debate? | |
| Who are the stakeholders, including supporters and opponents? What are their interests and values? | |
| What are the potential social, educational, and cultural perspectives associated with the policy option (e.g. lack of knowledge, fear of change, force of habit)? | |
| What are the potential impacts of the policy on other sectors and high priority issues (e.g. sustainability, economic impact)? | |
| ***Operational*** | |
| What are the resource, capacity, and technical needs developing, enacting, and implementing the policy? | |
| How much time is needed for the policy to be enacted, implemented, and enforced? | |
| How scalable, flexible, and transferable is the policy? | |
| **In assessing feasibility, identifying critical barriers that will prevent the policy from being adopted at the current time is important. For such policies, it may not be worthwhile to spend much time analyzing other factors (e.g. fiscal and economic impact). However, by identifying these critical barriers, you can be more readily able* | |
| **Economic and budgetary impacts: Comparison of the costs to enact, implement, and enforce the policy with the value of benefits** | |
| ***Budget*** | |
| What are the costs and benefits associated with the policy, from a budgetary perspective? | |
| E.g. for public (federal, state, local) and private entities to enact, implement, and enforce the policy? | |
| ***Economic*** | |
| How do costs compare to benefits (e.g. cost-savings costs averted, return on investments, cost-effectiveness, cost-benefit analysis, etc.)? | |
| How are costs and benefits distributed (e.g. for individuals, businesses, government)? | |

| | |
|---|---|
| What is the timeline for costs and benefits? | |
| Where are the gaps in the data/evidence-base? | |
| | |
| *** note where there are concerns about the quality or amount of data | |

After describing policy options, the next step is to assess policy options. Using the same criteria, policy options are independently scored based on a rating system seen in Table 2.

**Table 2: Policy Analysis Table**

| *Criteria* | *Public Health Impact* | *Feasibility* | *Economic and Budgetary Impact* | |
|---|---|---|---|---|
| **Scoring Definitions** | **Low**: small reach, effect size and impact on disparate populations | **Low**: No/small likelihood of being enacted | **Less favorable**: High costs to implement | **Less Favorable**: costs are high to benefits |

| | **Medium**: small reach with large effect size or large reach with small effect size<br>**Large**: large reach, effect size, and impact on disparate populations | **Medium**: Moderate likelihood of being enacted<br><br>**High**: High likelihood of being enacted | **Favorable**: Moderate cost to implement<br><br>**More Favorable**: Low costs to implement | **Favorable**: costs are moderate relative to benefits<br><br>**More Favorable**: costs are low relative to benefits |
|---|---|---|---|---|
| | | | *Budget* | *Economic* |
| **Policy 1** | Low/Medium/ High<br>Concerns about the amount or quality of data? Yes/No | Low/Medium/ High<br>Concerns about the amount or quality of data? Yes/No | Less Favorable/Favorable/ More Favorable<br><br>Concerns about the amount or quality of data? Yes/No | Less Favorable/Favorable/ More Favorable<br><br>Concerns about the amount or quality of data? Yes/No |
| **Policy 2** | Low/Medium/ High<br>Concerns about the amount or quality of data? Yes/No | Low/Medium/ High<br>Concerns about the amount or quality of data? Yes/No | Less Favorable/Favorable/ More Favorable<br><br>Concerns about the amount or quality of data? Yes/No | Less Favorable/Favorable/ More Favorable<br><br>Concerns about the amount or quality of data? Yes/No |
| **Policy 3** | Low/Medium/ High<br>Concerns about the amount or quality of data? Yes/No | Low/Medium/ High<br>Concerns about the amount or quality of data? Yes/No | Less Favorable Favorable/More Favorable<br><br>Concerns about the amount or quality of data? Yes/No | Less Favorable/Favorable/ More Favorable<br><br>Concerns about the amount or quality of data? Yes/No |

After policy options are assessed, policy options are evaluated against each other and policy options are prioritized based on the overall analysis.

Domain 3 is Strategy and Policy Development. This step is to "develop a strategy for furthering adoption of the policy solution" (Centers for Disease Control and Prevention, 2013). After a policy option is prioritized, a strategy is defined to get the policy enacted. To accomplish this, operational issues are clarified, information is shared, and, if needed, additional background

work is conducted. To clarify operational issues, “identify how the policy will operate and what steps are needed for policy implementation” (Centers for Disease Control and Prevention, 2013). To share information, share the results to stakeholders; to disseminate the information, develop products that “keep in mind the stakeholders’ information needs and preferred ways of receiving information” (Centers for Disease Control and Prevention, 2013). This can be done via a summarization sheet, presentation, meetings, or other methods. Lastly, additional background work is conducted if needed. If the policy scored low in specific areas or there are concerns with the data, the policy can be reworked to more effectively address the problem or issue.

