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Achieve is a joint publication of  
ACRIA and GMHC.



# Prosecuting HIV: Take the Test and Risk Arrest?



by Sean Strub

Imagine meeting someone online, having a nice chat, and then deciding to hook up. You have HIV, but you're adherent to your meds and have had an undetectable viral load for years. You and your sexual partner use a condom. Sometime later, the partner learns you have HIV and presses charges against you for failing to disclose your HIV status prior to sex.

Your life is suddenly turned upside down, with your name and picture splashed across the media. You are called an "AIDS Monster". You and your family and friends feel humiliated and embarrassed. Your employment, housing, and relationships may be put in jeopardy and you need to find tens of thousands of dollars for legal fees for the impending prosecution.

If convicted, you face decades in prison, lifetime registration as a sex offender, and other restrictions; if acquitted, your life is still never the same, because you will always be known as the "AIDS Monster".

Think about that for a moment: Consenting adults. No intent to harm. Undetectable viral load. A condom was used. No HIV transmission. Twenty-five years in prison. This isn't hypothetical; it is exactly what happened in a recent case in Iowa. In fact, as of July 2009 Iowa had charged nearly 2% of all Iowans with HIV with similar crimes.

There have been hundreds of prosecutions for HIV crimes in the U.S., all over the country. As of today, 34 states and territories have HIV-specific statutes, but a targeted law isn't required to prosecute an HIV crime. These prosecutions usually have little bearing on the actual level of risk of HIV transmission,

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*Achieve*

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## ACRIA Trials in Progress

### BMS-663068

People with HIV who are 18 and older and who have become resistant to more than one HIV medication will take BMS-663068 (an experimental HIV attachment inhibitor) or Reyataz for up to 96 weeks. Everyone will also take Isentress and Viread.

### Crofelemer

People with HIV who are 18 and older and have diarrhea that has not responded adequately to treatment will take crofelemer for up to a year.

### Cenicriviroc (TBR-652)

People with HIV who are 18 and older and who have not taken HIV meds will take either Cenicriviroc (an experimental CCR5 inhibitor) or Sustiva for a year. Everyone will also take Truvada.

### BI 201335

People aged 18 to 70 who have hepatitis C virus but not HIV, and who have not taken interferon, will take BI 201335 (an experimental HCV

protease inhibitor) with peg-interferon and ribavirin for 12-48 weeks.

### BI 201335

People aged 18 to 70 who have hepatitis C virus and HIV will take BI 201335 (an experimental HCV protease inhibitor) with peg-interferon and ribavirin for 12-48 weeks.

### Ibalizumab

People who are HIV negative will receive four weekly injections of ibalizumab (a monoclonal antibody) to study its safety and effect on the immune system.

### Selzentry

People with HIV who are 18 and older and who have not taken HIV meds will take either Selzentry or Truvada for 22 months. Everyone will also take Prezista with Norvir.

For more information on these trials, contact us at 212-924-3934, ext. 130.

Compensation is available for some studies.

## LETTERS TO THE EDITOR

To The Editor:

I have been a peer educator at a correctional facility for a while. I love educating and advocating.

Your publication is so informative – this is where I get my up-to-date statistics. I plead with the public to help teach the basics of healthy behaviors.

I face all types of young adults and even older people who still label you. It's sad because no one here in the prison system wants to be labeled, so they remain in denial.

I, for one, am very open. I'm living with HIV and HCV and choose

to speak. I want my voice heard. Once this incarceration is over, I plan to advocate on different issues – I want to be the person I was put on this earth to be.

I am organizing a World AIDS Day ceremony. Participants will dedicate a patch to someone and I will read the new statistics and tell my story.

I'd love to be on your mailing list and get info on volunteering because I'll be out in March.

Thank you,

Caridad

ignoring factors like whether a condom was used or the viral load of the person with HIV.

It's important that people with HIV and their advocates understand the issues at stake, the risk they present for people with HIV, and how they may undermine public health strategies to reduce HIV transmission. The issue is complicated, especially since the public is generally supportive of criminal prosecution of people with HIV who do not disclose their HIV status to a partner before sex. One study, from the University of Minnesota, showed that about 2/3 of gay men supported such prosecutions; among very young gay men, it approached 80%. Even among gay men with HIV, it was nearly 40%. Outside of gay men, it is likely that support for these statutes is even higher.

Criminalization supporters often believe these statutes are effective in reducing HIV transmission, but there are no data to support this; in fact, there is a growing body of research demonstrating that they do not reduce HIV transmission and may even contribute to its further spread.

### A Viral Underclass

Since the earliest days of the AIDS epidemic, stigma has been a major obstacle to effective HIV prevention and care. Even as fear of contagion from casual contact has lessened over the years, profound stigma persists. People with HIV face judgment, marginalization, discrimination, and misunderstanding about the actual risks of transmission.

Many people with HIV internalize and accept this judgment, perpetuating the perception of those with HIV as toxic, highly infectious, or dangerous to be around. This has serious adverse effects on them personally, as well as for the broader effort to combat the epidemic while protecting sexual freedoms.

Stigma discourages people at risk from accessing care – including testing for HIV – and it discourages people who know they are HIV positive from disclosing to potential sexual partners and others. Much of this stigma is based in racism and homophobia.



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These laws not only require people to disclose their HIV status to partners, but also to be able to prove it in a court of law. Imagine this line at a bar: “Let’s go home and get it on. Since I have HIV, could you sign this affidavit stating that I told you that? We can stop by a notary public on the way home and get it notarized.”

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Nothing drives stigma more than when government sanctions it by enshrining discriminatory practices in the law. That is what has happened with HIV, resulting in the creation of a “viral underclass” of people with rights inferior to other citizens. Stigma driven by HIV criminalization promotes illegal discrimination against people with HIV, including prohibitions on certain occupations and licensing.

After three decades of the epidemic, people with HIV continue to experience punishment, exclusion from services, and a presumption of guilt in a host of settings and for practices that are, for those

who have not tested positive for HIV, unremarkable.

This is reflected perhaps most dramatically in the criminal prosecution of people who know they have HIV but are unable to prove they disclosed their status prior to sexual contact. The ostensible purpose of these statutes is to deter HIV-positive people from putting others at risk. The inherent problem with these laws is that they focus primarily on the existence of proof of disclosure, not on the nature of the exposure, the actual level of risk present, or whether HIV was transmitted. Consequently, as studies have demonstrated, they do nothing to advance their intended purpose.

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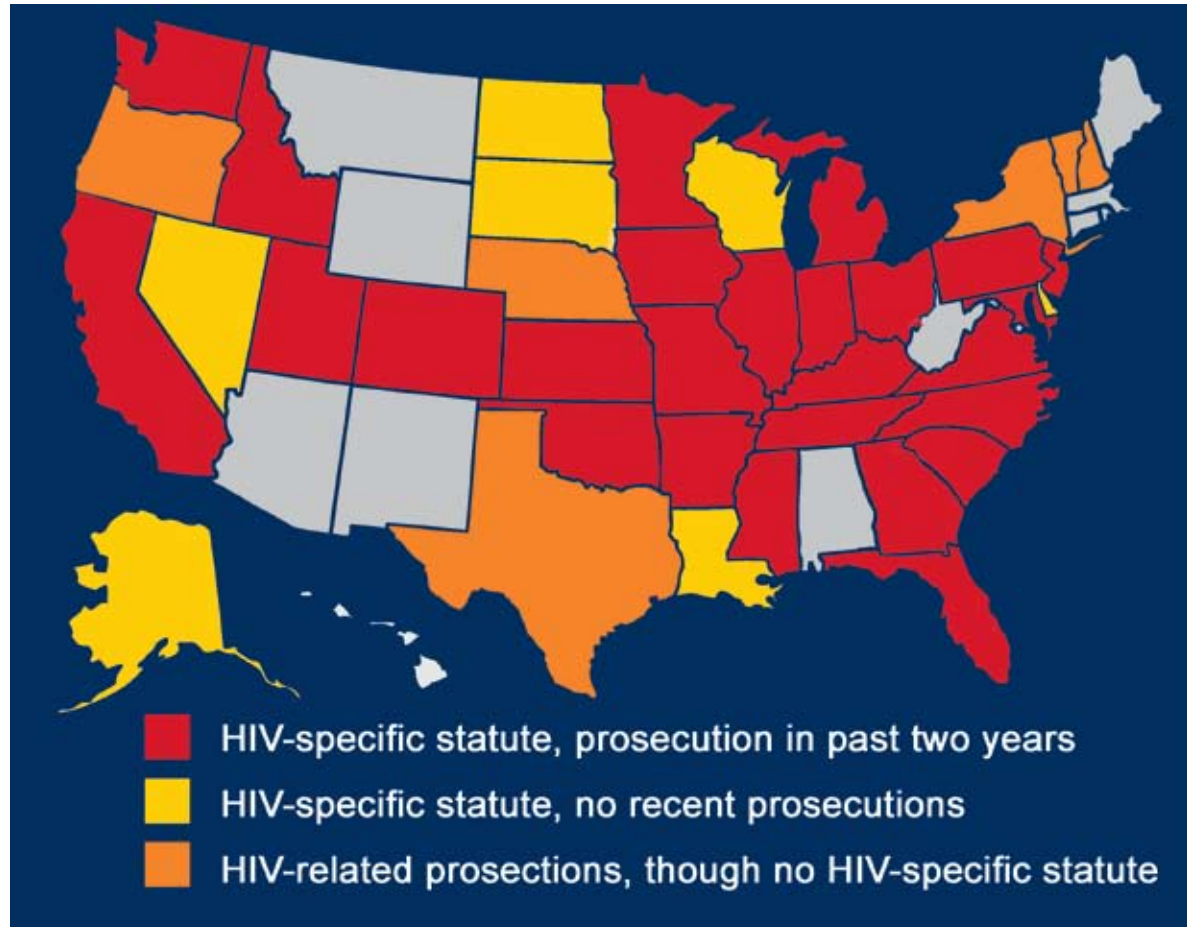
## The Origins of HIV Criminalization

