

## SEX, DRUGS, & HIV: MASS INCARCERATION'S HIDDEN PROBLEM

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### Abstract:

The United States' corrections system represents a significant source of HIV/AIDS risk that disproportionately impacts populations of color, as these populations experience disproportionately high rates of incarceration in the U.S. This Essay looks to the escalation of mass incarceration as a root cause for the dramatic and chilling rise in HIV/AIDS in the African American community. It emphasizes that AIDS is the leading cause of death among African American women between the ages of twenty-five and thirty-four, scrutinizes the link between incarceration and HIV prevalence among African Americans, and ultimately argues that mass incarceration is a vital transmission link to civilian contraction of HIV in African American communities. This Essay is the first of two by the Authors that address this problem.

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**CASE STUDY 1.**

Mrs. Davis is thankful for each new day and what she describes as small victories, such as being able to care for herself and enjoying the company of her two young adult children. An African American woman in her forties, Mrs. Davis lives with Human Immunodeficiency Virus (“HIV”). For the past five years, Mrs. Davis wakes up every morning, surviving against a disease that claims numerous women matching her demographic profile<sup>1</sup> and which took her husband’s life. She lives alone now.

Not unlike many other African American women caught in the quagmires of mass incarceration and the war on drugs,<sup>2</sup> Mrs. Davis reared her daughters as a single parent. In the wake of her husband’s arrest and fifteen-year imprisonment for drug offences more than two decades ago, she became one of thousands of African American

<sup>1</sup> See *HIV/AIDS, BLACK WOMEN’S HEALTH IMPERATIVE*, <http://www.bwhi.org/issues-and-resources/black-women-and-hiv-aids> (last visited Apr. 6, 2016).

<sup>2</sup> See Bernida Reagan, *The War on Drugs: A War Against Women*, 6 *BERKELEY WOMEN’S L.J.* 203, 203 n.1 (2013) (“The ‘War on Drugs’ refers to federal, state, and local government policies that are designed to eradicate drug use in affected communities. This ‘war’ has targeted the activities of inner-city youth and small-time drug dealers who are highly visible[,] but generally not responsible for importing the massive quantities of drugs that devastate low-income communities.”).

women confronting a similar social and economic pain.<sup>3</sup> When asked, Mrs. Davis reports that she is most proud of her two daughters, who have grown to be mature, educated, thoughtful, and caring young women. She tears up as she thinks, “I had a hand in that.”

When her husband was released from prison seven years ago, Mrs. Davis did not hesitate to take him back into her home; he was the only man she had ever loved and she believed he felt the same way about her. Within eighteen months of his return, he was dying of Acquired Immune Deficiency Syndrome (“AIDS”), and she received the devastating news that she was infected with HIV. Prior to her husband’s return, Mrs. Davis maintained a healthy lifestyle, including receiving annual check-ups from her primary care provider at a local community health center. Now, she receives antiretroviral medications with the assistance of a local advocacy group focused on providing HIV knowledge, screening, and facilitating medication adherence as a means of improving the survival rate among communities of color overwhelmed by the loss of its mothers and fathers.

While most days are good and she maintains high spirits, Mrs. Davis occasionally admits to struggling with questions such as “Why me? What did I do wrong?” She remains uncertain about what she would have done differently. She cannot imagine rejecting her husband—the father of her children—after his long awaited release from prison. She ached and longed for him too. What may be more certain, however, is that her infection might have been prevented had Mr. Davis been screened for HIV while incarcerated. Pre-release HIV screening and a diagnosis of infection would have linked him to mechanisms for treatment and provided Mrs. Davis with the opportunity to make more informed decisions about intimate contact with her first and only partner.

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<sup>3</sup> See BLACK WOMEN’S HEALTH IMPERATIVE, *supra* note 1.

## CASE STUDY 2.<sup>4</sup>

Jane Doe, aged fourteen, and her cousin Baby X, a toddler, have both been diagnosed with HIV, chlamydia, and herpes. D.W., their thirty-four year old relative, served six years in prison for sexual assault against minors. Upon D.W.'s release, he returned to the woman in his life, Jane Doe's mother. According to Jane Doe, D.W. "would often park on a cul-de-sac near her school and have sex [with her] in his car. The last time, they had unprotected sex."<sup>5</sup>

Doe's subsequent pregnancy and routine testing alerted health officials to her HIV status, the contraction of other sexually transmitted diseases, and the sexual assault of two minors by D.W. The unusual genital irritations on the toddler served as a horrifying clue to the sexual abuse that D.W. perpetrated against her. The toddler's HIV diagnosis was later confirmed by health officials. Given the severity of the toddler's injuries, she will require reconstructive surgery. Sadly for Jane Doe, her HIV status places her among an expanding statistical cohort, as the rate of HIV infection among Black youths dramatically outpaces that of their white counterparts and all other ethnic communities.<sup>6</sup> According to the Centers for Disease Control and Prevention, "African American youth are particularly affected" by HIV and AIDs.<sup>7</sup> The organization cites that of the approximately 21,000 new cases of HIV infection each year among African Americans, 34% are among young people between the ages of thirteen and twenty-four.<sup>8</sup> Furthermore, the rate of new HIV infection among Black female

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<sup>4</sup> The following case study was adapted from an article by Kalhan Rosenblatt, written for the Daily Mail, titled *Man, 34, Goes to Prison for Life After Infecting a 14-year-old Girl and a Toddler with HIV, Chlamydia and Herpes*. Kalhan Rosenblatt, *Man, 34, Goes To Prison For Life After Infecting a 14-Year-Old Girl and a Toddler with HIV, Chlamydia and Herpes*, DAILY MAIL (Mar. 18, 2016), <http://www.dailymail.co.uk/news/article-3498799/Man-34-goes-prison-life-infecting-14-year-old-girl-toddler-HIV-chlamydia-herpes.html>.

<sup>5</sup> *Id.*

<sup>6</sup> See CTRS. FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: HIV AMONG AFRICAN AMERICAN YOUTH 1 (Feb. 2014) [hereinafter HIV AMONG AFRICAN AMERICAN YOUTH], <http://www.cdc.gov/nchstp/newsroom/docs/factsheets/archive/cdc-youth-aas-508.pdf>.

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

teens is more than six times that of their young Hispanic counterparts and more than twenty times that of their young white counterparts.<sup>9</sup>

Despite the fact that D.W. will return to prison, never to be released, the girls too receive a life sentence, imposed by the diseases D.W. leaves behind. Although living with HIV no longer translates to a death sentence,<sup>10</sup> the chronic agony of the virus will forever remain with these girls. Interestingly, D.W. claims no remorse for the sexual abuse of Jane Doe, but explained to the judge that he is “sorry the HIV came into the situation.”<sup>11</sup> Did D.W. realize his HIV status? Had he ever been tested for HIV? Had he been tested in prison, might Jane Doe’s mother have been alerted?

## INTRODUCTION

Acquired Immune Deficiency Syndrome (“AIDS”) claims 25.3 million lives worldwide, and more than 36 million individuals currently live with Human Immunodeficiency Virus (“HIV”), the virus that causes AIDS and AIDS-related disease.<sup>12</sup> In the U.S., more than one million people live with HIV and more than half a million deaths have resulted from AIDS since the beginning of the epidemic, now three decades ago.<sup>13</sup> Despite its initial branding in the U.S. as a gay, white male disease,<sup>14</sup> the face of HIV/AIDS no longer reflects that

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<sup>9</sup> *Id.*

<sup>10</sup> See, e.g., Sandra Young, *HIV No Longer Considered Death Sentence*, CNN (Dec. 1, 2013), <http://www.cnn.com/2013/12/01/health/hiv-today/>.

<sup>11</sup> Rosenblatt, *supra* note 4.

<sup>12</sup> *Global HIV and AIDS Statistics*, AVERT (Oct. 2, 2015), <http://www.avert.org/professionals/hiv-around-world/global-statistics>.

<sup>13</sup> *HIV and AIDS in the United States of America (USA)*, AVERT (Oct. 2, 2015), <http://www.avert.org/professionals/hiv-around-world/western-central-europe-north-america/usa>. In the United States, HIV statistics are reported only for the forty states and five dependent areas for which confidential name-based reporting is available. AIDS statistics include all fifty states, the District of Columbia, and five U.S. dependent areas. U.S. figures for HIV/AIDS infection are likely an underestimate due to three factors: (1) confidential HIV testing is not available in all fifty states; (2) anonymous tests are not included in case reports; and (3) approximately 1 in 7 people living with HIV have not had their infection diagnosed. *Id.*

<sup>14</sup> See generally HEALTH RES. & SERVS. ADMIN., *GAY MEN AND THE HISTORY OF THE RYAN WHITE HIV/AIDS PROGRAM*, <http://hab.hrsa.gov/livinghistory/issues/Gay-Men.pdf> (last visited July 6, 2016) (describing the sudden emergence of HIV/AIDS in the U.S., and the fear, stigma,

demographic. The hues of HIV have changed dramatically since the disease was first described by the Centers for Disease Control and Prevention ("CDC") as an opportunistic infection, *Pneumocystis carinii* pneumonia, afflicting five males in Los Angeles in 1981.<sup>15</sup> Back then, vulnerable and sickly gay, white men shaped the political and social images of AIDS in the U.S.<sup>16</sup> Thirty-five years later, African American women,<sup>17</sup> making up just 12% of the total female population, now account for almost two-thirds of all new HIV infections among women.<sup>18</sup>

HIV is the leading cause of death for African American women ages twenty-five to thirty-four, and the third leading cause of death for African American women ages thirty-five to forty-four.<sup>19</sup> And as previously mentioned, the rate of new infections among young African American women is twenty times higher than that of their white female counterparts.<sup>20</sup> Research from the Black Women's Health Imperative further underscores the urgency of this crisis: "Every 35 minutes, a woman tests positive for HIV in this country."<sup>21</sup> The organization further explains that "the impact of HIV among Black women and girls is even more startling[,] . . . [as, n]ationally, [they] account for 66% of new cases of HIV among women."<sup>22</sup> The majority of these young women "are infected through heterosexual contact."<sup>23</sup>

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and misunderstanding surrounding its apparent penchant for homosexual males).

<sup>15</sup> *First Report of AIDS*, 50 MORBIDITY & MORTALITY WKLY. REP. 429, 429 (2001).

<sup>16</sup> See HEALTH RES. & SERVS. ADMIN., *supra* note 14.

<sup>17</sup> This Essay uses the terms "African American" and "Black" interchangeably to address the population of individuals born from African descent, living in the United States. In addition, the terms "white" and "Caucasian" are also used interchangeably.

<sup>18</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: NEW HIV INFECTIONS IN THE UNITED STATES 3 (Feb. 2016) [hereinafter NEW INFECTIONS FACT SHEET], <http://www.cdc.gov/nchhstp/newsroom/docs/factsheets/new-hiv-infections-508.pdf>.