## Chapter 5: Results

Using the CDC's Policy Analytical Framework, first, data was synthesized to identify the overarching problem that § 97-27-14 is not scientifically accurate and negatively impacts the HIV crisis in Mississippi (Table 3).

| **Domain 1: Problem Identification** | |
|---|---|
| *Step 1: Identify the Problem or Issue* | |
| Burden | Approximately 9,236 Mississippians living with HIV |
| Frequency | As of 2017, rate of 14.3 per 100,000 population. |
| Severity | Ranked 9 in the nation for diagnoses of HIV |
| Scope | Significantly impacts African American men who have sex with men, high rates of AIDS, current law scientifically incorrect and stigmatizing |
| *Identified Problem:* | § 97-27-14 is not scientifically accurate and negatively impacts the HIV crisis in Mississippi |

Table 3

Next, possible policy options were identified. Based on the National HIV/AIDS Strategy for the United States: Updated to 2020, U.S. Department of Justice Civil Rights' Best Practices Guide to reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors, Georgia Code ANN. § 16-5-60, and the 2016 act proposed by Representative Hines to amend the crime of endangerment for bodily substances, three possible policies were identified.

Based off the 2016 amendment proposed by Representative Hines, the first policy option amends Mississippi Code § 97-27-14 to include only blood and seminal fluid. The Policy 1 option states:

> "It shall be unlawful for any person to knowingly expose another person to human immunodeficiency virus (HIV). Prior knowledge and willing consent to the exposure is a defense to a charge brought under this paragraph. A violation of this subsection shall be a felony.
>
> (2)(a) A person commits the crime of endangerment by bodily substance if the person attempts to cause or knowingly causes a corrections employee, a visitor to a correctional facility or another prisoner or offender to come into contact with blood or seminal fluid.
>
> (b) As used in this subsection, the following definitions shall apply unless the context clearly requires otherwise:
>
> (i) "Corrections employee" means a person who is an employee or contracted employee of a subcontractor of a department or agency responsible for operating a jail, prison, correctional facility or a person who is assigned to work in a jail, prison or correctional facility.
>
> (ii) "Offender" means a person who is in the custody of the Department of Corrections.
>
> (iii) "Prisoner" means a person confined in a county or city jail.
>
> (c) A violation of this subsection is a misdemeanor unless the person violating this section knows that he is infected with human immunodeficiency virus (HIV, in which case it is a felony.

(3) Any person convicted of a felony violation of this section shall be imprisoned for not less than three (3) years nor more than ten (10) years and a fine of not more than Ten Thousand Dollars ($10,000.00), or both.

(4) Any person guilty of a misdemeanor violation of this section shall be punished by imprisonment in the county jail for up to one (1) year and may be fined One Thousand Dollars ($1,000.00), or both."

(5) The provisions of this section shall be in addition to any other provisions of law for which the actions described in this section may be prosecuted.

The second policy option includes the clause "with the intent to transmit HIV" and also only includes blood and seminal fluids in the list of bodily substances. This policy is based off Georgia Code ANN. § 16-5-60, the National HIV/AIDS Strategy for the United States: Updated to 2020, and the U.S. Department of Justice Civil Rights' Best Practices Guide to reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors. The Policy 2 Option states:

It shall be unlawful for any person to knowingly expose another person to human immunodeficiency virus (HIV) with the intent to transmit HIV. Prior knowledge and willing consent to the exposure is a defense to a charge brought under this paragraph. A violation of this subsection shall be a felony.

(2)(a) A person commits the crime of endangerment by bodily substance if the person attempts to cause or knowingly causes a corrections employee, a visitor to a correctional facility or another prisoner or offender to come into contact with blood or seminal fluid.

(b) As used in this subsection, the following definitions shall apply unless the context clearly requires otherwise:

(i) "Corrections employee" means a person who is an employee or contracted employee of a subcontractor of a department or agency responsible for operating a jail, prison, correctional facility or a person who is assigned to work in a jail, prison or correctional facility.

(ii) "Offender" means a person who is in the custody of the Department of Corrections.

(iii) "Prisoner" means a person confined in a county or city jail.

(c) A violation of this subsection is a misdemeanor unless the person violating this section intends to transmit HIV.

(3) Any person convicted of a felony violation of this section shall be imprisoned for not less than three (3) years nor more than ten (10) years and a fine of not more than Ten Thousand Dollars ($10,000.00), or both.

(4) Any person guilty of a misdemeanor violation of this section shall be punished by imprisonment in the county jail for up to one (1) year and may be fined One Thousand Dollars ($1,000.00), or both.

(5) The provisions of this section shall be in addition to any other provisions of law for which the actions described in this section may be prosecuted.

