



**Southern Exposure:
Human Rights and HIV in the Southern United States**

November 2010

I. Summary	1
II. Introduction	2
III. Human Rights in the South: An Environment of Risk for HIV	5
Poverty	6
Lack of Access to Health Care	7
Failure to Provide Comprehensive Sex and HIV/AIDS Education in Schools	13
Criminalization of HIV Exposure	16
Prison Policies	18
Failure to Promote Access to Sterile Syringes for Drug Users	19
IV. Conclusion: A Call to Act	23

I. Summary

The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

—United States Office of National AIDS Policy¹

This mission statement from President Obama’s National AIDS Strategy recognizes the key factors that continue to fuel the HIV/AIDS epidemic in the United States: poverty, racism, homophobia, and lack of access to health care. This is a welcome change from a largely indifferent approach to HIV/AIDS policy under his predecessors, and nowhere is federal leadership more urgently needed than in the southern states of the US where the nation’s epicenter of HIV/AIDS rages. In many states in the South,² socio-economic conditions combine with specific state laws and policies to undermine human rights and create an environment where the risk of acquiring, transmitting, and dying of HIV/AIDS is higher than any region in the country. This deadly combination is taking an especially devastating toll on minority communities, a crisis that federal and state governments are obligated under international law to address.

Many southern states are failing to meet these obligations both by neglecting the epidemic and by enforcing laws and policies that fuel the disease and intensify its impact on communities of color. The federal government has also neglected the epidemic in the South and bears the ultimate responsibility to ensure that all residents have access to health care and are free from discrimination.

This briefing paper examines the environment of risk and identifies policies in many southern states such as abstinence-based sex education, criminalization of HIV exposure, prison policies, and lack of harm reduction programs that deny life-saving information and sponsor stigma and discrimination against those most vulnerable to HIV/AIDS . These are not the only factors fueling HIV/AIDS in the South. The region ranks lowest in the nation in

¹ United States Office of National AIDS Policy, “National AIDS Strategy for the United States” July 2010, p. vii.

² As used in this report, “the South” refers to the 17 states of Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Texas, Tennessee, Virginia and West Virginia, unless otherwise noted. This is the definition utilized by the majority of primary reference databases cited in this report including the US Centers for Disease Control , the US Census Bureau and the Kaiser Family Foundation HIV/AIDS database. These sources, in turn, are relied upon in secondary documents cited such as the National AIDS Strategy for the United States and the Southern AIDS Coalition Manifesto and Update.

“overall health,” an analysis that includes not only poverty and access to health care but quality of care, education levels and health literacy, nutrition, and other factors that significantly affect HIV/AIDS prevention and treatment.³ But the harmful policies highlighted in this paper have had a profound impact on the course of the HIV/AIDS epidemic or, in the case of criminal laws relating to HIV, conflict with international and national guidelines and best practices for effective management of the disease. Addressing these key elements of a high-risk environment for HIV must be the immediate focus of federal and state government if there is to be any hope of accomplishing the national mission to eradicate HIV.

The federal government must lead the way by addressing HIV funding inequities that have disadvantaged the South and by modeling, monitoring, and rewarding policies that comply with national and international guidelines for reducing HIV infection. States must re-examine their investment in HIV/AIDS programs, seek to maximize federal support, and ensure that education and criminal justice policies promote proven HIV prevention strategies. Without immediate action on human rights conditions, the crisis of HIV in southern communities will continue unabated.

II. Introduction

HIV/AIDS continues to pose a major public health threat in the United States. Every nine-and-a-half minutes someone in the US is infected with HIV; 56,000 people are newly infected each year. More than 1.1 million people are living with HIV, and almost half of Americans know someone infected with the virus.⁴ Racial and ethnic minorities bear the overwhelming burden of the disease. Though comprising just 13 percent of the US population, 46 percent of those living with HIV/AIDS are black. Blacks are disproportionately represented in every transmission category, including men who have sex with men, women, heterosexual men, injection drug users, and children.⁵ The President’s Office of National AIDS Policy has called the toll of the epidemic on the black community “staggering.”⁶

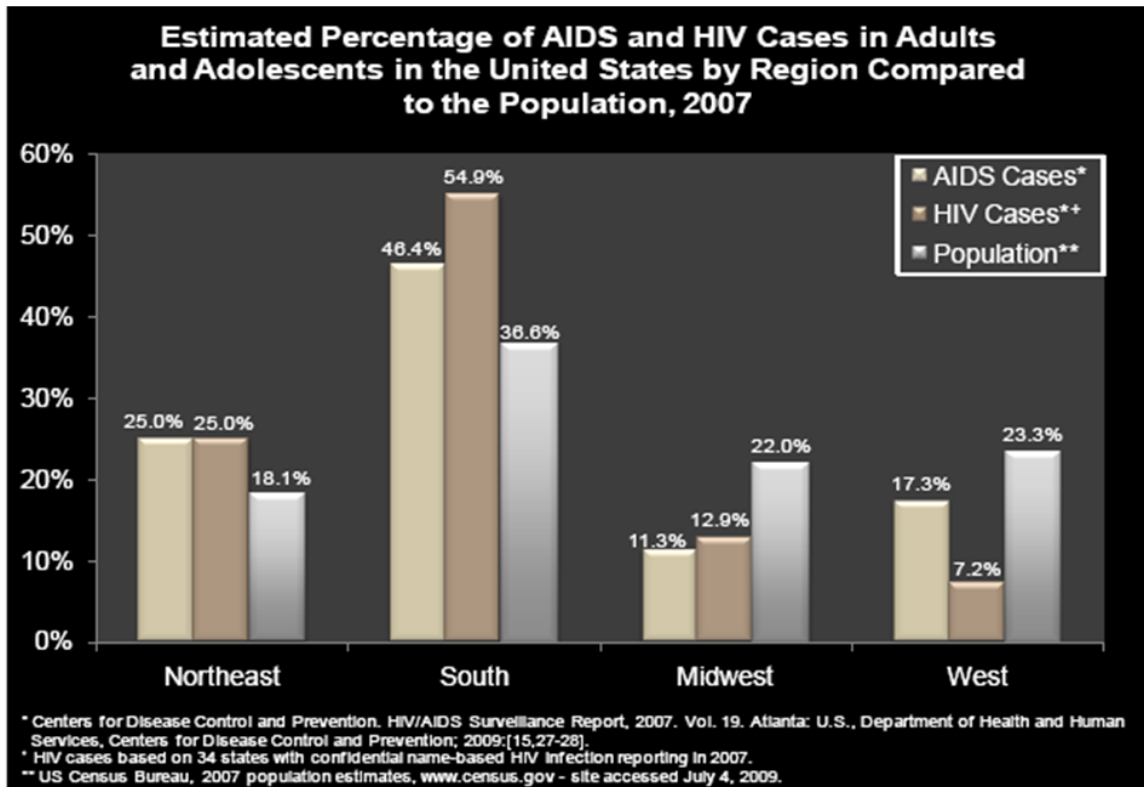
³ United Health Foundation, “America’s Health Rankings,” 2009 <http://www.americashealthrankings.org/> (accessed November 15, 2010); see also, Commonwealth Fund, “Aiming Higher: State Scorecard on Health System Performance,” 2007 <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Aiming-Higher-Results-from-a-State-Scorecard-on-Health-System-Performance.aspx> (accessed November 15, 2010.)

