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Care to Prevent HIV Infection in Prison: A Moral Right Recognized by Canada While the United States Lags Behind

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"This issue is neither sexy nor easy. But it must be addressed and we must somehow get across the message . . . ."[1]

I. HIV, A GLOBAL EPIDEMIC IMPACTING COMMUNITIES IN THE UNITED STATES

HIV/AIDS is a global epidemic. Since the epidemic began,

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1. J. Homer Perez, *AIDS Behind Bars: We Should All Care*, BODY POSITIVE, Jan. 1997, *available at* http://www.thebody.com/bp/jan97/aidsbe.html.

over 60 million people have been infected causing over 20 million deaths.[2] At the end of 2003, between 1,039,000 and 1,185,000 persons were estimated to be living with HIV/AIDS in the United States.[3] Between 24% and 27% of these infected individuals are estimated to be undiagnosed and unaware of their disease.[4] While efforts to educate Americans regarding methods of infection transmission (unprotected sex, mother-to-child infection, drug use) have been successful, certain populations remain vulnerable to infection. One of these populations is prisoners.

In 1997, the Health Resource Services Administration determined that the incidence of HIV in prison facilities was fourteen times greater than that of the general population.[5] Dr. Virginia Cargill of the Office of AIDS Research at the National Institutes of Health (NIH) warned in 2002 about the dangerous correlation between incarceration and HIV infection. According to Dr. Cargill "prisons are major amplification centers for HIV infection and AIDS."[6]

Although the U.S. Department of Justice reports that the number of HIV-infected inmates has been declining steadily since 1999, 2.8% of female state prison inmates, and 1.9% of male state prison inmates are HIV positive.[7] The national inmate infection rate is between approximately 2% and 3%, although three states have much higher infection rates.[8] New York, which tests every inmate entering its prison population, reports that 7.6% of its inmates are HIV positive, followed by Maryland (4.2% infection rate) and Florida (3.9%).[9] Within the New York and Maryland prison systems, over 10% of female inmates are HIV positive (NY

2. JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS), UNAIDS POLICY POSITION PAPER: INTENSIFYING HIV PREVENTION 7 (2005), *available at* http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf.

3. DIV. OF HIV/AIDS PREVENTION, CTR. FOR DISEASE CONTROL, A GLANCE AT THE HIV/AIDS EPIDEMIC, (2005) (citing M. Glynn & P. Rhodes, *Estimated HIV Prevalence in the United States at the End of* 2003, National HIV Prevention Conference (June 2005)), *available at* http://www.cdc.gov/hiv/topics/surveillance/basic.htm.

4. *Id.*

5. Perez, *supra* note 1.

6. Carla Garnett, *HIV and AIDS Still Gaining Strength Among Minorities, Women, Prevention Important*, Treatment Imperative, THE NIH WORD ON HEALTH, Nov. 2002 at 1, *available at* http://www.nih.gov/news/WordonHealth/nov2002/HIVAIDS.htm.

7. LAURA M. MARUSCHAK, DEP'T OF JUSTICE, HIV IN PRISONS, 2003: BUREAU OF JUSTICE STATISTICS BULLETIN 1 (2005), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/hivp03.pdf.

8. *Id.* at 2.

9. *Id.*

14.6%, MD 11.1%).[10]

II. High-Risk Behavior in Prison

The reality of prison culture is that high-risk HIV-transmission behavior occurs behind bars. This behavior stems from physical, social, and psychological sources.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) notes that overcrowding, sexual tension, and an atmosphere of violence and fear contribute to the problem.[11] Even boredom is a factor with prisoners seeking relief from the daily routine through sex and drugs.[12] UNAIDS has also recognized the threat of HIV infection transmission in prison, calling prison conditions an ideal breeding grounds for HIV infection.[13]

Not only does inmate behavior affect HIV transmission, U.S. policy choices affecting the type of persons incarcerated also increases the infection risk within prison walls. The U.S. National Commission on AIDS stated that "by choosing mass imprisonment as the . . . governments' [sic] response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection."[14] As of January 28, 2006, 53.5% of U.S. federal prisoners were incarcerated for drug-related crimes.[15] Additionally, between 20% and 26% of Americans living with HIV/AIDS are estimated to have spent time in prison.[16] Thus, not only are individuals in prison more likely to engage in high-risk behavior, this behavior is more dangerous because HIV infection is more prevalent in prison than in free society.

The incarceration of drug addicted persons populates prisons with individuals hungry for drugs, often with little regard to the risks of sharing contaminated needles. While frequency of drug

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10. *Id.* at 3.

11. *UNAIDS Report Focuses on HIV, TB in Prisons*, Health & Medicine Week, July 7, 2003, at 12, *available at* LexisNexis Academic.

