HIV care nurses’ knowledge of HIV criminalization: A feasibility study

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Disclosures

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Abstract

HIV-related criminal laws in some jurisdictions may hamper population health efforts to manage HIV and bring about an AIDS free generation. HIV care nurses have an instrumental role to play in ensuring equitable care and health for all in a context of HIV. The purpose of our study was to determine HIV care nurses’ knowledge of HIV-related criminal laws. Ecosocial theory and content expert opinion guided development of a questionnaire to assess nurses’ knowledge of HIV-related criminal laws. A total of 174 HIV care nurses from Canada (n = 23) and the United States (n = 151) completed the questionnaire. Knowledge gaps were observed in several aspects of HIV-related criminal laws that can influence nursing clinical practices. Nurses should increase their knowledge of HIV-related criminal laws to ensure the success of population health initiatives and to reduce stigma and discrimination experienced by people living with HIV.

Keywords: criminal laws, ecosocial theory, ethics, health equity, human rights, nursing practice
HIV care nurses’ knowledge of HIV criminalization in Canada and the United States

The overly broad use of criminal laws against people living with HIV (PLWH), often referred to as HIV criminalization, is a controversial structural (societal level) approach to managing HIV (Cameron, 2009; Center for HIV Law and Policy, 2014; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2013; United Nations Development Programme, 2012). This approach may limit the ability of people living with or at risk of acquiring HIV to benefit from biomedical (e.g., antiretroviral therapy) and public health interventions (e.g., voluntary counseling and testing), which have demonstrated efficacy in managing HIV at individual and population levels. Ongoing prosecutions of PLWH based on allegations of non-disclosure, or potential or perceived exposure to others, may limit the efficacy of biomedical and public health interventions (Burris & Cameron, 2008; Burris, Beletsky, Burleson, Case, & Lazzarini, 2007; Cameron, Burris, & Clayton, 2008; UNAIDS, 2010b; UNAIDS, 2014; Lazzarini, Bray, & Burris, 2002; United Nations Development Programme, 2012).

Approaches to HIV criminalization differ widely across and within international jurisdictions. For example, in Canada there is no HIV-specific criminal law, but PLWH do have a criminal-law obligation to disclose their HIV status (Dej & Kilty, 2012; Mykhalovskiy & Betteridge, 2012). In the United States at least 33 states have HIV-specific criminal laws (Lehman et al., 2014). Despite differences in legal approaches, there have been criminal prosecutions of PLWH in both countries. Approaches to HIV criminalization include sentence enhancements for other crimes when HIV is a factor in the case (sentence enhancements); court decisions that consider HIV a “deadly weapon,” resulting in PLWH being prosecuted for biting or spitting (non-sexual exposure); and laws that criminalize potential for or perceived HIV exposure without disclosure (exposure without disclosure). Evidence of intent to harm or
evidence of actual transmission are not required in most laws (Cameron, 2009; Center for HIV Law & Policy, 2014; Global Network of People Living with HIV, 2014). These prosecutions occur even when there is evidence that the PLWH had practiced safer sex by either using a condom or had an undetectable HIV viral load, or both – both of which reduce the risk of HIV exposure to near zero (Cameron, 2009; Center for HIV Law & Policy, 2014). Nurses’ knowledge of HIV-related criminal laws in North America may influence their abilities to provide high quality care to persons living with or at risk of acquiring HIV.

Background and Significance

North American HIV-related Criminal Law

Prosecutions for HIV exposure without disclosure and/or potential or perceived exposure have occurred in North America (Canada and the United States) and are increasing in some jurisdictions (Dej & Kilty, 2012; Mykhalovskiy & Betteridge, 2012). Canadian law does not explicitly criminalize HIV exposure, but decisions of the Supreme Court of Canada and other court decisions since 1998 (most recently in 2012) have created a legal context in which PLWH face an increasing likelihood of being prosecuted for HIV nondisclosure. Similarly, the United States has prosecuted at least 1,000 persons for HIV-related crimes, with 180 known prosecutions reported between 2008 and 2013 (Center for HIV Law & Policy, 2014; Global Network of People Living with HIV and HIV Justice Network, 2013). Additionally, some U.S. territories and the U.S. Military Code of Criminal Justice have HIV-specific criminal laws and PLWH have been prosecuted in those jurisdictions (Center for HIV law & Policy, 2014).