⁴ US Centers for Disease Control (CDC), Estimates of New HIV Infections in the United States, August 2008; CDC, HIV Prevalence Estimates-United States, 2006. Morbidity and Mortality Weekly Report (MMWR) 2008: 57(39): 1073-76.

⁵ CDC, HIV/AIDS Surveillance Report 2007; CDC, HIV/AIDS Surveillance by Race/Ethnicity, slide set, 2007.

⁶ G. Millett, Office of National AIDS Policy Blog, “White House Meeting on Black Men and HIV,” June 4, 2010, <http://www.whitehouse.gov/blog/2010/06/04/white-house-meeting-black-men-and-hiv> (accessed October 25, 2010.)

Latinos and Asian-Pacific Islanders also experience an HIV prevalence out of proportion to their numbers in the general population.⁷



Source: Southern AIDS Coalition

The South is at the epicenter of the HIV epidemic in the United States, with more people living with HIV and dying of AIDS than in any region in the country. The South has:

- the highest rates of new infections,
- the most AIDS deaths,
- the largest numbers of adults and adolescents living with HIV/AIDS.⁸

⁷ CDC, HIV/AIDS Among Hispanics/Latinos, August 2009 <http://www.cdc.gov/hiv/hispanics/index.htm>, (accessed October 25, 2010); CDC, HIV/AIDS Among Asians and Pacific Islanders, August 2008, <http://www.cdc.gov/hiv/resources/factsheets/API.htm> (accessed October 25, 2010.)

⁸ CDC, HIV/AIDS Surveillance Report, 2007; for comprehensive discussions of disproportionate impact of HIV/AIDS on minorities in the South, see, Southern AIDS Coalition, "Southern States Manifesto: Update 2008, HIV/AIDS and Sexually Transmitted Diseases in the South, July 21, 2008; Sutton, M., et al, "A review of the Centers for Disease Control and Prevention's Response to the HIV/AIDS Crisis Among Blacks in the United States, 1981-2009," American Journal of Public Health, (2009) 99:No. S2, pp. 351-9; CDC, HIV/AIDS Epidemic and HIV/AIDS Prevention in the Hispanic/Latino Community: Consultation with Leaders from the Hispanic/Latino Community, April 2008.

Though only 36 percent of the US population lives in the region, about half of people living with HIV or AIDS in the US live in the South.⁹

HIV has had a particularly devastating impact on minorities in the South. In southern states such as Alabama, Louisiana, Georgia and Mississippi, blacks comprise approximately 30 percent of the population but 65-75 percent of the cases of HIV.¹⁰ Of the 10 states with the highest rates of new HIV diagnosis for Latinos, seven were in the South. Florida and Louisiana have the second and third highest rates of HIV diagnoses for Latinos in the country.¹¹

People living with HIV in the south are at far greater risk of dying from AIDS than those living in other regions.¹² Many people are diagnosed with HIV late in the progression of the disease, at or near the point of full-blown AIDS, when treatment is less effective.¹³ In many southern states more than half of people who test positive for HIV and are aware of their status, are not receiving the minimum level of viral load testing and other periodic evaluations required for people considered to be “in care” for HIV. This is significantly higher than the national average of 33 percent.¹⁴

In Arkansas, for example, an alarming 65 percent are categorized by the federal government as “not in care” or “unmet need” for HIV/AIDS services; in Alabama, 72 percent of people testing positive for HIV are not in care.¹⁵ In Mississippi, estimates of unmet need range

⁹ Southern AIDS Coalition, “Southern States Manifesto,” p. 3. For additional epidemiological data on HIV/AIDS in the southern US, see, Fleming, P.L. et al, “The epidemiology of HIV/AIDS in women in the southern US”, *Sexually Transmitted Diseases* July 2006: 33(7) pp. S32-38; Reif, S. et al, “HIV Infection and AIDS in the Deep South,” *American Journal of Public Health*, June 2006: (96) 6: 970-3.

¹⁰ Alabama Department of Public Health, *Alabama Statewide Coordinated Statement of Need 2009*; Georgia Division of Public Health, *State of Georgia Comprehensive HIV Services Plan 2009-2012*; Louisiana Office of Public Health, *Statewide Coordinated Statement of Need and HIV Comprehensive Plan*; Mississippi Department of Health, *State of Mississippi 2009 Ryan White HIV/AIDS Statewide Coordinated Statement of Need and Comprehensive Plan*; (hereinafter, *State Comprehensive HIV/AIDS Plans*)

¹¹ CDC, *HIV/AIDS Surveillance Report 2007*; CDC, *HIV/AIDS Surveillance by Race/Ethnicity*, slide set, 2007.

¹² CDC, *HIV/AIDS Surveillance Report 2006*.

¹³ Krawczyk, C. et al, “Delayed Access to HIV Diagnosis and Care: Special Concerns for Southern United States”, *AIDS Care* (2006) 18:Supplement 1: S35-44.

¹⁴ *National AIDS Strategy*, p. 7.

¹⁵ *Alabama State Comprehensive HIV/AIDS Plan*; *Arkansas Department of Health, Arkansas Statewide Coordinated Statement of Need and Comprehensive Plan 2009-2010*; *Georgia State Comprehensive HIV/AIDS Plan*; *South Carolina State Comprehensive HIV/AIDS Plan*; *Mississippi State Comprehensive HIV/AIDS Plan*.

between 50 and 70 percent.¹⁶ 83 percent of people dying of AIDS in Mississippi are African-American.¹⁷ The Director of Mississippi's Sexually Transmitted Disease/HIV Office said :

Save yourself a transatlantic airline fare to a developing country. Just come to Mississippi, where we have a vast underserved population.¹⁸

III. Human Rights in the South: An Environment of Risk for HIV

The United States government and consequently, state governments, are obligated under international law to address the crisis of the HIV epidemic and the disproportionate impact of the disease on racial and ethnic minorities. Human rights instruments establish a right to health and the right of people living with HIV to access public health services without discrimination.¹⁹ Human rights treaties ratified by the United States establish an obligation to eliminate laws and policies that may not be discriminatory in intent but that result in clear discriminatory impact on racial and ethnic minorities.²⁰ Many southern states are failing to meet these obligations both by neglecting the epidemic and by enforcing laws and policies that fuel the disease and intensify its impact on communities of color. The federal government has also neglected the epidemic in the South and bears the ultimate responsibility to ensure that all residents have access to health care and are free from discrimination.

