United States

Sentenced to Stigma

Segregation of HIV-Positive Prisoners in Alabama and South Carolina

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Executive Summary

In Alabama, people in the visiting room recognize the armband worn by John S. and ask him if he has HIV. In South Carolina, Ronald B. was sentenced to 90 days in jail, but because he is HIV-positive he went to the maximum security prison that houses death row prisoners. In Mississippi, guards tell prisoners in the segregated HIV unit to “get your sick asses out of the way” when they pass them in the hall. Many prisoners with HIV will spend more time in prison because they are not eligible for programs that promote early release. These are some of the harsh consequences of HIV policies in Alabama, South Carolina and Mississippi, the only three states in the nation that have continued to segregate prisoners living with HIV. In March 2010, after reviewing the findings in this report, the Commissioner of the Mississippi Department of Corrections decided to terminate the segregation policy. The segregation and discrimination against HIV-positive prisoners continues to this day in Alabama and South Carolina, and constitutes cruel, inhuman and degrading treatment in violation of international law.

Upon entering the state prison system in Alabama, South Carolina or Mississippi, each prisoner must submit to a test for HIV. In Alabama and South Carolina, and until recently, in Mississippi, the result of this test will determine almost every aspect of a prisoner’s life for as long as he or she is in prison. More than the severity of the crime, the length of their sentence or almost any other factor, the HIV test will determine where he or she will be housed, eat, and recreate; whether there will be access to in-prison jobs and the opportunity to earn wages; and in South Carolina, how much “good time” can be earned toward an early release. The opportunity for supervised work in the community, often a key to successful transition after release, will be either restricted or denied altogether. During the entire period of incarceration, most prisoners who test positive will wear an armband, badge or other marker signifying the positive results of their HIV test.

The HIV policies in Alabama and South Carolina prisons stand in stark contrast to those in 48 other states and the federal Bureau of Prisons. The change in policy in Mississippi increased the isolation of Alabama and South Carolina in this regard. Now, only in these two states are prisoners with HIV isolated, excluded and marginalized as a matter of policy without medical justification. Only these two states combine mandatory HIV testing with immediate isolation and segregation, forcing prisoners to involuntarily disclose their health status in violation of medical ethics and international human rights law. Prisoners living with HIV in these states are still barred from equal access to many in-prison jobs and programs.

South Carolina is the only US state that maintains an absolute prohibition on access to work release for prisoners with HIV.

Segregation policies reflect outdated approaches to HIV that no longer have any rational basis in science or public policy. In the early days of the HIV/AIDS epidemic, fear and ignorance led to severely restrictive public policies, including quarantine and segregation in prisons. In 1985, for example, 46 of 51 state and federal prison systems segregated HIV-positive prisoners. As science and societal attitudes evolved, however, prison officials eliminated these policies. By 1994, only six prison systems had segregation policies, and by 2005, that number was down to the three states examined in this report. Today, integration of prisoners with HIV into the general population is the national norm and represents generally accepted best practice in correctional health.

Segregation of prisoners living with HIV without basis in science or public policy cannot be justified under human rights treaties ratified by the United States. Discrimination against prisoners with HIV not only violates human rights law but contravenes international and US guidelines for management of HIV in prisons. Moreover, additional violations of human rights flow from the fact of segregation and compound the harsh consequences of this policy for HIV-positive prisoners: involuntary disclosure of HIV status to family, staff and other prisoners; loss of liberty by assignment to higher security prisons; denial of work, program and re-entry opportunities; and policies that promote, rather than combat, fear, prejudice and even violence against persons living with HIV. These and other conditions documented in this report go well beyond discrimination. Viewed cumulatively, conditions for HIV-positive prisoners in Alabama and South Carolina constitute cruel, inhuman and degrading treatment of prisoners.

This report is a collaborative effort by Human Rights Watch and the American Civil Liberties Union National Prison Project (ACLU-NPP). The project was, to a great degree, informed by the extraordinary history of the ACLU-NPP in advocating for the rights of HIV-positive prisoners in these states for more than two decades. Throughout that time, HIV segregation policies have been controversial, contested, and intertwined with other fundamental issues of human and civil rights, including the right to adequate medical care and humane living conditions. For this report, Human Rights Watch, ACLU-NPP, and local ACLU affiliates conducted interviews of current and recently released prisoners in order to document the contemporary impact of continued housing segregation and ongoing inequality in access to jobs, programs, and work release opportunities. Human Rights Watch also interviewed HIV/AIDS service organizations providing education and counseling services inside the prisons, and community leaders, legislators, and others engaged in HIV policy issues in the

state prisons. Human Rights Watch and the ACLU interviewed prison administrators from Alabama, South Carolina, and Mississippi.

Alabama and South Carolina continue to insist that segregation is justified by the need to provide medical care and the goal of preventing HIV transmission in prison. The evidence clearly indicates otherwise. Prisons throughout the US and around the world meet their obligation under international law to provide medical care for HIV without requiring prisoners to forfeit other fundamental rights to privacy, confidentiality, and freedom from discrimination. The prevailing treatment model recognizes that, as with other chronic illnesses, people with HIV vary widely in individual health status, and properly distinguishes between those who need few medical services and those whose condition demands specialized or intensive care.

Similarly, everyone shares the goal of reducing transmission of HIV in prison, but this goal can be met without resort to segregation. Prison officials are obligated under international law to take steps to prevent the spread of HIV and other disease, but such steps should be compatible with other fundamental principles of human rights. Today, there is a developing body of evidence demonstrating that harm reduction programs including condom distribution, syringe exchange, and medication-assisted therapy for prisoners dependent on heroin or other opioids, reduce the risk of transmission of HIV and other sexually transmitted diseases, as well as hepatitis B and C in prisons. These programs have been implemented in the US and abroad with no negative consequences to prison security.

In addition to human rights concerns, the discrimination documented in this report makes little sense as a matter of public policy. Because the HIV units are located in high security prisons, low-custody prisoners must serve their sentences in far harsher, more restrictive, and more violent prisons, and at far greater cost to taxpayers. Otherwise eligible prisoners miss out on opportunities for jobs, training programs and other services designed to prepare prisoners for a productive return to society. Though work release has been shown to reduce recidivism, prisoners with HIV have limited or no access to these valuable programs.

In the Alabama, South Carolina, and Mississippi prison systems, decades of segregation and discrimination have promoted an unsafe atmosphere of fear, prejudice, and stigma against prisoners living with HIV. Although prisoners with HIV unquestionably have sympathetic allies among prison staff and general population prisoners, Human Rights Watch and ACLU-NPP found significant evidence of harassment and hostility toward prisoners living in the segregated units. This is a legacy of human rights violations that cannot be undone overnight. Concern for the safety of prisoners whose privacy and confidentiality has been

violated requires that changes in policy should include a choice, rather than a mandate, to enter the general population. In Mississippi, prison officials agreed to relocate currently segregated prisoners after making individualized determinations on a case by case basis. Human Rights Watch and the ACLU-NPP plan to monitor this process closely to ensure the safety and security of the prisoners during the transition.

Mississippi's decision to reverse its long-standing policy demonstrates that change is possible. Segregation of persons living with HIV is no longer justifiable inside or outside of prison. Prison systems throughout the US and around the world are providing medical care for HIV and preventing its transmission while respecting human rights. Alabama and South Carolina can, and should, end their own isolation by reforming these policies without delay.

Human Rights Watch and the ACLU-NPP call upon Alabama and South Carolina to immediately:

- End the policy of mandatory assignment to designated housing for prisoners with HIV. Incoming prisoners identified as HIV-positive after voluntary testing and counseling should be assigned to housing that is appropriate for that individual under the relevant classification plan. Prisoners currently housed in designated HIV units should be given the option of re-assignment to housing that is otherwise appropriate for that individual under the relevant classification plan.
- End policies and practices that restrict or deny equal access for HIV-positive prisoners to rehabilitative programs including in-prison jobs, education, faith-based or honor dorms, pre-release programs and re-entry training. End policies and practices that deny equal access to work release and community corrections opportunities.
- Implement harm reduction services consistent with international standards including condom distribution, syringe exchange, and medication-assisted therapy for prisoners dependent on heroin and other opioids to reduce the risk of transmission of HIV, hepatitis B and C, and sexually transmitted diseases.

Recommendations

To the Alabama and South Carolina Departments of Corrections

- Revise policy and practice on confidentiality of medical records and information to ensure that disclosure of HIV status occurs only to appropriate medical personnel or with the prisoner's consent. Medical records and information shared with others should occur only under exceptional and clearly defined circumstances set forth in the revised policy. The policy should contain specific sanctions for prison staff found to be in breach of confidentiality procedures.
- Put an immediate end to the policy and practice of placing prisoners in isolation cells following a positive HIV test result or until the diagnosis is confirmed. Isolation of prisoners with HIV should occur only on legitimate medical grounds, such as co-infection with active TB, and only under the direction of appropriate medical personnel.
- Put an immediate end to the policy and practice of mandatory assignment to designated housing for prisoners with HIV. Incoming prisoners identified as HIV-positive after voluntary counseling and testing should be assigned to housing that is appropriate for that individual under the relevant classification plan. Prisoners currently housed in designated HIV units should be given the option of re-assignment to housing that is otherwise appropriate for that individual under the relevant classification plan.
- Put an immediate end to all policies and practices that restrict or deny equal access for HIV-positive prisoners to in-prison jobs, including kitchen, canteen, barbershop, bloodhound detail, onsite construction crews, prison industries, and other employment opportunities.
- Put an immediate end to all policies and practices that restrict or deny equal access for HIV-positive prisoners to in-prison programs, including faith-based and honor dorms, pre-release programs, re-entry training programs, and programs designed for prisoners with short-term sentences.
- Put an immediate end to all policies and practices that restrict or deny equal access to work release or community corrections programs. Ensure that criteria for admission to these programs accurately reflect an individual's ability to participate in the program based upon the current state of his or her health. Ensure access to all

work release centers and programs on an equal basis with prisoners who are not HIV-positive.

- Implement harm reduction services consistent with international standards including condom distribution, syringe exchange, and medication-assisted therapy for prisoners dependent on heroin and other opioids to reduce the risk of transmission of HIV and other sexually transmitted diseases, as well as hepatitis B and C.
- Strengthen and expand HIV/AIDS education, counseling and support programs for prisoners , including peer education, and expand HIV/AIDS education and training for correctional staff.

To the South Carolina Department of Corrections

- Replace the policy of mandatory HIV testing with comprehensive voluntary counseling and testing programs that ensure privacy, informed consent and confidentiality. Ensure that adequate and accurate information, treatment and support are provided to inmates testing positive for HIV.

To the Governors of Alabama and South Carolina

- Support the elimination of mandatory testing for HIV in the state prisons.
- Support the elimination of policies that segregate and discriminate against HIV-positive prisoners.
- Support laws and policies that ensure access to voluntary and confidential HIV testing and comprehensive HIV/AIDS prevention, care and treatment services.
- Commission an independent review by correctional and public health experts of state prison policies and practices that segregate and discriminate against HIV-positive prisoners, of medical care and treatment models for HIV in prisons, and of harm reduction programs for disease prevention implemented in other prison systems. The commission should include representatives of HIV/AIDS service organizations and advocates, and former prisoners living with HIV/AIDS. Findings and recommendations should be reported to the Governor and to the Legislature.

To the Legislatures of Alabama and South Carolina

- In Alabama, repeal state laws that require mandatory testing for HIV in the state prisons.

- Support legislation eliminating policies that segregate and discriminate against prisoners with HIV.
- Support laws and policies that ensure access to voluntary and confidential HIV testing and comprehensive HIV/AIDS prevention, care and treatment services.
- Commission an independent review by correctional and correctional health experts of state prison policies and practices that segregate and discriminate against HIV-positive prisoners, of medical care and treatment models for HIV in prisons, and of harm reduction programs for disease prevention implemented in other prison systems. Findings and recommendations should be reported to the Governor and to the Legislature.

To the Legislature of Mississippi

- Repeal state laws that require mandatory testing for HIV in the state prisons.

To the President and Congress of the United States

- Support legislation, regulations, and policies promoting harm reduction programs in prisons, including condom distribution, syringe exchange, medication-assisted therapy and other efforts to reduce transmission of HIV and hepatitis B and C in prison and upon release.
- Ratify the International Covenant on Economic, Social and Cultural Rights.
- Ratify the Convention on the Rights of Persons with Disabilities.

To the US Department of State

- Address the policies that segregate and discriminate against prisoners living with HIV in Alabama and South Carolina when reporting to United Nations Human Rights Treaty Bodies pursuant to obligations under the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)and the International Covenant on Civil and Political Rights (ICCPR).

To the United Nations Human Rights Treaty Bodies, Special Rapporteurs and Human Rights Council

- Call upon the United States as party to the CAT and the ICCPR to put an immediate end to policies that segregate and discriminate against prisoners living with HIV in Alabama and South Carolina.