12. *Id.*

13. *Id.*

14. Canadian HIV/AIDS Legal Network, Info Sheet No. 1, HIV/AIDS in Prisons 2004/2005: HIV/AIDS and Hepatitis C in Prisons: The Facts 2 (3d ed. 2004), *available at* http://www.aidslaw.ca/Maincontent/issues/prisons/e-revinfo-pa1.pdf [hereinafter HIV/AIDS and Hepatitis C in Prisons: The Facts].

15. Federal Bureau of Prisons, U.S. Dept. of Justice, Quick Facts about the Bureau of Prisons: Types of Offense, *available at* http://www.bop.gov/news/quick.jsp#4 (last visited Feb. 11, 2006).

16. Elizabeth Kantor, Ctr. for HIV Info., Univ. of Cal. S.F. HIV InSite Knowledge Base Chapter: HIV Transmission and Prevention in Prisons, Feb. 2003, http://hivinsite.ucsf.edu/InSite?page=KB-07&doc=KB-07-04-13.

use typically decreases with incarceration, the likelihood that a prisoner will inject in an unsafe manner increases.[17] Canadian prisoners reported that the combination of prevalent injection drug use and the scarcity of needles often leads to a single needle being shared by between fifteen and twenty inmates.[18]

However, while high-risk injection drug use is one transmission behavior, prisoners also expose themselves to infection in other ways. One such transmission method is tattooing. In Canada, 45% of inmates admitted to tattooing themselves in prison.[19] This behavior, similar to injection drug use, requires the use of either needles or a makeshift tattooing device, which, as a shared commodity in prison, contributes to HIV transmission.

Finally, and perhaps most notoriously, unprotected sex is a real problem in prisons. Non-consensual sex is present in correctional facilities. One source deems prison rape "a fact of life" that is sometimes even condoned by prison guards as a disciplinary action.[20] Exact figures of prison rape are difficult to find because the issue of male rape is considered taboo in public discussion and is thus hidden behind a "curtain of silence."[21] However, academic studies identify "shockingly high rates of sexual abuse."[22]

In addition to non-consensual sex, individuals who identify themselves as heterosexuals often participate in consensual, homosexual sex while incarcerated.[23] A 2002 study of incarcerated female felons in Canada revealed that 37% of surveyed inmates reported being sexually active while in prison.[24] It is clear that sexual behavior within prison walls is varied and often different in character from an inmate's sexual lifestyle while not incarcerated.

Thus, prison walls house individuals more likely than the average citizen to be infected with HIV as a result of strict drug-

17. CANADIAN HIV/AIDS LEGAL NETWORK, INFO SHEET NO. 2, HIV/AIDS IN PRISONS 2004/2005: HIGH RISK BEHAVIOURS BEHIND BARS 1-2 (3d ed. 2004), *available at* http://www.aidslaw.ca/Maincontent/issues/prisons/e-revinfo-pa2.pdf [hereinafter HIGH RISK BEHAVIOURS BEHIND BARS].

18. *Id.* at 1.

19. *Id.* at 2.

20. Rita E. Watson & Jessica L. Riceberg, Op-Ed., *A Dangerous Gap on AIDS Care in Prison*, BOSTON GLOBE, July 13, 2002, at A15.

21. JOANNE MARINER, HUMAN RIGHTS WATCH, NO ESCAPE: MALE RAPE IN U.S. PRISONS: SUMMARY AND RECOMMENDATIONS 3 (2001) (quoting Stephen Donaldson of the Stop Prison Rape organization), *available at* http://www.hrw.org/reports/2001/prison/report1.html#_1_5.

22. *Id.* at 4.

23. *Id.* at 70.

24. HIV/AIDS: HIGH RISK BEHAVIOURS BEHIND BARS, *supra* note 17, at 2.

offense sentencing policies. Unfortunately, the public health risk these inmates represent is amplified by high-risk behavior that increases the likelihood individuals entering prison without infection will contract the disease while incarcerated.

III. CANADA'S MANAGEMENT OF HIV PREVENTION IN PRISON

Canada has responded to the problem of HIV transmission in prison much more aggressively than the United States. Studies of Canadian prisons demonstrated that the HIV seroprevalence in incarcerated individuals was ten times that of the general Canadian population.[25]

By as early as January 1, 1992, Canada responded by making condoms available to its federal prisoners.[26] Not only has Canada continued condom distribution within its federal prisons, the country has even responded to inmate hesitation to obtain condoms (for fear of homophobia) by making condoms, lubricant, and dental dams more discretely and easily available.[27]

Canada is not alone. According to a World Health Organization survey of fifty-two prison systems, twenty-three of those systems distributed condoms to inmates.[28]

