APL-2014-00012

COURT OF APPEALS
STATE OF NEW YORK

THE PEOPLE OF THE STATE OF NEW YORK,
Appellant,

vs.

TERRANCE WILLIAMS,
Respondent.

BRIEF OF *AMICI CURIAE* THE CENTER FOR HIV LAW AND POLICY, NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS, GAY MEN'S HEALTH CRISIS, NATIONAL BLACK LEADERSHIP COMMISSION ON AIDS, LATINO COMMISSION ON AIDS, SISTERHOOD MOBILIZED FOR AIDS/HIV RESEARCH & TREATMENT, HEALTH AND EDUCATION ALTERNATIVES FOR TEENS, AND DR. JEFFREY BIRNBAUM

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INTERESTS OF *AMICI CURIAE*

Amici curiae are medical, public health, community, and HIV advocacy organizations with highly-relevant expertise on the routes, risks, and consequences of HIV transmission, as well as state and federal policies concerning HIV disclosure. *Amici* seek to assist the New York Court of Appeals in evaluating complex issues and misconceptions surrounding HIV transmission, the consequences of an HIV diagnosis, and disclosure to sex partners.

The Center for HIV Law and Policy ("CHLP") is a national legal and policy resource and strategy center for people with HIV and their advocates. Based in New York, CHLP is a national leader in HIV policy development. CHLP's interest in this case is consistent with its mission to protect the rights of vulnerable individuals and marginalized communities affected by HIV. From its advocacy work, CHLP knows that exaggerated fears about HIV—and ignorance about the routes, risks, and consequences of HIV transmission—perpetuate stigma, discrimination, and unfair treatment of those living with HIV. Using the criminal law to prosecute and penalize people living with HIV for conduct that would be legal if they did not get tested or know their status reinforces prejudice and undermines important government-funded HIV testing, treatment, and prevention efforts.

The National Alliance of State and Territorial AIDS Directors ("NASTAD") represents the nation's chief state health agency staff who have programmatic responsibility for administering HIV and viral hepatitis healthcare, prevention, education, and supportive service programs funded by state and federal governments. NASTAD is

dedicated to reducing the incidence of HIV and viral hepatitis infections in the U.S. and its territories, providing comprehensive, compassionate, and high-quality care to all persons living with HIV and viral hepatitis, and ensuring responsible public policies. NASTAD provides national leadership to achieve these goals, and to educate about and advocate for the necessary federal funding to achieve them, as well as to promote communication between state and local health departments and HIV and viral hepatitis care and treatment programs. NASTAD supports and encourages the use of applied scientific knowledge and input from affected communities to guide the development of effective policies and programs.

The National Black Leadership Commission on AIDS, Inc. ("NBLCA"), founded in 1987, is the largest not-for-profit organization of its kind in the United States. NBLCA's mission is to educate, mobilize, and empower Black leaders to meet the challenge of fighting HIV/AIDS and other health disparities in their local communities. Working with a broad spectrum of community leaders, including clergy, public officials, medical practitioners, business and civic professionals, social policy experts, and the media, NBLCA achieves its mission through capacity-building training, education, policy advocacy, testing and referrals, research and evaluation, and resource and leadership development.

The Latino Commission on AIDS is a non-profit membership organization dedicated to fighting the spread of HIV/AIDS in the Latino community. The Commission realizes its mission by spearheading health advocacy for Latinos, promoting HIV education, developing model prevention programs for high-risk communities, and

by building capacity in community organizations. Through its extensive network of member organizations and community leaders, the Commission works to mobilize an effective Latino community response to the health crisis created by HIV/AIDS. The Commission also works to address stigma based on misconceptions about HIV.

Sisterhood Mobilized for AIDS/HIV Research & Treatment ("SMART") offers a holistic approach to treatment and health education for women living with HIV. Based in East Harlem, New York, SMART's mission is to improve the quality of life for its participants through a gender-specific, sequenced education model. SMART believes that knowledgeable and healthy women are the foundation for a strong and healthy community. Though education and leadership opportunities, SMART seeks to address health disparities and intersectional issues affecting women living with HIV.

Health and Education Alternatives for Teens ("HEAT") is the only comprehensive care program that provides age and developmentally appropriate, culturally competent care for young people (ages 13-24) who are living with or who are at very high risk for HIV in Brooklyn, New York. Established in 1991, HEAT is funded by the New York State Department of Health's AIDS Institute, and operates a full-service clinic, offering a full range of medical, mental health, and supportive services. In 2009, HEAT received an award from New York City Mayor Michael Bloomberg in recognition of its outstanding work on HIV. HEAT serves a leadership role in heightened public awareness about the effects of the HIV epidemic based on applied scientific knowledge and cultural competency.

Dr. Jeffrey Birnbaum, MD, MPH, is the founder and executive director of HEAT. He is a distinguished HIV specialist with decades of experience in clinical practice, teaching, and research. He is based at the State University of New York's Downstate Medical Center and serves on numerous local and state boards and committees related to HIV medical care, treatment, prevention, and public health—including committees that set standards for HIV testing and medical care in New York State. He has published HIV clinical guidelines and peer-reviewed articles, and has conducted research on the psychosocial factors affecting health outcomes in HIV positive youth and marginalized populations. In 2012, Dr. Birnbaum received the Laubenstein Award for HIV Clinical Excellence from the New York State Department of Health's AIDS Institute for making extraordinary contributions to the community and providing the highest quality of clinical care for people with HIV. He has also shared his expertise internationally, providing training sessions and consultation on HIV in Nigeria, Malawi, the Czech Republic, Poland, and Russia.

The Gay Men's Health Crisis ("GMHC") is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against HIV/AIDS. GMHC's mission is to reduce the spread of HIV disease; help people with HIV maintain and improve their health and independence; and keep the prevention, treatment and cure of HIV an urgent national and local priority. Founded in 1981, and based in New York City, GMHC provides HIV prevention and care services to thousands of people living with or at risk for HIV/AIDS and advocates for evidence-based, effective prevention and care interventions globally. Because this case implicates

the ability of organizations such as GMHC to employ "best practices" in the fight against the spread of HIV/AIDS, its resolution is a matter of significant concern to GMHC and to the people it serves.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

Mr. Williams is a young Black man living with HIV. The Onondaga County District Attorney charged Mr. Williams with reckless endangerment in the first degree—a felony punishable by a term of imprisonment of up to seven years—for having consensual sex.

The District Attorney's ("DA") exaggerated treatment of both the risk of HIV transmission through anal sex and the consequences of an HIV diagnosis sharply conflicts with well-established medical and scientific evidence. Contrary to the DA's assertions, HIV is a difficult virus to transmit and, even when partners engage in unprotected anal sex, transmission does not occur at least 97% of the time. When infection occurs, HIV is far from a "death sentence." Like many other conditions, including diabetes, HIV is a manageable, chronic condition with a relatively limited impact on life expectancy for those who visit a doctor regularly, take recommended medications, and lead a reasonably healthy lifestyle.