The legal obligation to disclose stems, in part, from the 1990 Ryan White CARE Act. That legislation required that states demonstrate an ability to prosecute intentional HIV exposure, a recommendation from President Reagan's AIDS commission. At the time, it was widely believed that simple exposure to the virus – or having intimate contact with someone who was infected – was a “death sentence”. This requirement was dropped in the 2000 renewal of Ryan White, but the criminalization statutes it spawned remain in force.

Some states considered their existing assault and public health statutes adequate to meet the Ryan White requirement, but many added HIV-specific laws (see map). These vary widely, both in what they punish and sentencing provisions.

In states without HIV-specific statutes, criminal law (and in one recent case, an anti-terrorism statute) has been used to prosecute people with HIV for behaviors that posed little or no risk of transmission. In these cases, HIV, or the blood, semen, or saliva of a person with HIV, is often characterized as a “deadly weapon”. Heterosexual men of color are the most likely to be prosecuted.

Typically, sentencing is vastly disproportionate to the harm caused or the level of risk present in the sexual encounter. In one Texas case, a man was sentenced to 35 years in prison for spitting at a police officer. In fact, about 25% of recent prosecutions are for behaviors like spitting or biting, which pose no measurable risk of HIV transmission. Many of the prosecutions for failing to disclose prior to sex have been of someone with an undetectable viral load and/or who used a condom, but who is still sentenced to decades in prison.



The ethical obligation of people with HIV to disclose health factors that could put sexual partners at risk was codified in the Denver Principles, the historic 1983 manifesto that launched the people with AIDS empowerment movement. Defining what constitutes a risk sufficiently serious to require such disclosure is where it gets tricky.

The Denver Principles also recognize sexual freedom as a fundamental human right, noting that people with HIV have a right “to as full and satisfying sexual and emotional lives as anyone else”. Fully integrating people with HIV into society, in part by allowing them to have fulfilling sexual lives without the risk of incarceration, is critical to combating the stubborn stigma that remains an enormous obstacle to preventing new HIV infections.

The fact that HIV is so linked with homosexuality and communities of color has made it easier to “punish” people with HIV – an example of how race or sexuality can be used to form

policies that isolate individuals and limit their freedoms.

Ethical obligations aside, criminalizing the sexual conduct of those living with HIV is justified only when there is proof of the intent to harm another person, like a situation where someone intentionally injected someone with HIV with a syringe or had sex with the explicit purpose of transmitting the virus. Existing state and federal criminal laws are adequate to deal with these extremely rare cases. Prosecutions in these instances should focus on the proof of intent to harm and the resulting injury.

Other cases – including some that have received widespread media attention – involve people with mental health issues who are recklessly and repeatedly putting others at risk. Those situations should be handled through existing public health policies for people with mental health issues.

Those who support criminal prosecution of people with HIV who fail to notify

partners in advance of intimate contact must consider whether they also support similar prosecutions of those with hepatitis viruses, herpes, viruses like CMV, EBV, HPV, and other pathogens that can be transmitted sexually.

## Prosecutions

Highly publicized HIV criminalization cases are frequently driven by inaccurate and inflammatory media coverage and sometimes by politically ambitious prosecutors. They feed into the public's ignorance and anxiety about HIV, reinforce negative stereotypes about people with HIV, and send conflicting messages about the real risks of HIV transmission.

They depict people with HIV as dangerous infectors who must be controlled and regulated, making it more difficult to create an environment that encourages people to get tested and disclose their status.

The Iowa case mentioned earlier provides a sobering illustration. The person with HIV who was charged with failing to disclose his status to a sexual partner was a 34-year-old gay man. He met a male partner online and went to his house. He was on HIV medication, had an undetectable viral load, and used a condom when anally penetrating his partner, so the risk of transmission was negligible to nonexistent.

When the partner heard the man had HIV, he went to the county prosecutor and pressed charges. The person with HIV was convicted and sentenced to 25 years in prison. Fortunately, advocates were successful in getting the sentencing reviewed, and after serving eleven months he was released on five years probation. But he must register as a sex offender for the rest of his life, may not be around his nieces or nephews

without adult supervision, is subject to wearing an ankle-monitoring bracelet, and cannot leave his home county without permission from the court. Iowa's statute is particularly broad – in theory, it could cause a person with HIV who kissed someone without disclosing to spend 25 years in prison – but other states' statutes are equally as absurd. Here are some examples:

- Texas doesn't have an HIV-specific statute, but Willy Campbell, who was sentenced to 35 years for spitting on a police officer, was convicted of "assault with a deadly weapon" even though spit from a person with HIV doesn't infect someone, let alone kill them.

- In late 2009, using laws designed to combat terrorism, Michigan charged Daniel Allen, who has HIV, with "possession of a harmful biological agent" after he was involved in an altercation with a neighbor. Prosecutors equated his HIV infection with "possession or use of a harmful device".
- A man with HIV in Ohio could not prove he had disclosed to his girlfriend that he was positive and was sentenced to 40 years in prison. He claims she knew he was positive and only went to a prosecutor after he stopped dating her and moved in with another woman.



- Gregory Smith was within a year of his release from a New Jersey prison when he was charged with attempted murder, assault, and terrorist threats following an incident in which he allegedly bit and spat on a guard (Smith denied the charges). An additional 25 years was added to his sentence; he died of AIDS in prison.

These cases highlight one of the significant problems with HIV criminalization statutes: Not only do they require people to disclose their HIV status to potential partners, but also to be able to prove it in a court of law. Imagine this line at a bar: "Let's go home and get it on. Since I have HIV, could you sign this affidavit stating that I told you that? We can stop by a notary public on the way home and get it notarized."

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Yet that scenario is not so far-fetched, as more people with HIV are seeking ways to document their disclosure, either by saving text or email messages, disclosing in the presence of a third-party witness, or in some cases taking a partner with them to a doctor's appointment and asking the doctor to note the disclosure in the medical record.

Spitting poses no risk of HIV transmission. Yet in the past several years, there have been at least six convictions of people with HIV for spitting. And as a practical matter, it is the person biting, rather than the person bitten, who is at the greater risk of acquiring the virus.

Criminalization is also reflected in "pile-on" charges and more aggressive prosecution or sentencing of people with HIV charged with other crimes. In 2009, a woman with HIV in Maine who was eligible for release was sentenced to continued confinement when the judge learned that she was pregnant.

He sought to "protect" the fetus from infection by having the jail supervise the woman's treatment, also typifying how

courts sometimes elevate the perceived interest of a fetus over the rights of a pregnant woman. Although legal advocates secured her release shortly thereafter, the desire of a federal judge to confine a woman with HIV to prison, despite testimony that she was engaged in appropriate prenatal care, reveals ignorance and an inclination to criminalize illness by even the most educated and privileged members of our society.

What all of the cases above have in common is that none of them resulted in transmission of HIV to another person.

