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DELIBERATELY INDIFFERENT: GOVERNMENT RESPONSE TO HIV IN U.S. PRISONS

*Kari Larsen**

At the end of 2003, 22,028 state inmates and 1631 federal inmates were known to be infected with HIV.¹ The HIV-positive inmates, a total of 23,659, accounted for 1.1% of all federal inmates and 2.0% of state inmates, or 1.9% of the entire prison population in the United States.² Several states had exceedingly high percentages of HIV-positive inmates. For example, 7.6% of state prisoners in New York and 4.2% of state prisoners in Maryland were confirmed to be HIV positive.³ Moreover, the number of confirmed AIDS cases was more than three times higher among state and federal prisoners than in the general population of the United States.⁴ Although the total number of HIV-positive inmates in 2003 decreased from the 23,864 recorded in 2002,⁵ this decrease reflects the deaths of 282 prisoners who succumbed to AIDS related causes during 2003.⁶ Taking these deaths into account, it is apparent that United States prison systems recognized 359 new cases of HIV in 2003. It is unclear whether these 359

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1. Laura M. Maruschak, U.S. Dep't of Justice, *HIV in Prisons*, 2003, at 1 (2005) [hereinafter Maruschak, *HIV in Prisons*, 2003].

2. *Id.*

3. *Id.* at 1-2.

4. *Id.* at 1, 5.

5. Laura M. Maruschak, U.S. Dep't of Justice, *HIV in Prisons and Jails*, 2002, at 1 (2004) [hereinafter Maruschak, *HIV in Prisons*, 2002].

6. See Maruschak, *HIV in Prisons*, 2003, *supra* note 1, at 1.

new infections were acquired by the inmates before they were taken into custody, or while they were incarcerated.

As a consequence of these formidable statistics, corrections officials have been faced with protecting the constitutional rights of HIV-positive prisoners, while at the same time protecting the other inmates from exposure to the virus. This is particularly difficult in an environment where behaviors known to spread the virus, particularly intravenous drug use and sex, are commonplace, even though prohibited. Exact statistics regarding intraprisoon transmission are difficult to ascertain, because most statistics include a combination of inmates who were infected prior to entering the system as well as persons infected while inside the system.⁷ However, the spread of HIV in prison has been documented in the United States,⁸ as well as abroad,⁹ and it is recognized as a grave concern.¹⁰

The difficulties faced by correctional administrators in containing the virus are intensified by the fact that the federal government, through its health agencies, has not established a national policy addressing HIV prevention in prison. The absence of a national policy to prevent HIV transmission in prison has led to a public health crisis, exacerbated by the federal courts' reluctance to interfere with the policies and practices of prison administrators, even when confronted with claims that correctional officials' approaches to HIV care and prevention violate the constitutional rights of prisoners.

The first part of this article will discuss HIV and its transmission in prison, the lack of a national policy to prevent transmission among prisoners, and the federal recommendations that are systematically ignored by prison administrations. The second part of the article will address the practice of segregating HIV-positive prisoners and how this may compromise the constitutional rights of privacy and due process. The last part of the article focuses on the Eighth Amendment and suggests that the distribution of

7. WHO, Policy Brief: Reduction of HIV Transmission in Prisons (2004), <http://www.wpro.who.int/NR/rdonlyres/6BD7C651-11A0-46CB-AAC5-2BE2C3485551/0/transmissionprisonen.pdf>.

8. See T.F. Brewer, D. Vlahov, E. Taylor, D. Hall, A. Munoz & B.F. Polk, *Transmission of HIV-1 Within a Statewide Prison System*, 2 AIDS 363 (1988).

9. See, e.g., Avril Taylor, et al., *Outbreak of HIV Infection in a Scottish Prison*, 310 BMJ 289 (1995); Avril Taylor & David Goldberg, *Outbreak of HIV in a Scottish Prison: Why Did It Happen?*, HIV/AIDS Pol'y & L. Rev., Apr. 1996, at 13.

10. See Ralf Jürgens, *Alarming Evidence of HIV Transmission in Prisons*, HIV/AIDS Pol'y & L. Rev., Jan. 1995, at 2.

prophylactic devices, such as condoms and sterile needles, is required under the Eighth Amendment to prevent the transmission of HIV among prisoners.

I. AIDS, HIV AND TRANSMISSION

The first known case of HIV-1 in a human was found in a blood sample collected in 1959 from a man in the Democratic Republic of Congo.¹¹ HIV-1 has since become the predominant strain of HIV in the developed world.¹² However, scientists were not aware of the significance of HIV until 1984, when it was determined that HIV is the virus that causes AIDS.

AIDS first appeared in the United States in the late 1970s, when doctors in Los Angeles and New York began to report rare types of pneumonia, cancer, and other illnesses occurring mainly in male patients who had had sex with other men.¹³ In 1982, health officials began to use the term Acquired Immunodeficiency Syndrome to describe the occurrences of opportunistic infections, Kaposi 's sarcoma, and *Pneumocystis carinii* pneumonia in previously healthy people.¹⁴ In 1984, scientists identified the virus that causes AIDS, but it was not given the name HIV until 1986.¹⁵

Although it is not known with certainty how HIV originated, the most widely accepted theory among scientists has been that HIV originated in other primates. In 1999, this theory was substantiated when an international team of researchers identified a subspecies of chimpanzees native to western Africa as the original source of the virus.¹⁶ The researchers, led by Dr. Beatrice H. Hahn, of the University of Alabama at Birmingham, concluded that HIV-1 was first transmitted to the human population when hunters

11. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., Where Did HIV Come From?, <http://www.cdc.gov/hiv/pubs/faq/faq3.htm> (last visited Feb. 1, 2008).

12. *Id.*

13. *Id.*

14. *Id.*

15. See Nat'l Insts. of Health, In Their Own Words . . . NIH Researchers Recall the Early Years of AIDS, Timeline, 1981-1988, <http://aidshistory.nih.gov/timeline/index.html> (last visited Feb. 1, 2008).

16. News Release, Nat'l Inst. of Allergy & Infectious Diseases, Nat'l Insts. of Health, NIAID-Supported Scientists Discover Origin of HIV-1 (Jan. 31, 1999), <http://www3.niaid.nih.gov/news/newsreleases/1999/hivorigin.htm>.

engaged in the bushmeat trade—the hunting and killing of chimpanzees for human consumption—were exposed to the chimpanzees' infected blood.¹⁷

HIV is categorized as a lentivirus, or “slow” virus, which means that there is generally a long period of time between initial infection and the emergence of serious symptoms.¹⁸ Once inside the body, HIV causes a gradual deterioration of the immune system by attacking and destroying a specific type of blood cell called CD4 positive (CD4+) T cells, which are blood cells that are critical to the normal function of the human immune system.¹⁹ As vital CD4+ cells are destroyed by HIV, the body's ability to fight off foreign bacteria, viruses, fungi, parasites, and other microbes decreases dramatically,²⁰ and the infected person becomes susceptible to numerous opportunistic infections that would not usually be dangerous to a person with a healthy immune system. When a person's CD4+ T-cell count has dropped below 200 per cubic milliliter of blood, he or she is diagnosed with AIDS, and his or her body will eventually succumb to one of these opportunistic infections.²¹

HIV is spread through sexual contact with an infected victim, sharing needles or syringes with an infected victim, receiving blood transfusions, childbirth, and breast feeding.²² Anal sex is regarded as the riskiest type of sexual contact because the lining of the rectum is thin and may allow the

17. *Id.*

18. Nat'l Inst. of Allergy & Infectious Diseases, Nat'l Insts. of Health, How HIV Causes AIDS (Nov. 2004), <http://www.niaid.nih.gov/factsheets/howhiv.htm>.

19. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., How Does HIV Cause AIDS?, <http://www.cdc.gov/hiv/pubs/faq/hiv aids.htm> (last visited Feb. 1, 2008).

20. Nat'l Inst. of Allergy & Infectious Diseases, *supra* note 18.

21. *Id.*

22. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., HIV and Its Transmission 1 (1999), <http://www.cdc.gov/hiv/resources/factsheets/PDF/transmission.pdf>.

virus to enter the body more easily.²³ Nonetheless, correct use of a latex condom greatly reduces a person's risk of contracting HIV during sex.²⁴

II. THE PERILS OF PRISON

A. Rape

In 1974, the rape of fellow inmates was characterized as the "most closely guarded secret activity of America's prisons."²⁵ During the thirty years since that characterization, the brutality and frequency of rape in prison have been well documented in civil actions brought by victimized inmates,²⁶ law review articles,²⁷ journals,²⁸ newspaper articles,²⁹ television programs,³⁰ and

23. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Can I Get HIV from Anal Sex?*, <http://www.cdc.gov/hiv/resources/qa/qa22.htm> (last visited Feb. 25, 2008).

24. Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *MALE LATEX CONDOMS AND SEXUALLY TRANSMITTED DISEASES 1* (2003), <http://www.cdc.gov/nchstp/od/condoms.pdf>.

25. CARL WEISS & DAVID JAMES FRIAR, *TERROR IN THE PRISONS: HOMOSEXUAL RAPE AND WHY SOCIETY CONDONES IT*, at x (The Bobbs-Merrill Co. 1974).

26. See, e.g., *City of Waco v. Hester*, 805 S.W.2d 807, 809 (Tex. App. 1990); *Mitchell v. Elrod*, 1104 N.E.2d 1104, 1105 (Ill. App. Ct. 1995); *Harrison v. Ohio Dep't of Rehab. & Corr.*, 695 N.E.2d 1248, 1249 (Ohio Ct. Cl. 1997).

27. See James E. Robertson, *A Clean Heart and an Empty Head: The Supreme Court and Sexual Terrorism in Prison*, 81 N.C. L. REV. 433 (2003); Richard D. Vetstein, Note, *Rape and AIDS in Prison, A Collision Course to a New Death Penalty*, 30 SUFFOLK U. L. REV. 863 (1997).

28. See Tom Cahill, *Cruel and Unusual Punishment: Rape in Prison*, 9 VICTIMOLOGY: AN INT'L J. 8 (1984); J.W. Wiggs, Letter, *Prison Rape and Suicide*, 262 JAMA 3403 (1989); Norman E. Smith & Mary E. Batiuk, *Sexual Victimization and Inmate Social Interaction*, PRISON J., Oct. 1989, at 29; Human Rights Watch, *NO ESCAPE: MALE RAPE IN PRISON* (2001), <http://www.hrw.org/reports/2001/prison/report.html>.

29. See Tamar Lewin, *Little Sympathy or Remedy for Inmates Who Are Raped*, N.Y. Times, Apr. 15, 2001, § 1, at 1; Charles M. Sennott, *Prison's Hidden Horror: Rape Behind Bars*, Boston Globe, May 1, 1994, Metro/Region, at 1; Gary Marx, *Lonely Mission: Stephen Donaldson Wants to Stop the Sexual Abuse of Inmates by Inmates*, Chi. Trib., June 23, 1995, Tempo, at 1.

court testimony. Even the U.S. Supreme Court has recognized the prevalence of rape in jail. In 1980, Justice Harry Blackmun wrote “a youthful inmate can expect to be subjected to homosexual gang rape his first night in jail or . . . even in the van on the way to jail.”³¹

One commentator has attributed the prevalence of rape in prison to the phenomenon of sexual terrorism, through which dominant inmates frighten weaker inmates as a means of controlling them.³² The prison environment fosters sexual attacks by “equating manhood with domination and femininity with subservience.”³³ Consequently, inmates rape others as a means of demonstrating their masculinity in a world devoid of what is typically associated with manliness.³⁴ For example, an all male population precludes the possibility of validation through female sexual partners,³⁵ and the intrusive rules restricting inmate conduct deprive men of their autonomy, which is also associated with masculinity.³⁶ Additionally, the forfeiture of most material items enjoyed in freedom denies inmates the affirmation of self through property ownership.³⁷

The victims of prison rape are socially reconstructed, becoming female in the eyes of the other inmates.³⁸ In accordance with this premise, victims of sexual assault are often called female names and terms indicative of gender

30. *60 Minutes: Profile: Prison Rape; Gang Rape Victims Advocate More Protection for Inmates* (CBS television broadcast Mar. 3, 1996).

31. *United States v. Bailey*, 444 U.S. 394, 421 (1980) (Blackmun, J., dissenting).

32. Robertson, *supra* note 27, at 440.

33. *Id.* (citing Lee H. Bowker, *Victimizers and Victims in American Correctional Institutions*, *The Pains of Imprisonment* 63, 64 (Robert Johnson & Hans Toch eds., Sage Publications 1982)).

34. *Id.* (citing *Schwenk v. Hartford*, 204 F.3d 1187, 1203 n.14 (9th Cir. 2000)).

35. *Id.* at 441 (citing Gresham M. Sykes, *The Society of Captives* 71–72 (Princeton University Press 1958)).

36. *Id.* (citing Sykes, *supra* note 35, at 76).

37. Robertson, *supra* note 27, at 441 (citing Sykes, *supra* note 35, at 69).

38. *Id.* at 440 (citing Human Rights Watch, *supra* note 28).

animus such as “bitch” and “pussy” during and after the assault.³⁹ The victims of prison rape suffer from numerous nightmares, deep depression, shame, loss of self-esteem, and self-hatred, and they often consider or attempt suicide.⁴⁰ They are also at risk of being exposed to HIV and other sexually transmitted diseases. The risk of exposure to HIV is heightened when an inmate is raped, as the violent nature of the attack frequently causes severe rectal bleeding,⁴¹ which increases the likelihood of transmission. When numerous assailants participate, the chances of infection are further increased.⁴²

It has been estimated that out of the forty-six million Americans who will enter the criminal justice system, ten million will be raped while in custody.⁴³ Other studies have shown that as many as “22.3% of respondent inmates had been pressured or forced into sex.”⁴⁴ Another estimate projects that approximately 360,000 male inmates are victims of sexual assaults every year.⁴⁵

Accurate statistics are not available because of the reluctance of inmates to report rapes. Most victims do not report that they have been raped out of embarrassment, shame,⁴⁶ or fear of retaliation. An inmate “who snitches or rats . . . violates a strict prison code, subjecting them to severe and violent retribution by the entire inmate community.”⁴⁷ If the victim is labeled an “informer” he may even be murdered for reporting his attacker.⁴⁸ Rather

39. *Id.* (citing *Schwenk v. Hartford*, 204 F.3d 1187, 1203 n.14 (9th Cir. 2000)).

40. *Id.* at 441–42 (quoting Human Rights Watch, *supra* note 28).

41. David M. Siegal, Note, *Rape in Prison and AIDS: A Challenge for the Eighth Amendment Framework of Wilson v. Seiter*, 44 Stan. L. Rev. 1541, 1549 (1992).

42. *Id.*

43. Vetstein, *supra* note 27, at 863 (citing Weiss & Friar, *supra* note 25, at 61).

44. *Id.* at 870 (citing Fred Bruning, *Prison Studies Are Few, but Point to ‘Targets’ of Sexual Assault*, Seattle Times, Apr. 23, 1995, at A16).

45. *Id.*

46. Robertson, *supra* note 27, at 443–44.

47. Vetstein, *supra* note 27, at 871.

48. *Id.*

than risk retaliation for reporting a rape, many victims or “punks” will seek protection by forming a sexual relationship with a strong or feared prisoner in exchange for their protection from being raped by other inmates.⁴⁹ This ongoing, coerced sexual relationship may be the only way for the inmate to avoid being repeatedly raped or retaliated against for reporting a sexual assault. These relationships blur the distinction between coerced and consensual sex, and make it even more difficult to ascertain the number of prisoners who are victims of coerced sexual intercourse while in custody. One expert has projected that the actual number of prison rapes “may be five or six times greater than the number of reported sexual assaults.”⁵⁰

B. Consensual Sex

Several different studies have estimated that the proportion of inmates engaging in consensual sexual intercourse can be as high as 65% in a California prison,⁵¹ or as low as 2%.⁵² Other studies have estimated that 30% of inmates engage in consensual homosexual intercourse.⁵³ Although it is difficult to ascertain exact statistics as to how prevalent consensual sex is in prison, it is clear that most of this sexual contact is unsafe, as the vast majority of prisoners do not have access to latex condoms, the most effective protection against transmission of HIV. 96% of state prison systems consider condoms to be contraband, and do not allow them inside facilities.⁵⁴

49. *Id.*

50. *Id.* at 870.

