

IN THE SUPREME COURT OF IOWA

SUPREME COURT NO. 12-0180
Black Hawk Co. Case No. PCCV112123

NICK RHOADES, Applicant/Appellant

vs.

STATE OF IOWA, Respondent-Appellee

APPEAL FROM THE IOWA DISTRICT COURT FOR
BLACK HAWK COUNTY
THE HONORABLE DAVID F. STAUDT, District Judge

APPLICANT/APPELLANT AMICUS CURIAE BRIEF

**BRIEF *AMICUS CURIAE* OF NATIONAL ALLIANCE OF STATE
AND TERRITORIAL AIDS DIRECTORS, THE CENTER FOR HIV
LAW AND POLICY, AND HIV LAW PROJECT IN SUPPORT OF
APPLICANT/ APPELLANT NICK RHOADES.**

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INTERESTS OF *AMICI CURIAE*

Amici curiae National Alliance of State and Territorial AIDS Directors, The Center for HIV Law and Policy, and HIV Law Project submit this *amicus* brief in support of appellant Nick Rhoades in his appeal of the denial of his petition for post-conviction relief. *Amici* are committed to providing the Court with a clear, scientifically sound understanding of HIV prevention and disclosure in order to ensure that persons living with HIV/AIDS are not targeted and criminally prosecuted on the basis of misinformation about how HIV is transmitted, how it is prevented, and the role and value of HIV disclosure.

The National Alliance of State and Territorial AIDS Directors (NASTAD), representing the nation's chief state health agency staff, has programmatic responsibility for administering HIV/AIDS 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/AIDS and viral hepatitis infections in the U.S. and its territories, providing comprehensive, compassionate, and high-quality care to all persons living with HIV/AIDS 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/AIDS 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 Center for HIV Law and Policy (CHLP) is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP's interest in this case is consistent with its mission to reduce the impact of HIV on vulnerable and marginalized communities and to secure the rights of people affected by HIV. Exaggerated fears about HIV and ignorance about the routes and relative risks of HIV transmission perpetuate discrimination and unfair treatment of those with HIV. Government endorsement of such fears, through the use of the criminal law to single out people with HIV for severe punishment on the basis of conduct that poses no risk to others, undermines national goals to engage people with HIV in medical care and to prevent further spread of the disease.

HIV Law Project (HLP) believes that all people deserve the same rights, including the right to live with dignity and respect, the right to be

treated as equal members of society, and the right to have their basic human needs fulfilled. These fundamental rights are elusive for many people living with HIV/AIDS. Through innovative legal services and advocacy programs, HIV Law Project fights for the rights of the most underserved people living with HIV/AIDS.

STATEMENT OF FACTS¹

In 2008, Nick Rhoades was living in Plainfield, Iowa. Mr. Rhoades learned he had HIV in 1999 and had been receiving treatment for HIV, including highly effective antiretroviral therapy (ART),² for several years at the time the events giving rise to this action occurred. He was in good health and his viral load³ was undetectable as of May 2008.

In June 2008, Mr. Rhoades connected with Adam Plendl on Gay.com, an online social networking site. After chatting online for some time, Mr. Plendl invited Mr. Rhoades to his residence in Cedar Falls, Iowa. Both parties stated during their online conversation that they intended to socialize,

¹ *Amici* relied on Statement of the Facts at 6-10 in Proof Brief of Applicant/Appellant and Request for Oral Argument filed on June 13, 2012 to inform this Statement of Facts.

² Antiretroviral therapy consists of combinations of medications to reduce HIV virus replication in the human body. Ctrs. for Disease Control & Prevention, *Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection 1* (Sept. 2009), available at <http://www.cdc.gov/hiv/topics/treatment/resources/factsheets/pdf/art.pdf>.

³ Viral load refers to the levels of human immunodeficiency virus in the blood stream. *Id.*

not to engage in sexual activity. Mr. Rhoades arrived and for several hours the two men engaged in social conversation. This progressed to consensual physical contact and then to oral sex. Neither man ejaculated during oral sex. The men did not use condoms during oral sex, and there is no evidence in the testimony, in the parties' statements made during the colloquy, or in the investigation report that Mr. Rhoades' semen came into contact with Mr. Plendl. The oral sex then progressed to anal intercourse, in which Mr. Rhoades was the insertive partner and Mr. Plendl was the receptive partner.⁴ Mr. Rhoades wore a prophylactic condom during anal intercourse. The men disagree on whether ejaculation took place.

