THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

HIV Transmission Science and Practice

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RULES OF HIV TRANSMISSION

- THERE ARE **THREE** (AND ONLY THREE) ROUTES OF HIV TRANSMISSION

  -**BLOOD** and blood products

  -**SEXUAL** mucosal contact, including penile-vaginal contact, anal contact, and possibly fellatio

  -**VERTICAL** transmission from mother to child pre- or peri-natal

Transmission of HIV
Biological Requirements

Infectious → **Susceptibility**

Inoculum (concentration)

Characteristics of the virus

Hereditary resistance

Innate resistance

Acquired (immune) resistance

Amplified Transmission of HIV

Infectiousness

- Blood Viral Load
- Inflammatory STDs
- Acute Infection
- Genital Tract Viral Load

Susceptibility

- Genital ulcers
- Inflammatory STDs
- Lack of Circumcision
- Cervical ectopy
- Genetics

Average risk and individual risk of HIV transmission

Average risk can be assessed reasonably confidently from studies of large numbers of people but cannot be used to confirm individual risk because risk of HIV transmission is influenced by factors such as:

- type of sexual activity (vaginal, anal, oral, other)
- roles during penetrative sex: insertive vs receptive
- amount of HIV in the bodily fluid to which the at-risk person is exposed
- whether or not a male or female condom has been used correctly and consistently
- presence or absence of other sexually transmitted infections (STIs) in both partners
- whether or not the penis of the potentially exposed male partner has been circumcised

Quantifying risk of acquiring HIV in a sex act

- A single value for the heterosexual infectivity of HIV-1 fails to reflect the variation associated with important cofactors.
  - commonly cited value 1 in 1000 risk per act is based on very heterogeneous estimates, ranging from zero transmissions after more than 100 penile-vaginal contacts to one transmission for every 3.1 episodes of heterosexual anal intercourse
- The value of 1 per 1000 was estimated among stable couples with low prevalence of high-risk cofactors and represents a lower bound
- Cofactor effects are important to include in epidemic models, policy considerations, and prevention messages
- Examples of infectivity differences per 1000 contacts:
  - 8.1 (95 % CI 0·4–15·8) more for uncircumcised versus circumcised men
  - 6.0 (3.3–8.8) more for individuals with genital ulcer disease
  - 1.9 (0.9–2.8) comparing late-stage to mid-stage index cases
  - 2.5 (0.2–4.9) comparing early-stage to mid-stage index cases

Source: KA Powers et al. Lancet Inf Dis 2008

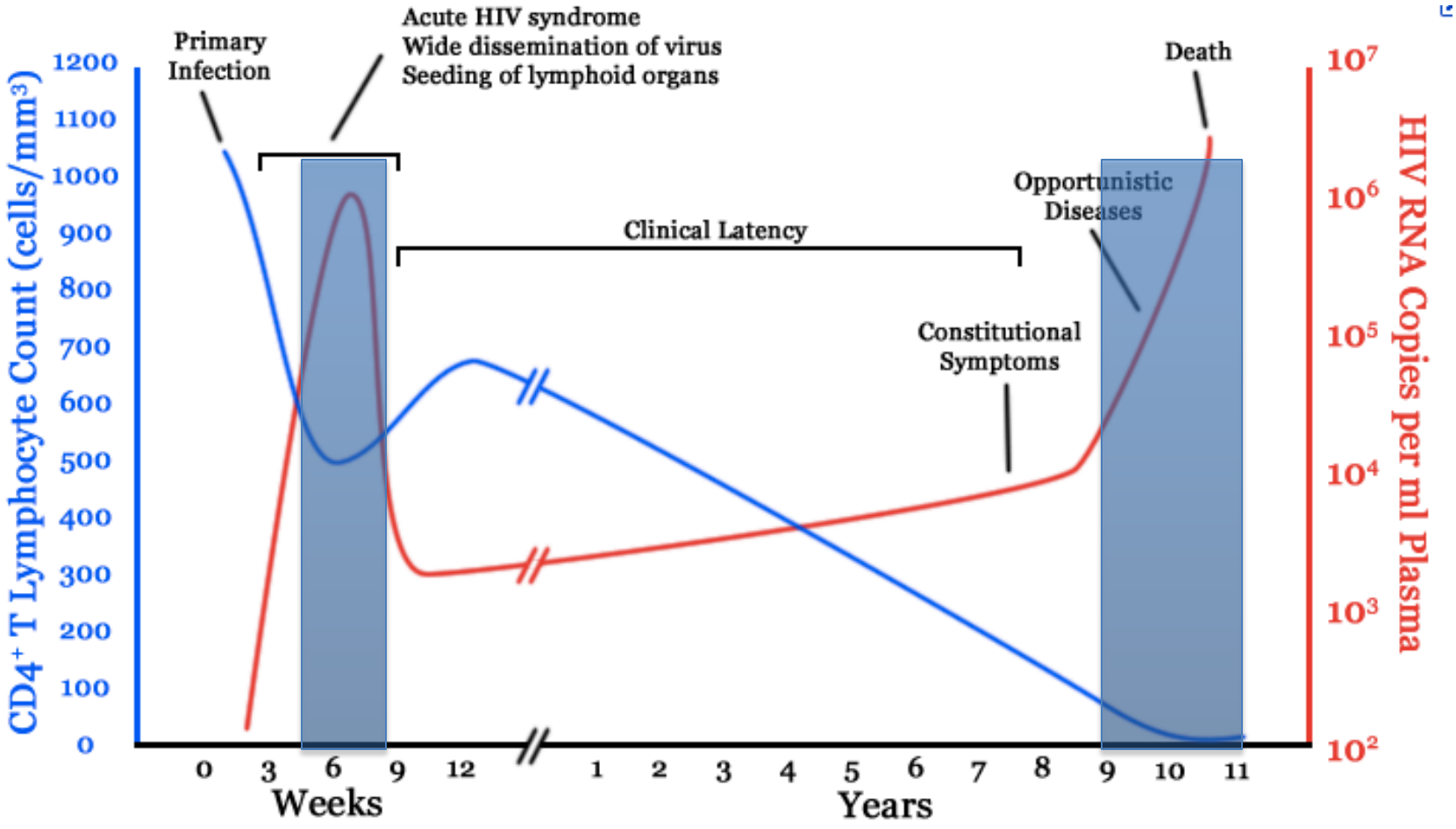
Risk of HIV transmission per act

(in the absence of antiretroviral drugs)

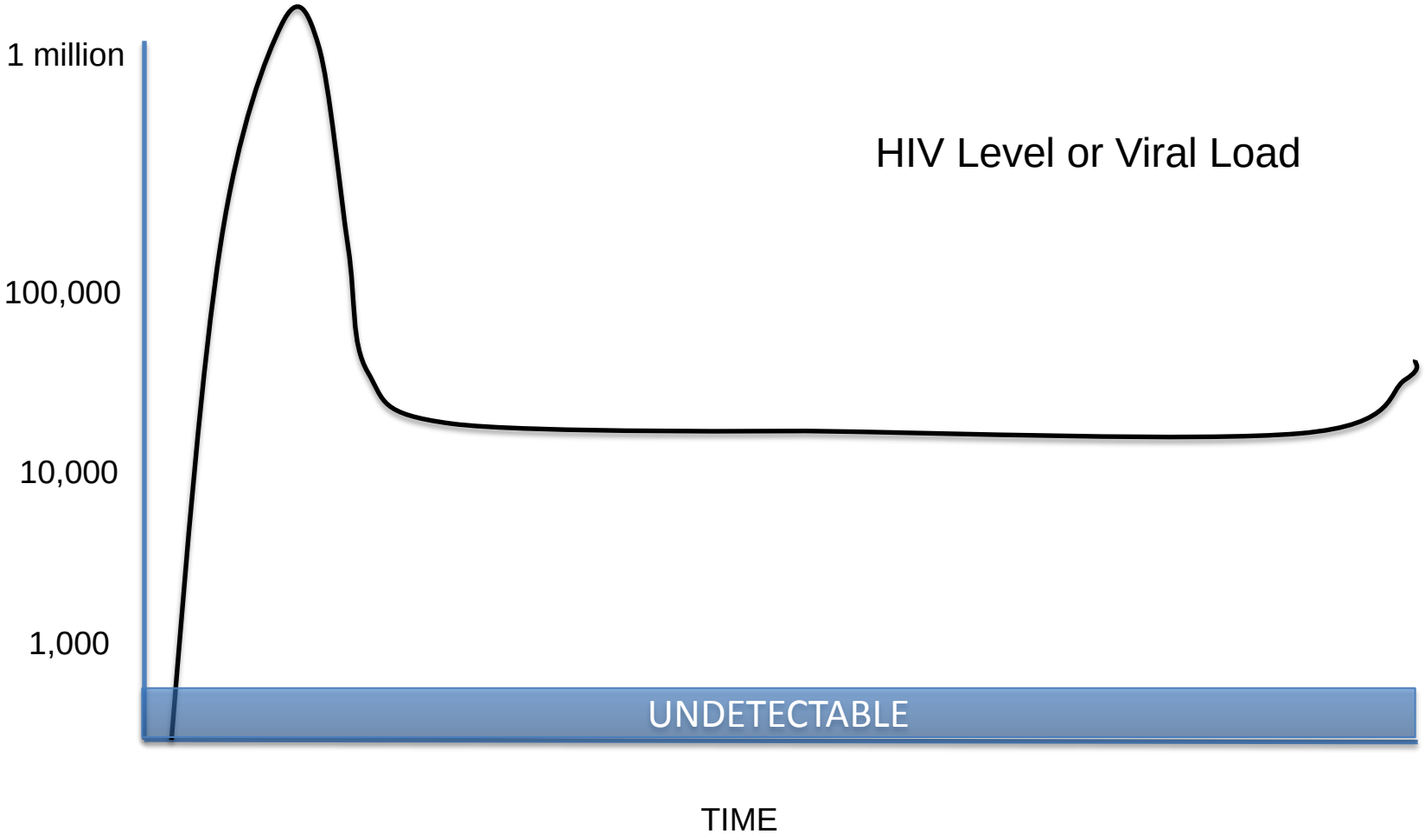
- Receptive anal sex: 1.7% [95% CI 0.3-8.9] 1 in 70
- Early HIV infection: 9.2 times [4.5-18.8] asymptomatic phase
- Late HIV infection: 7.3 times [4.5-11.9] asymptomatic phase
- Presence or history of genital ulcers in either person increases per-act risk 5.3 times [1.4-19.5]
- Estimates for acquisition among non-circumcised men at least double circumcised

