



CRITICAL CIVIL RIGHTS ISSUES FOR PEOPLE LIVING WITH HIV/AIDS IN THE UNITED STATES

A TO DO LIST FOR THE NEW U.S. ADMINISTRATION'S FIRST 100 DAYS

Civil and human rights have taken a hit in the United States over the last eight years, but some of the discrimination against people with HIV has been grinding on for much longer. Stigma and discrimination fuel the HIV/AIDS pandemic; protecting human rights protects the public's health.

The worst kind of discrimination against people with HIV is government-sponsored discrimination. At the very least, we should expect our government officials – federal, state and local – to reject policies that explicitly exclude people living with HIV or AIDS or that are interpreted in a way that marginalizes them. Government discrimination – such as the United States military's exclusion of enlistees with HIV, or many states' exclusion of HIV-positive applicants for trade schools and licensing – reinforces stigma by putting the "official" seal of approval on unsound treatment of those with HIV/AIDS.

Since the beginning of the epidemic, people with HIV and their advocates have been calling on the President of the United States to take visible leadership in condemning discrimination and supporting adequate services for people with HIV. Protecting the rights and dignity of people with HIV/AIDS must be a central part of a national AIDS strategy. In this document, we identify 15 steps – some requiring little more than a few strokes of the Executive Pen – that the next U.S. administration should take in its first 100 days to end government support and accommodation of HIV-related stigma and discrimination. Now more than ever, it is time for human and civil rights to be a central part of the U.S. national strategy to end AIDS.

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Health Care Access and Access to Other Essential Services

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DESCRIPTIONS OF ISSUES AND RECOMMENDED ACTIONS**Employment and Licensing:****1. Elimination of all HIV-specific exclusions of individuals from federal agencies and the military****• Background:**

Individuals with HIV are being excluded from certain federal agency programs and employment, solely on the basis of their HIV status. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, prohibits any “program or activity” receiving federal financial assistance from discriminating against an otherwise qualified individual on the basis of disability. Despite this requirement for individualized assessments, certain federal agencies still have blanket exclusions against employees or applicants with HIV.

The military imposes a number of limitations on individuals with HIV. Among others, it is Department of Defense policy to deny eligibility to HIV positive individuals for “appointment, enlistment, pre-appointment, or initial entry training for Military Service.”¹ This applies to applicants for “U.S. Service Academies, Reserve Officer Training Corps scholarship programs, and the Uniformed Services University of the Health Sciences” who test positive for HIV.² In addition, enlisted members of the Air Force who are “candidates for appointment through Officer Training School programs” who test positive for HIV must be disenrolled and the same is true with regard to enlisted members of the Army in Officer Candidate School.³ Although the

¹ Department of Defense Instruction Number 6485.01 (4.1); see also Army Regulation 600-110 (1-15); Air Force Instruction 48-135 (3.1).

² DoD Instr. No. 6485.01 (6.1.1).

³ Air Force Instr. 48-135 (A3.5); Army Reg. 600-110 (3-3(h)(3)).



Department of Defense has removed any blanket prohibition on active duty service members with HIV serving overseas,⁴ Army policy maintains this prohibition and requires that all active duty soldiers with HIV be “limited to duty within the U.S.”⁵ By contrast, the Air Force maintains the prohibition, but provides that “[w]aivers are considered using normal procedures established for chronic diseases.”⁶

- **Recommended Action:**

The Administration should issue an Executive Order to ensure that all federal agencies are complying with the Rehabilitation Act; to bar them specifically from using HIV infection as a basis for a blanket exclusion of, or other medically-unwarranted restrictions on, applicants, candidates, or employees from any position; and to require that all federal agencies must individually assess whether an individual with HIV can perform the functions of the position or activity and whether a reasonable accommodation can be made for that person if necessary to permit the individual’s employment or inclusion.