This complex legal context creates challenges for the delivery of high quality nursing and health care for persons living with or at risk for acquiring HIV. HIV is a reportable communicable disease in North America; however, some nurses are confused about the extent of
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their professional obligations regarding a duty to protect population health. Nurses’ uncertainties can be related to whether they have a “duty to warn” persons at risk of contracting HIV (for example, from a partner who has not disclosed his/her HIV status) and their duty to report a communicable disease. This confusion may be compounded by emotional responses on the part of nurses and other members of society brought on by sensationalized media reports about HIV criminalization cases. Emotional responses may be combined with a lack of understanding of the state of the science for the management of HIV at individual and population levels, including treatment and prevention efforts. For example, nurses and other health care providers may shape clinical practices based on their responses to media headlines such as “…man charged with using spit as a deadly weapon” (Boven, 2010, ¶ 1). Understanding what nurses know about HIV-related criminal laws is necessary for the development of training programs to enhance their abilities to provide care to persons living with and at risk of acquiring HIV and to effectively manage the HIV epidemics in North America.

Research Objectives and Methods

We describe the knowledge our HIV nurse participants had about HIV-related criminal laws in the jurisdictions where they practiced. The research question addressed in our study was, What knowledge do HIV-care nurses in Canada and the United States have about HIV-related prosecutions and legal processes?

The study was conducted in two phases. Phase 1 included initial development, content validation, and elaboration of the final questionnaire to determine participants’ knowledge of HIV-related criminal laws. Initial questionnaire development occurred after a focused literature review of published works indexed in the Computerized Index of Nursing and Allied Health Literature (CINAHL) and PubMed. The following keywords were used alone and in
combinations for the search: *AIDS, criminal, criminalisation, criminalization, HIV, law, legal, nursing, practice, health care provider, stigma, and discrimination*. The search retrieved 153 articles published between 1988 and 2013, including 99 case reports of HIV-related criminal prosecutions, 18 commentaries, 11 empirical studies (9 primary research, 1 content analysis, 1 secondary analysis), 5 legislative or policy updates, 1 clinical guide, 14 reviews (1 book review), and 5 summaries. In addition, pertinent legal and nursing professional organization reports were reviewed. Two documents provided the foundation for questionnaire development: a special issue on HIV criminalization and nursing practice, published in the journal *Aporia* (O’Byrne & Gagnon, 2013) and *Legal and clinical implications of HIV nondisclosure: A practical guide for HIV nurses in Canada* (Gagnon, 2013). Content validation was completed by experts from HIV-related nursing and a variety of other fields. Content experts were solicited from community partner agencies (nursing and HIV-community specific) and HIV legal advocacy agencies in Canada and the United States. Phase 2 of the study assessed the feasibility of delivering the online questionnaire to nurses experienced in providing care to PLWH and served as the foundation for a needs assessment to determine nurses’ knowledge of HIV-related criminal laws across the United States. The study was approved by the Research Ethics Board at the University of Ottawa and the Boards of Directors of the Association of Nurses in AIDS Care (ANAC; http://www.nursesinaidscare.org) and the Canadian Association of Nurses in AIDS Care (CANAC; http://www.canac.org).

**Conceptual Framework and Questionnaire Development**

The development of the questionnaire was guided by ecosocial theory (Krieger, 2008). Ecosocial theory originated from epidemiology and is useful for understanding complex factors, such as HIV criminalization, and perspectives that shape the health of communities and the
practices of nurses. Ecosocial theory values all stakeholder perspectives equally and advocates for studying the influences of policies (e.g., HIV criminalization), both codified (written down) and enacted, across all levels of the social environment, and is mindful of the simultaneous and reciprocal effects across each of those levels (Krieger, 2008; Phillips, 2011). Additionally, ecosocial theory can help HIV care nurses determine the most appropriate actions to provide optimal care for persons living with or at risk for acquiring HIV and explore the pathways and power dynamics that contribute to individual and population health outcomes.

Building on ecosocial theoretical foundations, we proposed that HIV criminalization created a social context environment for people living with and at risk of acquiring HIV and their health care providers in which health care providers served as agents of state oppression, responsible for ensuring that the behavior of PLWH was controlled and limited by existing legal structures in Canada and the United States (Figure 1). Within the ecosocial context of HIV, patients and nurses interact in patient-provider encounters that are influenced by laws and policies that govern those encounters. Overarching concepts that govern those encounters derived from international goals that strove for health as a human right and were influenced by the social determinants of health. Nurses, as health care professionals, interacting in the patient-provider encounter are governed by ethical, legal, and professional obligations derived from multiple levels of authority. To investigate the ecosocial context of HIV-related criminal laws and their influences on nursing practices, the questionnaire explored six conceptual dimensions: (a) knowledge of HIV-related criminal laws; (b) knowledge of disclosure requirements; (c) defense from prosecution, which generally included two legal defenses (disclosure and informed consent), contributing to a person’s knowledge of risk of prosecution and/or condom use; (d) risk of sexual HIV transmission; (e) scope of nursing practice; and (f) professional responsibility,
including ethical and regulatory obligations.