### **A New Strategic Approach**

Historically, the discussion among advocates and policy leaders concerning HIV criminalization has focused on civil liberties concerns. Yet a growing realization that HIV criminalization is also a serious public health challenge has helped propel the issue to the forefront. An important step was the recognition of the need for changing HIV criminalization statutes in President Obama's National HIV/AIDS Strategy, released this past July:

*... Since it is now clear that spitting and biting do not pose significant risks for HIV transmission, many believe that it is unfair to single out people with HIV for engaging in these behaviors and [they] should be dealt with in a consistent manner without consideration of HIV status. Some laws criminalize consensual sexual activity between adults on the basis that one of the individuals is a person with HIV who failed to disclose their status to their partner. CDC data and other studies, however, tell us that intentional HIV transmission is atypical and uncommon.... [These laws] may not have the desired effect and they may make people less willing to disclose their status by making people feel at even greater risk of discrimination.... In many instances, the continued existence and enforcement of these types of laws run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.*

Early in 2011, the National Alliance of State and Territorial AIDS Directors became the first major organization of public health professionals to join the effort to repeal HIV-specific criminal statutes. Their statement notes:

HIV criminalization undercuts our most basic HIV prevention and sexual health messages, and breeds ignorance, fear, and discrimination against people living with HIV.

Advocates who focus on the serious public health ramifications of HIV criminalization can help repeal or end reliance on criminalization statutes and other criminal laws that persecute and stigmatize people with HIV. They can also help educate law enforcement, prosecutors, and the media, ultimately lessening HIV-related stigma and discrimination.

### **Bad Public Health Policy**

HIV criminalization discourages people at risk from getting tested. Studies show that people with HIV who are aware of their status are more responsible in their sexual behavior than those who are unaware they have HIV. Testing is a basic tool of HIV prevention as well as an essential gateway to care.

Criminalization statutes also make it more difficult for people with HIV to disclose their status. Disclosing can be emotionally difficult, risking rejection from family and friends – often with great insult or abuse – and can jeopardize one’s employment, housing, relationships, or personal safety.

Criminalization of HIV legitimizes the ignorance, homophobia, racism, and sex-phobia that fuel the inflated fears of those with HIV. It undermines efforts to prevent new HIV infections and provide access to care in many ways:

- It undercuts the most basic HIV and STD prevention message: that every person must take responsibility for his or her own sexual health.
- Prosecuting the failure to disclose values the “right” to an illusion of safety over the privacy rights of those with HIV.
- Most new infections are caused by sexual contact with people who are unaware they have HIV, yet only those who have taken responsibility and gotten tested are subject to prosecution.
- Ignorance of one’s HIV status is the best defense against a “failure to disclose” prosecution, a powerful disincentive to getting tested and learning one’s HIV status.
- Young African-American men who have sex with men are among those at highest risk of acquiring HIV, yet also among the most difficult to persuade to get tested. The prospect of prosecution for failing to disclose – especially since these prosecutions often boil down to a “he-said/he-said” or “he-said/she-said” situation – is a powerful disincentive to disclosure. “Take the test and risk arrest” is the message increasingly being heard on the streets.

## Racism and Homophobia

Prosecuting HIV nondisclosure but not prosecuting the failure to disclose other STDs also reflects an unconscious racism and homophobia. Human papilloma virus (HPV) provides a useful

contrast. HPV causes a variety of cancers, including almost all cervical, genital, and anal cancers. Cervical cancer alone killed 4,000 women in the U.S. in 2009; every year hundreds of thousands of women in the U.S. get diagnosed with cervical dysplasia, which is caused by HPV and is a precursor to cervical cancer.

By the age of 50 more than 80% of American women will have contracted



at least one strain of HPV. Yet unlike HIV, HPV is not associated with “out-law sexuality” or with specific minority groups. HIV is associated with anal intercourse, gay men, African-Americans, and injection drug users, so racism and homophobia are inextricably linked with HIV stigma, discrimination, and criminalization.

## Conclusion

Since the earliest days of the epidemic, stigma and ignorance have hindered an effective response to the HIV epidemic. Stigma and ignorance sanctioned in the law are its most extreme manifestation and inherently unjust. HIV-specific criminal statutes do not slow the trans-

mission of HIV but may facilitate its further spread. Reducing HIV transmission can be achieved only when combating HIV criminalization and ignorance, and the associated stigma, are part of the approach.

To this end, nearly 40 HIV, human rights, public health, and other organizations founded the Positive Justice Project (PJP) in the fall of 2010 to end government reliance on a positive HIV

test result as proof of intent to harm. PJP is a project of The Center for HIV Law & Policy, a resource for leaders, attorneys, and advocates interested in HIV-related discrimination and criminalization. PJP’s Resource Bank ([hivlawandpolicy.org](http://hivlawandpolicy.org)) is a comprehensive database of research, reports, court decisions, briefs, policy analyses, and other materials of importance to people with HIV. ■

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*Sean Strub is a co-founder of and Senior Advisor to the Positive Justice Project, founder of POZ.com, and a member of the board of directors of the Global Network of People with HIV/AIDS/North America.*

# HIV and HCV in U.S. Prisons:

## Debunking the Myths

by Elizabeth Lovinger

**P**risoners in the U.S. are much more likely to be living with HIV and hepatitis C virus (HCV) than the general public. Though this may not be surprising, there is a widespread false belief that most inmates living with HIV and HCV were infected while in prison. Most inmates living with HIV or HCV, however, were infected before they started serving their current term in prison.

There are limited data on HIV infection in prison settings. The most complete set of data comes from a 2006 study by the Georgia Department of Corrections, which found that the majority of inmates with HIV had been infected before being incarcerated. From July 1988 to February 2005, all Georgia prisoners were required to be tested for HIV when entering prison. Of all the Georgia prisoners who tested HIV-positive during that time, 90% were already living with HIV when they entered prison. Only 88 inmates tested negative when they entered prison and later tested positive. This study covered only Georgia prisons, but it is the most thorough study of its kind in the country and could suggest how the epidemic exists in other prison systems as well.

A 2008 Washington Post article offers an explanation for this trend. The article points out the fact that communities of color with high incarceration rates, usually in inner cities, are the most affected by HIV of any communities in the U.S. Prisons play a very large role in the spread of HIV, but in more hidden ways. When members of a community are constantly being taken to and returned from prison, their partners are more likely to have other relationships. As people in this community have multiple sexual partners at the same time, sexually transmitted infections like HIV spread very quickly.

These communities also tend to have limited access to health care, so members might be less likely to know their own status or how to protect themselves from HIV and HCV. In fact, prison is often the first place these individuals will have access to health care, or the first time they will be tested. Members of these communities make up a large percentage of people in prisons, so the rates of HIV in prisons are likely to be much higher as a result.

When members of a community are constantly being taken to and returned from prison, their partners are more likely to have other relationships. As people in this community have multiple sexual partners at the same time, sexually transmitted infections like HIV spread very quickly.

### The Need for Treatment

HCV rates are also significantly higher in prisons and jails than among the general public. According to the CDC, one in three prisoners is living with HCV. In 2005, 39% of people with HCV in the U.S. had a history of serving time in prison or jail, and a 2000 study found that 79% of all state prisons (which house 94% of inmates in the U.S.) offered HCV testing at some point

during a prisoner's stay. But while prisons may sometimes be a good place to get tested, they rarely offer inmates the treatment they need. Between July 1, 1999, and June 30, 2000, only 7% to 27% of inmates who tested positive for HCV were being treated. The majority of HCV-positive prisoners weren't receiving treatment for reasons such as substance use, length of stay, and mental illness.

Many inmates have other health concerns that need more immediate attention, so medical staff prioritize those conditions over the HCV infection. Some medical staff aren't well trained to treat HCV, or don't want to start treatment on someone with a short sentence. Since standards of care vary between prisons, it's often difficult to maintain treatment when a prisoner is moved. Treatment is complex and sometimes painful, and only works about half the time.

But the most common reason given for the lack of HCV treatment in prisons is its cost. Treatment costs almost \$10,000 per inmate per year, and many prisons and jails claim they don't have those resources. Some inmates file lawsuits against the prisons that deny them care, but many die during the fight, and a recent Montana Supreme Court decision ruled in favor of the prison system. Despite the fact that prisons have some of the highest rates of HCV infections, they have some of the worst care standards.