The concentration of the HIV epidemic in the South is not new or sudden: between 2000 and 2003 the number of AIDS cases rose 35.6 percent in the six states that comprise the Deep

¹⁶ Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010. Mr. Thompson explained that some studies place the unmet need in the range of 70 percent.

¹⁷ Mississippi State Comprehensive HIV/AIDS Plan, p. 37.

¹⁸ Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010.

¹⁹ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI),

²¹ UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the US on October 5, 1977; WHO on HRs and HIV; Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, adopted August 11, 2000, paras. 12,18,34. UNAIDS, International Guidelines on HIV/AIDS and Human Rights (2006); Convention on the Rights of Persons with Disabilities, adopted December 13, 2006, UN Doc A/61/611, entered into force May 3, 2008, signed by the United States on July 30, 2009. For a report on the international policy dialogue on the applicability of the Disability Convention to people living with HIV/AIDS, see Dutch Coalition on Disability and Development, "Intersectionality HIV and Disability: New Questions Raised," October 12, 2009.

²⁰ International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 UN GAOR Supp. (No. 14) at 47, UN Doc A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on November 20, 1994, article 5.

South, while rising 5.2 percent nationally.²¹ By 2003 the South led the country in people living with HIV, people dying of AIDS, and diagnoses of AIDS.²² Yet federal funding for HIV/AIDS, chronically inadequate to address the nation's epidemic, has shortchanged the southern region for decades by relying on a formula based on cumulative AIDS cases, including deaths from the disease since the 1980s, rather than targeting money toward areas with rising rates of infection.²³ The Obama Administration's National AIDS Strategy acknowledges this problem and declares an intention to rectify it, but changes in federal policy alone will not impede the spread of the disease. In many states in the South, socio-economic conditions combine with state laws and policies incompatible with human rights to create a high-risk environment for HIV.²⁴

Poverty

Poverty's link to the risk of acquiring HIV is well documented both globally as well as in the United States.²⁵ The National AIDS Strategy identifies poverty, homelessness, and hunger as factors that impede access to prevention, treatment, and care. Federal health officials endorse a "holistic" approach to HIV that requires attention to social and economic factors as critical to health outcomes for individuals and communities.²⁶ As Kevin Fenton, director of the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention of the US Centers for Disease Control and Prevention (CDC), wrote:

Though individually based interventions have had some success, it is clear that their success is substantially improved when HIV prevention addresses broader structural factors such as poverty and wealth, gender, age, policy and power.²⁷

²¹ Whetten, K. et al, "Overview: HIV/AIDS in the Deep South Region of the United States," *AIDS Care* 2006; 18 (Supp.) 51-55. Whetten defined Alabama, Georgia, Louisiana, North Carolina, South Carolina and Mississippi as the Deep South.

²² Kaiser Family Foundation, "The HIV/AIDS Epidemic in the United States," September 2005.

²³ National AIDS Strategy, p. 15; United States General Accounting Office, "Ryan White Care Act of 1990: Opportunities to Enhance Funding Equity", November 1995. Southern AIDS Coalition, "Southern States Manifesto," p. 16.

²⁴ Tony Barnett and Alan Whiteside introduced the concept of "environment of risk" for *HIV/AIDS in the 21st Century*, (New York: Palgrave MacMillan, 2d ed., 2006).

²⁵ See, e.g. World Health Organization, "Closing the Gaps in a Generation: Health Equity Through Action on Social Determinants of Health," 2009; CDC, "New CDC Analysis Reveals Strong Link Between Poverty and HIV Infection," Press Release July 19, 2010, <http://www.cdc.gov/nchstp/newsroom/povertyandhivpressrelease.html> (accessed October 25, 2010); Dean, H.D. et al, "Social Determinants of Health," *Public Health Reports* 2010: 125 (Supp.4); Doherty, I. et al, "Social Determinants of HIV Infection in the Deep South," *American Journal of Public Health*, March 2007: 97 (3): 391.

²⁶ National AIDS Strategy p. 34.

²⁷ Fenton, K. and Hazel Dean, "Addressing Social Determinants of Health in the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections and Tuberculosis," *Public Health Reports* 2010: 125 (Supp.4), p.1.

The South is the poorest region in the United States. In comparison to other regions, southern states have:

- more individuals and families living below the federal poverty level (FPL),²⁸
- more children living in poverty,²⁹
- the lowest median household incomes in the nation.³⁰

Poverty prevents many southerners from accessing services for HIV. Poverty and poverty-related issues such as transportation, unstable housing, and food security are identified as barriers to HIV prevention, treatment, and care in each of the state HIV/AIDS plans prepared by public health authorities in southern states.³¹ After reviewing specific factors such as lack of transportation and housing that keep people out of treatment, the Comprehensive HIV/AIDS Plan for the State of Alabama reaches a simple and stark conclusion:

Many Alabamians living with HIV/AIDS disease are not in care because they cannot afford it.”³²

Lack of Access to Health Care

Lack of access to health care is a more serious problem for people in the South than in any other region. Residents of southern states are less likely to have health insurance than those in other regions.³³ The South has fewer medical providers with more people living in federally designated “health professional shortage areas” than any other area of the country. Nearly two in five southern residents are considered “medically disenfranchised,” meaning they lack access to a primary health care provider.³⁴ The shortage of health professionals specializing in HIV care, particularly in rural areas that dominate the South, is a major

²⁸ US Census Bureau, “Individuals and Families Below the Poverty Level-Number and Rate by State 2000-2007,” available online at www.census.gov.

²⁹ Ibid.

³⁰ US Census Bureau, “Median Household Income By State Ranked from Highest to Lowest Using 3-Year Average: 2007-2009” available on www.census.gov.

³¹ See, e.g. Arkansas State Comprehensive HIV/AIDS Plan, p. 22, 24, 27, et seq.

³² Alabama Comprehensive HIV/AIDS Plan, p. 66.