51. Christopher P. Krebs, *High Risk HIV Transmission Behavior in Prison and the Prison Subculture*, 82 *Prison J.* 19, 20 (2002) (citing Wayne S. Wooden & Jay Parker, *Men Behind Bars: Sexual Exploitation in Prison* (Da Capo Press 1982)).

52. *Id.* (citing C. Saum, H. Surratt, J. Inciardi & R. Bennet, *Sex in Prison: Exploring Myths and Realities*, 75 *Prison J.* 413 (1995)).

53. *Id.* (citing Peter L. Nacci & Thomas R. Kane, *The Incidence of Sex and Sexual Aggression in Federal Prison*, *Fed. Probation*, Dec. 1983, at 31).

54. *Id.* (citing Theodore M. Hammett, Patricia Harmon & Laura M. Maruschak, U.S. Dep’t of Justice, 1996-1997 Update: HIV/AIDS, STDs and TB in Correctional Facilities (1999), available at <http://www.ncjrs.gov/pdffiles1/176344.pdf>).

C. Intravenous Drug Use

As with sexual activity, the exact percentage of inmates who use drugs is difficult to ascertain. The criminal justice system is a “reservoir” for drug abusers,⁵⁵ most of whom continue to use drugs after being placed in custody.⁵⁶ “[B]oth visitors and correctional officers supply inmates with illegal drugs.”⁵⁷ Additionally, inside the prisons, drugs are sold by both the corrections officials and the inmates.⁵⁸ One study has shown that 58% of surveyed prisoners injected drugs during incarceration.⁵⁹

Two prominent theories have emerged with respect to the prevalence of drug use in prison. The first theory, known as the “deprivation model,” suggests that drug use inside prison is a response to the “pains of imprisonment,”⁶⁰ which are “produced by the loss of liberty, goods, and services, heterosexual relationships, autonomy, and security.”⁶¹ The adherence to an inmate code of behavior, which includes the abuse of drugs, helps the inmates neutralize the pains of imprisonment.⁶² The second theory, known as the “importation model,” suggests that “the values of the prison subculture are imported into prison from the outside world.”⁶³ Inmate

55. Wayne Gillespie, *A Multilevel Model of Drug Abuse Inside Prison*, 85 Prison J. 223, 225 (2005) (citing Carl G. Leukefeld & Frank R. Tims, *Drug Abuse Treatment in Prisons and Jails*, 10 J. Substance Abuse Treatment 77 (1993)).

56. *Id.* (citing Rachel Swann & Pam James, *The Effect of the Prison Environment Upon Inmate Drug Taking Behavior*, 37 How. J. Crim. Just. 252 (1998)).

57. *Id.* at 226.

58. Gillespie, *supra* note 55, at 226 (citing James A. Inciardi, Dorothy Lockwood & Judith A. Quinlan, *Drug Use in Prison: Patterns, Processes, and Implications for Treatment*, 23 J. Drug Issues 119 (1993)).

59. *Id.* at 225 (citing A. Edwards, S. Curtis & J. Sherrard, *Survey of Risk Behavior and HIV Prevalence in an English Prison*, 10 Int'l J. STD & AIDS 464 (1999)).

60. Krebs, *supra* note 51, at 23 (citing Sykes, *supra* note 35).

61. *Id.* at 23–24 (citing Sykes, *supra* note 35).

62. *Id.* at 24 (citing Sykes, *supra* note 35).

63. *Id.* (citing Clarence Schrag, *Leadership Among Prison Inmates*, 19 Am. Soc. Rev. 37 (1954)).

behavior is “an extension of the behavioral patterns of the inmates prior to incarceration,”⁶⁴ as pre-prison characteristics, behaviors, and experiences of inmates are imported into the prison with the inmate.⁶⁵

One study indicates that among inmates who inject drugs, 40% reported sharing injection equipment with others.⁶⁶ Inmates who inject drugs are likely to share unclean needles because both the needles and bleach, which can be used to sterilize the needles, are considered contraband and are therefore difficult to obtain.⁶⁷

D. Tattooing

Tattooing is customary in prison, and it continues to occur despite the fact that the needles used to make the tattoos are often shared and not sterile. Sterile tattoo needles are difficult to obtain in prison because they are considered contraband. The shortage of needles leads to the sharing of needles among inmates, which poses a risk of HIV transmission.⁶⁸ Although the CDC has no reports of HIV actually being spread through tattooing, it is still regarded as a risky behavior in prison. The handmade vibrating tattoo machines crafted by inmates in prison make multiple incisions, thereby increasing the risk of transmission.⁶⁹

E. Violence

Incidents of interpersonal violence, such as fights among two or more participants involving lacerations, bites, and bleeding, present risks of HIV transmission. Although prison authorities strive to prevent violence among prisoners with adequate staffing, supervision, and programming, the housing

64. *Id.* (citing John Irwin, *The Felon* (Prentice Hall 1970)).

65. *Id.*

66. *Id.* at 21 (citing M.C. Monroe, B.J. Colley-Neimeyer & G.A. Conway, S.C. Dep’t of Corr., *Report of Studies of HIV Seroprevalence and AIDS Knowledge, Attitudes, and Risk Behaviors in Inmates of South Carolina Department of Corrections* (1988)).

67. *Id.* (citing Nancy Mahon, *New York Inmates’ HIV Risk Behaviors: The Implications for Prevention Policies and Programs*, 86 *Am. J. Pub. Health* 1211 (1996)).

68. *Id.*

69. Elizabeth Kantor, *HIV InSite, HIV Transmission and Prevention in Prisons* (2006), <http://hivinsite.ucsf.edu/insite?page=kb-07-04-13>.

of more than one inmate per cell (common now in crowded institutions) “is a major contributing factor to incidents of violence and sexual assault.”⁷⁰

III. THE ABSENCE OF A NATIONAL POLICY TO PREVENT HIV IN PRISONS

In March 1991, the National Commission on AIDS “proposed that the U.S. Public Health Service develop guidelines for the prevention and treatment of HIV in all U.S. correctional facilities.”⁷¹ Five years later, the Centers for Disease Control and Prevention (CDC) recommended that education and prevention programs be implemented for inmates in prisons and jails to assist in reducing the transmission of HIV in the United States.⁷² In spite of the Commission’s proposal and the CDC’s logical deduction that the transmission of HIV in prisons will lead to the transmission of HIV in society, formal guidelines regarding the prevention of HIV in correctional facilities have never been issued by the federal government through the U.S. Public Health Service (USPHS), the CDC, or any other agency.⁷³ This omission was reflected in a 1992 study done for the World Health Organization, which revealed that among nineteen countries surveyed, “the United States was one of only four that did not have a national policy for HIV management in prison.”⁷⁴ That the U.S. remains without such a policy is appalling, especially in light of the fact that the U.S. has the world’s largest prison population,⁷⁵ at 2,258,983.⁷⁶ Furthermore, at least one U.S.

70. *Id.*

71. *Id.* (citing Nat’l Comm’n on AIDS, *HIV Disease in Correctional Facilities* (1991)).

72. Ctrs. for Disease Control & Prevention, *HIV/AIDS Education and Prevention Programs for Adults in Prisons and Jails and Juveniles in Confinement Facilities – United States, 1994*, 45 *Morbidity & Mortality Wkly. Rep.* 268 (1996), available at <http://www.cdc.gov/mmwr/PDF/wk/mm4513.pdf>.

73. Telephone Interview with the Office of Nat’l AIDS Policy (Oct. 2005).

74. Kantor, *supra* note 69 (citing T.W. Harding & G. Schaller, WHO Global Programme on AIDS, *HIV/AIDS and Prisons: Updating and Policy Review. A Survey Covering 55 Prison Systems in 31 Countries* (1992)).

75. See Int’l Ctr. for Prison Studies, *Entire World – Prison Population Totals*, http://www.kcl.ac.uk/depsta/rel/icps/worldbrief/highest_to_lowest_rates.html (last visited Feb. 16, 2008).

federal court has acknowledged that “[h]igh-risk behavior, particularly IV drug use and homosexual activity . . . is a given in the prison setting, and *no* correctional approach can eliminate it.”⁷⁷

As the CDC correctly stated, the vast majority of inmates in the United States are eventually released. Indeed, 95% of inmates are expected to be released and returned to society,⁷⁸ where they will reunite with their spouses, sexual partners, friends, and other social contacts. Studies have shown that within twelve hours of their release, inmates typically “celebrate” their liberation by engaging in conduct that is prohibited in prison. Typical celebratory conduct includes high-risk behavior, such as sexual intercourse or the injection of IV drugs. Heightening the risk of HIV transmission is the desire for “pure sex” without the use of a condom.⁷⁹

The only guidance given by the federal government regarding the prevention of HIV transmission in prisons appears in several suggestions made by the CDC and the National Commission of Correctional Healthcare (NCCHC). The suggestions from the CDC appear in the editorial notes of three issues of *Morbidity and Mortality Weekly Review*. In 1991, the editor acknowledged both the occurrence of transmission within prison settings and “the need for providing primary and secondary HIV-prevention services to populations within the U.S. correctional system.”⁸⁰ Five years later, in 1996, the editor bemoaned the missed opportunities to provide HIV/AIDS prevention programs in prisons and jails, and suggested the implementation of “programs of interactive education, counseling, testing, and practical risk reduction techniques (e.g. safer sex and safer drug injection)” for inmates.⁸¹

76. Bureau of Justice Statistics, U.S. Dep’t of Justice, Prison Statistics, <http://www.ojp.usdoj.gov/bjs/prisons.htm> (last visited Feb. 16, 2008).

77. *Harris v. Thigpen*, 941 F.2d 1495, 1520 n.36 (11th Cir. 1991).

78. Timothy Hughes & Doris J. Wilson, Bureau of Justice Statistics, U.S. Dep’t of Justice, Reentry Trends in the United States, <http://www.ojp.usdoj.gov/bjs/reentry/reentry.htm> (last visited Feb. 16, 2008).

79. T. Morales, C.A. Gomez & B.V. Marin, Freedom and HIV Prevention: Challenges Facing Latino Inmates Leaving Prison, Presentation at the 103d American Psychological Association Convention (1995).

80. Ctrs. for Disease Control & Prevention, *HIV Prevention in the U.S. Correctional System, 1991*, 41 *Morbidity & Mortality Wkly. Rep.* 389 (1992), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/00016871.htm>.

81. Ctrs. for Disease Control & Prevention, *supra* note 72.

While acknowledging that ten correctional facilities had implemented counseling, testing, and partner notification, the editor noted that few systems made available the recommended means to practice risk reduction, such as condoms or bleach.⁸²

In April 2006, the CDC published a study reporting that between 1992 and 2005, 91% of the HIV-positive prisoners in Georgia's prison system contracted the virus outside of prison.⁸³ Of the 88 inmates who seroconverted in prison, those available for interviews reported that they had engaged in at least some type of risky behavior. In spite of the CDC's gentle suggestion in the editorial note that corrections departments assess the feasibility and benefits of condom distribution in prisons,⁸⁴ the Georgia Corrections Department is reportedly not considering this policy but will use data from the study to help decide whether to house HIV-positive inmates at separate facilities.⁸⁵

The NCCHC's suggestions, somewhat stronger and more visible than those of the CDC, are the subject of a position statement entitled "Administrative Management of HIV in Correctional Institutions." The statement, originally published in 1987 and revised in October 2005, purports to "provide [] guidance to resolve administrative issues by suggesting common ground for the overarching goals and objectives of an HIV service delivery system."⁸⁶ The suggestions in the statement include screening inmates for HIV on a voluntary basis, integrated housing and programs, access to quality medical treatment, mental health support, effective education, and ongoing prevention services. The prevention services recommended by the statement explicitly include peer education with materials written in diverse languages and for low reading levels, and harm reduction techniques such as condom distribution, needle exchange,

82. *Id.*

83. Ctrs. for Disease Control & Prevention, *HIV Transmission Among Male Inmates in a State Prison System – Georgia 1992-2005*, 55 *Morbidity & Mortality Wkly. Rep.* 421 (2006), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5515a1.htm>.

84. *Id.*

85. Mike Stobbe, *CDC Finds Few Inmates Infected in Prison*, Associated Press, Apr. 20, 2006, <http://www.aegis.com/news/ap/2006/AP060434.html>.

86. Nat'l Comm'n on Corr. Health Care, *Administrative Management of HIV in Correctional Institutions* (Oct. 9, 2005), http://ncchc.org/resources/statements/admin_hiv2005.html [hereinafter NCCHC].

counseling, and availability of bleach tablets.⁸⁷ The statement also includes a disclaimer: “While NCCHC clearly does not condone illegal activity by inmates, the public health strategy to reduce the risk of contagion is our primary concern. NCCHC recommends that correctional administrators implement harm reduction strategies.”⁸⁸ The statement concludes by saying that, “combining universal precautions with implementation of harm reduction strategies is the most effective way to address the infection control issues of HIV within correctional facilities.”⁸⁹

A. THE IMPOTENCY OF FEDERAL SUGGESTIONS

Ten years after the CDC suggested the use of harm reduction techniques, U.S. correctional systems continue to turn a blind eye to inmates’ risky behavior and a deaf ear to the recommendations of our principal federal healthcare agency. The suggestions of the NCCHC, although written more forcefully and given a more prominent position than those of the CDC, are also universally ignored.

Federal health agencies suggest that prison administrations ought to distribute latex condoms to the sexually active populations committed to their care and custody. Although the United States had 1668 correctional facilities in 2000, only seven systems have heeded this suggestion.⁹⁰ Condoms were distributed to inmates in the homosexual dormitory on New York’s Riker’s Island (before it closed in 2006),⁹¹ are distributed to inmates in the San Francisco County jails, where the condoms are accompanied by counseling,⁹² to inmates in Philadelphia, Los Angeles, and Washington jail

87. *Id.*

88. *Id.*

89. *Id.*

90. James J. Stephan & Jennifer C. Karberg, U.S. Dep’t of Justice, *Census of State and Federal Correctional Facilities, 2000*, at 1 (2003).

91. Paul Von Zilbauer, *City Prepares to Close Rikers Housing for Gays*, N.Y. Times, Dec. 30, 2005, at B9.

92. Kantor, *supra* note 69.

systems,⁹³ and in the state prison in Vermont.⁹⁴ In Mississippi, inmates can purchase condoms from vending machines.⁹⁵

Currently, a bill (AB 1677) regarding condom distribution within California prisons is pending in the California State Assembly. If enacted, AB 1677 would allow not-for-profit organizations to distribute sexual barrier protection devices, such as condoms or dental dams, to inmates. Included in the bill is a disclaimer of sorts; a caveat to the reader that “the distribution of these devices shall not . . . be deemed to encourage sexual acts between inmates.”⁹⁶

Most U.S. prison systems refuse to distribute condoms for fear that 1) the condoms would be filled up with sand or dirt and used as weapons; 2) that the condoms would be used to hide contraband; and 3) that the distribution of condoms would implicitly suggest that sex is permitted.⁹⁷ Notwithstanding these concerns, the Joint United Nations Programme on HIV/AIDS (UNAIDS) recommends the distribution of condoms to all prisoners.⁹⁸ In keeping with this recommendation, 81% of prison systems in Europe provide condoms to inmates,⁹⁹ as do all Canadian federal prisons, where there have been no reported incidents of condoms being used as weapons.¹⁰⁰ However, 10% of Canadian prison guards view condoms as a nuisance, because prisoners use them as water balloons.¹⁰¹ In spite of the availability of condoms to Canadian prisoners, sexual conduct in prison

93. Rebecca Neremberg, *Spotlight: Condoms in Correctional Settings*, HEPP News (HIV & Hepatitis Educ. Prison Project, Providence, R.I.), Jan. 2002, at 6, available at <http://www.idronline.org/archives/jan02/jan2002.pdf>.