Some people may believe that Mr. Williams had a moral responsibility to disclose his HIV status to his sex partner; others would argue that each individual bears responsibility for his or her own sexual health and that, in any event, Mr. Williams posed little risk of infection based on the type of sex he had with the complainant. Regardless of Mr. Williams' moral views or related obligations, he did not have a *legal* obligation to

disclose his HIV status under either state or federal law. While New York state and federal policies actively encourage disclosure of one's HIV status to sexual partners, neither mandates it nor attaches penalties of any kind to an individual's refusal to identify sexual contacts. [1]

Voluntary disclosure is consistent with well-established public health policies and practices. When HIV positive individuals are able to decide for themselves whether to disclose their HIV status, they do so more readily and with better outcomes. Voluntary disclosure is associated with an increased likelihood of condom use, risk reduction, and better access to medical care and treatment, all of which lead to reduced rates of HIV transmission. The DA's treatment of Mr. Williams' failure to disclose as a serious felony is directly at odds with substantial public health investment in promoting voluntary HIV testing and disclosure, as well as the growing opposition to HIV-specific criminal prosecutions by medical, public health, and legal organizations across the country.

Accordingly, *amici* respectfully ask the Court to affirm the appellate court's ruling and reject the DA's reliance on scientifically unsupported characterizations of HIV that perpetuate persistent ignorance and stigma associated with the virus and those living with it.

[1] In this brief, "mandatory disclosure" refers to requiring an HIV positive individual to disclose his or her HIV positive status to a sex partner or "contact" with failure to disclose being punishable by law. This term is distinguished from "voluntary disclosure," which allows the individual to choose when and whether to share sensitive health information, with no penalties for non-disclosure.

ARGUMENT

I. HIV is a Difficult Virus To Transmit and Even Without Prophylaxis Transmission Does Not Occur At Least 97% of the Time in a Single Incident of Anal Intercourse.

Three decades into the HIV epidemic, there is clear consensus among medical, scientific, and public health professionals that HIV is not easily transmitted. There are only four possible transmission routes: anal or vaginal intercourse; sharing infected needles or syringes; mother to child before or during birth or through breast-feeding after birth; and significant exposure to HIV-infected blood/ blood products, or organ transplantation in very rare circumstances.[2]

The likelihood of transmission depends on various biological factors, such as a person's overall health, use of protective barriers such as condoms, and viral load (the amount of HIV in the person's bodily fluids).[3] Only certain bodily fluids, almost always blood or semen, containing sufficient viral load can cause transmission.[4] *See, e.g.*, *Henderson v. Thomas*, No. 11-CV-224, slip op. at 2 (M.D. Ala. Dec. 21, 2012) ("A

[2] "HIV can be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions." WHO, *HIV/AIDS Factsheet* (July 2014), *available at* www.who.int/mediacentre/factsheets/fs360/en/; *see also* CDC, *HIV Transmission* (Sept. 2014), *available at* www.cdc.gov/hiv/basics/transmission.html (describing HIV transmission).

[3] Julia Fox, *et al.*, *Quantifying Sexual Exposure to HIV Within an HIV-Serodiscordant Relationship: Development of an Algorithm*, 25(8) AIDS 1066 (2011) [hereinafter, Fox, *Sexual Exposure*], *available at* www.ncbi.nlm.nih.gov/pubmed/21537113 ("The risk of HIV transmission reflects two distinct entities, the relative risk of HIV acquisition amongst HIV-uninfected individuals, which represents a composite of genetic factors, immunological factors, nature and frequency of sexual exposure, and presence of concurrent sexually transmitted infections (STIs) and the onward transmission risk posed by HIV infected individuals which is determined by HIV plasma and genital tract viral load, concomitant STIs, viral characteristics.") (citations omitted); *see also* NAT'L. INST. OF ALLERGY & INFECTIOUS DISEASES, *HIV Risk Factors* (Mar. 2009), *available at* www.niaid.nih.gov/topics/HIVAIDS/Understanding/Pages/riskFactors.aspx (describing factors that increase risk of HIV transmission).

[4] CDC, *HIV and Its Transmission* (July 1999), *available at* www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/CDC%2C%20HIV%20and%20its%20transmission.pdf (noting that "contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.").

person would have to drink a 55-gallon drum of saliva in order for it to potentially result in a transmission."). During sexual contact, HIV cannot be transmitted if there is no meaningful exposure to blood or semen containing a substantial level of HIV virus.

Condom use and effective medical care and treatment can reduce the already low per-act risk of HIV transmission.[5] Yet even without these protections, studies on the risk of HIV transmission associated with sexual acts indicate that while the highest per-act risk of transmission is—at most—a three in 100 chance,[6] or 3%, in this case, complainant's per-act risk of unprotected insertive anal intercourse with Mr. Williams was about 0.06%, or 6 in 10,000.[7] Thus, as the insertive partner in anal sex with an HIV positive partner, the complainant's per-act risk of HIV infection was considerably less than the DA asserts.

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[5] David Wilson, *et al.*, *Relation Between HIV Viral Load and Infectiousness: A Model-Based Analysis*, 372 (9635) LANCET 314, 317 (2008), *available at* www.who.int/hiv/events/artprevention/wilson_relation.pdf (finding that "[a]lthough the primary purpose of antiretroviral therapy is to slow disease progression in people with HIV infection, it is likely to have the secondary benefit of reducing the risk of new transmission to HIV-negative sexual partners."); *see* Steven D. Pinkerton & Paul R. Abramson, *Effectiveness of Condoms in Preventing HIV Transmission*, 44(9) SOC. SCI. MED. 1303, 1303 (1997), *available at* www.ncbi.nlm.nih.gov/pubmed/9141163 (noting that "condoms are 90 to 95% effective when used consistently, i.e. consistent condom users are 10 to 20 times less likely to become infected when exposed to the virus than are inconsistent or non-users."); *see also* UNAIDS, *UNAIDS Best Practice Collection: Making Condoms Work for HIV Prevention* (June 2004), *available at* http://data.unaids.org/publications/irc-pub06/jc941-cuttingedge_en.pdf (describing the important role condoms play in reducing transmission risk).

[6] *Sexual Exposure*, *supra* note 3, at 1077 (finding the highest risk of transmission per exposure is between 0.04%-3.0% for unprotected receptive anal sex); *see also* Eric Vittinghoff, *et al.*, *Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners*, 150(3) AM. J. EPIDEMIOLOGY 306, 309 (1999), *available at* www.ncbi.nlm.nih.gov/pubmed/10430236 (noting that unprotected anal intercourse with an HIV affected partner poses the highest per contact risk of HIV transmission, but the transmission rate is only 0.82% per contact).

[7] *See id.* at 306; *see also* Rebecca Baggaley, *et al.*, *Systematic Review of Orogenital HIV-1 Transmission Probabilities*, 37(6) INT'L J. EPIDEMIOLOGY 1255 (Dec. 2008), *available at www.ncbi.nlm.nih.gov/pmc/articles/PMC2638872/.*

A. The Actual Transmission Rates for Sexual Intercourse Are Much Lower Than What the Public Generally Believes.

Vaginal and anal intercourse account for most HIV transmissions.[8] Yet even with this type of exposure—and without condom use or effective medical care and treatment that reduces viral load—experts agree that HIV is transmitted at a significantly lower rate than what is generally perceived by the public. The transmission risk for the receptive partner of a person living with HIV ranges from a low of 138 in 10,000 to a high of 3 in 100 for unprotected anal sex.[9] Unprotected insertive anal intercourse – the alleged route of transmission here - poses a per-act risk from .06%, or 6 in 10,000 to a .11% risk, or 11 in 10,000 chance of infection.[10] Clearly, HIV is one of the least transmissible of all sexually transmitted infections.[11]

It also is well-established that most HIV transmission occurs during the period of acute infection,[12] which is the one- to four-week period following the time when an

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[8] CDC, *HIV Transmission*, *supra* note 4.