³³ Kaiser Family Foundation, statehealthfacts.org, “Health Coverage and Uninsured,” <http://www.statehealthfacts.org/comparecat.jsp?cat=3&rgn=6&rgn=1> (accessed October 25, 2010); Holahan J. and Blumberg L., “How Would States Be Affected By Health Reform?” Urban Institute, January 2010.

³⁴ Commonwealth Fund Commission, “Aiming Higher: Results from a State Scorecard on Health Systems Performance,” June 2007; Kaiser Family Foundation, Kaiser Slides: Most Population in Primary Care Shortage Areas 2008.”

contributor to the failure of people who test positive for HIV to access medical care.³⁵ Latinos experience additional difficulty in accessing health care caused by language barriers and fear of immigration consequences.³⁶

People living with HIV/AIDS in the South without health insurance have two options: the Medicaid program or services provided under the Ryan White Act.³⁷ Medicaid is the joint federal/state insurance program intended to provide a “safety net” to people with serious medical and mental health conditions.³⁸ Nationally, 36 percent of people living with HIV/AIDS are on Medicaid and another 14 percent rely on Medicaid and Medicare, a government insurance program for the elderly.³⁹ Medicaid, however, is not health insurance for people living with HIV but rather disability insurance, covering a person with HIV only when it advances to full-blown AIDS and becomes disabling. Moreover, Medicaid is intended to cover only the “neediest” persons; states are largely permitted to set their own income eligibility requirements, resulting in significant variations among the 50 states.⁴⁰

In the South, states have established the most restrictive Medicaid income eligibility and offer the most limited benefits of any region in the country.⁴¹ As indicated by the graph below, Alabama sets the lowest income threshold for Medicaid eligibility in the nation at 11 percent of the Federal Poverty Level or US\$194 a month for jobless parents of a family of four.⁴² These rules put Medicaid out of reach for many people living with HIV/AIDS.

³⁵ National AIDS Strategy, p. 25; Heckman, TG et al, “Barriers to Care Among Persons with HIV/AIDS in urban and rural areas”, *AIDS Care* 1998; 10 (3): 365-75.

³⁶ Southern AIDS Coalition, *Southern States Manifesto*, p. 11; Latino Commission on AIDS, “The Deep South Project,” 2010; National Council on La Raza, “The Health of Latino Communities in the South: Challenges and Opportunities (2004).

³⁷ Ryan White Comprehensive AIDS Resources Emergency (Care) Act of 1990, Public Law No. 101-381, 104 Stat. 576, 42 USC. 300ff-300ff-121; Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415), reauthorization extended in 2009 (P.L. 111-87).

³⁸ US Centers for Medicare and Medicaid Services (CMS), “Medicaid Program-General Information”, <http://www.cms.gov/MedicaidGenInfo/>, (accessed October 25, 2010.)

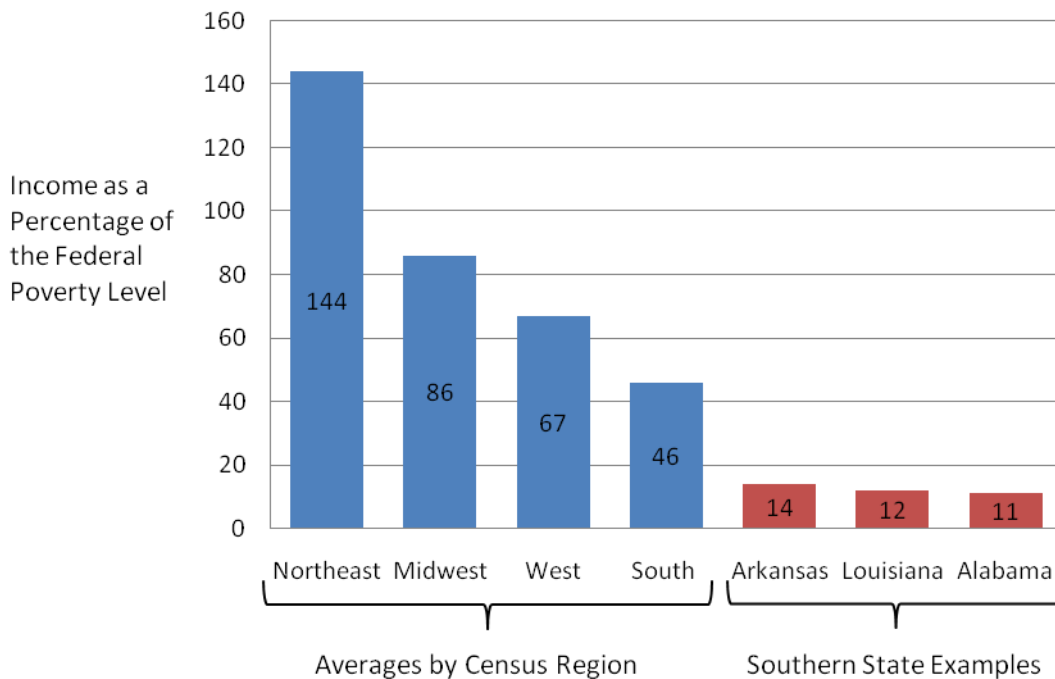
³⁹ Greenwald, R., “Health Care Reform: Updates to Federal Efforts to Improve Access to Care for People Living with HIV/AIDS,” Treatment Access Expansion Project, Harvard Law School, April 12, 2010.

⁴⁰ Ibid; CMS, “Medicaid Eligibility: Are You Eligible?” Kaiser Commission on the Uninsured, “Challenges of Providing Health Insurance for Parents and Children in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures and Cost-Sharing Provisions in Medicaid and SCHIP in 2009,” January 2009.

⁴¹ Kaiser Family Foundation, [statehealthfacts.org](http://www.statehealthfacts.org), “Income Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level, 2009.” <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (accessed October 25, 2010); Public Citizen Health Research Group, “Unsettling Scores: A Ranking of State Medicaid Programs, April 2007,” <http://www.citizen.org/hrg1807> (accessed October 25, 2010.)

⁴² Ibid.

Maximum Income for Medicaid Eligibility for a Jobless Family of Four⁴³



Those who do qualify for Medicaid face the additional challenge of restricted benefits. States have substantial discretion to set the Medicaid benefit package, and benefits in many southern states are among the most limited in the nation for all recipients, including those with HIV/AIDS.⁴⁴ Mississippi Medicaid, for example, does not cover physical or occupational therapy, non-emergency dental care, psychologist services, drug dependence therapy, dentures, speech therapy, prosthetic or orthotic devices, or hearing aids. Mississippi limits people on Medicaid to five prescription drugs per month, though most HIV/AIDS medication regimens typically exceed this limit.⁴⁵ Joseph, a man living with HIV/AIDS who moved recently from Louisiana to Mississippi, told Human Rights Watch, “My doctor in Louisiana

⁴³ Kaiser Family Foundation, “Income Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2009”, undated, <http://www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4> (accessed November 1, 2010).