A few days later after learning from a friend that Mr. Rhoades might be HIV-positive, Mr. Plendl contacted the police. The police initiated an investigation and gathered evidence including statements by both men, Mr. Rhoades' medical records, blood samples, and photographs of his HIV medication. Mr. Rhoades was arrested in September 2008 and prosecuted under Iowa Code Section 709C.1, the state's criminal transmission of HIV

⁴ An insertive partner is defined as a "participant plac[ing] his penis in the anus of his sex partner" and a receptive partner as a "[participant whose] sex partner place[s] his penis in the participant's anus." Teresa J. Finlayson *et al.*, *HIV Risk, Prevention, and Testing Behaviors Among Men Who Have Sex With Men — National HIV Behavioral Surveillance System, 21 U.S. Cities, United States, 2008*, 60(14) *Morbidity & Mortality Wkly. Rep. Surveillance Summaries* 4 (Oct. 28, 2011), available at <http://www.cdc.gov/mmwr/pdf/ss/ss6014.pdf>.

statute.⁵ It is undisputed that the events giving rise to this action did not result in HIV transmission.

SUMMARY OF ARGUMENT

To support a conviction of criminal transmission of HIV under Iowa Code Section 709C.1, the state must prove beyond a reasonable doubt that the defendant, knowing that he is HIV-positive, engaged in intimate conduct with another person.⁶ “Intimate contact” is defined as “the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in the transmission of the human immunodeficiency virus.”⁷

In appealing the denial of his petition for post-conviction relief, Mr. Rhoades contends that he received ineffective assistance of counsel during the criminal proceedings. Specifically, his attorney allowed him to plead guilty to criminal transmission of HIV when 1) Mr. Rhoades did not fully understand each element of the offense, and 2) there was no factual basis for the charge. Of particular importance is the requirement that “intimate contact”

⁵ Iowa Code § 709C.1 (2011).

⁶ Iowa Code § 709C.1 (2011). *State v. Stevens*, 719 N.W.2d 547, 549 (Iowa 2006).

⁷ Iowa Code § 709C.1(2)(b) (2011).

– that is, the intentional exposure of the body of one person to a bodily fluid of another person in a manner that could result in HIV transmission – occur between the parties. Mr. Rhoades’ contact with Mr. Plendl through protected anal intercourse and unprotected oral intercourse without ejaculation does not constitute intimate contact under Iowa Code Section 709C.1.

As amici illustrate below, Mr. Rhoades’ conduct – and the Iowa legislature’s accommodation of the sexual intimacy of HIV-positive individuals that poses no more than a theoretical risk of transmission with no further obligation to disclose – is consistent with Iowa state and federal public health policies and practices that encourage risk reduction through condom use and other safer sex practices, and that encourage, without mandating, an individual’s disclosure of HIV status to partners.

First, the use of condoms for vaginal and anal intercourse is the single most important safer sex practice emphasized in public health policies and practices. HIV transmission occurs overwhelmingly as a consequence of unprotected anal and vaginal sex, and even then is not easily transmitted. Transmission risks are further reduced to near zero – essentially, only a theoretical risk – when condoms are properly used and when the HIV-positive partner is on effective ART. Oral intercourse – even when

unprotected – poses an extremely low risk of HIV transmission, and there are no documented cases of transmission due to oral sex without ejaculation. The risk of transmission through oral sex with an HIV-positive individual with no measurable viral load as a consequence of effective ART, as is the case with Mr. Rhoades, is likely zero or near zero.

Second, Iowa Code Section 709C.1 contemplates the possibility that an HIV-positive person may engage in safer sex without disclosing his/her status. This is consistent not only with broadly held public health policies and practices, but with the realities of individual lives. The basis for these policies is the recognition that when HIV-positive individuals are able to decide for themselves whether or not to disclose and how to disclose their HIV status, they do so more readily, and with better consequences.