Source: Boily et al. Lancet Infect Dis 9: 118-29 2009

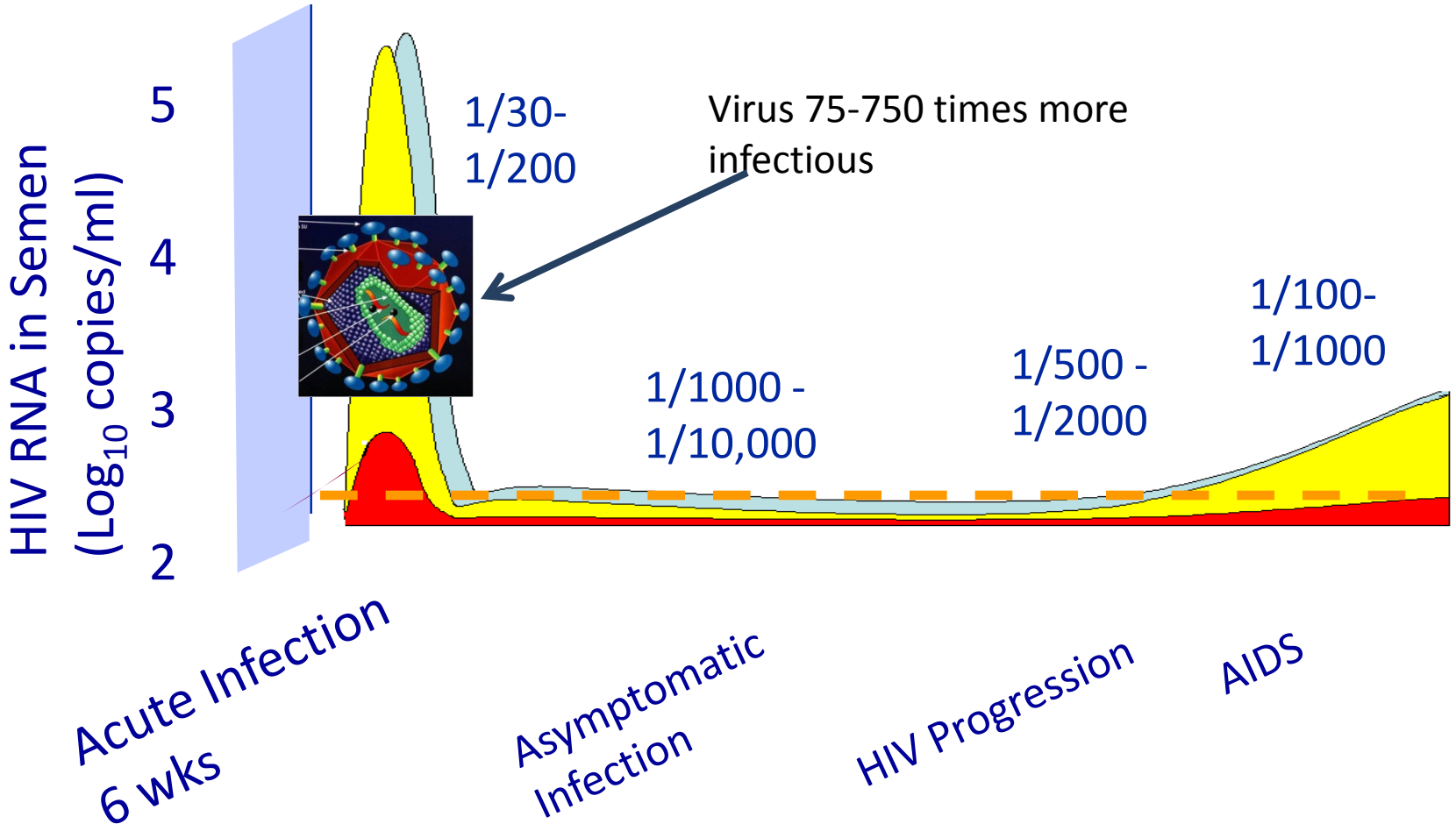
Timing Matters



Viral Load Matters

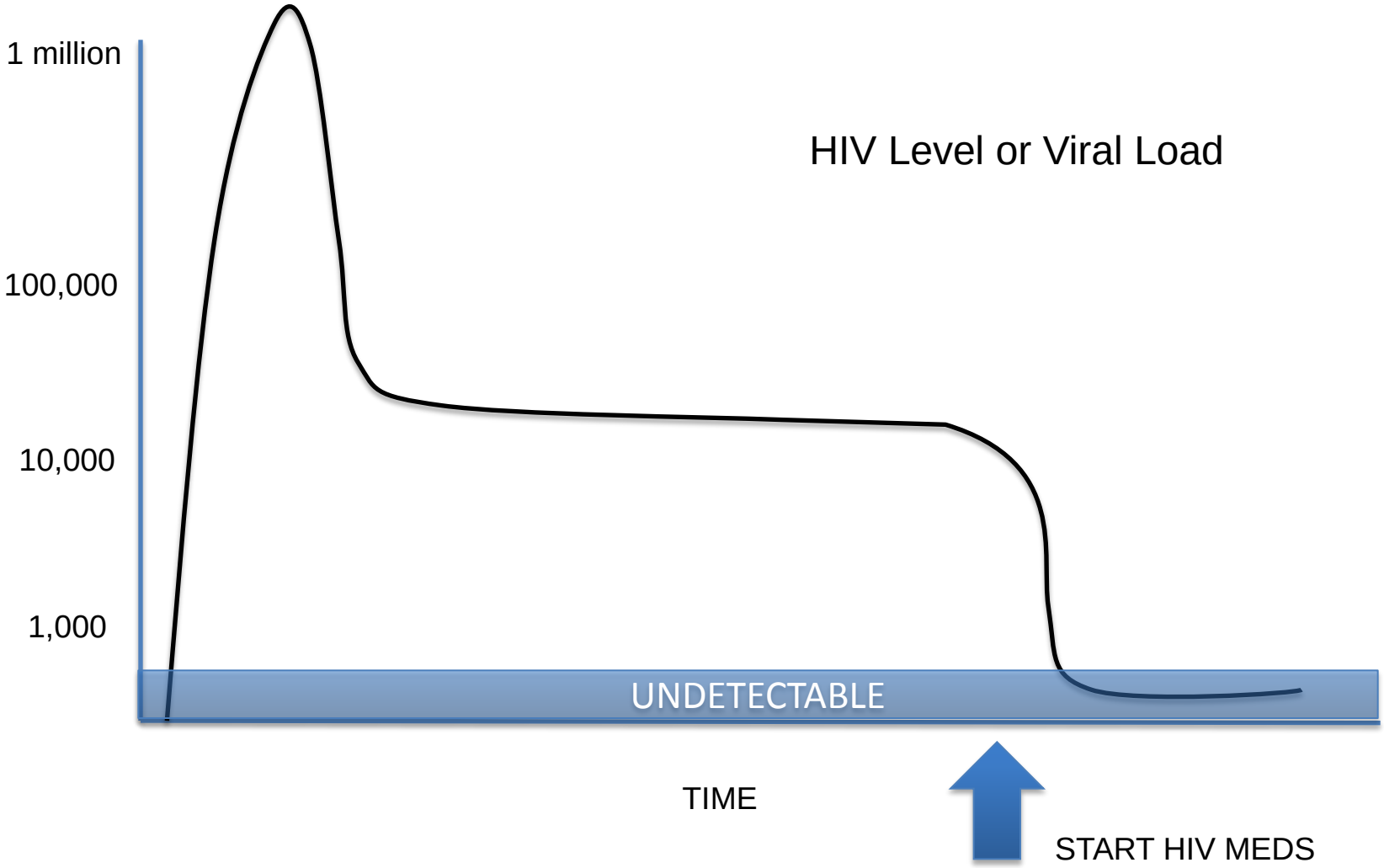


Increased Risk of Sexual Transmission of HIV



Cohen & Pilcher, J Infect Dis. 2005

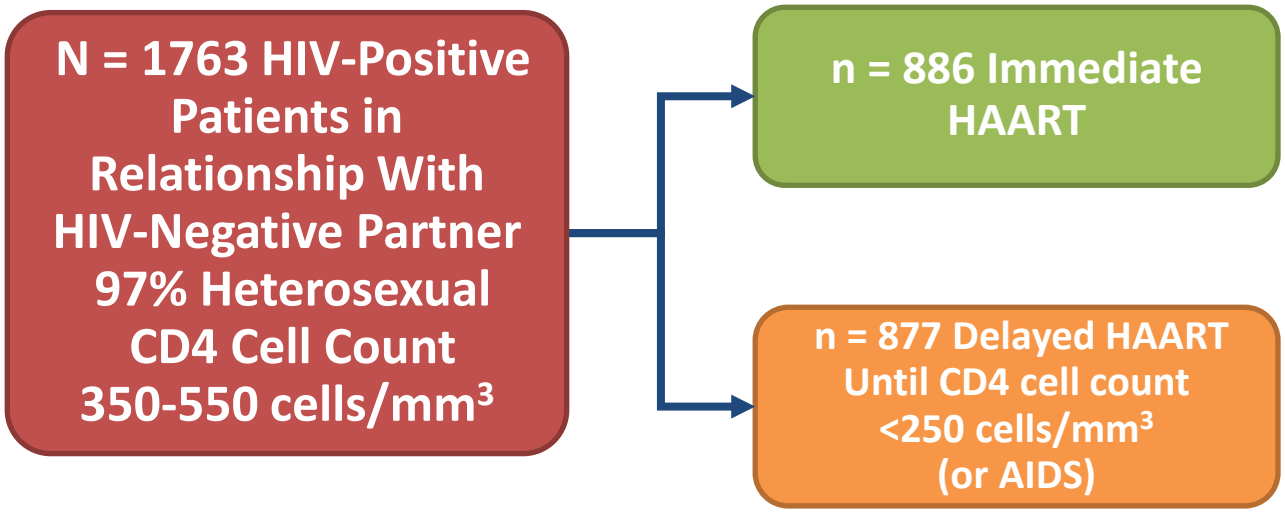
Viral Load Matters



US Federally Sponsored study - HPTN 052: HIV Treatment is HIV Prevention

Randomized, placebo-controlled efficacy and safety study

13 sites in Africa, Asia, and the Americas

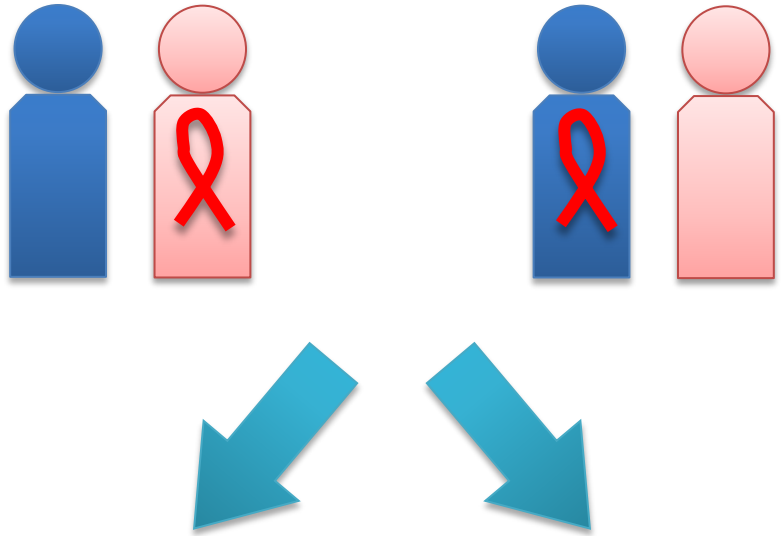


- All patients received ongoing safer-sex education/condoms
- Study stopped 4 years early by DSMB (May 2011)

Cohen MS, et al. N Engl J Med. 2016;375:830-839.

DSMB, Data and Safety Monitoring Board; HAART, highly active antiretroviral therapy; HPTN, HIV Prevention Trials Network.