⁴⁴ Kaiser Family Foundation, Medicaid Benefits Database, <http://medicaidbenefits.kff.org/index.jsp> (accessed October 25, 2010); Public Citizen Health Research Group, “Unsettling Scores.”

⁴⁵ Kaiser Family Foundation, Medicaid Benefits Database, Mississippi, <http://medicaidbenefits.kff.org/state.jsp?nt=on&cat=0&yr=0&st=25> (accessed October 25, 2010.)

prescribed me eight drugs, but Medicaid here only covers five. I've missed two months of meds."⁴⁶

Medicaid benefits throughout the US are minimal and inadequate benefits have created serious gaps in care for people living with HIV/AIDS in all regions of the country.⁴⁷ However, in states with rapidly rising new infections, some of the nation's highest numbers of people with HIV not in care, and high death rates from AIDS, lack of access to treatment is of particular concern. Recent reports from the State Health Care Access Research Project (SHARP) at Harvard Law School found that Medicaid benefit limitations in North Carolina, South Carolina, Alabama, Mississippi, and Arkansas created significant barriers to medical and mental health care for people living with HIV/AIDS.⁴⁸ SHARP noted that greater state participation in funding for Medicaid could make a difference in improving benefits for HIV services, particularly as poorer states receive higher levels of federal matching funds for the Medicaid program. As stated in the SHARP report on HIV/AIDS in Alabama:

A lack of sufficient investment in the Medicaid program leads to many missed opportunities to provide adequate Medicaid coverage for people living with HIV and AIDS in Alabama. The failure to adequately invest in the Alabama Medicaid program also results in a failure to maximize matching federal funding to support a comprehensive health safety net for low income people living with HIV and AIDS.⁴⁹

Health care reform legislation⁵⁰ will expand eligibility for Medicaid to all persons living at or below 133 percent of the federal poverty level. This will benefit people living with HIV/AIDS, particularly in the South, the region where the highest numbers of people will become newly eligible.⁵¹ This is an important example of federal government response to a health care crisis but this provision will not take effect until 2014.

⁴⁶ Human Rights Watch interview with Joseph P., Jackson Mississippi, August 26, 2010. Real names are not used for interviewees in order to protect their privacy and confidentiality.

⁴⁷ Greenwald, R., "Health Care Reform: Updates to Federal Efforts to Improve Access to Care for People Living with HIV/AIDS," Treatment Access Expansion Project, Harvard Law School, April 12, 2010.

⁴⁸ Health Law and Policy Clinic of Harvard Law School, State Healthcare Access Research Project (SHARP), "Alabama State Report"; SHARP, "Arkansas State Report"; SHARP, "North Carolina State Report." These reports are available online at http://www.taepusa.org/SHARP_library.html (accessed November 15, 2010.) Reports for Mississippi and South Carolina have been reviewed in draft form and are on file at Human Rights Watch pending publication in early 2011.

⁴⁹ SHARP, "Alabama State Report," Executive Summary.

⁵⁰ Patient Protection and Affordable Care Act, signed into law March 23, 2010; Health Care and Education Reconciliation Act, signed into law March 30, 2010.

⁵¹ Holahan J. and Blumberg L., "How Would States Be Affected By Health Reform?" Urban Institute, January 2010; Kaiser Commission on Medicaid and the Uninsured, "Briefing on State Medicaid Programs, the Recession and Health Reform," <http://www.kff.org/medicaid/Briefing-on-State-Medicaid-Programs-Recession-Health-Reform.cfm> (accessed November 15, 2010.)

Uninsured people living with HIV/AIDS who do not qualify for Medicaid can turn to services provided by the Ryan White Act. The Ryan White Act includes the AIDS Drugs Assistance Program (ADAP) that provides anti-retroviral and other essential medications for people who are uninsured or underinsured and meet income eligibility requirements.⁵² ADAP is a discretionary grant program that relies on annual federal appropriations and voluntary state funding contributions. Each state administers its own ADAP and can determine, in large part, eligibility standards and benefits provided.⁵³

The current recession and resulting unemployment has increased demand for the ADAP program, and a crisis has developed due to shortages of federal and state funding.⁵⁴ Many states have capped enrollment and are implementing or considering cost-saving measures that would limit eligibility or benefits. As of November 11, 2010, 3,811 individuals were on waiting lists for life-saving AIDS medications nationally, 90 percent of whom are residents of southern states (Florida, North Carolina, Georgia, South Carolina, and Louisiana).⁵⁵ ADAP enrollment reflects the racially disproportionate impact of HIV/AIDS, as more than 60 percent of ADAP recipients are African-Americans, with incomes ranging from zero to \$30,000 per year.⁵⁶

Nationally, states contribute an average of 14 percent of the total ADAP budgets. However, fiscal support from many southern states for the ADAP program has been lower than average, or nonexistent. Tennessee, in response to the crisis, stepped up its contribution from seven percent of the state ADAP budget in 2008 to 29 percent in 2009. Georgia and North Carolina's contributions of 24 and 31 percent exceeded the national average of 14 percent. But in 2009 Arkansas, Louisiana, Mississippi, and Kentucky continued their historical pattern of making no contribution to the ADAP program at all. South Carolina contributed 11 percent. Florida contributed only 9 percent, despite there being 2,043 Florida residents on a waiting list for medications (53 percent of the total ADAP waiting list).⁵⁷

The Ryan White HIV/AIDS program has been chronically underfunded by the federal government and its funding formula has shortchanged the South for decades. Under international law the federal government bears ultimate responsibility for the lack of services available for HIV/AIDS in the South. But states share responsibility for a pattern of

⁵² For comprehensive information about the ADAP program, see, National Alliance of State and Territorial AIDS Directors (NASTAD), National ADAP Monitoring Project Annual Report, May 2010.

⁵³ NASTAD, "Medicaid and ADAP", October 2006.

⁵⁴ Kevin Sack, *Economy Hurts Government Aid for H.I.V. Drugs*, New York Times, June 30 2010.

⁵⁵ NASTAD, "The ADAP Watch," November 11, 2010.

⁵⁶ *Ibid*, pp. 40-43.