## Transmission

Data show that, much like HIV, the majority of HCV infections happened before serving time in jail or prison. A 2002 CDC report estimated that 72 to 86% of injection drug users are infected with HCV. Since the vast majority of HCV infections are due to injection drug use, an untreated person is very likely to pass the virus on to a partner or another user. After being released from prison, many untreated users will continue to inject, often sharing needles and likely infecting others with HCV. As HCV cycles through communities of injection drug users, many of whom are arrested and imprisoned, the infection rates in prisons remain high. And the longer inmates are denied proper HCV treatment, the worse the epidemic gets.

HIV and HCV transmission does occur in prisons and jails, but it happens less often than most think. Sexual activity occurs in prisons between inmates, between inmates and staff, and during conjugal visits. Sex can be consensual or by sexual assault. There is little supervision during most prison activities, so it can happen often. Condoms and other preventive barriers are often not available to inmates, so the risk of HIV and HCV transmission during sexual activity is high. Injection drug use also continues within the prison system, and since there are usually no syringe exchange programs in U.S. prisons, most inmates end up sharing needles.

For most injection drug users in prisons and jails, however, the risk of infection was present long before their imprisonment. Many users have very little access to health care or HIV and HCV testing in their home communities. Many have been unknowingly living with an infection for quite some time. Drug treatment programs are also severely lacking in communities with high rates of injection drug use, and partners of drug users are often subject to the same risks of infection through sexual contact.

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The high rates of HIV and HCV infection in prisons seem to be a result of who gets sentenced. Out of the 1.7 million people in prisons and jails in 2000, 1.4 million were imprisoned due to possession or sale of narcotics, crimes to support their addiction, or offenses in which drug use was a factor. In that same year, 24% of inmates in state prisons and 14% in federal prisons had a history

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## PERSONAL PERSPECTIVE



by Priscilla Hall

It's tough having HIV in jail. It's not the place you want to be if you're sick. I spent eight months in there and it was really hard.

When I arrived, I met another inmate who told me how to protect myself. She said, "If you're HIV-positive, keep it to yourself." She told me not to tell anyone, not even the doctors. I asked her why and she said, "You'll live longer." That really scared me. Then she said, "You won't be singled out and you'll feel safe eating your food." I think she was telling me her own story. I decided to listen to her.

When I went to see the doctor I found out what she meant. There was a line of inmates waiting outside of the doctor's office, but there was nothing to protect their privacy. No door, nothing! You could hear everything they said. And when someone came out, everybody looked at them and knew their business. So when the doctor asked me if I was HIV-positive, I said no. And when he asked if I wanted an HIV test I said no again because I didn't want to have to be called back and have everyone hear my business.

If you got tested and the test came back positive, they wouldn't even give you counseling to handle the news. One inmate tried to hang herself when she found out she had HIV because she just couldn't take it. I became friends with her and told her I was HIV-positive and that everything was going to be okay. I told her people are living a lot longer than they used to and that she was going to get through it.

# Keep It To Yourself

I knew people who told the doctors they were HIV-positive as soon as they got there. But a lot of them had to wait weeks or months to get their meds. The doctor would just give them antibiotics until the meds came. And a lot of times it wasn't even the right meds. They would just have to keep waiting and praying they would get the right meds soon. While they were waiting, if they wanted to see the doctor they had to put their name on a list and the list would get posted on the wall so everyone could see. They would put "I.D." next to the names of people with HIV, which stands for "infectious disease." So the whole jail would know you had something.

Sometimes the correctional officers (COs) were the worst. You really didn't want them to find out! Especially if they didn't like you. They would tell everybody about your business and people would treat you differently.

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**When I arrived, I met another inmate who told me how to protect myself. She said, "If you're HIV-positive, keep it to yourself." She told me not to tell anyone, not even the doctors. I asked her why and she said, "You'll live longer."**

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If other inmates found out you had HIV they could jump you. You would have to stay on the other side of the prison to try to stay safe or they would try to beat you. One time, I saw an inmate who was HIV-positive get beat really bad by a CO because she accidentally touched him. He beat her and kicked her in the stomach even after she was on the floor. He kept scream-

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**I saw an inmate who was HIV-positive get beat really bad by a correctional officer. He kicked her in the stomach even after she was on the floor. He kept screaming at her, "Don't ever touch me, you monster!" It was horrible.**

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ing at her, "Don't ever touch me, you monster!" It was horrible.

That's why I didn't tell any of the doctors I was HIV-positive the eight months I was there. And because I didn't tell them, I didn't get any meds that whole time. It was only when I got really sick that they found out. At first, they thought I had TB and they kept me in a room away from the other inmates until they got back the test results. When I was negative for TB, the doctor asked me point blank, "Are you HIV positive?" And then I said yes. The doctor asked me, "Why didn't you say anything when you got here? Why did you wait so long?" I told him the truth. I was scared of being labeled and I was scared of what could happen to me if I told them. I ended up getting an AIDS diagnosis because I waited so long.

It's tougher being in jail than out on the street. The doctors are so unprofessional. If people start trouble with you, you can't get away. You just have to take it. And the people who are supposed to help you and protect you are the worst. Things really need to change. They need to respect us and take care of us because we're human beings just like everyone else. It shouldn't matter that we're in jail. ■

# Getting Out and Staying Out

## Making Discharge Planning Work

by Mark Milano

**O**ver 600,000 people are released from state and federal prisons every year. But unless they are prepared for life “on the outside” and get the support they need, chances are they will return to their former behaviors and possibly to prison. In addition, people with HIV have specific needs that must be addressed if they are going to make the transition successfully.

To try to understand this complex process, I interviewed Tracy Mack (pictured at right), Director of Transitional Services and HIV Testing at Exponents, a community-based organization in New York City.

### When should discharge planning start?

If it starts when a person enters the system, the outcome will be better, since a lot of the process is based on trust. If I’m an

Unfortunately, the system is now run by government agencies, and they don’t have the staff to invest the time needed to facilitate that change. If there’s a community-based organization working in the prison that calls them down twice a week, they can build a relationship.

inmate and I meet with a discharge planner, I have to believe that *you* care about me before *I’m* able to care about me. And even if I don’t care about me, the fact that you care makes a difference. I might just be engaging in the process for you, but once I get involved in it, I’m going to stay.

Unfortunately, the system is now run by government agencies, and they don’t

have the staff to invest the time needed to facilitate that change. Behavior is one of the hardest things to change, and if you only give a person five to ten minutes, that’s not enough. If there’s a community-based organization working in the prison that calls them down twice a week, they can build a relationship. They can trust the process and we can give them the time they need to digest all the information, answer questions, address their fears, and distinguish what’s factual from myths. Currently, the system is not set up to do that. They can’t spend that quality time with people.

### You have to take the time to get the person invested in the process.

Absolutely. They have to believe that their life is going to improve if they do things differently: “If I do this, then this may happen for me.” Often you have to want things for them that they may not realize they want. It’s often just about being there – setting up another appointment, creating structure. Structure is needed. You don’t want to act like a correctional officer, but you have to have boundaries in place. Let them know that there are certain things they have to do in order to receive services. You don’t want to hit them in the head, though – you have to be loose, but structured.

### What role do former inmates play?

Sometimes we bring in former inmates to do discharge planning, and it makes a difference. Some inmates think that unless you’ve been there, you can’t possibly help them. If I say, “You can do this,” they’ll respond, “Yeah, right – you tell everyone that.” But once they know that the person they’re sitting next to in a support group

came from the same penitentiary, knew that same prison guard, lived in the same dorm, and once they got out they got their GED or even Masters degree and became a substance use counselor, they're like, "Wow – I can do that too." And sometimes we're able to disclose, if it will help – if you're HIV positive and I'm positive, I can share that.

You can't hit your head against a wall until a client is ready to take positive steps. You have to provide them with the support mechanisms that facilitate that change. And it's not going to happen overnight. Some people come out with a plan: "I'm sick and tired of this and I'm not going back in. I really want to get my act together and do the right thing." But others just aren't ready. And that's okay, as long as you let them know the consequences of not being ready.

For example, one of my first clients had a long history of incarceration and substance use. I was really green – I wanted to save the world. I held his hand, I was present for him. But he just wasn't ready. He had other ideas. He stopped using drugs so he could fulfill his probation requirements, but as soon as he got off probation he went right back to using. I was crushed. I stuck with him, thought about it, and finally realized what the harm reduction process needs. I hadn't asked him what he wanted. Once I did, and found a way to fulfill the needs he articulated, he was able to make progress. Today, he has four years clean and hasn't been back to prison. But that took a good year and a half of work.