94. Kantor, *supra* note 69.

95. *Id.*

96. A.B. 1677, 2007-08 Leg., Reg. Sess. (Cal. 2007).

97. Neremberg, *supra* note 93.

98. UNAIDS, *Prisons and AIDS: UNAIDS Point of View 6* (1997).

99. Canadian HIV/AIDS Legal Network, *Prevention: Condoms* (2004), <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=710>.

100. Neremberg, *supra* note 93.

101. Kantor, *supra* note 69.

remains an institutional offense. When asked if the distribution of condoms in Canadian prisons implies that sexual activity is permitted, Ralf Jurgens, director of the Canadian HIV/AIDS legal Network, explained, "Fighting the spread of HIV is more important than upholding so-called morality when the activity is occurring (even in the absence of condoms)."¹⁰²

UNAIDS has commented on the unwillingness of other countries to distribute condoms in prison:

Unfortunately, there still exists a strong current of denial in many places about male to male sex (especially in prison) and a corresponding refusal to do anything which might be seen as condoning it. These attitudes will have to change if societies want to see the rate of HIV infection—inside prison and outside of it—decrease.¹⁰³

Along with the distribution of condoms, United States federal health agencies and UNAIDS recommend distribution of sterile injection equipment or bleach kits to prisoners who inject intravenous drugs. The benefits of a prison needle exchange program were demonstrated by a 1994 pilot project in Switzerland. The Hindelbank project performed a one-year study on the effects of a needle exchange program in a women's prison.¹⁰⁴ The study was a success, as there was no transmission of HIV or viral hepatitis, there was no increase in drug use, needles were not used as weapons, and fewer abscesses occurred among inmates.¹⁰⁵ In spite of the results of this well-known study, only two correctional systems in the United States distribute bleach kits, and none distribute sterile needles.¹⁰⁶ The virtual nonexistence of simple, inexpensive measures needed to prevent the transmission of HIV in prison is a testament to the impotence of federal suggestions made by the federal government.

While federal recommendations for effective education have not been completely disregarded by prison administrators, education provided to inmates about HIV prevention is often woefully inadequate. Many educational programs for prisoners do not meet the needs of the inmate

102. Neremberg, *supra* note 93, at 6.

103. UNAIDS, *supra* note 98, at 6–7.

104. J. Nelles, A. Fuhrer, H.P. Hirsbrunner & T.W. Harding, *Provision of Syringes: The Cutting Edge of Harm Reduction in Prison?* 317 *BMJ* 270, 270–71 (1998).

105. Kantor, *supra* note 69.

106. *Id.*

population. As many as 50% of U.S. prisoners are functionally illiterate, and many inmates are not native English speakers.¹⁰⁷ Consequently, most of the available literature about HIV and AIDS is beyond their comprehension.¹⁰⁸ In order to be effective, educational programs for prisoners must take into consideration the abilities of the prisoners, and brought to a level that all inmates can understand, even those who cannot read or understand English. Compounding the ineffectiveness of many prison educational programs is the fact that they give instructions regarding the use of condoms or sterilization of needles,¹⁰⁹ even though prison administrations refuse to allow prisoners access to these methods of protection. This practice has been characterized as “ironic and sad” by at least one commentator.¹¹⁰

The AIDS pandemic continues to proliferate in the United States, despite the availability of education and prevention measures. During the past nine years, more than one million people in the United States have died from AIDS-related causes,¹¹¹ and it is estimated that an additional 462,792 are currently living with HIV or AIDS.¹¹² It is also estimated that 20 to 26% of the people living with HIV/AIDS in the United States have spent time in U.S. correctional facilities.¹¹³ These figures call for dramatic changes in the way that HIV prevention is addressed in U.S. prisons.

107. *Id.*

108. *Id.*

109. Mark Parts, *The Eighth Amendment and the Requirement of Active Measures to Prevent the Spread of AIDS in Prisons*, 22 Colum. Hum. Rts. L. Rev. 217, 227–28 (1991).

110. *Id.* at 227.

111. Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health & Human Servs., HIV/AIDS Surveillance Report (1997); Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health and Human Servs., HIV/AIDS Surveillance Report (1999); Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health & Human Servs., HIV/AIDS Surveillance Report (2004).

112. Ctrs. for Disease Control & Prevention, U.S. Dep’t of Health & Human Servs., HIV/AIDS Surveillance Report 7 (2004).

113. Kantor, *supra* note 69 (citing Theodore M. Hammett, Patricia Harmon & William Rhodes, *The Burden of Infectious Disease Among Inmates and Releasees from Correctional Facilities*, in 2 *The Health Status of Soon-to-Be-Released Inmates: A Report to Congress* 13 (Nat’l Comm’n on Corr. Health Care ed., 2002)).

The opinions written by federal health agencies that prison administrators ought to implement effective education and risk reduction techniques to hinder the spread of HIV have failed to motivate correctional administrators to do so. Correctional administrators are formidably powerful, incongruously so, as they control the dissemination of information about HIV to more than two million inmates, as well as their access to sterile needles, bleach, and barrier protection from the virus. Prison officials have a significant opportunity to decrease the rate of HIV transmission in their communities, thereby decreasing the incidence of HIV transmission in society. Their refusal to employ this opportunity makes it clear that their amount of discretion should be reduced, and federal suggestions must immediately be replaced with compulsory federal directives regarding the prevention of HIV in prison. Additionally, federal courts must take a more assertive approach in their oversight of prison conditions and compel prison administrators to provide inmates with the effective education and harm reduction techniques contemplated by the federal health agencies. A progressive interpretation of the Eighth Amendment would effectively compel lower courts to take a proactive approach to HIV prevention in prison and mandate the distribution of prophylactic devices to inmates.

B. The Segregation of Prisoners

In the early days of the AIDS pandemic, many state prison systems implemented policies of segregating their HIV-positive populations as a means of preventing the spread of the virus. In 1985, thirty-eight state prison systems segregated all inmates with HIV.¹¹⁴ By 2001, the trend had changed, and many systems had moved away from the practice of segregation, in part due to the heightened understanding about transmission of the virus and the belief that isolation was not medically necessary.

Currently, the practice of segregation is not widely accepted as a sensible strategy because it contributes to the stigmatization of HIV-positive people, presents numerous logistical problems, and results in a costly duplication of services that is not medically necessary.¹¹⁵ Segregation has also been

114. Press Release, ACLU, Court Order Ends Discrimination Against HIV+ Prisoners in Mississippi, ACLU Welcomes Hard Fought Reform (June 17, 2004), <http://www.aclu.org/prison/medical/14779prs20040617.html>.

115. K. C. Goyer, *HIV/AIDS in Prison: Problems, Policies and Potential* (2003), available *at* http://www.iss.co.za/index.php?link_id=3&slink_id=422&link_type=12&slink_type=12&tmpl_id=3.

criticized as being an ineffective means of containing the virus. The isolation of HIV-positive inmates leads to misconceptions among the general inmate population that they are safe from exposure to the virus. These feelings of safety may lead to an increase of high-risk behavior among prisoners who are categorized as seronegative. However, some prisoners who are deemed seronegative may actually be HIV positive due to the occurrence of false negative tests, the incomplete testing of prison populations, and the “window” period between infection and the production of antibodies that can be detected on standard HIV antibody tests.¹¹⁶ The misplacement of HIV-positive inmates in a segregated system creates a more dangerous situation than an integrated system, where inmates are more aware of the possibility of exposure to the virus if they engage in high-risk behavior with other inmates.

Despite the widespread opinion that segregation of HIV-positive inmates is unnecessary, impractical, and ineffective, a number of prison systems in the United States remain segregated. State prison systems in Alabama, Mississippi, and South Carolina mandate complete segregation of housing for all HIV-positive inmates, and at least nine other systems—Alaska, Arizona, California, Delaware, District of Columbia, Illinois, Utah, Virginia, and Wisconsin—segregate HIV-positive prisoners according to a case-by-case determination.¹¹⁷

C. *The Reality of a Segregated Prison System*

The most notorious of the blanket segregation policies based upon HIV status were those implemented in the Alabama state correctional system in 1987 and the Mississippi state correctional system in 1991. Both systems have been the focus of the ACLU’s National Prison Project for many years.

The harsh conditions faced by Alabama prisoners segregated because of their HIV-positive status are documented in the case of *Onishea v. Hopper*¹¹⁸ and in several articles published in the *New York Times*.¹¹⁹ Since

116. Rachel Maddow, Nat’l Minority Aids Council, *Pushing for Progress: HIV/AIDS in Prisons* 18 (2002).

117. See Criminal Justice Inst., *The 2002 Corrections Yearbook: Adult Corrections* 57 (Camille Graham Camp ed., Criminal Justice Institute 2003).

118. *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999), cert. denied sub nom. *Davis v. Hopper*, 528 U.S. 1114 (2000).

119. Adam Liptak, *Alabama Prison at Center of Suit over AIDS Policy*, N.Y. Times, Oct. 26, 2003; Paul Von Zielbauer, *A Company’s Troubled Answer for Prisoners with H.I.V.*, N.Y. Times, Aug. 1, 2005, at A1.

1987, when its segregation policy began, the Alabama Department of Corrections has tested all prisoners in its custody for HIV. Male prisoners whose test results are positive are sent to the Limestone Correctional Facility in Harvest, Alabama, and female inmates whose test results are positive are sent to the Julia Tutweiler Correctional Facility, in Wetumpka, Alabama.

In *Onishea v. Hopper*,¹²⁰ a group of segregated prisoners brought an action against the Alabama Department of Corrections, claiming that their segregation based upon HIV status violated section 504 of the Rehabilitation Act of 1973, which prohibits the exclusion of otherwise qualified individuals from participation in any program or activity receiving federal financial assistance.¹²¹ After describing in detail the negative impact that segregation had on the prisoners, as well as the alleged benefits of segregation, the Eleventh Circuit denied the plaintiff prisoners' claim. The Supreme Court denied certiorari without rendering an opinion.

According to the plaintiff prisoners, from 1987 until 2005, the prison administration would not permit HIV-positive prisoners to participate in "Double O" squad jobs maintaining the prison grounds, jobs on the prison farm, bus squad jobs, facility maintenance jobs, trash detail jobs, kitchen jobs, runner jobs, upholstery classes, electrical technology classes, auto mechanics classes, construction trade classes, automotive body repair classes, horticulture classes, welding classes, staff barber jobs, inmate barber jobs, laundry jobs, gardening jobs in the prison's vegetable gardens, the "Free by Choice" program (in which prisoners go to schools to talk to pupils about substance abuse and criminality), basketball and baseball tournaments, and 'Alabama Volunteers in Corrections' meetings (to prepare prisoners for release).¹²²

The only programs accessible to HIV-positive inmates were "paralegal training classes (HIV-positive inmates see videotapes of live instruction), adult basic education, GED testing, Narcotics and Alcoholics Anonymous meetings, graduation ceremonies, drafting classes, haircuts, visitation, medical treatment, gymnasium and library time, chapel services, dining, and prisoner transportation."¹²³

120. *Onishea*, 171 F.3d at 1292.

121. 29 U.S.C. § 794(a) (2000).

122. *Onishea*, 171 F.3d at 1292.

123. *Id.* at 1293.

Inside Limestone, HIV-positive inmates were housed in a drafty, rat-infested warehouse from 1999 to 2003.¹²⁴ This crowded setting with its “open plan” was ideal for the spread of infectious diseases, and coupled with the notoriously poor medical care provided at the prison, contributed to the deterioration of the health of many HIV-positive inmates. The death of thirty-six inmates between 1999 and 2002,¹²⁵ more than twice the national prison average,¹²⁶ provoked a Miami attorney, David Lipman, to file a lawsuit on behalf of the HIV-positive prisoners in 2002.¹²⁷ The complaint alleged that the inadequate medical care and living conditions endured by HIV-positive inmates at Limestone violated their rights under the Eighth and Fourteenth Amendments.¹²⁸ One year after the lawsuit was filed, the Alabama Department of Corrections replaced its local healthcare provider, Naphcare, with Prison Health Services, the nation’s largest provider of prison healthcare.¹²⁹ Housing for segregated inmates was also changed, from the open warehouse plan to “dormitories” that consisted of customary cellblocks, each housing two inmates.¹³⁰ These changes were likely made in response to the negative publicity created by the lawsuit, or in anticipation of the terms of the settlement agreement, which was approved by the court in June 2004.¹³¹ The terms of the settlement agreement promised continued improvements to living conditions and medical care for HIV-positive inmates, as well as the appointment of a court monitor to make monthly assessments of living conditions and medical care at the prison.¹³²

124. See Von Zielbauer, *supra* note 119.

125. *Id.*

126. Maruschak, *supra* note 5, at 1.

127. Complaint, *Leatherwood v. Haley*, No. CV-02-BE-2812-W (N.D. Ala. filed Nov. 18, 2002).

128. *Id.*

129. Von Zielbauer, *supra* note 119.

130. Liptak, *supra* note 120.

131. Von Zielbauer, *supra* note 119.

132. *Id.*

Although positive changes were promised to Alabama's HIV-positive inmates in the settlement agreement, the conditions and medical care at Limestone Correctional Facility remain inadequate. In August 2005, a front-page article in the *New York Times* covered the grim circumstances of incarceration at Limestone.¹³³ The article documented the absence of a clerical staff, an incompetent nursing staff, and shortages of supplies such as soap, paper towels, and thermometers.¹³⁴ It also described a rat-infested HIV unit, "where broken windows had been replaced with plastic sheeting that was itself falling apart [and there were] thousands of doses of prescribed medications [that] had never been given, as far as the [court] monitor could tell from the slapdash records."¹³⁵

In January 2004, the Alabama Department of Corrections announced the integration of prison programs for their HIV-positive prisoners housed at Limestone Correctional Facility.¹³⁶ While these prisoners are still placed in housing that is segregated from the general population, they are allowed access to the prison's trade school and vocational programs, and are allowed to work at some, but not all, jobs within the prison camp.¹³⁷ In spite of the increased accessibility of programs to HIV-positive inmates at Limestone, HIV-positive women housed at Alabama's Julia Tutweiler Correctional Facility are still denied access to numerous programs. Because of their HIV status, they are ineligible to participate in

data processing classes, clerical classes, cosmetology classes, sewing classes, building trades classes, automotive repair classes, welding classes, floral design classes, small business machine repair classes, quantity foods service classes, nutrition classes, concerts and talent shows, softball and volleyball games, the "Free by Choice" program, college classes, literacy training, sewing factory jobs, data processing jobs, "downtown" jobs for government agencies, community projects jobs, road squad jobs,

133. *See id.*

134. *Id.*

135. *Id.*

136. Telephone interview with Brian Corbett, Pub. Info. Manager, Ala. Dep't of Corr. (July 27, 2005).

137. *Id.*

kitchen jobs, yard jobs, maintenance jobs, housekeeping jobs, laundry jobs, trash jobs, runner jobs, and haircutting jobs.¹³⁸

They are, however, able to access certain programs separately from the general population. For example, “chapel services, some rehabilitation programs such as substance abuse and stress management counseling, visitation, organized recreational activities such as May Day and Oktoberfest, dining, medical care, adult basic education, GED testing, library use, and prisoner transportation” are all accessible to segregated inmates at Julia Tutweiler.¹³⁹

Mississippi’s Department of Corrections also segregates its HIV-positive inmates from the general prison population.¹⁴⁰ Since 1990, Mississippi has screened all inmates for HIV, housing all male inmates who test positive for the virus at the Mississippi State Penitentiary in Parchman, Mississippi.¹⁴¹ All women who are in the custody of Mississippi’s Department of Corrections are housed at the Central Mississippi Correctional Facility in Rankin County, Mississippi.¹⁴² From 1990 to 2001, the segregation of Mississippi’s HIV-positive prisoners rendered them ineligible to participate in the educational and vocational programs that typically reduce sentences and increase the likelihood of employment upon release.¹⁴³

The ACLU began working with Mississippi’s segregated prisoners in 1998, lobbying for equal access to programs, better medical care, and improvement of their dangerous living conditions, which included rats and vermin, human feces and extreme heat.¹⁴⁴ At the urging of a coalition formed by the ACLU, local activists, and inmates’ families, Mississippi

138. *Onishea v. Hopper*, 171 F.3d 1289, 1293 (1999).