The Canadian government has responded similarly to the HIV infection risk contracted via injection drug use. Bleach can be used to sterilize shared needles and was made available to all Canadian inmates in the fall of 1996, after the release of a 1994 report by the Expert Committee on AIDS and Prisons (ECAP).[29] The report explained that the provision of bleach "in no way condones drug use, but rather emphasizes that in correctional facilities as elsewhere, the overriding concern . . . needs to be the health of the persons involved and of the community as a whole."[30] This holistic approach recognizes the risk of HIV transmission in prisons and chooses both inmate and community health over a

25. HIV/AIDS AND HEPATITIS C IN PRISONS: THE FACTS, *supra* note 14, at 1.

26. CANADIAN HIV/AIDS LEGAL NETWORK, INFO SHEET NO. 4, HIV/AIDS IN PRISONS 2004/2005: PREVENTION: CONDOMS 1 (3d ed. 2004), *available at* http://www.aidslaw.ca/Maincontent/issues/prisons/e-revinfo-pa4.pdf.

27. *Id.*

28. *Id.*

29. *See* CANADIAN HIV/AIDS LEGAL NETWORK, INFO SHEET NO. 5, HIV/AIDS IN PRISONS 2004/2005: PREVENTION: BLEACH 1 (3d ed. 2004), *available at* http://www.aidslaw.ca/Maincontent/issues/prisons/e-revinfo-pa5.pdf.

30. *Id.*

stubborn refusal to concede that such illegal behavior occurs even within prison walls.

Recently, Canada has taken another innovative approach to curbing the risk of contracting HIV in prison. Canada implemented a tattoo project in six of its correctional facilities, allowing inmates to be tattooed in a safer environment within the prisons.[31] The sites are funded by Correctional Service Canada and operated by professionally trained inmate tattoo artists.[32] Inmates pay $5 CAD per session, while the inmate-tattoo artist is paid $5 CAD daily for the service. While the project drew criticism for its hefty start-up costs (roughly $700,000 CAD), officials from Correctional Service Canada believe the investment is a smart one.[33] "The Center for Disease Control invests 10 times as much as the pilot program costs to treat offenders affected by HIV and hepatitis C . . . . For us, it is a public health issue."[34] Another spokesperson for Correctional Service Canada similarly explained, "we can take a practice that already occurs, and make it safer."[35]

Through condom and bleach distribution and an innovative prison tattooing system, Canada's actions to prevent HIV infection in prison go beyond simply outlawing high-risk behavior. Canada's model recognizes that prisoners break prison rules in ways that risk infection with a lethal virus. Instead of allowing its system to accept that risk, the Canadian response aims to stop infection transmission, even if it means recognizing that its own prisoners break prison rules.

IV. MANAGEMENT OF HIV INFECTION RISK IN UNITED STATES PRISONS

Unfortunately, the United States has not responded to the problem of HIV in its prison system in a progressive manner. In fact, it can be argued that the United States prison system and its management either ignore or do not care about the spread of HIV within prison walls. Rather than prevent HIV infection among inmates, the U.S. prison system attempts to regulate behavior that runs rampant in its prisons.

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31. Emanuella Grinberg, *Canadian Prisons Open Tattoo Pilot Program for Inmates,* COURT TV.COM, Nov. 23, 2005, http://www.courttv.com/people/2005/1122/prisontattoos_ctv.html.

32. *Id.*

33. *Id.*

34. *Id.*

35. Scott Reycraft, *Good News for Inmates Who Aren't Already Tattooed*, REUTERS, Nov. 26, 2005, *available at* http://au.news.yahoo.com/051125/15/p/wyjt.html.

The main argument advanced by prison officials against supplying U.S. prisoners with measures to prevent the spread of disease is that most of the high-risk behavior transmitting the virus is against prison rules.[36] For example, sex is forbidden in prisons (in exception of conjugal visits).[37] Engaging in sexual acts and making sexual proposals or threats are considered "high category" disciplinary violations.[38] Illegal drug use is similarly prohibited and is ranked in the "greatest category" of discipline violations.[39] However, the reality is that such forbidden activities occur regardless of the prison rules. This reality is evidenced by prison drug addiction and discipline policies and special housing policies for HIV positive sexually threatening inmates.[40]

Prison administrators do not dispute the fact that prophylactic materials (including bleach and condoms) reduce the risk that prisoners might contract HIV or other infectious diseases.[41] While many prisons have HIV/AIDS educational programs in place, those prisoners that receive such an education are denied the means to effectuate such safe habits.[42] Rather than use resources to curb the risk of such dangerous behavior, prison officials and administrators argue that providing condoms and bleach would give an "inappropriate and confusing message to prisoners" if materials were supplied to protect inmates participating in otherwise banned activities.[43] This logic is disappointing. The system effectively accepts transmission of an incurable and lethal disease to avoid the risk of "confusing" inmates about what is permitted within prison walls. Prisoner health succumbs to prison rules. Consequently, an inmate willing to violate sex and drug regulations has no protection from contracting a lethal disease.