Sample Characteristics

During Phase 1 of the study, content experts \((n = 7)\) evaluated the questionnaire. Content experts were asked to determine whether multiple response categories needed to be modified; to assess if questions needed to be added, reworded, or removed from the questionnaire; and to comment on the questionnaire’s length. Content experts were recruited from nursing specialty partner organizations (i.e., ANAC, CANAC), legal organizations specializing in the legal context of HIV (e.g., British Columbia Civil Liberties Union, The Center for HIV Law and Policy), and from HIV advocacy and service organizations in Canada and the United States. Consistent with ecosocial theoretical framework, the study included the perspectives of multiple stakeholder groups in the content validation phase to ensure that concerns and feedback from these groups were included. Canadian \((n = 4)\) and U.S. \((n = 3)\) content experts included health care professionals \((n = 2)\) and legal/advocacy professionals \((n = 5)\). Perspectives from PLWH \((n = 4)\) were also obtained.

After the questionnaire was developed and content validated, Phase 2 of the study commenced. During Phase 2, the questionnaire was tested by nurses from ANAC and CANAC to assess the feasibility of administering the questionnaire in an online format to nurses across Canada and the United States. Members of ANAC and CANAC were invited via electronic mail, social media networks, postcards inserted in conference participant bags, and posters at national conferences. HIV care nurses \((n = 230)\) accessed the online questionnaire, 184 provided partial responses, and 172 completed all HIV-related criminal law questions.

Statistical Analysis

Statistical analyses were descriptive in nature, due to the questionnaire’s design.
Questions that assessed nurses’ knowledge about HIV criminalization in the jurisdictions where they practiced were categorized as dichotomous variables labelled correct or incorrect. The categorization of a U.S. nurse’s response to these questions was based on information published in a joint United States Department of Justice (DOJ) and Centers for Disease Control and Prevention (CDC) publication Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States (Lehman et al., 2014). The use of this publication allowed for analysis of different jurisdictional approaches to HIV criminalization across the United States. Canadian nurses’ responses were categorized in accordance with the latest Supreme Court rulings in the cases of DC and Mabior (Supreme Court of Canada, 2012a; 2012b). Questions that assessed knowledge about HIV disease and HIV disease management were categorized using the dichotomous categories correct or incorrect based on data found on the CDC Website as of June 2014 (CDC, 2014). When completing knowledge questions, respondents could choose I do not know, which was considered incorrect for analytical purposes because a lack of knowledge could contribute to giving misinformation to patients or result in the nurse providing information unnecessarily to prosecutorial personnel such as police or attorneys. Chi-square tests were used to assess differences in knowledge of HIV-related criminal laws in HIV care nurses in Canada and the United States.

Results

Sample Characteristics

A total of 230 HIV care nurses accessed the online questionnaire and 172 completed all HIV-related criminal law questions, which yielded a 75% completion rate. Respondents were mostly from the United States (n = 149, 86.6%); 23 (13.4%) were from Canada. The average age of respondents was 51 ± 11 years of age (range = 23 - 73) and 68% were between 40 and 62
years of age. HIV care nurses were well educated with a majority \((n = 115, 66.9\%)\) having a baccalaureate or master’s degree. The majority were female \((n = 133, 77.3\%)\) and heterosexual \((n = 124, 70.9\%)\). Sample characteristics are summarized in Table 1.

Findings are reported using the six major conceptual dimensions explored: (a) knowledge of HIV-related criminal laws, (b) knowledge of disclosure requirements, (c) defense from prosecution (disclosure/informed consent contributing to a person’s knowledge of risk of prosecution and/or condom use, where available), (d) risk of HIV sexual transmission, (e) scope of nursing practice, and (f) professional responsibility.