The third policy option is to repeal Mississippi Code § 97-27-14. This option is based off of recommendations by the National HIV/AIDS Strategy for the United States: Updated to 2020 and the general best practice suggested by the U.S. Department of Justice Civil Rights' Best Practices Guide to reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors. The Policy 3 option states:

Repeal Mississippi Code § 97-27-14.

Next the policies were described and analyzed based on Public Health Impact, Feasibility, and Economic and Budgetary Impacts using Table 1: Policy Analysis: Key Questions. Tables 4-6 showcase the results.

| **Table 4: Policy Analysis: Key Questions** |
| --- |
| **Policy 1 Option** |
| **Framing Questions** |

| | |
|---|---|
| What is the policy lever – is it legislative, administrative, regulatory, other? | Legislative |
| What level of government institution will implement? | State |
| How does the policy work/operate? (e.g. is it mandatory? Will enforcement be necessary? How is it funded? Who is responsible for administering the policy?) | This is related to criminal justice, so this will be administered by the court system. Enforcement is necessary because it is a criminal law. |
| What are the objectives of the policy? | The objectives of this policy are to amend the existing law to be scientifically accurate and reduce stigma. |
| What is the legal landscape surrounding the policy (e.g. court rulings, constitutionality)? | Nationally: United States V. Moore, State: 2008 Shala Singleton Howell |
| What is the historical context (e.g. has the policy been debated previously)? | The law has been debated previously. A similar amendment was proposed in 2016 and failed. |
| What are the experiences of other jurisdictions? | 33 states, 67 HIV-Specific criminal laws, Center for Disease Control and Prevention and the Department of Justice encourage laws to be reassessed |
| What is the value-added of the policy? | Adds scientific accuracy to existing policy |
| What are the expected short, intermediate, and long-term outcomes? | Adds scientific accuracy when law is utilized; is only a temporary solution and will need to be amended again because the amendment still furthers stigma and is not the ideal public health solution |
| What might be the unintended positive and negative consequences of the policy? | Does not include clause for criminal intent, could further stigma with disparity in sentencing for misdemeanor versus felony |
| **Public Health Impact: Potential for the policy to impact risk factors, quality of life, disparities, morbidity and mortality** | |
| How does the policy address the problem or issue (e.g., increase access, protect from exposure)? | Makes the law scientifically accurate by including only bodily substances that can transmit HIV |
| What are the magnitude, reach, and distribution of benefit and burden (including impact on risk factor, quality of life, morbidity and mortality? | Impact HIV/AIDS Mississippians: approximately 200 prisoners, over 400 diagnoses yearly in Mississippi, over 9,000 living with HIV in Mississippi |
| What population(s) will benefit? How much? When? | HIV/AIDS populations as the law is scientifically correct. This has immediate impact as the |

| | |
|---|---|
| | amendment reduces misinformation thereby reducing some stigma. |
| What population(s) will be negatively impacted? How much? When? | HIV/AIDS populations as the law is still HIV-specific and is thereby still stigmatizing. |
| Will the policy impact health disparities/health equity? How? | The policy impacts health disparities in that HIV/AIDS disproportionately impacts Black men who have sex with men. The policy promotes health equity by including scientifically correct information. |
| Are there gaps in the data/evidence-base? | No. |
| **Feasibility*: Likelihood that the policy can be successfully adopted and implemented** | |
| ***Political*** | |
| What are the current political forces including political history, environment, and debate? | International/national agencies encouraging re-assessment of HIV criminalization laws. Similar amendment introduced in 2016 and failed. Original law used only once in 2008, but there may be other instances where the law has been used that are not as widely noted. |
| Who are the stakeholders, including supporters and opponents? What are their interests and values? | Mississippi Legislators (protecting Mississippians, getting re-elected, etc.), Mississippians living with HIV/AIDS, HIV/AIDS advocacy organizations (equitable laws, decreasing stigma) |
| What are the potential social, educational, and cultural perspectives associated with the policy option (e.g. lack of knowledge, fear of change, force of habit)? | Lack of knowledge, stigma, fear, heteronormality, abstinence-plus education |
| What are the potential impacts of the policy on other sectors and high priority issues (e.g. sustainability, economic impact)? | Limited impact |
| ***Operational*** | |
| What are the resource, capacity, and technical needs developing, enacting, and implementing the policy? | Advocacy to lawmakers, mobilization of HIV/AIDS advocates/community to educate lawmakers, education, education about law to prison systems |
| How much time is needed for the policy to be enacted, implemented, and enforced? | Minimum 6 months |
| How scalable, flexible, and transferable is the policy? | The policy has the potential to be scalable, flexible, and transferable in relation to Hepatitis B and Hepatitis C-specific criminalization policies. |