⁵⁷ NASTAD, ADAP Annual Report, p. 28.

neglect that has characterized the response to HIV in many southern states. State budgets throughout the country have been severely impacted by the economic downturn of recent years, but the failure of southern states to invest in programs critical to the survival of people with HIV is not new. ADAP has existed for decades, but South Carolina made no contribution to the program until 2006 when it spent \$500,000 to address an emergency in which two people died while on a waiting list.⁵⁸ The infusion of state funds eliminated the waiting list, and the state contributed \$2 million the next two years. In June 2010, however, the Governor vetoed the legislature's ADAP appropriation and the legislature failed to override the veto. As of November 2010 there were 239 persons on an ADAP waiting list in South Carolina.⁵⁹

Arkansas has never contributed state funds to ADAP or to programs targeted to assist people living with HIV/AIDS with housing or transportation, though Arkansas health officials point to lack of transportation and stable housing as primary barriers to accessing treatment.⁶⁰ Mississippi public health officials cite access to health care, ADAP medication adherence, and medical transportation as the highest priorities in the state HIV/AIDS plan. Yet in Mississippi the state HIV/AIDS allocation has remained under \$1 million (from budgets of approximately \$4 billion) with no allocations for housing or transportation and no contribution to ADAP in recent years.⁶¹ Public health officials in Mississippi told Human Rights Watch, "If it weren't for the federal government, there would be no HIV programs in Mississippi."⁶²

A comprehensive fiscal or health policy analysis is beyond the scope of this briefing paper; however, governments have an obligation to implement health programs in a non-discriminatory manner and to utilize available resources to protect the right to health.⁶³ Lack

⁵⁸ Human Rights Watch interview with Noreen O'Donnell, Ryan White administrator for the South Carolina Department of Health and Environmental Control, Columbia, South Carolina June 17, 2010. Ms. O'Donnell could not confirm or deny that the deaths occurred from the waiting list, but this fact was confirmed by the state HIV/AIDS director at the time. See Shaila Dewan, *Waiting List for Drugs Causes Dismay in South Carolina*, New York Times, December 29, 2006. Funding for ADAP has increased each year since 2006 until the veto by the Governor in 2010.

⁵⁹ Roddie Burris, *Legislature Upholds Governor's Budget Vetoes*, The State, June 17, 2010; NASTAD, "ADAP Watch."

⁶⁰ State Health Care Access Research Project, Harvard Law School, "Arkansas State Report: An Analysis of the Successes, Challenges and Opportunities for Improving Health Care Access," April 2010; Arkansas State Comprehensive HIV/AIDS Plan.

⁶¹ Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010; State of Mississippi General Fund Budget for FY 2009; State of Mississippi Budget FY 2010; State of Mississippi Executive Budget Recommendation for FY 2011.

⁶² Human Rights Watch interview with Craig Thompson, Director, STD/HIV Office, Mississippi State Department of Health, Jackson, Mississippi June 22, 2010.

⁶³ International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 UN GAOR Supp. (No. 14) at 47, UN Doc A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on November 20, 1994, article 5; International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR (no. 16) at 49, UN Doc. A/6316 (1966), 99 UNTS 3, entered into force January 3, 1976, signed by the US on October 5, 1977, articles 2, 12.

of federal government funding and leadership remain primarily responsible for limited access to health care for people living with HIV. But state funding determinations in many southern states deserve further scrutiny, particularly given the extremely disproportionate burden on minorities that results. At a minimum, the state's revenue and spending practices should prompt the question of whether state governments are doing everything they reasonably can to improve health care and services for people living with HIV/AIDS.

Failure to Provide Comprehensive Sex and HIV/AIDS Education in Schools

“These classes that talk about abstinence, they don't inform you how to protect yourself.”

—Tanya, 16, Jackson, MS⁶⁴

More than 47,000 young people ages 13-24 years are currently living with HIV/AIDS in the US.⁶⁵ In the age group 13-19 years, seventy percent of all HIV/AIDS diagnoses in 2006 were among black youth, primarily by sexual transmission. Among black and Latino men who have sex with men, the group with the most cases of HIV/AIDS in the US, most new infections are occurring in the youngest age group, ages 13-29 years.⁶⁶ Among women (and among black and Latina women), six of 10 new infections occur among women in the age group 13-39.⁶⁷

Sexually transmitted diseases (STDs) such as gonorrhea, Chlamydia, and syphilis can double the risk of acquiring HIV infection.⁶⁸ Public health officials throughout the South identify reducing rates of STDs as key elements in their comprehensive plans for reducing HIV infections.⁶⁹ In 2008 southern states ranked highest in the nation in rates of gonorrhea, Chlamydia, and syphilis. Mississippi ranked number one in both chlamydia and gonorrhea rates among the fifty states. Louisiana had the highest rates of syphilis in the country and the second-highest rates of gonorrhea.⁷⁰ Teen pregnancy rates in Mississippi and Arkansas

⁶⁴ Human Rights Watch interview with Tanya A., Jackson Mississippi, August 27, 2010.

⁶⁵ CDC, “HIV/AIDS Surveillance Report 2008”.

⁶⁶ CDC, “HIV/AIDS and young men who have sex with men,” May 2009.

⁶⁷ Kaiser Family Foundation, “HIV/AIDS Policy Fact Sheet” September 2009; Kaiser Family Foundation, “The HIV/AIDS Epidemic in the United States,” September 2009.

⁶⁸ CDC, “Sexually Transmitted Diseases,” <http://www.cdc.gov/std/hiv/STDFact-STD-HIV.htm> (accessed October 25, 2010.)

⁶⁹ See, e.g. Arkansas State Comprehensive HIV/AIDS Plan, p.29; South Carolina State Comprehensive HIV/AIDS Plan, p.76; Louisiana State Comprehensive HIV/AIDS Plan, p. 18; North Carolina State Comprehensive HIV/AIDS Plan p. 15.