139. *Id.*

140. Miss. Dep’t of Corr., Div. of Insts. State Prisons, http://www.mdoc.state.ms.us/division_of_institutions%20State%20Prisons.htm (last visited Apr. 12, 2006).

141. *Id.*

142. *Id.*

143. *Id.*

144. Press Release, ACLU, Mississippi Prisons End Segregation Based on HIV; ACLU Hails ‘Breakthrough,’ Vows to Continue Fighting (Apr. 30, 2001), <http://www.aclu.org/prison/medical/14666prs20010430.html>.

Department of Corrections (Mississippi DOC) commissioner Robert L. Johnson appointed a state HIV/AIDS Inmate Program Access task force in 2000.¹⁴⁵ One year later, the commissioner announced that he would implement the task force's recommendations, including the gradual integration of inmates with HIV into vocational and educational programs.¹⁴⁶ Although regarded as a "huge step forward" by the ACLU,¹⁴⁷ the gradual integration of HIV-positive inmates did not include integration into Mississippi's Community Corrections Program. In 2004, during the course of a lawsuit brought by the ACLU on behalf of Mississippi's HIV-positive prisoners,¹⁴⁸ the United States District Court for the Northern District of Mississippi issued an injunction ordering the Mississippi Department of Corrections to allow HIV-positive inmates to participate in the Community Corrections program, claiming this would help rehabilitate the prisoners and potentially shorten their sentences. The injunction was a result of negotiations between the parties, rather than a finding that the policies of the Mississippi DOC violated the rights of the prisoners under the U.S. Constitution or the Rehabilitation Act.¹⁴⁹ In April 2005, Magistrate Judge Jerry Davis issued an order to remove the injunction, recognizing the improvements made in the treatment of Mississippi's HIV-positive prisoners.¹⁵⁰ However, litigation continues in Mississippi, with a 2005 lawsuit brought by the ACLU regarding overcrowded living conditions, and inadequate medical care for HIV-positive prisoners.¹⁵¹ Specifically, the suit alleges that the overcrowded living conditions, inadequate sanitation practices by staff and prisoners, and insufficient laundry facilities led to the

145. *Id.*

146. *Id.*

147. *Id.*

148. *Gates v. Collier*, 349 F. Supp. 881 (N.D. Miss. 1972).

149. Telephone interview with Magistrate Judge Jerry Davis, U.S. Dist. Court for the N. Dist. of Miss. (May 2, 2006). Judge Davis credits both Margaret Winter, the ACLU attorney who represented the plaintiff prisoners, and the Mississippi Department of Corrections for reaching this agreement.

150. *Id.*

151. *Id.*

outbreak of a drug-resistant *Staphylococcus Aureus*, which the staff failed to contain.¹⁵²

D. Seroconversion Rates in Integrated and Segregated Prisons

In *Onishea v. Hopper*,¹⁵³ a group of HIV-positive prisoners sued the Alabama Department of Corrections, claiming their rights under the Rehabilitation Act¹⁵⁴ were violated by the department's policy of segregating HIV-positive inmates and denying their access to numerous prison programs. Each party presented evidence regarding the risk of HIV transmission in prison and during participation in prison programs. The prisoners presented expert testimony establishing that incidents of HIV transmission during many types of activities in prison are rare or virtually unknown. In fact, "at the time of trial there were no reported cases of transmission as a result of lesbian sex, sports injuries, stabbing, or tattooing."¹⁵⁵ Only "sporadic" instances of transmission had been reported from oral sex and fistfights.¹⁵⁶

In support of their position that integration would not put the general prison population at risk, the plaintiffs presented evidence that anal sex and needle sharing, although high-risk activities, were uncommon in the programs to which they sought access. The plaintiffs' rationale was that the rarity or absence of these high-risk activities in the past indicated that the behaviors would be unlikely to occur in the future. The plaintiffs also showed that because the programs at issue are in high demand, inmates would be unlikely to violate prison rules and risk being removed from the programs by engaging in the prohibited conduct. Additionally, the degree of supervision in most programs makes the occurrence of high-risk behavior implausible.

The defendants, on the other hand, introduced testimony that HIV transmission is possible whenever there is an exchange of blood between an infected person and an uninfected one. The defendants also introduced evidence that high-risk activities are widespread in prison. This evidence included "a six-inch high stack of incident reports from the past few years

152. *Presley v. Epps*, No. 4:05CV148-M-B (N.D. Miss. filed June 22, 2005).

153. *Onishea v. Hopper*, 171 F.3d 1289 (11th Cir. 1999).

154. 29 U.S.C. § 794 (2000).

155. *Onishea*, 171 F.3d at 1293.

156. *Id.* at 1293–94.

describing hidden hypodermic needles, homosexual acts, and bloody fights.”¹⁵⁷ Additionally, the defendants presented evidence that a 1991 outbreak of syphilis, wherein eighty-six HIV-positive inmates were infected, originated from a single inmate. Finally, the defendants offered evidence that “integrated prison systems in Maryland, Nevada, and Illinois have experienced seroconversions at *annual* rates of 0.41%, 0.19%, and 0.33%, respectively.” Alabama, by contrast, had an all-time seroconversion rate of 0.0067% over the course of eight years. Had Alabama’s seroconversion rate been similar to Illinois’, approximately five inmates per year would have contracted HIV while housed in the Limestone Correctional Facility.¹⁵⁸

IV. CONSTITUTIONAL CLAIMS MADE BY PRISONERS IN SEGREGATED PRISON SYSTEMS

The segregation of HIV-positive prisoners has given rise to a host of constitutional and civil claims by the segregated prisoners. Innumerable claims have been made against prison systems by HIV-positive inmates placed in segregated housing for violations of the First Amendment, the Fourth Amendment, the Fourteenth Amendment, and the right to privacy, among others. The basis of these claims has been mandatory screening for HIV, disclosure of screening results, segregated housing, denial of access to programs in prison and in the community, and inadequate medical care. The remaining sections of this article will examine claims brought by prisoners in both integrated and segregated prison systems, and the courts’ evaluations and responses to these claims.

It is well settled that inmates do not give up all of their constitutional rights upon entering a correctional facility. However, at times, a prisoner’s rights may be lawfully limited or compromised by the correctional administration. In 1987, the United States Supreme Court combined several principles established in prior decisions to create a four prong test to determine if a particular action or practice of a correctional staff or administration violates the constitutional rights of prisoners. In *Turner v. Safely*,¹⁵⁹ the Court analyzed a claim brought by a group of prisoners that regulations imposed by the Missouri Division of Corrections, restricting correspondence among inmates and the marriage of inmates violated their constitutional rights.

157. *Id.* at 1294.

158. *Id.*

159. *Turner v. Safely*, 482 U.S. 78 (1987).

The rule restricting correspondence only allowed written correspondence between immediate family members who were inmates at different institutions, and between inmates concerning legal matters, but allowed other forms of inmate correspondence only if the inmate's classification/treatment team deemed it in the best interest of the parties.¹⁶⁰ This regulation was imposed by the prison administration to further security interests, as mail between prisons may be used to communicate escape plans, to arrange violent acts, and to foster prison gang activity.

The rule restricting marriage of inmates prohibited inmates from marrying other inmates or civilians unless the prison superintendent determined that there were compelling reasons for marriage.¹⁶¹ According to testimony, typically the only sufficiently compelling reason would be a pregnancy or the birth of an illegitimate child.¹⁶² The Court held that when a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests.¹⁶³

As part of its holding, the Court set forth the following four factors, relevant in determining the reasonableness of the regulation in question. "First, there must be a valid, rational connection between the prison regulation and the legitimate governmental issue put forward to justify it."¹⁶⁴ The next consideration is whether inmates have access to alternative means of exercising the asserted right.¹⁶⁵ The third factor is the impact that the accommodation of the asserted right will have on guards, other inmates, and on the allocation of prison resources in general.¹⁶⁶ The final factor is the presence or absence of available alternatives to the challenged regulation.¹⁶⁷

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.* at 89.

164. *Id.* (citing *Block v. Rutherford*, 468 U.S. 567, 587 (1984)).

165. *Turner v. Safely*, 482 U.S. 78, 90 (1987) (citing *Pell v. Procunier*, 417 U.S. 817 (1974)).

166. *Id.*

167. *Id.*

After evaluating the challenged regulations in light of the relevant factors, the *Turner* Court determined that the Missouri rule restricting written correspondence among inmates was constitutional because it was reasonably related to legitimate security interests, it only barred inmate communication with a limited class of other people, the safety of other inmates and prison personnel could be threatened by written communication among inmates from different facilities, and there were no obvious, easy alternatives to the challenged regulation.¹⁶⁸ However, the Court found that the restriction of inmates from marrying unless the prison superintendent approved violated the prisoners' constitutional right to marriage under *Zablocki v. Redhail*,¹⁶⁹ as the restriction was not reasonably related to any penological objective, and there were easy, obvious alternatives to the regulation that would accommodate the right to marry while imposing only minimal burden on security objectives.¹⁷⁰

Although *Turner* did not address any issues of HIV status, courts have used its analysis to analyze claims that prisoners' rights have been violated by the mandatory screening for HIV, involuntary disclosure of screening results, segregated housing, denial of access to programs in prison and in the community, and inadequate medical care.¹⁷¹

A. Involuntary Disclosure of HIV Status

Courts have acknowledged that there are "few matters of a more personal nature" than the manner in which a person reveals his or her HIV diagnosis to others.¹⁷² The decision to disclose one's HIV status is an "emotional and sensitive" one,¹⁷³ as the consequences of disclosure may be devastating. In the context of personal relationships, family members may abandon the infected individual, or be emotionally unable to cope with the news.¹⁷⁴ In the confines of a prison, HIV-positive inmates are likely to suffer

168. *Id.*

169. *Zablocki v. Redhail*, 434 U.S. 374 (1978).

170. *Id.*

171. *See Turner v. Safely*, 482 U.S. 78 (1987).

172. *See Doe v. Coughlin*, 697 F. Supp. 1234, 1237 (N.D.N.Y. 1988).

173. *Id.*

174. *Id.*

harassment.¹⁷⁵ Outside of prison, persons suffering from AIDS or HIV are often subject to discrimination.¹⁷⁶ Ignorance and prejudice about the disease are widespread, and the decision of whether, when, or how to disclose HIV status is an extremely private one, and of great import.

In 1965, the United States Supreme Court established that citizens have a constitutional right to privacy in *Griswold v. Connecticut*.¹⁷⁷ It was in this opinion that Justice Douglas made his famous statement that penumbras emanate from specific guarantees in the Bill of Rights, and create zones of privacy. Although this decision was made in the context of a married couple's right to use contraceptives, the Court has expanded the right to privacy in its subsequent decisions.¹⁷⁸ In *Whalen v. Roe*,¹⁷⁹ the Court acknowledged that its privacy jurisprudence delineates at least two different kinds of privacy interests. "One is the individual interest in avoiding disclosure of personal matter, and another is the interest in independence in making certain kinds of important decisions."¹⁸⁰ Further, the Supreme Court reaffirmed its position "that the constitutional right to privacy embraces the 'individual interest in avoiding disclosure of personal matters'"¹⁸¹ in *Nixon v. Administrator of General Services*.¹⁸²

Numerous federal courts have acknowledged that the disclosure of a person's HIV status implicates both types of privacy interests.¹⁸³ However,

175. *Id.*

176. *Id.*

177. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

178. *See, e.g.*, *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Lawrence v. Texas*, 539 U.S. 558 (2003).

179. *Whalen v. Roe*, 429 U.S. 589, 598–99 (1977).

180. *Id.* at 599–600.

181. James F. Horner, Jr., *Constitutional Issues Surrounding the Mass Testing and Segregation of HIV-Infected Inmates*, 23 Mem. St. U. L. Rev. 369 (1993).

182. *Nixon v. Adm'r. of Gen. Servs.*, 433 U.S. 425, 457 (1977).

183. *See, e.g.*, *Doe v. Barrington*, 729 F. Supp. 376, 384 (D.N.J. 1990); *Faison v. Parker*, 823 F. Supp. 1198, 1202 (E.D. Pa. 1993); *Doe v. Delie*, 257 F.3d 309, 315 (3rd Cir. 2001); *Woods v. White*, 689 F. Supp. 874, 875 (W.D. Wis. 1988), *aff'd without published opinion* 899 F.2d 17 (7th Cir. 1990).

courts have disagreed on whether the involuntary disclosure of a prisoner's HIV-positive status violates that specific prisoner's constitutional right of privacy. The silence of the Supreme Court with respect to this particular issue has left the circuit and district courts without clear direction, resulting in a marked lack of consensus among the lower federal courts.

Since its decision in 1987, many federal courts have used the *Turner v. Safely*¹⁸⁴ analysis to determine if the involuntary disclosure of a prisoner's HIV status violates their constitutional right of privacy. In 1991, two federal courts evaluated this issue using the *Turner* analysis, and arrived at opposite conclusions. In *Harris v. Thigpen*,¹⁸⁵ the Eleventh Circuit evaluated a claim brought on the part of prisoners alleging that the Alabama Department of Corrections' policy of segregating all inmates who tested positive for HIV resulted in an unnecessary, gravely stigmatizing, and nonconsensual disclosure of the prisoners' HIV status, which violated their constitutionally guaranteed privacy rights.¹⁸⁶ The court began its discussion of the issue by acknowledging that the U.S. Supreme Court has held that "convicted prisoners do not forfeit all constitutional protections by reason of their conviction and confinement in prison,"¹⁸⁷ and that "[p]rison walls do not separate inmates from their constitutional rights."¹⁸⁸ The court even recognized that prison inmates retain certain fundamental rights of privacy,¹⁸⁹ but asserted that a prisoner retains only those rights that are consistent with his/her status as a prisoner or with the legitimate penological interests of the corrective system.¹⁹⁰ With a level of commitment that was later subject to differing interpretations, the Eleventh Circuit stated, "We nevertheless believe and assume *arguendo* that seropositive prisoners enjoy some significant constitutionally-protected privacy interest in preventing the

184. *Turner v. Safely*, 482 U.S. 78 (1987).

185. *Harris v. Thigpen*, 941 F.2d 1495, 1500 (11th Cir. 1991).

186. *Id.*

187. *Id.* at 1512 (citing *Bell v. Wolfish*, 441 U.S. 520 (1979)).

188. *Id.* (citing *Turner*, 482 U.S. 78).

189. *Id.* at 1513 (citing *Houchins v. KQED*, 438 U.S. 1, 5 n.2 (1978)).

190. *Harris v. Thigpen*, 941 F.2d 1495, 1513 (11th Cir. 1991) (citing *Pell v. Procunier*, 417 U.S. at 822).

non-consensual disclosure of their HIV-positive diagnoses to other inmates, as well as to their families and other outside visitors to the facilities in question.”¹⁹¹

In evaluating the plaintiffs’ claim, the court balanced the limited privacy interests of the plaintiff prisoners against the interests of the Alabama Department of Corrections in segregating the plaintiffs, using the four prong analyses that had been set forth by the U.S. Supreme Court in *Turner v. Safely*.¹⁹² The results of the court’s analysis were as follows: 1) segregation was connected to the legitimate goals of reducing HIV transmission and violence within the state’s penal system,¹⁹³ 2) the accommodation of the privacy rights of the plaintiff prisoners by reintegrating them in to the general population would have a severe impact on fellow inmates and guards, as it posed a realistic threat of violence from an intervening group of seronegative inmates, who vehemently opposed the reintegration of seropositive inmates,¹⁹⁴ and 3) although the alternative to the challenged regulation—mainstreaming HIV-positive inmates and implementing educational programs—was available and widely practiced among other prison systems, it was reasonably rejected by the Alabama prison administration because of reasonable fears that greater harm would result.¹⁹⁵ With respect to the remaining prong of the *Turner* test, whether the inmates have an alternative means of exercising the asserted right, the court bluntly acknowledged that there were no alternative means of protecting the inmates’ right of privacy, as “disclosure of one’s HIV status either occurs or it does not.”¹⁹⁶ The court abruptly dismissed this concern by declaring that the involuntary disclosure of one’s HIV status was an inevitable by-product of Alabama’s “identify and isolate policy.”¹⁹⁷ Apparently untroubled by the fact that this prong of the *Turner* test remained unsatisfied, the court held that the challenged regulation was valid because it was reasonably related to

191. *Id.* at 1513 (emphasis original).