Voluntary disclosure is associated with the increased likelihood of condom use, risk reduction, and better access to treatment, all of which lead to reduced rates of HIV transmission. Mandated disclosure, meanwhile, can cause genuine harm, and there is no evidence that it reduces HIV transmission rates. Rather, mandating disclosure undermines safer sex messages, by implying that reliance on disclosure, not safer sex practices, constitutes a reliable method of avoiding new disease.

For these reasons, *amici curiae* National Alliance of State and Territorial AIDS Directors, The Center for HIV Law and Policy, and HIV Law Project respectfully request this Court to grant Mr. Rhoades' petition for post-conviction relief.

ARGUMENT

I. Condom Use and Safer Sex are the Cornerstone of Iowa and National Public Health Policy and Practice.

Thirty years into the HIV epidemic, there is clear consensus among medical, scientific, and public health professionals on the four possible routes of HIV transmission:

- 1) by anal or vaginal intercourse, or in rare circumstances by fellatio;
- 2) by sharing infected needles or syringes;
- 3) by mother to child before or during birth or through breast-feeding after birth;
- 4) by exposure to infected blood, transfusions of infected blood, blood products, or organ transplantation in very rare circumstances.⁸

⁸ Ctrs. for Disease Control & Prevention, *Questions and Answers: How is HIV Passed from One Person to Another?* (Mar. 25, 2010) <http://www.cdc.gov/hiv/resources/qa/transmission.htm>; Nat'l. Inst. of Allergy & Infectious Diseases, *HIV Risk Factors* (Mar. 25, 2009), <http://www.niaid.nih.gov/topics/HIVAIDS/Understanding/Pages/riskFactors.aspx> (last visited Jun. 8, 2012); WHO, *HIV/AIDS Factsheet* (Nov. 2011) <http://www.who.int/mediacentre/factsheets/fs360/en/index.html>; Joint United Nations Programme on HIV/AIDS, *HIV Prevention Fast Facts*, available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/brochurepamphlet/2009/20090401_prevention_fast_facts_en.pdf (last visited Jun. 8, 2012).

Anal or vaginal intercourse is by far the most common transmission route for HIV.⁹ Yet with even this type of exposure, and even without condom use or effective ART that reduces viral load, experts agree that HIV transmission rates are much lower than what is generally perceived by the public. The transmission risk for an individual who is the receptive partner of an individual with HIV ranges from a high of 3 in 100 for anal sex to about 3 in 1000 for vaginal sex.¹⁰ A 2011 study developed a mathematical model to quantify individual risks of HIV infection among serodiscordant couples, where one partner is HIV-positive and the other HIV-negative.¹¹ Applying this model to over 70 studies, researchers found that unprotected receptive anal intercourse posed up to a 3% chance of HIV infection, or a three in 100 chance of infection per sexual encounter.¹² Unprotected insertive anal intercourse posed up to about a 0.06% chance of HIV infection, or a six in 10,000 chance of infection.¹³

⁹ Ctrs. for Disease Control & Prevention, *Questions and Answers: How is HIV Passed from One Person to Another?* (Mar. 25, 2010) <http://www.cdc.gov/hiv/resources/qa/transmission.htm>.

¹⁰ J. Fox *et al.*, *Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm*, 25(8) AIDS 1065, 1077 (2011).

¹¹ J. Fox *et al.*, *Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm*, 25(8) AIDS 1065 (2011).

¹² *Id.* at 1077.

¹³ J. Fox *et al.*, *Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm*, 25(8) AIDS 1065 (2011).

Condom use reduces that an already small risk to near zero, which is why condom use during intercourse is widely accepted as a critical element in reducing the risk of HIV transmission. In fact, in a joint position statement released in 2004 and updated in 2009, the United Nations Population Fund (UNFPA), World Health Organization (WHO), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) stated, “The male latex condom is the single, most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections.”¹⁴

The effectiveness of condom use in preventing HIV transmission between serodiscordant couples is well-established.¹⁵ In the case at hand, there is no evidence in the record to establish contact with bodily fluids through which HIV transmission was even possible. Regardless, careful analysis of multiple studies of consistent condom users demonstrates that condom use during penetrative vaginal and anal sex reduces the already very

¹⁴ WHO, *Position Statement: Condoms and HIV 1* (2009), available at http://www.who.int/hiv/pub/condoms/20090318_position_condoms.pdf.