<sup>19</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, CDC HIV/AIDS FACT SHEET: HIV/AIDS AMONG WOMEN 1 (Aug. 2008) [hereinafter HIV/AIDS AMONG WOMEN], <http://www.cdc.gov/hiv/resources/factsheets/pdf/women.pdf>.

<sup>20</sup> See HIV AMONG AFRICAN AMERICAN YOUTH, *supra* note 6, at 2.

<sup>21</sup> See BLACK WOMEN'S HEALTH IMPERATIVE, *supra* note 1.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

Quite literally, African American women represent a changing face for the HIV/AIDS epidemic in the U.S., one where infection results from contact with their African American male partners, who are also often unknowingly infected with HIV.<sup>24</sup> But what accounts for the failure to test? What accounts for the disproportionately high rates of HIV transmission? One significant, but critically overlooked aspect of the rise of HIV infection in this country is the U.S. criminal justice system, and its role in facilitating the dramatic increase in mass incarceration.<sup>25</sup> Groundbreaking research, recently published in *The Lancet* further confirms our concerns.<sup>26</sup>

In addition, notwithstanding advances in HIV treatment, which extend life and improve health for HIV infected persons, and the fact that the disease is now considered chronic and controllable, “a recent study . . . suggests that the introduction of antiretroviral therapy has also increased inequalities in AIDS-related mortality.”<sup>27</sup> In fact, the researchers “found that the association between SES [Socioeconomic Status] and AIDS-related mortality increased with the introduction of effective treatment, as persons at the higher end of SES have increasingly positive health outcomes.”<sup>28</sup>

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<sup>24</sup> See *HIV Among African Americans*, CTNS. FOR DISEASE CONTROL & PREVENTION (Feb. 4, 2016), <http://www.cdc.gov/hiv/group/raciaethnic/africanamericans/>.

<sup>25</sup> See Frank O. Bowman, III, *The Failure of the Federal Sentencing Guidelines: A Structural Analysis*, 105 COLUM. L. REV. 1315, 1328–32 (2005); Lateshia Beachum, *Prisons Around the World are Reservoirs of Infectious Disease*, WASH. POST (July 20, 2016), <https://www.washingtonpost.com/news/to-your-health/wp/2016/07/20/prisons-around-the-world-are-reservoirs-of-infectious-disease/>; Pamela Das & Richard Horton, *On Both Sides of the Prison Walls – Prisoners and HIV*, LANCET ONLINE FIRST (July 14, 2016), [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)30892-3.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30892-3.pdf).

<sup>26</sup> Rita Rubin, *US Prisons Missing Opportunities to Tackle HIV in Inmates*, LANCET ONLINE FIRST (July 14, 2016), [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)31078-9.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31078-9.pdf) (“[US inmates] are at least three times more likely to have HIV/AIDS than the general US population. . . . If HIV-positive inmates aren’t diagnosed and treated while incarcerated and then linked to care in the community, chances are that their viral load will increase and they will resume risky behaviours once released, endangering not only their health but the health of people in their communities[.]”).

<sup>27</sup> Jennifer A. Pellowski et al., *A Pandemic of the Poor: Social Disadvantage and the U.S. HIV Epidemic*, 68 AM. PSYCHOLOGIST 197, 205 (2013).

<sup>28</sup> *Id.* (citing Marcie S. Rubin et al., *Examination of Inequalities in HIV/AIDS Mortality in the United States from a Fundamental Cause Perspective*, 100 AM. J. PUB. HEALTH 1053 (2010)).

Much can be learned by examining the intersections of mass incarceration and the dramatic rise of HIV/AIDS among African Americans. The rate of U.S. incarceration outpaces that of all other developed nations.<sup>29</sup> According to a report by the Pew Center, one in thirty-one Americans is under criminal supervision in the U.S. – either under direct supervision in prison or jail, or under indirect supervision via probation or parole.<sup>30</sup> And while the U.S. comprises only 5% of the world's population, more than 20% of the globe's prison population is tethered to our criminal justice system, locked behind our concrete walls and wired fences.<sup>31</sup>

Overwhelmingly, the crimes that result in incarceration relate to drug offenses,<sup>32</sup> a reality that impacts women as well as men. The result manifests in a staggering two million Americans processed through U.S. jails and prisons at local, state, and federal facilities in a single year.<sup>33</sup> As Becky Pettit and Bryan Sykes observe, “[m]assive growth in the U.S. prison system since 1970 represents an institutional intervention that may have significant import for American demography and may portend a ‘third demographic transition’ at least among disadvantaged Americans.”<sup>34</sup> In sum, the war on drugs and mandatory sentencing laws result in the disproportionate incarceration of men and women of color, as well as acute and chronic traumas associated with policing, particularly among African Americans.<sup>35</sup>

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<sup>29</sup> *Id.*; see also ROY WALMSLEY, INST. FOR CRIM. POL'Y RESEARCH, WORLD PRISON POPULATION LIST (ELEVENTH EDITION) (Oct. 2015), <http://www.idcr.org.uk/wp-content/uploads/2010/09/WPPL-9-22.pdf>.

<sup>30</sup> See *One in 31: The Long Reach of American Corrections*, PEW CHARITABLE TRUSTS (Mar. 2, 2009), <http://www.pewtrusts.org/en/research-and-analysis/reports/2009/03/02/one-in-31-the-long-reach-of-american-corrections>.

<sup>31</sup> *The Prison Crisis*, ACLU, <https://www.aclu.org/prison-crisis> (last visited July 6, 2016).

<sup>32</sup> ANN E. CARSON, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ247282, BULLETIN: PRISONERS IN 2013, at 15 (Sept. 2014), <http://www.bjs.gov/content/pub/pdf/p13.pdf>.

<sup>33</sup> See Lauren E. Glaze & Danielle Kaeble, *Correctional Populations in the United States, 2013*, BUREAU OF JUSTICE STATISTICS (Feb. 8, 2016), <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5177>.

<sup>34</sup> Becky Pettit & Bryan Sykes, *The Demographic Implications of the Prison Boom: Evidence of a “Third Demographic Transition?”* 4 (unpublished manuscript) (July 2008), [http://faculty.washington.edu/blsykes/Papers/prison\\_demography\\_3.pdf](http://faculty.washington.edu/blsykes/Papers/prison_demography_3.pdf).

<sup>35</sup> See, e.g., Michele Goodwin, *Invisible Women: Mass Incarceration's Forgotten Casualties*, 94 TEX.

For example, while 1 in every 106 adult, white males is incarcerated in the U.S., roughly 1 in 15 adult, Black males fit that profile.<sup>36</sup> Indeed, the rise of policing and its traumatic impacts harm children and teens too. One report shows Black male teens are twenty-one times more likely to be killed by law enforcement than their white counterparts, even though the rate of criminal and anti-social behavior is about the same between those groups.<sup>37</sup> And while criminal law scholars eloquently describe and analyze the conditions that often lead to incarceration – including over-policing, cognitive biases, and abuse of prosecutorial discretion<sup>38</sup> – as well as the abuses that occur in the wake of arrests and sentencing,<sup>39</sup> in-prison health care issues deserve more attention.

Indeed, stark racial disparities permeate mass incarceration in the U.S., creating harsh externalities that pervade not only the lives of the incarcerated, but also their children, families, and communities.<sup>40</sup> This is an inescapable reality. Even Sesame Street now addresses this: a Muppet character of dark complexion, named Alex, struggles to explain to friends that his father cannot join in an activity with other dads.<sup>41</sup> The other Muppets ask, “Alex, maybe we can get our dads to make cars like that with us?”<sup>42</sup> Alex reluctantly responds that his father

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L. REV. 353, 357 (2015).

<sup>36</sup> *Id.*

<sup>37</sup> Nicole Flatow, *Report: Black Male Teens are 21 Times More Likely to be Killed by Cops Than White Ones*, THINK PROGRESS (Oct. 10, 2014), <http://thinkprogress.org/justice/2014/10/10/3578877/black-teens-were-21-times-more-likely-to-be-shot-dead-by-the-cops-reported-deaths-suggest/> (“The 1,217 deadly police shootings from 2010 to 2012 captured in the federal data show that blacks, age 15 to 19, were killed at a rate of 31.17 per million, while just 1.47 per million white males in that age range died at the hands of police.”).

<sup>38</sup> See, e.g., Bowman, *supra* note 25, at 1336–38.

<sup>39</sup> See, e.g., Kate Levine, *How we Prosecute the Police*, 104 GEO. L.J. 745, 746–51.

<sup>40</sup> See text accompanying notes 32–38.

<sup>41</sup> *Sesame Street, Incarceration* (Sesame Workshop), <http://www.sesamestreet.org/toolkits/incarceration/> (“The incarceration of a loved one can be very overwhelming for both children and caregivers. It can bring about big changes and transitions. In simple everyday ways, you can comfort your child and guide her through these tough moments. With your love and support she can get through anything that comes her way. Here are some tools to help you with the changes your child is going through.”).

<sup>42</sup> *Id.*

is somewhere else.<sup>43</sup> Unaware and unknowing, the other Muppet kids push, asking “where is he”?<sup>44</sup> Alex hesitatingly responds, “somewhere else” and walks away.<sup>45</sup> There is much more to Alex’s story. In reality, “67% [of incarcerated parents] were handcuffed in front of their children,” nearly 30% report that “weapons [were] drawn [by law enforcement] in front of their children[,]” and “children who witnessed an arrest of a household member were 57% more likely to have elevated posttraumatic stress symptoms compared to children who did not witness an arrest.”<sup>46</sup>

For many Americans, mass incarceration is an all too familiar institution in their lives. But for African Americans, the toll of mass criminalization and incarceration’s crippling effect devastates nearly every aspect of their neighborhoods, schools, communities, and lives.<sup>47</sup> As the state of Wisconsin recently reported, “[i]n Milwaukee County over half of African American men in their 30s have served time in state prison.”<sup>48</sup> Unsurprisingly, the State’s report concludes “[p]rison time is the most serious barrier to employment, making ex-offender

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<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Children and Families of the Incarcerated Fact Sheet*, NAT’L RES. CTR. ON CHILDREN & FAMILIES OF THE INCARCERATED, <https://nrccfi.camden.rutgers.edu/files/nrccfi-fact-sheet-2014.pdf> (last visited July 6, 2016) (citing Susan D. Phillips & Jian Zhao, *The Relationship Between Arrests and Elevated Symptoms of Posttraumatic Stress: Findings From a National Study of Children Involved in the Child Welfare System*, 32 CHILD. & YOUTH SERVS. REV. 1246, 1249–50 (2010)).