2. Revision of CDC guidelines on health care workers living with HIV

- **Background:**

In July 1991, CDC issued recommendations regarding health care workers with blood borne diseases. “Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures,” MORBIDITY & MORTALITY WEEKLY REPORT 1991: 40 (RR-8); 1-9 (“1991 CDC Recommendations”). Although it was already well known that the overwhelming majority of health care workers posed no risk of transmitting HIV to patients, the 1991 CDC Recommendations’ failure to adequately define “exposure-prone invasive procedures” resulted in enormous confusion about the actual risks and in outright discrimination against health care workers living with HIV. Because the 1991 CDC Recommendations are not based on accurate, scientific evidence, and because employers and courts have improperly relied on them to justify discrimination against healthcare workers with HIV, they should be immediately revoked.

Healthcare workers with HIV pose no risk to patients as long as they properly adhere to universal infection control procedures. The likelihood that a health care worker with HIV, who is functional and capable of performing his or her duties and scrupulously adheres to universal precautions (as all health care workers are required to do), will transmit HIV to a patient is virtually nil. The 1991 CDC Recommendations, however, in their emphasis on the nebulous category of “exposure-prone” procedures, have created a difficult environment for healthcare workers living with HIV, at the same time that there is a chronic shortage of certain vitally important healthcare professionals (in particular, nurses). The 1991 CDC Recommendations unnecessarily (and unfairly) force trained professionals out of the health care industry – contrary to science and contrary to our demonstrated societal need for more trained health care professionals, not fewer.

- **Recommended Action:**

The Administration should direct the CDC to revoke the 1991 CDC Recommendations and to issue new recommendations affirming that there is no measurable risk of HIV transmission posed by health care workers living with HIV.

3. Restoration of Americans with Disabilities Act to its protective purposes for people who experience disability discrimination

- **Background:**

⁴ See Service Members Legal Defense Network, *The Survival Guide* at 30 (2007).

⁵ See, e.g., Army Reg. 600-110 (1-15(e); 4-2).

⁶ Air Force Instr. 48-135 (3.8).



The ADA Amendments Act, signed into law on September 25, 2008, revised the Americans with Disabilities Act to restore some of its protective objectives. As the law itself recognizes, those changes need to be reflected in new implementing regulations from the Equal Employment Opportunity Commission, the Attorney General, and the Department of Transportation.

- Recommended Action:

The Administration should direct the Equal Employment Opportunity Commission, the Attorney General, and the Secretary of Transportation to promptly issue regulations implementing the ADA Amendments Act in accordance with its remedial purposes.

4. Issuance of federal guidance to eliminate states' exclusion of people with HIV from occupational training schools and licensing

- Background:

Across the country, a patch-work of individual state laws requiring infectious or communicable disease clearance for practitioners of certain occupations, or agency interpretations of these laws, have excluded people with HIV from occupational training, licensing, and employment in professions such as barbering, massage, food services and home health care. Addressing this issue through litigation on a state-by-state basis could take many more years, and even then is complicated by the fact that, in at least some states (such as Pennsylvania), multiple licensing boards are involved. This state-sponsored discrimination – the perpetuation of scientifically unsound restrictions on the lives and livelihoods of people with HIV – is a persistent manifestation of the stigma that dogs affected citizens and undermines public health efforts to encourage HIV testing and care.

- Recommended Action:

The Administration should direct the CDC to explore incentive mechanisms, much as it has done in its push for adoption of its 2006 HIV testing recommendations for health care settings, that will encourage states to take corrective action to eliminate laws and regulations which illegally discriminate against people with HIV. Incentives could include increased availability of prevention grants to states which eliminate these barriers. In addition, the Administration should direct the Department of Justice to address this continuing barrier by issuing official guidance or a directive letter to state officials/agency heads, clarifying that exclusion of people with HIV/AIDS from such training programs and profession licensing violates the ADA, and that such restrictions must be limited to diseases that actually pose a significant, measurable threat in the context at issue.

Access to Health Care and Other Essential Services:

5. ERISA legislation to restore protection against discriminatory denials of care and inadequate care, and to permit local healthcare reform efforts.