Methodology

This report represents a collaborative effort by Human Rights Watch and the American Civil Liberties Union National Prison Project (ACLU-NPP). The project began as an examination of the segregation policies for HIV-positive prisoners in three states: Alabama, South Carolina, and Mississippi. After reviewing the findings of the report in March 2010, the Mississippi Department of Corrections agreed to change its policy. This report documents that decision but includes the testimony of HIV-positive prisoners in the segregated unit at the Mississippi State Penitentiary at Parchman not yet affected by the recent change in policy.

The report is based on testimony collected by Human Rights Watch, the ACLU-NPP and ACLU local affiliates. In addition, the project was informed by the expertise of the ACLU-NPP in the conditions of confinement for HIV-positive prisoners in Alabama, South Carolina, and Mississippi, a familiarity that has resulted from more than two decades of complex litigation, negotiation and advocacy on their behalf. The ACLU-NPP regularly receives correspondence from HIV-positive prisoners in these and other state prisons describing general conditions, medical care, and access to in-prison programs and work release. The ACLU-NPP maintains contact with a substantial number of current and former prisoners who are, or were, participants in legal actions addressing these issues. Attorneys from the ACLU-NPP and the local ACLU affiliates meet and correspond regularly with prison officials in Alabama, South Carolina and Mississippi to discuss policies and practices relevant to prisoners living with HIV.

In July, August, and September 2009, Human Rights Watch, the ACLU of Mississippi, and the ACLU of Alabama conducted research to ensure that the report included testimony describing current conditions for HIV-positive prisoners in Alabama, South Carolina, and Mississippi. Confidential interviews were conducted with 20 current or recently released prisoners at the Limestone Correctional Facility and the Julia S. Tutwiler Prison for Women in Alabama, the Mississippi State Penitentiary at Parchman, the offices of Palmetto AIDS Life Support Services in Columbia, South Carolina, and Low Country AIDS Services in Charleston, South Carolina. Prisoners also wrote to Human Rights Watch and ACLU-NPP describing conditions in the HIV units in each of these states. Pseudonyms are used to ensure the privacy and safety of those interviewed or whose letters are quoted in the report.

Human Rights Watch and the ACLU interviewed directors and staff members of service organizations providing HIV/AIDS education, counseling, and re-entry services in these

prison systems, as well as community leaders and legislators involved in efforts to influence HIV/AIDS policies in the state prisons.

Human Rights Watch and the ACLU interviewed prison administrators from the Alabama, South Carolina, and Mississippi Departments of Corrections. In these interviews, we shared preliminary findings from the report in order to ensure accuracy and fairness. Alabama administrators also responded to the preliminary findings in writing. Medical, classification, work release, and HIV policy documents from the Alabama, South Carolina, and Mississippi Departments of Correction were reviewed. Supplemental documents were requested from the Alabama Department of Corrections under the Public Disclosure law, with no response as of the date of publication. All documents cited in the report are publicly available or on file with Human Rights Watch or the ACLU National Prison Project.

Background

HIV and Prisons in the US

More than 22,000 people incarcerated in federal and state prisons are living with HIV, a prevalence nearly four times higher than in the US general population.[1] Similarly, hepatitis B virus (HBV) and hepatitis C virus (HCV) prevalence is dramatically higher among prisoners than in the community.[2] Many prisoners are co-infected with HIV, HBV, and HCV.[3] It is estimated that 12-15 percent of Americans with chronic HBV infection, 39 percent of those with chronic HCV infection, and 14 percent of those with HIV infection pass through a US correctional facility each year.[4]

Incarceration of drug users contributes to the high rates of HBV, HVC, and HIV in prison, as injection drug use is a key risk factor for all three diseases. In the United States, 22 percent of people living with HIV and 48 percent of people living with HCV contracted the disease through injection drug use.[5] Twenty percent of state prisoners in the US are held on drug-related charges; in some states drug crimes account for as much as 40 percent of the prison

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[1] The prevalence of HIV/AIDS in US federal and state prisons in 2007 was 1.7% versus 0.44% in the general adult population. US Bureau of Justice Statistics "HIV in prisons, 2007-08"December 2009; Centers for Disease Control and Prevention,"HIV Prevalence Estimates--United States, 2006." *Morbidity and Mortality Weekly Report (MMWR)* 57 (39) October 3, 2008 ,1073-1076; Spaulding, A. et al., "HIV/AIDS Among Inmates of and Releasees from U.S. Correctional Facilities 2006:Declining Share of Epidemic but Persistent Public Health Opportunity" (2009) PLoS 4 (11): e7558.

[2] Compared to the US adult population, prison prisoners have 2.6-9.4 times the prevalence of HBV, 2-6 times the prevalence of chronic HBV, 8.9-22.8 times prevalence of HCV, and 9.2-26.9 times the prevalence of chronic HCV. C.M. Weinbaum et al. "Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention." *AIDS,* vol. 19 (Suppl 3), 2005, pp. 41 -6; GE Macalino et.al, "Hepatitis C infection and incarcerated populations," *International Journal of Drug Policy*, vol. 15, 2004, pp. 103-114.

[3] National data for co-infection are limited, but localized studies consistently reveal high rates of co-infection in both prisons and jails. In a recent investigation of Chicago and San Francisco jails, 50% of prisoners with HIV had HBV infection and 38% had HCV infection. K.A. Hennesse et al, "Prevalence of Infection with Hepatitis B and C Viruses and Co-infection with HIV in Three Jails: A Case for Viral Hepatitis Prevention in Jails in the United States." *Journal of Urban Health,* 86:1, 2009, pp. 93 -105. In New York, a 2005 study showed that 40% of prisoners testing positive for HIV were co-infected with Hepatitis C. Wang, et al., "HIV Prevalence Trends by HIV Testing History, Injection Drug Use and Sexual Risk Behaviors among Inmates Entering New York State Correctional Facilities from 1988 to 2005," 2008 (abstract presented at the 15th Conference on Retroviruses and Opportunistic Infections.)

[4] C. Weinbaum et al, "Hepatitis B, Hepatitis C, and HIV in Correctional Populations: a Review of Epidemiology and Prevention," *AIDS*, vol. 19 (3) (October 2005), p. 41; Spaulding, A. et al., "HIV/AIDS Among Inmates of and Releasees from U.S. Correctional Facilities 2006:Declining Share of Epidemic but Persistent Public Health Opportunity" (2009) PLoS 4 (11): e7558.

[5] Centers for Disease Control and Prevention, "HIV and AIDS in the United States: A Picture of Today's Epidemic," http://www.cdc.gov/hiv/topics/surveillance/united_states.htm (accessed 28 September 2009). Centers for Disease Control and Prevention, "Surveillance for Acute Viral Hepatitis, United States, 2007," Surveillance Summaries, *MMWR*, May 22, 2009. Vol. 58 / No. SS-3.

population.[6] Many more are in prison for committing property crimes often related to supporting a habit of drug use.[7]

While most prisoners living with HIV contracted the disease prior to incarceration, the risk of transmission in prison is a reality, particularly through unprotected sex or sharing injection equipment.[8] Regardless of institutional regulations, sexual activity, both consensual and coerced, is common in prisons around the world.[9] Prisoners who inject drugs are likely to share needles, increasing the risk of HIV transmission.[10] Tattooing is another common prison activity that poses a risk of HIV and hepatitis transmission from shared needles.[11]

Harm reduction in Detention

In recent years, many countries have responded to high rates of HIV and hepatitis in prisons by implementing harm reduction policies and programs. In contrast to punitive approaches that attempt to eliminate, stigmatize, and criminalize sexual activity and drug use, harm reduction emphasizes public health, individual quality of life, and respect for human rights.

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[6] U.S. Department of Justice, Bureau of Justice Statistics, "Prisoners in 2006"; T. Whitney, Illinois Criminal Justice Information Authority and TASC, "Disproportionate Sentencing of Minority Drug Offenders in Illinois," November 17, 2005, http://www.icjia.state.il.us/public/pdf/ResearchReports/Disproportionate%20Sentencing%20Report.pdf (accessed November 3, 2009.) Human Rights Watch has documented the impact of severe U.S. anti-drug laws and their disproportionate implementation against minority communities. See, *US-Cruel and Usual: Disproportionate Sentences for New York Drug Offenders,* vol. 9, no. 2 (B), March 1997, http://www.hrw.org/legacy/reports/1997/usny/; Human Rights Watch, *Collateral Casualties: Children of Incarcerated Drug Offenders in New York,* vol. 13, no. 3 (G), June 2002, http://www.hrw.org/legacy/rports/2002/usany/; Human Rights Watch, *Targeting Blacks: Drug Law Enforcement and Race in the United States,* May 2008,http://www.hrw.org/reports/2008/05/04/targeting-blacks; Human Rights Watch, Decades of Disparity: Drug Arrests and Race in the United States, March 2009,http://www.hrw.org/en/reports/2009/03/02/decades-disparity.

[7] U.S. Department of Justice, Bureau of Justice Statistics, Drug Use and Dependence, State and Federal Prisoners, 2004, p. 1. http://www.ojp.usdoj.gov/bjs/abstract/dudsfp04.htm, (accessed November 3, 2009).

[8] Centers for Disease Control and Prevention, "HIV Transmission Among Male Inmates in a State Prison System --- Georgia, 1992—2005," MMWR,vol. 55, no. MM15, April 21, 2006, p. 421; K Jafa, et al. "HIV Transmission in a State Prison System 1988–2005", *PLoS ONE* 4(5): (2009) e5416,doi10.1371/journal.pone.0005416. For a review of HBV, HCV and HIV transmission studies for both US and international prisons, see R. Jurgens, "HIV/AIDS and HCV in Prisons: A Select Annotated Bibliography," *International Journal of Prisoner Health,* vol. 2(2), June 2006. For a review of US literature on transmission in prison see T. Hammett, "HIV/AIDS and other infectious diseases among correctional inmates: transmission, burden and an appropriate response," *American Journal of Public Health,* vol. 96 (6), June 2006, p. 974.

[9] *See*, e.g., C.P. Krebs et al, "Intraprison transmission: an assessment of whether it occurs, how it occurs, and who Is at risk," *AIDS Education and Prevention* 14(Supp. B) (2002): 53; A. Spaulding et al, "Can unsafe sex behind bars be barred?" *American Journal of Public Health* 91(8) (2001): 1176; N. Mahon, "New York inmates' HIV risk behaviors: the implications for prevention policy and programs," *American Journal of Public Health* 86 (1996):1211; and Human Rights Watch, *No Escape: Male Rape in US Prisons*, 2001. For a global review of studies examining sexual activity in prisons, see WHO, *Evidence for Action Technical Papers: Interventions to Address HIV in Prison, Prevention of Sexual Transmission*, (Geneva 2007).

[10] R. Jurgens and G. Betteridge, "Prisoners who inject drugs," *Health and Human Rights*, vol. 8 (2005); R. Douglas Bruce and Rebecca A. Schleifer, "Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention," *The International Journal of Drug Policy*, vol. 19, no.1 (2008) p.19 (citing numerous studies).

[11] T. Abiona et al, "Body art practices among inmates: implications for transmission of bloodborne infections," *American Journal of Infection Control* (Oct 2009) .

Prison harm reduction is a pragmatic approach that acknowledges that prisoners engage in sexual activity and drug use while incarcerated and develops strategies that reduce risk of negative health consequences and link prison health to the health of the larger community.

According to the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and UNAIDS,[12] a comprehensive set of interventions in prisons should include:

- information and education, particularly through peers
- provision of condoms and other measures to reduce sexual transmission
- needle and syringe programs
- drug dependence treatment, in particular opioid substitution therapy
- voluntary counseling and HIV testing
- HIV care, treatment and support, including provision of antiretroviral treatment

There are many models for implementation of harm reduction policies in correctional settings, both within and outside the US. For example, large urban jails in New York, Los Angeles, San Francisco, Philadelphia, and Washington DC make condoms available to prisoners, and a condom distribution program has been successfully piloted in a medium-security state prison in California.[13] More than 50 prisons in 12 countries in Europe and Central Asia have established needle and syringe exchange programs to prevent HIV and other blood-borne diseases among prisoners.[14] Bleach and other disinfectants to sterilize needles and syringes have also been made available in a number of prison systems throughout the world.[15] Additionally, medication-assisted therapy (MAT) such as methadone or buprenorphine reduces the frequency of drug use and therefore lowers the risk of

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[12] WHO, UNODC & UNAIDS, *Effectiveness of interventions to address HIV in prisons*, 2007.

[13] J. May and E. Williams, "Acceptability of Condom Availability in a US Jail," *AIDS Education and Prevention*, vol. 14, supp. B, 2002; California Department of Corrections and Rehabilitation, "Prisoner Condom Access Pilot Program," December 2008 http://www.cdph.ca.gov/programs/aids/Documents/NEWSCDCRPrisConAccessPP.pdf (accessed November 24, 2009). T. Hammett et al, "National Survey of Infectious Diseases in Correctional Facilities: HIV and Sexually Transmitted Diseases " 2007, U.S. Department of Justice, January 2007, p. 15.