**Knowledge of Exposure Laws**

In some jurisdictions the act of potentially exposing someone to HIV without disclosure can result in criminal prosecution. For this reason, respondents were asked about their awareness of laws in the jurisdiction in which they worked that criminalized the act of potentially exposing someone to HIV in ways other than sexual, such as through injection drug use, biting, spitting, or throwing bodily fluids. Twenty percent \((n = 35)\) of the respondents correctly identified the presence or absence of these laws in the jurisdictions where they practiced. Most respondents \((n = 135, 79.4\%)\) did not correctly identify the presence or absence of these laws.

**Knowledge of Disclosure Requirements**

In the United States, HIV-related criminal laws and HIV disclosure requirements differ from state to state. In Canada, the legal expectation since 2012 has been that PLWH will disclose their HIV status to all sexual partners and persons with whom they engage in behaviors that constitute a “significant risk” and “realistic possibility” for acquiring HIV (Supreme Court of Canada, 2012a; 2012b). Respondents were asked to identify which practices were illegal in the jurisdictions in which they worked (e.g., sexual transmission of HIV without disclosure, sexual
transmission of HIV with disclosure, sexually exposing someone to HIV without disclosure). Half of our respondents \((n = 88, 50.3\%\) correctly identified the relevant statements for their jurisdictions. The rest \((n = 86, 49.1\%\) could not identify which practices were illegal in the jurisdictions where they worked.

These data were then compared between the two countries. When dividing the complete data set \((n = 174)\) by country of origin, nearly all Canadian nurses \((n = 22, 95.6\%\) correctly identified illegal practices compared to only 44.6% \((n = 66)\) of American nurses. Canadian respondents had a higher proportion of correct scores for identifying illegal practices related to HIV exposure without disclosure in their work jurisdictions than U.S. nurses \((\chi^2 = 20.8, p < 0.001)\).

**Defense from Prosecution**

Nurses are often in a position to counsel patients about challenges and risks related to HIV disease. Nurses who work with PLWH need to be aware of the potential for legal defenses in jurisdictions where HIV-related criminal prosecutions have occurred and the subtleties inherent in the HIV-related criminal laws or court cases that apply to defenses against criminal prosecution, including disclosure of HIV status and condom use as defenses, where they are available.

**Knowledge of risk of prosecution.** PLWH may assume that disclosing their HIV status before engaging in behaviors that have the possibility of exposure and/or transmission would protect them from criminal prosecution. At the time of this writing, in Canada (Supreme Court of Canada, 2012a; 2012b) and in 24 states, criminal prosecutions were based on non-disclosure of HIV status. In these jurisdictions PLWH should not be prosecuted if they have disclosed their HIV status, regardless of the level of risk of transmission (Lehman et al., 2014). While it is true
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that there could be a factual dispute about whether disclosure occurred, and it is likely to revolve on one person’s word against another’s, the onus is on the prosecutors to prove (beyond a reasonable doubt) that the disclosure did not occur, rather than for the person accused to prove that it did. To determine whether HIV care nurses were knowledgeable about criminal law with respect to disclosure of HIV status to sexual partners, respondents were asked the following question: To your knowledge, does disclosing HIV-status protect HIV-positive persons from criminal prosecution for HIV exposure or transmission? Less than one third (n = 53, 30.3%) correctly answered this question [responding yes]; 69.1% (n = 121) responded incorrectly [responding no].

Condom use as a legal defense. Condom use has been demonstrated to be an effective HIV prevention intervention globally. PLWH may assume that condom use is a defense against prosecution for exposing someone to HIV in the absence of disclosure of known HIV status. This assumption may not hold true in all jurisdictions. In the United States, only 4 states accepted condom use as an affirmative defense against criminal prosecution (Lehman et al., 2014). In Canada, according to the latest Supreme Court rulings (2012a; 2012b), the condom use defense was admissible in court only when a condom was used and the PLWH had a low viral load, which was defined as lower than 1,500 viral copies per milliliter of blood. When respondents were asked if a condom could be used as a defense against criminal prosecution in the jurisdiction in which they worked, 13.1% (n = 23) were correct and 86.3% (n = 151) were incorrect.

Risk of HIV Sexual Transmission

PLWH expect HIV care nurses to be knowledgeable about health and health risks, including potential risks associated with routes of HIV transmission. HIV care nurses are often
asked by PLWH to provide advice and guidance about general health and wellbeing in regard to day-to-day activities, including sexual health, and about sexual practices that reduce risks. In the questionnaire, respondents were asked to rank sexual practices (e.g., giving oral sex, receiving vaginal sex) based on the likelihood of HIV exposure or transmission in order from the most risky to the least risky sexual practice. Correct responses were obtained from the HIV Transmission fact sheet (CDC, 2014). Of our respondents, 19.4% (n = 34) successfully identified and classified the level of risk associated with sexual practices from most to least risky; 80.6% (n = 141) were not.