- Background:

ERISA was enacted primarily to protect private employee pension plans from fraud and mismanagement through creation of uniform federal guidelines, but the statute also covers most other aspects of employee benefits plans, including health plans. ERISA's "preemption clause," trumps all state laws to the extent that they "relate to" employer-sponsored health plans. The Supreme Court has interpreted the preemption clause very broadly; courts have held that ERISA prohibits both state laws that *directly* regulate employer-sponsored health plans, such as mandating that employers offer health insurance, and some laws that only *indirectly* affect plans, such as regulating the provider networks ERISA plans may use. ERISA also has limited states' ability to implement some types of health care initiatives. Moreover, ERISA preemption has been used in a way at odds with the Congressional intent to *protect* consumers by blocking malpractice actions against health plans, plan fiduciaries, and others in denial of care and



inadequate care cases, and to preempt state and municipal attempts at health care reform that benefit an entire state's citizenry.

- **Recommended Action:**

The Administration should propose ERISA reform and health care consumer protection legislation that eliminates counterproductive ERISA preemption, thereby allowing states to use the foundation of employer health insurance to adopt universal coverage programs and to fund health care coverage by taxing employers and/or their plans, and that incorporates protections, including mechanisms for judicial review, that address health plan exclusions of coverage for diseases and sound medical interventions.

6. Increased/maintained funding for HIV-related legal services and removal of restrictions on certain areas of practice that are critical to the health of the poor with HIV

- **Background:**

Legal services that protect the rights of the poor to basic housing, representation on immigration issues, and freedom from discrimination are a core part of federal HIV/AIDS services. Doctors as well as lawyers have pointed to the connection between legal assistance and maintaining the health of marginalized people with HIV and other serious illnesses and disabilities. Federally funded legal services for the poor are a vitally important source of assistance for the poor who are living with HIV.

- **Recommended Action:**

The Administration must ensure that Ryan White Care Act funding for legal services is maintained at a level proportionate to the continuing needs for these services and their centrality to ensuring access to health care. In addition, the Administration should direct the Legal Service Corporation to remove its restrictions on the use of legal services funding for the representation of needy individuals in the areas of immigration, housing, and discrimination in access to basic services or employment; to the extent that action by Congress is needed in order to lift restrictions, the Administration should propose legislation for that purpose

HIV Criminalization

7. Creation of federal HIV anti-stigma incentives to states that prosecute people on the basis of HIV status

- **Background:**

About half of the states have HIV-specific laws criminalizing sexual contact by people with HIV; most of them hinge prosecution on the failure of an HIV-positive person to disclose their HIV status and obtain consent from sexual partners. Importantly, none of these laws punish risk-taking behavior that actually is driving the epidemic -- unprotected sex between persons who don't know their HIV status. Rather, the statutes punish only those who have taken the step of actually getting tested for HIV. Consequently, it is not the risk of transmission, but the fact of an HIV test, that is the central predicate to prosecution.

Recent research increasingly has raised concerns about the rise in criminal prosecutions of people living with HIV, and the negative consequences of these prosecutions. An increasing number of people view HIV criminalization laws and prosecutions of people with HIV for being sexually active – even when no transmission occurs – as evidence of the continuing stigmatization of people living with HIV/AIDS. The most recent research demonstrates that there is no evidence that criminal prosecutions have any positive public health impact whatsoever. In fact, one study suggests that the criminalization of HIV transmission could prevent people from getting tested for HIV, causing transmission rates to rise by a third or more.



Numerous recent studies demonstrate that there are many valid cultural reasons why individuals do not disclose their HIV status to sexual partners or others, including fear of domestic violence, fear of familial or partner abandonment, and community rejection. HIV transmission, however, occurs not through a failure to disclose but through a failure of sexual partners to take responsible precautions against transmission of HIV and STDs. Prosecutors' sledgehammer approach to the issue of HIV exposure demonstrates not only lingering stigma, but also a failure to take into consideration the complexity of human relationships.

It is clear that, to model the behavior needed at an official level to end stigma and encourage treatment of HIV as a medical and public health issue, states that have HIV-specific criminal laws should repeal them. However, it is unlikely that the political will to do this will be found in most jurisdictions without federal incentives.