[9] *Compare Sexual Exposure*, *supra* note 3 (noting 3 in 100 for unprotected receptive anal sex) *with* CDC, *HIV Transmission Risk: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act* (July 2014) [hereinafter CDC, *Estimated Per-Act Probability*] (noting 138 in 10,000 for unprotected receptive anal sex), *available at* www.cdc.gov/hiv/policies/law/risk.html. *See also* Jeff Jin, *et al.*, *Per-Contact Probability of HIV Transmission in Homosexual Men in Sydney in the Era of HAART*, 24(6) AIDS 907 (Mar. 27, 2010) [hereinafter Jin, *Per-Contact Probability*], *available at* www.ncbi.nlm.nih.gov/pubmed/20139750 (noting that receptive anal sex risk without ejaculation is 1 in 154; risk increases to 1 in 70 with ejaculation).

[10] CDC, *Estimated Per-Act Probability*, *supra* note 9 (noting 11 in 10,000 for unprotected insertive anal sex); *see also* Jin, *Per-Contact Probability*, *supra* note 9 (noting that insertive anal sex risk for a circumcised man is 1 in 909; risk increases to 1 in 161 for an uncircumcised man).

[11] The Center for HIV Law and Policy, *HIV, STIs & Relative Risks in the United States* (finding "that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV.") [hereinafter The Center for HIV Law and Policy, *Relative Risks*], *available at* www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/HIV%20Infectious%20Disease%20Comparative%20Risk%20Table%20-%20U.pdf.

[12] Important facts remain unknown in this case, including whether Mr. Williams was the actual source of infection, and whether the complainant had any other sexual partners. At a minimum, the DA must explain the long delay, after complainant's last sexual contact with Mr. Williams – about four months - for acute

individual becomes infected.[13] Far fewer infections occur during the stage that, according to the record below, Mr. Williams was in during his sexual relationship with the complainant. In short, it is simply not scientifically sound to characterize as significant the risk of HIV transmission to the complainant as a consequence of his insertive anal sex with Mr. Williams.

B. HIV Treatment Significantly Reduces the Already-Low Level of Infectiousness and Transmission Risk of an Individual With HIV Who is Not in the Acute Infection Stage.

Current HIV treatment protocols not only control progression of the disease but also provide the collateral benefit of reducing the risk of onward transmission. Research now shows the significant impact of effective antiretroviral therapy[14] ("ART")—medicines for HIV infection—on transmission risk reduction, leading to broader awareness that effective treatment *is* effective prevention. Taking ART can reduce the already-low risk of HIV transmission by as much as 96%.[15]

Notably, in a 2000 study of over 400 serodiscordant couples—a sexual relationship in which one partner is HIV positive and the other is HIV negative—there were no instances of HIV transmission by HIV positive partners with undetectable viral

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infection symptoms that usually occur within two to four weeks of infection. NYSDOH, *Could it be Acute HIV?* (2007), *available at* https://www.health.ny.gov/publications/9585.pdf.

[13] Bluma G. Bremmer, *et al.*, *High Rates of Forward Transmission Events after Acute/Early HIV-1 Infection*, 195(7) J. OF INFECTIOUS DISEASES 951 (2005), *available at*, http://jid.oxfordjournals.org/content/195/7/951.full; *see also* Myron S. Cohen & Christopher D. Pilcher, *Amplified HIV Transmission and New Approaches to HIV Prevention*, 191(9) J. INFECT. DIS. 1391 (2005), *available at* http://www.who.int/hiv/events/artprevention/cohen_amplified.pdf.

[14] ART lowers the amount of the virus in the body. CDC, *Antiretroviral Treatment for Prevention of HIV Transmission* (Apr. 2013), *available at* www.cdc.gov/hiv/prevention/programs/pwp/art.html. More specifically, ART "consists of the combination of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease." WHO, *Use of Antiretrovirals for Treatment and Prevention of HIV Infection* (2014), *available at* www.who.int/hiv/topics/treatment/en/.

[15] CDC, *Estimated Per-Act Probability*, *supra* note 9 (collecting sources).

loads.[16] A 2011 review of seven studies involving serodiscordant couples found that the risk of HIV infection among HIV negative partners was more than five times lower when their HIV positive partners were receiving ART than when they were not.[17]

Consequently, the DA's assertion that ongoing anal sex would result in HIV transmission 100% of the time (Appellant's Br. at 20) has no foundation in medical research or scientific literature. Indeed, it represents a misleading and highly inaccurate statistical characterization: If HIV transmission cannot occur in the absence of sufficient HIV viremia, a lifetime of ongoing sexual encounters with an HIV positive person with an undetectable viral load—absent other critical factors such as untreated sexually transmitted infections—would never translate into a 100% risk of transmission.

II. HIV is a Chronic, Manageable Health Condition.

HIV remains a disease of consequence requiring ongoing, routine care and treatment, but for most affected people, it is now a chronic, manageable condition. While no one would deny that HIV remains incurable, or that it is a life-long condition requiring regular care and daily medication, it is hardly a death sentence:

> HIV medications and treatments have significantly changed the course of HIV infection since the early days of the epidemic. With daily medication, regular laboratory monitoring, and lifestyle changes (e.g., exercise, adequate sleep, smoking cessation), HIV can be manageable as a

[16] Thomas C. Quinn, *et al.*, *Viral Load and Heterosexual Transmission of Human Immundeficiency Virus Type 1*, 342 NEW ENG. J. MED. 921 (Mar. 30, 2000), *available at* www.ncbi.nlm.nih.gov/pubmed/10738050.

[17] Andrew Anglemyer, *et al.*, *Antiretroviral Therapy for Prevention of HIV Transmission in HIV-Discordant Couples*, 5 COCHRANE DATABASE OF SYSTEMATIC REVIEWS 1, 2 (2011), *available at* http://apps.who.int/rhl/reviews/CD009153.pdf.

> chronic disease. People living with HIV can enjoy healthy lives.[18]

The state's analogy of HIV exposure as a potential harm equivalent to an uncaged lion represents precisely the type of hyperbolic mischaracterization of HIV risks and consequences that perpetuate HIV phobia and stigma. Appellant's Br. at 20. An HIV diagnosis is not the health equivalent of a lion attack. Remarkable refinement of HIV drug treatments now make it possible to manage HIV with a single daily pill;[19] newly diagnosed individuals with access to medical care can anticipate a near-normal life expectancy.[20] In fact, "[a]s of 2013, a 20-year old with the HIV virus who is on ART and is living in the United States or Canada has a life expectancy into their early 70's, a life expectancy that approaches that of an HIV-negative 20-year old in the general population."[21]

The DA also grossly exaggerates the likelihood of complainant's hypothetical drug resistance. Appellant's Br. at 22-23. Once complainant has been assessed and placed on an effective treatment regimen that reduces HIV to a non-detectable level, a physician would actively monitor his treatment's effectiveness to reduce any risk of drug

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[18] U.S. DEP'T OF JUSTICE ("DOJ"), *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors* (July 15, 2014) [hereinafter DOJ, *Best Practices Guide*], *available at* http://aids.gov/federal-resources/national-hiv-aids-strategy/doj-hiv-criminal-law-best-practices-guide.pdf (citing DHHS, *Chronic Manageable Disease*, *available at* www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/overview/chronic-manageable-disease/).