Professional and Legal Responsibility

Our respondents’ perceptions about responsibilities for their actions and advice given to PLWH were also explored. Respondents were asked about two hypothetical clinical situations. First, they were asked who should be held responsible if they [the nurses] gave wrong advice in regard to lower risk sexual practices. Second, they were asked who should be held responsible if they [the nurses] gave wrong advice about the legal implications of non-disclosure and/or potentially exposing an individual to HIV or transmitting HIV to another person. In both cases, respondents reported that the responsibility should either be shared by the nurse and the patient (n = 67, 38.3% [sexual practices with reduced risks]; n = 71, 40.6% [legal]) or that they did not know who should be held responsible when wrong advice was given (n = 59, 33.7% [safer sex practices]; n = 58, 33.1% [legal]).

HIV Care Nurses’ Education Needs and Preferences

The final section of the questionnaire explored respondents’ perceptions about education strategies that would be most useful to enhance their knowledge of HIV and HIV-related criminal laws. The respondents were asked to identify where they would go to learn more about
HIV and the law and the education media they would prefer. They were asked to choose all options that applied to them from a list of options. In response to where they would go to obtain information about HIV and HIV-related criminal laws, the respondents chose school (n = 31, 18%), professional conferences (n = 113, 65.7%), and legal organizations (n = 146, 84.9%), in addition to quick searches using common search engines (n = 52, 30.2%) such as Google or Yahoo. In response to which type of education media they would prefer to obtain information about HIV and HIV-related criminal laws, the respondents reported that self-study (n = 98, 57%), Internet training (n = 124, 72.1%), and literature provided by professional organizations (n = 96, 55.8%) would be the most beneficial media for learning about HIV and HIV-related criminal law. Percentages in this section added up to more than 100% because respondents were allowed to select more than one option.

Discussion

Knowledge of HIV-related Criminal Laws

Findings from our study of HIV care nurses revealed a disconnect between the state of science for effective HIV management and social policy in the form of HIV-related criminal laws. Although these findings were disconcerting and somewhat disappointing, they were not surprising. The focus of HIV care nurses’ HIV-related efforts and care has been on the development, implementation, and evaluation of behavioral, biomedical, and public health interventions to prevent HIV transmission, treat people who become infected with HIV, and mitigate the biomedical and social challenges of HIV. These interventions have brought about the possibility of an end to AIDS. HIV care nurses across North America have been instrumental in developing and using those interventions. HIV care nurses across North America have advocated for reform or elimination of interventions and policies that limit a person’s freedoms...
and contribute to stigma and discrimination against PLWH. In contrast, although well intentioned, the implementation and continued application of social policy in the form of HIV-related criminal laws has been informed by the fear and stigma that contribute to discrimination against PLWH, which also contribute to morbidity and mortality. HIV-related criminal laws have the potential to undermine biomedical and public health successes and may facilitate the further spread of HIV disease (O’Byrne, Bryan, & Roy, 2013). The disconnect between scientific evidence and social policy has created dilemmas and challenges for nurses who provide care for PLWH. The basic ethical principle, “first, do no harm,” guides nursing practice as stated in the Nightingale Pledge; nurses pledge to:

abstain from whatever is deleterious and mischievous, … hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling, … and as a “missioner of health” I will dedicate myself to devoted service to human welfare. (Munson, 1949, p. 345)

In the presence of HIV-related criminal laws, especially when those laws are too broadly applied as they are in many North American jurisdictions, nurses are often ill-prepared to provide high quality care to persons living with or at risk of acquiring HIV because they do not have sufficient knowledge of the legal context of HIV in the communities where they practice. Nurses who are unfamiliar with HIV criminalization approaches in their jurisdictions may inadvertently document information that can be used against their patients in criminal proceedings or may provide more information than is necessary to prosecutorial personnel.

Our findings are especially troubling because they reflect a knowledge deficit in nurses who are specialized in HIV care across North America. We speculate that the reasons for this knowledge deficit stem from the fact that HIV care nurses have been practicing in an ethical and
evidence-informed way and have focused their efforts on effectively managing HIV at individual and population levels. The changing HIV-related criminal law landscape may be outside nurses’ usual knowledge acquisition parameters, which makes raising the awareness of HIV-related criminal law issues essential for nursing practice across North America. Because HIV prevention and treatment interventions have demonstrated efficacy based on scientific evidence, nurses ought to continue to focus their efforts on biomedical and public health interventions that have demonstrated effectiveness.