http://www.hptn.org/web%20documents/PressReleases/HPTN052PressReleaseFINAL5_12_118am.pdf

HPTN 052 asked, how well do ARVs prevent transmission, if at all?



886

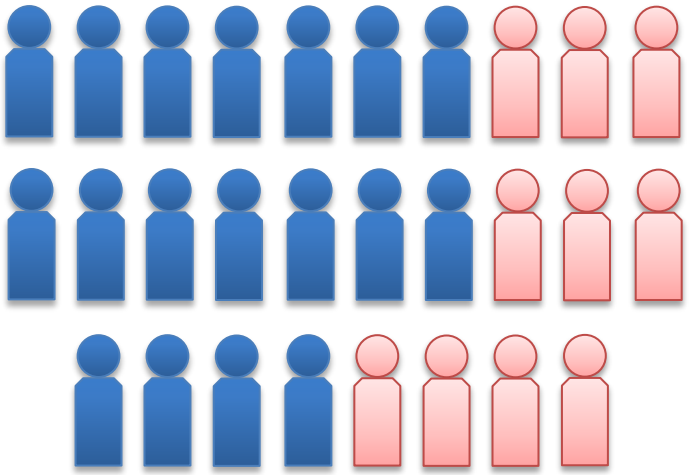
immediate start
(350-500)

877

delayed start
(≤ 250)

Cohen MS, et al. N Engl J Med. 2011 Aug 11;365(6):493-505.

HPTN 052

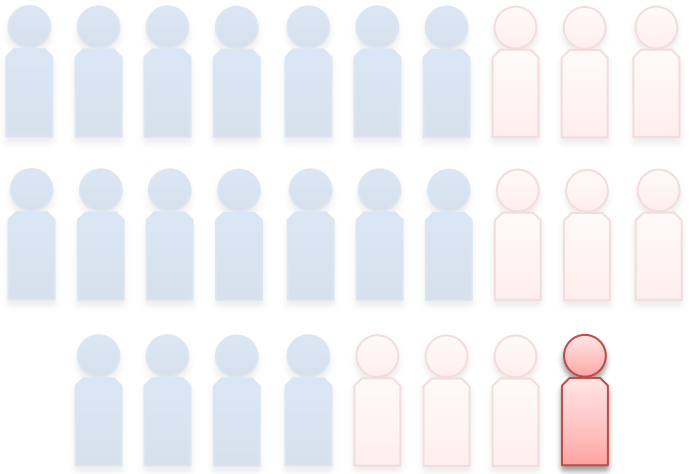


28

linked transmissions

Cohen MS, et al. N Engl J Med. 2011 Aug 11;365(6):493-505.

HPTN 052

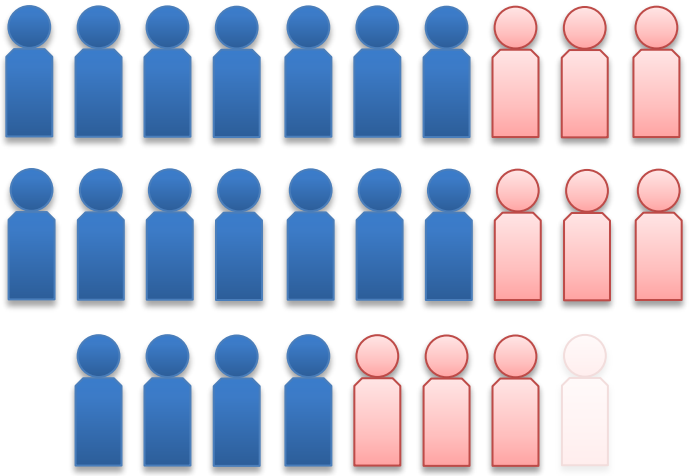


1

from immediate group

Cohen MS, et al. N Engl J Med. 2011 Aug 11;365(6):493-505.

HPTN 052



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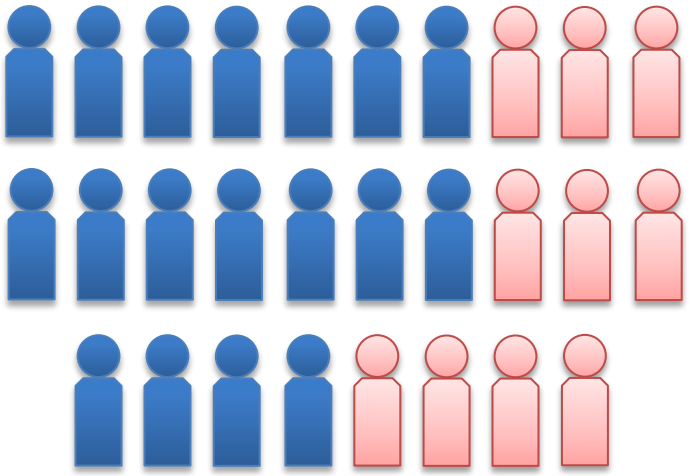
from the delayed group

Cohen MS, et al. N Engl J Med. 2011 Aug 11;365(6):493-505.