¹⁵ Joint United Nations Programme on HIV/AIDS, *UNAIDS Best Practice Collection: Making condoms work for HIV prevention* 15 (Jun. 2004), available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub06/jc941-cuttingedge_en.pdf (citing S. Weller & K. Davis, *Condom effectiveness in reducing heterosexual HIV transmission*, 1 *Cochrane Database of Systematic Reviews* 1, (2002); S. D. Pinkerton & P. R. Abramson, *Effectiveness of condoms in preventing HIV transmission*, 44(9) *Soc. Sci. Med.* 1303 (1997); K. R. Davis & S. C. Weller, *The effectiveness of condoms in reducing heterosexual transmission of HIV*, 31(6) *Fam. Plan. Perspectives* 272 (Nov.-Dec. 1999); and S. C. Weller, *A meta-analysis of condom effectiveness in reducing sexually transmitted HIV*, 36(12) *Soc. Sci. Med.* 1635 (Jun. 1993)).

low probability of HIV transmission by up to 95%.¹⁶ All of these studies, conducted largely before effective ART was available, make clear that even a lower rate of effectiveness significantly decreases an individual's risk of infection when having sex with someone who is HIV-positive."¹⁷

Oral intercourse carries with it a significantly lower risk of transmission than anal or vaginal intercourse. A 2011 meta-analysis of several studies on HIV transmission in serodiscordant couples between 1988 and 2010 found that HIV infection through receptive oral intercourse is extremely unlikely – at most 0.04%, or a four in 10,000 chance.¹⁸ Many of these studies took place prior to the availability of ART, where transmission was more likely due to higher viral loads.¹⁹

HIV treatment clearly provides yet another mechanism for reduced risk of HIV transmission. In 1994, a United States Public Health Service

¹⁶ Joint United Nations Programme on HIV/AIDS, *UNAIDS Best Practice Collection: Making condoms work for HIV prevention* 15-16 (Jun. 2004), available at http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub06/jc941-cuttingedge_en.pdf.

¹⁷ For example, if the infectivity of unprotected penile-vaginal intercourse is .0001, with even a 90% condom effectiveness rate the infectivity of protected intercourse is .00001, or effectively zero. S. D. Pinkerton & P. R. Abramson, *Effectiveness of condoms in preventing HIV transmission*, 44(9) Soc. Sci. Med. 1303, 1303 (1997). Condoms themselves are increasingly reliable; condom failure, including the breaking or slipping off of the condom during intercourse, has become very uncommon. WHO, *Effectiveness of Male Latex Condoms in Protecting Against Pregnancy and Sexually Transmitted Infections* (Jun. 2000), available at <https://apps.who.int/inf-fs/en/fact243.html>.

¹⁸ J. Fox *et al.*, *Quantifying sexual exposure to HIV within an HIV-serodiscordant relationship: development of an algorithm*, 25(8) AIDS 1065, 1077 (2011).

¹⁹ *Id.*

task force issued recommendations for the use of prenatal Zidovudine²⁰ for HIV infected pregnant women after a clinical trial showed that it could reduce the risk of mother-to-child HIV transmission from 25% to eight percent.²¹ Nine years later in 2004, a CDC study found that with 87% of the HIV-positive women surveyed receiving treatment, perinatal transmission had further decreased to 1.2%.²² Since then, and with the further expansion and remarkable refinement of HIV drug treatments, studies have documented an even more dramatic reduction of transmission risks in sexual relationships. Research now shows the significant, collateral impact of effective ART on transmission risk reduction, leading to broader awareness that treatment *is* prevention. In a 2000 study of over 400 serodiscordant couples, there were no instances of HIV transmission by HIV-positive partners with undetectable viral loads.²³ The study concluded that viral load

²⁰ Zidovudine (ZDV or AZT) is an antiretroviral drug that suppresses viral replication and improves symptoms. WHO, *Essential Medicines: WHO Model List 7* (Mar. 2005), available at http://whqlibdoc.who.int/hq/2005/a87017_eng.pdf.