<sup>47</sup> Sadly, for far too many African Americans communities, prison is as familiar, if not more familiar, than school. That is, as an institutional matter, prison is an influence that pervades African American lives. For some African Americans, prison and school merge into a single entity, as evidenced by the euphemistic “school to prison pipeline.” Marilyn Elias, *The School-to-Prison Pipeline*, 43 TEACHING TOLERANCE 39, 39–40 (2013) (“African-American students, for instance, are 3.5 times more likely than their white classmates to be suspended or expelled[, and while] . . . Black children constitute 18 percent of students, . . . they account for 46 percent of those suspended more than once.”); see also *School Discipline – Overview*, SCHOTT FOUND., <http://schottfoundation.org/issues/school-discipline/overview> (last visited July 6, 2016) (“A shocking 83 percent of African American males and 74 percent of Latino males in the study were suspended at least once, and one in seven students in the study was suspended at least 11 times.”).

<sup>48</sup> JOHN PAWASARAT & LOIS M. QUINN, EMP’T & TRAINING INST., UNIV. OF WIS.-MILWAUKEE, WISCONSIN’S MASS INCARCERATION OF AFRICAN AMERICAN MALES: WORKFORCE CHALLENGES FOR 2013, at 1 (2013), <https://www4.uwm.edu/eti/2013/BlackImprisonment.pdf>.

populations the most difficult to place and sustain in full-time employment.”<sup>49</sup> If the formerly incarcerated become shut off from employment, not only will the impact be felt individually, but also as a community.

However, the U.S. not only suffers the world’s highest rate of incarceration, it also boasts another sad distinction: “the highest rate of sexually transmitted diseases (STD’s) compared to other countries.”<sup>50</sup> In a chilling study, Carol Caico reports, “[t]he annual direct health care dollars spent within the health system on STD’s in the United States is 14.7 billion dollars.”<sup>51</sup> Moreover, “sexually transmitted infections (STI’s) continue to be a major public health concern and a significant source of morbidity,” particularly among youth,<sup>52</sup> because almost “3 million United States adolescents acquire an STI every year with almost 62% occurring in individuals under 25.”<sup>53</sup> This population maps at least three important domains: youth in prison,<sup>54</sup> college,<sup>55</sup> and military service.<sup>56</sup> In this Essay, we look solely at the prison population.

The CDC reports that, “[i]n 2010, the rate of diagnosed HIV infection among inmates in state and federal prisons was more than five times greater than the rate among people who were not incarcerated.”<sup>57</sup> Furthermore, “[a]mong jail populations, African

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<sup>49</sup> *Id.* at 14 (“A majority (89%) of full-time job openings in the region (in May 2009) required education and training beyond high school or occupation-specific prior job experience.”).

<sup>50</sup> Carol Caico, *Sexually Risky Behavior in College-Aged Students*, 4 OPEN J. PREVENTIVE MED. 354, 354 (2014), [http://file.scirp.org/pdf/OJPM\\_2014052913555043.pdf](http://file.scirp.org/pdf/OJPM_2014052913555043.pdf).

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> OFF. OF PROGRAM EVALUATION & RESEARCH, N.Y. ST. DEP’T OF HEALTH, ANNOTATED BIBLIOGRAPHY: SEXUAL BEHAVIOR AND STDs AND THE NEED FOR CONDOMS IN PRISONS 16 (Nov. 10), [https://www.health.ny.gov/diseases/aids/providers/corrections/docs/condoms\\_in\\_prisons.pdf](https://www.health.ny.gov/diseases/aids/providers/corrections/docs/condoms_in_prisons.pdf).

<sup>55</sup> Mason Bailey, *CDC Shows Increased Rate of STDs Reported From College-aged Population*, ST. NEWS (Jan. 15, 2016), <http://statenews.com/article/2016/01/increased-std-rates>.

<sup>56</sup> Adam Lidgett, *Sexually Transmitted Diseases in the US Military: Syphilis Cases See 41% Rise Since 2010*, INT’L BUS. TIMES (Oct. 20, 2015), <http://www.ibtimes.com/sexually-transmitted-diseases-us-military-syphilis-cases-see-41-rise-2010-2148735>.

<sup>57</sup> *HIV Among Incarcerated Populations*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 22,

American men are five times as likely as white men, and twice as likely as Hispanic/Latino men, to be diagnosed with HIV."<sup>58</sup> Ultimately, African American men suffer and die from HIV/AIDS at a disproportionately high rate—and so too do African American women.<sup>59</sup> However, much overlooked is the extent to which prison may be a contact point for HIV. And further, whether prevention programs in prisons and jails slow the spread of HIV/AIDS among prison populations generally, and among African Americans specifically.

At the end of 2010, the most recent year for which general population figures are available, the U.S. Department of Justice reported a steep decline in the number of U.S. prison inmates who died from HIV/AIDS.<sup>60</sup> However, as HIV testing is not routinely mandatory in the U.S.,<sup>61</sup> federal data likely underestimates the actual number of men and women infected with HIV in the prisoner and detainee population. Florida, New York, and Texas reported the largest number of prisoners infected with HIV or with confirmed AIDS cases.<sup>62</sup> As of 2008, twenty-four states reported that they test all inmates for HIV: twenty-three on admission, five while in custody, and six upon release.<sup>63</sup>

In this Essay, we focus on HIV infection in African American communities. Our position is that the high rate of HIV infection in such communities, including among African American women, is likely linked to mass incarceration. This Essay offers unique insights and makes an important contribution to public health discourse and health law literature by analyzing the alarming rate of HIV among Black women in the United States<sup>64</sup> in an effort to yield crucial policy

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2015), <http://www.cdc.gov/hiv/group/correctional.html>.

<sup>58</sup> *Id.*

<sup>59</sup> See *HIV Among African Americans*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 4, 2016), <http://www.cdc.gov/hiv/group/raciaethnic/africanamericans/>.

<sup>60</sup> LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, *HIV IN PRISONS, 2007-08*, at 3-5 (Dec. 2007), <http://bjs.ojp.usdoj.gov/content/pub/pdf/hivp08.pdf>.

<sup>61</sup> *See id.*

<sup>62</sup> *Id.*

<sup>63</sup> *Id.* at 5.

<sup>64</sup> See *BLACK WOMEN'S HEALTH IMPERATIVE*, *supra* note 1.

prescriptions that specifically consider compulsory HIV testing in prison. Our second Essay argues that government interest in preventing the devastating spread of HIV justifies mandatory screening with opt-out provisions in prison.<sup>65</sup> We address constitutional concerns in the second essay.

In Part I, we examine modes of HIV exposure in African American communities, turning to women as an overlooked population in HIV discourse. Part II turns to mass incarceration, where we analyze the links between the escalation of the U.S. prison population, recidivism, and HIV occurrence. Lastly, we conclude that exploring the impact of prison on Black lives may yield useful answers regarding the staggering rates of HIV infection in African American communities.

## I. THE BOUNDS OF DIFFERENTIAL RISK AND SUFFERING

Despite stabilizing rates of HIV/AIDS morbidity and mortality in the U.S.,<sup>66</sup> African Americans continue to be negatively impacted by this infection, and its related opportunistic diseases, in a significant way. According to the CDC, African Americans “have the most severe burden of HIV of all racial/ethnic groups” in the U.S.<sup>67</sup> In 2014, 44% of the new HIV diagnoses were among African Americans, despite the fact that they only comprise 12% of the U.S. population.<sup>68</sup> Further, despite declines among other ethnic cohorts between 2005 and 2014, the number of new HIV diagnoses among African American “men who have sex with men” (“MSM”) increased by 22%.<sup>69</sup> Even more dramatic, among gay and bisexual African American male teens and young adults (ages thirteen to twenty-four), the rate of HIV diagnoses increased by 87%.<sup>70</sup>

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<sup>65</sup> Michele Goodwin & Naomi Duke, *Mandatory HIV Testing in Prison is Legal* (forthcoming) (unpublished manuscript on file with author).

<sup>66</sup> See CTRS. FOR DISEASE CONTROL & PREVENTION, CDC FACT SHEET: ESTIMATES OF NEW HIV INFECTIONS IN THE UNITED STATES 1 (2008), <https://www.cdc.gov/nchhstp/newsroom/docs/fact-sheet-on-hiv-estimates.pdf>.

<sup>67</sup> *HIV Among African Americans*, *supra* note 59.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

HIV is the ninth leading cause of death for the African American community as a whole, and the third leading cause of death for African American men and women ages thirty-five to forty-four years old.<sup>71</sup> Within a lifetime, approximately 1 in 16 African American males and 1 in 30 African American females will be diagnosed with HIV in the U.S.<sup>72</sup> African Americans account for just about 50% of all new HIV infections in the fifty states.<sup>73</sup>

The rate of new infection for African American males is six times that of Caucasian males, three times that of Hispanic males, and twice that of African American females.<sup>74</sup> However, among women, African American women experience the highest rates of new HIV infection, higher than both Hispanic men and women, and higher than Caucasian men and women combined.<sup>75</sup> Currently, the rate of AIDS diagnoses for African American women is fifteen to twenty times that of Caucasian women and four times that of Hispanic women.<sup>76</sup>

Two modes of exposure place African American women at high risk of contracting HIV: injection drug use and heterosexual contact. However, heterosexual contact is the most frequent route of HIV transmission.<sup>77</sup> Factors rendering African American women vulnerable to HIV infection mirror worldwide social determinants of vulnerability among females, including gender disparities, poverty, and cultural and sexual norms.<sup>78</sup> In the U.S., African American women impacted by HIV/AIDS endure a multi-tiered burden of gender-based social and economic inequalities.<sup>79</sup> They are also impacted by ethnic

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<sup>71</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, HIV/AIDS AMONG AFRICAN AMERICANS 2 (Sept. 2010), <https://stacks.cdc.gov/view/cdc/6821>.

<sup>72</sup> *Id.* at 1.

<sup>73</sup> NEW INFECTIONS FACT SHEET, *supra* note 18, at 3.

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> Lily D. McNair & Cynthia M. Prather, *African American Women and AIDS: Factors Influencing Risk and Reaction to HIV Disease*, 30 J. BLACK PSYCHOL. 106, 108 (2004).

<sup>78</sup> Thomas C. Quinn & Julie Overbaugh, *HIV/AIDS in Women: An Expanding Epidemic*, 308 SCI. 1582, 1582-83 (2005).

<sup>79</sup> See, e.g., *AIDS and the African American Church*, PBS (Jan. 11, 2002), <http://www.pbs.org/wnet/religionandethics/2002/01/11/january-11-2002-aids-and-the->

origin, as well as individual community stigmatization and marginalization.<sup>80</sup>

Certain social and institutional factors influence African American women's risk for morbidity and mortality from HIV/AIDS.<sup>81</sup> So, even though contemporary notions of risk engender myths and racial stereotypes that purport a greater likelihood of hazardous and chance behaviors within this group, all things considered, African American women are actually no more likely to take risks, with regard to health behaviors, than their age-matched female peers.<sup>82</sup> To the contrary, it is group membership that defines a number of social factors impacting the probability of exposure to HIV/AIDS.<sup>83</sup>

For example, the sex ratio imbalance among African Americans, due to incarceration, translates into fewer available African American male partners for African American women,<sup>84</sup> particularly as African American women demonstrate the highest level of racial commitment and exclusivity in relationships.<sup>85</sup> That is, "[b]lacks tend to have sexual relations with other blacks, experts say, which works to confine the virus within the African-American 'sexual network.'"<sup>86</sup> This is not a new concern, simply one that remains unaddressed and unexplored.