### **How long does follow-up need to continue?**

It's open-ended. Some people know what they're going to do, they have things in mind, and they're insistent on attaining them. For others, it's a longer process. They may get sticky fingers – they still don't get the concept of paying for things they want; they need instant gratification. Substance use is a major issue, as well as mental health. We've had people who've attended every one of the twelve programs we run. Others just want to use a few of our services. They may go in and out of our program, but we always invite them back. There's no close date.

### **So clients come to you with a range of issues – not just their health.**

Yes, and we know those issues. Of course, we believe that people with HIV should get into care as soon as possible. But if they're homeless, that might be the issue they need to address first. Or "I'm using drugs and I want to continue to use, so I can't commit to taking meds or going to a doctor regularly." Or "I live with my family and I can't start treatment because God knows they're going to find out somehow." Some of these problems are very delicate and take time to resolve. For example, the housing program in this city may send you to places that are not conducive to well-being. We try to find a place clients can feel good about.

to take meds. I still want to see you on a weekly basis, but right now I want adequate housing. I want the support groups and your training program, but I'm not ready to talk about being HIV positive." And I say, "That's okay. When you are ready to talk about your HIV, I'm here. And I may ask about it every time. And if you accept that, cool." I find if I take that approach, those walls will come down.

I recently went to a meeting with some bigwigs from the Department of Health. They wanted to change the whole process of how they deal with the mentally ill coming out of jail. All these wonderful, smart policymakers – but not once did anyone say, "Let's ask the clients what they need."



You also have to work on a person's self-worth. If I don't feel good about myself, or if I have mental health issues, my HIV is irrelevant, especially if I'm not sick. Sometimes providers forget to ask clients, "What is it that you want?" I think if they did that more, rather than worrying about their agenda or their deliverables, they'd have better outcomes. If we engage them and invite them into the process, they'll be more apt to do what's needed. Now *they* can care about what they think and even if they say, "No, I don't want to see a doctor. I don't want

I've had people who are eager for care when they're inside: "I want your services. I want to connect to a provider." But then they jump out of the transport van at a red light as they are being brought to me after release. That's probably because other issues were not addressed, and health care was not one of their priorities. "I want to get laid, I want to smoke, I want to shoot some dope." If they have issues other than their health, we have to address those other needs first.

But the current system is not set up for that. It doesn't provide that comfort

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level and that level of safety. There was a time when community-based organizations did the discharge planning, and I think that worked a whole lot better than the way it is today. Now you have Department of Health care coordinators. They make appointments for people, but they send them to random places. Why don't they ask the person where they want to go? They may have a provider or place they like. I think if community-based organizations were more involved in the discharge planning process, the rate of connection would be higher.

### **What do you do with clients who do get into care but have heard horror stories about HIV meds?**

I had a client who was really ambivalent about the meds and I wound up shar-

sion on factual information. He wasn't being "informed" by misinformed people. We went through this together, and that made him feel safe. Both of us are still on the same meds and neither one of us had any side effects! It was a trust thing: If you could do it, I can do it. If it doesn't work, we can talk about the options, but let's do this together. You need to almost make a pact with people. It's "each one, teach one."

### **How does disclosure affect the process?**

Some clients hide their HIV status while in prison, but they feel safe here so they disclose. And they worry that if they have to go to the city's HIV/AIDS Services Administration, they might see somebody they know. That can be a problem if they haven't disclosed to anyone outside of our program. Luckily, now we have clinics that treat a broad range of illnesses, so we don't have to send them to an HIV clinic.



ing with him that I had just started them myself. And he counseled me! He walked me through the process and that enabled him to eventually go on the meds himself, because of that trust factor. He realized that everyone is different, that this is not 15 years ago, and that there are a lot of new meds with fewer side effects. I think because we talked about those things and read so much, he was able to base his deci-

I had a client the other day who was concerned about the family cat. He said, "I haven't told my family that I'm positive. How do I not mess with the litter box? They're going to question me." We tried to give him some options, because it's not about us telling him when to disclose. It's about helping him take care of himself. If we get them to care for themselves, that will allow them to care for other people, too.

### **What about people who don't tell their sex partners?**

Sometimes I just want to say, "Man, do the right thing!" One of my clients was a sex worker. On the inside, he was having a lot of sex, just to pass the time. When he came out, he was sleeping with his wife and with other women, but he would not disclose. When I asked if he used condoms, he said it "depended". I tried to engage him – not just about the disclosing part, not what he did while he was in prison, but, "Hey, how about using a condom for your own safety?" And I want to believe that he's gotten better with that – when I've asked again, he says, "I'm doing good." But "good" means a lot of different things. He may use a condom three times out of five, but that's better than no times out of five.

And the earlier that conversation happens, the better. If there are peer programs in prison where they feel comfortable enough to talk, that's great. In one of our programs, Project START, we do that from the very beginning. We talk about risk reduction and being safe. So when they come out, they've heard this idea, they know how to protect themselves and others. Because once they get out, they may have a whole other agenda. In prison, we have a captive audience. They don't mind coming down for the counseling. But once they're out, they're going to do what they want to do. So if the safer sex counseling can happen prior to release, I certainly think the outcome will be better.

### **Is it easier for clients to talk to a peer as opposed to service providers?**

The power division in correctional institutions is very clear. The staff doesn't care about anything except keeping order. So I can't act like I'm a correctional officer – I'm not your parole officer. I have to make it clear that we're in this together. It's not about you against me or me against you. It's an "us" thing. Then the client says, "Wow, you're inviting me in this process?" You know, I've actually seen care plans done without the client. How do you create a care plan without the client being there, and expect them to sign off on it? That's insane! So I engage them

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from the very beginning and let them know this is a partnership – it’s not about me being in control and you following my lead. It’s about, “What steps will you take to address your needs and how can I assist you?”

In prison, it’s all about being manipulative, about telling people what they want to hear. It’s about trying to be safe: “I don’t want you to be mad at me.” It’s the “bad parent, good parent” thing – always trying to please the person in power, to be good. Surprisingly, it’s often the person who acts out and has problems that makes progress. I’m more concerned about the people who always do what they’re supposed to do. How do you not act out in the process of growth? It has to be uncomfortable – it is uncomfortable.

People who are institutionalized get so conditioned to say the right things. I’ve had clients who’ve been to every program in the city, so they know exactly what providers are going to ask and they know the right answer – the answers that are going to meet their needs at that moment. It becomes a game: Who’s going to blink first? So I have to be very clear: “Hey, I’ve been there, I know what’s up.” And in the end, the reality is that I work for you. Your provider, your doctor – they work for you. You’re empowered here. We try to facilitate that understanding.



So they come to places like Exponents and begin to see things differently.

I had a client who said, “Wow, you laugh a lot in here.” I said, “We do. We do a lot of work, but we laugh a whole lot more than not.” And he kept coming back. I think it made a difference. At other places, it was all about, “Where’s your Medicaid card? You must be here on this day at this time.” But we have fun here, and people aren’t used to that. You

groups would be part of the transition for addicts, alcoholics, people with HIV or HCV, and any other serious problems. I would almost mandate that, but I don’t feel anyone should be forced to do anything. If you want something to work, the person has to buy into it. So let’s say I’d make it a strongly recommended “condition” of release.

I would make community-based organizations a part of the discharge planning once again. Condoms would be distributed freely inside prisons. And inmates would receive the same standard of medical care that is expected on the outside, from doctors who are experienced in HIV and HCV. I would immediately end the color-coding of medical charts and create private spaces for clinic visits, to protect confidentiality. And I would end the segregation and ghettoization of people with HIV and HCV. That doesn’t work – education does. Finally, medicines would not be withheld due to cost, and would be provided for at least 30 days after discharge.

If we really took discharge planning seriously – beginning it as soon as people enter the system and continuing it as long as needed after they are out – we would have a real chance to make sure they never have to go through it again. ■

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**I’ve actually seen care plans done without the client. How do you create a care plan without the client being there, and expect them to sign off on it? That’s insane! So I engage them from the very beginning and let them know this is a partnership.**

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A lot of clients come in with a poker face, with the intent to play the game. But once they get here, they realize they don’t have to. They can be real and vulnerable and still get their needs met, and they won’t be looked at as “less than”. They can’t be vulnerable and fearful in jail. They have to either wash people’s clothes and act like a doormat or fight back and maybe get cut. They don’t believe there’s a happy medium.

don’t have to pretend here, and people aren’t used to that. And once they know that, we can’t get rid of them!