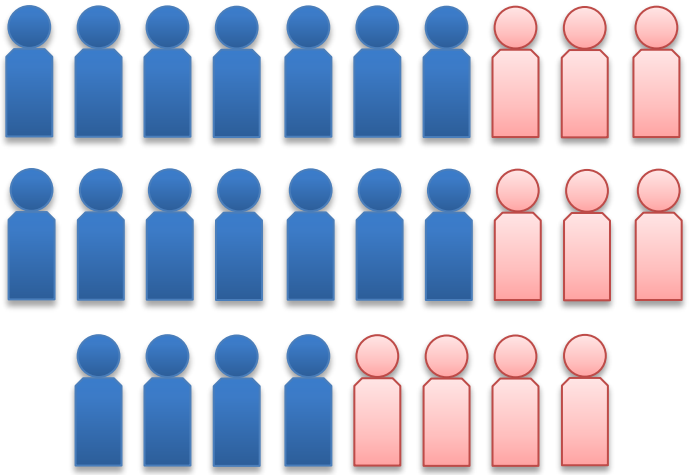
HPTN 052



96%

reduced risk of transmission
if you treat the HIV+ partner

HPTN 052 proved that treatment has a clear public health benefit

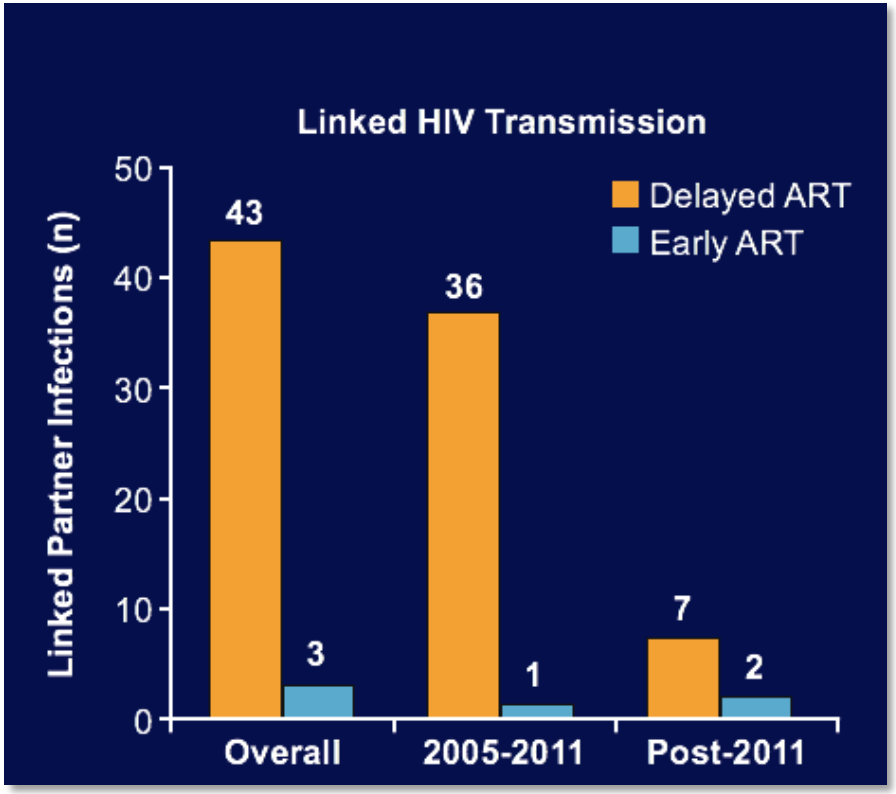


96%

reduced risk of transmission
if you treat the HIV+ partner

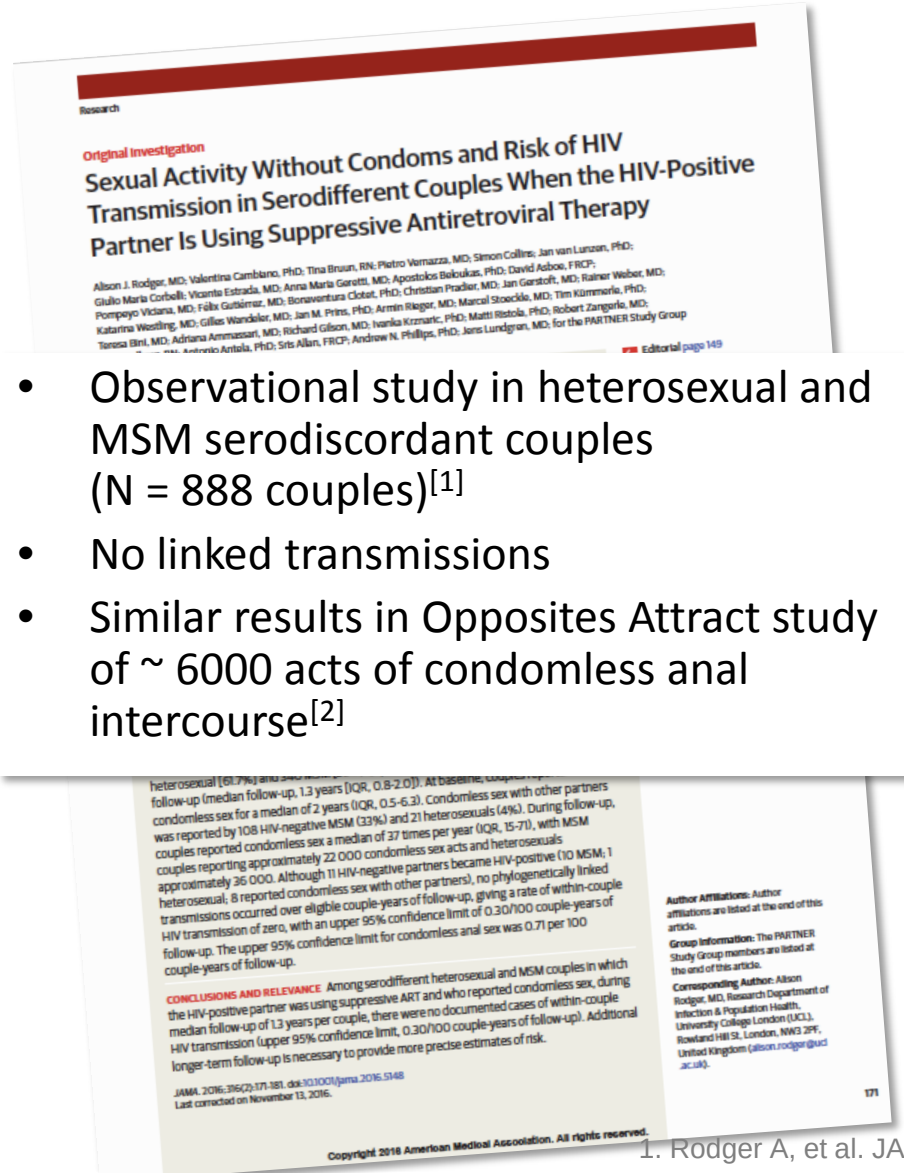
HPTN 052: Follow-Up Key Results

- N = 46 linked HIV transmissions to HIV-negative partner observed
  - Overall 93% reduction in risk of transmission with early therapy
- N = 8 linked partner infections diagnosed after index partner started ART
  - Recently initiated ART (n = 4)
  - Virologic failure (n = 4)
- No linked HIV transmissions where index partner suppressed on ART
- Rate of unlinked infections similar between arms



Cohen MS, et al. N Engl J Med. 2016;375:830-839.

PARTNER Study: Risk of HIV Transmission With Condomless Sex on Suppressive ART


Research

Original Investigation

Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy

Alison J. Rodger, MD; Valentina Cambiano, PhD; Tina Bruun, RN; Pietro Vernazza, MD; Simon Collins; Jan van Lunzen, PhD; Giulio Maria Corbelli; Vicente Estrada, MD; Anna Maria Geretti, MD; Apostolos Beloukas, PhD; David Asboe, FRCP; Pompeyo Viciana, MD; Félix Gutiérrez, MD; Bonaventura Clotet, PhD; Christian Pradier, MD; Jan Gerstoft, MD; Rainer Weber, MD; Katarina Westling, MD; Gilles Wandeler, MD; Jan M. Prins, PhD; Armin Rieger, MD; Marcel Stoeckle, MD; Tim Kümmerle, PhD; Teresa Bini, MD; Adriana Ammassari, MD; Richard Gilson, MD; Ivanka Krznaric, PhD; Matti Ristola, PhD; Robert Zangerle, MD; Antonio Antela, PhD; Sris Allan, FRCP; Andrew N. Phillips, PhD; Jens Lundgren, MD; for the PARTNER Study Group

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heterosexual [61.7%] and ... follow-up (median follow-up, 1.3 years [IQR, 0.8-2.0]). At baseline, ... condomless sex for a median of 2 years (IQR, 0.5-6.3). Condomless sex with other partners was reported by 108 HIV-negative MSM (33%) and 21 heterosexuals (4%). During follow-up, couples reported condomless sex a median of 37 times per year (IQR, 15-71), with MSM couples reporting approximately 22 000 condomless sex acts and heterosexuals approximately 36 000. Although 11 HIV-negative partners became HIV-positive (10 MSM; 1 heterosexual; 8 reported condomless sex with other partners), no phylogenetically linked transmissions occurred over eligible couple-years of follow-up, giving a rate of within-couple HIV transmission of zero, with an upper 95% confidence limit of 0.30/100 couple-years of follow-up. The upper 95% confidence limit for condomless anal sex was 0.71 per 100 couple-years of follow-up.

CONCLUSIONS AND RELEVANCE Among serodifferent heterosexual and MSM couples in which the HIV-positive partner was using suppressive ART and who reported condomless sex, during median follow-up of 1.3 years per couple, there were no documented cases of within-couple HIV transmission (upper 95% confidence limit, 0.30/100 couple-years of follow-up). Additional longer-term follow-up is necessary to provide more precise estimates of risk.

JAMA. 2016;316(2):171-181. doi:10.1001/jama.2016.5148
Last corrected on November 13, 2016.

Author Affiliations: Author affiliations are listed at the end of this article.

Group Information: The PARTNER Study Group members are listed at the end of this article.

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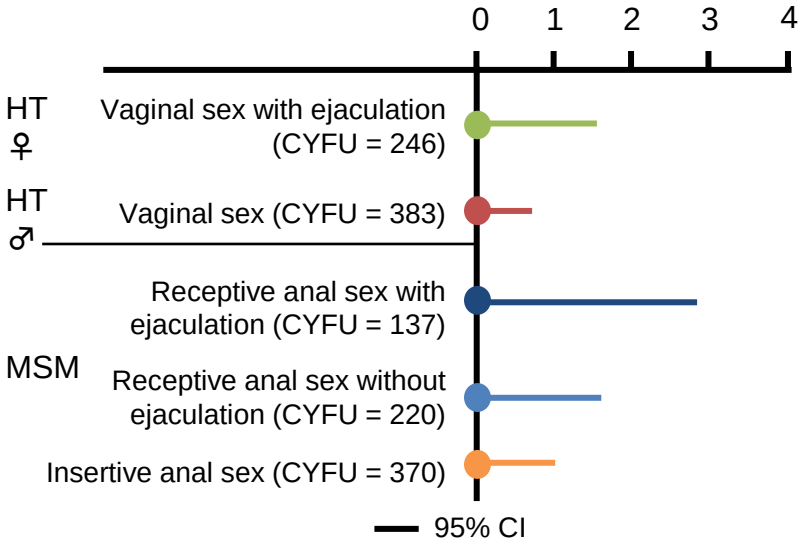
- Observational study in heterosexual and MSM serodiscordant couples (N = 888 couples)[1]
- No linked transmissions
- Similar results in Opposites Attract study of ~ 6000 acts of condomless anal intercourse[2]