| |
|---|
| **In assessing feasibility, identifying critical barriers that will prevent the policy from being adopted at the current time is important. For such policies, it may not be worthwhile to spend much time analyzing other factors (e.g. fiscal and economic impact). However, by identifying these critical barriers, you can be more readily able* |

| **Economic and budgetary impacts: Comparison of the costs to enact, implement, and enforce the policy with the value of benefits** | |
|---|---|
| ***Budget*** | |
| What are the costs and benefits associated with the policy, from a budgetary perspective? | Low costs |
| E.g. for public (federal, state, local) and private entities to enact, implement, and enforce the policy? | No cost change from previous policy |
| ***Economic*** | |
| How do costs compare to benefits (e.g. cost-savings costs averted, return on investments, cost-effectiveness, cost-benefit analysis, etc.)? | There is limited cost change from the previous policy, yet in amending the law to be scientifically accurate, the policy reduces stigma. Stigma is often a reason people do not get tested for HIV or do not access needed resources, and so, by alleviating stigma, persons living with HIV will access needed resources sooner preventing the spread of the virus and more costly health problems. |
| How are costs and benefits distributed (e.g. for individuals, businesses, government)? | Healthcare industry as less costly health services, those living with HIV/AIDS by accessing needed health resources sooner and with less stigma, prison system having less prisoners based on more correct laws |
| What is the timeline for costs and benefits? | 6 months in relation with enactment |
| Where are the gaps in the data/evidence-base? | No |

Table 4 entailing the Policy 1 Option

| **Table 5: Policy Analysis: Key Questions** | |
|---|---|
| **Policy 2 Option** | |
| **Framing Questions** | |
| What is the policy lever – is it legislative, administrative, regulatory, other? | Legislative |
| What level of government institution will implement? | State |
| How does the policy work/operate? (e.g. is it mandatory? Will enforcement be necessary? | This is related to criminal justice, so this will be administered by the court system. Enforcement is necessary because it is a criminal law. |

| | |
|---|---|
| How is it funded? Who is responsible for administering the policy?) | |
| What are the objectives of the policy? | The objectives of this policy are to amend the existing law to be scientifically accurate, to decrease stigma, and include a cause for criminal intent. |
| What is the legal landscape surrounding the policy (e.g. court rulings, constitutionality)? | Nationally: United States V. Moore, State: 2008 Shala Singleton Howell |
| What is the historical context (e.g. has the policy been debated previously)? | The law has been debated previously. A much more simplified amendment was proposed in 2016 and failed. |
| What are the experiences of other jurisdictions? | 33 states, 67 HIV-Specific criminal laws, Center for Disease Control and Prevention and the Department of Justice encourage laws to be reassessed encouraging clauses for intent if not repeal. There are several laws similar to this in states such as Georgia. |
| What is the value-added of the policy? | Adds scientific accuracy to existing policy, adds criminal intent to a criminal law |
| What are the expected short, intermediate, and long-term outcomes? | Adds scientific accuracy when law is utilized; includes clause relating to criminal intent. |
| What might be the unintended positive and negative consequences of the policy? | Potentially further stigma because of the difference between felony and misdemeanor, possibly stigmatize HIV as a possible weapon. Potentially makes the law more feasible in appeal to lawmakers and adds protection to those living with HIV who do not have criminal intent and those who could be victim to criminal intent as exemplified in domestic violence. |
| **Public Health Impact: Potential for the policy to impact risk factors, quality of life, disparities, morbidity and mortality** | |
| How does the policy address the problem or issue (e.g., increase access, protect from exposure)? | Makes the law scientifically accurate, adds criminal intent to decrease stigma |
| What are the magnitude, reach, and distribution of benefit and burden (including impact on risk factor, quality of life, morbidity and mortality? | Impact HIV/AIDS Mississippians: approximately 200 prisoners, over 400 diagnoses yearly in Mississippi, over 9,000 living with HIV in Mississippi |
| What population(s) will benefit? How much? When? | HIV/AIDS populations as the law is scientifically correct/includes criminal clause to decriminalize |
| What population(s) will be negatively impacted? How much? When? | HIV/AIDS populations as the law is still HIV-specific and thereby still stigmatizing |