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african-american-church/19938/ (transcript of PBS broadcast); JANET R. JAKOBSEN & ANN PELLEGRINI, *LOVE THE SIN: SEXUAL REGULATION AND THE LIMITS OF RELIGIOUS TOLERANCE* 77 (2003); *THE GREATEST TABOO: HOMOSEXUALITY IN BLACK COMMUNITIES* 117 (Delroy Constantine-Simms ed., 2001).

<sup>80</sup> *AIDS and the African American Church*, *supra* note 79.

<sup>81</sup> *Id.*

<sup>82</sup> In general, among women in the U.S., heterosexual contact is the main risk factor for transmission of HIV (80%) and injection drug use is the second most common mode of HIV transmission (19%). Among African American women, heterosexual contact is the most common mode of HIV transmission (80%), with transmission via injection drug use being the next most common mode (18%). Among women with AIDS, 17% of African American women report injection drug use, 21% of Hispanic women report injection drug use, and 31% of white, non-Hispanic women report injection drug use. Quinn & Overbaugh, *supra* note 78; *HIV Among Women*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 16, 2016), <http://www.cdc.gov/hiv/group/gender/women/>; CTRS. FOR DISEASE CONTROL & PREVENTION, *HIV AND INJECTION DRUG USE* 1 (Apr. 2015), <http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-idu-fact-sheet.pdf>.

<sup>83</sup> See *AIDS and the African American Church*, *supra* note 79.

<sup>84</sup> See Pettit & Sykes, *supra* note 34.

<sup>85</sup> McNair & Prather, *supra* note 77, at 106.

<sup>86</sup> Linda Villarosa, *AIDS Fears Grow For Black Women*, N.Y. TIMES (Apr. 5, 2004), <http://>

A New York Times article by Linda Villarosa, dating back to 2004, noted that “[i]n government studies of 29 states, a black woman was 23 times more likely to be infected with AIDS than was a white woman, and black women accounted for 71.8 percent of new H.I.V. cases in women from 1999 to 2002.”<sup>87</sup> Even then, evidence pointed to heterosexual contact as a likely means of HIV contraction among Black women, but it seems few scholars and public health officials took up the call to tackle the issue. For example, Villarosa further reported that while it appeared HIV among Black women was stabilizing, “the number of those who have been infected through heterosexual sex” was rising.<sup>88</sup>

Nearly fifteen years ago, the Kaiser Family Foundation, “estimated 67 percent of black women with AIDS contracted the virus through heterosexual sex, compared with 58 percent four years earlier.”<sup>89</sup> On a larger scale, “[b]lack women accounted for half of all HIV infections acquired through heterosexual sex, in men or women, from 1999-2002.”<sup>90</sup> These studies point to the fact that Black women are more likely to contract HIV through heterosexual contact than any other female population, because the rate of infection among African Americans exceeds all other groups.<sup>91</sup> Nor is the problem going away, despite past opportunities for policy interventions, social awareness campaigns, and education.<sup>92</sup>

AIDS should no longer be generally perceived as an exclusively gay, white male concern, particularly by African Americans. As one reporter explained, “in the past, concern about black women and AIDS was mainly focused on those who had used drugs or had had sex with users.”<sup>93</sup> However, increasingly, bridge transmission of HIV through heterosexual contact impacts Black women’s lives, as do the dynamics

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[www.nytimes.com/2004/04/05/us/aids-fears-grow-for-black-women.html](http://www.nytimes.com/2004/04/05/us/aids-fears-grow-for-black-women.html).

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> See, e.g., *HIV/AIDS Initiatives*, MAGIC JOHNSON FOUND., <http://magicjohnson.org/programs/hiv-aids-initiatives/> (last visited July 15, 2016).

<sup>93</sup> Villarosa, *supra* note 86.

of social and cultural conditions of dating and sexual contact in Black communities, because, again, Black women date more exclusively within their ethnic cohort than any other group.<sup>94</sup>

The reduced opportunities to find male partners, self-identifying in the same racial category as themselves, may result in the perception, by African American women, that they wield less power to negotiate relationship parameters, including safety in sexuality.<sup>95</sup> Fears, regarding relationship conflict and possible dissolution, especially if the partner feels challenged or confronted in some way, render some Black women silent.<sup>96</sup> This directly impacts the ability of these women to proactively query male partners about past behaviors and risk exposures.<sup>97</sup> These issues are generally not explored in public health literature, but deserve a considered look.

An unwritten code of silence increases risk to African American women and is perpetuated by several factors: (1) the comparative paucity of institutions within Black communities addressing homosexuality;<sup>98</sup> (2) Black male masculinity remains a focal point within major institutions, namely religious organizations, within Black communities;<sup>99</sup> (3) inequality within Black communities socialize Black women to avoid questioning of their men;<sup>100</sup> (4) homophobia within

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<sup>94</sup> McNair & Prather, *supra* note 77, at 106.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* at 109.

<sup>97</sup> *Id.*

<sup>98</sup> See THE GREATEST TABOO, *supra* note 79, at 117; see also Benoit Denizel-Lewis, *Double Lives On The Down Low*, N.Y. TIMES MAG. (Aug. 3, 2003), <http://www.nytimes.com/2003/08/03/magazine/double-lives-on-the-down-low.html?pagewanted=all> (“For African-Americans, facing and addressing the black AIDS crisis would require talking honestly and compassionately about homosexuality – and that has proved remarkably difficult, whether it be in black churches, in black organizations or on inner-city playgrounds.”).

<sup>99</sup> Brandon Ambrosino, *Why Some Black Men Prefer the Down Low and What It Says About the Black Church in America*, WASH. POST (Sept. 4, 2015), [https://www.washingtonpost.com/national/religion/why-some-black-men-prefer-the-down-low-and-what-it-says-about-the-black-church-in-america/2015/09/04/59788754-533b-11e5-b225-90edbd49f362\\_story.html](https://www.washingtonpost.com/national/religion/why-some-black-men-prefer-the-down-low-and-what-it-says-about-the-black-church-in-america/2015/09/04/59788754-533b-11e5-b225-90edbd49f362_story.html); Anthony J. Lemelle, Jr. & Juan Battle, *Black Masculinity Matters in Attitudes Toward Gay Males*, 47 J. HOMOSEXUALITY 39 (2004), <https://www.usc.edu/student-affairs/glbss/PDFS/BlackMenMasculinity.pdf>.

<sup>100</sup> See, e.g., PATRICIA HILL COLLINS, *BLACK FEMINIST THOUGHT* 123 (Routledge 2d ed. 2000) (“As Evelyn Hammonds points out, ‘Black women’s sexuality is often described in metaphors of

some Black religious communities;<sup>101</sup> and (5) information asymmetries.<sup>102</sup> Among Black women, too many hold to an outmoded belief that AIDS primarily and predominantly impacts gay, white men.<sup>103</sup> Thus, unprotected intercourse with a male partner, especially when in a monogamous relationship, fails to resonate as a potentially high-risk activity.<sup>104</sup> Even further, because MSM, more often than not, self-identify as heterosexual, both men and women have trouble assessing the risk of certain sexual activities.<sup>105</sup>

To paint the portrait of Black women and HIV status more clearly: high rates of racial exclusivity in heterosexual partnership show that Black women often partner with Black men, and, because Black men experience the highest rate of HIV/AIDS among any racial or ethnic subgroup, Black women are severely at-risk.<sup>106</sup> Even more disconcerting, a 2008 study of nearly two dozen major U.S. cities revealed that greater than 70% of African American MSM were unaware of their HIV infections.<sup>107</sup> Low rates of disclosure regarding bisexuality and serostatus among Black men poses increased risk of HIV transmission to their Black female partners.<sup>108</sup> Thus, for Black women, a partner's past behaviors may represent a greater influence on HIV transmission than their own past behaviors.<sup>109</sup>

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speechlessness, space, or vision; as a 'void' or empty space that is simultaneously ever-visible (exposed) and invisible, where black women's bodies are already colonized[.]'"

<sup>101</sup> JACOB LEVENSON, *THE SECRET EPIDEMIC: THE STORY OF AIDS AND BLACK AMERICA* (2004); Michael Paulson, *Black Clergy Rejection Stirs Gay Marriage Backers*, BOS. GLOBE, Feb. 10, 2004, at B1; see also Charles Taylor, *The Black Church and Juneteenth*, NJCJC, <http://www.njclc.com/njclchistory.html> (last visited Apr. 6, 2016).

<sup>102</sup> Rosenblatt, *supra* note 4.

<sup>103</sup> LEVENSON, *supra* note 101.

<sup>104</sup> McNair & Prather, *supra* note 77, at 106.

<sup>105</sup> David Malebranche, *The Truth About the "Down Low"*, AM. PSYCHOL. ASS'N (Apr. 2011), <http://www.apa.org/pi/aids/resources/exchange/2011/04/down-low.aspx>.

<sup>106</sup> McNair & Prather, *supra* note 77, at 106.

<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> Historical and contemporary circumstances highlight the significance of contextual factors in increasing the risk of HIV exposure for African American women. The intersection of poverty, unemployment, limited access to services and social support, and discriminatory treatment when seeking medical care all result in low motivation for participation in health-promoting behaviors and health screenings. The hardships and limited resources associated

## II. SOCIAL AND INSTITUTIONAL CAUSES OF DISEASE

What accounts for the high rates of transmission in African American communities? What might social and legal interventions achieve in combating the disease? Traditionally, research and public health interventions aimed at combating HIV/AIDS concentrated on individual differences in risk behaviors in an attempt to understand and explain disparities in morbidity and mortality.<sup>110</sup> Despite the dispatch of health educators and practitioners to communities with culturally relevant messages that focus on behavior change and education campaigns that continue to enhance advocacy efforts on the ground, the ability of these campaigns to achieve large-scale impact remains unclear, particularly given CDC data that indicates that HIV/AIDS remains a leading cause of death among particular African American cohorts.<sup>111</sup> So, why is this?

### A. Implicit Bias

Racial bias in medicine is one contributing factor to disparities in the diagnosis and treatment of diseases; it is well-documented that it stymies appropriate medical interventions in the lives of African Americans.<sup>112</sup> One of the most revealing studies to document the

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with diffusing knowledge of these negative consequence renders African American women vulnerable to abuse by male partners. Women who are struggling may be more likely to acquiesce to prevailing cultural notions of masculinity, including male dominance, mastery, and control in the home. Aggression and violence in relationships may become a norm. In the end, priorities for personal health and protection become displaced by competing demands for food, shelter, and money. *Id.* at 106, 111-14.