- **Recommended Action:**

The Administration should direct the CDC to explore incentive mechanisms, much as it has done in its push for adoption of its 2006 HIV testing recommendations for health care settings that will encourage states to take corrective action. Incentives could include research grants that would monitor changes in testing and risk behavior following repeal of HIV criminal laws; or prevention project grants in correctional facilities in states that eliminate barriers to prisoner testing, such as the threat of prosecution for having consensual sex after diagnosis. Legislative incentives also should be explored, e.g., law enforcement block grants that reward the repeal of, or the refusal to adopt, laws that criminalize consensual sexual conduct.

HIV testing:

8. Revision of CDC HIV testing guidelines to reinforce the importance of specific informed consent and prevention counseling

- **Background:**

The CDC's Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings issued in September 2006 ("2006 CDC Recommendations") fail to ensure that individuals are providing specific, written consent for HIV testing after receiving information and counseling about HIV.

We believe that the following aspects of the CDC recommendations work directly against the public health goal of ensuring that individuals provide truly informed consent for an HIV test: opt-out testing, rather than opt-in testing; no requirement for specific consent for the HIV test, but instead deeming a "general consent" for all medical care to be consent for the HIV test; no pre-test prevention counseling; and mandatory testing for newborns. Following those recommendations is likely to result in some individuals being tested without their knowledge and in many not learning vital information about HIV, its treatment, and prevention, all of which are crucial to preventing the spread of HIV and the stigma associated with HIV.

Opt-out testing decreases the likelihood that individuals will give an informed consent regarding the HIV test specifically. Someone who is tested without realizing that the test is being administered, or without understanding the possible significance of the test, is far less likely to engage in care and prevention of further HIV transmission. Communication between the patient and the health care provider, which the CDC acknowledges is an important part of informed consent, is more likely when specific written consent and counseling are required.

With regard to the mandatory testing of newborns, the most effective way to prevent HIV transmission to newborns is through mandatory HIV counseling and offer of voluntary testing to pregnant women. The risk of neonatal transmission of HIV can be almost eliminated (2% risk) through a combination of drug therapy for the mother during pregnancy and delivering the child



by caesarian section. Indeed, perinatal transmission of HIV has been virtually eliminated in the United States, including in states that require specific written informed consent.⁷

- **Recommended Action:**

The Administration should direct the CDC to revise the 2006 CDC Recommendations to recommend: opt-in testing; a requirement for specific written consent for the HIV test; pre- and post-test prevention counseling; emphasis on offering testing, counseling, and treatment for pregnant women, rather than on mandatory testing for newborns; and that testing for newborns should occur only after receipt of the specific, informed, written consent of the legal parent or guardian.

9. Removal of mandatory HIV testing requirements as a condition of federal funding

- **Background:**

When federal funding is contingent on certification by states that certain laws or regulations are in place, states are often put in the position of creating poorly planned and ill-advised public health policy. This is especially problematic when states are forced to mandate HIV testing for certain populations or risk the loss of millions of dollars in federal funding. In the interest of sound public health policy, such conditions must be stricken from federal legislation.

For example, the Ryan White Treatment Modernization Act of 2006⁸ requires that states, in order to be eligible for the early diagnosis grant program, institute a combination of either (1) opt-out testing of pregnant women and universal testing of newborns, or (2) opt-out testing of clients at sexually transmitted disease clinics and opt-out testing of clients at substance abuse treatment facilities. Although opt-out testing is technically voluntary, in reality it will inevitably lead to some people being tested without their consent or knowledge. The fact that the legislation's definition of opt-out testing explicitly states that pre-test counseling is not required further demonstrates that informed consent is not a priority in trying to reach the goal of testing those who are most at risk for HIV infection.

Similarly, the Violence Against Women and Department of Justice Reauthorization Act of 2005⁹ requires the federal government to withhold funds unless a state or local government certifies that laws or regulations are in place to compel HIV testing of those defendants who are indicted for a crime involving sexual assault. Ostensibly, the goal of such laws or regulations would be to provide the victim with information that would help her make decisions about her own care. However, even with the advent of rapid testing, the reality is that the results of the defendant's HIV test may not be informative. This is especially true if the defendant is in the "window period" between infection and development of antibodies, when the defendant will test negative despite his positive status. In this situation, the defendant's test will give the victim nothing more than a false sense of security, and a missed opportunity to prevent her own infection with timely prophylactic treatment.