[19] Monica Gandhi, *et al*., *Single-Pill Combination Regimens for Treatment of HIV-1 Infection*, NEW ENG. J. MED. 248 (2014), *available at* http://www.nejm.org/doi/full/10.1056/NEJMct1215532.

[20] Gus Cairns, *Many Patients Diagnosed with HIV Today Will Have Normal Life Expectancies, European Studies Find*, AIDSMAP (Feb. 22, 2010), *available at* www.aidsmap.com/Many-patients-diagnosed-with-HIV-today-will-have-normal-life-expectancies-European-studies-find/page/1437877/.

[21] DOJ, *Best Practices Guide*, *supra* note 18 at 5 (citing Hasina Samji, *et al.*, *Closing the Gap: Increases in Life Expectancy among Treated Individuals in the United States and Canada*, PLOS ONE, *available at* www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0081355).

resistance.[22] In the event of resistance to one regimen, health care providers can identify a different, effective regimen from the variety of treatment options available today.[23]

Consequently, there is no medical or scientific basis for singling out HIV status in the context of consensual sex as the basis for a criminal indictment in the absence of independent evidence that the individual with HIV had the specific intent to harm an individual, and to do so through contact that posed a reasonable likelihood—not a small theoretical possibility—of causing that harm.[24] The likelihood that Mr. Williams's indictment is the product of an overreaction to HIV is bolstered by the fact that other sexually transmitted, incurable infections with equivalent health consequences, such as the Human Papilloma Virus ("HPV"), are not the target of felony indictments in New York.[25] Treating the possible transmission of HIV—a chronic, manageable but preventable disease that poses a low risk of transmission—as reckless endangerment in the first degree effectively places the state government's approval on persistent ignorance about HIV, and the consequent fear and stigma associated with the disease.

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[22] DHHS, *HIV Treatment: Drug Resistance* (May 2014) ("Adherence to an effective HIV treatment regimen reduces the risk of drug resistance. Adherence means taking HIV medicines every day and exactly as prescribed."), *available at* http://aidsinfo.nih.gov/education-materials/fact-sheets/21/56/drug-resistance.

[23] *Id.*; *see also* AIDSMEDS, *Your Ultimate Guide to HIV Care* (Sept. 2014) *available at* www.aidsmeds.com/list.shtml (illustrating a diverse array of HIV medicines and treatment options).

[24] *See, e.g.*, DOJ, *Best Practices Guide*, *supra* note 18; *see also United States v. Dacus*, 66 M.J. 235, 241 n.1 (C.A.A.F. 2008) (Ryan, J., concurring) ("There is at least a question whether traditional notions of aggravated assault comport with current scientific evidence regarding HIV and AIDS.")

[25] The Center for HIV Law and Policy, *Relative Risks*, *supra* note 11; *see also* CDC, HPV (Feb. 2013) (discussing HPV-related cancers), *available at* www.cdc.gov/hpv/signs-symptoms.html.

III. Creating Criminal Penalties for an Individual's Failure to Disclose His or Her HIV Status to a Sexual Contact is at Odds With Well-Established State and Federal Public Health Policies and with the Complexity of Disclosure for Many People Living With HIV.

A. New York Policies Protect HIV Confidentiality and Rely on Voluntary Disclosure.

Under New York law, Mr. Williams' HIV status is private and confidential.[26] *See* N.Y. Pub. Health Law, Article 27-F §§ 2780-2787. The New York legislature decided that HIV-related information must be strictly protected in order to encourage individuals to voluntarily learn their HIV status, seek medical treatment, and change behavior to avoid transmitting HIV.[27] Confidentiality provisions help reduce the risk of discrimination and other harms caused by unnecessary or unauthorized disclosures of HIV-related information.[28]

Since June 1, 2000, the State has required public health authorities to make reasonable efforts to notify known "contacts" (sexual and needle sharing partners) of an

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[26] "The principle of confidentiality encompasses the view that a person should be entitled to privacy with regard to his or her most personal physical and psychological secrets; but it is also the basis for an effective relationship between patient/client and health care provider, and hence the basis for the effectiveness of many public health interventions which rest on these relationships." Joint United Nations Programme on HIV/AIDS ("UNAIDS") & World Health Organization ("WHO"), *Opening Up the HIV/AIDS Epidemic: Guidance on Encouraging Beneficial Disclosure, Ethical Partner Counseling & Appropriate Use of HIV Case-Reporting* at 10 (Nov. 2000) [hereinafter UNAIDS & WHO, *Encouraging Beneficial Disclosure*], *available at* www.who.int/ethics/topics/opening_up_ethics_and_disclosure_en_2000.pdf

[27] *See, e.g.*, *Flynn v. Doe*, 553 N.Y.S.2d 288, 289 (Sup. Ct. N.Y. Cnty. 1990) ("The Legislature's purpose in providing additional protection of the confidentiality of HIV related information [is] to encourage the expansion of voluntary confidential testing for the human immunodeficiency virus (HIV) so that the individuals may come forward, learn their health status, make decisions regarding the appropriate treatment, and change the behavior that puts them and others at risk of infection.") (internal quotation marks and citations omitted); *see also Nolley v. Cnty. of Erie*, 802 F. Supp. 898, 904 (W.D.N.Y. 1992) ("The existence of article 27-F indicates that the New York Legislature is concerned with the unauthorized disclosure of a person's HIV status and the potential injury that such disclosure can cause.").

[28] UNAIDS & WHO, *Encouraging Beneficial Disclosure*, *supra* note 26 ("Examples of harmful disclosure involve cases where disclosure is made without the consent of the person who is HIV positive and has adverse consequences for that person, such as stigma, abandonment, physical violence, imprisonment, loss of job or housing, or other forms of discrimination.").

HIV positive person that he or she may have been exposed to HIV (N.Y. Pub. Health Law, Article 21 § 2133). While physicians and public health authorities may ask people who have been diagnosed with HIV to voluntarily name their contacts, individuals are not required to reveal their partners,[29] and cannot be penalized for refusing to do so.[30]

B. Federal Public Health Policies Encourage Safe, Voluntary Disclosure.

Federal public health policies—including guidance from the Centers for Disease Control and Prevention ("CDC")—stress voluntary disclosure and partner notification.

The National HIV/AIDS Strategy ("NHAS"), the first comprehensive plan to address the HIV epidemic in the United States, identifies fighting stigma and discrimination as key components of reducing HIV transmission, and explicitly cites the harmful effects of mandatory disclosure.[31] Recognizing that the ability to control when and how an HIV positive individual discloses his or her status to another is important to personal safety and autonomy, the NHAS stresses that protecting the privacy of people with HIV is central to fostering an environment in which people feel safe getting tested and seeking treatment. The sense of safety, and the diagnosis and entry into care that it facilitates, is an essential factor in reducing new infections.[32]

Reflecting the NHAS emphasis on role that voluntary disclosure plays in HIV prevention strategies, in 2012, a joint committee with the CDC, Presidential Advisory

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[29] New York State Department of Health ("NYSDOH"), *HIV Reporting and Partner Notification* (Nov. 2013), *available at* www.health.ny.gov/diseases/aids/providers/regulations/reporting_and_notification/question_answer.htm ("Patients will be asked to name partners voluntarily. This will not be done in a coercive manner.").