Our findings should serve as a call to action for nurses to advocate for evidence-informed change that is not based on fear and stigma (e.g., the development and implementation of prosecutorial guidance that is consistent with up-to-date science and fundamental legal and public health principles, and which protects civil and human rights) and legislative modernization (reform) of overly broad HIV-related criminal laws. The continued use of overly broad criminal laws against PLWH limits efforts to overcome HIV epidemics in North America and the ability to achieve the broader goal of “zero new HIV infections, zero discrimination, and zero AIDS-related deaths” (UNAIDS, 2010a). Nurses ought to open a dialog within the profession about the effects of the overly broad use of HIV-related criminal laws on our clinical practices and our abilities to provide care to persons living with and at risk of acquiring HIV.

Nurses ought to educate themselves and their patients about HIV-related laws and policies in the jurisdictions where they practice. Nurses who are knowledgeable about less risky sexual practices, share current HIV prevention and treatment strategies, and are proficient in imparting this knowledge to persons living with and at risk for acquiring HIV in the communities they serve have the ability to provide high quality care that respects human dignity.

Professional and Legal Responsibility
Nurses, in collaboration with other health care providers, legal advocates, and PLWH, should develop a framework for legal responsibility. Our findings related to nurses’ lack of understanding about who should be legally responsible when erroneous information about HIV was given to a patient highlighted the complexity of the ethical and legal reasoning required of nurses and other health care providers in a context of HIV. Our finding that HIV care nurses were willing to inform patients about HIV-related legal considerations, but less willing to accept legal responsibility if they provided erroneous information may be the result of the lack of HIV-related legal knowledge. Nurses who are aware of the laws and policies that govern their practices and are familiar with the use and limitations to prosecutorial defenses (e.g., disclosure, condom use, undetectable viral load) for PLWH may be more willing to accept responsibilities for providing information about all aspects of HIV to their patients. Nurses need to be able to access current, accurate, relevant information that is evidence-informed to provide the highest quality care to patients and communities affected by HIV. Our findings indicated that nurses search a variety of sources for legal information. Nurses should have access to information and legal resources they can consult to correctly inform patients about legal issues and less risky sexual behaviors.

**Addressing the HIV-related Criminal Law Knowledge Gap**

Collectively, nurses specialized in HIV care across Canada and the United States advocate for effective HIV disease management at individual and population levels. ANAC and CANAC have initiated efforts to address the challenges HIV-related criminal laws pose for the delivery of effective HIV prevention and treatment across Canada and the United States and the knowledge gaps that exist among nurses and other health care providers. Under the leadership of nurses in both organizations, dialogue about the influence of HIV-related criminal laws on
nursing practice has begun. CANAC has partnered with the Canadian AIDS Treatment
Information Exchange (CATIE) and published the ground-breaking document, *Legal and
clinical implications of HIV non-disclosure: A practical guide for HIV nurses in Canada*
(CANAC, 2013). The publication was intended to facilitate dialogue between nurses and other
health care providers and included case studies and scenarios that could be used to stimulate
discussion about HIV-related criminal laws. The scenarios were based on prosecutorial facts
from court cases that contributed to the Supreme Court of Canada decisions that guided the
application of HIV-related criminal prosecutions in Canada. The guide informed part of the
development of our questionnaire and may have contributed to the increased knowledge
observed in the Canadian nurse participants in our study. In addition, CANAC advocacy
influenced court decisions and CANAC submitted an amicus brief to the recent Supreme Court
of Canada cases in 2012.

ANAC’s efforts to address the existence and application of overly broad HIV-specific
criminal laws has been one of the organization’s policy agenda pillars since 2012 (ANAC, 2012).
Actions taken by the organization have included submission of amicus briefs in state HIV-related
criminal court cases; reading testimony to the Presidential Advisory Council on HIV/AIDS
(PACHA) in favor of modernizing, if not repealing, HIV-specific criminal laws; and
participation in national and international fora to advocate for scientific evidence-informed legal
reform that is consistent with good public health policy, human dignity, and respect for persons
living with and at risk of acquiring HIV.