²¹ Ctrs. for Disease Control & Prevention, *Commentary: Enhanced Perinatal Surveillance – 15 Areas, 2005-2008*, 16(2) HIV Surveillance Report – Supplemental Report, Apr. 2011, at 5, available at http://www.cdc.gov/hiv/surveillance/resources/reports/2010supp_vol16no2/pdf/Enhanced_Perinatal_Surveillance_2005-2008-20110419_01.pdf.

²² Ctrs. For Disease Control & Prevention, *Achievements in Public Health: Reduction of Perinatal Transmission of HIV Infection – United States, 1985-2005*, 55(21) Morbidity & Mortality Wkly. Rep. Surveillance Summaries 592-591 (Jun. 2, 2006), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5521a3.htm>.

²³ Thomas C. Quinn et al., *Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1*, 342 New Eng. J. Med. 921 (Mar. 30, 2000).

is the primary predictor of heterosexual transmission of HIV.²⁴ A 2011 review of seven studies involving serodiscordant couples and ART 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.²⁵ In 2008, four HIV experts on behalf of the Swiss Federal Commission for HIV/AIDS produced a consensus statement resolving that “[a]n HIV-infected person on antiretroviral therapy with completely suppressed viraemia (“effective ART”) is not sexually infectious, i.e. cannot transmit HIV through sexual contact.”²⁶

Consequently, it is completely reasonable from both an individual and public health perspective for HIV-positive individuals to remain sexually active while protecting themselves and their partners from disease risk through condom use, safer sex, and consistent medical care and treatment. The record demonstrates that Mr. Rhoades acted with the intent to protect his partner by preventing his contact with bodily fluids in a manner that could transmit HIV.

²⁴ *Id.*

²⁵ Andrew Anglemyer *et al.*, *Antiretroviral therapy for prevention of HIV transmission in HIV-discordant couples*, 5 Cochrane Database of Systematic Reviews 1, 2 (2011), <http://apps.who.int/whl/reviews/CD009153.pdf>.

²⁶ Edwin J. Bernard, *Swiss experts say individuals with undetectable viral load and no STI cannot transmit HIV during sex*, AIDSmap, Jan. 30, 2008, <http://www.aidsmap.com/page/1429357/>.

Mr. Rhoades adhered to risk reduction and safer sex approaches that are completely consistent with public health standards and counseling provided to those who are HIV-positive and in care.²⁷ He used a condom during intercourse, the most effective means to protect against HIV transmission, and Mr. Plendl was never exposed to Mr. Rhoades' semen. Mr. Rhoades engaged in oral intercourse without ejaculating. His adherence to ART and other regular health care, resulting in his consequent undetectable viral load, effectively reduced an already infinitesimally small transmission risk to zero or near zero. Under these circumstances, there is no basis for a finding that Mr. Rhoades acted with intent to expose his sexual partner to bodily fluids in a way that can result in HIV transmission. To the contrary, all evidence suggests that Mr. Rhoades' intent was precisely the opposite, that is, to avoid exposing Mr. Plendl to any bodily fluids in any way that posed a transmission risk.

II. State of Iowa Policy and Federal HIV Prevention Priorities Reflect the Fact that Mandatory Disclosure is Inconsistent with Both Long-Standing Public Health Policy and with the Realities of Individual Lives That Inform That Policy

²⁷ Ctrs. for Disease Control & Prevention, *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, 52(RR12) Morbidity & Mortality Wkly. Rep. 1 (Jul. 18, 2003), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>.

A. State of Iowa Policy Protects HIV-Related Confidentiality and Relies on Voluntary Disclosure by Individuals Living with HIV

Iowa Code Section 709C.1, by its very terms, contemplates that an HIV-positive person may engage in safer sex that does not intentionally expose a partner to HIV without disclosing his/her HIV status. By limiting criminal liability to conduct pursued with the intent to expose another to bodily fluids in a manner that can transmit HIV, and allowing the affirmative defense of disclosure and consent in those instances, the statute effectively allows an individual with HIV to choose non-exposing, safer sex in the absence of disclosure without incurring criminal liability. This is consistent not only with broadly held public health policies and practices, but with the realities of individual lives. Rather than prohibit sexual intimacy on the basis of a disability, such as HIV, Iowa allows sexual intimacy without disclosure in the numerous, complex personal circumstances in which disclosure would pose physical, emotional, or economic risk to an individual with HIV or their loved ones.