⁷⁰ CDC, “Sexually Transmitted Disease Surveillance 2008.”

are ranked number one and number three respectively with Louisiana, Tennessee, and Kentucky among the top ten and Alabama, Florida, Georgia, North Carolina and South Carolina among the top twenty.⁷¹

Requirements for abstinence-based education in the schools are common in all regions of the country, with 25 states mandating that where sex or HIV is discussed, abstinence before marriage shall be “stressed” or “strongly emphasized.”⁷² The establishment of abstinence-based sex education as a state standard continues despite little evidence that it prevents HIV/AIDS or other sexually transmitted diseases.⁷³ Education programs that emphasize abstinence while restricting discussion of condoms suppress important HIV prevention evidence and impede the right of students, who are clearly sexually active, to potentially life-saving information.⁷⁴ Human Rights Watch has documented the negative consequences and human rights concerns raised by government-mandated abstinence-only programs both internationally and in the United States.⁷⁵

Abstinence-based education is not recommended by the CDC Task Force on Community Preventive Services, which found “insufficient evidence of its effectiveness” in preventing pregnancy in adolescents as well as sexually transmitted diseases including HIV/AIDS. The CDC Task Force on Community Preventive Services recommends “comprehensive risk reduction” education that may or may not include abstinence but which directly addresses use of contraceptive devices such as condoms and may include condom distribution and demonstration.⁷⁶

The states in the South with the highest rates of HIV, sexually transmitted disease, and teen pregnancy are not ensuring that students receive comprehensive, evidence-based education in sexuality and HIV/AIDS. Alabama, Arkansas, Louisiana, and Mississippi do not require sex education at all; of these states, only Alabama requires HIV/AIDS education be taught in the

⁷¹ National Center for Health Statistics, “State Disparities in Teenage Birth Rates in the United States”, Data Brief No. 46, October 2010.

⁷² Guttmacher Institute, “State Policies in Brief, Sex and STI/HIV Education”, October 1, 2010.

⁷³ CDC Task Force on Community Preventive Services, “Findings on Prevention of HIV/AIDS, STIs and Pregnancy: Group-Based Intervention Programs for Adolescents” (2010) ; Naomi Starkman and Nicole Rajani, *The Case for Comprehensive Sex Education*, AIDS Patient Care and STDs, Vol. 16, 2002.

⁷⁴ ICESCR, article 12. The Committee on Economic, Social and Cultural Rights has interpreted article 12 to obligate states to take steps necessary for the “prevention, treatment and control of epidemic, occupational and other diseases”, including the “establishment of prevention and education programmes for behavior-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting reproductive health.” General Comment No. 14, *The Right to the Highest Attainable Standard of Health*, Committee on Economic, Social and Cultural Rights, 22nd sess. 2000, para. 16.

⁷⁵ Human Rights Watch, *The Less They Know, the Better: Abstinence-Only HIV/AIDS Programs in Uganda*, New York, March 2005, <http://www.hrw.org/en/node/11803/section/1> (accessed October 25, 2010); Human Rights Watch, *Ignorance Only: HIV/AIDS, Human Rights and Federally Funded Abstinence-Only Programs in the United States*, New York: September 2002.

⁷⁶ *Ibid.*

schools. Florida, Georgia, North Carolina, and South Carolina do require sex education to be taught in the schools, and North Carolina recently replaced its abstinence-based education policy with the Healthy Youth Act, legislation that requires local schools to teach evidence-based information approved by experts in sexual and reproductive health.⁷⁷ However, Alabama, Arkansas, Louisiana, Mississippi, Florida, and South Carolina all require that where schools teach do sex or HIV/AIDS education, abstinence before marriage shall be “stressed” or “strongly emphasized.”⁷⁸

No US state requires that use of contraception or condoms be emphasized. However, Arkansas, Florida, Georgia, Louisiana, and Mississippi do not require that contraception be addressed at all.⁷⁹ All southern states reported rates of sexual activity by teens higher than the national average. Mississippi, Alabama, and Arkansas also report the highest rates of teens having sex before the age of 13.⁸⁰ In Mississippi, 61 percent of high school students report having had sex at least once, significantly higher than the national average of 46 percent.⁸¹ Mississippi’s sex education statute provides:

The discussion may include contraceptives but only if such discussion includes a discussion of the risks (failure rates, diseases not protected against). In no case shall there be a demonstration of how condoms or any other contraceptives are applied.⁸²

In Mississippi, 33 percent of teens reported not using a condom during their last sexual encounter.⁸³ Restricting information about how to prevent transmission of sexually transmitted diseases, including HIV, endangers young people and undermines public health.

These policies also carry, and in some cases mandate, negative messages about homosexuality that harm lesbian, gay, bisexual and transgender (LGBT) youth. In some southern states, the law requires educators to not only promote heterosexual marriage as

⁷⁷ Healthy Youth Act, Session Law 2009-213.

⁷⁸ Guttmacher Institute, *State Policies in Brief*; South Carolina’s legislation requires both comprehensive sex education legislation and an abstinence-only emphasis. In addition, reports indicate that implementation in South Carolina of the comprehensive sex education component is inconsistent. See, Southern Health Access Research Project, *South Carolina Report*, 2010, pp41-50.

⁷⁹ Guttmacher Institute, *State Policies in Brief*.

⁸⁰ CDC Youth Risk Behavior Surveillance, United States, 2009.

⁸¹ *Ibid.*

⁸² Miss. Code Ann. 37-13-171.

⁸³ Mississippi State Comprehensive HIV/AIDS Plan, p.40.

the only appropriate setting for sexual relations,⁸⁴ but also either prohibit discussion of homosexuality altogether⁸⁵, prohibit its discussion except in relation to increased risk for sexually transmitted diseases,⁸⁶ or teach that it is “not a lifestyle acceptable to the general public and a criminal offense under the laws of the state.”⁸⁷ This last provision is a reference in the Alabama sex education statute to anti-sodomy laws that remain on the books despite the ruling of the US Supreme Court in 2003 declaring such laws to be unconstitutional.⁸⁸

Mandating anti-homosexual messages in the schools discriminates against LGBT youth and impedes their right to relevant and necessary health information. In addition, these policies create a hostile school environment that conflicts with their right to an education free of discrimination.⁸⁹ Such policies reflect, and accelerate, stigma in southern states that is driving gay men away from essential HIV/AIDS services. Public health authorities in the South cite extreme stigma surrounding homosexuality as a primary factor in avoidance of testing and care among men who have sex with men.⁹⁰ State-sponsored stigma in the public schools conflicts with fundamental principles of human rights for LGBT youth and contradicts efforts to protect the public health.

Criminalization of HIV Exposure

32 states in the US, including 12 southern states, criminalize behavior related to HIV exposure or transmission.⁹¹ The majority of these laws impose liability only on persons who are aware of their HIV status and fail to disclose it to a sexual partner. Most statutes require neither specific intent nor actual transmission of HIV to trigger prosecution, and, indeed, in most cases that have been prosecuted transmission has not occurred.⁹² Criminalization of HIV exposure has been criticized by international and domestic public health authorities.

⁸⁴ See, e.g. Mississippi Code Ann. 37-13-171; Florida Statute Title XLVIII, 1003.46.

⁸⁵ Sexuality Information and Education Council of the United States (SIECUS), “Sex Education in the Sunshine State: How Abstinence-Only Until Marriage Programs are Keeping Florida’s Youth in the Dark”, <http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureid=1591&pageid=611&parentid=479> (accessed October 25, 2010.)