**If you were king of NYC, how would you improve transition services?**

That’s a tall order! Well, first, I would make sure that housing was available for everyone who needed it, along with job training and placement services. Support

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*Mark Milano is the Editor of Achieve.*



# Since When Are Condoms Illegal?

by Melissa Ditmor, Angela Torregoza, and Andrew Silapaswan

**M**en who have sex with men (MSM) and sex workers are among the most vulnerable to HIV. To combat this, prevention programs have focused on encouraging condom use to help prevent transmission. Prisoners need them, since the reality of prison life often includes sexual activity. Sex workers need easy access to condoms and other safer sex supplies, and the ability to carry and use them without fear of arrest or violence.

Yet there are laws in the U.S. that make it difficult for people to protect themselves, especially people who interact with the criminal justice system. The lack of condoms in prisons and laws that use condoms as evidence of prostitution are examples of these policies. These laws increase the likelihood of HIV transmission both in and out of prisons. Plus, they single out certain groups as “unworthy” of protection, and make everyone less safe. But activists are fighting back to secure their rights and to help prevent the transmission of HIV.

## Condoms in Prisons and Jails

Condoms are currently illegal in most of the country’s jails and prisons, even

though there is an increasing need to protect the health and well-being of inmates. The lack of condoms is a big problem because prisoners are highly vulnerable to HIV, hepatitis B virus (HBV), hepatitis C virus (HCV), and other infectious diseases. In 2008 alone, 1.5% of all U.S. prisoners had HIV, four times higher than the rate in the general population.

The high rate of sexual assault in prisons fuels calls for condoms to be made

Despite the occurrence of high-risk sexual activity, rape, and the risk of STIs, only five county jail systems (New York, Philadelphia, San Francisco, Los Angeles, and Washington, D.C.) and two state prison systems (Vermont and Mississippi) allow inmates access to condoms. This represents less than 1% of all U.S. prisons. Increasing condom availability in the prison system will go a long way toward protecting inmates.

Studies show that sex workers, LGBT people, and inmates who are smaller framed are at greatest risk of sexual assault. In the context of prison rape, a lack of condoms places prisoners at increased risk of HIV and other STIs.

available. According to the Bureau of Justice Statistics, 60,500 inmates experienced at least one incident of sexual assault by other inmates or staff in 2007. Studies show that sex workers, LGBT people, and inmates who are smaller framed are at greatest risk of sexual assault. In the context of prison rape, a lack of condoms places inmates at increased risk of HIV and other STIs.

The success of current programs that offer condoms to prisoners proves how helpful that can be. The Central Detention Facility of Washington, D.C., began providing condoms to prisoners in 1993. Each month condoms are provided through public health and AIDS service organizations. Condoms are available at health education classes, during voluntary HIV test counseling,

or upon request to health care staff. Since condoms were made available, 55% of inmates and 64% of correctional officers support the measure. Only 13% of correctional officers are aware of any problems with condom availability, but details about these issues have not been provided. Likewise, no security issues have been reported relating to condom availability and there is no evidence that sexual activity has increased.

Although a majority supports making condoms available in prisons, 89% of inmates have not requested them. Also, 65% of those who have received condoms never used them. These results suggest that although condoms are available when a prisoner is able to request them, not many condoms are distributed throughout the prison. A possible explanation for this is that inmates are unwilling to request condoms because this would also be an admission that he or she is engaging in sexual activity. Policy makers should take this into consideration when creating new HIV prevention policies.

The U.S. can look to Canada as an example, since condoms have been available in Canadian prisons since 1992. Like the Washington Detention facility, condoms were initially available only through health care providers in the prisons. Many inmates reported that they would be more likely to access condoms if they were made available apart from health services. In response, condoms have been made available since 1994 in areas where inmates are not seen by staff or other inmates. Condoms are placed in bowls and other containers in sites such as washrooms, shower areas, and libraries. The introduction of condoms in Canadian prisons has met with much success, and no facility

that has made condoms available has reversed the policy.

### **The Fight Continues**

Often those who oppose providing condoms to prisoners argue that it supports homosexual activity, which conflicts with their religious, cultural, or moral beliefs. Others fear it will increase sexual activity,

in prisons were passed in 2005 and in 2007, but both times were vetoed by Governor Schwarzenegger. Senator Velmanette Montgomery sponsored a bill in the New York Senate in 2011 that would require prisons to provide condoms. The bill has yet to come to a vote. On the federal level, the Justice Act was introduced by Barbara Lee (see page 22), including this language:



fighters, drug trafficking, and rape. Studies show, however, there is no evidence that security threats, prison rape, or sexual activity increase with access to condoms.

Those against allowing condoms in prisons argue that since sexual activity is illegal in prisons, condoms should not be offered. But, as is widely known, sexual activity is common in prisons. Moral judgments about sexual activity must not direct public health policy. Condoms are a proven prevention tool against HIV and are necessary to protect the health of inmates.

Unfortunately, efforts to change policies regarding condoms in prisons have met challenges at the state and federal levels. In California, bills that would allow condoms

*Not later than 30 days after the date of enactment of this Act, the Attorney General shall direct the Bureau of Prisons to allow community organizations to distribute sexual barrier protection devices and to engage in STI counseling and STI prevention education in Federal correctional facilities.*

Activists continue to fight, and there are opportunities for people to take action. The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have called for access to condoms in prisons and jails as part of an HIV prevention strategy. The AIDS Coalition to Unleash Power (ACT UP) has also consistently advocated for

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HIV care reform and condom availability in prisons. ACT UP staged a demonstration at the Harlem State Office Building in 2004, and since then other demonstrations have gained momentum. These types of advocacy efforts can be replicated and demonstrate the potential for community members to get involved and to advocate for policy reform.



### **Condoms as Evidence of Prostitution**

In New York State there are additional barriers that limit access to safer sex supplies, particularly the fact that the law allows police to seize condoms as evidence during a prostitution arrest. Lawyers can use these condoms in court to “prove” the guilt of the individual arrested. Many are unaware that there are similar laws in most states.

In New York City, many sex workers report being harassed and arrested merely for carrying condoms. Many

sex workers share a misunderstanding that it is a crime to carry a certain number of condoms. As a result, sex workers may avoid carrying any, meaning they cannot protect themselves or their partners. Transgender women in particular are afraid to carry condoms because they are frequently subject to police profiling and arrested as prostitutes even if they are not. This causes great harm and is a misuse of limited government resources.

False arrests, especially those resulting from illegal searches, cost taxpayers.

This practice is not in line with the NYC Department of Health’s public health efforts, which distribute thousands of free condoms a year. Even some legal businesses are worried that if they provide city-sponsored free condoms, they can be viewed as houses of prostitution and shut down. Thus this practice harms prevention efforts, and many see it as a human rights and civil liberties issue.

Fortunately, these issues have been noticed by state legislators. Senator Velmanette Montgomery and Assemblymember Barbara Clark co-sponsored a bill that would prohibit condoms

from being used as evidence of prostitution. The bill also requires police officers to be instructed about this change in the law. Since most prostitution cases do not go to trial, this education is important to ensure the law is effective.

Sex workers have rallied around the bill and are fighting back against this unjust practice. Sex Work Awareness and the Sex Workers Project have hosted lobbying trainings, and sex workers and allies have met with lawmakers to tell them the police should never use as “evidence” the very tools sex workers need to keep themselves and their sexual partners safe. HIV prevention organizations, civil rights organizations, and medical providers have come out in support of the bill. Even the NYC Council has introduced a resolution in support. These groups have sent a strong message that the current law is not helpful in preventing new HIV infections.

### **Conclusion**

Studies show that making sex work illegal is generally harmful to public health efforts to prevent the spread of HIV and other STIs. These kinds of barriers to HIV prevention only make the problem worse. In spite of their fear of arrest, sex workers report that they continue to carry condoms to the best of their ability because health and protection come first. Encouraging safer sex practices among sex workers will result in health benefits and empower workers to make positive choices regarding their health, safety, and well-being.

The policies that allow condoms to be used as evidence of prostitution and the lack of condoms in prisons seriously hinder HIV prevention. Not only do they violate individuals’ rights to protect themselves, they directly increase the risk of HIV transmission both in and out of the prison system. Moving forward, the HIV prevention and treatment community and our elected officials must continue to advocate for condom availability and encourage condom use. ■

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*Melissa Ditmore is a research consultant and Angela Torregozo is a policy intern at the Sex Workers Project at the Urban Justice Center. Andrew Silapaswan is a public policy intern at GMHC.*

of injection drug use, while 340,000 state inmates and 170,000 federal inmates had shared needles at some time. If such a high proportion of people in prison have a history of drug use, and specifically injection drug use, prisons are bound to have higher rates of HIV and HCV infection than the general population.