Iowa's Health Related Activities law includes a voluntary partner notification program for people who test positive for HIV. Under the law, health care providers "shall be encouraged to refer for counseling and HIV

testing any person with whom the person has had sexual relations or has shared drug injecting equipment.”²⁸ In furtherance of this law, and pursuant to guidance from the Centers for Disease Control and Prevention (CDC), the Iowa Department of Public Health implemented a Partner Counseling and Referral Services (PCRS) program to aid people living with HIV in informing partners.²⁹ The program encourages voluntary disclosure of HIV status and provides counseling to partners on how to avoid infection or, if already infected, on how to reduce risks of further transmission.³⁰ PCRS in Iowa is particularly useful in helping people with HIV to disclose their status to partners with an anticipated violent or abusive reaction.³¹ In addition, the Iowa Department of Public Health emphasizes the importance of offering training and guidance to help people with HIV disclose their status to their partners.³²

***B. Federal Public Health and HIV Prevention Policy
Encourages Safe, Voluntary Disclosure by Individuals
with HIV***

²⁸ Iowa Code § 141A.5 (2011).

²⁹ Iowa Dept. of Pub. Health, *Iowa Comprehensive HIV Plan 2007-2009* 11-33, available at <http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=56BFE770-95BC-4A91-A75F-DE58CD860BA0>.

³⁰ *Id.*

³¹ *Id.*

³² Iowa Dept. of Pub. Health, *Iowa Comprehensive HIV Plan 2007-2009* 11-77, 11-89, available at <http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=56BFE770-95BC-4A91-A75F-DE58CD860BA0>.

The CDC also stresses voluntary partner notification and counseling in transmission reduction.³³ This public health initiative encourages HIV-positive people to seek counseling on how to notify partners about their seropositive status.³⁴

The National HIV/AIDS Strategy (NHAS) is this country's first comprehensive plan to address the HIV epidemic. The NHAS has three primary goals: 1) reducing the number of new infections; 2) increasing access to care and optimizing health outcomes for people living with HIV; and 3) reducing HIV-related health disparities. The NHAS identifies fighting stigma and discrimination as a key component of reducing HIV transmission and toward this end explicitly cites the harmful effects of mandatory disclosure.³⁵ Recognizing that the ability to control when and how an HIV-positive individual discloses her/his 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. That sense of safety, and the

³³ Ctrs. for Disease Control and Prevention, *HIV Partner Counseling and Referral Services* (Jan. 22, 2007), available at http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/Interim_partnercounsel.htm.

³⁴ *Id.*

³⁵ National HIV/AIDS Strategy for the United States, 35-36 (Jul. 2010), available at <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>.

diagnosis and entry into care that it facilitates, is an essential factor in reducing new infections.³⁶

C. Mandatory Disclosure Places Individuals at Risk of Harm Without Advancing Legitimate Public Health Goals.

The foundation of state and federal policies discussed above is the recognition that when HIV-positive people feel empowered to decide for themselves whether or not to disclose and how to disclose their HIV status, they do so more readily and with better consequences.³⁷ Voluntary disclosure is associated with increased likelihood of using condoms and

³⁶ National HIV/AIDS Strategy for the United States, 36 (Jul. 2010), available at <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>.

³⁷ Joint United Nations Programme on HIV/AIDS & WHO, *Opening up the HIV/AIDS epidemic: Guidance on encouraging beneficial disclosure, ethical Partner counselling & appropriate use of HIV case-reporting* 19 (Nov. 2000), available at <http://www.who.int/hiv/pub/vct/en/Opening-E%5b1%5d.pdf>.

decreased likelihood of acquiring new sexual partners.³⁸ While there is evidence that mandatory disclosure³⁹ results in disincentives to seek counseling, voluntary disclosure is associated with fewer mental health symptoms related to HIV, including a decline in anxiety and depression.⁴⁰

Mandatory disclosure plays an extremely limited role in state and federal policy because it can cause genuine harm and there is no evidence that it reduces HIV transmission. In fact, reliance on mandatory disclosure might actually encourage behavior that increases the likelihood of infection.