[14] For example, Mexico, France, Ukraine, Australia, Estonia, Spain, Switzerland, Luxembourg, Armenia, Kyrgyzstan, and Moldova. R. Jurgens, et.al., "Interventions to reduce HIV transmission related to injecting drug use in prison," *Lancet Infectious Diseases*, vol. 9, 2009, pp. 57-66 ; International Harm Reduction Association, "Global State of Harm Reduction 2008," August 2008.

[15] WHO/UNODC/UNAIDS, *Interventions to Address HIV in Prisons: Needle and Syringe Progammes and Decontamination Strategies*, 2007, p. 19. For a recent review of successful implementation of prison harm reduction programs in an Eastern European country, see "Harm Reduction in Prison: the Moldova Model," Open Society Institute Public Health Program, July 2009.

infectious disease transmission, and has been shown to be feasible in a wide range of prison settings in the US and abroad.[16]

HIV and Segregation

In the early days of the HIV/AIDS epidemic, HIV was poorly understood by scientists, policymakers, and the public. Panic, fear and confusion led to the passage of highly restrictive public policies and harsh interpretations of existing criminal and mental health laws. Between 1980 and 1990, 25 states enacted broad public health laws under which people who engaged in vaguely defined behaviors perceived to spread disease could be restricted, quarantined or subject to criminal action.[17] At the same time, scientists increasingly understood the modes of HIV transmission and effective methods of prevention. Public health authorities began to dispel myths about HIV transmission, emphasizing that HIV could not be transmitted through food or food handling, insects, kissing, air, water, saliva, or tears.

When HIV first appeared in prison populations, prison policies were very restrictive. HIV-positive prisoners were placed in isolation and had no access to programs, work or activities. Prisoners died of AIDS in alarming numbers; in 1995, 33 percent of all deaths in prison were attributable to AIDS-related causes.[18] The year 1995, however, also saw the advent of Highly Active Anti-retroviral Therapy (HAART), treatment that would permit HIV to move into the category of primary care along with other chronic diseases such as diabetes and hypertension.[19] As more became known about HIV, dramatic changes occurred in the HIV policies of both state and federal prisons as well as local city and county jails. The number of prison systems with segregated housing policies for prisoners with HIV or AIDS dropped from 46 of 51 federal or state systems in 1985 to 6 of 51 in 1994.[20]

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[16] MAT has been adopted in prisons in Spain, Brazil, Canada, New Zealand, the Czech Republic, Albania, and the United States (Puerto Rico), and large urban jails in the United States, including in Albuquerque, New Mexico; Orange County, Florida; Rikers Island Jail in New York City; and jails in three counties in Pennsylvania. R. Jurgens, et.al "Interventions to reduce HIV transmission related to injecting drug use in prison" *Lancet Infectious Diseases*, 9: (2009) 57-66.

[17] R Bayer et al. "AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior" *American Journal of Public Health*, Vol. 83, No. 10, October 1993, p. 1471; N. Ford and M. Quam, "AIDS Quarantine: the legal and practical implications," *Journal of Legal Medicine*, vol. 8 (1987) p. 353; K. Sullivan and M. Field, "AIDS and the Coercive Power of the State," *Harvard Civil Rights-Civil Liberties Review*, 23:1 (1988) p. 139.

[18] U.S. Bureau of Justice Statistics, "HIV in Prisons and Jails, 1995."

[19] JG Bartlett et al. "A Guide to Primary Care of People with HIV/AIDS" U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, 2004.

[20] U.S. Department of Justice, "*1994 Update: HIV/AIDS and STDs in Correctional Facilities".* December 1995. Table 24.

Today, only three states place all HIV-positive prisoners into separate, specially designated housing units: Alabama, South Carolina and Mississippi, with the policy in Mississippi to be phased out. In each of these states, controversy and litigation have surrounded prison officials' response to HIV. In 1987, the ACLU challenged Alabama's segregation policy for HIV-positive prisoners on constitutional grounds as well as under the federal Rehabilitation Act. The 11th Circuit Court of Appeals decided that the segregation policy did not violate the prisoners' constitutional rights to privacy and confidentiality as it was reasonably related to the legitimate correctional goal of preventing the spread of disease. The Rehabilitation Act claims were sent back to the trial court for further proceedings but ultimately dismissed by the 11th Circuit *en banc*.[21] In 2004, the Southern Center for Human Rights challenged the adequacy of medical care for HIV on behalf of prisoners at Limestone Correctional Facility in Harvest, Alabama. The case was settled in 2004, but compliance issues persisted throughout the two year period of the settlement agreement.[22] Gradually, as a result of legal action and intense advocacy efforts by the ACLU and other community leaders, access to programs, jobs, and activities has improved significantly for prisoners living with HIV in Alabama. For example, in July 2009 a new corrections administration in Alabama changed the work release policy to permit the participation of HIV-positive prisoners.

In Mississippi, the ACLU pursued both litigation and advocacy to address medical care, conditions of confinement, and opportunities for programs for HIV-positive prisoners.[23] In 1999, the ACLU-NPP won an injunction requiring the Mississippi Department of Corrections to provide all HIV-positive prisoners with medical treatment consistent with federal guidelines.[24] In 2000-2001, at the urging of the ACLU and a coalition of state legislators, prisoners' family members and local advocates, the Commissioner of the Mississippi Department of Corrections convened a task force to study HIV-positive prisoners' access to programs, appointing the ACLU to serve along with officials from MDOC and the Mississippi public health department. In May 2001, the Commissioner, adopting the Task Force's recommendations, ordered that all in-prison programs other than food service jobs be

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[21] ***Harris v. Thigpen*, 941 F2d 1495 (11th Cir. 1991), later *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999), *cert. denied*, 528 U.S. 1114 (2000). Plaintiffs' attempt to add claims under the Americans with Disabilities Act was dismissed by the trial court after remand.**

[22] ***Leatherwood v. Campbell*, CV-02-BE-2812-W, U.S. District Court, Northern District of Alabama (2004) . For a comprehensive account of efforts to obtain adequate medical care in the HIV unit at Limestone, see B. Fleury-Steiner and C. Crowder, Dying Inside: the HIV/AIDS Ward at Limestone Prison, (University of Michigan Press: Ann Arbor, 2008).**

[23] ***Gates v. Collier*, 4:71cv6, *consolidated with Moore v. Fordice*, 4:90cv-125. Prospective relief in *Moore* was terminated in 2005 pursuant to the Prison Litigation Reform Act (PLRA), based on the district court's finding that constitutional violations within the purview of the case had been remedied. Portions of *Gates*, relating to conditions at Mississippi State Penitentiary, Unit 32 (Mississippi's death row and super-maximum security facility) are ongoing; on November 18, 2009, the State moved to terminate under the PLRA.**

[24] ***Moore v. Fordice*, 4:90cv-125, (N.D. Miss. July 19, 1999)**

integrated.[25] On the issue of work release, however, the Commissioner deferred decision. In 2004, the United States District Court in the ongoing class action on behalf of HIV-positive prisoners ordered the Department to permit HIV-positive prisoners to participate in work release and community corrections programs.[26] As of March 2010, Mississippi prison officials can be credited with ending the segregation policy. According to Commissioner of Corrections Christopher Epps, all incoming prisoners will be housed according to the criteria set forth in the state classification plan rather than on the basis of their HIV status.[27] Currently segregated prisoners will be evaluated for relocation on an individualized, case by case basis to ensure their safety and security. [28]

In South Carolina, HIV-positive prisoners at the Broad River Correctional Institution, proceeding without the assistance of counsel, asked the court to determine that the testing and segregation policies violated their constitutional rights. The trial court upheld the policies and this decision was affirmed by the 4th Circuit Court of Appeals.[29]

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[25] "Commissioner Johnson Adopts HIV/AIDS Task Force Recommendations," press release dated April 27, 2001, http://www.mdoc.state.ms.us/pressreleases/2001/NewsReleases/HIV%20AIDS%20Task%20force.htm, accessed March 15, 2009.

[26] Order, Civ.No. 4:90cv125-JAD (N.D. Miss. June 7, 2004).

[27] Human Rights Watch/ACLU-NPP teleconference with Mississippi Commissioner of Corrections Christopher Epps and General Counsel Leonard Vincent, March 11, 2010. The decision to integrate HIV-positive prisoners was later confirmed in email communications to Human Rights Watch/ACLU-NPP dated March 16, 2010.

[28] In an interview with the Jackson, MS Clarion ledger dated March 18, 2010, Commissioner Epps stated that he would have ended the segregation policy previously but the "ACLU asked that they remain segregated" when the Moore litigation was terminated in 2005. This distorts the ACLLU's longstanding opposition to segregation of HIV-positive prisoners. Rather, the ACLU expressed concern at the time for the safety of prisoners in the segregation unit should they be summarily released into the general population after having been compelled to involuntarily disclose their HIV status. The decision by the Mississippi Department of Correction to evaluate each currently segregated prisoner on a case by case basis strikes an acceptable balance between these concerns.

[29] *Bowman v. Beasley*, 8 Fed.Appx.175 (C.A.4(S.C) 2001).

Human Rights Standards

The Universal Declaration of Human Rights declares that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[30] The prohibition is also a matter of *jus cogens*, a peremptory norm of customary international law binding on all states.[31] This principle is enshrined in the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) and the International Covenant on Civil and Political Rights (ICCPR), two treaties signed and ratified by the United States.[32] Cruel and inhuman treatment includes that which inflicts severe pain and suffering, physical or mental, without a legitimate purpose or justification, at the instigation of or with the consent or acquiescence of public officials.[33] Degrading treatment has been defined as "the infliction of pain or suffering, whether physical or mental, which aims at humiliating the victim."[34]

As stated in the ICCPR, prisoners have the right "to be treated with humanity and with respect for the inherent dignity of the human person."[35] Key to the interpretation of this right is the principle that the loss of liberty itself should be the only form of punishment. The only rights forfeited at the prison door are those that are "unavoidable in a closed environment."[36] Prisoners retain rights to privacy, informed consent, confidentiality and the right to be free from discrimination.[37] The ICCPR protects the right of prisoners to rehabilitation, including access to educational, vocational, and in-prison work programs. [38]

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[30] Universal Declaration of Human Rights, UNGA Res. 217 (III), UN GAOR, 3d Session, Supp. No. 13, UN Doc. A/810 (1948), Article 5.

[31] M. Nowak and E. McArthur, *The United Nations Convention Against Torture: A Commentary* (Oxford University Press, 2008), p. 8 (hereinafter *Commentary*.. A peremptory norm is one which is "accepted and recognized by the international community of States as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character." Vienna Convention on the Law of Treaties (1969), art. 53.

[32] Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (CAT), adopted December 10, 1984, G.A. Res. 39/46, annex, 39 UN GAOR Supp. (no. 51) at 197,UN Doc. A/39/51 (1984) entered into force June 26, 1987, ratified by the US on October 14, 1994,para.3; International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc.A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the U.S. on June 8, 1992, art.7.

[33] Even with a legitimate purpose, the infliction of pain should not be excessive or disproportional. Commentary, p. 558.

[34] Ibid.

[35] International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc.A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the U.S. on June 8, 1992, arts. 6,7 10(1).

[36] UN Committee on Human Rights, General Comment No. 21, Article 10, Humane Treatment of Prisoners Deprived of their Liberty, UN Doc. HRI/Gen/1/Rev.1 at 33 (1994), para. 3.

[37] United Nations Standard Minimum Rules for the Treatment of Prisoners, May 13, 1977, Economic and Social Council Res., 2076 (LXII); Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111 (1990); Body of Principles

Informed Consent

In Alabama and Mississippi, prisoners are subjected to mandatory testing as a matter of state law; in South Carolina, mandatory testing is a Department of Corrections policy.[39] The right to make decisions about personal life and health based on informed consent is a bedrock principle of medical ethics and an integral part of international human rights law.[40] Mandatory testing *per se* interferes with the right to privacy, as the right covers the inviolability of the individual's person.[41] Such interference could only be justifiable where it is medically necessary, proportionate and non-discriminatory.

Mandatory HIV testing is incompatible with human rights standards and contrary to international guidelines and best practice for managing HIV in a correctional setting. The World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the United Nations Joint Programme on AIDS (UNAIDS) have taken unequivocal positions against mandatory HIV testing in prisons. For example, the WHO Guidelines on HIV Infection and AIDS in Prison state: "Compulsory testing of prisoners for HIV is unethical and ineffective and should be prohibited."[42]

Mandatory testing of prisoners is also suspect under the obligations of the United States with respect to the prohibition on ill-treatment. The Special Rapporteur on Torture has stated with regard to HIV testing that "If forcible testing is done without respecting consent and

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for the Protection of All Persons Under any form of Detention or Imprisonment, UN General Assembly Resolution 43/173/(1988).

[38] ICCPR, article 10 (3); Human Rights Committee, "Concerning Humane Treatment of Persons Deprived of their Liberty," General Comment 21 (replacing General Comment 9) 10/04/92, para. 11.

