

A Cautionary Tale: Black Women, Criminal Justice, and HIV

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I. INTRODUCTION

For two decades, the face of HIV/AIDS was a White gay male. Now, in its third decade, the face of the HIV/AIDS epidemic is African-American.¹ AIDS was first recognized by the Centers of Disease Control (CDC) in June of 1981. HIV is the virus by which AIDS is transmitted.² Although Black men are disproportionately infected with HIV, the infection rate for Black women is alarming. In similar fashion, the incarceration rate for Black men is the subject of national debate while little attention is given to the disproportionate number of incarcerated Black women.

The criminal justice system provides a prism through which this Article analyzes the socio-legal complexities of HIV transmission and the Black community, and in doing so, it provides a platform for a much broader discussion. Like *The Canterbury Tales*, this Article is comprised of many stories leading to a final destination. In this case, the journey leads to changes in HIV laws and policies.³ This Article had its impetus in an earlier published work.⁴ Accordingly, this Article examines the following: 1) the rising number of African-Americans, especially women, living with HIV/AIDS; 2) the concordant rise in the number of incarcerated African-Americans living with HIV/AIDS; 3) the legal issues arising from HIV/AIDS-related medical care and privacy concerns; and 4) controversial changes in HIV/AIDS-related privacy policies to save the lives of women.

II. HIV/AIDS and Black Female Inmates

A report to Congress on prisoners with HIV/AIDS described the disease as

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1. BLACK AIDS INST., *EXIT STRATEGY: ENDING THE AIDS EPIDEMIC IN BLACK AMERICA: THE STATE OF AIDS IN BLACK AMERICA* 74 (2012).

2. CENTERS FOR DISEASE CONTROL & PREVENTION, *Thirty Years of HIV—1981–2011*, in 60 *MORBIDITY & MORTALITY WEEKLY REPORT*, 2011, 21, 689.

3. See GEOFFREY CHAUCER, *THE CANTERBURY TALES* (Neil Coghill ed., Penguin Books 2003).

4. Gloria J. Browne-Marshall, *To Be Female, Black, Incarcerated, and Infected with HIV/AIDS: A Socio-Legal Analysis*, 41 *CRIM. L. BULL.* 3 (2005). The primary focus of this article was the manner in which the Federal and State correctional systems were addressing the rising number of women inmates living with HIV/AIDS, the majority of whom were African-American. See *id.*

a virus transmitted through sexual relations and exposure to blood. Acquired immunodeficiency syndrome (AIDS) results when human immunodeficiency virus (HIV) attacks the body's immune system, leaving the individual highly susceptible to a range of infections, cancers, and other illnesses. HIV infection also attacks the central nervous system, causing progressive dementia, and it may lead to a serious wasting syndrome.⁵

In the 20th century, HIV/AIDS was categorized as a terminal disease transmitted primarily between homosexual men and intravenous drug users. However, any such narrow perspectives on this disease have evolved since its official discovery in 1981, particularly as advances in medical research have led to a better understanding of treatment and prevention of HIV/AIDS. HIV remains a preventable disease without a known cure. Advances in medical treatment have allowed people with the infection to live longer relatively healthy lives.⁶ With people living longer with HIV, there is an increased chance of knowing someone with the virus, thus reducing the stigma originally associated with this disease. About one-third of American adults have a family member or know someone who has HIV/AIDS or has died from AIDS.⁷ Nearly 60 percent of African-Americans know someone who has tested positive for HIV or has died of AIDS compared with 38 percent of Whites and 37 percent of Latinos.⁸ The image of former athlete and businessman Irvin "Magic" Johnson living over twenty years with the virus is easing the social stigma. There is a decline in the stigma. However, in a CDC survey on attitudes toward HIV/AIDS, 36 percent of Americans surveyed are uncomfortable with having a roommate with HIV, 29 percent are uncomfortable allowing their child to be taught by an HIV-positive teacher, and 18 percent are uncomfortable with having a co-worker with HIV.⁹

HIV/AIDS is contracted through the exchange of fluids.¹⁰ It can be contracted through both heterosexual and homosexual intercourse, including certain lesbian sex.¹¹ Unfortunately, the casualness with which HIV is now regarded may have contributed to the spread of the disease among women. Globally, women represent half of all people infected with HIV.¹² Women contract HIV/AIDS primarily through heterosexual relations and, to a lesser degree, intravenous drug use.¹³ In 2009, women accounted for 23 percent of the 11,200 reported new HIV infections in the United States.¹⁴

5. NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS 16 (2002) [hereinafter THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES].

6. THE WHITE HOUSE, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES viii (2010).

7. KAISER FAMILY FOUND., HIV/AIDS AT 30: A PUBLIC OPINION PERSPECTIVE 19 (2011).

8. *Id.* at 13.

9. *Id.* at 7.

10. *See generally* How is HIV Passed from One Person to Another?, HIV TRANSMISSION (March 25, 2010), <http://www.cdc.gov/hiv/resources/qa/transmission.htm>.

11. *See generally id.*

12. KAISER FAMILY FOUND., FACT SHEET: THE GLOBAL HIV/AIDS EPIDEMIC (June 2012).

13. KAISER FAMILY FOUND., FACT SHEET: WOMEN AND HIV/AIDS IN THE UNITED STATES (March 2012).

14. *Id.*

A. HIV/AIDS and African-American Women

Blacks represented only 14 percent of the American population but 44 percent of new HIV cases and 45 percent of AIDS diagnoses in 2009.¹⁵ Based on the most recent studies by the Centers for Disease Control and Prevention (CDC), at some point in their lifetimes one in thirty-two Black women will become infected with HIV, and one in sixteen Black men will be infected.¹⁶ In 2009, Black women accounted for about 31 percent of new HIV cases among Blacks while Black men accounted for the other 69 percent of new infections.¹⁷

Women represent 38 percent of all AIDS cases involving heterosexual relations.¹⁸ However, while the level of new HIV infections among Black women has decreased, the rate of infection through heterosexual relations has increased by 10 percent.¹⁹ In 2009, 85 percent of Black women who became infected with HIV did so through heterosexual relationships.²⁰ Furthermore, Black females with a higher rate of sexually transmitted infections (STIs) have a greater chance of contracting HIV, as the presence of STIs indicates that a person has engaged in unprotected or high-risk sex.²¹

Although HIV infection rates have stabilized in the Black community, infection rates among Black men who have sex with other men (MSM) demonstrated a significant increase from 2006 to 2009.²² Of the nearly 1.2 million Americans living with HIV, 46 percent are African-American.²³ The rate of infection for Black men is about 6.5 times higher than White men.²⁴ Over 116,000 African-Americans are unaware that they are infected with HIV.²⁵ Testing services for HIV are widely available in the United States, yet one in five persons with HIV is undiagnosed.²⁶

Of new HIV infections, 69 percent are among Black men, and 52 percent of

15. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS (Nov. 2011). See Connie M. Mayer, *Unique Mental Health Needs of HIV-Infected Women Inmates: What Services are Required Under the Constitution and The Americans with Disabilities Act?*, 6 WM. & MARY J. WOMEN & L. 215 (1999).

16. CENTERS FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: HIV AND AIDS AMONG AFRICAN AMERICANS 1 (2011).

17. CENTERS FOR DISEASE CONTROL & PREVENTION, *Thirty Years*, *supra* note 2. Latinos represent 16 percent of the population and comprise 20 percent of the AIDS cases diagnosed in 2011. *Id.*

18. KAISER FAMILY FOUND., FACT SHEET: THE HIV/AIDS EPIDEMIC IN THE U.S. (June 1999).

19. Christine Johnson & Steven Kurvink, *Media Watchdogs Blast Fumento: Has the Politicization of Aids Left Science in the Lurch?*, 8 RETHINKING AIDS 1, 2 (Oct. 2000).

20. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS, *supra* note 15.

21. CENTERS FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: THE ROLE OF STD DETECTION & TREATMENT IN HIV PREVENTION (Dec. 2007).

22. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS, *supra* note 15, at tbl.; BLACK AIDS INST., *supra* note 1, at 33.

23. HIV SURVEILLANCE—UNITED STATES, 1981–2008, 689–93, (2011), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6021a2.htm#Tab>.

24. CENTERS FOR DISEASE CONTROL & PREVENTION, FACT SHEET: HIV IN THE UNITED STATES (Nov. 2011).

25. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AND AIDS AMONG AFRICAN AMERICANS, *supra* note 15.

26. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS: BASIC STATISTICS (Aug. 2011).

those infections are among men who have sex with other men (MSM).²⁷ Thirty-one percent of the new infections in the Black community are Black women.²⁸ HIV infection remains the leading cause of death for Black women 25–34 years of age and the third leading cause of death for Black women 35–44 years old.²⁹ All women are affected by HIV/AIDS, though. HIV infection was the fifth leading cause of death for women of all race and ethnicities 25–34 years of age.³⁰ In 2009, Black women were infected at a rate fifteen times higher than White women and three times that of Latinas.³¹ In 1992, women were about 14 percent of those living AIDS; by 2005, their number had increased to 23 percent.³² Black women represent over 64 percent of all American women living with HIV/AIDS.³³ The rate of AIDS diagnosis for Black women is 23 times the rate for White women and four times the rate for Latinas.³⁴ By the end of 2008, an estimated 240,627 African-Americans died of AIDS in the United States.³⁵

Intravenous drug use represents the second most common means of HIV transmission to women.³⁶ The CDC reported that 26 percent of injection drug-related HIV/AIDS cases involve women.³⁷ Drug use is also a vector for the transmission of other sexually transmitted infections, hepatitis, and tuberculosis.³⁸ Moreover, chronic users of drugs are more susceptible to infectious illnesses.³⁹

Women are also at risk of contracting HIV from other women.⁴⁰ One study reported a case of woman-to-woman HIV transmission of HIV.⁴¹ The lesbian

27. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AND AIDS AMONG AFRICAN AMERICANS, *supra* note 15, at tbl; BLACK AIDS INST., *supra* note 1, at 33.

28. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AND AIDS AMONG AFRICAN AMERICANS, *supra* note 15, at tbl.

29. LEADING CAUSES OF DEATH BY AGE GROUP, BLACK FEMALES—UNITED STATES, 2007, *available at* http://www.cdc.gov/women/lcod/07_black_females.pdf (last visited April 16, 2012).

30. WISQARS, 10 LEADING CAUSES OF DEATH, UNITED STATES, 1999–2004.

31. CENTERS FOR DISEASE CONTROL & PREVENTION, FACT SHEET: HIV AND AIDS AMONG AFRICAN AMERICANS, *supra* note 15.

32. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS SURVEILLANCE REPORT 1, 1–46 (2007).

33. CENTERS FOR DISEASE CONTROL & PREVENTION, FACT SHEET: HIV/AIDS AMONG WOMEN (Aug. 2008).

34. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS SURVEILLANCE REPORT, *supra* note 32.

35. CENTERS FOR DISEASE CONTROL & PREVENTION, FACT SHEET: HIV AMONG AFRICAN AMERICANS, *supra* note 15.

36. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV/AIDS: BASIC STATISTICS, *supra* note 26.

37. CENTERS FOR DISEASE CONTROL & PREVENTION, CASES OF HIV INFECTION AND AIDS IN THE UNITED STATES AND DEPENDENT AREAS (2007), tbl. 1.

38. See SEXUALLY TRANSMITTED DISEASES TREATMENT GUIDELINES, 2010: HEPATITIS C (Jan. 28, 2011), <http://www.cdc.gov/std/treatment/2010/hepc.htm>.

39. See OFFICE OF NAT'L DRUG CONTROL POLICY, *The Consequences of Illegal Drug Use, in THE NATIONAL DRUG CONTROL STRATEGY 2000 ANNUAL REPORT* (2000), *available at* http://www.ncjrs.gov/ondcppubs/publications/policy/ndcs00/chap2_10.html.

40. Helena A. Kwakwa & M.W. Ghobriel, *Female-to-Female Transmission of Human Immunodeficiency Virus*, 36 CLINICAL INFECTIOUS DISEASES e40, e40–41 (Feb. 2003), *available at* <http://cid.oxfordjournals.org/content/36/3/e40.full.pdf>.

41. *Id.*

women who contracted HIV in the study had no history of intravenous drug use, blood transfusions, body tattoos, body piercing, or heterosexual relationships.⁴² The study concluded that although the risk of HIV transmission from woman-to-woman is small, the possibility remains if there is bleeding during sex.⁴³ This finding debunks the notion that woman-to-woman HIV transmission is impossible. Consequently, more research is needed to determine whether the rape of a female inmate perpetrated by an infected female would result in the transmission of HIV/AIDS.

There is a link between a woman's high-risk sexual behavior and sexual abuse.⁴⁴ Women who have experienced sexual abuse as children are more likely to be in abusive relationships as adults or form sexual relationships with multiple partners, which increases the chances of contracting HIV/AIDS.⁴⁵ These women may be more likely to abuse drugs and alcohol as a coping mechanism.⁴⁶ Women with a history of sexual abuse as children are also more likely to engage in high-risk behaviors such as drug abuse and criminal behavior, which could lead to incarceration and a subsequent increased risk of HIV transmission.⁴⁷ Statutory rape and child sexual abuse have a devastating effect on the self-worth and life choices made by its victims. They have difficulty refusing unwanted sex and may be more likely to exchange sex for drugs or engage in high-risk sexual behavior with different partners.⁴⁸

B. Heterosexual Transmission of HIV

Men are infecting women. Although prostitution and injection drug use are behaviors found among some women with HIV (24 percent), heterosexual contact was the overwhelming means of HIV transmission (74 percent).⁴⁹ Women are more susceptible than men to contracting HIV through vaginal intercourse.⁵⁰ Although condom use is the primary method of HIV prevention after abstinence, statutory rape and other relationships of intimidation or coercion undermine a female partner's ability to protect herself against contracting HIV.⁵¹ Such high-risk sexual behavior if started at an early age increases the chance of consistent high-risk behavior in adult life. One third of Black and Hispanic urban high school girls had their first sexual relationship

42. *Id.* at e40.

43. *Id.* at e41.

44. See Janet L. Mullin et al., *Assessing the Relationship Between Child Sexual Abuse and Marginal Living Conditions on HIV/AIDS-Related Risk Behavior Among Women Prisoners*, 24 *CHILD ABUSE & NEGLECT* 677, 678 (2000).

45. *Id.*

46. See generally Mark Singer & Marcia Petchers, *The Relationship Between Sexual Abuse and Substance Abuse Among Psychiatrically Hospitalized Adolescents*, 13 *CHILD ABUSE & NEGLECT* 319 (1989).

47. *Id.*

48. See generally *id.*

49. CENTERS FOR DISEASE CONTROL & PREVENTION, *FACT SHEET: HIV AMONG WOMEN*, *supra* note 33.

50. See *id.*; EUROPEAN STUDY GROUP ON HETEROSEXUAL TRANSMISSION OF HIV, *Comparison of Female to Male and Male to female Transmission of HIV in 563 Stable Couples*, 304 *B.M.J.* 809 (1992).

51. K.S. Miller, L.F. Clark, J.S. Moore, *Sexual Initiation with Older Male Partners and Subsequent HIV Risk Behaviors Among Female Adolescents*, 29 *FAM. PLAN. PERSP.* 212, 212-14 (1997).

with a male three or more years their senior.⁵² A quarter of pregnant teen girls become pregnant by men over 18.⁵³

It is important to reach girls and young women before they become infected with STIs and HIV. Poverty, lack of formal education, and sexual abuse all increase the chances of engaging in high-risk behaviors, which in turn could lead to imprisonment and contraction of HIV/AIDS. These socioeconomic issues place a person at higher risk.

There are also women who may choose to have a relationship with an infected male partner. She does so willingly, voluntarily, and with an understanding of the risks. A woman who knows her male partner is infected can protect herself while engaging in a sexual relationship. In recent studies, condoms and pre-exposure antiretroviral prophylaxis have reduced, by 96 percent, the likelihood of an HIV-negative partner acquiring the virus from his or her HIV-positive partner.⁵⁴ By reducing the infected person's viral load with antiretroviral therapy, the ability to transmit the disease is reduced, as well.⁵⁵ Clinical trials are continuing. HIV-negative people may be less likely to become infected if antiretroviral drugs are taken daily prior to sexual contact.⁵⁶

Yet, even with this promising medical news, the future is bleak because most African-American women are unaware of their male partner's HIV status. In one study of males 23–29 years of age living with HIV who self-identify as MSM (men who have sex with other men), 34 percent of Black males, 26 percent of Latinos, and 13 percent of White males acknowledged also having sexual relations with women.⁵⁷ In another study, 65 percent of young men reported having sex with other men, yet only 6 percent of Black women and 6 percent of Latinas reported being in bi-sexual relationships while 14 percent of White women reported being in bi-sexual relationships.⁵⁸ A woman's male partners may have unknowingly acquired the virus from other men, injection drugs use, or sex with an infected female partner. One in sixteen Black men and one in thirty-two Black women will be infected with HIV.⁵⁹ The study did not indicate if the women surveyed believed they were in a monogamous heterosexual relationship, living together with their partner, or married.⁶⁰

The CDC action plan devised to reduce HIV in the Black community entails

52. *Id.*

53. *See id.*

54. M.S. Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 NEW ENG. J. MED. 493, 493–505 (2011).

55. T.C. Quinn et al., *Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1*, 342 NEW ENG. J. MED. 921, 921–29 (2000).