[30] *Id.* ("There is no penalty for not naming partners.").

[31] NHAS at 35-37 (2010), *available at* http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf (noting "[w]e know that many people feel shame and embarrassment when they learn their HIV status. And, there is too much social stigma that seeks to assign blame to people who acquire HIV.").

[32] *Id.*

Council on HIV/AIDS ("PACHA"), and the Health Resources and Services Administration ("HRSA") of the U.S. Department of Health and Human Services ("DHHS"), issued a set of national guiding principles and recommendations on HIV disclosure.[33] The federal joint committee recognized as starting principles:

> - The ultimate autonomy of each individual faced with the opportunities and challenges of disclosing her or his HIV status;
>
> - That disclosure of HIV status is not a single, discrete event but rather an ongoing process that spans a lifetime and a myriad of contexts; and [that]
>
> - The disclosure process necessarily involves multiple parties.[34]

Consistent with this, the federal joint committee recommendations incorporate the societal obligation to create a safe environment for HIV and other sexually transmitted disease disclosure:

> There is an obligation and a responsibility for society to create a safe environment for people to voluntarily disclose their HIV status as well as other sexually transmissible infections. *Accordingly, any laws and policies that create disincentives to an individual's safe and voluntary disclosure of her or his HIV status, e.g., by increasing HIV stigma and discrimination, should be eliminated.* All relevant federal, state and local laws and policies should incorporate the current state of medical science, best practices in public health, and evidence-based strategies and priorities for effectively addressing the HIV epidemic

[33] CDC, PACHA & HRSA/DHHS Joint Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Care, *HIV Disclosure Summit* (June 2012), *available at* http://aids.gov/federal-resources/pacha/meetings/2013/feb-2013-joint-letter-to-sec-of-health.pdf (recognizing "the ultimate autonomy of each individual faced with the opportunities and challenges of disclosing her or his HIV status").

[34] *Id.*

> and should strive to create and maintain resources and environments conducive to safe and voluntary disclosure.[35]

Since an individual's considerations concerning HIV disclosure typically are complex and can even raise issues of personal safety, federal public health officials acknowledge that non-disclosure is a valid option:

> A complex constellation of cultural and social factors influences every individual's ability to safely disclose her or his HIV status. These factors must be respected in order to create environments that facilitate safe and voluntary disclosure. Only if we understand and appreciate the external pressures militating against safe, voluntary disclosure, can we create solutions that allow for all people to access the support, treatment and education resources that they need and deserve. [36]

The emphasis placed on individual autonomy is pragmatic as well as principled, in that the success of public health policy depends on the cooperation of affected individuals. Populations at risk for HIV will not seek testing or treatment services if they fear that it will result in adverse consequences.[37]A policy environment that allows for safe, voluntary disclosure encourages individuals living with HIV to access support and care with far less fear of stigma or persecution.[38]

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[35] *Id.* (emphasis added).

[36] *Id.* (urging that "any laws and policies that create disincentives to an individual's *safe and voluntary disclosure* of her or his HIV status, e.g., by increasing HIV stigma and discrimination, should be eliminated") (emphasis added).

[37] *Id.*

[38] *Id.*

C. Reliance on Mandatory Disclosure Places Both Individuals Living with HIV and Those Who Are HIV Negative at Greater Risk of Harm Without Advancing Any Legitimate Public Health Goal.

The foundation of the state and federal public health policies that emphasize voluntary, rather than coercive, engagement in health care systems is the recognition that when HIV positive people are permitted to decide for themselves whether or not to disclose and how to disclose their HIV status, they do so more readily, with less trepidation and with better consequences.[39] Mandatory disclosure plays an extremely limited role in state and federal policy because it can cause serious harm, and there is no evidence that it reduces HIV transmission.[40]

In fact, reliance on mandatory disclosure might actually encourage behavior that increases the likelihood of infection.[41] While there is evidence that mandatory disclosure is a disincentive to seek counseling and other services that encourage risk reduction, voluntary disclosure is associated with increased an likelihood of using condoms and decreased likelihood of acquiring new sexual partners.[42] Research also shows that voluntary disclosure is associated with fewer mental health symptoms related to HIV,

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[39] UNAIDS & WHO, *Encouraging Beneficial Disclosure*, *supra* note 26 (disclosure must be voluntary, and respect the autonomy and dignity of people living with HIV).

[40] "[T]here are no clear data indicating that the mandatory [disclosure to] partners is more effective in preventing transmission." UNAIDS & WHO, *Encouraging Beneficial Disclosure supra* note 26, at 19.

[41] "[F]orced disclosure drives people away from HIV services, reducing opportunities to encourage and empower people to change their behaviour in order either to avoid getting infected or to avoid passing on their infection." UNAIDS & WHO, *Encouraging Beneficial Disclosure supra* note 26, at 12.

[42] P. J. Kissinger, *et al.*, *Partner Notification for HIV and Syphilis: Effects on Sexual Behaviors and Relationship Stability*, 30(1) SEXUALLY TRANSMITTED DISEASES 75 (Jan. 2003), *available at* http://www.ncbi.nlm.nih.gov/pubmed/12514447; *see also* T. Hoxworth, *et al*., *Changes in Partnerships and HIV Risk Behaviors After Partner Notification*, 30(1) SEXUALLY TRANSMITTED DISEASES 83 (Jan. 2003), *available at* http://www.ncbi.nlm.nih.gov/pubmed/12514448.

including a decline in anxiety and depression.[43]At an equally practical level, encouraging people to rely on what they believe they know about their partners' HIV status is not an effective means of reducing risk of infection. When a partner's HIV status is unknown, as is the case among those who have not been tested or those in the acute infection stage who test negative on an antibody test, the assumption that sex is safe is both unfounded and unwise.[44] Preventing transmission of HIV and other sexually transmitted infections ultimately remains within the control, and the responsibility, of most individuals who are sexually active.[45] The DA overlooks the actual decision-making role that two consenting adults share with respect to sex and maintaining their health. *See, e.g.*, *Bukowski v. Clarkson Univ.*, 19 N.Y.3d 353 (2012) (holding that, under the doctrine of assumption of risk, a voluntary participant in an activity assumes the risks inherent in that activity). Indeed, for an uninfected person, every sexual encounter presents some risk of acquiring HIV.[46]

Many people living with HIV are unaware of their HIV status. The CDC estimates that roughly 15% to 20% of people living with HIV are unaware of their

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[43] R. Hays, *et al.*, *Disclosing HIV Seropositivity to Significant Others*, 7 AIDS 425 (Mar. 1993), *available at* http://www.ncbi.nlm.nih.gov/pubmed/8471207; *see also* WHO, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes* (2004) [hereinafter "WHO, *Gender Dimensions*"], *available at* http://www.who.int/gender/documents/women_and_girls/9241590734/en/.