[39] In Alabama and Mississippi, mandatory testing of incoming prisoners is required by state law. Alabama Code Sec. 22-11A-17, 38 (2008); Mississippi Code Annotated Sec. 41-23-1 (2008). The South Carolina Department of Corrections HIV testing policy is set forth in Policy Number PS- 10.01. Mandatory testing of prisoners for HIV has been upheld in the federal courts. See, *Harris v. Thigpen*, 941 F.2d 1495 (11th Ci. 1991); *Dunn v. White*, 880 F.2d 1188 (10th Cir. 1989).

[40] ICCPR, Art. 17; International Covenant on Economic, Social and Cultural Rights (ICESCR),adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR (no. 16) at 49, UN Doc. A/ 6316 (1966), 99 UNTS 3,art. 12, entered into force January 3, 1976, signed by the US on October 5, 1977; Beijing Declaration and Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995), para. 108(e); United Nations Educational, Scientific, and Cultural Organization (UNESCO), Universal Declaration on Bioethics and Human Rights, adopted October 2005, SHS/EST/05/CONF.204/3 REV, arts. 6and 9.

[41] ICCPR, Article 17. See, Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary 2nd edition,* (Kehl am Rhein: N.P. Engel, 2005) p. 386.

[42] WHO, *Guidelines on HIV Infection and AIDS in Prisons* (1999), para.10; UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006),para.21(e); UNODC,*HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response* (2006),p.18.

necessity requirements, it may constitute degrading treatment, especially in a detention setting."[43]

Confidentiality

Denial of the right to informed consent is compounded by failure to maintain confidentiality of test results. The ICCPR protects an individual's right to privacy, which includes confidentiality of personal and health information.[44] The right to health established under the International Covenant for Economic, Social and Cultural Rights (ICESCR) robustly protects the rights of privacy and confidentiality in relation to one's health status. Although the US has signed but not ratified ICESCR, limiting its obligations under the treaty, as a signatory it remains obligated to refrain taking steps that would undermine its intent and purpose.[45]

International guidelines for management of HIV in prisons emphasize the importance of guaranteeing the confidentiality of HIV status in a prison setting.

The WHO Guidelines state:

> Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to medical personnel...Routine communication of the HIV status of prisoners should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells, or papers to indicate their HIV status.[46]

The UNODC 's "HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings" states that prison officials should:

> Ensure that prisoners are not involuntarily segregated or isolated based on their HIV status and are not housed, categorized or treated in a fashion that discloses their HIV status.[47]

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[43] Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, "Promotion and Protection of all Human Rights, Civil, political, Economic, Social and Cultural Rights, including the Right to Development", A/HRC/10/44, January 14, 2009.

[44] ICCPR, Article 17.

[45] Vienna Convention on the Law of Treaties (VCLT),adopted May 23, 1969, entered into force January 27, 1980, Article 18.

[46] WHO "Guidelines on HIV Infection ," paras. 31, 33.

[47] UNODC "HIV Prevention, Care, Treatment and Support in Prison Settings," p. 15.

Discrimination

Involuntary disclosure threatens to undermine other human rights by exposing HIV-positive prisoners to the risk of stigma, discrimination and violence from both staff and other prisoners. As stated by the UNODC:

> Inside of prisons, people living with HIV/AIDS are often the most vulnerable and stigmatized segment of the prison population. Fear of HIV/AIDS often places HIV-positive prisoners at risk of social isolation, violence and human rights abuses from both prisoners and prison staff.[48]

Under international guidelines for management of HIV in prisons, administrators should take steps to combat stigma and discrimination. Segregated housing and exclusion from programs, activities and work opportunities promote, rather than reduce, stigma, isolation, and differential treatment. In the absence of legitimate medical grounds, these policies are discriminatory and incompatible with international human rights law and guidelines for health and human rights in prisons.

As set forth in the WHO Guidelines:

> Prisoners' rights should not be restricted more than is absolutely necessary on medical grounds...HIV–infected prisoners should have equal access to workshops and to work in kitchens, farms and other work areas, and to all programmes available to the general population. [49]

The European Committee for the Prevention of Torture, which oversees the regional European equivalent of CAT has made it clear that "there is no medical justification for the segregation of a prisoner solely on the grounds that he is HIV-positive." [50]

Policies that test without consent, segregate without medical justification, and discriminate against prisoners with HIV are incompatible with long-standing obligations of the United States under international law, and also may fall foul of the standards in the most recent human rights treaty signed by President Obama. On July 30, 2009 the United States signed

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[48] UNODC "HIV Prevention, Care, Treatment and Support in Prison Settings," p. 12.

[49] WHO "Guidelines on HIV Infection," para .27.

[50] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) "The CPT Standards" 2006, para. 56, interpreting the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, (ECPT), signed November 26, 1987, E.T.S. 126, entered into force February 1, 1989.

the Convention on the Rights of Persons with Disabilities. This treaty prohibits any exclusion, restriction or distinction on the basis of disability that "has the purpose or effect of impairing the recognition, enjoyment or exercise of all human rights on an equal basis with others."[51] The interpretation of the treaty in relation to people living with HIV has yet to be determined,[52] but the HIV policies in the Alabama, South Carolina, and Mississippi state prison systems may not withstand scrutiny under this Convention.

Right to Health and Harm Reduction Services

Finally, prisoners are entitled to medical care without having to sacrifice other fundamental human rights. There is broad international consensus that prisoners have a right to health care that is at least equivalent to that provided in the general community.[53] Under the ICCPR, prisoners have a right not to forfeit their privacy guaranteed under the treaty, in order to enjoy their right to adequate medical care. [54] The International Covenant on Economic, Social and Cultural Rights specifically prohibits discrimination against people living with HIV/AIDS in obtaining equal access to health care.[55]

Human Rights standards protect the right of prisoners to access harm reduction services that reduce the risk of transmission of HIV, hepatitis, and other infectious disease. The Special Rapporteur on Torture and the Special Rapporteur on the Right to the Highest Attainable Standard of Health have both addressed the importance of harm reduction measures in detention settings, including syringe exchange programs and medication-assisted therapy for opioid dependence. [56]

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[51] Convention on the Rights of Persons with Disabilities, adopted December 13, 2006, UN DOC A/61/611, entered into force May 3, 2008, signed by the United States on July 30, 2009, Article 2.

[52] For a report from an international policy dialogue on the applicability of the Convention to people living with HIV/AIDS, see Dutch Coalition on Disability and Development, "Intersectionality HIV and Disability: New Questions Raised,"October 12, 2009.

[53] Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111 (1990), principles 5 and 9; United Nations Standard Minimum Rules for the Treatment of Prisoners, May 13, 1977, Economic and Social Council Res., 2076,article 22; UNODC, "HIV Prevention, Care, Treatment and Support in a Prison Setting," p. ix; Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia (2004), principle 2.

[54] ICCPR, Articles 6,7,10,and 17. The Human Rights Committee has found that governments "must provide adequate medical care during detention." *Pinto v. Trinidad and Tobago* (Communication No. 232/1987) Report of the Human Rights Committee, vol. 2, UN Doc A/45/40, p. 69. *See also* UN Committee on Human Rights, General Comment No. 20, Article 7, Humane Treatment of Prisoners Deprived of their Liberty, (1992), paras. 10,11.

[55] Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, paras. 12, 18, 34.

[56] Letter from Anand Grover and Manfred Nowak to the Commission on Narcotic Drugs, December 10 2008, para. 1.

Cruel, Inhuman and Degrading Treatment

Violations of any of the rights to which prisoners living with HIV are entitled, be that informed consent, confidentiality, or freedom from discrimination, without medical or other justification is unacceptable. Taken cumulatively, detention conditions that require prisoners with HIV to forfeit these rights solely on the basis of their medical status, while subjected to an atmosphere that promotes prejudice, stigma and even violence against them may constitute cruel, inhuman and degrading treatment. The Convention Against Torture obligates the United States to take "positive effective measures" to ensure the prevention, investigation and elimination of any such treatment in any territory under its jurisdiction.[57]

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[57] Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (CAT), adopted December 10, 1984, G.A. Res. 39/46, annex, 39 UN GAOR Supp. (no. 51) at 197,UN Doc. A/39/51 (1984) entered into force June 26, 1987, ratified by the US on October 14, 1994,Article s 12,16; Committee Against Torture, "Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment" General Comment No. 2, 1/24/08 UN Doc CAT/C/GC/2, para. 4.

Findings

Cruel, Inhuman and Degrading Treatment

Upon entry to the state prison systems in Alabama, South Carolina, and Mississippi, prisoners are subjected to mandatory HIV testing at the reception centers, which is followed by immediate isolation in the case of a positive test. Human Rights Watch and the ACLU National Prison Project (ACLU-NPP) found that isolation at reception and assignment of all HIV-positive prisoners to designated "HIV/AIDS" units without medical justification violates prisoners' right to privacy and confidentiality by forcing involuntary and widespread disclosure of personal health information.

Segregated housing promotes myths and misinformation about HIV transmission among staff, other prisoners and the community. These messages undermine educational efforts intended to combat stigma and marginalization, creating instead an atmosphere of hostility and harassment that places the safety of HIV-positive prisoners at risk.

Despite significant improvement in this area over the past decade, prisoners in the HIV/AIDS units remain subject to differential and discriminatory treatment that relegates them to harsher and more restrictive environments and arbitrarily limits their eligibility for jobs, programs, and work release. Many of these restrictions have the potential to lengthen the period of incarceration and impair their ability to productively re-enter society.

Human Rights Watch and ACLU-NPP found that, taken together, conditions of detention for HIV-positive prisoners in Alabama and South Carolina violate the prohibition under international law against cruel, inhuman and degrading treatment of prisoners. The same is true for HIV-positive prisoners currently segregated in Mississippi and not yet affected by the recently announced change in policy. The testimony of prisoners in Mississippi is included in this report with the expectation that, in the future, conditions for prisoners living with HIV will comply with human rights standards.

Isolation and Separation of Prisoners with HIV

Ronald B. recalled arriving at the Kirkland Reception Center in South Carolina in December 2008:

> I arrived at Kirkland, and went through intake. They took a blood test. I didn't know my status. I was with everyone else, in a big dorm, and they are letting us recreate and go to chow and all that. Suddenly they come and pull you out...they put you in what was literally a dungeon, a dark cell way down some stairs, and that's it. I was in there 23 hours a day after that, they fed me through the door, I couldn't even take a shower every day. You'd have to yell upstairs to reach anyone, and sometimes they came, and sometimes they didn't.[58]

John S. described a similar experience in Alabama in March 2009:

> The process of entering the system and getting tested for HIV is miserable. Prisoners arrive at Kilby which is the receiving unit, and if you test positive they take you straight to lockup. They tell you you've got AIDS and are going to die. They put you in the hole and now guys are staying 2- 3 months because they are so overcrowded, there are no beds in [designated HIV units] dorm B or C.[59]

Female prisoners told of Alabama's use, until recently, of the "green room", a small, sparsely furnished room used for housing prisoners with mental health problems as well as for segregating women who test positive for HIV:

> The green room is scary because women are back there yelling and screaming. If this is your first diagnosis, you really think you've got AIDS and you're dying.[60]
> – Debbie A., Alabama

In each of the three states, prisoners with positive test results were immediately separated from the group and placed in isolation cells on 23 hour lockdown. People remained in these isolation cells for periods of a week to several months, waiting first for a confirmation test and then for a bed to open in the HIV unit. The absence of medical justification for

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[58] Human Rights Watch interview with Ronald B., Charleston, South Carolina, August 20, 2009.

[59] Human Rights Watch interview with John S.,Limestone Correctional Facility, Harvest, Alabama, August 7, 2009.

[60] Human Rights Watch interview with Debbie A., Julia S. Tutwiler Prison for Women, Wetumpka, Alabama, August 4, 2009;Human Rights Watch interview with Mary W., Julia S. Tutwiler Prison for Women, Wetumpka, Alabama, August 5, 2009.

placement in isolation [61] was compounded by the lack of education, information or counseling following the positive test. Though one prisoner mentioned speaking with a counselor in South Carolina, most described the trauma of having little or no information provided about the HIV diagnosis or what was going to happen to them in the prison system. In the women's unit in Alabama, a prisoner from the HIV unit is occasionally permitted to visit the reception area and answer questions from those just entering the system. For Leslie G., however, this was not the case:

> When I came to the system, I went to the receiving unit. They took my blood. Then they came and told me that I needed to be isolated, and they put me in the green room. They didn't give me any information, I was crying. The nurse told me I was HIV-positive. I went off. I was in such a state of shock. There was no chaplain, no medical people, they just said go in this 4 x 4 cell and stay there.[62]

For many prisoners, placement in the isolation cells at the reception unit was a devastating, and lasting, breach of confidentiality.

> Once they put you in lockup at reception, you're a marked man.[63]
> –Adam D., Alabama

> You're marked as HIV, so from day one, it's over.[64]
> –Lorna P., South Carolina

> When they finally let you out of reception, you got to sneak on the doggone bus because everybody knows by then you're HIV.[65]
> –Andrew W., South Carolina

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[61] *See*, e.g. NCCHC Position Statement, "Administrative Management of HIV in Correctional Institutions," revised October 8,2005; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) "The CPT Standards" 2006, para. 56.