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 who are in fact HIV-infected but test

³⁸ 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). See also T. Hoxworth *et al.*, *Changes in Partnerships and HIV Risk Behaviors After Partner Notification*, 30(1) *Sexually Transmitted Diseases* 83 (Jan. 2003).

³⁹ By "mandatory disclosure," we mean the requirement of an HIV-positive individual to disclose his or her positive status to a sexual partner prior to sexual contact, with failure to disclose being punishable by law. This term is distinguished from "voluntary disclosure," which refers to the free sharing of HIV-positive status with a sexual partner or partners where failure to disclose is not punishable by law.

⁴⁰ WHO, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes* 17 (2004), available at <http://www.who.int/gender/documents/en/genderdimensions.pdf>. See also R. Hays *et al.*, *Disclosing HIV Seropositivity to Significant Others*, 7 *AIDS* 425 (Mar. 1993).

negative on an antibody test, the assumption that all sex is therefore safe is both unfounded and unwise.⁴¹

Many people with HIV are unaware of their seropositive status. The CDC estimates that roughly 25% of HIV-positive people are unaware of their infection and that these 25% account for about 70% of new infections.⁴² Even if an individual does get tested for HIV, those who have been recently infected will not have sufficient antibody in their systems for test detection; there is a “window period” after exposure in which a newly infected individual will have a negative test result.⁴³ During this period, an individual is both unaware of the fact of HIV infection and at his or her most infectious.⁴⁴ Consequently, the failure of sex partners to take precautions through condom use and low-risk contact such as oral sex on the basis of what is and isn’t disclosed prior to sex is a major driver of the HIV epidemic.

⁴¹ 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). 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).

⁴² 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).

⁴³ Ctrs. for Disease Control & Prevention, *Basic Information about HIV and AIDS* (Apr. 11, 2012), available at <http://www.cdc.gov/hiv/topics/basic/>.

⁴⁴ Ctrs. for Disease Control & Prevention, *Basic Information about HIV and AIDS* (Apr. 11, 2012), available at <http://www.cdc.gov/hiv/topics/basic/>. Evidence shows that the virus may be up to 10 times more infectious and easily transmitted during this window period. 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).

Disagreement about whether disclosure has taken place and whether sexual risk was discussed is common among sexual partners. A recent CDC study that surveyed 855 heterosexual women and their partners, all identified as being at heightened risk for HIV, found that nearly half (44%) of couples disagreed about whether or not they had discussed their HIV status.⁴⁵ This disagreement may be in part because discussion of sexual risk and disease status is complex and can involve non-verbal elements and many unspoken assumptions. Research documents that many individuals substitute certain environmental “clues” for actual disclosure. For example, some people assume that leaving ART medication bottles visible in their home is a sufficient substitute for verbal disclosure.⁴⁶

Regardless of expectations for disclosure prior to 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.⁴⁷ Nondisclosure is likely owing to a

⁴⁵ 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, N.M. (Sept. 12-15, 2011).

⁴⁶ 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).

⁴⁷ 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).

variety of factors. Denial of HIV status among the newly diagnosed⁴⁸ is a common psychological defense mechanism in the face of serious or stigmatized illness.⁴⁹ In addition, many HIV-positive individuals fear the stigma and discrimination in various aspects of their lives that could result from disclosure.⁵⁰ That fear, even in current times, is well-founded.⁵¹ Anticipation of stigmatizing responses from health care and service providers leads to reduced health-seeking behavior among people with HIV.⁵²

Individual consequences of involuntary disclosure, under circumstances that can create physical, emotional, or economic risk, can

⁴⁸ J. B. von Ornsteiner, *D for "Diagnosis" or for "Denial"? Coming to Grips with Being Newly Diagnosed*, *Body Positive* (Oct. 2001), available at <http://www.thebody.com/content/art30530.html>.

⁴⁹ R. Goldbeck, *Denial in Physical Illness*, 43(6) *J. Psychosomatic Res.* 575 (Dec. 1997).

⁵⁰ WHO, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes* 12-13 (2004), available at <http://www.who.int/gender/documents/en/genderdimensions.pdf>. 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).