192. *Turner v. Safely*, 482 U.S. 78 (1987).

193. *See Harris*, 941 F.2d at 1517.

194. *Id.* at 1518.

195. *Id.* at 1519.

196. *Id.* at 1517.

197. *Id.*

legitimate penological interests and, therefore, was not a violation of the plaintiff inmates' constitutional right of privacy.

Several weeks after the Eleventh Circuit decided *Harris v. Thigpen*,¹⁹⁸ a federal district court in New York heard a similar case, and declined to follow the ruling of *Harris*. In *Nolley v. County of Erie*, corrections staff placed red stickers on the plaintiff prisoner's documents and possessions, thus revealing her HIV-positive status to non-medical staff and fellow inmates.¹⁹⁹ Because of her HIV-positive status, the plaintiff was also removed from the general population and placed in segregated housing with inmates who were psychologically unstable or carried infectious blood-borne diseases.²⁰⁰ The plaintiff claimed, among other things, that the placement of red stickers and her segregation from the general population resulted in an involuntary disclosure of her HIV-positive status in violation of her constitutional right of privacy.²⁰¹ The court began its analysis of her claim by acknowledging that prison inmates have a constitutional right of privacy that protects them from the unwarranted disclosure of their HIV status.²⁰² In doing so, the court mentioned a series of federal cases that have upheld this right,²⁰³ and dismissed the few cases that refused to recognize this right as "not compelling."²⁰⁴ The court went on to apply the analysis set forth in *Turner v. Safely* in order to determine whether this particular disclosure of HIV status was reasonably related to legitimate penological interests.

The court determined that although the correctional administration had a legitimate interest in protecting the staff from infection, the placement of red stickers on the plaintiff's documents and possessions was not reasonably related to this interest. The practice of universal precautions, already implemented at this facility, was a more reliable method of preventing infection. This is because a number of inmates who carried infectious

198. *Harris*, 941 F.2d at 1495.

199. *Nolley v. County of Erie*, 776 F. Supp. 715, 717 (W.D.N.Y. 1991).

200. *Id.*

201. *Id.*

202. *Id.* at 731.

203. *Id.* at 730–31.

204. *Nolley v. County of Erie*, 776 F. Supp. 715, 731 (W.D.N.Y. 1991).

diseases were unknown to the staff. Additionally, the universal precautions were exactly the same as those enumerated on red stickers. As a result, the court concluded that the red stickers were an “exaggerated response” to prison concerns, that the red stickers did nothing to further the protection of the staff from blood borne infection, and that universal precautions were a “notably superior” alternative.²⁰⁵ The court also conceded that there was no alternative means for the plaintiff to exercise the right of privacy, as “[o]nce it is lost, it is lost forever.”²⁰⁶ Accordingly, the court found that the disclosure of the plaintiff’s HIV status through the placement of red stickers on her documents and possessions was a violation of her constitutional right of privacy.

The *Nolley* court also determined that the removal of the plaintiff from the general population and her subsequent placement in segregated housing resulted in the involuntary disclosure of her HIV status. In determining whether this disclosure violated the plaintiff’s constitutional right of privacy, the court again applied the *Turner* analysis to evaluate whether the segregation of HIV-positive inmates was rationally related to the legitimate purpose of protecting inmates in the general population from exposure to the virus. The court found that the segregation was *not* rationally related to the protection of inmates in the general population. The segregation involved placing the plaintiff among HIV-negative inmates who were emotionally unstable and engaged in behavior that made it more likely that the virus would be accidentally transmitted. Additionally, the policy of separating only inmates known to be infected with HIV did very little to protect the general population because there were a number of inmates who were likely HIV-positive, but whose HIV status remained unknown.

The court noted that HIV-positive status alone is not enough to constitute a threat of transmission to other inmates. Rather, it is the behavior of an inmate toward other inmates that carries the risk of HIV transmission. A facility’s “decision to segregate only on the basis of an inmate’s HIV status, without regard to their [sic] behavior, while it may slightly reduce the possibility of accidental HIV transmission, does not seriously further that goal.”²⁰⁷ The court also found that the automatic segregation of HIV-positive inmates was an exaggerated response because the correctional facility already had a written policy stating that inmates would not be segregated based upon HIV status alone and that other factors would be considered, such as medical needs and disruptive or threatening behavior.

205. *Id.* at 733.

206. *Id.*

207. *Id.* at 736.

The contrast between the opinions of the Eleventh Circuit in *Harris* and the district court in *Nolley* is striking. Although *Harris* was decided by a court of higher authority and has since been followed,²⁰⁸ the district court's reasoning in *Nolley* is more sound and more faithful to the Supreme Court's opinion in *Turner v. Safely*. In *Nolley*, the court painstakingly ensured that each prong of the *Turner* test was analyzed and satisfied. *Harris*, on the other hand, failed to give adequate consideration to two of the four prongs, specifically, the existence of alternative means for inmates to exercise the asserted right (there are none), and the presence or absence of ready alternatives to the challenged regulation (there are many). Additionally, *Nolley's* preference of universal precautions over the disclosure and segregation of those known to be HIV positive in prisons was sensible. Universal precautions are recommended by the NCCHC²⁰⁹ and are a more effective means of achieving the penological interest in preventing the accidental transmission of HIV than the mass testing and segregation upheld by *Harris*. Even in systems where all inmates are screened for HIV, the incidence of false negative test results and the "window" period between infection and detection will likely result in several cases of HIV that remain unknown to prison personnel. Most importantly, as stated by the district court in *Nolley*, it is the behavior of an inmate toward other inmates rather than the inmate's HIV status that carries the likelihood of accidental transmission.²¹⁰

The court's decision in *Nolley* is consistent with numerous other decisions within the Second Circuit. For example, in 1988, *Doe v. Coughlin*²¹¹ held that the involuntary segregation of prisoners based upon their HIV-positive status violated their constitutional right of privacy, and in 1989, *Rodriguez v. Coughlin*²¹² held that a prisoner being transported in a "hygiene suit" due to his HIV status had a valid constitutional claim on right to privacy grounds because the suit revealed his HIV status to fellow inmates, who threatened him with bodily harm. In 1999, the Second Circuit held that a prisoner has a constitutional right of privacy with respect to his or her transgender status

208. *E.g.*, *Moore v. Mabus*, 976 F.2d 268, 271–72 (5th Cir. 1992); *Onishea v. Hopper*, 171 F.3d 1289, 1301–02 (11th Cir. 1999).

209. NCCHC, *supra* note 86.

210. *Nolley*, 776 F. Supp. at 736.

211. *Doe v. Coughlin*, 697 F. Supp. 1234 (N.D.N.Y. 1988).

212. *Rodriguez v. Coughlin*, No. CIV-87-1577E, 1989 WL 59607, at *1-3 (W.D.N.Y. June 5, 1989).

and HIV status.²¹³ Other jurisdictions have agreed with this position of the Second Circuit. For example, the Tenth Circuit,²¹⁴ the Ninth Circuit,²¹⁵ and courts within Third²¹⁶ and Seventh²¹⁷ Circuits have all recognized that inmates have a constitutional right of privacy with respect to their HIV status.

Notwithstanding the position of the many courts mentioned above, there are a number of courts that refuse to acknowledge any constitutional right of privacy with respect to medical information. For example, in *Doe v. Wigginton*,²¹⁸ the Sixth Circuit denied the defendant's claim that the disclosure of his HIV status to corrections officers violated his constitutional right to privacy. The court held that individuals do not have a constitutional right to privacy that includes a right of nondisclosure of private information. The court rejected the idea that *Whalen v. Roe* and *Nixon v. Administrator of General Services* established a constitutional right of nondisclosure, and stated that only "isolated statements" when "read out of context" would lend some support to such a claim.²¹⁹ In its decision, the court cited one previous decision that also refused to recognize a constitutional right of nondisclosure,²²⁰ albeit in the very different context of the dissemination of juvenile delinquents' societal histories to the courts where they were being adjudicated.²²¹ The court ultimately opined that not all privacy interests are "of constitutional dimension." Similarly, in *Adams v. Drew*,²²² the District

213. *Powell v. Schriver*, 175 F.3d 107, 108 (2d Cir. 1999).

214. *E.g.*, *A.L.A. v. West Valley City*, 26 F.3d 989, 990 (10th Cir. 1994).

215. *E.g.*, *Hilaire v. Ariz. Dep't of Corr.*, No. 90-15344, 1991 WL 90001, at *2 (9th Cir. May 30, 1991).

216. *E.g.*, *Faison v. Parker*, 823 F. Supp. 1198 (E.D. Pa. 1993); *Albrecht v. Lehman*, No. CIV.A.93-0318, 1993 WL 346216, at *3-4 (E.D. Pa. Sept. 1, 1993).

217. *E.g.*, *Woods v. White*, 689 F. Supp. 874 (W.D. Wis. 1988).

218. *Doe v. Wigginton*, 21 F.3d 733, 734 (6th Cir. 1994).

219. *Id.* at 740.

220. *Id.* at 740 (citing *J.P. v. DeSanti*, 653 F.2d 1080, 1089-90 (4th Cir. 1981)).

221. *J.P.*, 653 F.2d at 1091.

222. *Adams v. Drew*, 906 F. Supp 1050, 1057 (E.D. Va. 1995).

Court for the Eastern District of Pennsylvania declined to “discover” new constitutional rights regarding privacy, after discussing the divided judicial landscape and lack of direction from the Supreme Court about the issue.

Other jurisdictions have tenuously recognized that such a right may exist, but deny that the right has been “clearly established.” For example, in *Tokar v. Armontrout*,²²³ the Eighth Circuit held that there was no clearly established right of confidentiality in medical records for prisoners. The court noted that there was no Supreme Court case or appellate holding granting such a right to prisoners, stating that the closest case was *Harris v. Thigpen*. The court focused on the Eleventh Circuit’s statement in *Harris* that the right of privacy with respect to medical information was “rather ill-defined,” but for purposes of the opinion the court assumed a privacy right existed.²²⁴ The Eighth Circuit and other courts have construed this portion of *Harris* as a failure to clearly establish a constitutional right of privacy in one’s HIV status.²²⁵ These courts have also taken the position that courts that have unequivocally recognized a constitutional right to privacy in medical information, such as the district courts within the Second Circuit or the Seventh Circuit, lack the necessary status to “clearly establish” a constitutional right.²²⁶

The viewpoint that there is no clearly established right of privacy for prisoners with respect to medical information has led to a trend among federal courts of denying plaintiff prisoners’ claims that their constitutional right to privacy has been violated through the nonconsensual disclosure of their HIV status by granting qualified immunity to the defendant prison staff members. The doctrine of qualified immunity “shields government officials from liability for damages on account of their performance of discretionary official functions ‘insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.’”²²⁷ The vast majority of defendants in these types of cases are granted governmental immunity, even in the Second Circuit. The

223. *Tokar v. Armontrout*, 97 F.3d 1078, 1084 (8th Cir. 1996).

224. *Id.* (citing *Harris v. Thigpen*, 941 F.2d 1495, 1512–13 (11th Cir. 1991)).

225. *Id.* (citing *Anderson v. Romero*, 72 F.3d 518, 524 (7th Cir. 1995)).

226. *Tokar*, 97 F.3d at 184 n.9 (“In any event, ‘district court decisions cannot clearly establish a constitutional right.’” (quoting *Anderson*, 72 F.3d at 524)).

227. *Rodriguez v. Phillips*, 66 F.3d 470, 475 (2d Cir. 1995) (quoting *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)).

most recent court to address this issue is the court that heard *Doe v. Magnusson* in 2005.²²⁸ In *Doe*, the plaintiff prisoner claimed that his constitutional right of privacy had been violated when corrections officers removed his HIV medication from a private location in his cell and placed it in an area where it was visible to correctional staff and other inmates, thus disclosing the fact that he was HIV-positive. In an unreported decision, a federal district court in Maine concluded that there is a “Fourteenth Amendment right to privacy that protects private medical information from unjustified disclosure by governmental actors.”²²⁹ However, in keeping with the current federal judicial trend, the court explained that this right to privacy was not clearly established at the time the alleged violation took place, and granted governmental immunity to the defendant correctional officers, dismissing the claim.²³⁰

The U.S. Supreme Court has never evaluated a claim that the involuntary disclosure of a prisoner’s HIV status violates the constitutional right of privacy. The only two occasions wherein the Supreme Court considered the rights of an HIV-positive prisoner were in *Farmer v. Brennan*, and *Davis v. Hopper*. In *Farmer*, the Court held that corrections staff showed deliberate indifference to the plaintiff prisoner’s medical needs, in violation of the Eighth Amendment.²³¹ In *Davis*,²³² the plaintiffs claimed that the segregation of HIV-positive inmates in Alabama’s Correctional facilities violated their rights under section 504 of the Rehabilitation Act.²³³ The plaintiffs did not raise privacy or any other constitutional claims. The Supreme Court denied certiorari, upholding the Eleventh Circuit’s decision that the segregation of HIV-positive prisoners did not violate the Rehabilitation Act.²³⁴

228. *Doe v. Magnusson*, No. CIV.04-130-B-W, 2005 WL 758454, at *1 (D. Me. Mar. 21, 2005).

229. *Id.* at *10.

230. *Id.* at *11.

231. *Farmer v. Brennan*, 511 U.S. 825, 826 (1970).

232. *Onishea v. Hooper*, 171 F.3d 1289, 1289 (11th Cir. 1999), *cert. denied sub nom. Davis v. Hopper* 528 U.S. 1114 (2000); 29 U.S.C. § 794(a) (2000).

233. *Onishea*, 171 F.3d at 1300–01.

234. *Davis*, *supra* note 232.

B. Due Process

A claim often made by prisoners who have been segregated because of their HIV-positive status is that the segregation from the general prison population violates their right to due process. The Fourteenth Amendment provides that “no person shall be deprived of life, liberty or property without due process of law.”²³⁵ It is the liberty interest guaranteed by the Fourteenth Amendment that is arguably compromised by the administrative segregation of HIV-positive prisoners, and its “consequent lack of social, recreational, and rehabilitative opportunities” for the prisoners.²³⁶ Although the United States Supreme Court has never addressed this specific issue, in *Meachum v. Fano*,²³⁷ the Court held that the Due Process Clause, in itself, does not protect a duly convicted prisoner against a transfer from a medium security prison to a maximum security person where life is much more disagreeable. Similarly, in *Hewitt v. Helms*,²³⁸ the Court held that a prison inmate does not have a federal constitutional right to be placed in the general prison population. In keeping with this principle, the majority view among federal courts is that the administrative segregation of HIV-positive inmates in a jail or prison does not violate the inmate’s right to due process, as long as such segregation is within the contemplation of terms of the prisoners’ original sentences.²³⁹

V. THE EVOLUTION OF THE EIGHTH AMENDMENT

The Eighth Amendment to the U.S. Constitution prohibits the government from inflicting cruel and unusual punishments on prisoners.²⁴⁰ Although it was ratified in 1791, the Eighth Amendment was not interpreted by the U.S. Supreme Court until 1890 in *In Re Kemmler*.²⁴¹ The Court explicitly stated that the Eighth Amendment prohibited punishments that involve torture,

235. U.S. Const. amend XIV.

236. *Cordero v. Coughlin*, 607 F. Supp. 9, 10 (S.D.N.Y. 1984).

237. *Meachum v. Fano*, 427 U.S. 215, 225 (1976).

238. *Hewitt v. Helms*, 459 U.S. 460, 461, 470–71 (1983).

239. *See Cordero*, 607 F. Supp. at 10.