<sup>110</sup> See, e.g., Michele Rountree & Courtney McElhaney Peebles, *HIV and People of Color*, ENCYCLOPEDIA SOC. WORK (Apr. 2014), <http://socialwork.oxfordre.com/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-941>.

<sup>111</sup> HIV AMONG AFRICAN AMERICAN YOUTH, *supra* note 6, at 2.

<sup>112</sup> See generally Michele Goodwin & Naomi Duke, *Cognitive Bias in Medical Decision-Making*, in IMPLICIT RACIAL BIAS ACROSS THE LAW 95-112 (Justin D. Levinson & Robert J. Smith eds., Cambridge Univ. Press, 2012) (explaining that implicit bias may manifest in researchers lacking awareness of what tools to utilize in combating health concerns in African American communities or who rely on misconceptions and stereotypes to study health harms); see also Michelle A. Albert et al., *Perceptions of Race/Ethnic Discrimination in Relation to Mortality Among Black Women: Results From the Black Women's Health Study*, 170 ARCHIVES INTERNAL MED. 896 (2010) (documenting poor health outcomes by race and sex); Vicky L. Shavers et al., *The State of Research on Racial/Ethnic Discrimination in the Receipt of Health Care*, 102 AM. J. PUB. HEALTH 953 (2012); UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH

dramatic impacts of racial bias involved over 700 physicians who were tasked to diagnose and make recommendations regarding treatment of patients.<sup>113</sup> The physicians watched videos of individuals who complained of certain symptoms.<sup>114</sup> Unbeknownst to the doctors, the patients were actually actors – and all followed the same script.<sup>115</sup> The study revealed that doctors were 40% less likely to refer Blacks for cardiac catheterization, and Black women were less likely than Black men to receive the basic standard of treatment.<sup>116</sup>

Studies that document racial disparities in medicine paint a dark picture about racial biases – implicit and explicit – in medicine. Sadly, racial bias in medicine can be deadly.<sup>117</sup> In *The Science of Inequality*, researchers explain that, “[i]n addition to documenting outcome disparities, a robust literature also demonstrates that racial and ethnic discrimination are associated with a wide variety of adverse health

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CARE (Brian D. Smedley et al. eds., Nat'l Acad. Press 2003) (empirically substantiating that racial bias and unequal treatment is widespread throughout medicine); Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physician's Perceptions of Patients*, 50 SOC. SCI. & MED. 813 (2000) (providing a robust empirical analysis of racial bias in the delivery of medicine and the chilling outcomes for Black patients); Jose M. Abreu, *Conscious and Nonconscious African American Stereotypes: Impact on First Impression and Diagnostic Ratings by Therapists*, 67 J. CONSULTING & CLINICAL PSYCHOL. 387 (1999) (illuminating how cancer diagnosis, screenings, and subsequent care and recommendations may be influenced by unconscious racial bias); Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504 (2013).

<sup>113</sup> Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 618 (1999) (explaining that race and sex can be pernicious barriers to equal treatment, with Black women suffering the most through heightened implicit bias).

<sup>114</sup> *Id.*

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> In the case of Barbara Dawson, she died after a hospital refused to diagnose her. Ms. Dawson made pleas for help and adamant proclamations of an inability to breathe. Rather than affording Ms. Dawson appropriate care, stabilizing her, or properly diagnosing, the hospital called law enforcement, which arrested her, withheld oxygen, and then failed to resuscitate her as she died. Jacquellena Carrero & Shamar Walters, *Barbara Dawson, Florida Woman, Dies After Being Removed From Hospital*, NBC NEWS (Dec. 23, 2015), <http://www.nbcnews.com/news/us-news/barbara-dawson-florida-woman-dies-after-being-removed-hospital-n485186>; Kevin Clark, *Medical Examiner: Woman Dies of Blood Clot to Lungs*, WCTV.TV (Dec. 23, 2015), <http://www.wctv.tv/home/headlines/Woman-Dies-Shortly-after-Being-Arrested-in-Blountstown-363282091.html>.

outcomes, including higher mortality, lower use of cancer screening, elevated blood pressure, and higher incidences of substance abuse, mental and physical health disorders, obesity, and smoking.”<sup>118</sup> As their study notes, “the literature suggesting that implicit bias may play a role in health care disparities is convincing.”<sup>119</sup>

Historically, those dispatched to identify and record endemic health and social problems among African Americans lack familiarity with the communities they study and, though well-meaning, bring an outsider perspective to their important work.<sup>120</sup> The mildest form of these implicit biases may influence how research is designed, what questions are pursued, what presumptions made, and interpersonal interactions. The *Washington Post*'s report on white medical students' shocking racial biases toward African American patients particularly underscores this point.<sup>121</sup>

Equally, AIDS prevention efforts traditionally follow a path that is laden with stereotypes. For example, “AIDS prevention efforts have generally focused on drug users and men who have sex with men.”<sup>122</sup> However, findings, dating back over a decade, point out the dangerous gaps in that approach and the apathy that ensues when outbreaks occur among African American populations that do not fit the stereotype.<sup>123</sup> Research demonstrates that Black MSM usually identify as heterosexual.<sup>124</sup> Thus, health intervention programs that only track

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118 RACHEL D. GODSIL ET AL., PERCEPTION INST., *THE SCIENCE OF EQUALITY, VOLUME 1: ADDRESSING IMPLICIT BIAS, RACIAL ANXIETY, AND STEREOTYPE THREAT IN EDUCATION AND HEALTH CARE* 40 (Nov. 2014), [http://perception.org/app/uploads/2014/11/Science-of-Equality-111214\\_web.pdf](http://perception.org/app/uploads/2014/11/Science-of-Equality-111214_web.pdf).

119 *Id.* at 41.

120 Melody Loya, *Racial Attitudes in White Social Workers: Implications for Culturally Sensitive Practice*, 3 *POLS. BUREAUCRACY & JUST.* 23, 23 (2012) (“[O]ver one-third of participants in this cross-sectional study fell within the negative racial attitude types of Conflictive and Dominative, raising questions about these practitioners’ ability to provide culturally sensitive services.”).

121 Sadhya Somashekhar, *The Disturbing Reason Some African American Patients may be Undertreated for Pain*, *WASH. POST* (Apr. 4, 2016), <https://www.washingtonpost.com/news/to-your-health/wp/2016/04/04/do-blacks-feel-less-pain-than-whites-their-doctors-may-think-so/>.

122 Villarosa, *supra* note 86.

123 *Id.*

124 Malebranche, *supra* note 105.

self-identifying gay men in Black communities, as a focus for HIV prevention, profoundly miss the mark.

Health officials should worry that prevention strategies tailored strictly to gay men or intravenous drug users will be more illusory than real in halting the spread of HIV and AIDS. Ultimately, such strategies are less effective for those who do not identify as homosexual, but still “have casual sex with men.”<sup>125</sup> Problematically, not only do these men not view themselves as being at high risk for HIV infection, neither did the CDC.<sup>126</sup>

For example, in February 2004, health officials identified a rapidly spreading outbreak of infections among eighty-four men in North Carolina.<sup>127</sup> Over 80% of these men were Black, educated, and in college.<sup>128</sup> They spanned thirty-seven colleges—representing a potential tinderbox for HIV contraction.<sup>129</sup> Nevertheless, the CDC was slow to act, claiming to news media that “it doesn’t have the money to do widespread testing following the discovery of an increase in HIV infections among male black college students in North Carolina.”<sup>130</sup> Certainly, economic constraints in this domain remain a serious matter, and Congress and local governments should address that concern. However, the notion that the CDC might have approached the crisis differently if the HIV outbreak were spread across nearly forty campuses populated by white students is hard to ignore, especially in light of the potential tragedy exacerbated by a clear lack of early action by the CDC.<sup>131</sup>

In this 2004 outbreak, federal officials failed to provide additional funding (at least in the early stages, when it was needed most), despite the fact that medical officials knew there was “every reason to believe there’s continuing ongoing transmission,” impacting African

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<sup>125</sup> Lloyd Vries, *CDC Apathy on College HIV Charged*, CBS NEWS (Mar. 10, 2004), <http://www.cbsnews.com/news/cdc-apathy-on-college-hiv-charged/>.

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

Americans.<sup>132</sup> In the end, other cases were linked to that outbreak, with a spread of “up to a dozen cases related to the outbreak ... in schools in Georgia, Florida, South Carolina, Virginia, West Virginia, and the District of Columbia.”<sup>133</sup> Even more worrisome, those cases only reflected the identified transmission of HIV. Far too often, AIDS is a ticking, undetected time bomb.

According to Dr. Peter Leone, who was the HIV Medical Director at the North Carolina Department of Health and Human Services at the time, the CDC’s lack of action “suggest[ed] apathy at the federal level[.]”<sup>134</sup> possibly because this mode of transmission did not fit the narrative or prior presumptions about HIV contraction in the U.S. Dr. Ron Valdiserri, Deputy HIV Chief at the CDC, defended the institution, explaining that they were simply unprepared to address the North Carolina outbreak, because “[m]ost Americans would not think about college students as a high-risk group.”<sup>135</sup> However, this too is a dangerous stereotype, rooted in implicit bias. After all, according to the CDC, “nearly half of the 20 million new sexually transmitted diseases (STDs) diagnosed each year are among young people aged 15-24.”<sup>136</sup> Moreover, “about 1 in 4 (26 percent) of all new HIV infections is among youth ages 13 to 24 years.”<sup>137</sup>

HIV is not a socioeconomic disease. Nor are African Americans, or any other group, immune by virtue of a high school education and college admission. However, if African Americans are not equally

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<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.* (explaining to a reporter that “I’m mortified more isn’t being done”).

<sup>135</sup> *AIDS Hitting Young Black Males in College*, NBC NEWS (Feb. 11, 2004), [http://www.nbcnews.com/id/4240372/ns/health-aids/t/aids-hitting-young-black-males-college/#.V3lLb\\_krJhE](http://www.nbcnews.com/id/4240372/ns/health-aids/t/aids-hitting-young-black-males-college/#.V3lLb_krJhE).

<sup>136</sup> *College Health and Safety*, CTNS. FOR DISEASE CONTROL & PREVENTION (Aug. 18, 2015), <https://www.cdc.gov/family/college/>; see also Justine J. Reel & Erin Hellstrom, *Risky Business in Student Dorms: Sexual Health and Sexually Transmitted Infection Prevention Programming Imperative for College Campuses*, 3 J. CMTY. MED. & HEALTH EDUC. 1 (2013), <http://www.omicsonline.org/risky-business-in-student-dorms-sexual-health-and-sexually-transmitted%20infection-prevention-programming-imperative-for-college-campuses%20-2161-0711.1000211.pdf>; Caico, *supra* note 50 (“[Among female college students,] 50.9% had unprotected vaginal intercourse not using condoms and of those 45.8% either do not insist on condom use or only use them occasionally.”).