[44] T. Suarez & J. Miller, *Negotiating Risks in Context: A Perspective on Unprotected Anal Intercourse and Barebacking Among Men Who Have Sex with Men—Where Do We Go From Here?,* 30(3) ARCHIVES OF SEXUAL BEHAV. 287 (2001), *available at* http://www.ncbi.nlm.nih.gov/pubmed/11330118. *See also* R. S. Gold & M. J. Skinner*, Desire for Unprotected Intercourse Preceding its Occurrence: The Case of Young Gay Men with an Anonymous Partner*, 4(6) INT'L J. OF SEXUALLY TRANSMITTED INFECTIONS & AIDS 326 (Nov.-Dec., 1993), *available at* http://www.ncbi.nlm.nih.gov/pubmed/8305572.

[45] Beena Varghese, *et al.*, *Reducing the Risk of Sexual HIV Transmission: Quantifying the Per-Act Risk for HIV on the Basis of Choice of Partner, Sex Act, and Condom Use*, 29 SEXUALLY TRANSMITTED DISEASES 38 (2002), *available at* www.ncbi.nlm.nih.gov/pubmed/11773877.

[46] *Id.*

infection,[47] and these undiagnosed individuals account for approximately 70% of new infections.[48] Even if an individual does get tested for HIV, those who have been recently infected will not have sufficient antibodies in their systems for the test most routinely used to screen for HIV; there is a "window period" after exposure in which a newly infected individual will have a negative test result.[49] During this period—when an individual is the most infectious[50]—the person would be unaware of his or her HIV infection,[51]and my conclude erroneously that they are free of HIV. The failure of sex partners to take precautions based on what is—or is not—disclosed before sex is a major driver of the HIV epidemic.

Disagreement about whether disclosure took place and whether sexual risk was discussed is common among sexual partners. In a survey of 855 heterosexual women and their partners—all identified as being at heightened risk for HIV—the CDC found that nearly half (44%) of couples disagreed about whether or not they had discussed their HIV status.[52] This disagreement may be in part because discussion of sexual risk and disease

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[47] CDC, *Monitoring Selected Nat'l HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Dependent Areas—2011* (Oct. 2013), *available at* http://www.cdc.gov/hiv/pdf/2011_Monitoring_HIV_Indicators_HSSR_FINAL.pdf (As of 2010, an estimated 1,144,500 persons aged 13 and older are living with HIV in the United States, including 180,900 (15.8%) persons whose infections had not been diagnosed.).

[48] Carol Galletly & Steven Pinkerton, *Conflicting Messages: How Criminal HIV Disclosure Laws Undermine Public Health Efforts to Control the Spread of HIV*, 10(5) AIDS BEHAV. 451, 456 (Sept. 2006) [hereinafter Galletly, *Conflicting Messages*], *available at* www.ncbi.nlm.nih.gov/pubmed/16804750.

[49] CDC, *Act Against AIDS: Testing* (Feb. 2014), *available at* www.cdc.gov/actagainstaids/basics/testing.html.

[50] Evidence shows that HIV may be up to 10 times more infectious and easily transmitted during the window period. *See, e.g.*, Galletly, *Conflicting Messages*, *supra* note 48.

[51] CDC, *Act Against AIDS: Testing* (Feb. 2014), *available at* www.cdc.gov/actagainstaids/basics/testing.html.

[52] K. Hagerman, *et al.*, *Couple Agreement of HIV-Related Behaviors, Communication, and Knowledge: Heterosexual Partner Study, 16 U.S. Cities, 2006-2007,* Tenth AIDS Impact Conference in Santa Fe, NM

status is complex and can involve non-verbal elements and many unspoken assumptions. Research shows that individuals may substitute certain environmental "clues" for verbal disclosure. For example, some people assume that leaving HIV medication bottles visible in their home is a sufficient substitute for verbal disclosure.[53]

Regardless of expectations for disclosure before intimate contact, nondisclosure is common. In a recent study of 839 HIV positive men and women, about one-third reported having sex without disclosure of HIV status in the previous three months.[54] Nondisclosure is likely the result of a complex constellation of cultural and social factors. Denial of HIV status among the newly diagnosed[55] is a common psychological defense mechanism in the face of a stigmatized illness.[56] Many HIV positive individuals fear the stigma and discrimination in various aspects of their lives that could result from disclosure.[57] This fear, even in current times, is well-founded.[58] *See, e.g.*, *Doe v. Deer Mountain Day Camp Inc.*, 682 F. Supp. 2d 324 (S.D.N.Y. 2010) (child denied permission to attend a basketball camp due to his HIV positive status). In fact, anticipation of

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(Sept. 12-15, 2011), *available at* www.aidsmap.com/Couples-often-disagree-on-what-theyve-told-each-other-study-finds/page/2083538/.

[53] Galletly, *Conflicting Messages*, *supra* note 48.

[54] G. Marks & N. Crepaz, *HIV-Positive Men's Sexual Practices in the Context of Self-Disclosure of HIV Status*, 27(1) J. OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 79 (May 1, 2001), *available at* www.ncbi.nlm.nih.gov/pubmed/11404524.

[55] J. B. von Ornsteiner, *D for "Diagnosis" or for "Denial"? Coming to Grips with Being Newly Diagnosed*, BODY POSITIVE (Oct. 2001), *available at* www.thebody.com/content/art30530.html.

[56] R. Goldbeck, *Denial in Physical Illness*, 43(6) J. PSYCHOSOMATIC RES. 575 (Dec. 1997), *available at* www.ncbi.nlm.nih.gov/pubmed/9430071.

[57] WHO, *Gender Dimensions*, *supra* note 41. *See also* L. Moneyham, *et al.*, *Experiences of Disclosure in Women Infected with HIV*, 17(3) HEALTH CARE WOMEN INT'L 209 (May-Jun. 1996), *available at* www.ncbi.nlm.nih.gov/pubmed/8852223.

[58] After revealing his HIV-positive status to a manager, an employee was prohibited from touching office doorknobs and was followed by coworkers who cleaned surfaces he touched with Lysol. Todd Heywood, *Detroit Man Alleges HIV Discrimination By Lysol-Spraying Dental Clinic Coworkers,* POZ (Dec. 8, 2011), *available at* www.poz.com/articles/detroit_hiv_lysol_401_21587.shtml.

stigmatizing responses from health care and service providers leads to a reduction in health-seeking behavior among many people living with HIV.[59]

Individual consequences of mandatory disclosure, under circumstances that can create physical, emotional, or economic risk, can include lower adherence to treatment, leading in turn to greater infectiousness and, thus, higher risk of transmission.[60] Adverse reactions and responses to disclosure—including increased suspicion and scrutiny of the HIV positive person's lifestyle—can lead to exacerbation of anxiety, anger, and depression.[61] Voluntary disclosure, on the other hand, may result in improved social support networks and better access to treatment,[62] which leads to lower viral loads and reduced rates of transmission.

Fear of domestic violence for those in actual or potentially abusive situations is another significant barrier to disclosure for many people living with HIV. Mandatory disclosure may eliminate an HIV positive person's control of the time, place, and manner of disclosure and may aggravate the profound mental distress associated with this fear.

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[59] Galletly, *Conflicting Messages*, *supra* note 48; *see also* J. D. Fortenberry, *et al.*, *Relationship of Stigma and Shame to Gonorrhea and HIV Screening*, 92(3) AM. J. OF PUB. HEALTH 378 (Mar. 2002), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1447083/; *see also* R. O. Valdiserri, *HIV/AIDS Stigma: An Impediment to Public Health*, 92(3) AM. J. OF PUB. HEALTH 34 (Mar. 2002), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC1447072/.