### Recommendations

State and federal prisons should be concerned with protecting inmates from HIV and HCV infection, but they also need to address the stigma and homophobia that inmates are faced with. For inmates who enter prison already living with one of these viruses, confidentiality is of utmost importance. When HIV-positive inmates receive HIV meds, they should never have to wait in a separate line from their peers, which puts them at risk of ridicule, isolation, and severe emotional and physical abuse. Similarly, prison officials should be well trained in the



need for confidentiality and sensitivity toward HIV- and HCV-positive inmates. They should also be sensitive to the needs of lesbian, gay, bisexual, and transgender inmates since HIV stigma is still linked with this community. HIV stigma and homophobia only serve to push sexual activity and drug use further underground, putting inmates at greater risk of being infected or infecting others.

In addition, prisons should increase education about HIV and HCV prevention and care. For prisoners who have never received adequate health care and comprehensive sexual educa-

When HIV-positive inmates receive HIV meds, they should never have to wait in a separate line from their peers, which puts them at risk of ridicule, isolation, and severe emotional and physical abuse.

tion, the prison could be a turning point in their lives. If prisons use this unique opportunity to reach out to inmates, they could keep inmates healthier long after they leave the facility. This information could then serve to lower infection rates when prisoners return to their communities.

Passing out condoms and clean syringes could also have a positive impact on communities affected by high incarceration and injection drug use rates. The more people who leave prison HIV- and HCV-negative, and the more people living with an infection who leave prison healthier and more knowledgeable, the healthier their communities will be.

These communities could also see a dramatic drop in the spread of HIV and HCV if incarceration becomes less common. The “stop-and-frisk” policies that target people in these communities are often driven by racism, homophobia, and transphobia, and create unstable and unsafe environments for the most vulnerable populations.

Lastly, the instability in some communities that is driven by incarceration and fuels the spread of HIV and HCV is made even worse by high rates of recidivism (going back to jail or prison). The constant cycling in and out of prison leaves a community devastated. But this could be prevented with the proper resources. Research shows that if prisons educate inmates and assist them in finding employment, they are much less

likely to return to prison. If real opportunities were provided on a large scale, communities could begin to see much lower prison rates and, as a result, HIV and HCV infections. When communities are educated, the virus is less likely to spread.

By addressing the health and prevention needs of prisoners and their communities, prisons can help end the cycles of HIV and HCV infection. ■

*Elizabeth Lovinger is a Policy Associate at GMHC.*

# Freed From Prison, But Not Free

by Michael Booth

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+ 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.

My rapes – like most instances of rape behind bars – were preventable. California prisons are required to separate likely victims from likely perpetrators in their housing assignments. The person who raped me is a convicted rapist who had a documented history of assaulting gay cellmates. I'm gay and small statured and I should never have been housed with this vicious man.

I was scared from the first day I was moved into his cell. Before I went to bed that night, he tortured a mouse right in front of me. I told my psychologist the next day and she said she would talk to custody staff about having me moved. But it didn't happen.

The second night, he raped me for the first time. He pulled me off my bunk, held me down, and threatened me with a knife when I resisted. When it was over, he told me that he would kill me if I told anyone. He made it clear that he was serving a life sentence and had nothing to lose.

The following days were hell. Each night, he found new ways to humiliate and abuse me – each assault worse than the one before. During the day, he would brag to other prisoners about what he was doing to me and offer to “pass” me along to them. They talked about me like I was a piece of property. I felt so low.

When I thought it was safe, I tried multiple times to get help from staff. They just made me feel like I was the problem. The officers ridiculed me and shrugged off my pleas for help. They acted like I was just complaining about a “lovers' spat”.

Luckily after several days of this, my rapist was taken to the medical ward because of chest pains. I begged the first officer I saw to help me, but he ignored me. Luckily, a second officer who happened to be passing by took me seriously and got me out of the cell.

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**He pulled me off my bunk, held me down, and threatened me with a knife when I resisted. When it was over, he told me that he would kill me if I told anyone. He made it clear that he was serving a life sentence and had nothing to lose.**

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Now out of immediate danger, I began to sense the devastating consequences of the assaults. It was very difficult for me to deal with the overwhelming anger, stress, and depression. The emotional and spiritual defeat that I experienced led to a complete mental breakdown. My doctors tell me that the physical and emotional trauma from the attacks worsened my HIV status and resulted in changes to my viral load. When I entered prison, my viral load was undetectable and my CD4 count was 700. After the attack, my viral load was over 70,000 and my CD4 count dropped to around 200. I don't have words to describe what this decline meant to me; my attacker had shattered my soul – and stolen my health.



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The trauma from the attacks worsened my HIV status and resulted in changes to my viral load. I don't have words to describe what this decline meant to me; my attacker had shattered my soul – and stolen my health.

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I can be strong now because the folks at JDI, my mom, and some close friends believed in me. Their support gave me strength. I am also a much healthier person; my viral load is undetectable again and my CD4 count is back up over 500. Even now, almost two years later, JDI still provides me with the support I need.

Not everyone is so lucky. Of the hundreds of thousands of men, women, and children who are sexually abused each year in U.S. detention, most do not get even the delayed response that I got from prison staff. Many do not have the benefit of support from family and friends. For them, the impact can be even worse than what I've suffered.

Knowing first-hand the devastation of prisoner rape, I want to make sure this kind of abuse doesn't happen to anyone else – ever. The prison where I was incarcerated should have never let a rapist get near me. When he raped me, they should have listened to me and responded quickly and professionally.

It's not easy to share this story. But if another survivor of prisoner rape reads it and feels less alone, or if it inspires an AIDS service organization to become more involved with HIV-positive prisoners, or if it motivates anyone to contact a prison official or elected representative and ask what they're doing to end prison rape, I will have done my job. Through sharing my story, I know I am making a difference. ■

I've heard of people who are HIV positive who go ten or more years without having to go onto medications. Before I was assaulted, my doctor and I agreed that I could be one of those people. After the attack, I had no choice but to begin a regimen. And once you start one, you have to stay on it. When I think about the inconvenience of taking daily medications and the side effects, I feel like my rapist robbed me of my future.

As I slowly started to regain touch with reality, I made contact with a human rights organization called Just Detention International. They are the only organization dedicated to ending sexual violence behind bars and they held my hand through the mail as I tried to put my life back together. They put me in contact with rape crisis services and were also able to help me find legal resources to seek justice.

# Anti-HIV Criminalization Bill Introduced

By Julie Turkewitz

**C**ongresswoman Barbara Lee (D-CA) has introduced an unprecedented piece of legislation that could put an end to laws that impose cruel and unfair penalties on HIV-positive people in the U.S.

The bill, called the REPEAL HIV Discrimination Act, calls for a review of all federal and state laws, policies, and regulations regarding the criminal prosecution of individuals for HIV-related offenses. It then creates incentives for governments to reform existing policies that use the law to target HIV-positive people.

Introduced on September 23rd, the legislation “relies on science and public health, rather than punishment, as the lead response to HIV exposure and transmission incidents,” said Catherine Hanssens, executive director of the New York-based Center for HIV Law and Policy.

“It embodies the courage and leadership needed to replace expensive, pointless and punitive reactions to the complex challenge of HIV with approaches that can truly reduce transmission and stigma.”

Thirty-four states and two U.S. territories have criminal statutes that punish people for exposing a person to HIV or transmitting it. Punishments range from a fine to up to 30 years in prison, according to the Center for HIV Law and Policy. In some states, exposure or transmission is a felony, and convicted individuals are sometimes forced to register as sex offenders, a label

that drastically affects job, housing and education prospects for the rest of their lives.

“This bill gives a lot of people hope,” said Tracy Johnson, 23, an HIV-positive man from Ohio, where engaging in sexual activity without disclosing you have HIV is a felony. “These laws have made me feel like I’m a criminal because I have this illness. Even if I disclose, I know I can still be arrested if my partner gets mad at me and tells the police I didn’t do so.”

For years, many AIDS activists have argued that laws that punish HIV exposure or transmission cannot be applied justly. Instead of protecting the public health, activists argue, these statutes often backfire, discouraging people from seeking testing.