56. R.M. Grant et al., *Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men*, 363 NEW ENG. J. MED. 2587, 2587–99 (2010).

57. J.P. Montgomery, E.D. Mokotoff, A.C. Gentry & J.M. Blair, *The Extent of Bisexual Behavior in HIV-Infected Men and Implications for Transmission to their Female Partners*, 15 AIDS CARE 829, 829–37 (2003).

58. L.A. Valleroy, D.A. MacKellar, S.K. Behel & G.M. Secura, abstract, *Young Men's Survey: The Bridge for HIV Transmission to Women from 23-to-29-year-old Men Who Have Sex with Men in 6 U.S. Cities*, National HIV Prevention Conference (July 2003).

59. CENTERS FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: HIV AND AIDS AMONG AFRICAN AMERICANS, *supra* note 15.

60. Valleroy et al., *supra* note 58.

1) regular testing, 2) timely antiretroviral therapy for those diagnosed with HIV, and 3) minimizing exposure to HIV through condom use.⁶¹ However, this action plan is beyond the reach of those incarcerated men who engage in MSM and are unable to access HIV testing. Since Black males are disproportionately represented in the correctional system,⁶² once released, these men become yet another way Black women become infected with HIV.

III. HIV/AIDS IN U.S. PRISONS AND JAILS

The need for testing upon release from correctional facilities is crucial to saving lives in the Black community and to reducing infection rates among Black women. However, testing for HIV is restricted in correctional facilities despite the prevalence of unprotected MSM, forced and voluntary sex, tattooing, and drug abuse. Without testing upon release from prison, all communities, and especially the Black community, will continue to experience disproportionate HIV infection rates. America incarcerates approximately 2.1 million individuals in its correctional facilities, prisons and jails.⁶³ Black males, with an incarceration rate of 6,838 inmates per 100,000 U.S. males, were incarcerated at a rate more than six times higher than white males (990 inmates per 100,000 U.S. males) and 3.75 times higher than Hispanic males (1,822 inmates per 100,000 U.S. males).⁶⁴ The overall incarceration rate in jails has decreased slightly (0.2 percent), while there is a corresponding increase of more than 3 percent in federal incarcerations.⁶⁵

From nearly five times the national average of confirmed AIDS cases in 1999, AIDS cases among the incarcerated declined from 0.58 percent to 0.46 percent, while the percentage of AIDS cases within the general population increased from 0.12 percent to 0.17 percent.⁶⁶ The rate of HIV in correctional facilities—both jails and prisons—remains 2.4 times higher than the rate of infection in the U.S. general population.⁶⁷ Although approximately 0.1 percent of women and 0.29 percent of men are living with HIV nationally,⁶⁸ 2.4 percent of incarcerated women and 1.6 percent of incarcerated men are HIV-positive.⁶⁹ According to a 2006 initiative at Riker's Island in New York City that tested 68.9

61. See CENTERS FOR DISEASE CONTROL & PREVENTION, A HEIGHTENED NATIONAL RESPONSE TO THE HIV/AIDS CRISIS AMONG AFRICAN AMERICANS (June 2007).

62. See Ian F. Haney López, *Post-Racial Racism: Racial Stratification and Mass Incarceration in the Age of Obama*, 98 CALIF. L. REV. 1023 (2010).

63. HEATHER C. WEST, BUREAU OF JUSTICE STATISTICS, PRISONERS AT YEAREND 2009—ADVANCED COUNTS 1 (2010), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/py09ac.pdf>.

64. *Id.*; Peter Wagner, PRISON POLICY INITIATIVE, THE PRISON INDEX: INCARCERATION & ITS CONSEQUENCES, available at <http://www.prisonpolicy.org/prisonindex/prisoners.html> (last visited April 16, 2012).

65. WEST, *supra* note 63.

66. BUREAU OF JUSTICE STATISTICS, HIV IN PRISONS Tbl. 4 (2006), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp06.pdf>.

67. BUREAU OF JUSTICE STATISTICS, HIV IN PRISONS, 2007–08 (2009).

68. HIV SURVEILLANCE, *supra* note 23.

69. *Id.* This includes inmates in custody of state and federal prison authorities and reported to be positive for the human immunodeficiency virus (HIV) or to have confirmed AIDS by gender in 2006. *Id.*

percent of those entering jail, 9.8 percent of women and 4.7 percent of men tested HIV-positive.⁷⁰ When these results were adjusted to include those not among the 68.9 percent tested, total HIV prevalence among the incarcerated was estimated at 14 percent for females and 6.5 percent for males.⁷¹ Notably, the HIV infection rate in New York City's jail is four times higher than the national average.⁷²

Among reporting states in 2007 and 2008, the number of incarcerated males with HIV/AIDS remained stable at 1.5 percent of the prison population.⁷³ Over the same years, the number of HIV-positive female inmates decreased slightly from 2.1 percent to 1.9 percent.⁷⁴ In New York State, however, more than 10 percent of females in custody are HIV-positive or have AIDS.⁷⁵ Florida, New York, and Texas report the largest number of prisoners who are HIV-positive.⁷⁶ Although these states account for only 24 percent of state prisoners nationally, 46 percent of incarcerated persons living with HIV or AIDS are in Florida, New York, and Texas.⁷⁷ Florida has the largest number of female HIV-positive state prison inmates, followed by New York and Texas, respectively.⁷⁸ California alone has experienced a marked increased rate of HIV infection among its incarcerated population, while HIV infection decreased in other state prisons.⁷⁹

Due to the high rates of infection among inmates, the Red Cross no longer accepts blood donations from people who have been held in a correctional facility, prison, jail, detention center, or halfway house for more than seventy-two consecutive hours.⁸⁰ Given the prevalence of high-risk behavior among incarcerated or detained men, the Red Cross prohibits blood donations from any person who fits within the following eight categories:

- 1) have ever used needles to take drugs, steroids, or anything not prescribed by your doctor;
- 2) are a male who has had sexual contact with another male, even once, since 1977;
- 3) have ever taken money, drugs or other payment for sex since 1977;
- 4) have had sexual contact in the past 12 months with anyone described above;
- 5) received clotting factor concentrates for a bleeding disorder such as hemophilia;
- 6) were born in, or lived in, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, Niger, or Nigeria, since 1977;
- 7) since 1977, received a blood transfusion or medical treatment with a blood product in any of these countries; or
- 8) had sex with anyone who, since 1977, was born in or

70. Elizabeth M. Begier, et al., *Undiagnosed HIV Infection Among New York City Jail Entrants*, 2006: *Results of a Blinded Survey*, 54 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 93, 93 (2010).

71. *Id.*

72. *Id.*

73. LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, BULLETIN: HIV IN PRISONS, 2007–08 1 (Dec. 2009), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf>.

74. *Id.*

75. BUREAU OF JUSTICE STATISTICS, HIV IN PRISONS, *supra* note 66, at tbl. 4.

76. KAISER FAMILY FOUND., INMATES IN CUSTODY OF STATE OR FEDERAL PRISON AUTHORITY WITH HIV OR AIDS, 2008 (Dec. 2009), available at <http://www.statehealthfacts.org/comparemaptable.jsp?ind=564&cat=11>.

77. See MARUSCHAK, *supra* note 73.

78. *Id.* at tbl. 1.

79. *Id.*

80. Margaret Newkirk, *Prison Inmates Can Bring AIDS Home When They Get Out*, AKRON BEACON J., April 6, 2002, at A6.

lived in any of these countries.⁸¹

The Red Cross list is based on factors placing one at risk for contracting HIV and therefore possibly donating contaminated blood. In Indiana, as in many states, intentionally donating contaminated blood is a felony.⁸²

Although AIDS-related deaths among the incarcerated population has decreased drastically, the death rate remains higher than among the general population.⁸³ Of those incarcerated, the number of AIDS-related deaths is highest among incarcerated Blacks.⁸⁴ In 2006, 114 Blacks, twenty-nine Whites, and twelve Hispanics died in state prisons due to AIDS-related illness.⁸⁵ Of those 155 deaths, only seven were women.⁸⁶ AIDS-related deaths are highest among inmates between the ages of 35–54.⁸⁷

Because sexual relationships are usually between people of the same race or ethnicity, Black women are therefore at an increased risk, and many Black women contract STIs and HIV through unprotected heterosexual relationships with infected Black men.⁸⁸ The high incarceration rate of Black males has directly, or indirectly, led to an increase in the number of Black women infected with HIV.⁸⁹ Indeed, the increase in the number of Black ex-inmates living with HIV/AIDS corresponds with the increase in the number of women, especially Black women, contracting HIV/AIDS through heterosexual relationships.⁹⁰ Over 17 percent of the estimated 229,000 persons in the general public living with AIDS in the United States had some interaction with the correctional system.⁹¹ An estimated 98,500 to 145,500 HIV-positive inmates were released from prisons and jails in 1996, which represented 13–19 percent of all HIV-positive individuals in the United States that year.⁹²

81. AMERICAN RED CROSS, *Eligibility Criteria By Topic*, <http://www.redcrossblood.org/donating-blood/eligibility-requirements/eligibility-criteria-topic> (last visited Feb. 14, 2012).