| | |
|---|---|
| Will the policy impact health disparities/health equity? How? | The policy impacts health disparities in that HIV/AIDS disproportionately impacts Black men who have sex with men. The policy promotes health equity by including scientifically correct information and accounts for criminal intent, decriminalizing certain behaviors. |
| Are there gaps in the data/evidence-base? | No |
| **Feasibility*: Likelihood that the policy can be successfully adopted and implemented** | |
| ***Political*** | |
| What are the current political forces including political history, environment, and debate? | International/national agencies encouraging re-assessment of laws. Similar amendment failed in 2016. Original law used only once in 2008, but there may be other instances where the law has been used that are not as widely noted. Amending HIV-specific criminalization laws to include criminal intent is suggested by the Department of Justice, and these policies are seen in other states. |
| Who are the stakeholders, including supporters and opponents? What are their interests and values? | Mississippi Legislators (protecting Mississippians, getting re-elected, etc.), Mississippians living with HIV/AIDS, HIV/AIDS advocacy organizations (equitable laws, decreasing stigma) |
| What are the potential social, educational, and cultural perspectives associated with the policy option (e.g. lack of knowledge, fear of change, force of habit)? | Lack of knowledge, stigma, fear, heteronormality, abstinence-plus education, |
| What are the potential impacts of the policy on other sectors and high priority issues (e.g. sustainability, economic impact)? | Limited impact |
| ***Operational*** | |
| What are the resource, capacity, and technical needs developing, enacting, and implementing the policy? | Advocacy to lawmakers, mobilization of HIV/AIDS advocates/community to educate lawmakers, education, education about law to prison systems |
| How much time is needed for the policy to be enacted, implemented, and enforced? | Minimum 6 months |
| How scalable, flexible, and transferable is the policy? | The policy has the potential to be scalable, flexible, and transferable in relation to Hepatitis B and Hepatitis C-specific criminalization policies. |
| **In assessing feasibility, identifying critical barriers that will prevent the policy from being adopted at the current time is important. For such policies, it may not be worthwhile to spend much time analyzing other factors (e.g. fiscal and economic impact). However, by identifying these critical barriers, you can be more readily able* | |
| **Economic and budgetary impacts: Comparison of the costs to enact, implement, and enforce the policy with the value of benefits** | |

| ***Budget*** | |
|---|---|
| What are the costs and benefits associated with the policy, from a budgetary perspective? | Low costs |
| E.g. for public (federal, state, local) and private entities to enact, implement, and enforce the policy? | No cost change from previous policy |
| ***Economic*** | |
| How do costs compare to benefits (e.g. cost-savings costs averted, return on investments, cost-effectiveness, cost-benefit analysis, etc.)? | There is limited cost change from the previous policy, yet in amending the law to be scientifically accurate and including a clause for criminal intent, the policy reduces stigma. Stigma is often a reason people do not get tested for HIV or do not access needed resources, and so, by alleviating stigma, persons living with HIV will access needed resources sooner preventing the spread of the virus and more costly health problems. |
| How are costs and benefits distributed (e.g. for individuals, businesses, government)? | Healthcare industry as less costly health services, those living with HIV/AIDS by accessing needed health resources sooner and with less stigma, prison system having less prisoners based on more correct laws |
| What is the timeline for costs and benefits? | 6 months in relation with enactment |
| Where are the gaps in the data/evidence-base? | No |

Table 5 entailing Policy 2 option.

| **Table 6: Policy Analysis: Key Questions** | |
|---|---|
| **Policy 3 Option** | |
| **Framing Questions** | |
| What is the policy lever – is it legislative, administrative, regulatory, other? | Legislative |
| What level of government institution will implement? | State |
| How does the policy work/operate? (e.g. is it mandatory? Will enforcement be necessary? How is it funded? Who is responsible for administering the policy?) | This is related to criminal justice, so this will be administered by the court system. Because this is a repeal of a criminal law, enforcement is no longer necessary. |

| | |
|---|---|
| What are the objectives of the policy? | The objectives of this policy are to decrease stigma for HIV/AIDS populations as based on the Center for Disease Control and Prevention and the Department of Justice suggestions and best practices. |
| What is the legal landscape surrounding the policy (e.g. court rulings, constitutionality)? | Nationally: United States V. Moore, State: 2008 Shala Singleton Howell |
| What is the historical context (e.g. has the policy been debated previously)? | The law has been debated previously. A less extreme was proposed in 2016 and failed. |
| What are the experiences of other jurisdictions? | 33 states, 67 HIV-Specific criminal laws, Center for Disease Control and Prevention and the Department of Justice encourage laws to be reassessed |
| What is the value-added of the policy? | Decreases stigma associated with criminalizing HIV |
| What are the expected short, intermediate, and long-term outcomes? | Ultimately decrease stigma for those living with HIV |
| What might be the unintended positive and negative consequences of the policy? | Fear related to HIV, increased education of lawmakers an and other communities |
| **Public Health Impact: Potential for the policy to impact risk factors, quality of life, disparities, morbidity and mortality** | |
| How does the policy address the problem or issue (e.g., increase access, protect from exposure)? | Decriminalizes HIV thereby decreasing stigma related to HIB |
| What are the magnitude, reach, and distribution of benefit and burden (including impact on risk factor, quality of life, morbidity and mortality? | Impact HIV/AIDS Mississippians: approximately 200 prisoners, over 400 diagnoses yearly in Mississippi, over 9,000 living with HIV in Mississippi |
| What population(s) will benefit? How much? When? | HIV/AIDS populations |