PARTNER: Rate of Within-Couple Transmission Events/100 CYFU, % (95% CI)*[1]



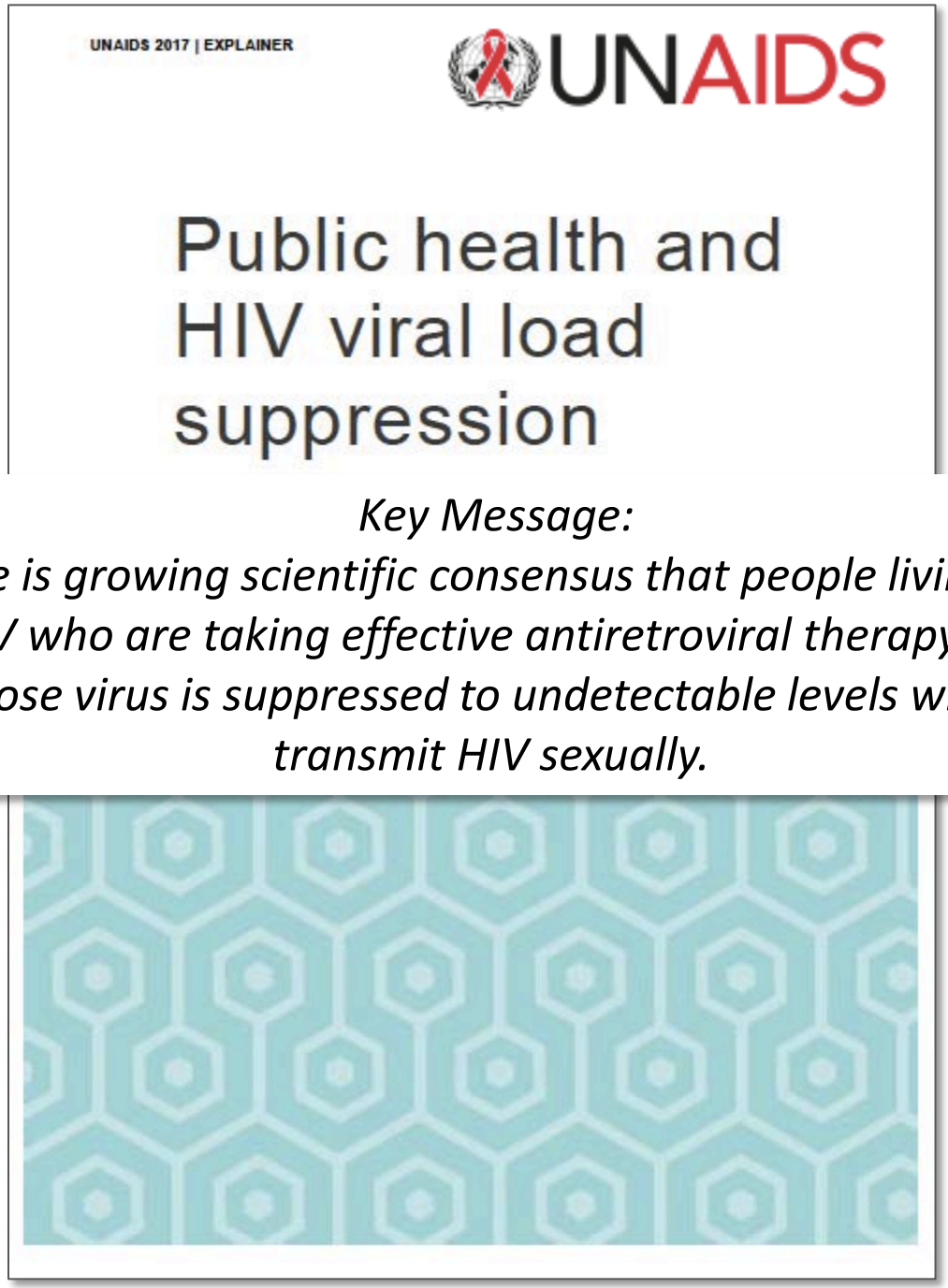
*Median follow-up: 1.3 yrs; ~ 58,000 sex acts

1. Rodger A, et al. JAMA. 2016;316:171-181. 2. Grulich A, et al. CROI 2015. Abstract 1019LB.

Opposites Attract: PrEP in Serodiscordant MSM Couples

- International, prospective cohort study assessing the incidence of linked HIV transmission in serodiscordant MSM couples when HIV-infected partner on ART and virologically suppressed
  - N = 343 couples; 591 CYFU; 16,889 acts of CLAI
- For HIV-infected partner, HIV-1 RNA undetectable for 95% of CYFU; for uninfected partner, PrEP use for 19% of CYFU
- No linked infections; 3 infections occurring during study contracted from outside partners

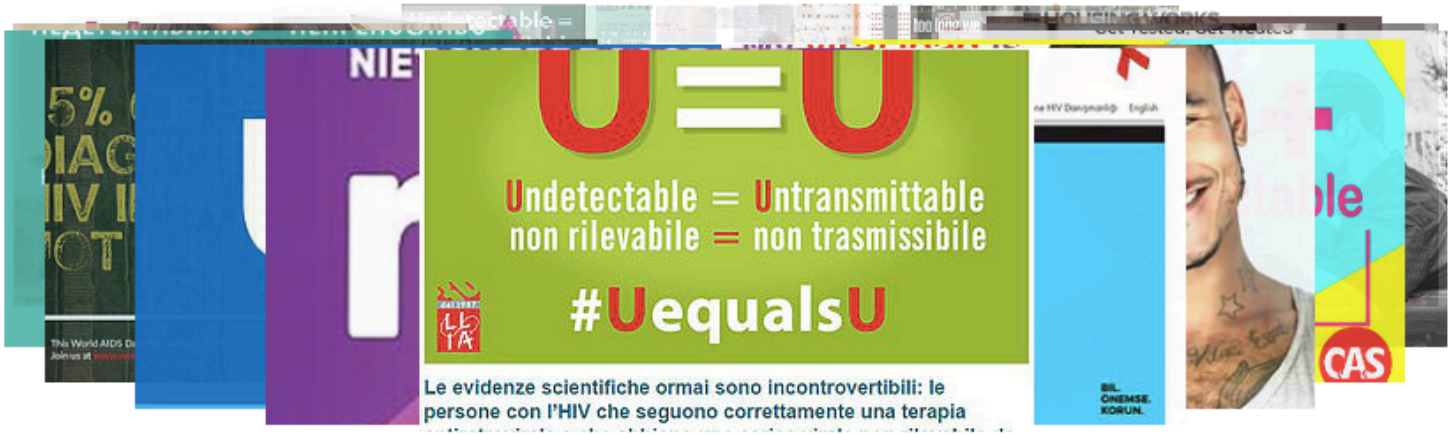
Bavinton BR, et al. IAS 2017. Abstract TUAC0506LB.



Key Message:

There is growing scientific consensus that people living with HIV who are taking effective antiretroviral therapy and whose virus is suppressed to undetectable levels will not transmit HIV sexually.

Undetectable = Untransmittable

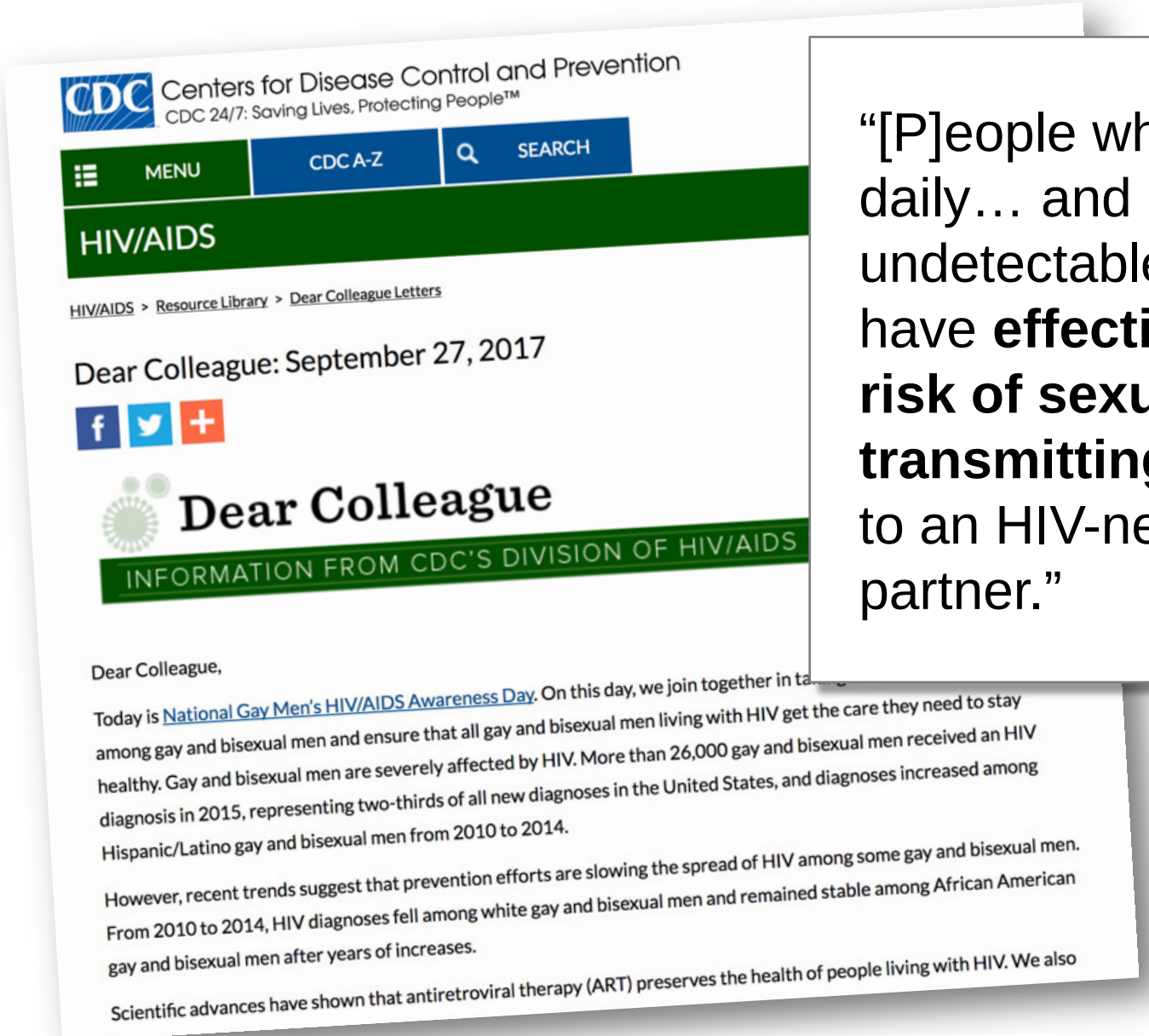


Click on the photos to scroll through examples of Community Partner U=U campaigns.
For an extensive list of U=U messaging from around the world see our U=U Message Guide.