82. IND. CODE § 35-42-1-7 (1993). Titled “Transferring contaminated body fluids,” the statute sets forth that “A person who recklessly, knowingly, or intentionally donates, sells, or transfers blood, a blood component, or semen for artificial insemination (as defined in IC 16-41-14-2) that contains the human immunodeficiency virus (HIV) commits transferring contaminated body fluids, a Class C felony.” *Id.* at § 35-42-1-7(b). “However, the offense is a Class A felony if it results in the transmission of the human immunodeficiency virus (HIV) to any person other than the defendant.” *Id.* at § 35-42-1-7(c).

83. See Matt Clarke, PRISON LEGAL NEWS, *U.S. Department of Justice Releases Report on Deaths in Jail* (April 16, 2012), available at <https://www.prisonlegalnews.org/%28S%28g0zwk0jou1x4vz45tgqzpf45%29%29/displayArticle.aspx?articleid=22841&AspxAutoDetectCookieSupport=1>.

84. *See id.*

85. BUREAU OF JUSTICE STATISTICS, *HIV IN PRISONS*, *supra* note 66, at tbl. 7.

86. *Id.*

87. *Id.*

88. *Women and Girls*, THE LAW & POLICY GRP., <http://www.lawandpolicygroup.org/index.asp?pageID=116> (last visited June 17, 2012).

89. Newkirk, *supra* note 80, at A6.

90. *Id.* Some believe this connection is more tenuous, or even a “myth.” See THE BODY, *What Really Fuels the HIV/AIDS Epidemic in Black America?* (Feb. 6, 2012), <http://www.thebody.com/content/65639/what-really-fuels-the-hiv-aids-epidemic-in-black-am.html?getPage=9>.

91. NAT’L COMM’N ON CORR. HEALTH CARE, 1 THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES: A REPORT TO CONGRESS 3 (2002).

92. *Id.* at x.

Male inmates may become infected through a number of different means while in prison. Some acquire the virus through voluntary or involuntary sexual relations with other male prisoners.⁹³ The rape of incarcerated persons can lead to HIV infection, high-risk behavior, and emotional trauma affecting the inmate while incarcerated, as well as after release. The prevalence of rape in prison led to the enactment of the Prison Rape Elimination Act (PREA).⁹⁴ The Act's provisions include the establishment of a commission to study the issue of prison rape as well as the consequences for incarcerated persons.⁹⁵ In 2011, the PREA estimated that 12 percent of youth in state juvenile facilities and large non-state facilities experienced one or more incidents of sexual victimization by another juvenile in the facility or by facility staff.⁹⁶ Interestingly, 95 percent of youth in juvenile facilities reporting staff sexual misconduct cited female staff as the perpetrators.⁹⁷ In 2008, 42 percent of the staff in state juvenile facilities was female.⁹⁸ In adult facilities, 54 percent of substantiated incidents of sexual victimization involved other inmates while 46 percent of substantiated incidents involved staff members.⁹⁹ One or more incidents of sexual victimization by another inmate or staff member within the past twelve months was reported by 4.4 percent of federal and state prisoners and 3.1 percent of jail inmates.¹⁰⁰

Other inmates become infected through intravenous drug use employing contaminated needles¹⁰¹ that must be shared in prison because they are deemed contraband. Prison tattoos and body piercing also commonly involve contaminated needles, leading to the spread of HIV.¹⁰² Consequently, clean needles are not readily available, although homemade disinfectant is utilized when available.

An HIV-positive inmate may leave prison and return to, or begin, a heterosexual relationship without knowing his status. The male former inmate may be too ashamed to disclose a homosexual relationship that took place while incarcerated, especially if he was raped. In a study of 167 state and federal prisons, 286 local jails, and 10 special corrections facilities, a total of 81,566 inmates were interviewed about sexual victimization in prison.¹⁰³ An estimated 4.4 percent of prison inmates and 3.1 percent of jail inmates reported having been the victim of one or more sexual attacks by either an inmate or guard.¹⁰⁴ About 54 percent of substantiated sexual assaults involved only inmates; however, 46 percent involved staff members.¹⁰⁵ Furthermore, the trauma of prison rape by a guard or by an inmate or detainee with the guard's knowledge may prevent an

93. Newkirk, *supra* note 80, at A6.

94. See Prison Rape Elimination Act of 2003, 42 U.S.C. §§ 15601–15609 (2006).

95. *Id.* at § 15606.

96. BUREAU OF JUSTICE STATISTICS, PREA DATA COLLECTION ACTIVITIES 1 (2011).

97. *Id.*

98. *Id.*

99. *Id.* at 2.

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

inmate from being tested for HIV while in prison or upon his release from prison. Consequently, any subsequent female partner, unaware of his earlier homosexual relationships, is less likely to protect herself.

The male former inmate in a heterosexual relationship may also be unaware of his HIV status, given uneven testing practices and the stigma surrounding testing. Although many inmates leave prison uninformed of their status, all federal offenders are tested upon entry.¹⁰⁶ All inmates must have testing on demand while incarcerated and upon notice of release from the facility. Despite the demonstrated effectiveness of testing for HIV, which allows for effective treatment and reduces the unwitting spread of HIV, not every state prison provides these tests. Instead, each state can determine the extent of its HIV/AIDS testing.¹⁰⁷ Consequently, the triggers for such testing, including imprisonment and release, vary widely from state to state.¹⁰⁸

During 2008, twenty-four states reported testing all inmates for HIV at entry or sometime during custody.¹⁰⁹ Among these states, twenty-three tested upon entry, five tested while in custody, and six tested upon release.¹¹⁰ Compared to the preceding decade, when states tested only self-identified homosexuals and refused to test on demand without the stigma of admitting to a sexual encounter, states are progressing.¹¹¹ In 2008, fifty states and the federal system tested incarcerated persons if they had HIV-related symptoms or requested a test.¹¹² Forty-two states and federal prisons tested after incidents involving possible HIV transmission, whereas eighteen states and the federal system tested those in high-risk groups.¹¹³

Once tested, most incarcerated persons are not re-tested for HIV/AIDS unless they are willing to admit to engaging in high-risk behavior or the institution judges re-testing prudent.¹¹⁴ Depending on the facility's jurisdiction, an inmate who tests negative for HIV upon his entrance could contract the disease while in prison and be released without receiving another HIV test.¹¹⁵ Even if tested, medical research reveals that evidence of HIV infection may not show up on tests until several months after infection.¹¹⁶

Men who have sex with men (MSM) may not identify as homosexual or bisexual but nonetheless engage in behavior that can lead to HIV transmission.¹¹⁷

106. BUREAU OF JUSTICE STATISTICS, HIV IN PRISONS, *supra* note 66.

107. See HIV TESTING IMPLEMENTATION GUIDANCE FOR CORRECTIONAL SETTINGS (Jan. 2009), available at http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/pdf/Correctional_Settings_Guidelines.pdf.

108. See generally *id.* Testing for hepatitis also varies based on the federal, state, or local jurisdiction. See generally *id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

114. *Id.*

115. See *id.*

116. HIV & AIDS Health Center, WEBMD, <http://www.webmd.com/hiv-aids/pregnancy-hiv-testing> (last visited June 16, 2012).

117. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS, *supra*

Men who have sex with men, typically without informing their women partners, are engaged in behavior commonly referred to as the “down low.”¹¹⁸ Unfortunately, a “down low” relationship could have taken place while incarcerated, where HIV prevalence is much greater than in the general community. As such, the secrecy surrounding a prior or ongoing sexual relationship with another man extends well beyond the former inmate.