Efforts to increase awareness about HIV-related criminal laws for nurses and other health
care providers in Canada and the United States are planned by CANAC and ANAC in the future.
CANAC has already worked with the Canadian HIV/AIDS Legal Network to provide education
activities at its national conference. ANAC has offered webinars about HIV-related criminal laws and is collaborating with the Center for HIV Law and Policy to provide other education offerings to enhance nurses’ and other health care providers’ knowledge of HIV-related criminal laws and their effects across the United States.

**Future Directions**

The findings of our study provided evidence of a need to better understand the knowledge nurses and other health care providers have about the influence HIV-related criminal laws have on the delivery of quality HIV care across Canada and the United States. To that end, a wider needs assessment is underway. Funding was secured to expand the questionnaire to nurses across the southern United States, a region that continues to face an uphill battle with HIV disease. For that study, we obtained support from the American Nurses Association, which has advertised the questionnaire on their Website and through weekly member communications. At the time of writing, initial phases of data analysis were underway to assess the knowledge of nurses across the United States.

The findings from this feasibility study and evidence obtained from the larger study will be used to inform the design of interventions that may transform clinical practices related to HIV. The goal of this further work will be to enlighten and empower nurses and other health care providers to change their clinical practices in a way that is respectful of the dignity of PLWH and persons who are at risk of acquiring HIV. This approach will require nurses to reflect on their current clinical practices with regard to HIV care. Nurses ought to challenge the status quo by asking whether current practices contribute to achieving an AIDS-free generation or contribute to ongoing HIV epidemics through institutionalized stigma and discrimination in the form of HIV-related criminal laws. These laws and their attendant prosecutions perpetuate institutionalized
stigma and discrimination, and potentially drive those most in need of HIV services away from the clinical services and health care that are required to effectively manage HIV. Persons living with and at risk of acquiring HIV who are deterred from seeking appropriate health care harm their own health and, potentially, that of their partners, families, and communities. Nurses are respected health care providers with the responsibility to ensure optimal health services for the communities they serve. This responsibility extends to advocating for the implementation of HIV management strategies that are based on scientific evidence, good public health practice, and respectful of the human rights and dignity of all members of society.

The limitations of our study stem primarily from the small sample size and the inability to generalize findings to the larger population of nurses across Canada and the United States. Our sample was too small to generalize findings to all nurses providing care to PLWH in the two countries and may be biased because we only recruited nurses who were members of ANAC and CANAC. Additionally, the study may not have been sufficiently powered to detect statistically significant differences across national or jurisdictional contexts within or between the two countries. Despite these limitations, the feasibility of administering an online questionnaire about a controversial topic to nurses across Canada and the United States was demonstrated. We were able to obtain complete questionnaire data from a total of 172 nurses. This leads us to believe that we will be able to obtain responses from a more representative sample of nurses as our questionnaire is offered to wider nursing audiences.

**Conclusion**

We found that nurses who specialized in HIV care lacked knowledge about HIV-related criminal laws, a factor that might limit their abilities to effectively meet the needs of the people and communities they serve. Findings from our study suggest the feasibility of expanding a
modified version of the questionnaire to nurses from all specialty areas across the United States. Findings from the study and our continued efforts to assess the lack of knowledge and understanding that the influence HIV-related criminal laws have on the provision of health care services are essential for the wellbeing of persons living with or at risk of acquiring HIV and their communities. Understanding the influence that HIV-related criminal laws have on nursing practices across Canada and the United States is needed. Working with nurses to transform clinical practice environments where HIV-related criminal laws and the potential for prosecutions contribute to complex challenges for PLWH will help reverse the involuntary process whereby nurses serve as agents of state oppression and contribute to stigma and discrimination experienced by PLWH. Nurses have a professional obligation to strive for the social justice goals of eliminating stigma, discrimination, and marginalization of all patients, especially those who are singled out for unjust treatment based on fear and discrimination, which is the case for PLWH under current HIV-related criminal law approaches in Canada and across much of the United States. We encourage nurses in Canada and the United States to become informed about HIV-related criminal laws that may influence their clinical practices and advocate for changes that will respect the health and human dignity of all.
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http://journals.lww.com/ajnonline/Citation/1949/06000/Lystra_E__Gretter_.19.aspx


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Key Considerations

- Nurses, as trusted health care providers, should be knowledgeable about the effects of HIV criminalization on persons living with and at risk of acquiring HIV.

- Nurses should open a dialog about how best to address the needs of all members of society in relation to HIV and advocate for approaches to HIV care that respect human rights and dignity.