- **Recommended Action:**

The Administration should propose legislation to strike mandates of HIV testing in federal funding legislation (including, but not limited to, the Ryan White Treatment Modernization Act of 2006 and the Violence Against Women and Department of Justice Reauthorization Act of 2005) and should oppose (with threat of veto) proposals to include such mandates in new federal funding legislation.

⁷ See, e.g., Massachusetts STD and HIV/AIDS Surveillance Report: 2005, available at http://www.mass.gov/dph/cdc/aids/2005_surveillance.pdf; HIV/AIDS Surveillance Biannual Summary: Commonwealth of Pennsylvania, June 2005, available at http://www.dfs.health.state.pa.us/health/lib/health/epidemiology/biannual_summary_june2005.pdf; Annual Review of HIV Trends in Michigan (2001-2005), April 2007, available at http://www.michigan.gov/documents/mdch/MIRReport07_195579_7.pdf.

⁸ P.L. No. 109-415, 120 Stat. 2767 (2006).

⁹ P.L. No. 109-162, 119 Stat. 2960 (2006).

**Immigration:****10. Lifting of bans on HIV-positive immigrants and visitors to U.S. & on adjustment of status****• Background:**

Since 1987, the U.S. has banned persons living with HIV from entering the U.S. as visitors or immigrants. The statutory requirement for that ban was recently removed, but existing regulations keep the ban in place. The HIV ban is based on prejudice and unwarranted fears, not on medical knowledge and sound public health principles. In 1991, the U.S. Department of Health and Human Services stated that public health concerns about admission of persons with contagious diseases did not warrant banning people with HIV, given the ways in which HIV is transmissible, a view shared by many major medical groups. Continuing the ban is discriminatory to people living with HIV, fosters misunderstanding among the American public about HIV transmission, and fuels stigma against PLWH. The U.S. ban is one of the most restrictive and regressive HIV immigration policies in the world. Similarly, the inclusion of gonorrhea and syphilis on the list of diseases requiring automatic exclusion reflects the fact that the diseases for which individuals are inadmissible into the United States have remained much the same as at the end of the nineteenth century, and no longer reflect current medical knowledge.¹⁰

• Recommended Action:

The Administration should direct the Secretary of Health and Human Services to propose new regulations that remove HIV infection, and sexually transmitted diseases that are not a risk to citizens through casual contact, from the list of “communicable diseases of public health significance.”

11. Provision of confidential, timely, and effective access to HIV treatment for immigrant detainees**• Background:**

Currently, thousands of immigrants are held in detention facilities (Federal Bureau of Prison facilities, service processing centers, private contract detention facilities, and state and local government facilities) each year. The persons incarcerated in these facilities include undocumented persons, legal permanent residents, asylum seekers, families, and unaccompanied children. The July 2007 death of Victoria Arellano, a transgender woman with HIV incarcerated in a federal detention facility in California, brought some attention to the serious problems experienced by detainees with HIV. Human Rights Watch recently reported the results of its investigation into conditions for such detainees, documenting significant deficiencies including failures to: “deliver complete anti-retroviral regimens in a consistent manner;” “conduct the necessary monitoring of detainees’ clinical condition, including CD4 and viral load testing as well as resistance testing;” “prescribe prophylactic medications when medically indicated to prevent opportunistic infections;” “ensure continuity of care as detainees are transferred between facilities;” and “ensure confidentiality of medical care.”¹¹ In summary, Human Rights Watch found that “medical care for HIV positive detainees in [U.S. Immigration and Customs Enforcement] custody was delayed, interrupted, and inconsistent to an extent that endangered the health and lives of the detainees.”¹²

¹⁰ See Department of Health and Human Services, Centers for Disease Control and Prevention, Medical Examination of Aliens – Revisions to Medical Screening Process, Interim final rule, 73 FED. REG. 194, 58047, 58-4859053 (Oct. 6, 2008).

¹¹ Human Rights Watch, “Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States (Dec. 2007).”