[62] Human Rights Watch interview with Leslie G., Julia S. Tutwiler Prison for Women, Wetumpka, Alabama, August 5, 2009.

[63] Human Rights Watch interview with Adam D., Limestone Correctional Facility, Harvest, Alabama, August 7, 2009.

[64] Human Rights Watch interview with Lorna P., Charleston, South Carolina, August 21, 2009.

[65] Human Rights Watch interview with Andrew W.,Charleston, South Carolina, August 21, 2009.

Segregated Housing

Once released from isolation at the reception centers, HIV-positive prisoners are assigned to specially designated "HIV/AIDS" housing units that are located in maximum-security prisons. In Alabama, the B and C dorms at Limestone Correctional Facility house approximately 250 male HIV-positive prisoners; 25-30 HIV-positive women are housed in dorm E at the Julia S. Tutwiler Prison for Women. In South Carolina, 600 HIV-positive male prisoners are housed at the Broad River Correctional Facility, in the Marion and Wateree dorms; 40 women are housed at the Camille Griffin Graham facility in the HIV/AIDS unit known as Whitney B. Approximately 150 male HIV-positive prisoners in Mississippi are currently assigned to Buildings A and B of the Mississippi State Penitentiary at Parchman; 25-30 female prisoners living with HIV/AIDS at the Central Mississippi Correctional Facility, the state's only prison for women, are not segregated. Both the Broad River facility in South Carolina and the Mississippi State Penitentiary also house these states' death row.

Prisoners testified that the assignment to designated housing triggered a fear of exposure from other prisoners, many of whom they know from their hometowns:

> That's the bad thing about it, everybody knows as soon as you go in that dorm that you're HIV-positive. I don't think it's fair they've got us singled out like that, when folks have come in and not told their families yet. I think we should have freedom of choice whether to be tested or not.[66]
> –Mary W., Alabama

> You haven't even dealt with it, you're still in denial, disbelief, but everybody knows and they call your family and friends. You get letters from your people saying "we heard you're dying of AIDS." [67]
> –Lorna P., South Carolina

An Alabama prisoner wrote to say that his brother discovered his status during a visit to the Alabama Department of Corrections website. As recently as November 2009, the website listed the prisoner as housed in the "Limestone Special Unit." The Limestone facility description stated that all prisoners with HIV/AIDS are housed in a segregated unit at that facility. He wrote:

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[66] Human Rights Watch interview with Mary W., Julia S. Tutwiler Correctional Facility, Wetumpka, Alabama, August 5, 2009.

[67] Human Rights Watch interview with Lorna P., Charleston, South Carolina, August 21, 2009.

> I wanted to tell my brother about my HIV status on my own, rather than him finding out on the internet. This was very hurtful to me and I don't believe that they should be able to disclose my HIV status without my permission.[68]

Until December 2009, the women housed in the HIV unit in Alabama were listed on the website as living in the "Tutwiler infirmary," a designation certain to raise questions from family and friends. Alabama's public disclosure of prisoners' health status on its website was unnecessary and unjustified.

Further eroding confidentiality is the requirement that HIV/AIDS unit prisoners wear visible insignia of that status on their person. At Limestone Correctional Facility in Alabama, male prisoners from the HIV/AIDS dorms must wear white armbands at all times. Although prisoners from some of the other dorms also wear armbands, it is generally known that the color associated exclusively with the HIV/AIDS dorm is white. In South Carolina, male prisoners from the HIV unit carry a blue dot on their identification badges, while the women's uniforms bear the name of the HIV/AIDS dorm, "Whitney B."

Prisoners expressed deep resentment about these insignia. Ken D., a prisoner at Limestone Correctional Facility, told us:

> The thing I have the most trouble with is the armband. It's disclosing my medical confidentiality to the whole prisoner population without my consent. How do I want you to know my business? It's depressing, it's stressful, being treated this way.[69]

John S. recalled an incident in the visiting room:

> Someone saw the armband and said 'that guy's got the ninja [HIV].' Then your people find out and you haven't even told them yet. That's not right. [70]

Requiring HIV-positive prisoners to wear insignia announcing their medical status is just one of the ways that they are stigmatized and singled out for differential and often discriminatory treatment. In South Carolina, prisoners from the HIV/AIDS unit eat separately in the dining

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[68] Letter from Richard E. dated November 30, 2009 to Jackie Walker, HIV/AIDS Coordinator, ACLU-NPP. Since December 2009 the ADOC website no longer indicates "special unit" or "infirmary" for HIV-positive prisoners.

[69] Human Rights Watch interview with Ken D., Limestone Correctional Facility, Harvest, Alabama, August 7, 2009.

[70] Human Rights Watch interview with John S.,Limestone Correctional Facility, Harvest, Alabama, August 7, 2009.

hall. They are permitted to attend church services, but must sit together on one side of the chapel. In Alabama, HIV-positive prisoners are allowed to attend trade school but they must enter and exit separately and are called out separately during the periodic headcounts. HIV-positive prisoners can attend classes for substance abuse at the therapeutic community program, but then must leave after the class is over as they are not permitted to reside in the community with the other prisoners. Ken D. said "This messes with your head. You can't get the benefit of it because you get upset about how they treat you."[71]

Harassment and Discrimination

Human Rights Watch and the ACLU- NPP documented pervasive stigma, harassment and discrimination against prisoners separated into HIV-only housing units.

Fear, Prejudice and Stigma

In South Carolina, prisoners described the experience of being ordered to turn their faces to the wall when general population prisoners passed them in the halls. Joseph T. stated, "I heard one officer telling guys from another dorm, 'that's the HIV unit, stay away from them now. You don't want to catch that stuff do you?'"[72]

An HIV counselor visiting the women's unit in South Carolina heard an officer tell a prisoner, 'don't cough on me, you've got that package.' The counselor told Human Rights Watch and ACLU-NPP, "They treat the women in the HIV unit with no respect. There's no excuse for how they speak to them."[73]

Mary W. said that most of the officers assigned to the women's unit in Alabama are "okay, but when temps fill in for the regular officers, they act like we're contagious. They don't come into the dorm, they stay out in the hall because they don't want to be near us.[74]

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[71] Human Rights Watch interview with Ken D., Limestone Correctional Facility, Harvest, Alabama, August 7, 2009.

[72] Human Rights Watch interview with Joseph T., Columbia, South Carolina, August 18, 2009.

[73] Human Rights Watch interview with Sarah McClam, Women's Health Council Project Coordinator, Palmetto AIDS Life Support Services, Columbia, South Carolina, August 19, 2009.

[74] Human Rights Watch interview with Mary W., Julia S. Tutwiler Correctional Facility, Wetumpka, Alabama, August 5, 2009.

Mississippi prisoner Larry P. stated*:*

> There is no confidentiality at all about our HIV, everyone knows. We're not referred to as HIV-positive, but as 'the AIDS guys'. Officers wear gloves when they come onto our tiers.[75]

Mississippi prisoners described constantly being called "punks and faggots—the guards assume we're all gay."[76] Another Mississippi prisoner, Michael G., stated, "the guards tell us to 'get our sick asses out of the way' when they pass us in the hallway." [77]

In South Carolina and Mississippi the HIV-positive prisoners eat by themselves in the dining hall, and the prisoners who serve them reportedly display attitudes ranging from fear of contact to spitting and putting other bodily fluids into the food. [78] According to Mississippi prisoner Tom E., "the kitchen staff shove the trays at us to avoid accidentally touching us."[79]

Each of these prison systems provide periodic information sessions to both staff and prisoners about HIV/AIDS. However, the decision to segregate HIV-positive prisoners actively promotes myths and misinformation about the disease. Separation that has no medical justification facilitates prejudice, stigma, and discrimination within the prison and to community members aware of these policies. Despite the gradual improvements that have taken place in permitting HIV-positive prisoners to access programs, jobs and other in-prison activities, segregated housing remains incompatible with acceptance, inclusion and equality. As one prisoner put it, "they do education sometimes on HIV, but how can they say we're the same as everyone else when they don't treat us that way?"[80]

Compromised Classification, Safety and Security

Assignment to the HIV/AIDS housing unit is not based on the factors that corrections officials normally consider for safely classifying prisoners, but solely on the result of the HIV test. Indeed, Alabama, South Carolina, and Mississippi disregard their own classification plans when it comes to housing HIV-positive prisoners. Discrimination based on HIV status

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[75] ACLU of Mississippi interview with Larry P., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[76] ACLU of Mississippi interview with Tom E., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[77] ACLU of Mississippi interview with Michael G., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[78] Human Rights Watch interview with David S., Charleston, South Carolina, August 21, 2009; ACLU of Mississippi interview with Tom E., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[79] ACLU of Mississippi interview with Tom E., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[80] Human Rights Watch interview with David S., Charleston, South Carolina, August 21, 2009.

also affects the length of incarceration and the conditions of confinement for HIV-positive prisoners. Permitting HIV status to be determinative of housing assignment can also place the safety of prisoners at risk.

Alabama, South Carolina, and Mississippi have developed detailed classification policies that are intended to promote individualized determinations for housing, programs and other aspects of prison life. These policies are based upon the classification standards set by the American Correctional Association, an expert body whose guidelines state that prison officials should:

> Use the classification process to assign individuals to different levels of control on the basis of valid criteria regarding risk (to self and others) and individual needs, matching these characteristics with appropriate security, level of supervision, and program services.[81]

In South Carolina, for example, the classification policy states, "an inmate's custody should be based on behavior and criminal history" and lists no fewer than 10 factors to consider in determining an prisoner's custody level, including history of assault, escapes, disciplinary offenses, detainers, gang membership and others.[82]

Many prisoners told us that, if it were not for their HIV status, they would be eligible for assignment to minimum or medium security units based on the variety of factors that are taken into consideration under the classification policy adopted by each prison system. In South Carolina and Mississippi, the HIV/AIDS units are located in maximum security prisons that also house death row. In South Carolina, prisoners with sentences as short as 90 days are assigned to the HIV unit at Broad River, a facility local newspapers describe as "a maximum security prison housing South Carolina's most dangerous male criminals."[83]

The location of the HIV/AIDS units in maximum security prisons proves problematic for prisoners whose security and custody status would normally be in the medium or minimum range. Prisoners incarcerated at maximum security prisons suffer a significant loss of liberty and privileges by assignment to high security prisons where low custody status is not

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[81] ACA Policy Resolution, "Public Correctional Policy on Classification," January 12, 2005, http://www.aca.org/government/policyresolution/view.asp?ID=5 (accessed November 25, 2009).

[82] South Carolina Department of Corrections Classification Plan, OP-21.04, para. 2.9. See also, Alabama Department of Corrections, Administrative Regulation No. 400 "Classification of Inmates," November 10,2004.

[83] "s on Lockdown at Broad River Prison," *The State*, May 5, 2009.

available, movement is restricted, other prisoners pose a greater risk of violence,[84] and the atmosphere is much more tense with frequent facility-wide lockdowns.[85]

Prisoners complained of chronic lockdowns due to disturbances in other areas of the prison:

> Right now my dorm has been locked down from Saturday 29th day of August through now September 6th. I have had only one shower, also the way they feed us during lockdowns is inhumane.[86]
> —Jay J., South Carolina

Permitting HIV status to be determinative of housing assignment can compromise safety and security. In Alabama, the HIV/AIDS unit is located at Limestone Correctional Facility, a medium-security prison housing prisoners with both medium and minimum custody designations. Alabama officials told Human Rights Watch and the ACLU-NPP that there are no deviations from the classification plan for HIV-positive prisoners.[87] However, all medium and minimum custody prisoners living with HIV are placed in the segregated unit at Limestone. Disregard of the factors emphasized in the classification policies for housing determination such as criminal history, behavior in prison, tendencies toward predation or aggression, can lead to incidents such as that occurring in the HIV/AIDS unit at Limestone on June 22, 2009. On that date, one prisoner savagely attacked another prisoner with a baseball bat, fracturing his skull and also injuring another prisoner who tried to help the victim. The attacker had a sentence of life without parole, while the victim's sentence was less than five years.[88] Without knowing the behavioral history of the prisoners involved, it is not possible to determine whether, outside of the HIV/AIDS unit, they would have been housed together. What is certain, however, is that the decision to house them together was not based on security considerations or other factors set forth in the state classification plan, but because both of them tested positive for HIV.

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[84] See, e.g. Alabama Department of Corrections Monthly Reports, 2008-2009 showing 221 assaults in maximum and medium security prisons during the period August 2008-August 2009, with one assault in a minimum security facility during the same period.

[85] "s on Lockdown at Broad River Prison," *The State*, May 5, 2009; "Broad River on Lockdown After Fatal Stabbing," *The State*, August 31, 2009.

[86] Letter to Human Rights Watch from Jay J., prisoner at Broad River Correctional Facility, Columbia, South Carolina, September 5, 2009.

[87] Letter to Human Rights Watch/ACLU-NPP and the ACLU of Alabama from Commissioner of Corrections Richard Allen dated March 12, 2010.