#UequalsU

The U.S. Centers for Disease Control and Prevention (CDC) "Dear Colleague" letter confirms that "people who take ART daily as prescribed and achieve and maintain an undetectable viral load have **effectively no risk** of sexually transmitting the virus to an HIV-negative partner." (September, 2017)

CDC on board with U=U?

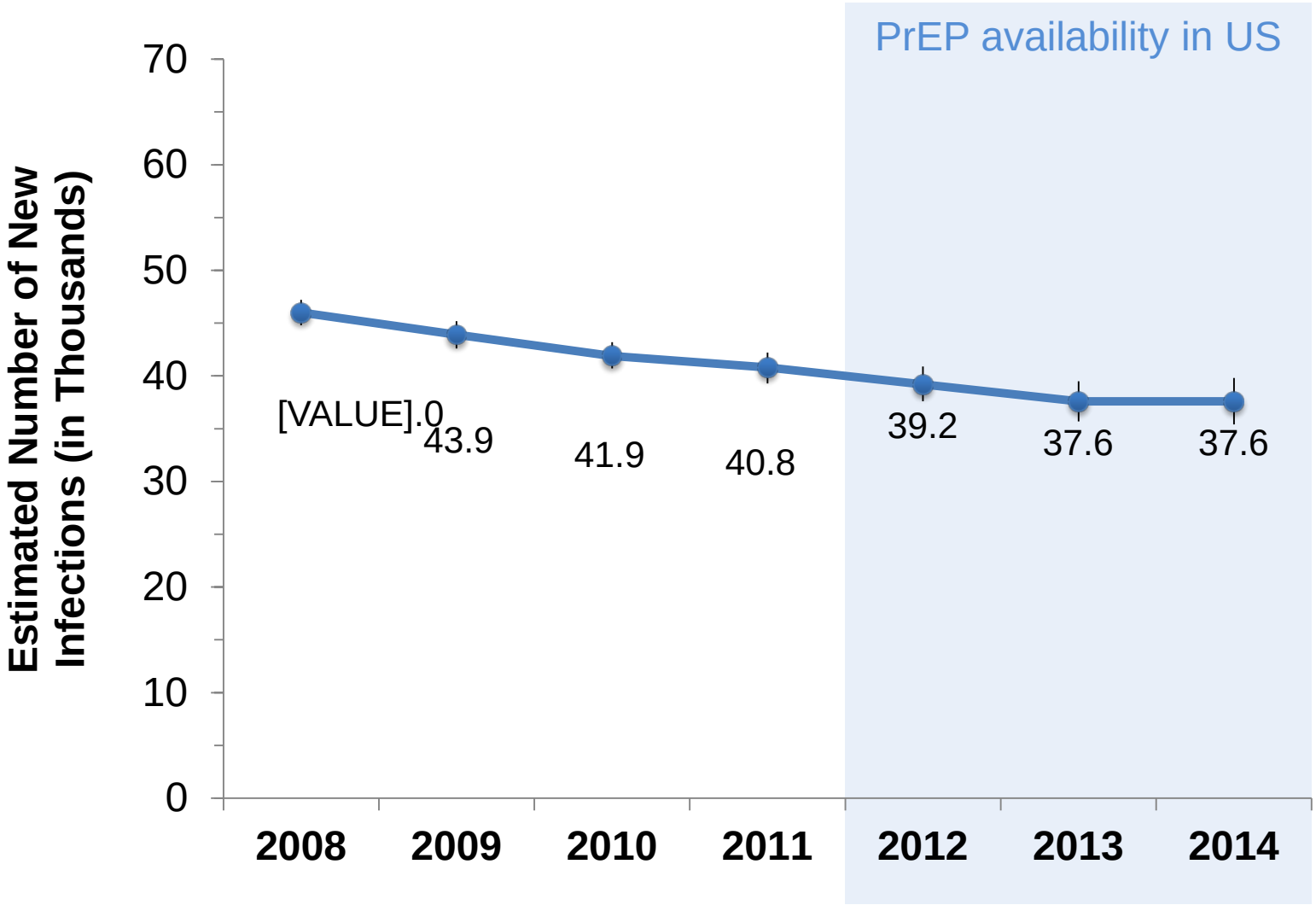

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
MENU
CDC A-Z
SEARCH
HIV/AIDS
HIV/AIDS > Resource Library > Dear Colleague Letters
Dear Colleague: September 27, 2017
Dear Colleague
INFORMATION FROM CDC'S DIVISION OF HIV/AIDS
Dear Colleague,
Today is National Gay Men's HIV/AIDS Awareness Day. On this day, we join together in ta
among gay and bisexual men and ensure that all gay and bisexual men living with HIV get the care they need to stay
healthy. Gay and bisexual men are severely affected by HIV. More than 26,000 gay and bisexual men received an HIV
diagnosis in 2015, representing two-thirds of all new diagnoses in the United States, and diagnoses increased among
Hispanic/Latino gay and bisexual men from 2010 to 2014.
However, recent trends suggest that prevention efforts are slowing the spread of HIV among some gay and bisexual men.
From 2010 to 2014, HIV diagnoses fell among white gay and bisexual men and remained stable among African American
gay and bisexual men after years of increases.
Scientific advances have shown that antiretroviral therapy (ART) preserves the health of people living with HIV. We also

"[P]eople who take ART daily… and maintain an undetectable viral load have **effectively no risk of sexually transmitting the virus** to an HIV-negative partner."

https://www.cdc.gov/hiv/library/dcl/dcl/092717.html

HIV incidence in United States, 2008-2014

By CD4 model (2017)



Hall HI *et al*. JMIR Public Health Surveill 2017 Feb 3;3(1):e8.
Satcher Johnson A *et al*. JAIDS 2017 Oct 1;76(2):116-22

Its not just about HIV medication

Research

Original Investigation

Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States

Jacek Skarbinski, MD; Eli Rosenberg, PhD; Gabriela Paz-Bailey, MD, MSc, PhD; H. Irene Hall, PhD; Charles E. Rose, PhD; Abigail H. Viall, MA; Jennifer L. Fagan, MA; Amy Lansky, PhD; Jonathan H. Mermin, MD, MPH

IMPORTANCE Human immunodeficiency virus (HIV) transmission risk is primarily dependent on behavior (sexual and injection drug use) and HIV viral load. National goals emphasize maximizing coverage along the HIV care continuum, but the effect on HIV prevention is unknown.

OBJECTIVES To estimate the rate and number of HIV transmissions attributable to persons at each of the following 5 HIV care continuum steps: HIV infected but undiagnosed, HIV diagnosed but not retained in medical care, retained in care but not prescribed antiretroviral therapy, prescribed antiretroviral therapy but not virally suppressed, and virally suppressed.

DESIGN, SETTING, AND PARTICIPANTS A multistep, static, deterministic model that combined population denominator data from the National HIV Surveillance System with detailed clinical and behavioral data from the National HIV Behavioral Surveillance System and the Medical Monitoring Project to estimate the rate and number of transmissions along the care continuum. This analysis was conducted January 2013 to June 2014. The findings reflect the HIV-infected population in the United States in 2009.

MAIN OUTCOMES AND MEASURES Estimated rate and number of HIV transmissions.

RESULTS Of the estimated 1 148 200 persons living with HIV in 2009, there were 207 600 (18.1%) who were undiagnosed, 519 414 (45.2%) were aware of their infection but not retained in care, 47 453 (4.1%) were retained in care but not prescribed ART, 82 809 (7.2%) were prescribed ART but not virally suppressed, and 290 924 (25.3%) were virally suppressed. Persons who are HIV infected but undiagnosed (18.1% of the total HIV-infected population) and persons who are HIV diagnosed but not retained in medical care (45.2% of the population) were responsible for 91.5% (30.2% and 61.3%, respectively) of the estimated 45 000 HIV transmissions in 2009. Compared with persons who were HIV diagnosed and undiagnosed (6.6 transmissions per 100 person-years), persons who were HIV infected but not retained in medical care were 19.0% (5.3 transmissions per 100 person-years) less likely to transmit HIV, and persons who were virally suppressed were 94.0% (0.4 transmissions per 100 person-years) less likely to transmit HIV. Men, those who acquired HIV via male-to-male sexual contact, and persons 35 to 44 years old were responsible for the most HIV transmissions by sex, HIV acquisition risk category, and age group, respectively.

CONCLUSIONS AND RELEVANCE Sequential steps along the HIV care continuum were associated with reduced HIV transmission rates. Improvements in HIV diagnosis and retention in care, as well as reductions in sexual and drug use risk behavior, primarily for persons undiagnosed and not receiving antiretroviral therapy, would have a substantial effect on HIV transmission in the United States.