A. Inmate Testing Protects Prison Officials, Not Inmates

The Federal Prison system does provide some protection from

36. *See* 28 C.F.R. § 541.13 (2006).
37. *Id.*
38. *Id.*
39. *Id.*
40. *Id.; see also* 28 C.F.R. § 541.62 (2006).
41. Dr. Robert L. Cohen, MD, Written testimony submitted to the Commission on Safety and Abuse in America's Prisons 5 (July 20, 2005), *available at* http://www.prisoncommission.org/statements/cohen_robert.pdf. Dr. Cohen is the former Director of Medical Services on Rikers Island, New York (1982-86) and is now an expert on correctional medical care.
42. Perez, *supra* note 1.
43. *Id.*

HIV positive inmates who pose danger to others.[44] This policy allows prison officials to place known HIV positive inmates in controlled housing status if they pose a health risk to others.[45] This risk may arise from predatory or promiscuous sexual behavior, assault involving the potential transmission of body fluids, or needle sharing.[46] However, although this policy addresses known HIV positive inmates with known threats to others, it does not provide protection from HIV infected inmates who are non-violent or whose HIV status is not known to prison administrators.[47]

Inmate HIV infection testing policies aim to prevent the infection risk for prison workers more than the inmate population itself.[48] Federal inmates whose sentences are six months or longer are tested if clinically indicated.[49] However, such testing may be refused by an inmate.[50] Mandatory testing (not requiring an inmate's consent) is available if there is well-founded reason to believe the inmate may have infected a prison employee.[51] Yet, there is no similar provision in place for a well-founded belief that an inmate has infected another inmate.[52]

Additionally, the Bureau of Prisons may initiate surveillance testing.[53] This testing may be refused, with the only consequence being a refusal to obey an order incident report.[54]

Finally, inmates may request testing.[55] However, this will only be performed once every twelve months unless the Bureau of Prisons feels further testing is warranted.[56] What qualifies as further warranted testing is not defined.[57]

Thus, the United States lags behind its northern neighbor in its response to the HIV infection problem in prisons. Prisoners, through high-risk behavior like sex, drug use, and tattooing, face a great risk of HIV infection while incarcerated.[58] Additionally, because of the United States' strict drug offense sentencing poli-

44. 28 C.F.R. § 541.60 (2006).
45. *Id.*
46. 28 C.F.R. § 541.62 (2006).
47. *See id.*
48. 28 C.F.R. § 549.12 (2006).
49. *Id.*
50. *Id.*
51. *Id.*
52. *See generally id.*
53. *Id.*
54. *Id.*
55. *Id.*
56. *Id.*
57. *See generally id.*
58. HIGH-RISK BEHAVIOURS BEHIND BARS, *supra* note 17, at 1-2.

cies, one can presume that drug users will cycle in and out of prisons and the free community.[59] While certain provisions are in place to prevent HIV infection, such as policies forbidding high-risk behavior in prisons, inmates remain engaged in these activities to the detriment of their own health and that of the free community.

Legal solutions are needed to push the prison system toward a more humane and effective response to HIV infection. However, as this comment details, our current legal system does not easily afford inmates the remedy of more effective prophylactic measures.

V. CONSTITUTIONAL ISSUES

The Supreme Court wrote in *Giannatti v. County of Los Angeles* that, "While a prisoner loses some civil rights . . . 'he continues to be protected by the due process and equal protection clauses which follow him through prison doors.'"[60]

The basis of these protections is detailed in *DeShaney v. Winnebago County Department of Social Services*.[61] In *DeShaney*, the Supreme Court recognized that the State has a duty to protect inmates it incarcerates.[62] Because the State deprives inmates of the ability to care for themselves, the Court reasoned, it is only "just" that the State be required to care for the inmate.[63] Therefore, the State's right to incarcerate individuals carries with it a corresponding duty to provide for the inmate's well-being and safety:[64]

> [W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – *e.g.*, food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.[65]

Justice Rehnquist explained that this duty arose not from the

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59. *See* HIV/AIDS AND HEPATITIS C IN PRISONS: THE FACTS, *supra* note 14, at 2,

60. Giannatti v. County of Los Angeles, 402 U.S. 992 (1971) (Douglas, J., dissenting) (quoting Jackson v. Bishop, 404 F. 2d 571, 576 (8th Cir. 1968)).

61. DeShaney v. Winnebago County Department of Social Services, 489 U.S. 189 (1989).

62. *Id.* at 199.

63. *Id.*

64. *Id.* at 200.

65. *Id.*

State's awareness of the risks an individual faced, or from the inmate's requests for protection or provision of care, but from the limitation the State has imposed on the inmate's freedom to provide for himself.[66] Thus, the right to a certain amount of protection arises simply from the inmate's incarceration.