The trauma of incarceration increases high-risk behavior after release.¹¹⁹ Being incarcerated in a prison, jail, or juvenile detention center leads to high-risk behaviors upon release, especially within twelve months of release from incarceration, that can result in contracting HIV.¹²⁰ HIV risk-related behaviors include having more than five sexual partners, exchanging sex for money or drugs, injecting illicit drugs, contracting a STD from unprotected sex, and having a female partner who injected drugs.¹²¹ For males between 25–44 years of age who had been incarceration in jail or prison, 27 percent reported at least one of these HIV high-risk behaviors within twelve months of release.¹²²

Males in heterosexual relationships with no history of incarceration are also increasingly becoming infected with HIV/AIDS through secret MSM liaisons.¹²³ In 2009, Black MSM represented an estimated 73 percent of new infections among all Black men and 37 percent of new infections among all MSM.¹²⁴ New infections among young Black MSM increased by 48 percent from 2006–2009.¹²⁵ The women in heterosexual relationships with MSM may not be informed of their partner’s high-risk sexual liaisons or drug use. Hence, women are contracting HIV/AIDS from males who maintain heterosexual relationships while participating in MSM relationships.¹²⁶

IV. THE U.S. CONSTITUTION, WOMEN INMATES, AND MEDICAL CARE

Adequate medical care has prolonged the life of inmates living with HIV and AIDS. For example, AIDS-related deaths decreased from 32 percent of all deaths in state prisons in 1995 to 6 percent in 2000.¹²⁷ Similarly, during 2006, twelve federal inmates died from AIDS-related causes, down from twenty-seven federal inmates in 2005.¹²⁸ As noted previously, medical professionals serving

note 15.

118. Anjan Chandra et al., *HIV Risk-Related Behaviors in the United States Household Population Aged 15–44 Years: Data from the National Survey of Family Growth, 2002 and 2006–2010*, 46 NAT’L HEALTH STATISTICS REP. 1, 8–9 (2012).

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.*

123. CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS, *supra* note 15.

124. *Id.*

125. *Id.*

126. *See generally id.*

127. BUREAU OF JUSTICE STATISTICS, HIV IN PRISONS 7 (2000), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp00.pdf>.

128. Press Release, Bureau of Justice Statistics, Number of HIV-Positive State and Federal Inmates Continues to Decline (April 23, 2008).

private and public patients began reducing the number of AIDS-related deaths with medical intervention such as antiretroviral therapies.¹²⁹ Although the numbers have decreased over time, AIDS-related deaths remain higher in the prison population than in the general population.¹³⁰

Inmates are dependent upon the correctional system for their medical needs. Current medical problems among prisoners include arthritis, asthma, cancer, diabetes, heart problems, HIV, hypertension, kidney problems, paralysis, stroke, hepatitis, and tuberculosis.¹³¹ More than half of female and male inmates reported a current medical problem.¹³² Among prison inmates admitted to state prisons, 15.9 percent reported fight-related injuries while 8.3 percent of federal prison inmates reported such injuries.¹³³

Although the number of incarcerated persons with HIV is decreasing in certain jurisdictions, the cost of caring for prisoners with HIV/AIDS is high and growing. One study estimates the cost of lifetime treatment for a person with HIV at \$155,000.¹³⁴ The impact of caring for prisoners with HIV/AIDS on a prison budget is further strained by increase in the prison population and the national austerity plans state and federal lawmakers are forced to implement. In Maryland, half of the correctional system's entire budget for pharmaceuticals goes toward HIV treatment.¹³⁵ Maryland's prison health care budget is approximately \$61 million.¹³⁶

Every new HIV infection represents substantial economic liability for the correctional facility as well as public benefits or private insurance upon an inmate's release. The lifetime costs for treating an individual person living with HIV, in the private sector, is over \$618,000.¹³⁷ However, because providing medical care to prisoners with HIV and AIDS is a constitutional, statutory, and judicial responsibility, the lack of funds or high costs does not excuse failure to provide adequate medical care.¹³⁸ Once released from a correctional facility, the formerly incarcerated are assisted in some states, such as New York, in

129. See Cohen et al., *supra* note 54; Quinn et al, *supra* note 55; Grant et al., *supra* note 56.

130. See generally HIV/AIDS STATISTICS AND SURVEILLANCE: BASIC STATISTICS (Aug. 11, 2011), available at <http://www.cdc.gov/hiv/topics/surveillance/basic.htm#dpdhi>.

131. LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF PRISONERS Table 2 (2008), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mpp.pdf> ; LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF JAIL INMATES 1 (2006), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mpji.pdf>.

132. MARUSCHAK, MEDICAL PROBLEMS OF JAIL INMATES, *supra* note 131, at 2.

133. *Id.* at tbl. 6.

134. HIV PREVENTION STRATEGIC PLAN THROUGH 2005, 64 (2001), available at <http://www.cdc.gov/hiv/resources/reports/psp/pdf/prev-strat-plan.pdf> [hereinafter HIV PREVENTION STRATEGIC PLAN THROUGH 2005].

135. *Id.*

136. *Id.*

137. A.B. Hutchinson et al., *The Economic Burden of HIV in the United States in the Era of Highly Active Antiretroviral Therapy*, 43 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 451, 451–57.

138. *Harris v. Thigpen*, 941 F.2d 1495, 1509 (11th Cir. 1991) (stating: "We are aware that systemic deficiencies in medical care may be related to a lack of funds allocated to prisons by the state legislature. Such a lack, however, will not excuse the failure of correctional systems to maintain a certain minimum level of medical service necessary to avoid the imposition of cruel and unusual punishment").

connecting with the social services needed to maintain medical treatment.¹³⁹ Ironically, once released, most formerly incarcerated persons are unable to receive medical care using private insurance because their HIV status is deemed a pre-existing condition.¹⁴⁰ If upheld as constitutional, the Affordable Care Act will allow anyone with a pre-existing condition to receive medical insurance.¹⁴¹

A prisoner's safety and welfare is the responsibility of the correctional facility where she is housed. In *Estelle v. Gamble* the Supreme Court held that the state has an affirmative duty to provide medical care vis-à-vis the limitations placed on an incarcerated individual which prevent her from providing for her own medical needs.¹⁴² The Court stated that failure to comply with this duty constitutes cruel and unusual punishment, thus violating the Eighth Amendment of the United States Constitution.¹⁴³

In *DeShaney v. Winnebago County Department of Social Services*, the Supreme Court reiterated that a person in custody must have her medical needs met by the government:

[W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. . . . The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment.¹⁴⁴

In *DeShaney*, a child under the "observation" of social services presented physical evidence of abuse but remained in his father's home until he was beaten

139. See generally *Best of the Web: Community Information: Formerly Incarcerated People*, N.Y. PUB. LIBRARY, <http://www.nyp.l.org/welinks/1492> (last visited June 17, 2012).

140. See Mark Scherzer, *HIV and Insurance: Some Questions and Answers*, THE BODY, <http://www.thebody.com/content/art2794.html> (Oct. 1998).

141. See INCREASING ACCESS TO AFFORDABLE CARE: PROVIDING ACCESS TO INSURANCE FOR UNINSURED AMERICANS WITH PRE-EXISTING CONDITIONS, healthcare.gov (last visited June 17, 2012).

142. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976). See also *Harris*, 941 F.2d 1495 (stating: "Federal and state governments . . . have a constitutional obligation to provide minimally adequate medical care to those whom they are punishing by incarceration"); *Wellman v. Faulkner*, 715 F.2d 269, 271 (7th Cir. 1983) (stating: "When a state imposes imprisonment as a punishment for crime, it accepts the obligation to provide persons in its custody with a medical care system that meets minimal standards of adequacy").

143. *Estelle*, 429 U.S. at 104. The Eighth Amendment states that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted." U.S. CONST. amend. VIII. This obligation is applicable to the states through the Fourteenth Amendment of the U.S. Constitution. See U.S. CONST. amend. XIV § 1. Notably, the Eighth Amendment has been given a more restricted interpretation by the present U.S. Supreme Court than by earlier Courts. Martin A. Greer, *Human Rights and Wrongs in Our Own Backyard: Incorporating International Human Rights Protections Under Domestic Civil Rights Law—A Case Study of Women in United States Prisons*, 13 HARV. HUM. RTS. J. 71, 94 (2000). Similarly, federal prison policies follow a more restricted interpretation of cruel and unusual punishment. See *id.* at 90–91. However, some state courts interpret these protections more broadly, providing prisoners with protection from cruel or unusual punishment. *Id.* at 96.