<sup>137</sup> *College Health and Safety*, *supra* note 136.

identified and tracked for prevention outreach as part of the college population, then strategies to intervene at the college level will simply not reach that population. Peer-reviewed research underscores the importance of our argument. In one study of sexually risky behavior in college-aged students, researchers found that “47.2% are not worried about getting AIDS[,] . . . 41.3% are not concerned with genital lesions[, and] . . . 42.4% would rate themselves as not being very knowledgeable about sexually transmitted infections.”<sup>138</sup>

In this case, the data is quite compelling. North Carolina health researchers “were shocked to find that students represented more than 1 in 5 of the state’s new HIV infections among 18- to 30-year olds.”<sup>139</sup> In fact, “college students were 3.5 times more likely than non-students to become infected.”<sup>140</sup> Furthermore, that infected population was “34 times more likely than non-college men to have sex with other college students.”<sup>141</sup>

Much can be learned from the North Carolina crisis. For years, many researchers assumed that HIV/AIDS transmission reflected homosexual identification among Blacks and high rates of drug use alone.<sup>142</sup> Therefore, intervention efforts largely followed that lens. Yet, with respect to HIV transmission, Dr. Kim Blankenship and colleagues argue that anointing African American stereotypes as a guiding principle of HIV intervention fails to address the true root causes of transmission.<sup>143</sup> In their groundbreaking empirical work, *Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System*, she and her colleagues challenge the well-settled assumptions that drive research and advocacy on this issue.<sup>144</sup> Their analysis and

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<sup>138</sup> Caico, *supra* note 50, at 354.

<sup>139</sup> Vries, *supra* note 125.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.*

<sup>142</sup> See *History of HIV and AIDS Overview*, AVERT (Jan. 26, 2016), <http://www.avert.org/professionals/history-hiv-aids/overview>.

<sup>143</sup> Kim M. Blankenship et al., *Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System*, 16 J. HEALTH CARE POOR & UNDERSERVED 140, 141 (Supp. B 2005).

<sup>144</sup> *Id.*

conclusions reveal how misconceptions can be baked into well-meaning policies and approaches to disease.<sup>145</sup>

However, structural and institutional problems also impact HIV risk, morbidity, and mortality in African American communities. Deliberately taking a step back from individual health behaviors as the focal point for intervention and prevention of HIV infection, we examine the evidence presented by Bruce Link and Jo Phelan<sup>146</sup> regarding social determinants of health. Link and Phelan identify two roles for social conditions as a cause for disease: (1) through the contextualization of risk; and (2) more directly as a mediator of resource acquisition.<sup>147</sup> Applying the social determinants framework to the problem of HIV infection among African American women, the following questions arise: What is it about the life circumstances of African American women that place them at risk for HIV infection? What policies must be addressed to reduce inequality of resources needed to avoid risk?

### B. Mass Incarceration

The U.S. war on drugs, which gives rise to an exponential expansion of the criminal justice system as discussed in Part I,<sup>148</sup> yields significant contextual risk for HIV/AIDS among African American women. Racial disparities across all levels of the corrections system, in large part due to a U.S. drug policy that imposed mandatory minimum sentencing, penalty enhancements for the sale and use of drugs in certain areas, and expanded disparities in penalties associated with the use or possession of crack versus powder cocaine,<sup>149</sup> continue to result

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<sup>145</sup> For example, other than marijuana, African Americans report less lifetime and past year use of illicit drugs and do not engage in riskier sexual behaviors than their Caucasian counterparts. Dr. Blankenship's research indicates that a more expansive and *institutional* approach to both research and interventions on HIV/AIDS in Black communities must be pursued. *Id.* at 141-42.

<sup>146</sup> Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80 (Extra Issue 1995).

<sup>147</sup> *Id.* at 80.

<sup>148</sup> See Bowman III, *supra* note 25, at 1328-32.

<sup>149</sup> See *id.*

in widespread disruption of relationships, families, and social networks within the African American community.<sup>150</sup>

Sentencing practices of this kind result in greater likelihood that African American offenders will be sentenced to incarceration,<sup>151</sup> while their Caucasian counterparts are more likely to end up in treatment.<sup>152</sup> In fact, African American males are twenty times more likely to be incarcerated for drug offenses, despite comparable rates of drug involvement among Caucasians and Hispanics.<sup>153</sup> And upon return to the community, newly released African American males are a reflection of their previous prison environment, harboring the scars of poor mental and physical health.<sup>154</sup>

As an economic matter, the U.S. war on drugs contributes to rapidly increasing incarceration rates, and therefore costs,<sup>155</sup> placing a significant burden on prison resources, particularly in the case of health care.<sup>156</sup> As a policy matter, these health care burdens shift squarely onto the shoulders of jail and prison systems, materializing in the form of increased budget constraints despite an ever-escalating

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<sup>150</sup> See Reagan, *supra* note 2, at 203–04.

<sup>151</sup> See Dorothy E. Roberts, *The Social and Moral Cost of Mass Incarceration in African American Communities*, 56 STAN. L. REV. 1271, 1271–77 (2004).

<sup>152</sup> See, e.g., Keri Blakinger, *Heroin Addiction Sent Me to Prison. White Privilege Got Me Out and to The Ivy League.*, WASH. POST (Jan. 21, 2015), <https://www.washingtonpost.com/posteverything/wp/2015/01/21/heroin-addiction-sent-me-to-prison-white-privilege-got-me-out-and-to-the-ivy-league/>.

<sup>153</sup> Ernest Drucker, *Drug Prohibition and Public Health: 25 Years of Evidence*, 114 PUB. HEALTH REPS. 14, 26 (1999).

<sup>154</sup> See, e.g., Neil Genzlinger, *Review: From Lifers to Ex-Cons, a Bumpy Road Home, on 'POV'*, N.Y. TIMES (May 22, 2016), <http://www.nytimes.com/2016/05/23/arts/television/tv-review-pbs-pov-the-return.html>.

<sup>155</sup> EXEC. OFF. OF THE PRESIDENT OF THE U.S., NATIONAL DRUG CONTROL STRATEGY: FY 2010 BUDGET SUMMARY 1 (2009), <https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/fy10budget.pdf> (“In Fiscal Year 2010, the President requests \$15.1 billion in support of these key [drug] policy areas, which is an increase of \$224.3 million or 1.5 percent over the FY 2009 enacted level of \$14.8 billion.”). In reality, President Barack Obama allocated \$25.9 billion in the fiscal year 2010 for fighting the Drug War. EXEC. OFF. OF THE PRESIDENT OF THE U.S., FY 2012 BUDGET AND PERFORMANCE SUMMARY: COMPANION TO THE NATIONAL DRUG CONTROL STRATEGY 5 (2011), [https://www.whitehouse.gov/sites/default/files/ondcp/Fact\\_Sheets/FY2012-Budget-and-Performance-Summary-April-2011.pdf](https://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/FY2012-Budget-and-Performance-Summary-April-2011.pdf).

<sup>156</sup> Karina K. Rapposelli et al., *HIV/AIDS in Correctional Settings: A Salient Priority for the CDC and HRSA*, 14 AIDS EDUC. & PREVENTION 103, 103–04 (Supp. B 2002).

population of inmates.<sup>157</sup> U.S. jails and prisons increasingly house populations ailing upon entry, as many individuals are not properly connected to a health facility and/or provider prior to incarceration.<sup>158</sup> America's public health is deeply tied to the penal system and prisons serve a vital health care role in the U.S.<sup>159</sup>

For example, the vast range of health threats faced by incarcerated individuals not only includes HIV, but also sexually transmitted infections (e.g., syphilis, chlamydia, and gonorrhea), tuberculosis, hepatitis (high prevalence of hepatitis C), physical and sexual violence victimization,<sup>160</sup> and health problems more unique to women, such as breast cancer, ovarian cancer, and cervical cancer.<sup>161</sup> In addition, the deinstitutionalization of mental illness and use of psychotropic medications continues to contribute to an emptying of mental health hospitals.<sup>162</sup> And with no place to go, many suffering from mental illness live on the street.<sup>163</sup> Law enforcement campaigns to reduce or impact the conditions that lead to incarceration, such as reducing drug trafficking at the street level and vagrancy, often fail and create a pipeline into prisons.<sup>164</sup> This also contributes to prisons becoming de facto "mental health facilities."<sup>165</sup>

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<sup>157</sup> See Maria Schiff, *Examining State Prison Health Care Spending: Cost Drivers and Policy Approaches*, HEALTH AFFAIRS (Nov. 2, 2014), <http://healthaffairs.org/blog/2014/11/04/examining-state-prison-health-care-spending-cost-drivers-and-policy-approaches/>.

<sup>158</sup> See Harold Pollack, *Our Insane Health-Care System: Free Health Care in Prison, Nothing Afterward*, WASH. POST (Dec. 26, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/12/26/our-insane-health-care-system-free-health-care-in-prison-nothing-afterward/>.

<sup>159</sup> See *id.*

<sup>160</sup> Nicholas Freudenberg, *Jails, Prisons, and the Health of Urban Populations: A Review of the Correctional System on Community Health*, 78 J. URB. HEALTH 214, 218-20, 224 (June 2001).

<sup>161</sup> *Women's Health Care in Correctional Settings*, NCCHC.ORG (Oct. 19, 2014), <http://www.ncchc.org/women%E2%80%99s-health-care>.

<sup>162</sup> See, e.g., E. FULLER TORREY ET AL., TREATMENT ADVOCACY CTR., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 1-4 (2010), [http://www.treatmentadvocacycenter.org/storage/documents/final\\_jails\\_v\\_hospitals\\_study.pdf](http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf).

<sup>163</sup> Freudenberg, *supra* note 160, at 220, 223.

<sup>164</sup> See, e.g., Eduardo Porter, *Numbers Tell of Failure in Drug War*, N.Y. TIMES (July 13, 2012), <http://www.nytimes.com/2012/07/04/business/in-rethinking-the-war-on-drugs-start-with-the-numbers.html>.

<sup>165</sup> Freudenberg, *supra* note 160, at 220, 223.