A. Prisoners Rights via Equal Protection Claims

Prisoners also have rights which stem from the equal protection doctrine. Section one of the Fourteenth Amendment, ratified July 9, 1968, states: "nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protections of the laws."[67] Although the Federal Prison system is not administered by the states (and thus not analyzed under the Fourteenth Amendment), the Supreme Court stated in *Buckley v. Valeo* that "[e]qual protection analysis in the Fifth Amendment area is the same as that under the Fourteenth Amendment."[68] Thus, equal protection analysis under the Fourteenth Amendment applies to both state and federal prisons.

Prisoners may assert that their status as prisoners (as opposed to free persons) unconstitutionally limits rights they are entitled to under the Equal Protection Clause. However, these equal protection claims prove difficult under *Dandridge v. Williams,* a 1979 equal protection suit brought against the Maryland Department of Public Health.[69] In *Dandridge*, the Supreme Court ruled that Maryland was free to cap funds disbursed to welfare recipients, despite differences in family size.[70] While Dandridge and others argued this practice was discrimination in violation of the Equal Protection Clause, the Court disagreed.[71] The regulation in question dealt with the social and economic fields, not with freedoms protected by the Bill of Rights.[72] The Court stated that so long as the classification has some "reasonable basis," the Equal Protection Clause is not violated simply because such classification is "merely . . . imperfect" and results in some inequal-

66. *Id.*

67. U.S. CONST. amend. XIV, § 1.

68. Buckley v. Valeo, 424 U.S. 1, 93 (1976) (citing Weinberger v. Wiesenfeld, 420 U.S. 636, 638 n.2 (1975)).

69. Dandridge v. Williams, 397 U.S. 471 (1970).

70. *Id.* at 487.

71. *Id.* at 486.

72. *Id.* at 484.

ity.[73] The Court held that although Maryland's regulation may not have been wise, ideal, or the most just and humane system possible, the Constitution does not allow the Court to second-guess state officials responsible for allocating limited public welfare resources within the pool of possible recipients.[74]

Thus, *Dandridge* allows state prison officials to allocate their limited resources as they see fit. So long as access to preventative health care is not protected by the Bill of Rights, states may allocate limited funds as they wish.[75] *Dandridge* requires only that there be a reasonable justification for the state's decision.[76] Therefore, to overcome an equal protection claim the prison system need only demonstrate a reasonable justification for using funds for prophylactic materials elsewhere.

B. Prisoners Claims via the Eighth Amendment

In addition to rights prisoners may assert via the Equal Protection Clause, prisoners may also attempt to frame failed prevention of HIV infection in prison as cruel and unusual punishment under the Eighth Amendment. This Amendment, ratified April 8, 1913, states that "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."[77]

In 1976, the Supreme Court heard *Estelle v. Gamble* and clarified the elements necessary for a prisoner to bring an Eighth Amendment claim against a prison system.[78] Gamble's suit arose from a back injury sustained when a six hundred pound bale of cotton fell on him while he unloaded a truck.[79] Gamble's complaint alleged that Estelle, the Corrections Director, and others subjected him to cruel and unusual punishment, in violation of the Eighth Amendment.[80] However, he had been seen by seventeen medical professionals over a period of three months and his Eighth Amendment claim did not survive.[81]

Writing for the majority, Justice Marshall explained that while the Eighth Amendment originally concerned prohibition

73. *Id.* at 485.
74. *Id.* at 487.
75. *See id.* at 485.
76. *Id.*
77. U.S. CONST. amend. VIII.
78. Estelle v. Gamble, 429 U.S. 97 (1976).
79. *Id.* at 98-99.
80. *Id.* at 101.
81. *Id.* at 107.

against torture and other barbaric means of punishment, current prohibitions of the Eighth Amendment are broader.[82] The Eighth Amendment, as an embodiment of dignity, civilized standards, decency, and humanity, proscribes more than physical brutality.[83] The majority cited *Trop v. Dulles*, to recognize that punishments incompatible with "evolving standards of decency that mark the progress of a maturing society" are in violation of the Eighth Amendment.[84] These principles combine to require the government to provide medical care for incarcerated individuals.[85] Unnecessary pain and suffering, through denial of medical care, do not serve any penological purposes, and conflict with modern standards of decency.[86] Similarly, "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' . . . proscribed by the Eighth Amendment."[87] The Supreme Court concluded that to succeed under the Eighth Amendment, a prisoner must express not merely medical negligence, but deliberate indifference so as to offend evolving standards of decency.[88]

Nearly twenty years after *Estelle v. Gamble*, the Supreme Court revisited the issue of Eighth Amendment violations for prison inmates.[89] A transsexual inmate, Dee Farmer, sued various individuals within the Bureau of Prisons for violation of his Eighth Amendment rights after being transferred to a prison with a more violent population.[90] There, he was raped and beaten.[91] Farmer alleged that the prison officials were deliberately indifferent to his safety, particularly considering the vulnerability he faced as a transsexual.[92]