| | |
|---|---|
| What population(s) will be negatively impacted? How much? When? | Conversation surrounding the policy could negatively impact HIV/AIDS populations initially. General population could be negatively impacted regarding potential for domestic violence and criminal intent, yet these are mild concerns that have the potential to be addressed in other laws. |
| Will the policy impact health disparities/health equity? How? | The policy impacts health disparities in that HIV/AIDS disproportionately impacts Black MSM. The policy promotes health equity by decriminalizing HIV. |
| Are there gaps in the data/evidence-base? | No |
| **Feasibility*: Likelihood that the policy can be successfully adopted and implemented** | |
| ***Political*** | |
| What are the current political forces including political history, environment, and debate? | International/national agencies encouraging re-assessment of HIV criminalization laws. Similar amendment introduced in 2016 and failed. Original law used only once in 2008, but there may be other instances where the law has been used that are not as widely noted. Repealing HIV-specific criminal laws is the best practice as suggested by the Department of Justice. |
| Who are the stakeholders, including supporters and opponents? What are their interests and values? | Mississippi Legislators (protecting Mississippians, getting re-elected, etc.), Mississippians living with HIV/AIDS, HIV/AIDS advocacy organizations (equitable laws, decreasing stigma) |
| What are the potential social, educational, and cultural perspectives associated with the policy option (e.g. lack of knowledge, fear of change, force of habit)? | Lack of knowledge, stigma, fear, heteronormality, abstinence-plus education, want to protect Mississippi citizens |

| | |
|---|---|
| What are the potential impacts of the policy on other sectors and high priority issues (e.g. sustainability, economic impact)? | Limited impact |
| ***Operational*** | |
| What are the resource, capacity, and technical needs developing, enacting, and implementing the policy? | Advocacy to lawmakers, mobilization of HIV/AIDS advocates/community to educate lawmakers, education, education about law to prison systems |
| How much time is needed for the policy to be enacted, implemented, and enforced? | Minimum 6 months |
| How scalable, flexible, and transferable is the policy? | The policy has the potential to be scalable, flexible, and transferable in relation to Hepatitis B and Hepatitis C-specific criminalization policies. |
| **In assessing feasibility, identifying critical barriers that will prevent the policy from being adopted at the current time is important. For such policies, it may not be worthwhile to spend much time analyzing other factors (e.g. fiscal and economic impact). However, by identifying these critical barriers, you can be more readily able* | |
| **Economic and budgetary impacts: Comparison of the costs to enact, implement, and enforce the policy with the value of benefits** | |
| ***Budget*** | |
| What are the costs and benefits associated with the policy, from a budgetary perspective? | Low costs |
| E.g. for public (federal, state, local) and private entities to enact, implement, and enforce the policy? | No cost change from previous policy |
| ***Economic*** | |
| How do costs compare to benefits (e.g. cost-savings costs averted, return on investments, cost-effectiveness, cost-benefit analysis, etc.)? | There is limited cost change from the previous policy, yet in decriminalizing HIV, the policy greatly reduces stigma. Stigma is often a reason people do not get tested for HIV or do not access needed resources, and so, by alleviating stigma, persons living with HIV will access needed resources sooner preventing the spread of the virus and more costly health problems. |

| | |
|---|---|
| How are costs and benefits distributed (e.g. for individuals, businesses, government)? | Healthcare industry as less costly health services, those living with HIV/AIDS by accessing needed health resources sooner and with less stigma, prison system having less prisoners based on more correct laws |
| What is the timeline for costs and benefits? | 6 months in relation with enactment |
| Where are the gaps in the data/evidence-base? | No |

Table 6 entailing Policy 3 option.

After describing policy options, the policy options were scored independently based on Public Health Impact, Feasibility and Economic and Budgetary Impact. Table 6 shows the scoring results.

**Table 7: Policy Analysis Table**

| *Criteria* | *Public Health Impact* | *Feasibility* | *Economic and Budgetary Impact* | |
|---|---|---|---|---|
| **Scoring Definitions** | **Low**: small reach, effect size and impact on disparate populations<br>**Medium**: small reach with large effect size or large reach with small effect size<br><br>**Large**: large reach, effect size, and impact on disparate populations | **Low**: No/small likelihood of being enacted<br>**Medium**: Moderate likelihood of being enacted<br><br>**High**: High likelihood of being enacted | **Less favorable**: High costs to implement<br><br>**Favorable**: Moderate cost to implement<br>**More Favorable**: Low costs to implement | **Less Favorable**: costs are high to benefits<br>**Favorable**: costs are moderate relative to benefits<br>**More Favorable**: costs are low relative to benefits |
| | | | *Budget* | *Economic* |
| **Policy 1** | Low<br><br>Concerns about the amount or quality of data? No | Medium<br><br>Concerns about the amount or quality of data? No | More Favorable<br>Concerns about the amount or quality of data? No | More Favorable<br>Concerns about the amount or quality of data? No |
| **Policy 2** | Medium | Medium | More Favorable | More Favorable |