[60] Stephanie Bouis, *et al*., *An Integrated, Multidimensional Treatment Model for Individuals Living with HIV, Mental Illness, and Substance Abuse*, 32(4) Health & Soc. Work 268, 277 (Nov. 2007), *available at* www.ncbi.nlm.nih.gov/pubmed/18038728.

[61] G. M. Herek, "Illness, Stigma, and AIDS," *Psychological Aspects of Serious Illness* 103, 120 (P. Costa & G.R. VandenBos eds. 1990), *available at* http://psychology.ucdavis.edu/faculty_sites/rainbow/html/AIDS_stigma_1990_pre.pdf.

[62] WHO, *Gender Dimensions*, *supra* note 41.

Many women living with HIV mention fear of violence as a barrier to disclosure.[63] This fear is born of experience:[64] many women have reported violence and abuse as a direct result of disclosing their HIV status.[65] Because forcing all HIV positive individuals to disclose their status could result in considerable risk of physical and psychological injury, public health policies have long avoided such measures.

While voluntary disclosure and the related reduction in stigma are elements of HIV prevention, only the practice of safer sex, and especially the use of condoms, can protect sexually active persons from sexually transmitted infections, including HIV. State and federal public health policies hinge HIV prevention efforts on consistent condom use and other risk reduction measures. Over-emphasis on disclosure seriously undermines this message by implying that reliance on disclosure—and not condom use—is a reliable method of avoiding disease.[66]

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[63] *Id*.

[64] Violence as a consequence of being HIV-positive is often reported, particularly by women. Violence and abuse are serious deterrents to disclosure. *See* White House, *Interagency Federal Working Group Report: Addressing the Intersection of HIV/AIDS, Violence Against Women and Girls & Gender-Related Health Disparities* (Sept. 2013), available at www.whitehouse.gov/sites/default/files/docs/vaw-hiv_working_group_report_final_-_9-6--2013.pdf; *see also* A. C. Gielen, *et al*., *Women's Disclosure of HIV Status: Experiences of Mistreatment and Violence in an Urban Setting*, 25 WOMEN'S HEALTH 19, 25 (1997), *available at* www.ncbi.nlm.nih.gov/pubmed/9273981; *see also* A. C. Gielen, *et al.*, *Women Living with HIV: Disclosure, Violence, and Social Support*, 77(3) J. URBAN HEALTH 480 (2000), *available at* www.ncbi.nlm.nih.gov/pubmed/10976619 (finding that violence is widespread).

[65] In 2000, Susan Teffo discovered that she was HIV-positive. When she told her partner, he burnt her face over a stove. WHO, *Violence Against Women and HIV/AIDS: Critical Intersections* (2004), *available at* www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf (reporting that violence or fear of violence is a barrier to disclosure), *see* A. C. Gielen, *et al.*, *Women's Lives After an HIV-Positive Diagnosis: Disclosure and Violence*, 4(2) Matern. Child Health J. 111 (2000), *available at* www.ncbi.nlm.nih.gov/pubmed/10994579 (45% of women reported experiencing emotional, physical, or sexual abuse at some time after their diagnosis); *see also* R. L. North & K. H. Rothenberg, *Partner Notification and the Threat of Domestic Violence Against Women with HIV Infection*, 329 NEW ENG. J. OF MED. 1194 (Oct. 1993), *available at* http://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=1161&context=fac_pubs.

[66] Galletly, *Conflicting Messages*, supra note 48.

In sum, a policy that mandates disclosure in all cases would suggest, incorrectly, that all forms of intimate contact are equally risky and that no form of sexual intimacy with an HIV positive individual is safe. This kind of message is at direct odds with current federal and state HIV prevention campaigns. It would also inaccurately and cruelly suggest that those living with HIV are simply too toxic for meaningful adult intimacy.[67]

IV. There is Substantial, Growing Consensus Among Government, Law Enforcement, Medical, Public Health, and HIV Agencies That Criminal Prosecutions Targeting the Consensual Sex of People Living with HIV Fuel Stigma and Undermine Substantial Taxpayer Investment in HIV Prevention and Treatment Campaigns.

Stigma[68] is one of the most significant barriers to public health efforts to prevent HIV transmission:

> Roughly one in four Americans have continued to either believe that one can get HIV from sharing a drinking glass, or remain unsure whether this is the case. Similarly, roughly one in six believe the same about HIV transmission via shared toilet seats, and 12 percent either think you can

[67] In this case, the DA suggests that "a reasonable person" would not have knowingly engaged in sexual activity with Mr. Williams if he had disclosed his HIV status. (*See* Appellant's Br. at 16; *see also* Reply Br. at 4 & 6.) This suggestion is wrong and misguided: there are many sexual relationships in which one partner is HIV-positive and the other is HIV-negative. Public health officials encourage healthy, consensual sexual relationships regardless of the HIV status of the sexual partners. *See, e.g.*, DHHS, *Mixed-Status Couples* (Oct. 2014), *available at* www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/friends-and-family/mixed-status-couples/.

[68] "[S]tigma exists when the following four interrelated components converge: 1) individuals distinguish and label human differences, 2) dominant cultural beliefs link labeled persons to undesirable characteristics (or negative stereotypes), 3) labeled persons are placed in distinct categories to accomplish some degree of separation of 'us' from 'them,' and 4) labeled persons experience status loss and discrimination that lead to unequal outcomes." Anish P. Mahajan, *et al.*, *Stigma in the HIV/AIDS Epidemic: A Review of the Literature & Recommendations for the Way Forward*, AIDS (Aug. 2008), *available at* www.ncbi.nlm.nih.gov/pmc/articles/PMC2835402/. "[D]ynamic social/economic/political processes [ ] simultaneously produce and intensify stigma and discrimination." *Id.*; *see also* Ginia Bellafante, *Out, But Not About That*, N.Y.TIMES (May 3, 2013) (discussing the lingering stigma of HIV), *available at* www.nytimes.com/2013/05/05/nyregion/the-lingering-stigma-of-hiv.html?_r=0.

> get HIV by swimming in a pool with someone with HIV, or are not sure whether this is the case.[69]

Misconceptions about the routes, relative risks, and consequences of HIV transmission are the foundation for social exclusion, discriminatory laws and policies, and other manifestations of stigma.[70] *See, e.g.*, *Mother Smith v. Milton Hershey Sch.*, No. 11-CV-7391 (E.D. Pa. 2012) (school refused to consider student for enrollment because he had HIV);[71] *see also* Settlement Agreement Between the U.S. Dep't of Justice ("DOJ") and City of Stockton, Cal., DOJ Complaint No. 204-11E-344 (Nov. 9, 2007)[72] (noting that a man "was denied emergency medical services by the City's Fire Department because he has HIV/AIDS").

There is growing consensus among medical experts, public health officials, and policy makers that bringing criminal charges against individuals like Mr. Williams institutionalizes and promotes HIV stigma.[73] In fact, over the last two years, the

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[69] Kaiser Family Foundation, *HIV/AIDS at 30: A Public Opinion Perspective, A Report Based on the Kaiser Family Foundation's 2011 Survey of Americans on HIV/*AIDS, 6 (June 2011), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8186.pdf.