144. *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 199–200 (1989).

unconscious and suffered irreversible brain damage.¹⁴⁵ The Court did not uphold liability on the part of the state social services agency because the child was not in state custody at the time of the incident.¹⁴⁶

The U.S. Constitution thus protects an inmate's right to basic medical care. An Eighth Amendment violation takes place if prison officials act with "deliberate indifference" to the medical needs of a person in custody.¹⁴⁷ Deliberate indifference has both an objective and subjective component.¹⁴⁸ First, deliberate indifference occurs when administrators are made aware of the inmate's medical condition and refuse to provide adequate medical care.¹⁴⁹ Second, the deliberate indifference standard requires a "sufficiently serious" deprivation.¹⁵⁰ Hence, an inmate's dissatisfaction with her medical care is not the determining factor in the court's decision. However, medical needs may be compromised to the point of a constitutional violation when prison officials fail to provide trained medical personnel.¹⁵¹ Unfortunately, prisons for women have historically lacked adequately staffed hospitals. For instance, a class action complaint against the Bedford Hills Correctional Facility in New York highlighted the poor medical conditions for women at the prison, including the prison's failure to have a single physical on permanent duty.¹⁵² Conversely, inmates have a constitutional right to refuse health care.¹⁵³

Incarcerated persons living with HIV/AIDS have unique medical needs. With regard to psychological impairments, prisons have only a limited legal obligation to provide inmates with medical attention.¹⁵⁴ According to *Harris v. Thigpen*, the psychological condition must be of a serious medical nature.¹⁵⁵ In *Harris*, the Eleventh Circuit held that failure to treat HIV-related depression did not constitute a sufficiently serious medical problem.¹⁵⁶ However, the court

145. *Id.* at 191–92.

146. *Id.* at 197–99.

147. *Estelle*, 429 U.S. at 103–05. In *Estelle*, the Court held that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' . . . whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Id.* at 104–05.

148. *Wilson v. Seiter*, 501 U.S. 294, 298 (1991).

149. FRED COHEN, *THE MENTALLY DISORDERED INMATE AND THE LAW* 4-3 (2d ed. 2008).

150. *Wilson*, 501 U.S. at 298.

151. COHEN, *supra* note 149, at 14-1.

152. *Todaro v. Ward*, 431 F. Supp. 1129 (S.D.N.Y. 1977), *aff'd*, 565 F.2d 48 (2d Cir. 1977).

153. See *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261 (1990). "[A] competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." *Id.* at 278. However, "determining that a person has a liberty interest under the Due Process Clause does not end the inquiry; whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Id.* at 279 (internal quotation marks omitted).

154. While the constitutional standard of deliberate indifference still applies, it is only for "severe" mental illness, which is defined as one "that has caused significant disruption in an inmate's everyday life and which prevents his functioning in the general population without disturbing or endangering others or himself." *Tillery v. Owens*, 719 F. Supp. 1256, 1286 (W.D. Pa. 1989), *aff'd*, 907 F.2d 418 (3rd Cir. 1990). See *Harris v. Thigpen*, 941 F.2d. 1495, 1511 (11th Cir. 1991).

155. *Harris*, 941 F.2d at 1511.

156. *Id.* Nevertheless, the court reaffirmed that "prisoners are guaranteed the right under the

acknowledged that a prison's failure to respond "to specific psychiatric disorders and conditions that accompany the presence of HIV infection, such as AIDS-related dementia, could constitute" an Eight Amendment violation.¹⁵⁷ AIDS dementia complex is a serious neuropsychological disorder that likely qualifies as a significant medical need under Eighth Amendment jurisprudence, particularly at later stages of the disorder.¹⁵⁸ As such, AIDS dementia complex may meet the *Harris* standard as a sufficiently serious medical condition.

HIV-positive prisoners also have statutory rights to protect them against discrimination while imprisoned. The Supreme Court has held that the Americans with Disabilities Act of 1990 (ADA) encompasses state prisons;¹⁵⁹ thus, prisoners with HIV/AIDS are covered by the ADA.¹⁶⁰ Consequently, prisoners who qualify for prison programs cannot be discriminated against due to their medical condition.¹⁶¹

The courts are divided over whether prisoners with HIV/AIDS enjoy a right to privacy.¹⁶² For instance, the Court of Appeals for the Seventh Circuit has held that a prison official did not violate a clearly established right when he revealed an inmate's HIV-status to another prisoner in order to safeguard him from infection.¹⁶³ However, the court indicated that the prison could not refuse haircuts and social activities as a means of "punishing" a prisoner for HIV status.¹⁶⁴

V. CHANGING THE IMPACT OF HIV/AIDS ON THE BLACK COMMUNITY

Black female former inmates living with HIV/AIDS face special obstacles. Most ex-inmates, male and female, lack adequate job preparation, formal education, and support networks.¹⁶⁵ Without health insurance, an HIV-infected

[E]ighth [A]mendment to be free from deliberate indifference by correctional institutions to their serious physical or psychological needs." *Id.* at 1505.

157. *Harris*, 941 F.2d. at 1511.

158. Mayer, *supra* note 15, at 254.

159. *Pennsylvania Dep't of Corrections v. Yeskey*, 524 U.S. 206, 213 (1998) (holding that the language of ADA Title II unambiguously applies to state prisons).

160. *Bragdon v. Abbott*, 524 U.S. 624, 641 (1998) (holding that plaintiff's HIV was a disability under the ADA). However, the Court did not address whether HIV is a *per se* disability under the ADA. *Id.* at 641-42. See also JOHN W. PALMER, CONSTITUTIONAL RIGHTS OF PRISONERS 257 (8th ed. 2006).

161. Nevertheless, Alabama and South Carolina continue to segregate prisoners based on their HIV/AIDS status. ACLU NATIONAL PRISON PROJECT & HUMAN RIGHTS WATCH, SENTENCED TO STIGMA: SEGREGATION OF HIV-POSITIVE PRISONERS IN ALABAMA AND SOUTH CAROLINA 1 (2010).

162. See *Chapter 22: AIDS in Prison*, 31 COLUM. HUM. RTS. L. REV. 355, 377-80 (2000).

163. *Anderson v. Romero*, 72 F.3d 518, 523-24 (7th Cir. 1995). However, the court's decision was based on the doctrine of official immunity, not a motivation to safeguard inmates from infection. *Id.* The court did note, however, that a prisoner does not have a "right to conceal his HIV status" largely because HIV is a communicable disease and that the law does not clearly hold that "a prison cannot without violating the constitutional rights of HIV-positive inmates reveal their condition . . . in order to enable . . . other inmates and . . . guards to protect themselves from infection." *Id.* at 524.

164. *Id.* at 526 (distinguishing between warning prisoners of an inmate's HIV status and "punishing" a prisoner for HIV status by refusing haircuts or outdoor exercise).

165. See generally HILDA SOLIS & ERIC HOLDER, REINTEGRATION GRANTS PROVIDE OPPORTUNITY TO REBUILD LIVES, U.S. DEP'T OF LABOR, <http://social.dol.gov/blog/reintegration-grants-provide-opportunity-to-rebuild-lives/> (last visited June 17, 2012).

former inmate must rely on governmental services. In turn, her health status may interfere with her ability to obtain employment or prevent her from working altogether. Former inmates also carry the social stigma of incarceration. Black female ex-inmates living with HIV/AIDS must handle all of these challenges in addition to family care issues, gender discrimination, and racial bias.¹⁶⁶ Too often these factors result in a downward spiral leading to recidivism.¹⁶⁷

The prevalence of HIV/AIDS, as well as hepatitis and tuberculosis, among Black women and men is devastating the Black community. In 1999, half of all men diagnosed with HIV and almost two-thirds of all women with AIDS were African American.¹⁶⁸ African American children represent 54 percent of all reported pediatric AIDS cases.¹⁶⁹ The majority of Black families are led by a single female parent.¹⁷⁰ In 2012, with AIDS and HIV remaining a leading cause of death in the Black community, significant changes in governmental policies are needed.

VI. MECHANISMS FOR CHANGE

A. Saving Lives Through Mandated Testing and Reporting

Protecting public health and, in particular, the lives of Black females from HIV/AIDS requires breaching certain privacy assumptions. HIV is a public health emergency. It has been pronounced an epidemic by most and a pandemic by many. In most states, there are mechanisms to contain life threatening communicable diseases such as syphilis and tuberculosis.¹⁷¹ Procedures for testing, contacting possible partners, and delivering medical treatment are established and implemented under state law.¹⁷² Since voluntary HIV testing has proven ineffective, medical professionals should be required, by law, to test anyone presenting for medical treatment who demonstrates high-risk behavior. In New Jersey, for example, certain medical professionals are required by law to follow procedures if presented with someone who appears to have tuberculosis.¹⁷³ The list of required personal includes those in correctional

166. See Mayer, *supra* note 15, at 219–221 (discussing challenges faced by HIV-positive women and HIV-positive women inmates, including unique family responsibilities and stigmatization, and their impact on women’s mental health).

167. See Elizabeth Piper Deschenes, Barbara Owen & Jason Crow, *Recidivism Among Female Prisoners: Secondary Analysis of the 1994 BJS Recidivism Data Set (January 2007)* (unpublished manuscript) (available at <http://www.ncjrs.gov/pdffiles1/nij/grants/216950.pdf>).