| | | | | |
|---|---|---|---|---|
| | Concerns about the amount or quality of data? No | Concerns about the amount or quality of data? No | Concerns about the amount or quality of data? No | Concerns about the amount or quality of data? No |
| **Policy 3** | High<br><br>Concerns about the amount or quality of data? No | Low<br><br>Concerns about the amount or quality of data? No | More Favorable<br>Concerns about the amount or quality of data? No | More Favorable<br>Concerns about the amount or quality of data? No |

Table 7

Based on the policy analysis, Policy 2 is prioritized, but concerns are noted for the overall public health impact.

Finally, during Strategy and Policy Development, a strategy is created to account for the public health impact.

| Domain 3: Strategy and Policy Development | |
|---|---|
| **Clarifying Operational Issues** | Discuss Policy 2 with relevant stakeholders, educate Mississippi state legislators about implications of current policy, get a Mississippi state legislator to sponsor the bill, continue to advocate for bill |
| **Sharing Information** | Share with relevant stakeholders including AIDS Services Coalition, My Brother's Keeper, Inc, Center for Mississippi Health Policy, Mississippi legislature public health committees, Mississippians living with HIV |
| **Conducting Additional Background Work** | Based on concerns with Policy 2's public health impact, modify the policy strategy to be more incremental in advocating for Policy 2 while continuing to work for Policy 3 |

Table 8

As the strategy and policy development in Table 7 show, the prioritized policy is Policy option 2 to amend Mississippi's HIV-specific criminalization law to be scientifically correct and include a criminalization clause. Because this is not the ideal public health solution, the strategy is modified to be more incremental in building the foundation for Mississippi's HIV-specific criminalization law to be repealed while advocating for the current best policy option, Policy Option 2.

Enactment of Policy 2 while building the foundation to decriminalize HIV is done by first discussing the current policy option and strategy with stakeholders including AIDS Services

Coalition, My Brother's Keeper, Inc, Center for Mississippi Health Policy, Public Health Committees in the Mississippi Legislature, Mississippians living with HIV, and other relevant stakeholders. Once the policy option and strategy are discussed, see if changes should be made to the policy option and/or strategy. After discussing the policy and strategy with stakeholders, begin educating Mississippi state legislators about the implications of the current policy while also addressing the HIV/AIDS crisis in Mississippi and implications of HIV-criminalization as a whole. After educating legislators, get a Mississippi state legislator to sponsor the bill. Finally, mobilize stakeholders to continue to advocate for the bill throughout the Mississippi House of Representatives and Senate.

## Chapter 6: Findings and Discussion

After identifying the overarching problem being that Mississippi Code § 97-27-14 is not scientifically accurate and negatively impacts the HIV crisis in Mississippi, three policy options were identified. Policy 1 amends the original policy to only blood and seminal fluid, Policy 2 amends the original policy to only include blood and seminal fluid and includes criminal intent, and Policy 3 is to repeal Mississippi Code § 97-27-14.

When describing the policy options, there were varied concerns with each policy. Policy 1 amends the original law to be scientifically correct, yet the law is still stigmatizing as it does not include a clause for criminal intent, includes the disparity in sentencing for a misdemeanor versus felony, singles out persons living with HIIV, and further stigmatizes those living with HIV. Policy 2 amends the original law by including criminal intent and scientifically correct information, yet this policy option still stigmatizes as the policy singles out persons living with HIV, includes the disparity in sentencing for a misdemeanor versus felony, and still further stigmatizes person living with HIV in the idea of HIV as a weapon. Policy 3 is the repeal of Mississippi Code § 97-27-14; while this policy option is the least stigmatizing option for persons living with HIV, the major concern is regarding feasibility. While all of the policy options regard extensive education for policy makers, repealing Mississippi Code § 97-27-14 requires the most extensive educational measures and raises concerns with the concept of  protecting Mississippians.

After describing policy options, Policy 1, 2, and 3 were assessed. Policy 1 scored low for Public Health Impact, medium for Feasibility, and more favorable for both Economic and Budgetary Impact. While Policy 1 amends the law to be scientifically accurate, the law does not account for criminal intent, which makes it have a limited public health impact. Also, this law is

still stigmatizing because this is still a HIV-specific criminal law and the discrepancy still exists between misdemeanor and felony. Despite the very similar amendment to the 2016 Mississippi Legislature failing, this policy has a moderate likelihood of being enacted if proper advocacy measures are put in place including stakeholder mobilization and education of lawmakers. This policy change would ultimately cost the same as Mississippi Code § 97-27-14 while possibly reducing healthcare costs through the alleviation of stigma ultimately making this policy more favorable for Economic and Budgetary Impact.