240. U.S. Const. amend. VIII.

241. *In re Kemmler*, 136 U.S. 436, 446–47 (1890).

lingering death, or mutilation of the body.²⁴² Twenty years later, the Court held that punishments grossly disproportionate to the committed offense also violate the Eighth Amendment.²⁴³ For the next several decades, the Court exercised judicial restraint with respect to the constitutional claims of prisoners and generally avoided interfering with the problems of prison administration.²⁴⁴ This inactivity was likely premised on the belief expressed in an opinion written by Justice Powell that the “courts are ill-equipped to deal with the increasingly urgent problems of prison administration and reform.”²⁴⁵

In the mid “1970s and early 1980s, the Supreme Court and lower federal courts began to scrutinize prison administration more closely to rid the prisons of inhumane conditions that were regarded as cruel and unusual punishment.”²⁴⁶ In 1976, the Court expanded its interpretation of the Eighth Amendment to prohibit punishments that involve the unnecessary and wanton infliction of pain.²⁴⁷ Later that year, in the case of *Estelle v. Gamble*,²⁴⁸ the Court acknowledged that at times, the circumstances of a punishment, including the inadequacy of the medical care provided in prison, may violate the Eighth Amendment. The Court in *Gamble* held that in order for a prisoner to succeed in an Eighth Amendment claim based upon inadequate medical care, he or she must establish that the supervising prison officials showed “deliberate indifference” to the prisoner’s serious medical needs.²⁴⁹ The court explained that neither mere negligence, nor the inadvertent failure to provide adequate medical care, nor ordinary medical

242. *Id.* at 446–47.

243. *See Coker v. Georgia*, 433 U.S. 584, 992 (citing *Weems v. United States* 217 U.S. 349 (1910)).

244. *See Turner v. Safely*, 482 U.S. 78 (1986); *Procunier v. Martinez*, 416 U.S. 396 (1974) (overruled on other grounds).

245. *Martinez*, 416 U.S. at 405.

246. Siegal, *supra* note 41, at 1553.

247. *See Gregg v. Georgia*, 428 U.S. 153 (1976).

248. *See Estelle v. Gamble*, 429 U.S. 97 (1976).

249. *See id.* at 104–05.

malpractice violates the Eighth Amendment unless the act or omission was the result of the deliberate indifference of the responsible officials.²⁵⁰

Although the basis of the prisoner's claim in *Gamble* was that he was denied adequate medical care, the "deliberate indifference" standard created in this opinion was subsequently used by courts to evaluate Eighth Amendment claims based upon other factual scenarios, such as squalid living conditions,²⁵¹ sexual violence,²⁵² and excessive exposure to secondhand smoke.²⁵³

The deliberate indifference standard created by *Gamble* was subsequently developed by the Court in *Rhodes v. Chapman*,²⁵⁴ *Wilson v. Seiter*,²⁵⁵ and then *Farmer v. Brennan*.²⁵⁶ In these cases, the Court extended the "deliberate indifference" standard to cases involving claims other than inadequate medical care, such as crowding, squalid living conditions, and unsafe conditions due to the violence of other inmates.

Rhodes v. Chapman established that a deprivation suffered by a prisoner during confinement had to be sufficiently serious in order to violate the Eighth Amendment.²⁵⁷ Decided in 1981, *Chapman* evaluated the claim of a prisoner that his Eighth Amendment rights were violated by an Ohio prison's policy of "double celling," or housing two inmates in one cell.²⁵⁸ The Court denied the claim, holding that in order for a prisoner to be successful in an Eighth Amendment challenge of prison conditions, he or

250. *See id.* at 105–06.

251. *See Williams v. Griffin*, 952 F.2d 820, 824–25 (4th Cir. 1991) (summary judgment by district court reversed; case remanded for further consideration of plaintiff's claim); *Tillery v. Owens*, 907 F.2d 418, 422–28 (3d Cir. 1990) (plaintiff's claim granted).

252. *See Farmer v. Brennan*, 511 U.S. 825 (1994) (plaintiff's claim granted); *LaMarca v. Turner*, 995 F.2d 1526, 1533–39 (11th Cir. 1993) (plaintiff's claim granted).

253. *See Helling v. McKinney*, 509 U.S. 25 (1993) (plaintiff's claim granted).

254. *See Rhodes v. Chapman*, 452 U.S. 337 (1981).

255. *See Wilson v. Seiter*, 501 U.S. 294 (1991).

256. *See Farmer v. Brennan*, 511 U.S. 825 (1994).

257. *See Rhodes*, 452 U.S. 337.

258. *Id.*

she had to establish that the conditions of imprisonment deprived inmates of their “minimal civilized measure of life’s necessities.”²⁵⁹ In its opinion, the Court stated that the Constitution does not mandate comfortable prisons, and that no static test can exist by which courts determine whether conditions of confinement are cruel and unusual,²⁶⁰ for the Eighth Amendment must draw its meaning from “evolving standards of decency that mark the progress of a maturing society.”²⁶¹

Ten years later, the Court decided *Wilson v. Seiter*,²⁶² which evaluated the claim that an inmate’s Eighth Amendment rights were violated by various conditions of his confinement, including overcrowding, excessive noise, inadequate heating and cooling, improper ventilation, unclean and inadequate restrooms, unsanitary dining facilities, and housing with mentally and physically ill inmates. The Supreme Court vacated the Sixth Circuit’s order affirming summary judgment, and remanded the case for further consideration of the plaintiff’s claim.²⁶³ In its opinion, the Court established that an evaluation of an Eighth Amendment prison claim had two components: an objective one and a subjective one. The objective component asks whether the deprivation alleged by the inmate is sufficiently serious to violate the Eighth Amendment: *Was the inmate deprived of the minimal civilized measure of life’s necessities?*²⁶⁴ The subjective component inquires into whether the corrections official acted with a sufficiently culpable state of mind: *Did the corrections official act or fail to act with deliberate indifference to the needs of the prisoner?*²⁶⁵ The Court failed to clearly define deliberate indifference, other than by referring to *Estelle v. Gamble*, where the court merely explained that it was a state of mind more blameworthy than negligence.²⁶⁶

259. *See Farmer*, 511 U.S. at 834 (quoting *Rhodes*, 452 U.S. at 347).

260. *Id.* at 822.

261. *Id.* (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)).

262. *See Wilson v. Seiter*, 501 U.S. 294, 296 (1991).

263. *Id.*

264. *See id.* at 298 (citing *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)).

265. *See id.* at 298–303.

266. *See id.* at 302–03; *Estelle v. Gamble*, 429 U.S. 97, 105–06 (1976).

Shortly after the Court decided *Wilson*, the decision was criticized by at least one commentator, who argued that the subjective standard set forth in *Wilson* places too much of a burden on inmates who attempt to establish that the conditions of their confinement violate the Eighth Amendment. This is particularly true, the critic asserted, when an inmate alleges that a prison official's failure to stop prison rape comprises cruel and unusual punishment. The critic refers to *Wilson*'s subjective standard as an "insurmountable barrier" to a successful claim, and declares that the subjective prong of the *Wilson v. Seiter* analysis may be "too inflexible to respond adequately to the potentially life threatening danger posed by the combined situation" of prison rape and AIDS.²⁶⁷

Another difficulty presented by *Wilson* was its failure to clearly define deliberate indifference. Without a clear definition, lower courts often interpreted deliberate indifference as recklessness. This led to disagreement among the lower courts, as recklessness is defined differently by different bodies of law. Civil law defines a reckless person as one who acts or fails to act in the face of an unjustifiably high risk of harm that is either known or so obvious that it should be known.²⁶⁸ Criminal law, on the other hand, generally permits a finding of recklessness only when a person disregards a risk of harm of which he is aware.²⁶⁹ The disparity between the civil and criminal theories of recklessness gave rise to predictable inconsistencies in the lower courts. For example, in *McGill v. Duckworth*,²⁷⁰ the Seventh Circuit held that "deliberate indifference" requires a subjective standard of recklessness. Under this standard, the prison official has actual knowledge of the risk of harm to inmates. Six months later, in *Young v. Quinlan*,²⁷¹ the Third Circuit adopted the objective standard. Under this standard, a "prison official is deliberately indifferent when he knows or should have known of a sufficiently serious danger to an inmate."²⁷²

267. Siegal, *supra* note 41, at 1556.

268. *Farmer v. Brennan*, 511 U.S. 825, 836 (1984) (citing W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on Law of Torts* § 34 at 213-14 (5th ed. 1984); *Restatement (Second) of Torts* § 500 (1965)).

269. *Id.* at 836-37 (citing R. Perkins & R. Boyce, *Criminal Law* 850-51 (3d ed. 1982)).

270. *McGill v. Duckworth*, 944 F.2d 344, 348 (7th Cir. 1991).

271. *Young v. Quinlan*, 960 F.2d 351, 360-61 (3rd Cir. 1992).

272. *Id.* (emphasis omitted).

The Supreme Court resolved these differences in 1994, when it clearly defined “deliberate indifference” in *Farmer v. Brennan*.²⁷³ Prior to this decision, however, lower courts evaluated numerous claims that inmates’ potential exposure to HIV were in violation of the Eighth Amendment using *Wilson* as their guideline.

A. Eighth Amendment Claims of Prisoners in Integrated Prison Systems

The prevalence of HIV in prisons combined with the high incidence of risk behavior and absence of prevention measures have led to a multitude of claims by prisoners asserting that their rights under the Eighth Amendment have been violated by the potential exposure to HIV while in custody. By 1991, the Supreme Court had established that the Eighth Amendment requires prison officials to provide adequate medical care,²⁷⁴ the “minimal civilized measures of life’s necessities,”²⁷⁵ and to “take reasonable measures to guarantee the safety of the inmates themselves.”²⁷⁶ The Eighth Amendment therefore compels prison officials to take reasonable steps to protect inmates from contracting communicable diseases from other inmates when the failure to do so reflects the “deliberate indifference to serious medical needs.”²⁷⁷ The Eighth Amendment’s requirement that corrections officials “take reasonable measures to guarantee safety of the inmates”²⁷⁸ includes protecting them from harm at the hands of other inmates²⁷⁹ and from self-inflicted harm.²⁸⁰ Although claims involving exposure to HIV in prison often implicate both the right to adequate medical care and the right

273. *Farmer*, 511 U.S. at 837.

274. *Estelle v. Gamble*, 429 U.S. 97, 103–05 (1976).

275. *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).

276. *Hudson v. Palmer*, 468 U.S. 517, 527 (1984).

277. *Lareau v. Manson*, 651 F.2d 96, 109 (2d Cir. 1981) (quoting *Estelle*, 429 U.S. at 106).

278. *Farmer*, 511 U.S. at 832 (quoting *Palmer*, 468 U.S. at 526–27).

279. *Id.* at 833 (quoting *Cortes-Quinones v. Jimenez-Nettleship*, 842 F.2d 556, 558 (1st Cir. 1988)); *see also* *Fischl v. Armitage*, 128 F.3d 50, 55 (2d Cir. 1997) (quoting *Farmer*, 511 U.S. at 833).

280. *Lee v. Downs*, 641 F.2d 1117, 1121 (4th Cir. 1981); *see generally* *De’Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003).

to safety, the vast majority of these claims have been denied. In 1993, the Supreme Court decided *Helling v. McKinney*, holding that a prisoner may have a claim under the Eighth Amendment if prison officials, acting with deliberate indifference, expose a prisoner to a sufficiently substantial “risk of serious damage to his future health.”²⁸¹ Although the factual basis of the claim in *Helling* was that a prisoner was exposed to secondhand smoke, this decision is relevant to cases involving the transmission of HIV in prison because the Court acknowledged that exposure to serious contagious disease may also violate the Eighth Amendment if corrections officials acted or failed to act with deliberate indifference to the risk of the inmate’s health or safety.²⁸²

This dictum was referenced in a number of cases involving the potential exposure to HIV, including *Glick v. Henderson*,²⁸³ which determined that prison’s failure to segregate inmates with HIV/AIDS did not violate the Eighth Amendment based upon the recommendation of the U.S. Department of Health and Human Services that HIV is not spread through casual contact. Later, in *Deutsch v. Federal Bureau of Prisons*,²⁸⁴ inmate Melvin Deutsch claimed that his Eighth Amendment rights had been violated when he was housed with an HIV-positive cellmate and not notified of his cellmate’s HIV status. The district court rejected Deutsch’s claim, stating that he failed to establish that prison officials showed deliberate indifference to Deutsch’s serious medical needs.²⁸⁵ The court considered the HIV-related policies of the corrections facility, which included the screening of new inmates for HIV and counseling for those who were HIV positive. The court also considered the policies of prohibiting conduct known to transmit the virus, such as sexual contact and needle sharing, and the removing of HIV-positive inmates from the general prison population when there was reliable evidence that their conduct may pose a health risk to other inmates.²⁸⁶ The court also highlighted the fact that Deutsch had not claimed that any of the prison officials had specific knowledge that the cellmate might engage in conduct

281. *Helling v. McKinney*, 509 U.S. 25, 35 (1993).

282. *Id.* at 32–33; *see also Lareau*, 651 F.2d at 109 (quoting *Estelle*, 429 U.S. at 106).

283. *Glick v. Henderson*, 855 F.2d 536, 539 (8th Cir. 1988).

284. *Deutsch v. Fed. Bureau of Prisons*, 737 F. Supp. 261, 267 (S.D.N.Y. 1990).

285. *Id.*

286. *Id.*

that would expose Deutsch to a high risk of contracting AIDS or that they had tacitly condoned or allowed this conduct to occur.²⁸⁷ *Deutsch* was subsequently cited by numerous courts in other jurisdictions.²⁸⁸

In 1994, the Supreme Court made significant strides in Eighth Amendment jurisprudence when it decided *Farmer v. Brennan*.²⁸⁹ In *Farmer*, the Court explicitly defined deliberate indifference in its evaluation of the Eighth Amendment claim of a transsexual inmate who was raped in prison and allegedly contracted HIV during the attack.²⁹⁰ The district court had denied the plaintiff's claim, holding that prison officials had no actual knowledge of danger to the plaintiff because the plaintiff did not express any safety concerns to them.²⁹¹ The court of appeals affirmed the district court's ruling,²⁹² but the Supreme Court vacated their decisions, finding that the district court erred in placing decisive weight on the plaintiff prisoner's failure to notify prison staff of a danger.²⁹³ In its decision, the Court held that a prison official may be held liable under the Eighth Amendment for denying an inmate humane conditions of confinement only if the official knows of and disregards an excessive risk to the inmate's health²⁹⁴ or safety.²⁹⁵ The Court emphasized that "the official must both be aware of the facts from which the inference could be drawn that a substantial risk of

287. *Id.*

288. See, e.g., *Johnson v. United States*, 816 F. Supp. 1519, 1524 (N.D. Ala. 1993); *Marcussen v. Brandstat*, 836 F. Supp. 624, 628 (N.D. Iowa 1993); *Martin v. Vaughn*, 1995 WL 458977, *2 (E.D. Pa. 1995); *Portee v. Tollison*, 753 F. Supp. 184, 187 (D.S.C. 1990); *Goss v. Sullivan*, 839 F. Supp. 1532, 1536 (D. Wyo. 1993); *Bolton v. Goord*, 992 F. Supp. 604, 629 (S.D.N.Y. 1998).

289. *Farmer v. Brennan*, 511 U.S. 825 (1994).

290. *Id.* at 837.

291. *Id.* at 831–32.

292. *Id.* at 832.

293. *Id.* at 848–49.

294. Siegal, *supra* note 41, at 1541.

295. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

serious harm exists, and he must also draw the inference.”²⁹⁶ The Court also stated that the “Eighth Amendment does not outlaw cruel and unusual ‘conditions;’ it outlaws cruel and unusual ‘punishments.’”²⁹⁷ Under this ruling, an inhumane prison condition does not become an inhumane punishment prohibited by the Eighth Amendment unless and until a corrections official becomes aware of the inhumane condition and fails to respond reasonably to it.