[88] Letter dated August 12,2009 from Olivia Turner, Executive Director of the ACLU of Alabama to Richard F. Allen, Commissioner of the Alabama Department of Corrections; reply dated September 8, 2009 from Kim Thomas, General Counsel, Alabama Department of Corrections.

Segregation policies that perpetuate fear, prejudice and stigma also place prisoners' safety at risk. Prisoners in Mississippi's unit 29 described an atmosphere charged with hostility from staff and other prisoners. In Mississippi, both prisoners and guards signed petitions protesting the transfer in 2008 of the HIV housing units to Buildings A and B in Unit 29 where prisoners with HIV would have more contact with the general population during the day. HIV-positive prisoners sent to disciplinary lock-up have experienced beatings from other prisoners while housed in that cellblock.[89] Larry P. stated:

> One time an HIV-positive prisoner got placed by accident in C or D building...when he was moved and walked over to A and B buildings, the prisoners there went crazy when they knew they'd had an HIV-positive prisoner in their midst. I fear for my safety because of the ignorance in this place about this disease.[90]

Particularly in Mississippi, HIV-positive prisoners expressed fear that if the segregation policy was discontinued, they would suffer violence in the general population because their HIV status was already known.[91]

Prisoners who suffer abuse or ill treatment by other prisoners often have no recourse, as prison staff themselves frequently treat them with disrespect. In South Carolina, an ex-prisoner told Human Rights Watch and the ACLU-NPP that homophobia and prejudice on the part of correctional officers assigned to the HIV/AIDS unit compromised his security. Joseph T., who was in Broad River until June of 2009, said he was raped by three other prisoners but when he complained, nothing was done.

> The officers told me, 'oh you're all gay, we can't get involved in that.' Another said to me 'all you guys have sex together, you wear makeup, we don't want to hear it'.[92]

Joseph explained that after hearing the attitude of the officers, he never filed a formal complaint, grievance or report.

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[89] ACLU of Mississippi interview with Michael G., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[90] ACLU of Mississippi interview with Larry P., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[91] ACLU of Mississippi interviews with Larry P., Michael G. and Ted E., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009, as well as correspondence from Mississippi prisoners to ACLU-NPP and Human Rights Watch.

[92] Human Rights Watch interview with Joseph T., Columbia, South Carolina, August 18, 2009.

Restricted Access to Jobs, Programs and Work Release

When the designated HIV/AIDS units first opened in the 1990's, prisoners in Alabama, South Carolina and Mississippi had virtually no access to jobs or programs in the general population. One South Carolina prisoner recalled,

> They literally put up a fence around us and cut us off from everything and everybody. It was like they said 'we're going to take all you guys who have this virus and put you on an island by yourself.' It took a lot out of me, it really did.[93]

Though the segregation policy has remained in place, a combination of legal action, intense advocacy, and more progressive correctional administration has led to improved access to activities open to the general population. Prisoners from the HIV/AIDS units now attend classes, religious services and substance abuse programs, and they are eligible for certain prison industry and labor crew employment. Significant discrimination persists, however, despite the lack of medical justification for restrictions on employment, programs and work release. Opportunities are not yet equal for prisoners assigned to the segregated units.

In-prison Jobs

In each of the three states HIV-positive prisoners are prohibited from working in the kitchen, dining hall or canteen. This policy has no medical justification and has been expressly rejected by the scientific community. The US Centers for Disease Control and Prevention (CDC) states:

> There is no known risk of HIV transmission to co-workers, clients, or consumers from contact in industries such as food-service establishments (see information on survival of HIV in the environment). Food-service workers known to be infected with HIV need not be restricted from work unless they have other infections or illnesses (such as diarrhea or hepatitis A) for which any food-service worker, regardless of HIV infection status, should be restricted.[94]

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[93] Human Rights Watch interview with Aiden P., Columbia, South Carolina, August 18, 2009.

[94] CDC HIV/AIDS Factsheet, online at http://www.cdc.gov/hiv/resources/factsheets/transmission.htm. In addition, the WHO Guidelines on HIV Infection and AIDS in Prison states, "HIV infected prisoners shall have equal access to workshops and to work in kitchens, farms and other work areas, and to all programmes available to the general prison population." WHO Guidelines, para.27.

Particularly disturbing is Alabama and South Carolina's admission that the policy has no medical basis but defers to fear and prejudice that exists among the prisoner population. In Alabama, prison officials took a "survey" of prisoners in the Limestone facility and found that "80 percent of those polled were opposed to HIV-positive prisoners working in food service."[95] Alabama officials told Human Rights Watch and the ACLU-NPP that the ban was justified because, they asserted, general population prisoners would not tolerate "openly gay" prisoners as food service workers, the assumption apparently being that prisoners with HIV must be "openly gay". Human Rights Watch and the ACLU-NPP confirmed with Alabama officials that "openly gay" prisoners, regardless of HIV status, are also barred as a matter of policy from working in the kitchen. [96] This policy has serious human rights implications that demand further investigation.

The approach to these issues by Alabama officials demonstrates how prejudice against persons with HIV is often inextricably linked with homophobia. Moreover, Alabama officials conceded that but for the segregation policy that identifies HIV-positive prisoners to the rest of the population, prisoners living with HIV could work in the kitchen without incident.[97] Thus the "security" problem is one created solely by the officials themselves by compelling involuntary disclosure of prisoners' HIV status to other prisoners.

In South Carolina, the prison HIV/AIDS policy states on page 3, "No HIV/AIDS positive prisoner shall be assigned to kitchen detail. The perceived risk of transmission by food service becomes a severe management problem." Rather than addressing this erroneous perception, South Carolina has chosen to deny an entire category of in-prison employment on the basis of HIV status. Again, prison officials cite a "security" issue that arises only from their own policy of segregation. Kitchen work can be beneficial to a prisoner in several ways. Many prisoners worked in kitchens, cafes, or restaurants prior to incarceration, and continued employment in that area could help them upon re-entry. Moreover, in many prisons, including South Carolina, kitchen work offers the opportunity to earn high amounts of "good time" credits as well as wages. As Bob C. explained, "if I could get a kitchen job I could cut down my time a whole lot—I could get 10 months of good time as opposed to 4 months with my job in the yard."[98]

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[95] Letter to Human Rights Watch/ACLU-NPP and the ACLU of Alabama from Commissioner of Corrections Richard Allen dated March 12, 2010.

[96] Human Rights Watch/ACLU-NPP and ACLU of Alabama teleconference with Commissioner of Corrections Richard F. Allen , Deputy Commissioner James LaRoach and staff, March 16, 2010.

[97] Human Rights Watch/ACLU-NPP and ACLU of Alabama teleconference with Commissioner of Corrections Richard F. Allen, Deputy Commissioner James LaRoach and staff, March 16, 2010.

[98] Human Rights Watch interview with Bob C.,Charleston, South Carolina, August 21, 2009.

Prisoners with HIV in South Carolina are ineligible for other jobs classified as "special" and reserved for prisoners with good behavior and low security status, e.g. bloodhound detail and in-prison construction crews. In South Carolina, no prisoners with HIV are eligible to work at the Director's residence. These are elite jobs that permit prisoners to accrue significant "earned work credits" that can apply toward early release from prison. [99] Denial of access to these jobs is categorical and purely discriminatory, with no attempt to assess an individual's health status or ability to perform the work.

In Mississippi the access of HIV-positive prisoners to in-prison jobs is limited. Jobs in the kitchen, barbershop, selected prison industries such as textiles and carpentry, and administrative offices are not open to prisoners from the HIV/AIDS units. The primary job available is ground crew, which involves cleaning up and cutting the grass around unit 29. Such severe restriction of work opportunities is discriminatory and contradicts Mississippi's stated policy promoting rehabilitation and to "assist all offenders in becoming productive, law-abiding citizens."[100]

Barring prisoners with HIV from jobs promotes fear, stigma and discrimination. There is, for example, no health-related justification for prohibiting prisoners with HIV from working in the barbershop. Indeed, the US Department of Justice has recently issued guidelines clarifying that such a prohibition outside of prison violates the Americans with Disabilities Act.[101] It is no coincidence that in Mississippi, prisoner barbers display negative attitudes toward prisoners from the HIV-segregated units. Michael G. told us, "The prisoners who cut our hair are real quick about it and don't want to give us real haircuts."[102]

Commissioner Epps has assured Human Rights Watch and the ACLU-NPP that under Mississippi's new policy, HIV-positive prisoners will be eligible on an equal basis for all in-prison jobs including the kitchen and the barbershop.[103]

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[99] Human Rights Watch interview with David Tatarsky, General Counsel, South Carolina Department of Corrections, September 21, 2009; South Carolina Code of Laws, Title 24, Section 24-13-230.

[100] Mission Statement, Mississippi Department of Corrections website, www.mdoc.state.ms.us (accessed November 24, 2009.)

[101] US Department of Justice, "Questions and Answers: Americans With Disabilities Act and the Rights of Persons with HIV/AIDS to Occupational Licensing and Training, July 2009, http://www.ada.gov/qahivaids_license.htm (accessed November 24, 2009).

[102] ACLU of Mississippi interview with Michael G., Mississippi State Penitentiary, Parchman, Mississippi, September 10, 2009.

[103] Email communication between Human Rights Watch/ACLU-NPP and Commissioner Christopher Epps dated March 16, 2010.

In-Prison Programs

HIV-positive prisoners also face program restrictions, many of which also have the potential to lengthen the time they spend in prison. HIV-positive prisoners in Alabama are not permitted to reside in either the "faith-based" or the "honor" dorms. These are opportunities earned by good behavior in prison and are likely to be looked upon favorably by the Parole Board. Moreover, the Governor of Alabama recently launched a "faith-based re-entry initiative" that links prisoners to faith-based support groups in the community.[104] One would expect that prisoners from the faith-based dorms would be likely candidates for access to this important re-entry assistance. "Therapeutic community" programs have been identified by experts as among the most effective models for in-prison substance abuse treatment.[105] In Alabama, however, HIV-positive prisoners are not eligible for the residential aspect of these programs. Rather, they are permitted to attend the classes but must return to the HIV/AIDS unit at the end of each day. HIV-positive prisoners are barred completely from the residential pre-release program at Limestone, a new initiative that provides intensive vocational and rehabilitative services to prisoners preparing for return to the community.

As an Alabama prisoner explained,

> I have only a year to go before parole. I can drive a tractor, I have my driver's license. I should be getting my custody lowered, getting a job, looking at pre-release programs, things that can help me when I get out of here. But I can never get my custody lowered because I'm HIV.[106]

In South Carolina, there are designated pre-release centers for male and female prisoners, but HIV-positive prisoners are ineligible for transfer to these facilities.[107] In South Carolina, prisoners with HIV are ineligible for the Short-Term Offender Program (STOP), a program designed specifically for the needs of prisoners with sentences of one year or less that

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[104] State of Alabama Press Office Release, "Gov. Riley Rallies Faith and Community Groups to Help Ex-Offenders Avoid Return to Crime", dated May 19, 2008; "Governor's Faith-Based Re-entry Initiative," Alabama Department of Corrections Budget Briefing 2008-09, p. 21.

[105] National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations- A Research-Based Guide* (2007); National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars II: Substance Abuse and America's Prison Population Report,* p. 51.

[106] Human Rights Watch interview with John S., Limestone Correctional Facility, Harvest, Alabama, August 7, 2009.

[107] South Carolina Department of Corrections Classification Plan, OP-21.04.

"provides practical and useful life skills training developed to reintegrate the offenders back into the society."[108]

Work Release

Work release programs offer prisoners the opportunity to reside in low security facilities while working for either a state or a private employer. Prisoners are permitted to keep a percentage of their wages while demonstrating responsibility and establishing a relationship that might lead to employment when their sentence is completed. In states such as South Carolina, prisoners are able to earn union wages, collect unemployment compensation and enjoy other benefits of employment while completing their sentence. Corrections officials in Alabama, South Carolina and Mississippi have recognized the importance of work release opportunities to achieving a successful re-entry into society. As stated in the Alabama Department of Corrections Work Release policy:

> The fundamental purposes of Alabama's work release program are to assist selected prisoners in preparing for release and to aid in making the transition from a structured institutional environment back into the community.[109]

Integrated work release programs, like integrated housing for HIV-positive and non-positive prisoners, are the national norm. In a survey conducted by the ACLU-NPP, 25 of 27 states with work release programs reported no restriction on participation for HIV-positive prisoners.[110]

In Alabama, HIV-positive prisoners were ineligible for work release until July 2009, when the Department of Corrections, in response to extensive advocacy efforts by the ACLU, reversed its policy barring prisoners with HIV from participating. Commissioner of Corrections Richard Allen described the change in policy as "doing the right thing," stating, "We've looked at how the attitude about AIDS has evolved from people being terrified of it to it being a disease that's difficult to transmit and one that can be managed."[111] However, Human Rights

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[108] STOP Program, South Carolina Department of Corrections website, www.doc.sc.gov. (accessed November 24, 2009).

[109] Administrative Regulation No. 410, online at http://www.doc.state.al.us/docs/AdminRegs/AR410.pdf,(accessed November 10, 2009).