The majority opinion, written by Justice Souter, explained that the Constitution does not require that prisons be comfortable.[93] However, prisons must provide humane confinement conditions to include adequate food, shelter, clothing, medical care, and

82. *Id.* at 102.
83. *Id.*
84. *Id.* (citing Trop v. Dulles, 386 U.S. 86, 101 (1958)).
85. *Id.* at 103.
86. *Id.*
87. *Id.* at 104 (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).
88. *Id.* at 104, 106.
89. Farmer v. Brennan, 511 U.S. 825 (1994).
90. *Id.* at 830-31.
91. *Id.*
92. *Id.* at 831.
93. *Id* at 832 (citing Rhodes v. Chapman, 452 U.S. 337, 349 (1981)).

protection from violence inflicted by other prisoners.[94] While the Court warned that government officials are not free to let nature take its course in prisons, it recognized that not every injury inflicted in prison elicits a constitutional claim.[95] To reach the level of a constitutional violation, the alleged deprivation must pose a substantial risk of serious harm and the prison official must have acted with deliberate indifference to inmate health or safety.[96]

While Farmer sought an objective test of deliberate indifference, the Court adopted a subjective test.[97] To be liable, a prison official must "know[] of and disregard[] an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."[98] A violation of the Eighth Amendment does not occur simply because prison conditions are inhumane; rather, courts must look to the prison official's state of mind.[99] Justice Souter, however, wrote that an obvious risk can reach the level of deliberate indifference, particularly if it is longstanding, pervasive, well-documented, and expressly noted.[100]

Similarly, knowledge of a specific threat is not required; a risk of serious damage to an inmate's future health is sufficient.[101] Prison officials are not liable if they responded reasonably to a known risk, even if the response did not protect the inmate from harm.[102] Justice Souter wrote that while such behavior by prison officials may be "no cause for commendation, [it] cannot under our cases be condemned as the infliction of punishment."[103]

Thus, while *Farmer v. Brennan* permitted a claim to arise out of deliberate indifference or obvious risk to inmate's health, prison officials were protected if their response was reasonable. Under this rule, the prison administration's regulation against HIV transmission behaviors may constitute a reasonable response to the threat of infection.

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94. *Id.* at 832-833 (citing Hudson v. Palmer, 468 U.S. 517, 526-27 (1984)).
95. *See id.*
96. *Id.* at 834.
97. *See id.* at 837.
98. *Id.*
99. *Id.* at 838 (citing Wilson v. Seiter, 501 U.S. 294, 299 (1991)).
100. *Id.* at 840, 842.
101. *Id.* at 843.
102. *Id.* at 844.
103. *Id.* at 838.

In 1993, the Supreme Court once again reviewed conditions under which a prisoner can bring an Eighth Amendment claim against prison officials.[104] The claim involved an inmate whose cell-mate smoked five packs of cigarettes every day.[105] Justice White reviewed the Court's holding in *Hutto v. Finney*,[106] which held that the Eighth Amendment required a remedy for prison crowding that led to infectious maladies such as hepatitis and venereal disease.[107] This remedy was required even though the alleged harm was not immediate, and despite the fact that the risk might not affect all inmates that are exposed.[108] The Court refused to hold that "prison officials may be deliberately indifferent to the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms."[109]

The Court reiterated that the Eighth Amendment protects against sufficiently imminent dangers to prison inmates and is not limited to current serious health problems.[110] The condition must be such that it violates contemporary standards of decency, such that the risk is not one that society today tolerates.[111]

C. *Difficulties Prisoners Face in Posing Eighth Amendment Violation Claims*

Prison inmates face a variety of impediments in bringing claims for Eighth Amendment violations. The standard set forth in *Estelle v. Gamble* requires that prison officials act with deliberate indifference to serious medical needs of prisoners.[112] Such deliberate indifference must be of the sort that offends evolving standards of decency.[113] Prison officials may argue that prisoners are effectively protected from HIV transmission by the regulation of inmate lifestyle already in place. Prisons make behavior that transmits HIV illegal and prison administrators may argue that is enough.

Farmer v. Brennan added that the deliberate indifference

104. Helling v. McKinney, 509 U.S. 25 (1993).
105. *Id.* at 28.
106. 437 U.S. 678 (1978).
107. *Helling*, 509 U.S. at 33.
108. *Id.*
109. *Id.*
110. See *id.* at 34, 36.
111. *Id.* at 36.
112. Estelle v. Gamble, 429 U.S. 97, 106 (1976).
113. *Id.*

must be significantly serious to reach an Eighth Amendment claim.[114] Furthermore, the *Farmer* Court limited prisoners' potential claims by clarifying that the test for deliberate indifference is not an objective one.[115] A prison official must know of and disregard a risk to inmates' health or safety.[116] Additionally, because testing of inmates entering the prison system is not automatic, prison officials may claim ignorance of a specific inmate's infection.[117] However, one can argue that the general data from both government and health agencies demonstrates that prisons are a reservoir for HIV infection. This knowledge, while not specific to one prison over another, may put prison officials on notice that lethal infections may be lurking within prison walls, resulting in a serious risk to all inmates.