The standard set forth in *Farmer* is an objective standard, consistent with the criminal definition of recklessness. As such, an inmate is required to prove that corrections officials had actual knowledge of a substantial risk to the inmate’s safety or health in order to establish a violation of the Eighth Amendment. However, the Court adopted a broad interpretation of this standard, explaining that a prisoner need not establish that the prison officials were actually notified of the danger. Rather, the Court explained, “requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, . . . and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.”²⁹⁸

Farmer’s standard of requisite knowledge, allowing a factfinder to draw an inference of knowledge from an obvious risk of serious harm weakens the “insurmountable barrier”²⁹⁹ created by *Wilson*. This broad interpretation of subjective knowledge charges corrections officials with awareness of obvious prison conditions and does not allow prison officials to insulate themselves from liability for failing to protect an inmate by intentionally turning a blind eye or a deaf ear to harmful prison conditions. Under *Farmer*, corrections officials will no longer be able to hide behind claims that because they had not been notified about a particular risk, they were unaware of it. The Supreme Court’s Eighth Amendment jurisprudence has delineated two separate rights of prisoners relevant to the transmission of HIV in prison: the right to be protected from harm, and the right to be provided with adequate medical care.

296. *Id.* at 837.

297. *Id.*

298. *Id.* at 842.

299. Siegal, *supra* note 41, at 1556.

B. Reasonable Measures to Protect Inmates from Harm Include the Distribution of Prophylactic Devices to Prevent the Transmission of HIV in Prison

The Eighth Amendment requires prison officials to take reasonable measures to protect prisoners from harm.³⁰⁰ Although the threat of rape in prison, by itself, has not been considered “pervasive” by the courts, the existence of all types of risk behavior combined can very reasonably be characterized as “pervasive.” As *Farmer* explained, “it does not matter whether the risk [of harm] comes from a single source or multiple sources.”³⁰¹

When obvious conditions exist in the prison culture, such as the threat of rape, the commonplace use of intravenous drugs, and regular homosexual activity among both heterosexual and homosexual prisoners, a factfinder may, pursuant to the holding of *Farmer*, infer that a corrections official has knowledge of a substantial risk of HIV transmission among prisoners. This applies particularly in prison systems that neither segregate their HIV-positive population, nor permit the distribution of bleach kits, sterile needles, or barrier devices such as condoms or dental dams. The substantial risk of HIV transmission during these widespread and well-known prison behaviors poses a serious risk to inmates, about which prison officials may not be deliberately indifferent any longer.³⁰²

A reasonable measure of protection from this particular source of harm is the distribution of prophylactic devices, such as condoms, dental dams, and sterile needles or bleach kits to avert the risk of HIV transmission among prisoners engaging in risky behavior. A corrections official’s failure to distribute such prophylactic devices when high-risk behaviors are inevitably and obviously occurring may violate the Eighth Amendment. If a prisoner has a substantial risk of contracting HIV due to commonplace activities in the prison, and corrections officers know about the high-risk situation and do nothing to lower that risk, the prisoner may have a claim under the Eighth Amendment.

Two obvious arguments will be made against this position. The first and most obvious argument is that the corrections officials are not exposing the inmates to the risk of HIV; the inmates are exposing themselves. Therefore, the holdings of *Farmer* and *Helling* do not apply, as they do not specifically require corrections officers to take reasonable steps to avert a self-imposed

300. See *Hudson v. Palmer*, 468 U.S. 517, 526–27 (1984).

301. *Farmer*, 511 U.S. at 843.

302. See *Helling v. McKinney*, 509 U.S. 25, 33–34 (1993).

risk of harm to an inmate's health or safety. The second argument is that correctional officials have already taken reasonable measures to prevent the spread of HIV by prohibiting all types of risk behavior in prison.

The first argument, that the corrections officials are not required to avert a risk of harm when an inmate exposes himself or herself to the risk, is easily discredited. Federal courts have held that corrections officials are required to intervene when inmates are at risk of harm, even when the risks are created by the inmates themselves. For example, the Eighth Amendment requires corrections officials to take adequate precautions to prevent an inmate's suicide.³⁰³ Adequate precautions to prevent a suicide may include increased surveillance, as well as the removal of belts, shoelaces, or other objects that an inmate may employ to harm himself.³⁰⁴ Federal courts have also held that the Eighth Amendment requires that corrections officials protect inmates from self-injury,³⁰⁵ and at least one court has characterized an inmate's need for protection against continued self-mutilation as a "serious medical need to which prison officials may not be deliberately indifferent."³⁰⁶ The requirement of corrections officials to take adequate precautions to prevent the suicide or self-inflicted injury of inmates also requires corrections officials to take adequate precautions to prevent inmates from exposing themselves to HIV.

The second argument, that the prohibition of high-risk behavior in prison is an adequately reasonable measure to protect inmates from the transmission of HIV, is also easily debunked. The mere prohibition of conduct that is known to transmit the virus is not an adequate precaution. In cases involving suicide or self-mutilation by prisoners, it is acknowledged that the mere prohibition of an activity is not an adequate measure of prevention, and courts recognize that the Eighth Amendment requires corrections officials to take additional measures to prevent the self-

303. See *Barber v. City of Salem, Ohio*, 953 F.2d 232 (6th Cir. 1992); *Hare v. City of Corinth* 74 F.3d 633 (5th Cir. 1996).

304. See, e.g., *Hare*, 74 F.3d at 644 ("[A] state jail official might be liable for a suicide resulting from the official's failure to remove a pair of scissors from the cell of a pretrial detainee known to be suicidal, even if the state official had otherwise provided the mentally disturbed detainee with constitutionally sufficient medical care.").

305. *Lee v. Downs*, 641 F.2d 1117, 1121 (4th Cir. 1981); see also *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (holding that an inmate's self-mutilation was a serious medical need about which corrections officials could not be deliberately indifferent).

306. *De'Lonta*, 330 F.3d at 634.

destructive behavior by inmates. Thus, it follows that the Eighth Amendment commands corrections officials to take additional measures, beyond mere prohibition, to prevent the spread of HIV through obvious high-risk behavior in prison.

C. Adequate Medical Care Includes the Distribution of Prophylactic Devices to Prevent HIV Transmission in Prison

The Eighth Amendment's requirement of adequate medical care for prisoners requires the distribution of prophylactic devices to prevent the transmission of HIV.³⁰⁷ This argument was asserted by commentator Mark Parts in 1991, three years before *Farmer v. Brennan*³⁰⁸ was decided. Parts argues that since "prevention is the only effective means of combating AIDS, preventive measures are necessary medical care and required by the eighth amendment [sic]."³⁰⁹

Parts explains that there are two ways of demonstrating that *Estelle v. Gamble*'s prohibition of "deliberate indifference to serious medical needs" may require that preventative measures be made available to inmates at risk of contracting HIV: first, by showing that the prison doctor is of the opinion that such measures are medically necessary, and second, by showing that the opinion of the medical community at large is of the opinion that such preventative measures are medically necessary.³¹⁰

According to Parts, if a prison doctor or a doctor who practices outside the prison has instructed an inmate to use condoms, sterile needles, or other measures to protect against the transmission of HIV, prison officials will violate the Eighth Amendment if they refuse to allow the prisoner to comply with the doctor's orders.³¹¹ This is clear from the language in *Estelle*, which explicitly prohibits prison officials from "intentionally interfering with the treatment once prescribed."³¹² Federal courts have established that a medical need is "serious" if it has been diagnosed by a physician as

307. Parts, *supra* note 109.

308. *Farmer v. Brennan*, 511 U.S. 825 (1994).

309. Parts, *supra* note 109, at 219.

310. *Id.* at 230.

311. *Id.* at 230–31.

312. *Id.* at 230 (citing *Estelle v. Gamble*, 429 U.S. 97, 105 (1976)).

requiring treatment,³¹³ and when prison officials prevent an inmate from receiving recommended treatment for a serious medical need, they have acted with deliberate indifference.³¹⁴ Parts' other method of demonstrating that the Eighth Amendment requires the distribution of prophylactic measures is by showing that the medical community at large is of the opinion that they are medically necessary to prevent the spread of HIV in prison. To support this argument, Parts quotes language in *Estelle* that "incorporates an extrinsic standard by which an inadequate response to prisoners' medical needs must be measured."³¹⁵ Parts rhetorically questions whether the recommendations of the Surgeon General, American Medical Association, and World Health Organization for preventative measures are sufficient to establish the need for preventative care.³¹⁶ He then points to the recommendations of numerous healthcare agencies, including the CDC, World Health Organization, National Commission on AIDS, and the Council of Europe, all of whom recommend that prisoners be given the means to prevent HIV transmission.³¹⁷

The article continues with the discussion of three "central objections" that can be raised to against the argument that the Eighth Amendment requires preventative measures to control the spread of HIV in prison: that constitutional protections do not apply to preventative medical care, that constitutional protections do not apply to voluntarily encountered disease risks, and that constitutional protections are outweighed by the state interest in regulating high risk activities.³¹⁸ Parts begins by asserting that these objections would not be viable if the preventative medical care at issue was a vaccine against HIV, rather than condoms, bleach, or sterile needles. Parts

313. *Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) (quoting *Pace v. Fauver*, 479 F. Supp. 456, 458 (D.N.J. 1979), *aff'd* 649 F.2d 860 (3d Cir. 1981)).

314. *Id.* (quoting *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 762 (3d Cir. 1979)).

315. Parts, *supra* note 109, at 231–32. The language in *Estelle* quoted by Parts as providing this extrinsic standard is that "the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care." *Estelle*, 429 U.S. at 104–05.

316. Parts, *supra* note 109, at 232–33.

317. *Id.* at 234–36.

318. *Id.* at 237.

claims that it is a “relatively uncontroversial proposition” that the Eighth Amendment would require such a vaccine, and “[t]he fact that a prophylactic device is stuck into the arm rather than worn on the penis is not a difference of constitutional significance.”³¹⁹

Regarding the potential objection that the Eighth Amendment does not require preventative medical care, Parts points out that most medical treatment administered is preventative by nature.³²⁰ For example, painkillers are administered in advance, tumors are removed before they consume the body, and vaccinations are administered to prevent disease.³²¹ Additionally, Parts cites several cases indicating that the Eighth Amendment requires corrections officials to protect inmates from contracting communicable diseases from other inmates.³²² This line of cases suggests that *Estelle* includes preventative medical care in its requirement of adequate medical care for prisoners.

The next objection Parts diffuses is that constitutional protections do not apply to voluntarily encountered risks of disease.³²³ Parts points to cases which held that corrections officials must treat prisoners who have harmed themselves and to cases which held that corrections officials have a duty to take reasonable measures to prevent inmates from committing suicide.³²⁴ Parts then gives a number of hypothetical situations where “it is inconceivable that courts would deny care for prisoners in the following situations: a smoking prisoner with lung cancer, an alcoholic prisoner with cirrhosis, an addicted prisoner with hepatitis caused by a contaminated needle, a sexually active prisoner with syphilis contracted in prison, or a prisoner injured in an escape attempt.”³²⁵ Since courts would not deny inmates treatment in those instances, Parts argues neither should they deny care to those prisoners at risk of contracting HIV. After all, prevention is the

319. *Id.* at 237–38.

320. Parts, *supra* note 109, at 238–39.

321. *Id.*

322. *Id.* at 239 (citing *Lareau v. Manson*, 651 F.2d at 109 (1981); *Smith v. Sullivan*, 553 F.2d 373, 380 (1977); *DeGidio v. Perpich*, 612 F. Supp. 1383, 1389–90 (1985)).

323. *See id.* at 242–45.

324. *Id.*

325. *Id.* at 243.

only form of medical care which averts the risk of exposure to HIV. Parts also argues that some risk behavior in prison may not be strictly voluntary, as some behaviors, such as the injection of drugs and sexual intercourse, may be labeled compulsive.³²⁶

The final potential objection that Parts addresses is that constitutional protections, providing preventative means, undermine the state interest in regulating high-risk activities.³²⁷ Parts responds to this argument by quoting Justice John Paul Stevens' dissent in *Estelle*, that "denial of medical care is surely not part of the punishment which civilized nations may impose for crime."³²⁸ Parts maintains that the distribution of prophylactics does not prevent prison officials from prohibiting homosexual activity or drug use.³²⁹ He also comments that preventive measures are necessary because prison administrations have failed to stop high-risk behavior from occurring in prisons and it seems "very tenuous to base a state interest on the continued use of a failing policy."³³⁰

In short, Parts presents a very compelling argument that the Eighth Amendment's requirement of adequate medical care requires the distribution of prophylactic devices to protect prisoners from the transmission of HIV. Parts' conclusion is furthered by a separate argument that evolving standards of decency command that which is only bolstered by the Court's tendency to expand the rights of citizens in keeping with changes in our society.

D. Evolving Standards of Decency Require the Distribution of Prophylactic Devices to Prevent the Transmission of HIV in Prison

In 1958, Chief Justice Warren wrote "[t]he Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."³³¹ Although he was writing specifically about the Eighth Amendment, the Court had already embraced this ideology when it expanded the equal protection clause of the Fourteenth Amendment in

326. *Id.* at 244–45.

327. *See id.* at 236–39.

328. *Id.* at 246–47 (quoting *Estelle v. Gamble*, 429 U.S. 97, 116 n.13 (1976) (Stevens, J., dissenting)).

329. *Id.* at 248.

330. *Id.* at 249.

331. *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

Brown v. Board of Education.³³² In *Brown*, the Court applied “the evolving standards of decency that marked the progress of our maturing society,” and struck down the “separate but equal” doctrine that was established in *Plessy v. Ferguson*.³³³

Similarly, “the evolving standards of decency that mark the progress of our maturing society” caused the Court to establish a right of privacy for married couples in 1965, when in *Griswold v. Connecticut* the court struck down a law prohibiting the sale of contraceptive devices to married couples.³³⁴ The right of privacy was continually expanded by the court until most recently, in 2003, the court in *Lawrence v. Texas* extended the right of privacy to homosexual couples, allowing them to enjoy sexual relationships without governmental interference.³³⁵ In these examples, the evolving standards of decency that marked the progress of our maturing society have required the Court to overturn previous decisions and expand the protections offered by different amendments. In both examples, the Court’s decisions were unpopular with a segment of society.

As our society continues to mature and our standards of decency evolve, the Supreme Court will continue to increase the protections offered to marginalized populations. Protections offered to prison inmates, by far the most marginalized of all populations, will also continue to increase.

The Supreme Court laid a foundation in terms of the expanding the protections of prisoners in *Farmer v. Brennan*.³³⁶ A factfinder can now draw an inference that corrections officers knew about an inhumane prison condition if that condition was obvious.³³⁷ Prison officials work among inmates with HIV and inmates who frequently engage in different types of high-risk behavior. If the risk of infection is not sufficiently obvious from the circumstances in the prison, statistical data about the prevalence of HIV

332. See *Brown v. Board of Ed.*, 347 U.S. 483 (1954).

333. See *id.* (invalidating underlying doctrine of *Plessy v. Ferguson*, 163 U.S. 537 (1896)).

334. See *Griswold v. Connecticut*, 381 U.S. 479 (1965).

335. In *Lawrence v. Texas*, 539 U.S. 558 (2003), the United States Supreme Court overturned *Bowers v. Hardwick*, 478 U.S. 186 (1986), which held that the constitutional right of privacy did not protect consensual homosexual acts.

336. *Farmer v. Brennan*, 511 U.S. 825 (1994).

337. *Id.*

infections and sociological research about the pervasiveness of risky behavior in prisons is readily accessible. For example, the U.S. Department of Justice reports that 7.6% of state prisoners in New York are HIV-positive, as are 4.2% of state prisoners in Maryland and 3.9% in Florida.³³⁸ Additionally, sociological studies have revealed that up to 65% of inmates engage in sexual intercourse³³⁹ and 58% of inmates have injected drugs while in prison.³⁴⁰ Our evolving standards of decency cannot allow corrections officials to ignore such information. Likewise, when corrections officials are confronted with such information, our standards of decency ought not allow them to refuse to provide life saving measures to those in their custody and care. To do so would allow corrections officials to show deliberate indifference to prisoners' serious medical needs and safety, in violation of the Eighth Amendment.

E. Post Farmer Decisions

Since *Farmer*, inmates have greater success in their claims that injuries from prison rape were caused by the deliberate indifference of corrections officials.³⁴¹ However, some courts remain reluctant to abide by *Farmer's* ruling that corrections officials' knowledge of prison conditions may be inferred from the fact that such conditions are obvious. The case of *Bolton v. Goord*³⁴² involved an Eighth Amendment claim based upon a prison's policy

338. Maruschak, *Hiv In Prisons*, 2003, *supra* note 1, at 2

339. Christopher P. Krebs, *High Risk HIV Transmission Behavior in Prison and the Prison Subculture*, 82 *Prison J.* 19, 20 (2002) (citing Wayne S. Wooden & Jay Parker, *Men Behind Bars: Sexual Exploitation in Prison* (Da Capo Press 1982)).