Ultimately, the inability to prevent, treat, and manage health threats in U.S. prison systems creates negative health impacts in the low-income communities to which most of the incarcerated return.<sup>166</sup> And in turn, this magnifies poor health prospects for African American communities because of the high rates of recidivism associated with drug related offenses,<sup>167</sup> causing a large minority of African American men to move back and forth between incarceration and freedom for the remainder of their lives.<sup>168</sup> Even for the one-time offenders, missed opportunities for health screening and care while in jail means greater health risk to the public at large when these former inmates attempt re-entry into the community.<sup>169</sup>

The burden of HIV/AIDS for the imprisoned population is substantial. Approximately 17% of those with HIV have been in a correctional facility (20% for males and 10% for women).<sup>170</sup> Overall, the estimated prevalence of HIV/AIDS is 1.5% among incarcerated males and 1.9% among incarcerated females.<sup>171</sup> Placed in context, these conservative figures are striking when compared to estimates for the prevalence of HIV among U.S. adults in the civilian, non-institutionalized, household population, which is only 0.47% (0.72% for males and 0.22% for females).<sup>172</sup> Despite the fact that most persons

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<sup>166</sup> *See id.*

<sup>167</sup> *See generally* MARC MAUER, SENT'G PROJECT, U.S. COMM'N ON CIVIL RIGHTS, THE CRISIS OF THE YOUNG AFRICAN AMERICAN MALE AND THE CRIMINAL JUSTICE SYSTEM (1999), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Crisis-of-the-Young-African-American-Male-and-the-Criminal-Justice-System.pdf> (describing the structural and institutional forces leading to imprisonment and re-imprisonment of African American males).

<sup>168</sup> *See, e.g.*, MATTHEW R. DUROSE ET AL., BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 244205, RECIDIVISM OF PRISONERS RELEASED IN 30 STATES IN 2005: PATTERNS FROM 2005 TO 2010 (Apr. 2014), <http://www.bjs.gov/content/pub/pdf/rprts05p0510.pdf>.

<sup>169</sup> OFF. OF PROGRAM EVALUATION & RESEARCH, *supra* note 54, at 5 ("Our baseline model shows that, compared to no [counseling and testing], offering [counseling and testing] to 10,000 inmates detects 50 new or previously undiagnosed infections and averts 4 future cases of HIV at a cost of \$125,000 to prison systems. However, this will save society over \$550,000.").

<sup>170</sup> Anne C. Spaulding et al., *HIV/AIDS Among Inmates of and Releasees from US Correctional Facilities, 2006: Declining Share of Epidemic but Persistent Public Health Opportunity*, 4 PLOS ONE 1, 6 tbl.7 (2009).

<sup>171</sup> MARUSCHAK, *supra* note 60.

<sup>172</sup> GERALDINE MCQUILLAN & DEANNA KRUSZON-MORAN, U.S. DEP'T OF HEALTH & HUMAN

infected with HIV, or suffering from an AIDS-related illness, during confinement contracted the virus prior to incarceration, peer-reviewed research confirms that HIV transmission occurs while in prison too.<sup>173</sup> Despite bans on sexual intercourse in U.S. prisons, the modes for transmission of the virus among inmates include sexual contact, intravenous drug use (IVDA), and tattooing.<sup>174</sup>

For men contracting HIV in prison, early data reveals transmission occurs more often via sexual contact.<sup>175</sup> Despite prison policies banning sex, both consensual sex and rapes are common in U.S. prison facilities.<sup>176</sup> The California Coalition Against Sexual Assault (“CCASA”) estimates “20 percent of inmates in men’s institutions are sexually abused at some point during their incarceration.”<sup>177</sup> Using anal rape as an example, it is estimated that a man raped once by five perpetrators while in prison has a 1 in 477 risk of becoming infected with HIV.<sup>178</sup> If that man is later raped an additional seven to thirty-five times, the risk of contracting HIV may be as high as 1 in 98.<sup>179</sup> Using estimates of a prison population of 1.4 million, with a 1% chance of being raped (which would mean about 14,000 have been raped while imprisoned, a very conservative estimate), between 43 and 93 of these men will acquire HIV as a result of those rapes.<sup>180</sup> With a prison

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SERVS., NCHS DATA BRIEF NO. 4, HIV INFECTION IN THE UNITED STATES HOUSEHOLD POPULATION AGED 18-49 YEARS: RESULTS FROM 1999-2006, at 7 (Jan. 2008), <http://www.cdc.gov/nchs/data/databriefs/db04.pdf>.

<sup>173</sup> Christopher P. Krebs & Melanie Simmons, *Intraprison HIV Transmission: An Assessment of Whether It Occurs, How It Occurs, and Who Is at Risk*, 14 AIDS EDUC. & PREVENTION 53, 58 (Supp. B 2002).

<sup>174</sup> *Id.* at 53.

<sup>175</sup> *Id.* at 60. The same data reveals that men contracting HIV in the community (after leaving prison) more often do so via IVDA. *Id.*

<sup>176</sup> Brenda V. Smith, *Rethinking Prison Sex: Self Expression and Safety*, 15 COLUM. J. GENDER & L. 185, 193-96 (2006); see also CAL. COAL. AGAINST SEXUAL ASSAULT, *Survivors Behind Bars*, in “SUPPORT FOR SURVIVORS” TRAINING MANUAL 5 (2010), <http://www.calcasa.org/wp-content/uploads/2010/12/Survivors-Behind-Bars.pdf> (“Sexual abuse behind bars is one of the most widespread and neglected human rights crises in the U.S. today.”).

<sup>177</sup> *Id.*

<sup>178</sup> Steven D. Pinkerton et al., *Model-Based Estimates of HIV Acquisition Due to Prison Rape*, 87 PRISON J. 295, 295 (2007).

<sup>179</sup> *Id.*

<sup>180</sup> *Id.*

population of over two million and estimates of male inmate-on-inmate rape anywhere between 7% and 22%,<sup>181</sup> the threat of HIV for male inmates is very real.<sup>182</sup>

Yet, only 10% of state and federal prisons, and 5% of city and county jails report offering comprehensive HIV prevention programs.<sup>183</sup> All fifty-two U.S. prison systems offer HIV testing, but local, state, and federal policies govern how testing is carried out.<sup>184</sup> In general, HIV testing may be performed upon inmate request (forty-six systems), in the case of clinical indications of HIV (forty-six systems), by order of the court (forty-three systems), and as mandatory procedure following incident with blood or body fluid exposure (forty-one systems).<sup>185</sup> Testing is offered less often and less “systematically” in jails, and there are no jails that have mandatory testing at intake.<sup>186</sup>

Twenty-three prison systems perform routine testing upon entry into the system, and six prison systems perform routine testing on

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<sup>181</sup> JOANNE MARINER, AMERICAS DIV., HUMAN RIGHTS WATCH, NO ESCAPE: MALE RAPE IN U.S. PRISONS 103 (Apr. 2001), <http://f1.findlaw.com/news.findlaw.com/cnn/docs/hrw/hrwmalrape0401.pdf>.

<sup>182</sup> The corrections system represents a significant source of HIV/AIDS risk that disproportionately impacts populations of color (since these populations are more likely to be incarcerated). However, while it is in prison that these HIV/AIDS issues are directly unfolding, without some systematic means to deal with their presence in the prison system, the threat will inevitably pass on to the larger community. In the case of African American males, who make up the majority of the imprisoned population in the U.S., the passing on of this threat chiefly occurs through transmission of the virus to their partners—primarily African American women who have been waiting for their release. See Lynette Clemetson, *Links Between Prisons and AIDS Affecting Blacks Inside and Out*, N.Y. TIMES (Aug. 6, 2004), [http://www.nytimes.com/2004/08/06/us/links-between-prison-and-aids-affecting-blacks-inside-and-out.html?\\_r=0](http://www.nytimes.com/2004/08/06/us/links-between-prison-and-aids-affecting-blacks-inside-and-out.html?_r=0).

<sup>183</sup> Karina K. Rapposelli et al., *HIV/AIDS in Correctional Settings: A Salient Priority for the CDC and HRSA*, 14 AIDS EDUC. & PREVENTION 103, 104 (Supp. B 2002). The quality of the programs is subject to factors such as overcrowding, staff availability, and fiscal resource availability. *Id.*

<sup>184</sup> Robin MacGowan et al., *HIV Counseling and Testing of Young Men in Prison*, 12 J. CORRECTIONAL HEALTH CARE 203, 204 (2006).

<sup>185</sup> *Id.*

<sup>186</sup> Anne C. Spaulding et al., *Human Immunodeficiency Virus in Correctional Facilities: A Review*, 35 CLINICAL INFECTIOUS DISEASES 305, 307 (2002).

release.<sup>187</sup> For systems that do not require HIV testing upon entry into prison, the rationale to forgo mandatory testing may be linked to concerns about the incubation period.<sup>188</sup> Further, prison officials are making policy choices: preferring instead to fall back on prison policies against sexual contact, aggression-based housing and segregation, and HIV/AIDS awareness training programs, even if they fail to halt the rates of transmission.<sup>189</sup>

Powerful, personal accounts of prison rapes, collected from inmate letters sent to Just Detention International, make clear that “no sex” policies not only do not work, but, instead, mask the frequent horrors of sexual violence behind bars. The personal accounts are jarring, yet they help to debunk the notion that prison rape does not occur. Sexual assaults behind bars are endemic, entrenched, and hidden as cases of rape in U.S. prisons and jails are rarely identified or tracked by news media or taken up in legal scholarship. The accounts of these victims provide an urgent view into a problem that impacts many thousands of lives:

*1. Bill's Story:*

They put me in a large cell with a bunch of guys . . . two men started demanding cigarettes from me, which I didn't have . . . they started slapping me around . . . a guard walked by the cell and told them to quiet down. I might have been able to defend myself against one . . . the bigger guy told me that if I sucked his dick he would leave me alone . . . I decided that it would be better to do that than to be beaten by these guys more . . . I was scared as hell and didn't know what else to do. It got more and more brutal and humiliating. I was forced to perform oral sex on the other one while the big one sat on me. He lifted my legs and I was penetrated anally . . . more than once, and I can never be sure, but I believe there was a third man . . . my eyes and lips were swollen . . . I was bleeding . . . they finally stopped when I vomited after one of them men [sic] ejaculated and urinated in my mouth.

The next day I was supposed to see the judge. For some reason I was still afraid to call my parents. A corrections officer, who I'm sure knew

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<sup>187</sup> MARUSCHAK, *supra* note 60.

<sup>188</sup> Up to three months can pass, after exposure, before antibodies in the blood can be detected. See *HIV Test Window Periods*, SFAF.ORG, <http://sfaf.org/hiv-info/testing/hiv-test-window-periods.html> (last visited June 27, 2016).

<sup>189</sup> CAL. COAL. AGAINST SEXUAL ASSAULT, *supra* note 176, at 8–10.

I was raped, helped me clean up. At the courthouse I spoke with my court appointed lawyer and told him the story – but he didn't seem to care. When I got into the courtroom my lawyer asked for bail. It was set at \$500 and my friend bailed me out . . . the judge gave me 2 years probation and ordered me to a rehab. A month later I tried to kill myself and was confined to a psychiatric hospital. I joined AA and got on with my life.

. . . .