A fact sheet created by the Center for HIV Law and Policy, AIDS United, Lambda Legal and the ACLU AIDS Project summarizes the problems with HIV criminalization and the measures the new bill takes to address them. The bill has 12 cosponsors. Is your representative one of them?

Cosponsors: Reps. Donna Christensen (D-VI), Hansen Clarke (D-MI-13), Steve Cohen (D-TN-9), Raul Grijalva (D-AZ-7), Maurice Hinchey (D-NY-22), Jesse Jackson (D-IL-2), Eleanor Holmes Norton (D-DC), Mike Quigley (D-IL-5), Charles Rangel (D-NY-15), Gregorio Kilili Camacho Sablan (D-MP), Jose Serrano (D-NY-16), Lynn Woolsey (D-CA-6).

*Julie Turkewitz is the staff writer at Housing Works.*

## The New York State Criminal Justice Initiative

The Criminal Justice Initiative (CJI) was developed by the NYS DOH AIDS Institute in 1990 in response to the needs of inmates and ex-offenders with or at risk for HIV. Its goal is to provide a continuum of HIV prevention and supportive services, and funding is divided in the following categories: Services to Women; Services to Men; Community Services Coordination upon Release; and a prison HIV hotline.

The services provided in correctional settings include HIV prevention interventions, peer educator training, HIV counseling and testing, HIV supportive services, and transitional planning.

The CJI also funds community-based organizations to provide re-entry assistance for ex-offenders with HIV, including transportation, supportive services, risk reduction counseling, coordination of health and human services, and referral to community case management. The Prison HIV Hotline offers state inmates the opportunity to call collect for HIV information and counseling.

In facilities served by DOH and its contractors, voluntary HIV testing, anonymous or confidential, is offered. Dixon Valderruten of the Osborne Association (funded by CJI since 1990) says, “Inmates often feel more comfortable when they get services from an outside agency. For example, they may choose to take the HIV test with us because we’re not part of the system.”

Agencies funded as of March 2011 are: Pathstone Corporation ([pathstone.org](http://pathstone.org)), Women’s Prison Association ([wpaonline.org](http://wpaonline.org)), AIDS Community Services of Western New York ([aidscommunityservice.com](http://aidscommunityservice.com)), Action for a Better Community ([abcinfo.org](http://abcinfo.org)), Southern Tier AIDS Program ([stapinc.org](http://stapinc.org)), Center for Community Alternatives ([communityalternatives.org](http://communityalternatives.org)), AIDS Community Resources ([aidscommunityresources.com](http://aidscommunityresources.com)), AIDS Council of Northeastern New York ([aidsCouncil.org](http://aidsCouncil.org)), Mid Hudson Valley AIDS Task Force ([arcs.org](http://arcs.org)), Osborne Association ([osborneny.org](http://osborneny.org)), Community Health Action of Staten Island ([chasingny.org](http://chasingny.org)), Group Ministries ([groupministries.com](http://groupministries.com)), and Roswell Park ([roswellpark.org](http://roswellpark.org)).

## The Prison Rape Elimination Act

Many may turn the other cheek, or even feel the act justified, but there is nothing acceptable about prison rape. Prison rape in the U.S. corrections system is a serious issue that places victims of the assault at great risk of contracting sexually transmitted diseases, including HIV, and hepatitis C virus. In 2007 alone, 60,500 inmates experienced at least one incident of sexual assault by other inmates or staff while incarcerated. This does not include all those who were raped and did not come forward out of fear of negative consequences. This alarming statistic indicates that inmates' health and safety are not being protected.

To address the devastating effects of prison rape, President George W. Bush signed the Prison Rape Elimination Act (PREA) in 2003. This legislation established a set of guidelines for preventing and addressing rape in prisons, data collection requirements, and grant funding. Under PREA, a bipartisan panel called the National Prison Rape Elimination Commission (NPREC) was formed to conduct research on how best to prevent, report, and respond to prison rape. This research was featured in a 2009 report outlining several recommendations regarding rape prevention and response planning, including training prison staff in ways they can help prevent and respond to cases of sexual assault. The report also recommends methods to ensure that all allegations of sexual victimization are fully investigated.

Although the report recommends a variety of improvements to national standards for addressing prison rape, it falls short in areas necessary to protect inmates adequately. This is especially true for those at most risk of sexual assault.

The training and education recommendations featured in the NPREC report are rather general. For example, they do not outline any specific information based on sexual orientation or gender identity – two issues that cannot be ignored when addressing sexual assault in prisons.

Studies show that inmates who are gay or perceived to be gay, transgender, or gender nonconforming, are at high risk of sexual assault in prisons. One study conducted by Wooden and Parker found that 41% of gay men are sexually assaulted in prison, compared with 9% of heterosexual men. The Human Rights Watch also lists several characteristics that place individuals at increased risk of sexual assault, including youth, small size, being gay, and possessing “feminine characteristics.” Since lesbian, gay, bisexual, and transgender (LGBT) people are particularly vulnerable to sexual abuse, staff must receive appropriate training that addresses LGBT-specific issues.

Sexual abuse committed by staff members of the opposite sex is also a great concern, and many inmates report sexual assault at the hands of prison staff. NPREC advised against staff viewing or supervising inmates of the opposite sex who are nude or performing bodily functions. Although this strategy offers some protection to inmates, it fails to address same-sex abuse committed by staff. Furthermore, the supervision standards do not even begin to address the needs of transgender or gender-nonconforming inmates, who are also at high-risk of sexual assault in prisons.

The NPREC report was submitted to U.S. Attorney General Eric Holder for review. In February 2011, Attorney General Holder released a new report with a much weakened set of federal guidelines to respond to prison rape. Many of the report's recommendations were watered down in Holder's new proposal. For example, the NPREC report advised that correctional facilities be monitored by independent auditors, to ensure they follow the proposed standards. Holder did not adopt this requirement, however, and omitting it jeopardizes NPREC's standards from being enforced and correctional facilities from adhering to them.

The new report has been especially criticized for allowing cross-gender pat-downs. This completely ignores the potential for continued abuse from correctional facility staff.

Furthermore, the new report has also been criticized for the exclusion of immigration detention facilities. This is especially problematic since immigration detention facilities are known for their poor living conditions. According to a *New York Times* article in 2008, nine out of 66 people who died in a detention facility died from HIV-related complications, often because they were denied treatment. Removing immigration detention facilities from the NPREC's standards undermines HIV prevention efforts

and further compromises inmates' overall health and safety.

From a legal standpoint, inmates have certain rights that are protected under the U.S. Constitution. It is arguable that current practices are violating inmates' health and safety. According to PREA, “the deliberate indifference to the substantial risk of sexual assault violates inmates' rights under the Cruel and Unusual Punishment Clause of the Eighth Amendment.” It is therefore essential that NPREC's standards are quickly adopted, and not weakened. In fact, its recommendations could be bolstered to improve protections for the most vulnerable inmates.

PREA is an important step in reducing the rate of prison rape and protecting the health and well-being of inmates. The Department of Justice estimates that final recommendations for rape prevention will be published later this year. It remains to be seen, however, how far the standards will actually go toward protecting inmates from sexual assault. ■



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## ACRIA, Statewide Center of Expertise on Aging and HIV, STIs, and Hepatitis

ACRIA has been awarded five-year funding from the New York State DOH AIDS Institute as a Center of Expertise on Aging and HIV, STIs, and Viral Hepatitis. ACRIA will lead the development of training curricula and deliver in-person and live webinar trainings throughout New York State. This funding allows ACRIA to strengthen the work done in early 2010 with the State Office on Aging and regional partner and participant organizations.

For more information about training centers funded by the NYSDOH/AIDS Institute go to [www.nyhealth.gov/diseases/aids/training](http://www.nyhealth.gov/diseases/aids/training). For more information on ACRIA's trainings, contact Hanna Tessema, at 212-924-3934 x 135 or [htessema@acria.org](mailto:htessema@acria.org).

## Cut the Deficit, Not the Care!

### A CALL TO ACTION

Medicaid could be a target for deep cuts by the "super committee", the group of Congressional members in charge of reducing the federal budget.

Millions of Americans, including people with HIV, rely on Medicaid for their basic health care needs. In order to reduce new infections and save on long-term healthcare costs, we must continue funding care, prevention, treatment, and support services programs for those living with or at risk for HIV. These include Medicaid, Medicare, and current reforms promising extended health care coverage.

Call your legislators at 202-224-3121, and tell them not to cut Medicaid and Medicare! Penalizing people with HIV will only cost more in lives and money.