168. HIV PREVENTION STRATEGIC PLAN THROUGH 2005, *supra* note 134, at 12.

169. CENTERS FOR DISEASE CONTROL & PREVENTION, *HIV/AIDS SURVEILLANCE REPORT* (June 2000), tbl. 15.

170. See THE NAT’L URBAN LEAGUE, *THE STATE OF BLACK AMERICA 2000*, 118 (2000) (stating: “Families headed by black single females in particular are at the lowest end of the wealth spectrum, and such families account for most black children under 18 years of age”).

171. See generally N.J. ADMIN. CODE §§8:57-5.1–.18 (2011) (providing guidelines and procedures for the management of communicable diseases and, in this subchapter, for tuberculosis in particular).

172. *Id.*

173. *Id.*

facility administrators.¹⁷⁴

Medical professionals in correctional facilities are not currently required to inform partners of an inmate's HIV or AIDS diagnosis. In New York, for example, physicians in correctional facilities are required to follow the same reporting procedures as private physicians. They must complete a "Medical Provider HIV/AIDS and Partner/Contact Report Form" (PRF) on all newly diagnosed patients and submit it to the New York City Department of Health and Mental Hygiene "upon initial determination that a person is infected with human immunodeficiency virus (HIV), or (b) upon initial diagnosis that a person is afflicted with the disease known as acquired immune deficiency syndrome (AIDS), or (c) upon initial diagnosis that a person is afflicted with HIV related illness."¹⁷⁵

Requirements for physicians to report are the same whether they are working in a correctional setting or in a community or private medical office. Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code.¹⁷⁶ The primary responsibility for reporting rests with the physician;¹⁷⁷ moreover, laboratories,¹⁷⁸ school nurses,¹⁷⁸ day care center directors,¹⁷⁹ nursing homes or hospitals,¹⁸⁰ and state institutions¹⁸¹ or other locations providing health services¹⁸² must report. Certain diseases, like tuberculosis and syphilis, warrant prompt action and are to be reported immediately to the local health department by phone, followed by submission of the confidential case report form (in NYC, form PD-16).¹⁸³

However, for tuberculosis, medical providers and infection control practitioners are required by the New York City Health Code to report all patients suspected and confirmed with tuberculosis (TB) to the New York City Department of Health and Mental Hygiene (DOHMH), Bureau of Tuberculosis Control, within twenty-four hours of diagnosis or clinical suspicion.¹⁸⁴ Medical providers must report these patients even though microbiologists and pathologists are also required to report findings consistent with TB.¹⁸⁵ Note that the reports must be received by the DOHMH within twenty-four hours, whether

174. *Id.* Those primarily responsible for implementing this subchapter are health officers, public health nurse case managers, health care providers, hospital administrators, and correctional facility administration. *Id.* The subchapter provide that "[h]ealth officers in areas where a person with suspected or confirmed infectious or potentially infections TB disease resides, frequents, or receives care, may take any action authorized under this subchapter when necessary to protect the health of the person with disease and/or the public." *Id.* at §8:57-5.1.

175. N.Y. PUB. HEALTH LAW § 2130 (2000).

176. N.Y. COMP. CODES R. & REGS. Tit. 10, §§ 2.10, 2.14 (2011).

177. *Id.* at § 2.10.

178. *Id.* at § 2.12.

179. *Id.* at § 2.12.

180. *Id.* at § 405.3(d).

181. *Id.* at § 2.10(a).

182. *Id.* at § 2.12.

183. THOMAS FARLEY, NYC DEP'T. OF HEALTH & MENTAL HYGIENE, DIAGNOSIS: REPORTING REQUIREMENTS FOR TUBERCULOSIS (2011), available at http://www.nyc.gov/html/doh/downloads/pdf/tb/reporting_requirements_for_tuberculosis.pdf.

184. N.Y.C. HEALTH CODE §§ 11.03, 11.05, 11.21 (2011).

185. *Id.* at §§ 11.03, 11.05, 11.21.

by express or overnight mail, fax, telephone, or electronically.¹⁸⁶

Partners and others who could have become infected with TB are contacted by law.¹⁸⁷

However, those persons diagnosed with HIV or AIDS and their physicians do not have mandated partner notification. The New York State Public Health Law only requires that providers talk with HIV-infected individuals about their options for informing sexual and needle-sharing partners that they may have exposed to HIV, and the Contact Notification Assistance Program (CNAP) of the New York City Department of Health and Mental Hygiene provides assistance to HIV-positive individuals and to providers who would like help notifying partners.¹⁸⁸ The New York States Public Health Law articulates all of the privacy afforded to HIV positive patients in addition to what is covered under HIPAA.¹⁸⁹ Although an inmate is informed of his status upon entering the facility, the partner of an incarcerated person could be infected for years before realizing their health has been compromised. Under current law and policy, the sexual partner of any infected person must rely totally on the moral conscience of the infected person to divulge their HIV status. His privacy outweighs her health, giving rise to a pandemic in the Black community.

If a person tests positive for HIV, then relevant information, similar to the forms required with a positive tuberculosis test, should be completed and immediately provided to the Public Health Office. The office should obtain the names and possible location or address of the person's sexual contacts. Those contacts must be informed of a possible HIV transmission and the need to be tested. In this way, medical treatment can begin immediately. Unlike with tuberculosis, the patient will not be quarantined and forced to undergo medical treatment. However, treatment will be strongly encouraged. Correctional facilities must be required to follow a similar procedure. Partners and sexual contacts both inside and outside the facility should be contacted, especially if conjugal visits are permitted.

While the United States Constitution does not explicitly articulate a right to privacy, the Supreme Court "has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution."¹⁹⁰ Similarly, the Federal Rules of Evidence recognize certain privileged relationships.¹⁹¹ Hence, a prison physician is not permitted to disclose the patient's medical information without the patient's express permission.¹⁹²

Social stigma is associated with tuberculosis and syphilis. Yet, with tuberculosis, the public health concerns are deemed to outweigh the privacy

186. *Id.* at §§ 11.03, 11.05, 11.21.

187. NYC DEP'T OF HEALTH & MENTAL HYGIENE, HIV EPIDEMIOLOGY & FIELD SERVICES (2012), available at http://www.nyc.gov/html/doh/html/dires/hcpreporting_partner.shtml#1.

188. NYC DEP'T. OF HEALTH & MENTAL HYGIENE, CONTACT NOTIFICATION ASSISTANCE PROGRAM (CNAP) (2012), available at <http://www.nyc.gov/html/doh/html/std/std3.shtml>.

189. N.Y. PUB. HEALTH LAW § 2782 (2000).

190. *Roe v. Wade*, 410 U.S. 113, 152(1973) (acknowledging that the United States Constitution "does not explicitly mention any right of privacy" but citing a line of Supreme Court decisions recognizing this right).

191. FED. R. EVID. 501.

192. *See generally id.*

objections. Since the societal stigma associated with HIV/AIDS has lessened somewhat, the over-riding privacy concerns should be re-evaluated. The law recognizes that intentionally inflicting a person with HIV is a crime. Under government policy, a person living with HIV/AIDS is not required to inform his/her sexual partner, yet there are laws under which one intentionally infecting another person with HIV/AIDS may be charged with assault, sexual felony, or possibly attempted murder.¹⁹³ The concern is maintaining a balance between privacy rights and the protection of innocent women and men. International organizations seek to prevent the criminalization of HIV.¹⁹⁴ However, encouraging infected people to reveal their status to sexual partners has not kept pace with infection rates.

While not legally required, an individual living with HIV/AIDS should feel a moral duty to inform his or her partner of their health status. However, 70 percent of the partners of HIV-positive individuals have not been informed of their partner's health status.¹⁹⁵ Many women are consequently left unaware of their partner's HIV status until they are diagnosed.

Most states allow individuals with HIV/AIDS to determine if and when they wish to inform their partners. However, required reporting is necessary given the very low rate of voluntary self-reporting and possible criminal action for intentionally infecting a sexual partner.¹⁹⁶

Just as prison officials have a legal duty to protect the inmates in their care, this duty should extend to the partner of the inmate. When an inmate tests positive for HIV, prison officials should act under the same statutes that govern private physicians and medical staff at the health centers. Both mandatory HIV/AIDS testing within prisons and mandatory reporting of test results to partners have been resisted by organizations such as the American Civil Liberties Union (ACLU) National Prison Project.¹⁹⁷

B. Women and Girls Need Public Awareness Regarding MSM

The CDC has initiated high impact prevention programs in the Black community. The CDC's Act Against AIDS campaign delivers culturally

193. See generally MICH. COMP. LAWS § 333.5210 (2009) (stating: (1) A person who knows that he or she has or has been diagnosed as having acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex, or who knows that he or she is HIV infected, and who engages in sexual penetration with another person without having first informed the other person that he or she has acquired immunodeficiency syndrome or acquired immunodeficiency syndrome related complex or is HIV infected, is guilty of a felony.