- Nurses should share accurate and evidence-based information about the biomedical and public health approaches that have made HIV a chronic manageable disease, in an effort to reform HIV-related criminal laws so those laws are consistent with current scientific evidence.
Table 1

Demographic Characteristics of HIV Care Nurses (N = 174)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>n</th>
<th>%</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Identity</strong></td>
<td>Male</td>
<td>36</td>
<td>20.9</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>132</td>
<td>76.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>4</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td>Heterosexual</td>
<td>123</td>
<td>72.4</td>
<td>170</td>
</tr>
<tr>
<td></td>
<td>Gay</td>
<td>31</td>
<td>18.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lesbian</td>
<td>10</td>
<td>5.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bisexual</td>
<td>5</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td>First Nations/Native American</td>
<td>1</td>
<td>0.6</td>
<td>170</td>
</tr>
<tr>
<td></td>
<td>White/Caucasian</td>
<td>132</td>
<td>77.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>South East Asian</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic White</td>
<td>9</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hispanic Black</td>
<td>6</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>African American</td>
<td>13</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caribbean Black</td>
<td>2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Afro-Caribbean</td>
<td>2</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Black-African</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>3</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td><strong>Highest level of Education</strong></td>
<td>No health-related education</td>
<td>2</td>
<td>1.2</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>High School or GED</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 years of college/AA degree/technical school training</td>
<td>15</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>College (BA or BS)</td>
<td>55</td>
<td>31.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Master’s degree</td>
<td>62</td>
<td>35.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional degree (MD, Law, etc.)</td>
<td>15</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doctorate (PhD, PsyD, etc.)</td>
<td>23</td>
<td>13.3</td>
<td></td>
</tr>
</tbody>
</table>

*Note. Total frequencies do not equal total sample size because of non-response or respondents signifying the preference not to answer demographic questions = 1-4 respondents. GED = graduate equivalency degree; AA = associate degree; BA = bachelor of arts; BS = bachelor of science; MD = medical doctor; PhD = doctor of philosophy; PsyD = doctor of psychology.
Table 2

Key Questionnaire Findings

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>n</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worked with someone concerned about being charged with an HIV-related crime</td>
<td>Yes</td>
<td>82</td>
<td>47.4</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>92</td>
<td>53.2</td>
<td></td>
</tr>
<tr>
<td>Worked with someone prosecuted for an HIV-related crime</td>
<td>Yes</td>
<td>26</td>
<td>15.2</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>145</td>
<td>84.8</td>
<td></td>
</tr>
<tr>
<td>In your city of practice, are there any laws regulating the EXPOSURE of HIV in other ways than sexual? (e.g., injection drugs, biting, spitting, throwing bodily fluids, sports, violence, etc.)</td>
<td>Yes</td>
<td>28</td>
<td>16.4</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>34</td>
<td>19.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I do not know</td>
<td>108</td>
<td>63.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I prefer not to answer</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Taking into consideration the jurisdiction of every person answering this question, we have determined if they were correct or incorrect using the CDC and DOJ joint document on HIV criminalization (Lehman et al., 2014).</td>
<td>Correct</td>
<td>35</td>
<td>20</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>Incorrect</td>
<td>135</td>
<td>79.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I prefer not to answer</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>To your knowledge, does disclosing HIV-status protect HIV-positive persons from criminal prosecution for HIV exposure or transmission?</td>
<td>Yes</td>
<td>59</td>
<td>34.3</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>28</td>
<td>16.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I do not know</td>
<td>84</td>
<td>48.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I prefer not to answer</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Taking into consideration the jurisdiction of every person answering this question, we have determined if they were correct or incorrect using the CDC and DOJ joint document on HIV criminalization (Lehman et al., 2014).</td>
<td>Correct</td>
<td>53</td>
<td>30.8</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>Incorrect</td>
<td>118</td>
<td>68.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>1</td>
<td>0.6</td>
<td></td>
</tr>
</tbody>
</table>

Note. *Total frequencies do not equal total sample size because of non-responses to demographic questions = 2-3 respondents. CDC = Centers for Disease Control and Prevention; DOJ = Department of Justice.
Figure 1. Sources of obligations and levels of authority influencing nurses’ practices during patient-provider encounters* in a context of HIV.

Note. *A people-centered approach in which PLWH are integral to addressing the challenges inherent in HIV criminalization. Dashed lines signify the dynamic interactions that occur across ecosocial context levels. HCP = health care professional.