D. Fundamental Problems: Standing and the Prison Inmate

It seems extremely difficult for a prison inmate to successfully assert either an Equal Protection or Eighth Amendment claim to secure HIV prevention materials while incarcerated. However, despite the fact that these claims will likely fail under current law, a more fundamental problem exists regarding prisoner suits aiming to secure prophylactic materials. The standing doctrine ensures that the elements of a case or controversy, as required by Article III of the Constitution, exist in each claim.[118]

In *Lujan v. Defenders of Wildlife,* Justice Scalia articulated the elements necessary for standing: injury in fact which is concrete and particularized, actual or imminent; the existence of a fairly traceable causal connection between the injury and the action of the defendant, not some third party; and the likelihood, rather than speculation of, the injury.[119]

The power of the injury requirement is illustrated by examination of *City of Los Angeles v. Lyons*, a case seeking an injunction to prevent the continued use of the Los Angeles Police Department's chokehold policy.[120] Mr. Lyons had been stopped by police and put in a chokehold that left him unconscious and physically

114. Farmer v. Brennan, 511 U.S. 825, 834 (1994).
115. *Id.* at 837.
116. *Id.*
117. *See supra* notes 44-54 and accompanying text.
118. U.S. CONST. art. III, § 2, cl. 1.
119. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992).
120. City of Los Angeles v. Lyons, 461 U.S. 95, 98 (1983).

injured.[121] Although several other citizens had been killed via similar chokeholds, the Court held that Lyons did not meet the case or controversy requirements of Article III.[122] Lyons' claim that he could be choked again by the L.A.P.D. did not create an actual controversy required for the Court to enter a declaratory judgment.[123] Thus, because Mr. Lyons could not definitively prove that he would be choked again, his injunction request failed.[124]

Inmates uninfected with HIV face similar problems asserting injury. Like Mr. Lyons, inmates are unlikely to prove they will be victimized by HIV infection. Although it is possible that any inmate in our nation's hyper-infected prison system will contract HIV, infection remains a mere hypothetical possibility.

Similarly problematic, the standing doctrine requires that the injury be fairly traceable to the defendant.[125] Prison authorities will have the actions of third parties (other prison inmates) to protect them from the causal connection required for an Article III case or controversy. After all, it is not the prison authorities themselves infecting inmates, but other prisoners harboring the virus.

Unfortunately, legal relief seems difficult to secure for HIV seronegative prisoners seeking HIV prevention measures and materials during incarceration. Not only do inmates face serious hurdles in asserting either Equal Protection or Eighth Amendment claims, it is unlikely that a healthy inmate will meet the requirements to secure Article III standing.

VI. Protection of Prisoners as Economic Gain

One obvious benefit to protecting every prisoner from contracting HIV in prison is the health of the inmate himself.[126] The benefit is economic as well. Prisoners contracting HIV infection while incarcerated will require expensive medication for the rest of their lives.[127] It has been estimated that persons suffering from

121. *Id.* at 97-98.
122. *Id.* at 105.
123. *Id.* at 104.
124. *Id.* at 105-06.
125. *Id.* at 560.
126. For the purposes of this paper, inmates will be referenced as males. However, it is important to understand that a greater percentage of women are infected in the prison system than percentage of men. At the end of 2003, 2.6% of female inmates were infected with HIV, compared to 1.8% of male inmates. Maruschak, *supra* note 7, at 3.
127. Interview with Edgardo Resto, Clinical Case Manager, South Florida AIDS Network at Jackson Mem'l Hosp., in Miami, Fla. (Feb. 2, 2006).

AIDS require medication costing between $3,000 USD and $7,000 USD monthly.[128] This cost will be absorbed either by the prison medical system or by other agencies or service providers when, or if, the inmate returns to the general population.