Invited Commenta... page 596

Supplemental co... jamainternalmed...

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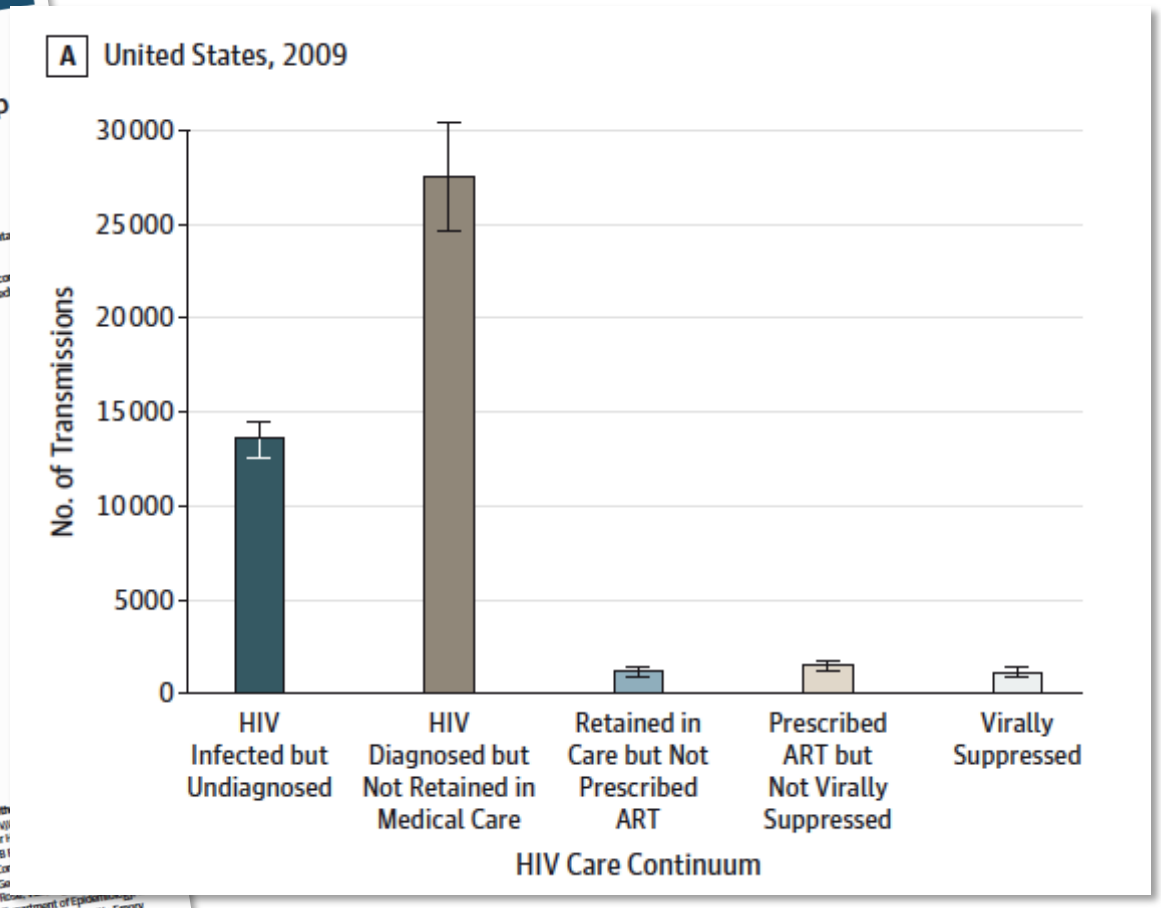
Corresponding Author: Jacek Skarbinski, MD, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, 1600 Clifton Rd NE, Mail Stop E-46, Atlanta, GA 30333 (jskarbinski@cdc.gov).

...ernalmedicine.com



Skarbinski J et al. JAMA Internal Med, 2015

Other exposures: Healthcare Worker Post-Exposure Prophylaxis

DEFINITION OF EXPOSURE

- Percutaneous exposure to contaminated body fluid
- Mucous membrane exposure to contaminated body fluid
- Non-intact skin expose to contaminated body fluid
- Infectious fluids: blood, CSF, vaginal secretions, semen, synovial, pleural, peritoneal, pericardial, amniotic
- Feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomitus are not considered potentially infectious unless they are visibly bloody.

RULES OF HIV for LAWYERS – Part 1

- ALL TRANSMISSION OF HIV REQUIRES AN INFECTED SOURCE AND A SUSCEPTIBLE HOST
- MOST SEXUAL ENCOUNTERS ARE CONCORDANT NEGATIVE
- EFFICIENCY OF TRANSMISSION IS GREATLY AFFECTED BY INSTANTANEOUS COFACTORS THAT DETERMINE THE INFECTIOUSNESS OF THE INDEX CASE AND THE SUSCEPTIBILTY OF THE NEGATIVE PARTNER AT ONE (SPECIAL) MOMENT IN TIME
- MOST SEXUAL TRANSMISSION OF HIV OCURS IN NEWLY FORMED RELATIONSHIPS, ESPECIALLY WHEN THE HIV POSITIVE PARTNER IS NEWLY INFECTED (~4.9 MONTHS OF MAXIMAL CONTAGION RISK)
- “LONG-TERM” (>3 MONTHS) RELATIONSHIPS WITH AN HIV POSITIVE PERSON CAN RESULT IN AN HIV TRANSMISSION EVENT, BUT GENERALLY WITH LESS EFFICIENCY THAN OBSERVED THAN WHEN THE INFECTED PARTNER IS AT THE EARLY OR LATER STAGES OF HIV DISEASE
- LATEX CONDOMS REDUCE HIV TRANSMISSION SIGNIFICANTLY

RULES OF HIV FOR LAWYERS – Part 2

- HIV THERAPY REDUCES INFECTIOUSNESS GREATLY IF THE MEDICATION IS TAKEN AND THE VIRAL LOAD IS SUPPRESSED IN THE SHARED FLUID

HIV CRIMINALIZATION

An Overview of Current Laws, Science and Implications for Practice

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Attorney at Law

OVERVIEW

- Introduction to HIV Criminalization
  - Scope and features of HIV criminal laws
  - What's wrong with HIV criminal laws?
  - PJP *Guiding Principles* and Consensus Statement
- Practice Questions and Issues
  - Questions for a Client in an HIV-Related Criminal Case
  - Annotated List of Motions and Issues in an HIV-Related Criminal Case
- Ethical Considerations in HIV Criminal Case Representation
- What Can Criminal Defense Attorneys Do?

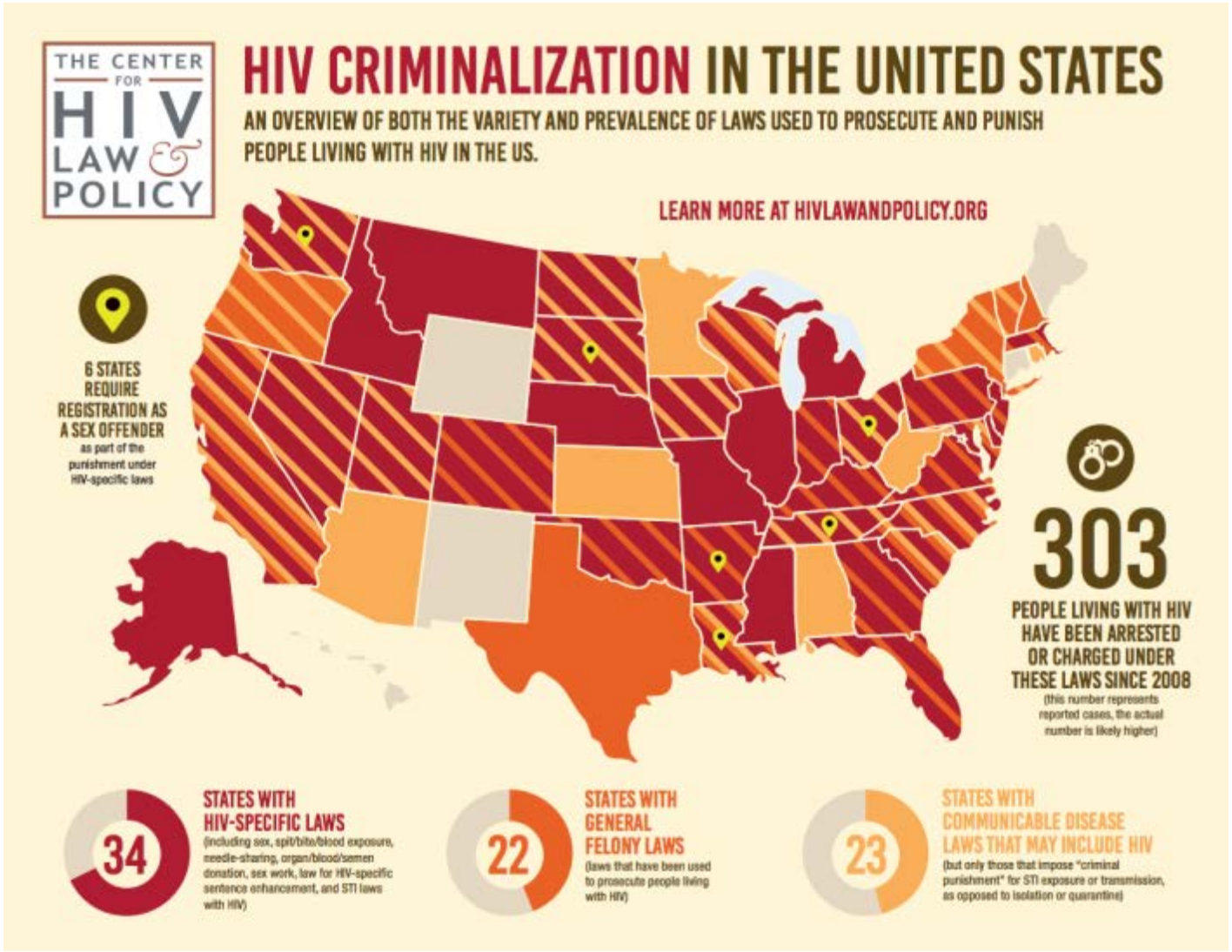
SCOPE AND FEATURES OF HIV CRIMINAL LAWS

HIV criminalization is the prosecution and imprisonment of people living with HIV for things that are perfectly legal or only minor crimes for people who have not tested positive.