Policy 2 scored medium for Public Health Impact, medium for Feasibility, and more favorable for both Economic and Budgetary Impact. Policy 2 amends the law to be scientifically accurate and includes the clause of criminal intent to be a felony. Yet, this policy is still classified as a HIV-specific law furthering stigma, and there is still the clause for a misdemeanor, which does not account for criminal intent. Yet, HIV-specific policies are created with the intention of protecting citizens, despite limited evidence that it works, and so, this policy's criminal intent clause benefits both parties as it accounts for those affected by criminal intent and persons living with HIV who did not have criminal intent. Overall, this policy has a medium public health impact because of its large reach and small effect size. Because this policy appeals to various stakeholders in accounting for criminal intent, this policy has a moderate likelihood of being enacted if proper advocacy measures are put in place including the mobilization of stakeholders and continued educational efforts of lawmakers. Policy 2 would ultimately cost the same as Mississippi Code § 97-27-14 while possibly reducing healthcare costs through the alleviation of stigma and possibly reduce criminalization rates ultimately making this policy more favorable for Economic and Budgetary Impact.

Policy 3 scored large for Public Health Impact, low for Feasibility, and more favorable for both Economic and Budgetary Impact. Policy 3 is the repeal of Mississippi Code § 97-27-14. This policy has the greatest public health impact in that this repeal decriminalizes HIV greatly reducing stigma for people living with HIV. While this policy has the most significant public health impact, based on current attitudes, understanding, and pre-existing stigma of HIV by Mississippi legislators and other Mississippians, this policy has a significantly lower chance of being implemented. Policy 3 would ultimately cost the same as Mississippi Code § 97-27-14 while possibly reducing healthcare costs through the alleviation of stigma and ultimately reducing criminalization rates making this policy more favorable for Economic and Budgetary Impact.

Once policy options were assessed and scored, Policy 2 was prioritized based on the moderate Public Health Impact and Feasibility, yet concerns were noted that Policy 2 is not the ideal public health solution. To account for the fact that the ideal public health solution is to repeal the HIV-specific criminal law, the strategy was modified to be more incremental in advocating for the immediate policy solution to be Policy 2 while building the foundation and continuing to work for Policy 3. This is done by first discussing Policy 2 and the strategy with relevant stakeholders to possibly modify the policy and strategy and mobilize stakeholders. After discussing Policy 2 with stakeholders, educate Mississippi legislators about the Mississippi HIV/AIDS crisis, implications of Mississippi Code § 97-27-14, and overall stigmatizing effects of HIV-specific criminalization while advocating for Policy 2. In this education and advocacy phase, the immediate policy solution is advocated for while the educational foundations and decrease of stigma are beginning for the foundation for the repeal of Mississippi Code § 97-27-

14. After this step, get a Mississippi legislator to sponsor the bill and continue to advocate for the bill as it goes through Mississippi State House of Representatives and Senate.

## Chapter 7: Conclusion and Directions for Future Research

Ultimately, Mississippi § 97-27-14 must be reformed to reflect national standards and to decrease misinformation and stigma for those living with HIV in Mississippi. The current best policy option based on Public Health Impact and Feasibility is to amend the code to be scientifically accurate and include a clause for criminal intent. Because this is not the ideal public health solution, the strategy must include building the foundation to continually work for ultimately repealing Mississippi's HIV-specific criminalization law while advocating for the current best policy solution. Amidst the HIV/AIDS crisis in Mississippi, it is critical that Mississippi Code § 97-27-14 is reformed to decrease stigma that continues to hurt Mississippians living with HIV.

The findings of this policy analysis suggest directions for future research. Mississippi is currently ranked second in the nation for percentages of prisoners living with HIV. This is an alarming number, and yet, no literature exists about the high percentage, and it is not mentioned in the Mississippi State Department of Health 2017-2021 Integrated HIV Prevention and Care Plan. It is critical that the high percentage is further researched, so that the health needs of this population are met. Secondly, Hepatitis B and Hepatitis C are included in Mississippi Code § 97-27-14, yet for the purpose of this study, Hepatitis B and C were not included. Further research and analysis should be done for Hepatitis B and C-specific criminalization laws to determine if the suggested policy option determined for Mississippi's HIV-criminalization laws would be applicable. Lastly, there are numerous policies by the Mississippi Department of Health regarding HIV treatment and prevention efforts. It is important for these laws to be re-examined and reformed to meet national standards, improve access for those living with HIV, and ensure these policies meet the health needs of vulnerable Mississippians.

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