Robert L. Cohen, MD, an advocate of prison health care reform, expressed concern in a report submitted to the Commission on Safety and abuse in America's Prisons.[129] Dr. Cohen stressed the need for HIV prevention in the incarcerated community.[130] Dr. Cohen reasons that because doctors will eventually be obligated to treat prisoners who contract venereal disease in prison, there is no reason not to provide condoms to inmates to prevent such spread of disease.[131] Dr. Cohen's testimony addresses not only the rights of prisoners to health care, but also the importance of infectious disease transmission prevention both from economic incentives and the requirement that physicians provide inmates quality care.[132]

VII. Impact of HIV on the Non-Incarcerated Community

Perhaps the most compelling societal reason to strengthen HIV prophylaxis in prison is the impact this HIV "amplification center" has on the greater community.[133] Regardless of one's personal beliefs about the rights of the incarcerated individual, it is hard to argue that protecting the general population from the dangers of an individual infecting others in the community is not worthwhile. It is the morally right thing to do, both for protection of prisoners themselves and for the free community. The 1996 United Nations Commission on Human Rights warned, "[p]risoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities."[134]

Dr. David Wohl, an infectious disease physician at the Uni-

128. *Id.*
129. Cohen, *supra* note 41.
130. *See id.*
131. *Id.* at 5.
132. *See id.*
133. Carla Garnett, *HIV and AIDS Still Gaining Strength Among Minorities, Women, Prevention Important*, Treatment Imperative, The NIH Word on Health, Nov. 2002 at 1, *available at* http://www.nih.gov/news/WordonHealth/nov2002/HIVAIDS.htm.
134. Canadian HIV/AIDS Legal Network, Info Sheet No. 12, HIV/AIDS in Prisons 2004/2005: A Moral Obligation to Act 2 (3d ed. 2004), *available at* http://www.aidslaw.ca/Maincontent/issues/prisons/e-revinfo-pa12.pdf.

versity of North Carolina, presented a study of eighty HIV-infected North Carolina prisoners.[135] Dr. Wohl designed a study to investigate the extent to which HIV-infected inmates contributed to HIV infection in their communities upon their release from prison.[136] Dr. Wohl's study concluded that HIV-infected inmates are at high-risk of infecting their partners upon release from prison.[137] Over half of inmates surveyed revealed they had sex since their release.[138] Almost one third of these inmates believed it was "very likely" or "somewhat likely" that their main partner would be infected.[139] Dr. Wohl's study concluded there is an urgent need for development of interventional programs to address these issues and reduce HIV infection within prisoners' communities.[140]

VIII. A Moral Obligation to Incarcerated Individuals

With the spread of HIV into less traditionally stigmatized populations, society has become more acutely aware of HIV as a disease that could impact us all. Additionally, the current strict sentencing guidelines for drug offenses in the United States yields a population of offenders that may cycle in and out of prison for drug convictions throughout their lifetimes.[141] This cyclical process transfers the inmate in and out of the general population, putting those citizens whom he or she encounters at risk for HIV infection. It is a stubborn and dangerous position, both economically and morally, to subject inmates to HIV infection simply because these persons engage in forbidden activities in prison such as sex and drug use. Because the HIV epidemic threatens us all, standards of decency should evolve to require that all inmates be afforded HIV prevention materials, not only for their sake, but for our own.

J. Homer Perez, an HIV positive activist, expressed similar concerns in an article entitled "AIDS Behind Bars: We Should All

135. David A. Wohl et al., *HIV Transmission Risk Behaviors among HIV-Infected Individuals Released from Prison*, 10th Conference on Retroviruses and Opportunistic Infections, Abstract 36, (February 10-14, 2003), *available at* http://www.aegis.com/conferences/croi/2003/36.html.

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. *See* HIV/AIDS and Hepatitis C in Prisons: The Facts, *supra* note 14, at 2.

Care" published in a 1997 issue of *Body Positive* magazine.[142] Mr. Perez poignantly stated:

> This issue is neither sexy nor easy. But it must be addressed and we must somehow get across the message . . . that incarcerated individuals deserve quality HIV prevention as well as care services. A criminal record should not be the criteria for being able to obtain life-saving and life-sustaining interventions and therapies. Until the needs of the incarcerated communities are embraced and articulated as part of our comprehensive, national agenda, these individuals will continue to fall through the cracks and become needlessly infected.[143]

VIII. CONCLUSION

Prisons house a population with HIV infection rates much higher than the general population. This offers an opportunity to enhance infection prevention that the United States has failed to embrace. While our Canadian neighbors began implementing condom and bleach distribution programs in the early 1990's, the United States has failed to make even preventative material available to its Federal prisoners. Although legal bases exist for such prisoners' claims, it seems unlikely that the claims will succeed under current law. However, the more compelling avenue for this important change is the moral obligations our communities have to one another. This problem highlights an area where the public health obligation is clear, while constitutional and criminal law fails to provide relief. And while it is easy to differentiate individuals in free society and prisoners as "us" and "them," the reality of the HIV epidemic is that this boundary is blurred. Although United States courts have failed to impose liability on prisons for HIV infection spread within prison walls, American prison officials must accept the hard truth that high-risk behavior exists in prisons, and that the infections prisoners acquire in prison harm not only inmates, but the greater community to which we all belong.

142. Perez, *supra* note 1.
143. *Id.*