[110] "Policies of Federal and State Prison Programs Regarding Access to Work Release and Food Service Jobs" April 17, 2008, on file with the ACLU-NPP. 40 states and the Bureau of Prisons responded to the survey. 27 states had work release programs similar to that in Alabama, in which prisoners wear civilian clothes and are supervised by civilian employers. Of these, 25 states have no restrictions for participation of HIV-positive prisoners. Only Nevada and South Carolina reported ineligibility of HIV-positive prisoners for work release.

[111] "Prisons' HIV Decision Shows Progress," *Montgomery Advertiser*,14 August 2009.

Watch and ACLU-NPP have concerns about unnecessary restrictions that remain in Alabama's work release policy.

Although there are 11 work release centers in Alabama (9 for men, 2 for women) under the revised policy, HIV-positive men may be assigned only to the center in Decatur; women may be assigned only to Montgomery. Restriction to a single center is likely to unnecessarily prevent many prisoners from getting a job near their home and family. Limitation to a single center is also likely to result in a "cap" on the number of HIV-positive prisoners who can participate in work release once the single center reaches its capacity.

The policy also imposes unnecessarily restrictive medical clearance criteria. HIV-positive prisoners, if taking HIV medication, must have a viral load of "less than 48 for four consecutive readings, and a CD4 count greater than 450" to be eligible for work release. If not taking HIV medication, prisoners must have "a viral load of less than 1000 and a CD4 count greater than 700."[112] But, as recognized in federal statutes and regulations, an HIV-positive person's ability to work involves an analysis of clinical symptoms and functional capacities, not an arbitrary and exclusive reliance on CD4 and viral load test results.[113] The policy's imposition of numerically-driven cutoff points for eligibility is virtually guaranteed to arbitrarily exclude many prisoners from the program without any legitimate medical justification.

After reviewing the policy, Josiah Rich, M.D., professor of Medicine and Community Health at Brown University and medical director of HIV/AIDS Services for the Rhode Island Department of Corrections stated,

> Alabama's criteria bears no relation to an individual's capacity for employment. Individuals living with HIV may be fully able to work even if they have CD4 and viral load counts different from than that listed in the criteria.[114]

In South Carolina, HIV-positive prisoners are barred from all work release programs.[115] Several people recently released from the HIV/AIDS units described the importance of work release to their transition from prison:

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[112] Alabama Department of Corrections, Policy No. B-1(e), June 10, 2009.

[113] See, US Social Security Administration, *Disability Evaluation Bluebook*, Section 14.00, October 2008; US Department of Justice, Civil Rights Division, Disability Rights Section, "The Americans with Disabilities Act and Persons with HIV/AIDS." http://www.ada.gov/pubs/hivqanda.txt (accessed November 24, 2009.)

[114] Human Rights Watch telephone interview with Dr. Rich, December 14, 2009.

> It's so hard to find an offender-friendly employer, but with work release you get a chance to prove yourself. I would have been eligible because my custody level was minimum, but I couldn't go because I have HIV. That's not right. Without work release, I went out the same way I came in.[116]

> With work release, you've got a chance to earn some money. I know that UPS (United Parcel Service) has been hiring guys from the program. I could get an apartment, maybe a car.[117]

> Work release determines whether you're going to make it or not. If you can be near your family, they can fight for you and that can keep you from going back to prison.[118]

Lorna P. told Human Rights Watch and ACLU-NPP:

> In South Carolina, the work release camp is right next door [to the HIV unit]. So you're looking at it through the barbed wire, and you're so close but yet so far.[119]

In Mississippi, HIV-positive prisoners have been permitted to participate in work release since 2004, when the Department of Corrections was ordered by the federal court to change its policy as a result of litigation brought by the ACLU-NPP. According to Commissioner Epps, his decision to change the segregation policy was based, in part, on the successful integration of HIV-positive prisoners at the work release centers in Mississippi.[120]

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[115] Human Rights Watch telephone interview with David Tatarsky, General Counsel, South Carolina Department of Corrections, 9/21/09.

[116] Human Rights Watch interview with Lorna P., Charleston, South Carolina, August 21, 2009.

[117] Human Rights Watch interview with Bob C.,Charleston, South Carolina, August 21, 2009.

[118] Human Rights Watch interview with Allen C., Charleston, South Carolina August 20, 2009.

[119] Human Rights Watch interview with Lorna P., Charleston, South Carolina, August 21, 2009.

[120] [120] Human Rights Watch/ACLU-NPP teleconference with Mississippi Commissioner of Corrections Christopher Epps and General Counsel Leonard Vincent, March 11, 2010.

State Arguments for Continuing to Segregate Prisoners with HIV

"In order to ensure the optimum care, health and security of all inmates at Limestone, HIV-positive inmates continue to be housed separately from other inmates."

– Commissioner Richard F. Allen, Alabama Department of Corrections[121]

Administrators from Alabama and South Carolina repeatedly advanced two rationales in support of the policy of segregation: first, that such policies are necessary to facilitate the delivery of adequate medical care for HIV/AIDS; and second, that such policies are necessary to reduce the risk of transmission of HIV within the prison to other prisoners or to staff.[122] These assertions are unsupported by medical evidence and best practice, and plainly violate the rights of HIV-positive prisoners. Medical care and transmission prevention are indeed essential goals for prison administrators, but both may be achieved without sacrificing the rights of prisoners with HIV.

Medical Care for HIV/AIDS

Segregation is inconsistent with the position taken by leading correctional health experts in the United States. The National Commission on Correctional Health Care (NCCHC) "endorses the concept that medical management of HIV-positive prisoners and correctional staff should parallel that offered to individuals in the noncorrectional community."[123] The NCCHC Position Statement on HIV further provides that:

> Decisions on housing HIV-positive prisoners should be based on what is appropriate for their age, gender, and custody class. NCCHC opposes routine segregated housing for HIV-positive prisoners. HIV-positive prisoners, like any other prisoner, may require a higher level of care that may not be

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[121] Letter dated June 24, 2009 from Richard F. Allen, Commissioner of the Alabama Department of Corrections to Olivia Turner, Executive Director of the ACLU of Alabama.

[122] Human Rights Watch telephone interview with David Tatarsky, General Counsel, and Glen Alewine, M.D., Medical Director, South Carolina Department of Corrections, September 21, 2009; Human Rights Watch/ACLU-NPP and ACLU of Alabama teleconference with Commissioner of Corrections Richard F. Allen , Deputy Commissioner James DeLoach and staff, March 16, 2010. Public documents advancing these rationales include the Alabama Department of Corrections "HIV Inmates Set to Join Work Release," Corrections News, Alabama Department of Corrections, Oct 2009; the HIV/AIDS Policy (No. PS-10.01) of the South Carolina Department of Corrections; pleadings filed by South Carolina Department of Corrections, *Bowman v. Beasley*, 8 Fed. Appx. 175 (C.A. 4 (S.C.) 2001); Mississippi Department of Corrections press release, "Response to District Court Ruling," March 31, 2005.

[123] NCCHC Position Statement, "Administrative Management of HIV in Correctional Institutions," revised October 8,2005.

> available at all institutions. This is a clinical judgment, based upon the acuity of care required for the patient. Patients with HIV infection may require isolation if, for example, they have pulmonary tuberculosis. HIV patients should not be medically isolated solely because of their HIV status.[124]

Best practice for HIV treatment and services is not "one size fits all." People with HIV vary widely in individual health status, with many living for years without symptoms and without need for medication. Those suffering from opportunistic infection or experiencing complications may need hospitalization and other targeted services. There is no one medication regimen that is "best" for all patients infected with HIV. The time to start antiretroviral therapy (ART) for HIV depends upon several factors, including the person's T cell count, age, underlying medical conditions, history of an AIDS-defining illness, and the person's willingness to commit to lifelong treatment. Proper utilization of ART requires ongoing patient monitoring to assess therapeutic response and to identify adverse events related to chronic administration of potentially toxic medications. Patients who are started on ART should generally have follow-up within one to two weeks to ask patients about adverse effects, adherence, and prevention of transmission. Once patients are clinically stable on their ART regimen, medical visits generally decrease to every three months.[125]

Clearly, segregation is not intrinsically related to high quality medical care. When prisoners were first segregated In Alabama and Mississippi decades ago, they initially received such poor care that federal court action was required.[126] In the US, forty-seven other states and the federal Bureau of Prisons provide medical care to prisoners with HIV without segregating them from other prisoners. These include Florida and New York, the two states with the highest numbers of prisoners living with HIV. These states, as well as Texas, California and many others, make individual health determinations and distinguish between prisoners needing routine medical care and prisoners requiring more intensive services. Prisoners in the latter group are transferred to medical units where prisoners with a variety of medical conditions, not only HIV, have greater access to specialty care. [127]

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[124] Ibid.

[125] U.S. Department of Health and Human Services, AIDS Info-HIV Clinical Guidelines, Guidelines for the Use of Antiretroviral agents in Adults and Adolescents, December 1, 2009.

[126] *Moore v. Fordice*, A-90CV-125 (N.D. Miss. July 19, 1999); *Leatherwood v. Campbell*, CV-02-BE-2812-W, U.S. District Court, Northern District of Alabama (2004).;

[127] Memorandum from Jackie Walker of the ACLU-NPP, "Communications with state prison officials re: HIV care" September 25, 2009, on file with Human Rights Watch and ACLU-NPP.

In Alabama and South Carolina, HIV-related primary care is rendered at the segregated housing units by medical staff assigned specifically to those units and trained in HIV and AIDS. According to prison officials, the presence of specially trained staff in the housing units has improved the level of care significantly. In South Carolina, officials maintain that assigning all prisoners with HIV to the Broad River facility in Columbia increases access to specialty care from doctors at the nearby University of South Carolina Hospital. As stated by the South Carolina Department of Corrections, "we are proud of the level of medical care we provide to prisoners with HIV."[128]

Human Rights Watch and ACLU-NPP make no findings in this report regarding the quality of the medical services provided to prisoners with HIV. Rather, the report focuses on the compatibility of the state response to HIV with fundamental principles of human rights. Prisoners should not, and need not, be asked to forfeit their human rights to privacy, confidentiality and non-discrimination in order to receive adequate medical care.

Prevention of HIV Transmission

Officials in Alabama and South Carolina claim that segregation is necessary to reduce the risk of HIV transmission within the prison. Alabama Commissioner of Corrections Richard F. Allen has frequently stated that the HIV transmission rate in that state's prisons is "almost zero" and that segregation is essential in order to "keep it that way."[129] Human Rights Watch and ACLU-NPP have requested documentation of Alabama's transmission rates, with no response as of the date of publication. South Carolina and Mississippi have not studied transmission rates nor assessed the impact of segregation on reducing the risk of transmission.[130]

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[128] Human Rights Watch telephone interview with David Tatarksy, General Counsel for the South Carolina Department of Corrections, September 21, 2009.

[129] Letter from Commissioner Richard Allen to Human Rights Watch/ACLU-NPP/ACLU of Alabama dated March 12, 2010; Alabama Department of Corrections press release, "ADOC Announces Policy Changes for HIV Positive Prisoners" October 31, 2007. During the trial of *Onishea v Hopper*, 171 F.3d 1289 (1999), Alabama corrections officials offered evidence of a .00067 percent seroconversion rate (prisoners who became HIV-positive while in prison during an 8- year period.) *Onishea*, p. 1264. Human Rights Watch and the ACLU-NPP have requested recent data, analysis or studies that might document transmission rates, reduced transmission or the impact of segregated housing on transmission but to date, Alabama has provided no documentation as of the date of this report.

[130] South Carolina points to a lower number of HIV-positive prisoners since instituting the segregation policy, but this claim confuses the issue of transmission with the number of prisoners entering the system already infected with HIV. Email communication dated September 28, 2009 from David Tatarsky, General Counsel to the South Carolina Department of Corrections, to Human Rights Watch.