SCOPE AND FEATURES OF HIV CRIMINAL LAWS

- 34 states and two U.S. territories have HIV-specific criminal laws, including sentence enhancements for sex workers or for underlying sex crimes.
- Two types of behavior that are primarily targeted:
  - Sexual contact without prior disclosure of HIV+ status (may include vaginal, anal or oral sex but is often defined to include activities posing no or low risk of HIV transmission)
  - Spitting, biting, or other modes of exposure to bodily fluids (often specific to law enforcement or corrections officers)
- PLHIV also prosecuted under general criminal laws (e.g., reckless endangerment or attempted homicide)

The Center for HIV Law and Policy, *HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice* (2017), http://www.hivlawandpolicy.org/sourcebook



SNAPSHOT OF HIV CRIMINAL LAWS

HIV criminal laws are present across the United States.

ELEMENTS OF HIV CRIMINAL LAWS

What gets you in trouble?

- Tested HIV-positive
- Had any kind of contact viewed as “sex”
- Scuffle with law enforcement + HIV status
- Being a sex worker while living with HIV
- HIV+ survivor of sexual assault

What doesn’t help?

- Verbal consent
- In most states: Lack of intent to harm/transmit, or level of risk. Use of condoms, sticking to oral sex, low viral load, engaging in near-zero risk conduct usually not relevant

The Center for HIV Law and Policy, *HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice* (2017), http://www.hivlawandpolicy.org/sourcebook

WHAT ARE PRIMARY PROBLEMS WITH CRIMINAL HIV LAWS AND PROSECUTIONS?

- No *mens rea* requirement: unlike other crimes against the person, prosecutor does not have to prove intent to harm/intent to transmit
- Revolve around perception that having HIV is physically and socially life-ending
- Treatment as prevention is important–but this is less legally relevant than the significant reduction in risk of suffering and premature death thanks to ART
  - HIV's low per-act transmission risk has been known for years Courts have said that even very small risk is "significant" when the risked outcome is death; lowering risk has reduced, not ended, charges
  - Those most vulnerable to prosecution less likely to have treatment access

Consensus Statement on HIV "Treatment as Prevention" in Criminal Law Reform, July 2017, http://www.hivlawandpolicy.org/resources/consensus-statement-hiv-treatment-as-prevention-criminal-law-reform

WHAT'S WRONG WITH HIV CRIMINAL LAWS?

The disconnect between HIV criminalization and science:

CDC's *Estimated Per-Act Probability of acquiring HIV, by type of exposure* (2015)

- Insertive vaginal sex (4 per 10,000 exposures)
- Receptive vaginal sex (8 per 10,000 exposures)
- Insertive anal sex (11 per 10,000 exposures)
- Receptive anal sex (138 per 10,000 exposures)
- Insertive oral sex (Low)
- Receptive oral sex (Low)

Spitting cannot transmit HIV; biting poses near-zero risk. Sex while virally undetectable on effective therapy poses effectively zero risk.

Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act, CDC, https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html

CDC, "Dear Colleague," September 27, 2017 at: https://www.cdc.gov/hiv/library/dcl/dcl/092717.html

WHAT'S WRONG WITH HIV CRIMINAL LAWS?

HIV criminal laws are based on the idea that HIV is a highly transmissible, "deadly weapon," and that an HIV diagnosis is equivalent to a death sentence

- The reality is that HIV is not an easy disease to transmit.
- HIV is a manageable, chronic condition, not a death sentence
- With today's treatment, a person diagnosed in their 20s can expect to enjoy a near-normal lifespan

See generally Hasina Samji, et al., Closing the Gap: Increases in Life Expectancy Among Treated Individuals in the United States and Canada, 8 PLoS One 1 (2013), available at http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0081355.

WHAT'S WRONG WITH HIV CRIMINAL LAWS?

Contrary to the claims of some supporters, HIV criminal laws *do not* promote public health.

- **No evidence** that these laws or prosecutions deter risky behaviors or actually promote disclosure
- **No evidence** that laws have reduced rate of new HIV diagnoses
- **Disincentive** to learn HIV status
- **Alienates** patients from health care providers
- Sends **one-sided message** regarding prevention responsibility
- Disproportionately impacts **marginalized populations,** including people of color, LGBTQ communities, sex workers, and undocumented immigrants.
- **Promotes stigma**, which pushes people to the margins and weakens effective response to HIV

POSITIVE JUSTICE PROJECT GUIDING PRINCIPLES FOR REFORM

PositiveJusticeProject

a. No disease-specific criminal law or sentence enhancement;
b. Must prove specific intent to harm + conduct likely to do intended harm;
c. Steps to reduce risk = no intent to harm;
d. No airborne/casually transmitted diseases;
e. Proportionate penalty, no sex offender status;
f. No felony laws for transmitting/exposing another to disease; and
g. No new or increased penalties for others.

DEFENDING CRIMINAL CASES THAT INVOLVE HIV

- **First Principles**
  - Challenging outdated, inaccurate information re: HIV with current science on the routes and risks of HIV transmission, treatment efficacy, and life expectancy
  - Tackling HIV Sensationalism and Stigma
- **The Criminal Statute in your State?**
- **From the Science to . . . the Science: Experts Are Critically Important**

QUESTIONS FOR A CLIENT IN AN HIV-RELATED CRIMINAL CASE

- Parties to the Alleged Incident
  - Who is the complaining witness (CW)?
- Factual Basis for the Charge
- Beginning of Investigation or Criminal Case
- Client's History and Circumstances

LEGAL ISSUES IN AN HIV-RELATED CRIMINAL CASE

- Privacy of client's health information
- Defenses to Nondisclosure of Status
- Use of Medical Evidence
- Appellate and Postconviction Litigation

MOTIONS TO FILE IN AN HIV-RELATED CRIMINAL CASE

- Suppress health-related information
- Constitutional challenges
- Evidentiary Matters and Motions *in Limine*
- Sentencing issues

ETHICAL CONSIDERATIONS IN HIV CRIMINAL CASE REPRESENTATION

- Issues related to disclosure of health records
- Dealing with client's family
  - How to manage the information stream with client's family?
- In court representation
  - How much can be discussed on the record in light of health privacy issues?
  - Should attorneys waive reading of the charges in light of the privacy issues?

ETHICAL CONSIDERATIONS: CONFIDENTIALITY

Persistent stigma toward persons in risk groups, and myths about infectiousness, prejudice clients inside and outside of court

ABA MODEL RULE OF PROFESSIONAL CONDUCT 1.6, CONFIDENTIALITY OF INFORMATION

- *"A lawyer shall not reveal information relating to the representation unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or [enumerated exceptions apply]."*
- Duty exists to safeguard confidential information and to limit breadth and effect of disclosures when they happen or are necessary. COMMENTARY TO RULE 1.6, NOTE 18: "*Factors to be considered in determining the reasonableness of the lawyer's efforts [to protect confidences] include, but are not limited to, the sensitivity of the information, the likelihood of disclosure if additional safeguards are not employed, the cost of employing additional safeguards, the difficulty of implementing the safeguards, and the extent to which the safeguards adversely affect the lawyer's ability to represent clients[].*"

In court, before the media, and even among clients' family and supporters, do not assume that client has disclosed

ETHICAL CONSIDERATIONS: CONFIDENTIALITY

Consider current knowledge about HIV transmission methods and risks, efficacy of treatments, and manageable nature of HIV disease when considering exceptions to general rule of confidentiality.

- *Permissive* disclosures "to prevent reasonably certain death or substantial bodily harm" or to prevent future crime, RULE 1.6(B)(1), (2), are unlikely to apply.

Criminal defendants suffer in particular because

- Usually impossible to argue that HIV status isn't relevant to alleged offense
- Public nature of criminal charges means status is disclosed when client charged, often before counsel even enters the case
- Media treatment of case can be irresponsible, even hysterical; "predator" storylines bring mouse clicks

ETHICAL CONSIDERATIONS: CONFIDENTIALITY

While a single disclosure can mushroom, counsel should guard against further breaches of confidentiality

- Alert prosecutors, court officials, and state health agencies to disclosure limits in state public health statutes -- and insist on compliance
  - Request hearings in chambers beginning at first appearance: arraignment, status conferences, pretrial release, to extent possible under state law
  - Demonstrate compelling need for privacy protections in face of open courtroom policies and public trial requirements; standards are tough, see *Presley v. Georgia*, 130 S. Ct. 721, 724 (2010), but may persuade court at least as to nonjury matters.
- Move *in limine* to bar or limit testimony about matters not strictly relevant to proceedings, such as details of treatment

WHAT CAN CRIMINAL DEFENSE ATTORNEYS DO?

- Counsel people living with HIV with legal questions, drafting amicus curiae briefs, or providing actual legal representation;
- Advise CHLP staff on local practice and procedures, particularly in the attorney's area of expertise;
- Serve as a point of contact for a case CHLP is monitoring and documenting;
- Review draft modernization legislation, CHLP publications, and other documents;
- Endorse PJP Consensus Statement & post on website; and
- Join the HIV Legal Collaborative (HLC). To learn more go to http://www.hivlawandpolicy.org/initiatives/hiv-legal-collaborative.