⁵¹ See, e.g., *Doe v. Deer Mountain Day Camp Inc.*, 682 F.Supp.2d 324 (S.D.N.Y. 2010) (where youth was denied admission to basketball academy in violation of the Americans with Disabilities Act on the basis of his infection with Human Immunodeficiency Virus); See also, Todd Heywood, *Detroit Man Alleges HIV Discrimination By Lysol-Spraying Dental Clinic Coworkers*, *POZ*, Dec. 8, 2011, available at http://www.poz.com/articles/detroit_hiv_lysol_401_21587.shtml (where, after revealing HIV positive status to manager, Detroit man was prohibited from touching office doorknobs, followed by coworkers who cleaned surfaces he touched with Lysol, and fired for excessive unexcused absences after being hospitalized for a week); See also, Michael Martinez & Chuck Johnston, *Student with HIV Sues Private Residential School for Denied Admission*, *CNN*, Dec. 1, 2011, http://articles.cnn.com/2011-12-01/us/us_pennsylvania-hiv-hershey-school_1_hiv-milton-hershey-school-middle-school?_s=PM:US (where thirteen year old boy alleged denial of admission in violation of Americans with Disabilities Act because of his HIV status).

⁵² 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, 458 (Sept. 2006). 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). See also, R. O. Valdiserri, *HIV/AIDS stigma: An Impediment to Public Health*, 92(3) *Am. J. of Pub. Health* 341 (Mar. 2002).

include lower adherence to treatment, leading in turn to lower CD4 counts and greater infectiousness and thus higher risk of transmission.⁵³ Negative responses to disclosure, including increased suspicion of the HIV-positive person's lifestyle, can lead to exacerbation of anxiety, anger, and depression.⁵⁴ Voluntary disclosure, on the other hand, may result in improved social support networks and better access to treatment,⁵⁵ 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 with HIV. HIV disclosure mandates that eliminate an HIV-positive person's control of the time and place of disclosure aggravate the profound mental distress associated with this fear. Women with HIV mention fear of violence as a significant barrier to disclosure in one quarter of all studies on the relationship between disclosure and violence.⁵⁶ This fear is borne of experience; many women have reported abuse and violence as a direct result

⁵³ 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).

⁵⁴ G. M. Herek, *Illness, Stigma, and AIDS*, in *Psychological Aspects of Serious Illness* 103, 120 (P. Costa & G.R. VandenBos eds.1990).

⁵⁵ WHO, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes* 17 (2004), available at <http://www.who.int/gender/documents/en/genderdimensions.pdf>.

⁵⁶ WHO, *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes* 13 (2004), available at <http://www.who.int/gender/documents/en/genderdimensions.pdf>. In a study in Baltimore, 12% of women surveyed identified fear of abuse as a deterrent to disclosure of HIV status. 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).

of disclosure of HIV status.⁵⁷ 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 STI and HIV prevention, only the practice of safer sex, and especially the use of condoms, can protect sexually active persons from infection with HIV and other disease. State and federal public health policies hinge HIV prevention efforts on consistent condom use and other risk reduction measures. Overemphasis on disclosure would undermine this message by implying that reliance on disclosure, not condom use, is a reliable method of avoiding new disease.⁵⁸

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 HIV prevention campaigns. It also

⁵⁷ 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).

⁵⁸ 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, 455 (Sept. 2006).

inaccurately, and cruelly, would suggest that those living with HIV are simply too toxic for meaningful adult intimacy.⁵⁹

CONCLUSION

For the foregoing reasons, *amici curiae* National Alliance of State and Territorial AIDS Directors, The Center for HIV Law and Policy, and HIV Law Project respectfully request this Court to grant Mr. Rhoades' petition for post-conviction relief.

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⁵⁹ Joint United Nations Programme on HIV/AIDS, *The Criminalisation of HIV Non-Disclosure Exposure and Transmission: Background and Current Landscape: Prepared as Background for the Meeting on the Scientific, Medical, Legal and Human Rights of the Criminalisation of HIV Non-disclosure, Exposure and Transmission* 23, in Geneva, Switz. (Aug. 31-Sept. 2, 2011).

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PROOF OF SERVICE AND CERTIFICATE OF FILING

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