My name is Bill. I am a rape survivor.<sup>190</sup>

### *2. Pleas for Help:*

I told the people here that I got raped before, I didn't tell them it was at their reception center, and that I knew that meant I would be raped again. They didn't do anything different and I'm in general population. One of the big people in here approached me last week. I know what's coming, so I slit my wrists to get out of here. Some people will say that I did it to get attention. That's not true. I did it because I know what's coming. Today I got placed in a cell with one of the biggest drug dealers and gang leaders up in here. He told me he paid for me already and I'm his slave. I tried to kill myself again, unfortunately I didn't succeed. I don't know what else to do.<sup>191</sup>

### *3. Strategizing to Minimize Abuse:*

If you gotta have a man, you should pick carefully. Pick one that don't rent you out, or at least keeps your ass for himself, and one that lets you say you won't do certain stuff. I have a decent one right now. It's not all bad and he's enough of a shot-caller that all I have to say if anyone else starts hassling me is, "got a problem? Talk to my husband."<sup>192</sup>

### *4. Sex As Prison Property:*

For eighteen months, from September 2000 to April 2002, I was subjected to a system of gang-run sexual slavery at the James Allred Prison in Texas. I was an openly gay, first-time offender convicted of non-violent drug charges – in other words, a target. After arriving at the facility, I was immediately pressured by gang members to sleep with someone in exchange for protection. At first I resisted these approaches, but it wasn't long until I was raped. The perpetrator promised to keep me from being

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<sup>190</sup> *Id.* at 4.

<sup>191</sup> *Id.* at 7.

<sup>192</sup> *Id.* at 6.

owned by the gangs if I would only have sex with him. Instead, he and his gang forced me to have sex with other gang members and also sold my services to other inmates.

I was being assaulted in the showers, stairwells, my cell, and other cells. After I made complaints to prison officials, they told me, "Go down there and fight like a man, or get a man." Prison officials also threatened me for exposing their misconduct, by seeking help through the courts.<sup>193</sup>

#### *5. Joe's Story:*

I am one of the 216,600 people who are sexually abused each year in prisons, jails, youth facilities, and immigration detention. In the fall of 2008, I went to prison in California for attempted armed robbery. I had been in prison before so I thought I knew what to expect. I was wrong. I never expected to be housed with a convicted rapist who would torture me repeatedly for days. I was already living with HIV when I went back to prison. The stress and depression caused by the assaults burdened my already deficient immune system and sent my body into a downward spiral. My diagnosis changed from HIV-positive to AIDS. I was sentenced to three and a half years for my crime. I've served my time, but I'm still living a life sentence—the nearly unbearable psychological pain that I carry with me.<sup>194</sup>

#### *6. Prison, HIV, and The Indelible Mark:*

During the first weeks of my incarceration, I was attacked and raped in the shower by two other inmates while a third stood look-out. As a result, I've learned to live with the unending emotional stress, nightmares, grief, anger, shame, fear and even embarrassment . . . .

. . . .

. . . .

Because of the rape, I have contracted HIV, which I am currently taking medicine for. Sometimes I wish it would just hurry up and kill me so I will be free of the mental anguish! I know this sounds selfish because I have two beautiful children, not to mention my other family and friends that would miss me terribly. But the stress, anxiety, and preoccupation with thoughts of the events have left an indelible stain in my mind that

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<sup>193</sup> *Survivor Stories: Roderick*, JUST DETENTION INT'L, <http://justdetention.org/story/roderick/?pageno=1> (last visited July 13, 2016).

<sup>194</sup> *Survivor Stories: Joe*, JUST DETENTION INT'L, <http://justdetention.org/story/joe/?pageno=1> (last visited July 13, 2016).

could never be erased. All I can hope to accomplish is to keep on persevering and pray times will get a little easier.

I don't know how it would be possible for anyone who has had to endure similar agonies to gain any strength from my sufferings, but if my story helps anyone at all in their pain, than [sic] it would make it a little worthwhile.<sup>195</sup>

Not all inmates will be raped or exposed to sexual violence. However, a significant percentage will experience some form of sexual contact behind bars whether for pleasure, rape, in trade for commissary items, in coercion for protection, as property, or by abuse of guards.<sup>196</sup> From a policy perspective, given the high prevalence of sexually transmitted diseases in prisons and jails, addressing HIV in those sectors makes sense.

Some prison systems provide pre-test counseling to all inmates, usually in the form of a group health orientation at intake, while others do not have required pre-test counseling at all.<sup>197</sup> Post-test counseling is usually only required for individuals testing positive.<sup>198</sup> Despite the lack of uniformity in testing and screening procedures, incarceration may awaken an individual to the fact that previous behaviors place him or her at risk for HIV infection, thus potentially convincing the individual to welcome the opportunity to be tested as part of a comprehensive HIV management program.<sup>199</sup>

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<sup>195</sup> *Survivor Stories: Chris*, JUST DETENTION INT'L, <http://justdetention.org/story/chris-2/?pageno=5> (last visited July 13, 2016).

<sup>196</sup> See Smith, *supra* note 176; CAL. COAL. AGAINST SEXUAL ASSAULT, *supra* note 176.

<sup>197</sup> In September 2006, the CDC revised its recommendations for HIV testing in health care settings. The recommendations replace the CDC's 1993 *Recommendations for HIV Testing Services for Inpatients and Outpatients in Acute-Care Settings*. The key differences are: (1) that all patients in all healthcare settings aged thirteen to sixty-four years will be screened unless the patient declines after being notified that testing will be performed; (2) HIV testing of people at high risk for HIV infection should be performed at least once a year; (3) screening should be incorporated into the general consent for medical care; separate written consent is not recommended; (4) prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health care settings. There are not specific caveats noted in this guideline with regard to health settings for the imprisoned population. See Barnard M. Branson et al., *Revised Recommendations For HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings*, 55 MORTALITY & MORBIDITY WKLY. REP. 1, 1 (2006).

<sup>198</sup> *Id.*

<sup>199</sup> Spaulding et al., *supra* note 186, at 307.

HIV testing in prisons is not mandated,<sup>200</sup> and this likely contributes to the unintentional, negligent, or intentional spread of HIV, both in prison and in the civilian population upon release. The CDC has long taken the position that testing is “essential for improving the health of people living with HIV and reducing new HIV infections.”<sup>201</sup> We agree with the CDC on this important point. However, many prison facilities choose not to test as they “weigh the costs of HIV testing and treatment against other needs, and some correctional systems may not provide such services.”<sup>202</sup> We urge the institutionalization of HIV testing in prisons because there is a government interest in preventing deaths and promoting community health. Early diagnosis and treatment can save lives.<sup>203</sup> We take up these issues in our second essay.<sup>204</sup>

## CONCLUSION

The national crime rate, especially violent crime, has fallen over the past decade in the United States.<sup>205</sup> Nevertheless, the number of people sent to jail and prison is actually increasing.<sup>206</sup> More adults are being convicted and sentenced to serve time for non-violent crimes, which is primarily a result of the U.S. war on drugs.<sup>207</sup> Presently, over

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<sup>200</sup> See MARUSCHAK, *supra* note 60.

<sup>201</sup> See *State HIV Testing Laws: Consent and Counseling Requirements*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 18, 2015), <http://www.cdc.gov/hiv/policies/law/states/testing.html>; see also CTRS. FOR DISEASE CONTROL & PREVENTION, MONITORING SELECTED NATIONAL HIV PREVENTION AND CARE OBJECTIVES BY USING HIV SURVEILLANCE DATA—UNITED STATES AND 6 DEPENDENT AREAS—2010 (June 2012), [http://www.cdc.gov/hiv/pdf/statistics\\_2010\\_HIV\\_Surveillance\\_Report\\_vol\\_17\\_no\\_3.pdf#page=3](http://www.cdc.gov/hiv/pdf/statistics_2010_HIV_Surveillance_Report_vol_17_no_3.pdf#page=3).

<sup>202</sup> *HIV Among Incarcerated Populations*, *supra* note 57.

<sup>203</sup> See, e.g., Ann Pietrangelo, *Detecting HIV: Why Seroconversion Time is Important*, HEALTHLINE (July 30, 2013), <http://www.healthline.com/health/hiv-aids/seroconversion-time#Overview1>.

<sup>204</sup> Goodwin & Duke, *supra* note 65.

<sup>205</sup> See Inimai Chettiar, *The Many Causes of America's Decline in Crime*, ATLANTIC (Feb. 11, 2015), <http://www.theatlantic.com/politics/archive/2015/02/the-many-causes-of-americas-decline-in-crime/385364/>.

<sup>206</sup> See *The Prison Crisis*, *supra* note 31.

<sup>207</sup> See *id*; see also John Pfaff, *For True Penal Reform, Focus on the Violent Offenders*, WASH. POST

two million people are confined in U.S. prisons or jails, representing a 500% increase in the incarcerated population in the last thirty years<sup>208</sup> and three quarters of all individuals incarcerated on drug offenses are people of color.<sup>209</sup> “Most of these individuals are not high-level drug traders or traffickers, and most have no criminal record of any violent offense.”<sup>210</sup>

However, these shifts in the demographics of the prison population are not without collateral consequence. In this Essay, we have teased out those concerns with regard to the spread of HIV. Given high, disparate rates of incarceration among African Americans,<sup>211</sup> as well as the dramatic rise in HIV, the health impacts necessarily bleed into the community in a terrible feedback loop.<sup>212</sup> The high HIV contraction and death rates among Black women underscore our point.<sup>213</sup> Thus, in this Essay, we have explored what these concerns mean for Black women. In our second essay, we take up mandatory HIV testing in prisons to further unpack prevention, detection and the law.<sup>214</sup>

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(July 26, 2015), [https://www.washingtonpost.com/opinions/for-true-penal-reform-focus-on-the-violent-offenders/2015/07/26/1340ad4c-3208-11e5-97ae-30a30cca95d7\\_story.html](https://www.washingtonpost.com/opinions/for-true-penal-reform-focus-on-the-violent-offenders/2015/07/26/1340ad4c-3208-11e5-97ae-30a30cca95d7_story.html).

<sup>208</sup> *Criminal Justice Facts*, SENT'G PROJECT, <http://www.sentencingproject.org/criminal-justice-facts/> (last visited June 27, 2016).

<sup>209</sup> *Id.*

<sup>210</sup> SENT'G PROJECT, FACT SHEET: TRENDS IN U.S. CORRECTIONS 3 (Dec. 2015), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf>.

<sup>211</sup> WILLIAM J. SABOL & HEATHER COUTURE, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 221944, BULLETIN: PRISON INMATES AT MIDYEAR 2007 (June 2008), <http://www.bjs.gov/content/pub/pdf/pim07.pdf>.

<sup>212</sup> Daniel J. Kruger & E. Hill DeLoney, *The Association of Incarceration with Community Health and Racial Disparities*, 3 PROGRESS CMY. HEALTH P'SHIP: RES., EDUC. & ACTION 95 (2009).

<sup>213</sup> See BLACK WOMEN'S HEALTH IMPERATIVE, *supra* note 1; HIV/AIDS AMONG WOMEN, *supra* note 19.

<sup>214</sup> Goodwin & Duke, *supra* note 65.