340. Wayne Gillespie, *A Multilevel Model of Drug Abuse Inside Prison*, 85 *Prison J.* 223, 225 (2005) (citing Carl G. Leukefeld & Frank R. Tims, *Drug Abuse Treatment in Prisons and Jails*, 10 *J. Substance Abuse Treatment* 77 (1993)).

341. *See, e.g.*, *James v. Tilghman*, 194 F.R.D. 408, 419 (D. Conn. 1999) (denying post-trial motions on grounds that a jury found fault with defendants' continued placement of a sexual assailant in a cellblock with new inmates, despite strong suggestion of the assailant's sexual tendencies); *Spruce v. Sargent*, 149 F.3d 783, 786 (8th Cir. 1998) (upholding the liability of a defendant warden who testified that "inmates had to 'fight' against sexual aggressors"); *Skinner v. Uphoff*, 234 F. Supp. 2d 1208, 1214–16 (D. Wyo. 2002) (holding defendants liable where an Eighth Amendment "failure to protect" case arose out of conditions at a prison where inmate-on-inmate assaults were common but never addressed by prison officials).

342. *Bolton v. Goord*, 992 F. Supp. 604 (S.D.N.Y. 1998).

of double celling, and its potential to expose inmates to a serious, contagious, and infectious disease, such as tuberculosis or HIV. The district court acknowledged that a prisoner could state an Eighth Amendment claim for confinement in the same cell as an inmate with a serious contagious disease that is spread by airborne particles, such as tuberculosis, but rejected the inmate's claim because he could not establish the deliberate indifference of corrections officials regarding the spread of infectious disease.³⁴³ On the contrary, the evidence showed that the prison administration was attentive to the risk of exposure to tuberculosis and HIV, and carefully considered the health of each inmate before double celling.³⁴⁴ Inmates with active tuberculosis were not housed in cells with other inmates, and inmates with HIV were deliberately double celled, based on two rationales. First was the premise that there was no evidence of the transmission of HIV through double celling. Second was the theory that automatic exclusion of HIV infected inmates would lead to a false sense of security, and in turn give rise to more high-risk activity among inmates.³⁴⁵ Additionally, inmates were educated on how to protect themselves from the spread of HIV.³⁴⁶

In *Bolton*, there was no allegation of a dangerous prison condition beyond the mere presence of a cellmate with HIV. However, in *Sosa v. Cleaver*,³⁴⁷ inmate Andres Sosa claimed that prison officials violated his Eighth Amendment rights by double celling him with an HIV-positive inmate. Sosa alleged that he told corrections officials that he was afraid to be in the same cell with an HIV-positive inmate and that he and the cellmate had had problems in the past.³⁴⁸ The court denied Sosa's claim, ignoring the ruling of *Farmer*, and stated that the plaintiff could not establish the deliberate indifference of prison officials absent an allegation that the cellmate threatened to infect him or made recent specific threats of violence, and corrections officers had notice of such threats.³⁴⁹ The court cited *Goss v.*

343. *Id.* at 626–27.

344. *Id.* at 614–615, 628.

345. *Id.* at 628–29.

346. *Id.* at 629.

347. *Sosa v. D.H.O. Cleaver*, No. 3:03CV1707DJSTPS, 2005 WL 1205119 (D. Conn. 2005).

348. *Id.*

349. *Id.*

Sullivan,³⁵⁰ a pre-*Farmer* decision, which held that complaints alleging only a generalized fear of contracting AIDS from an allegedly aggressive HIV-positive inmate, and containing conclusory allegations that prison officials were aware of such intentions but did nothing to intervene, were insufficient to demonstrate the culpable state of mind as required under the Eighth Amendment. The court's unwillingness to draw an inference of knowledge in this case, as permitted by *Farmer*, is perplexing.

Fortunately, the ruling of *Farmer* has been embraced by Congress. Nine years after the decision, the 108th Congress passed the Prison Rape Elimination Act of 2003 (PREA).³⁵¹ Under PREA, a cause of action may be brought by victims of prison rape.³⁵² The PREA mandates training and education programs for corrections officials,³⁵³ as well as grant money to state prison systems in order to further assist in their protection of inmates.³⁵⁴ Additionally, the PREA requires the U.S. Department of Justice to collect and analyze data about sexual assaults in federal, state, and local correctional facilities, and established the National Prison Rape Elimination Commission to study the data, evaluate the responses of prison officials, and make recommendations for national standards of prison safety.³⁵⁵ Taking these recommendations into consideration, the Attorney General is to issue "national standards for the detection, prevention, reduction, and punishment of prison rape."³⁵⁶

350. *Id.* (citing *Goss v. Sullivan*, 839 F. Supp. 1532, 1537 (D. Wyo. 1993)).

351. Prison Rape Elimination Act of 2003, Pub. L. No. 108-79, 117 Stat. 972 (2003) (codified at 42 U.S.C. §§ 15601-09).

352. See David K. Ries, *Duty-to-Protect Claims by Inmates After the Prison Rape Elimination Act*, 13 J.L. & Pol'y 915, 918 (2005).

The high incidence of sexual assault within prisons involves actual and potential violations of the United States Constitution. In *Farmer v. Brennan*, the Supreme Court ruled that deliberate indifference to the substantial risk of sexual assault violates prisoners' rights under the Cruel and Unusual Punishment Clause of the Eighth Amendment. *Id.* at 918, n.21 (citing 42 U.S.C. § 15601(13) (2005)).

353. See 42 U.S.C. § 15604(a)(2).

354. See *id.* § 15605.

355. See *id.* § 15606.

356. See *id.* § 15607.

F. Inadequate Medical Care

The failure of the corrections administration to provide adequate medical care has been the basis of numerous claims, as well as a topic of interest in the media. Typical claims based upon inadequate medical care allege failure to test or diagnose HIV,³⁵⁷ failure to disclose HIV-positive status to an inmate,³⁵⁸ the misdiagnosis of HIV,³⁵⁹ the failure to provide medication,³⁶⁰ and the inadequate services of prison physicians.³⁶¹ Other claims have been brought for the failure to provide nutritional supplements³⁶² and appropriate equipment.³⁶³ In evaluating these claims, the courts have used the deliberate indifference standard set forth in *Estelle v. Gamble*.³⁶⁴ In *Maynard v. New Jersey*,³⁶⁵ the estate of a deceased inmate sued the New Jersey Department of Corrections on the ground that prison officials failed to diagnose or treat the decedent's AIDS. The decedent was in the defendant's care for five months, during which he suffered from numerous symptoms of AIDS. When the decedent collapsed, the defendant doctor and nurse did not diagnose the cause, but instead gave him throat lozenges. Eleven days later, he died of AIDS-related causes. The United States District Court for the

357. See *Maynard v. New Jersey*, 719 F. Supp. 292 (D.N.J. 1989).

358. See *McIlwain v. Prince William Hosp.*, 774 F. Supp. 986 (E.D. Va. 1991).

359. See *McDuffie v. Rikers Island Med. Dep't*, 668 F. Supp. 328 (S.D.N.Y. 1987); *Bailey v. Aida Unit-San Quentin State Prison*, No. C 95-0071-CAL, 1995 WL 274370 (N.D. Cal. May 3, 1995).

360. See *Rivera v. Sheahan*, No. 97 C 2735, 1998 WL 53187 (N.D. Ill. Aug. 14, 1998).

361. See *Macomber v. Davis*, No. CIV. A. 92-6112, 1993 WL 79593 (E.D. Pa. Mar. 22, 1993).

362. See *Polanco v. Dworzack*, 25 F. Supp. 2d 148 (W.D.N.Y. 1998); *Holmes v. Emerson*, No. C99-5206 CRBPR, 1999 WL 1285411 (N.D. Cal. Dec. 23, 1999).

363. See *Hallett v. N.Y. State Dep't of Corr. Servs.*, 109 F. Supp. 2d 190 (S.D.N.Y. 2000).

364. *Estelle v. Gamble*, 429 U.S. 97 (1976).

365. *Maynard v. New Jersey*, 719 F. Supp. 292 (D.N.J. 1989).

District of New Jersey held that the alleged pattern of repeatedly refusing to provide medical treatment for the decedent's AIDS symptoms, together with the alleged refusal to treat the decedent after his collapse, if proven, amounted to a pattern of deliberate indifference.³⁶⁶

In *McIlwain v. Prince William Hospital*,³⁶⁷ the plaintiff prisoner was tested for HIV during a stay at a local hospital. Although hospital personnel notified prison medical staff of the inmate's HIV-positive status, the prison staff neither notified nor treated the inmate. Upon release, the inmate allegedly infected his wife with the virus. Although it was not determined whether the prison doctor named in the lawsuit was actually aware of the inmate's HIV-positive status, the court held that "the knowing failure to inform a prison patient that he has been exposed to the AIDS virus constitutes deliberate indifference to serious medical needs of prisoners."³⁶⁸

In *McDuffie v. Rikers Island Medical Department*,³⁶⁹ the plaintiff prisoner was diagnosed with Kaposi's sarcoma after two skin biopsies. The diagnosis was followed by a letter to Riker's Island Medical Department that the plaintiff was suffering from AIDS. As a result of this letter, the plaintiff was placed in segregated housing for five months, until a second letter was sent, which corrected the misdiagnosis and explained that the defendant did not have AIDS. The United States District Court for the Southern District of New York held that the misdiagnosis of the plaintiff did not constitute deliberate indifference to his serious medical needs, especially in light of the lack of medical knowledge about AIDS in 1982 and that a test for the AIDS virus was not discovered until 1985.³⁷⁰ Similarly, in *Bailey v. Aida Unit—San Quentin State Prison*,³⁷¹ the District Court for the Northern District of California held that a false positive test result for HIV that resulted in the notification of an inmate that he was HIV-positive and his or her subsequent placement in segregated housing for seven months did not constitute deliberate indifference to the prisoner's serious medical needs.

366. *Id.* at 295.

367. *McIlwain v. Prince William Hosp.*, 774 F. Supp. 986 (E.D. Va. 1991).

368. *Id.* at 991.

369. *McDuffie v. Rikers Island Med. Dep't.*, 668 F. Supp. 328 (S.D.N.Y. 1987).

370. *Id.* at 330.

371. *Bailey v. Aida Unit—San Quentin State Prison*, No. C 95-0071-CAL, 1995 WL 274370 (N.D. Cal. May 3, 1995).

In *Rivera v. Sheahan*,³⁷² the plaintiff prisoner notified corrections officials at the time she was taken into custody that she suffered from AIDS and needed daily medication. The plaintiff received no treatment for her condition, even after she started to exhibit symptoms of AIDS. It was not until she was found comatose in her cell that she was treated for her medical condition and rushed to a hospital. The District Court for the Northern District of Illinois found that the allegations in the complaint, if true, were almost criminal, and that the complaint alleging defendant's failure to treat the prisoner's AIDS established deliberate indifference to her serious medical needs.³⁷³

In *Macomber v. Davis*,³⁷⁴ the plaintiff prisoner claimed in his allegations that the treatment he received for AIDS was inadequate and improper. In denying the defendant's motion for dismissal, the District Court for the Eastern District of Pennsylvania held that the following circumstances could constitute deliberate indifference to a prisoners serious medical needs: 1) a prison doctor's refusal to treat an inmate until hospitalization is required, allowing AIDS to progress to the point that the inmate is in danger of dying from what would otherwise be a treatable infection, 2) a prison doctor's refusal to treat more than one of an inmate's medical problems at a time, unless due to an exercise of medical judgment, and 3) a prison doctor's refusal to provide an inmate with pain medication that would allow plaintiff to take his prescribed AZT.

In *Polanco v. Dworzack*,³⁷⁵ the plaintiff prisoner alleged that the defendant prison staff's refusal to provide him with the name brand nutritional supplement that he demanded showed deliberate indifference to his serious medical needs. The District Court for the Western District of New York held that the failure of prison personnel to provide the dietary supplement ENSURE to the plaintiff did not constitute deliberate indifference to his serious medical needs, as the defendant's weight was stable, the prison doctor did not believe it was necessary, and the plaintiff did receive a daily snack in response to his request. Similarly, in *Holmes v. Emerson*,³⁷⁶ the court dismissed the plaintiff prisoner's complaint that the

372. *Rivera v. Sheahan*, No. 97 C 2735, 1998 WL 53187 (N.D. Ill. Aug. 14, 1998).

373. *Id.* at *6.

374. *Macomber v. Davis*, No. CIV. A. 92-6112, 1993 WL 79593 (E.D. Pa. Mar. 22, 1993).

375. *Polanco v. Dworzack*, 25 F. Supp. 2d 148 (W.D.N.Y. 1998).

376. *Holmes v. Emerson*, No. C99-5206 CRBPR, 1999 WL 1285411 (N.D. Cal. Dec. 23, 1999).

prison staff's failure to provide him with a nutritional supplement showed deliberate indifference to his serious medical needs.

In *Hallett v. New York State Dept. of Correctional Services*,³⁷⁷ the plaintiff prisoner's claim was based upon the confiscation of his personal wheelchair by prison personnel and its replacement with a wheelchair that could only be entered and exited by plaintiff with great difficulty. The prison wheelchair caused the plaintiff back pain and a fall, which resulted in a head injury. The District Court for the Southern District of New York denied the defendant's motion to dismiss this claim, holding that the plaintiff may have a claim under the Eighth Amendment.

VI. CONCLUSION

Significant reforms must be made in the way the United States approaches the prevention of HIV in prison. The judiciary, legislature, and corrections officials must all agree that minimizing the transmission of this deadly virus in prison is paramount, as 96% of all inmates are released, and a reduction of HIV transmission in prisons would probably bring about a reduction of HIV transmission throughout society at large.

While implementing universal precautions for both staff and inmates, prison systems should integrate their HIV-positive populations, as segregation is unnecessary and may compromise the rights of HIV-positive inmates. As suggestions and recommendations of the federal government have been remarkably ineffective, minimum standards in terms of HIV-related education for prisoners and the distribution of harm reduction devices at all correctional facilities should be mandated. All prisoners should be screened as a prevention measure. Those who are HIV positive must be counseled as to risky behavior, methods of prevention, partner notification, and applicable criminal penalties for exposing others to the disease. Those who are HIV negative must also be educated at an appropriate level about risky behaviors and how to avoid exposure to the virus.

The federal government and prison administrations must abandon their abstract, if not artificial, concerns that the distribution of prevention devices such as condoms and sterile needles may be interpreted as the condonation of prohibited risky behavior. Numerous judiciaries, the Department of Justice, and Congress have acknowledged the high incidence of risky behavior that, while prohibited, nonetheless occur with great frequency in prisons. Efforts by the prison administrations to stop this behavior have been to no avail. The legislative and executive branches have not responded appropriately, and even so, the courts have been reluctant to compel prison

377. *Hallett v. N.Y. State Dep't of Corr. Servs.*, 109 F. Supp. 2d 190 (S.D.N.Y. 2000).

administrations to implement new policies for harm reduction. Rather, the courts have allowed prison administrations to impose their ignorance, fear, and “morality” on a marginalized group of human beings given to their custody and care, denying them protection from a deadly virus. Many prisoners, who relied on the prison administration to protect them from harm, now bear the additional burden of being HIV-positive.

The thirty-year-old premise that “courts are ill-equipped to deal with the increasingly urgent problems of prison administration and reform” has no place in the age of the HIV/AIDS pandemic. The premise must be rejected. Courts must interpret the Eighth Amendment to require the distribution of prophylactic devices to inmates to prevent the transmission of HIV. Such distribution is necessary to protect the health and safety of the inmates, and is also regarded by the medical community as a necessary preventative measure. To deny prisoners access to these simple, life saving tools is to be deliberately indifferent to their safety and health. This violates the modern interpretation of the Eighth Amendment.