To be sure, the presence of high risk behavior in prisons such as sexual activity, injection drug use and tattooing is well documented.[131] However, data on in-prison rates of transmission of HIV are scarce. Studies thus far have documented rates of transmission that are "low, but not negligible."[132] One study found that between 1988 and 2005, 88 prisoners seroconverted to HIV in the Georgia State Department of Corrections, with transmission related to sexual activity and tattoos.[133] A 2006 study in a southeastern state identified a .63 percent seroconversion rate (33 of 5,265 male prisoners) over a period of 22 years.[134]

Today, there is a developing body of evidence demonstrating that harm reduction programs including condom availability, syringe exchange and medication-assisted therapy for prisoners dependent on heroin and other opioids reduce the risk of transmission of HIV and other sexually transmitted infections (STIs) as well as Hepatitis B and C in prisons.[135] None of these approaches are available in any of the three states, though Mississippi does make condoms available for prisoners on conjugal visits. HIV-positive prisoners, however, are not eligible for conjugal visits.[136]

In 2007, the World Health Organization (WHO), the United Nations Agency on AIDS (UNAIDS), and the United Nations Office on Drugs and Crime (UNODC) conducted a world-wide literature review evaluating the efficacy and feasibility of prison condom distribution programs. The report found that prisoners use condoms to reduce transmission of HIV and other STIs, with no negative consequences to security, and with a high level of acceptance

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[131] *See*, e.g., C.P. Krebs et al, "Intraprison transmission: an assessment of whether it occurs, how it occurs, and who Is at risk," *AIDS Education and Prevention* 14(Supp. B) (2002): 53; A. Spaulding et al, "Can unsafe sex behind bars be barred?" *American Journal of Public Health* 91(8) (2001) 1176; N. Mahon, "New York inmates' HIV risk behaviors: the implications for prevention policy and programs," *American Journal of Public Health* 86 (1996):1211; and Human Rights Watch, *No Escape: Male Rape in US Prisons*, 2001. For a global review of studies examining sexual activity in prisons, see WHO, *Evidence for Action Technical Papers: Interventions to Address HIV in Prison, Prevention of Sexual Transmission*, (Geneva 2007). Jurgens and G. Betteridge, "Prisoners who inject drugs," *Health and Human Rights*, vol. 8 (2005); T. Abiona et al, "Body art practices among inmates: implications for transmission of bloodborne infections," *American Journal of Infection Control* (Oct 2009)...

[132] Okie, S. "Sex, Drugs, Prisons, and HIV" *New England Journal of Medicine* 356 (2007) 105-108,p. 106.

[133] Centers for Disease Control and Prevention, "HIV Transmission Among Male Inmates in a State Prison System --- Georgia, 1992—2005," MMWR,vol. 55, no. MM15, April 21, 2006, p. 421. This study estimates that the 88 prisoners seroconverting in prison represented 9 percent of all HIV-positive prisoners in the Georgia State prisons, though the actual percentage may be higher or lower due to variables not in the scope of the investigation.See, Jafa,K. et al. "HIV Transmission in a State Prison System 1988–2005", *PLoS ONE* 4(5): (2009) e5416,doi10.1371/journal.pone.0005416.

[134] Krebs, C.P. "Inmate Factors Associated with HIV Transmission in Prison" *Criminology and Public Policy*, 51 (2006) 113-136.

[135] See, e.g. "Harm Reduction in Prison: the Moldova Model," Open Society Institute Public Health Program, July 2009; WHO/UNODC/UNAIDS, *Evidence for Action Technical Papers-Interventions to Address HIV in Prisons. Comprehensive Review.* Geneva, 2007; Correctional Services of Canada, "Evaluation of HIV/AIDS Harm Reduction Measures in the Correctional Service of Canada," April 1999.

[136] Mississippi Department of Corrections, "Conjugal Visits", online, http://www.mdoc.state.ms.us/conjugal_visits.htm (Accessed March 17, 2010).

by staff and prisoners once the program is introduced. [137] By decreasing risky behavior such as needle sharing and unprotected sex, harm reduction programs provide an evidence-based approach to HIV prevention that remains respectful of human rights.

In addition to human rights concerns, segregation of HIV-positive prisoners is not recommended as a matter of public health. Prisons generally can be incubators for infectious disease, but close confinement of individuals with compromised immune systems may spread infection more rapidly through this more vulnerable population. Two of the three prisons examined in this report have experienced serious outbreaks. In 2000, a tuberculosis outbreak infected 32 prisoners in South Carolina's Broad River Correctional Facility HIV unit and in 2004 there was a widespread outbreak of Methicillin-resistant Staphylococcus aureus (MRSA) infection in the HIV unit in Mississippi.[138] The South Carolina TB outbreak is cited by WHO, UNAIDS and UNODC in its conclusion that: "Policies of mandatory testing and segregation can be counterproductive and have negative health effects for segregated prisoners."[139] Infection control for TB and MRSA has also been problematic in the HIV unit at Limestone.[140]

Segregation also may lead to a false sense of security among prisoners in the general population that HIV has been effectively removed, thereby increasing the likelihood of unsafe sexual, injection or tattooing behaviors. Within the segregated units, unsafe behaviors increase the risk of re-infection with new strains of HIV, other sexually transmitted diseases and hepatitis B and C.[141] The reliance on segregation in lieu of comprehensive harm reduction measures to prevent disease transmission places the health of the entire prison population at risk.

Everyone shares the goal of reducing transmission of HIV in prison, but this goal can be met without resort to segregation. Prison officials are obligated under international law to take

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[137] WHO/UNODC/UNAIDS, *Evidence for action technical papers: Interventions to Address HIV in Prisons: Prevention of Sexual Transmission,* Geneva 2007.

[138] Patterson, et al, "Drug-Susceptible TB Outbreak in a state correctional facility housing HIV-infected inmates," MMWR 49 (46), 2000, p. 1041; "At Hearing on Health Conditions for HIV-Positive Prisoners, ACLU Says Officials Failed to Prevent Staph Infection," ACLU-NPP Press Release June 24, 2004.

[139] WHO/UNODC/UNAIDS,*Evidence for Action Technical Papers-Interventions to Address HIV in Prisons.* Geneva, 2007, p. 69.

[140] Leatherwood v. Campbell, CV-02-BE-2812-W, U.S. District Court, Northern District of Alabama (2004) report from Dr. Joseph Bick, August 2004.

[141] Centers for Disease Control, "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV," 2003; P. Halkitis e t al, "Seroconcordant sexual partnering of HIV-seropositive men who have sex with men," AIDS, vol 19, supp. 1 (2005) p. 577.

steps to prevent the spread of HIV and other disease, but such steps should, and can, be compatible with other fundamental principles of human rights.

Segregation is Bad Public Policy

Segregation and discrimination against prisoners with HIV not only violates the human rights of the individuals concerned, it is also expensive, in both financial and public health terms. Policies that support the myths, misinformation and stigma surrounding HIV/AIDS are counterproductive to efforts to educate, encourage testing and reduce risky behavior. Discrimination against people with HIV drives the disease further underground among prisoners, staff and in the community.

Policies that restrict the opportunity of a prisoner to work, to earn “good time” or other credit toward release keep people in prison longer, and thus make little sense, particularly in difficult economic times. In Alabama, incarceration costs an average of $41.00 per day per prisoner; in South Carolina, that cost is $35.00 and in Mississippi, $40.00 per day.[142] In addition, many HIV-positive prisoners are housed in maximum security prisons when lower custody facilities are less expensive. For example, in Mississippi, it costs $52 dollars per day to house a prisoner in maximum security at the Mississippi State Penitentiary (where the HIV unit is located) compared to $32 dollars per day at a medium or minimum security facility, an additional $7,300 per year per prisoner. [143]

Work release and community corrections programs also are more cost-effective than continuing to incarcerate a prisoner until the last day of his or her sentence. In 2003 the ACLU conducted a study of the cost savings to Alabama if prisoners from the segregated HIV units were placed into work release at the same rates as other prisoners. The report found that due to a $5,000-7,000 difference in the annual cost of incarceration compared with the cost of work release, the state could save between $306,000 and $372,000 per year by repealing the prohibition on work release for prisoners with HIV.[144] Alabama has since done so, but the work release policy still unreasonably limits eligibility, thus reducing the amount of savings that could be realized.

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[142] Alabama Department of Corrections, “Frequently Asked Questions,” online, http://www.doc.alabama.gov/faq.asp (accessed December 13, 2009); Response from South Carolina Department of Corrections to ACLU request for documents under the Freedom of Information Law, dated June 22, 2009;Mississippi Department of Corrections, “Cost Per Inmate Day by Facility Type FY 2009”, online, www.mdoc.state.ms.us (accessed December 12, 2009).

[143] Mississippi Department of Corrections, “Cost Per Inmate Day by Facility Type FY 2009”, online, www.mdoc.state.ms.us (accessed December 12, 2009).

[144] Maddow, R., “The Cost of Excluding Alabama State Prisoners with HIV/AIDS from Community-Based Programs” April 2003, on file with Human Rights Watch and ACLU-NPP.

Prisoners earning money from work release jobs pay child support, victim restitution, and often contribute to the cost of their room and board while on the program. In South Carolina, for example, prisoners contribute 20 percent of their wages to victim restitution and 35 percent to child support. These requirements have generated millions of dollars for the South Carolina Victims Compensation Fund.[145]

Finding and maintaining a job is a critical element of prisoner re-entry. Work release programs have been shown to significantly reduce recidivism.[146] Prisoners on work release establish relationships with outside employers. If they remain employed after release, they become tax-paying citizens. As a matter of fiscal policy, promoting, rather than restricting, work release opportunities is the more cost-effective approach.

Similarly, targeted pre-release programs can improve a prisoner's chances of a successful transition to the community. South Carolina's STOP program provides an example. The South Carolina Department of Corrections describes the Short Term Offender Program (STOP) as follows:

> The STOP Unit is a fast track program addressing the needs of male offenders that have shorter sentences, one year or less. It provides practical and useful life skills training, education, vocational, rehabilitation, and employment assistance for offenders who may not have previously had access to intensive institutional programs, pre-release preparation or community resources.[147]

Yet HIV-positive prisoners with sentences as short as 90 days are ineligible for STOP. Rather, they are assigned to the segregated unit at the maximum security prison that houses death row. This policy undermines the mission of the South Carolina Department of Corrections which is to "provide rehabilitation and self-improvement opportunities for prisoners." [148] Depriving prisoners of opportunities to become productive citizens is costly and unwise as

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[145] South Carolina Department of Corrections, "Inmates Now Contributing More to Help Victims," online, http://www.doc.sc.gov/victim_services/news1199.jsp (accessed December 12, 2009).

[146] Urban Institute, Justice Policy Center, "Understanding the Challenges of Prisoner Re-entry" (January 2006);Solomon, A. et al, "From Prison to Work: The Employment Dimensions of Prison Re-entry, A Report of the Re-entry Roundtable," Urban Institute, October 2004; For a recent review of studies associating work release with reduced recidivism, see, Washington State Institute for Public Policy, "Does Participation in Washington's Work Release Facilities Reduce Recidivism?" November 2007.

[147] South Carolina Department of Corrections, "Broad River Correctional Facility," online, http://www.doc.sc.gov/institutions/brci.jsp (accessed December 12, 2009).

[148] Mission Statement, South Carolina Department of Corrections website, www.doc.sc.gov. (accessed November 24, 2009).

well as unjust. Lifting these barriers would bring short and long term benefits to the individuals, their families, and the community.

Conclusion

In Alabama, South Carolina and, until recently, Mississippi, prisoners with HIV forfeit numerous fundamental rights: to informed consent, to confidentiality, and to non-discrimination, while at the same time they are subject to an atmosphere of prejudice, stigma, and hostility from both staff and other prisoners. Taken together, these conditions constitute cruel, inhuman and degrading treatment in violation of international law.

After reviewing the findings of this report, Mississippi has agreed to end its long-standing policy of segregation, thus increasing the isolation of Alabama and South Carolina in this regard. Now, only in these two states do prison officials continue to systematically isolate, marginalize and exclude this population without medical justification. These policies reflect outdated approaches to HIV that no longer have any basis in science or modern correctional health. Segregation is also bad public policy, as keeping people in prison longer simply because they have HIV is not only unfair, but more expensive. Failing to prepare prisoners for transition to the community increases their chances of returning to prison, at great cost to individuals, families, and communities.

Prison systems throughout the US and around the world are providing medical care for HIV and preventing its transmission while respecting human rights. Alabama and South Carolina can, and should, end their own isolation by reforming these policies without delay.

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Sentenced to Stigma

Segregation of HIV-Positive Prisoners in Alabama and South Carolina

Upon entering the state prison system in Alabama, South Carolina or Mississippi, each prisoner must submit to a test for HIV. In Alabama and South Carolina, and until recently, in Mississippi, more than the severity of the crime, the length of sentence or almost any other factor, the HIV test determines where prisoners are housed, eat, and recreate. It determines access to in-prison jobs or supervised work in the community; and in South Carolina, how much "good time" can be earned toward early release. During the entire period of incarceration, most prisoners who test positive will wear an armband, badge or other marker signifying the positive results of their HIV test.

When prisoners with HIV are segregated they are forced to forfeit many of their rights, while at the same time they are subject to an atmosphere of prejudice, stigma and hostility from staff and other prisoners. Taken together, these conditions constitute inhuman and degrading treatment in violation of international law.

After reviewing the findings of this report, Mississippi agreed to end its long-standing policy of segregation. Now, only in two states – Alabama and South Carolina - do prison officials systematically isolate, marginalize and exclude this population without medical justification. These policies reflect outdated approaches to HIV that no longer have any basis in science or modern correctional health. Segregation is also bad public policy, as keeping people in prison longer simply because they have HIV is not only unfair, but more expensive. Failing to prepare prisoners for transition to the community increases their chances of returning to prison, at great cost to individuals, families, and communities.

Prison systems throughout the U.S. and around the world provide medical care for HIV and prevent its transmission while respecting human rights. Alabama and South Carolina can, and should, end their own isolation by reforming these policies without delay.

Julia Tutwiler Prison for Women in Wetumpka, Alabama.

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