¹² *Id.*



- **Recommended Action:**

The Administration should direct the Department of Homeland Security to take steps to ensure the adequacy of care for immigrant detainees, including: increasing the number and quality of inspections by the DHS Office of Inspector General; revising the Medical Care Detention Standards, including the provisions related to HIV, to conform to nationally recognized standards requiring medical care equivalent to that afforded in the community. In addition, DHS should add non-discrimination provisions to the Detention Standards and promote alternatives to detention for immigrants with HIV. The revised Standards should be incorporated into contracts with private, local, or county detention facilities and compliance with the revised Standards should be made an express condition of those contracts and the Administration should direct DHS to convert the Detention Standards into regulations that are then published for public comment. The Administration also should adopt additional steps suggested by Human Rights Watch in order to ensure the adequacy of care for immigrant detainees and increase the accountability of detention facilities for compliance failures.¹³

Prevention:**12. Repeal of the ban on federal funding of needle exchange/syringe access programs**

- **Background:**

Since 1988, Congress has banned the use of federal HIV prevention funds for any type of needle exchange or syringe access program unless the Surgeon General first determined that such programs would be effective in reducing drug abuse and HIV transmission.¹⁴ In 2000, the Surgeon General issued findings that there is “conclusive scientific evidence” that needle exchange programs: (1) decrease new HIV infections; (2) increase the number of injection drug user referred to and retained in substance abuse treatment; and (3) play a unique role in reaching and serving the most disenfranchised populations in meaningful HIV prevention interventions and medical care.¹⁵ Notwithstanding the requisite determinations made by the Surgeon General, the ban has not been lifted and no federal funds have been allocated for needle exchange programs.

The federal ban on funding of needle exchange programs hinders critical efforts to combat the spread of HIV, Hepatitis C (HVC), and Hepatitis B (HBV). Injection drug use is a primary factor in the proliferation of these diseases and, in particular, factors heavily in cases of HIV among women. The efficacy of needle exchange programs is undisputed in the federal agencies and the medical and scientific communities. In addition to the Surgeon General and the Secretary of Health and Human Services, the efficacy of needle exchange programs has been endorsed by, among others, the National Institutes of Health, the National Research Council, the Institute of Medicine, the National Commission on AIDS, the American Medical Association, the American Academy of Pediatrics, and organizations of government officials such as the National Black Caucus of State Legislators and the U.S. Conference of Mayors. Because the federal government is the primary source of funding for HIV prevention in the United States, the ban on federal funding for needle exchange limits these programs and costs lives.

¹³ See *id.* at p. 4-6.

¹⁴ See 42 U.S.C. § 300ee-5 (no public health service funds “shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome”).

¹⁵ See U.S. Department of Health and Human Services, *Evidence-Based Findings On the Efficacy of Syringe-Exchange Access Programs: An Analysis From the Assistant Secretary for Health And Surgeon General of the Scientific Research Completed Since April 1998 (2000)* at <http://www.harmreduction.org/issues/surgeongenrev/surgreview.html>.



- **Recommended Action:**

The Administration should direct the Surgeon General to immediately re-issue findings reflecting the conclusive scientific evidence showing that needle exchange and syringe access programs reduce drug abuse and prevent HIV infection to protect public health. The Administration should urge Congress to appropriate federal funds for these programs, as the requisite findings have been made.

Prisons:**13. Provision of comprehensive HIV prevention programming in correctional facilities**

- **Background:**

According to the U.S. Centers for Disease Control and Prevention (CDC), HIV prevalence is nearly five times higher among incarcerated populations than the general population. At the end of 2006, 1.6% of male inmates and 2.4% of female inmates in state and federal prisons were HIV-positive. Many of the activities that lead to incarceration for both men and women are the same activities that put them at risk for HIV (e.g., injection drug use, sex work). Further, once incarcerated, inmates are more likely to engage in activities that create the potential for exposure to HIV, including unprotected sex, tattooing, body piercing, and injection drug use. In light of these facts, and that approximately 95% of inmates will ultimately return to the community, it is imperative that correctional facilities develop, adopt, and implement comprehensive HIV prevention programs to educate HIV-negative inmates about how not to be infected and to show HIV-positive inmates how to avoid transmitting the virus to others. A comprehensive program of this nature must necessarily involve *voluntary* HIV testing of all inmates with their informed consent, education about HIV and how it is transmitted, and distribution of sexual barrier devices.