(2) As used in this section, "sexual penetration" means sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, but emission of semen is not required.)

194. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, POLICY BRIEF: CRIMINALIZATION OF HIV TRANSMISSION (2008), available at http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf.

195. Benjamin F. Neidl, *The Lesser of Two Evils New York's New HIV/AIDS Partner Notification Law and Why the Right of Privacy Must Yield to Public Health*, 73 ST. JOHN'S L. REV. 1191, 1235 (1999) (citing a CDC study).

196. *Id.* at 1234-36.

197. See AM. CIVIL LIBERTIES UNION, HIV TESTING AND PRIVACY, available at <https://www.aclu.org/hiv-aids/hiv-testing-and-privacy> (last visited June 17, 2012).

appropriate messages about HIV infection.¹⁹⁸ Expanding Testing Initiative (ETI) is a testing program for Blacks and Latinos.¹⁹⁹ However, any effective public service campaign on HIV prevention needs to address MSM from all perspectives. The current billboards are directed at educating young Black males.²⁰⁰ However, Black women between 19–44 who are dying from AIDS contracted through heterosexual relationships are being ignored.²⁰¹ MSM is a sensitive and controversial issue. Handled poorly, such a campaign could cause harm. However, Black women’s lives are at stake. “Young Men of Color Who Have Sex with Men (YMCWSM)” and “Young Transgender Persons of Color” focus prevention on these at-risk groups.²⁰² “WILLOW” emphasizes gender pride among HIV-positive Black women.²⁰³ “Sister to Sister” provides health information that is culturally sensitive.²⁰⁴ “Nia” educates heterosexual men about HIV/AIDS.²⁰⁵ “Defend Yourself!” and “Many Men, Many Voices” “address social, cultural, and religious norms, promote condom use, and assist Black MSM in recognizing and handling HIV risk-related racial and sexual bias.”²⁰⁶

The rising number of women with HIV speaks to the importance of public safety information that focuses on limiting the spread of HIV from Black men to Black women.²⁰⁷ Advertisements and public safety information must continue to address avoidance of high-risk behavior. However, public service announcements must also address how women can better protect themselves in heterosexual relationships. Despite the acknowledged prevalence of MSM, public service information has not addressed this sensitive, but crucial, issue of public safety. The need to reach the “down-low” phenomenon is critical to saving the lives of Black women and girls.

Girls are becoming infected through statutory rape, or illegal sexual encounters, with infected men. Statutory rape is a crime. Statutory rape is defined as sexual relations between persons deemed by state law to be unable to make their own decisions about sex.²⁰⁸ Public information should address

198. ACT AGAINST AIDS, CENTERS FOR DISEASE CONTROL & PREVENTION (May 7, 2012), <http://www.actagainstaids.org>.

199. EXPANDED TESTING PROGRAM OVERVIEW (Aug. 22, 2011), <http://www.cdc.gov/hiv/resources/factsheets/HIV-ETP.htm>.

200. See generally CENTERS FOR DISEASE CONTROL & PREVENTION, HIV AMONG YOUTH (Dec. 2011).

201. See LEADING CAUSES OF DEATH, *supra* note 29.

202. See generally FUNDING OPPORTUNITY ANNOUNCEMENT (FOA) PS11-1113: HUMAN IMMUNODEFICIENCY VIRUS (HIV) PREVENTION PROJECTS FOR YOUNG MEN OF COLOR WHO HAVE SEX WITH MEN AND YOUNG TRANSGENDER PERSONS OF COLOR (Sept. 28, 2011), <http://www.cdc.gov/hiv/topics/funding/PS11-1113/index.htm>.

203. WILLOW (Aug. 27, 2009), http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance/willow.htm.

204. SISTER TO SISTER, <http://www.sistertosister.org/> (last visited June 17, 2012).

205. NIA: A PROGRAM OF PURPOSE (Feb. 24, 2009), <http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/nia.htm>.

206. D-UP: DEFEND YOURSELF! (Aug. 27, 2009), http://www.cdc.gov/hiv/topics/prev_prog/ahp/resources/guidelines/pro_guidance?d-up.htm; MANY MEN, MANY VOICES (2MV) (Apr. 5, 2011), <http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/3mv.htm>.

207. HIV PREVENTION STRATEGIC PLAN THROUGH 2005, *supra* note 134.

208. See BLACK’S LAW DICTIONARY 1288 (8th ed. 2004).

statutory rape as a crime and include sex education and STI as well as HIV prevention classes. Young girls are contracting STIs from older teens or grown men, indicating unprotected high-risk sex. While 50 percent of Black teenage girls have a STI, only 20 percent of White teen girls have a STI.²⁰⁹ These numbers are unacceptable for either group.

The increasing acceptance of homosexual relationships and gay marriage has led to increased public service information directed at the gay community. Public service announcements must honestly depict how male and female inmates can become infected, especially given the infection of women in heterosexual relationships. Public service announcements are especially needed in light of the reduced vigilance around HIV transmission that has resulted, in part, from the longevity of Magic Johnson's illness. HIV/AIDS now appears to be just another disease that can be maintained with appropriate medical advice and prescriptions. However, there are grave concerns within the medical community that attempts to alleviate stigma of HIV may have undermined the work of prevention.²¹⁰ There is no cure for this preventable disease, and unlike cancer or diabetes, it is communicable to others.

C. Improve Health Conditions in Correctional Facilities

The level of medical care, education, and preventive services afforded inmates in America's prisons and jails has largely improved in the last ten years. Rikers Island jail in New York City has developed aggressive education programs, health care, testing, and follow-up care in the community upon release.²¹¹ Over 90 percent of HIV-positive inmates serving sentences at Rikers Correctional Facility are released with a healthcare plan.²¹² Unfortunately, the economic obstacles facing most city and state budgets mean correctional facilities must reduce funding and personnel budgets for these new post-release healthcare initiatives. These budgetary reductions must take into consideration the legal obligations placed on each state to provide adequate medical care to inmates.

In July 2010, the Obama Administration released the National HIV/AIDS Strategy, a comprehensive roadmap for reducing the impact of HIV. Setting targets for HIV prevention, this initiative seeks to lower the number of infections, increase the status rate (people who know of their infection) to 90 percent of the infected population, reduce the HIV transmission rate by 30 percent, increase the percentage of newly diagnosed individuals in care, and increase by 20 percent the detectable viral loads among gays, bisexuals, Blacks, and Latinos infected

209. *In Honor of Black HIV/AIDS Awareness Day: Young Black Women Need HIV Prevention*, HIV LAW PROJECT (Feb. 4, 2010), <http://hivlawproject.org/StayInformed/releases/national-black-hiv-aids-awareness-day-2010.html>.

210. See, CONDOM SENSE: A GUIDE TO SEXUAL SURVIVAL IN THE NEW MILLENNIUM (2004).

211. Alison O. Jordan et al., NYC Dep't of Health & Mental Hygiene Health Care Access & Improvement, Speech at the National Conference on Correctional Health Care: HIV Continuum of Care: From Rikers Island Intake Jail to Community Provider (October 28, 2008), available at <http://enhancelink.org/sites/hivjailstudy/HIV%20Cont%20of%20Care.pdf>.

212. *Id.*

with HIV who have undetectable viral loads.²¹³ In July 2012, the United States hosted the twenty-ninth International AIDS Conference in Washington, D.C.²¹⁴ It was the first time in decades that the United States hosted the conference.²¹⁵ Issues related to the infection rates among women as well as prison populations were examined from an international perspective.²¹⁶

Worldwide, prisons are virulent environments for spreading communicable, debilitating diseases. In America, too many prisons and jails have only rudimentary educational programs on HIV/AIDS and STIs. More materials must be provided to soon-to-be-released inmates about the spread of HIV/AIDS, hepatitis, and STIs. The future impact of the prison health crisis on the civilian population is tremendous.

Ultimately, the rate of HIV/AIDS infection among women is a litmus test. The methods of contracting the disease have evolved with the circumstances. The outside community must become better informed about the health crisis fomenting within prisons and jails. The general public needs to make the connection between the conditions within prisons and the spread of disease outside of prisons. Once that important connection is made, the fight against the spread of HIV/AIDS and other communicable diseases will improve radically.

213. HIGH-IMPACT HIV PREVENTION: CDC'S APPROACH TO REDUCING HIV INFECTIONS IN THE UNITED STATES (2011), available at http://www.cdc.gov/hiv/strategy/dhap/pdf/nhas_booklet.pdf. See also OFFICE OF NAT'L AIDS POLICY, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES (2010), available at <http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf>.

214. AIDS 2012, XIX INTERNATIONAL AIDS CONFERENCE, aids2012.org (last visited June 29, 2012).

215. *Id.*

216. *Id.*