[70] Center for American Progress, *HIV/AIDS Inequality: Structural Barriers to Prevention, Treatment, and Care in Communities of Color*, 14 (July 12, 2012) ("One of the biggest barriers to health equity surrounding HIV/AIDS is the stigma and relative silence associated with the disease. In communities of color in particular, the stereotype of HIV/AIDS as the consequence of an individual's deviant behavior has perpetuated shame and discouraged people from knowing their status and treating it."), *available at* https://www.americanprogress.org/issues/lgbt/report/2012/07/27/11834/hivaids-inequality-structural-barriers-to-prevention-treatment-and-care-in-communities-of-color/.

[71] Settlement Agreement *available at* www.ada.gov/milton-hershey_sa_aids.htm.

[72] *Available at* The Center for HIV Law and Policy's HIV Policy Resource Bank (2007), www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/DOJ%20and%20Stockton%20Settlement%20Agreement_0.pdf.

[73] *See, e.g.*, PACHA, *Resolution on Ending Federal and State HIV-Specific Criminal Laws, Prosecutions, and Civil Commitments* (2013) (noting that the criminalization of HIV-affected people fuels HIV stigma), *available at* http://hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/PACHA_Criminalization_Resolution%20Final%20012513.pdf; American Medical Association, *Modernization of HIV Specific Criminal Laws* (2014), *available at* http://hivlawandpolicy.org/news/ama-adopts-a-resolution-opposing-hiv-

Presidential Advisory Council on HIV/AIDS, the U.S. Conference of Mayors, the National Alliance of State and Territorial AIDS Directors, the American Medical Association, the HIV Medicine Association, the Association of Nurses in AIDS Care, among other national medical, public health, and policymaking organizations,[74] have issued statements calling for an end to the use of the criminal law to target the conduct of people living with HIV.[75]

It is particularly harmful when the government[76] effectively enshrines stigma through laws and policies that reflect outdated notions of the nature of HIV.[77] This

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criminalization; HIV Medicine Association, *Repeal of HIV-Specific Criminal Statutes* (2012), *available at* www.hivma.org/uploadedFiles/IDSA/Careers_and_Training/Opportunities_for_Students_Residents/ID_Career_Paths/HIVMA%20Policy%20Statement%20on%20HIV%20Criminalization.pdf; Nat'l Alliance of State and Territorial AIDS Directors, *Nat'l HIV/AIDS Strategy Imperative: Fighting Stigma and Discrimination by Repealing HIV-Specific Criminal Statutes* (2011), *available at* www.nastad.org/Docs/114641_2011311_NASTAD%20Statement%20on%20Criminalization%20-%20Final.pdf); U.S. Conference of Mayors, *Resolution on HIV Discrimination and Criminalization* (2013), *available at* www.usmayors.org/resolutions/81st_Conference/csj11.asp; Positive Justice Project, *Nat'l Consensus Statement on the Criminalization of HIV* (2012), *available at* www.hivlawandpolicy.org/resources/positive-justice-project-consensus-statement-criminalization-hiv-united-states-positive. In response to this trend, bipartisan proposed legislation has been introduced in Congress to encourage modernization of current criminal law approaches to HIV. *See* Repeal Existing Policies that Encourage and Allow Legal (REPEAL) HIV Discrimination Act, H.R. 1843 (May 2013), *available at* https://www.govtrack.us/congress/bills/113/hr1843; *see also* LOS ANGELES TIMES, Editorial, *Get Rid of those Outdates HIV Laws* (June 6, 2013), *available at* http://articles.latimes.com/2013/jun/06/opinion/la-ed-hiv-state-laws-review-2013060. In July 2014, the U.S. Department of Justice issued guidance providing technical assistance to states to ensure that HIV-related criminal laws reflect the contemporary medical and scientific understanding of HIV. *See* DOJ, *Best Practices Guide*, *supra* note 18. *See also* UNAIDS, *The Criminalisation of HIV Non-Disclosure Exposure and Transmission: Background and Current Landscape* at 23 Feb. 2012), *available at* www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2012/BackgroundCurrentLandscapeCriminalisationHIV_Final.pdf (raising serious objections to treating sex between adults, in the absence of disclosure of known HIV-positive status, as a physical or sexual assault despite the absence of intent to harm).

[74] *Id.*

[75] Notably, the Positive Justice Project's *Nat'l Consensus Statement on the Criminalization of HIV* has more than 1000 organizational and individual endorsements from across the United States. *See* The Center for HIV Law and Policy, *Nat'l Call to End HIV Criminal Laws Gains Momentum* (2014), *available at* http://www.hivlawandpolicy.org/news/national-call-end-hiv-criminal-laws-gains-momentum.

[76] Law enforcement and prosecutorial scrutiny of consensual, intimate sexual conduct raises serious constitutional concerns. The U.S. Supreme Court has consistently rejected government intrusion into the "personal and private life of the individual." *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (finding

government endorsement of ignorance provides a visible and powerful disincentive for those at risk for HIV to get tested, let alone access medical care and treatment that keeps them and their communities healthy[78]

consenting adults have a "full right to engage in [private sexual conduct] without intervention of the government"). In this case, the DA should be reminded that individual moral and sexual choices are protected by the U.S. Constitution.

[77] In New York, over-zealous prosecutors have brought criminal charges with harsh prison sentences in response to acts, such as spitting and biting, which pose no risk of HIV infection. *See, e.g.*, *People v. Plunkett*, 19 N.Y.3d 400, 408-9 (2012) (holding that an HIV positive person's saliva is not a "dangerous instrument")*; see also* CDC, *HIV Transmission* (Sept. 2014), *available at* http://www.cdc.gov/hiv/basics/transmission.html ("HIV cannot be spread through saliva."). It is not surprising that "[e]ach year, an estimated 1 in 7 persons living with HIV pass through a correctional facility." CDC, *HIV in Correctional Settings* (Feb. 20, 2014), *available at* http://www.cdc.gov/hiv/risk/other/correctional.html. Since the HIV epidemic disproportionately affects communities of color, criminalization has a particularly harmful and disparate impact on already marginalized and vulnerable populations. *See* CDC, *Morbidity and Mortality Weekly Report* (Oct. 15, 2010) *available at* http://www.cdc.gov/mmwr/pdf/wk/mm5940.pdf (noting that 1 in 22 African-Americans and 1 in 52 Latinos will receive an HIV diagnoses during their lifetime compared to 1 in 170 Whites).

[78] Notably, there is growing consensus that medical and health care providers should not participate in the criminal prosecutions of their patients. This stems from a strong interest in respecting and protecting the relationship between people living with HIV and their providers. Involving medical and health care providers in the criminal prosecutions of their patients raises serious trust and confidentiality concerns that can have a powerful chilling effect on HIV medical care and treatment. *See, e.g.*, Dr. Wendy Armstrong, *HIV Criminalization: A Physician's Perspective* (2014), *available at* http://hivlawandpolicy.org/fine-print-blog/hiv-criminalization-a-physicians-perspective (noting that criminalization corrodes the physician-patient privilege) (excerpt from The Center for HIV Law and Policy, et al., *A Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People with HIV* (2014), *available at* http://hivlawandpolicy.org/resources/a-roadmap-change-federal-policy-recommendations-addressing-criminalization-lgbt-people-and).

CONCLUSION

Amici curiae respectfully ask the Court to affirm the appellate court's ruling and reject the DA's dangerous misapplication of the criminal law to the consensual sex of individuals with HIV as contrary to science and sound public health policy.

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Respectfully submitted,

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