In 2007, Rep. Barbara Lee of California introduced the JUSTICE Act of 2007,¹⁶ which would require federal prisons to, among other things, allow community organizations to distribute condoms to inmates, and encourages state prisons to do the same. Distribution of condoms would include information about their appropriate use, as well as information about sexually transmitted infections and how to avoid them. There is ample evidence that condom use greatly decreases the risk of transmitting HIV and other sexually transmitted infections, and that distribution of condoms in correctional settings has not resulted in security problems. Evidence also shows that the more people are educated about the associated risks, the more likely they are to take precautions intended to reduce those risks. As a matter of sound public health policy, it is imperative that legislation of this nature be supported and moved through Congress as quickly as possible.

- **Recommended Action:**

The Administration should direct the Department of Justice to issue guidelines to ensure that inmates in federal prisons have ready access to comprehensive sexual health and HIV prevention services that include condom distribution. The Administration also should support legislation requiring federal prisons to allow community organizations to assist with the provision of such services, through sexual health education programs that distribute condoms to prisoners and educate them about their appropriate use.

14. Provision of confidential, voluntary, and effective HIV testing and health care in correctional facilities

- **Background:**

The high HIV prevalence among incarcerated populations makes HIV testing and HIV-related health care in correctional settings extremely important. But testing must be handled in ways that will ensure that it is voluntary, non-coercive, and informed. Informed consent prior to

¹⁶ H.R. 178, 110th Cong. (1st Sess. 2007).



testing is a legal and ethical requirement. Moreover, it is imperative that testing results and HIV-related care be provided confidentially, so that other inmates, correctional officers, and others will not learn an inmate's HIV status. In order for testing and treatment programs to succeed, inmate confidentiality must be ensured. Fear of other inmates knowing their status will keep inmates from being tested unless they can be assured that their health information will be kept confidential.

Prompt linkage to quality health care is essential from a public health standpoint and also is constitutionally mandated. As the U.S. Supreme Court recognized more than thirty years ago in *Estelle v. Gamble*, "deliberate indifference to serious medical needs" in the prison context is a constitutional violation. "An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."¹⁷ Delaying or switching the provision of HIV medications on the basis of cost considerations rather than medical efficacy, when the change or delay has a negative impact on an inmate's health, violates the inmate's protected rights to adequate medical care.

- **Recommended Action:**

The Administration should direct the Department of Justice to issue policies and implementation guidelines to ensure that inmates in federal prisons are offered voluntary, non-coercive, confidential, informed HIV testing. Agency guidelines should allow for the provision of HIV counseling and testing services by community-based service providers. In addition, the Department of Justice should issue policies and guidelines to ensure that HIV-related care is provided confidentially, promptly, and in keeping with medical standards of care and to ensure that individuals released from custody receive appropriate discharge planning including linkages to uninterrupted healthcare.

15. Provision of greater protections for confidentiality of prisoners with HIV during incarceration and upon re-entry to the community

- **Background:**

Prisoners' rights to the confidentiality of their HIV-related information are protected under most state laws and also by federal and state constitutional protections. While maintaining confidentiality in the closed environment of prisons presents special challenges, these can be met through establishment of clear policies on record maintenance and limitations on staff and inmate access to these records. Individual inmates' willingness to be tested for HIV may hinge to a significant degree on the extent to which assurances of confidentiality are guaranteed. Further, the ability and willingness of ex-offenders to secure health services, employment, and reconnection with the community to which they return can be significantly affected by the extent to which nonconsensual disclosure about the inmate's HIV status is strictly limited to the rare situations where it is medically necessary.

- **Recommended Action:**

The Administration should direct the Federal Bureau of Prisons to incorporate into its regulations the confidentiality provisions of the CDC's HIV testing guidance for correctional facilities and should ensure that federal support for corrections-based HIV care and prevention initiatives prioritize jurisdictions and programs that adopt similar policies for protection of inmate confidentiality.

¹⁷ *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976).