⁸⁶ See, e.g. SC Code Ann 59-32-30 (5).

⁸⁷ Code of Alabama, 16-40A-2-(8).

⁸⁸ *Lawrence v. Texas*, 539 US 558 (2003); Code of Alabama 13A-6-60.

⁸⁹ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc.A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the US on June 8, 1992, arts. 6,7 10(1), article 26 (right to equal protection under the law); Yogyakarta Principles, Principle 16.

⁹⁰ See, e.g. Arkansas State Comprehensive HIV/AIDS Plan, p. 25; Louisiana State Comprehensive HIV/AIDS Plan, p. 24; Mississippi State Comprehensive HIV/AIDS Plan, p. 84.

⁹¹ Prevention Justice Project, Center for HIV Law and Policy, “State by State Prosecutions 2008-2010”.

⁹² *Ibid.*

The Joint United Nations Programme on HIV/AIDS, UNAIDS, found little evidence that criminal statutes promote either criminal justice or prevention of HIV transmission, and stated further:

Prosecutions and convictions are likely to be disproportionately applied to marginalized groups, such as sex workers, men who have sex with men and people who use drugs. These groups are often “blamed” for transmitting HIV despite insufficient access to HIV prevention information, services or commodities, or the ability to negotiate safe sex with their partners.⁹³

Emerging data indicates that this is indeed the case. According to the Center for HIV Law and Policy, Tennessee prosecuted 48 people for HIV-specific criminal offenses during the period 2008-2010, 39 of whom were alleged to be engaging in prostitution.⁹⁴

Prosecuting only those who know their HIV status discourages HIV testing and may negatively impact an individual’s willingness to access treatment services. For example, Louisiana public health officials have expressed concern about criminal laws in their state, noting that criminalization “is not the answer” as it “may cause persons not to disclose for fear of reprisal.”⁹⁵

Criminalization can promote misinformation because cases such as those that have been prosecuted in Tennessee, Georgia, and Texas target behaviors that have little or no potential for transmitting HIV such as spitting and biting.⁹⁶ Texas is responsible for an infamous 2008 case where an HIV-positive man was sentenced to 35 years in prison for spitting at a police officer.⁹⁷ As stated in the National AIDS Strategy, which recommends against criminalization of HIV transmission:

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.⁹⁸

The federal Office of National AIDS Policy calls upon state legislatures to “review HIV-specific criminal statutes to ensure that they are consistent with current knowledge about HIV

⁹³ UNAIDS Policy Brief: Criminalization of HIV Transmission (Geneva) August 2008, p. 3. See also, Burris, S. and Cameron, E. “The Case Against Criminalization of HIV transmission,” JAMA 2008; 300 (5): 578-81.

⁹⁴ Prevention Justice Project, Center for HIV Law and Policy, “State by State Prosecutions 2008-2010”.

⁹⁵ Louisiana State Comprehensive HIV/AIDS Plan, p. 80.

⁹⁶ Ibid.

⁹⁷ G. Kovach, *Prison for Man with H.I.V. Who Spit on Police Officer*, New York Times, May 16, 2008.

⁹⁸ National AIDS Strategy, p. 37.

transmission and support public health approaches to preventing and treating HIV.”⁹⁹ The federal government should monitor this recommendation closely in the South to ensure that criminal laws do not impede efforts to contain the HIV epidemic.

Prison Policies

The United States has the highest incarceration rate in the world, placing one in 100 adults behind bars. More than two million people are in US state or federal prisons.¹⁰⁰ Human Rights Watch and others has documented the racial dimension of incarceration in the United States, which imprisons blacks and Latinos in numbers far out of proportion to their numbers in the general population.¹⁰¹ Within the US, southern states incarcerate more of their residents than any other region.¹⁰² Louisiana has the highest imprisonment rates in the US, incarcerating its residents at a rate 67 percent higher than the national average.¹⁰³

The link between incarceration and HIV risk in affected communities is increasingly well documented. Researchers have correlated high rates of incarceration with high rates of sexually transmitted disease in nearby communities.¹⁰⁴ Although most prisoners acquired HIV before they entered prison, a recent study in North Carolina suggests that incarceration itself may contribute to HIV transmission in a community because social networks and partnerships are disrupted, promoting higher-risk behaviors in partners left behind.¹⁰⁵ As stated in the US National AIDS Strategy:

Although the available data suggests that relatively few infections occur in prison settings, there is evidence that some people with HIV who had received medical care while incarcerated have difficulty accessing HIV medications on release— affecting their health and potentially increasing the likelihood that they will transmit HIV. High rates of incarceration within certain communities can also be

⁹⁹ Ibid.

¹⁰⁰ The Pew Center on the States, “One in 100: Behind Bars in America 2008.”

¹⁰¹ Human Rights Watch, Targeting Blacks New York May 2008. <http://www.hrw.org/en/node/62236/section/3> (accessed October 25, 2010)

¹⁰² Kaiser Family Foundation, “Incarceration Rate (per 100,000 US Residents) 2008,” <http://www.statehealthfacts.org/comparemaptable.jsp?ind=760&cat=1&sort=a&gsa=2> (accessed October 25, 2010).

¹⁰³ Louisiana State Comprehensive HIV/AIDS Plan, p. 32.

¹⁰⁴ Adimora, A.A., et al, “HIV and African-Americans in the Southern United States: Sexual Networks and Social Context,” *Sexually Transmitted Diseases* 2006: 33(7): 539-45; Khan, M.R., et al, “Incarceration and risky sexual partnerships in a southern US city,” *Journal of Urban Health* 2008: Jan: 85(1): 100-113; Thomas, et al, “Incarceration and Sexually Transmitted Infections,” *Journal of Urban Health*, 2007, 85(1), doi:10.1007/s11524-007-9231-1; Comfort, M., “HIV Risk among male prisoners, formerly incarcerated men and their female partners,” Center for AIDS Prevention Studies, University of California at San Francisco, 2010.

¹⁰⁵ Adimora, “HIV and African-Americans in the Southern United States.”

destabilizing. When large numbers of men are incarcerated, the gender imbalance in the communities they leave behind can fuel HIV transmissions by increasing the likelihood that the remaining men will have multiple, concurrent relationships with female sex partners.¹⁰⁶

Despite the expression of this concern, the National AIDS Strategy fails to make any recommendation related to incarceration or for prisoners re-entering society. Public health officials in many southern states include prison issues in their state comprehensive HIV/AIDS plans, citing the need to improve re-entry services linking HIV-positive prisoners to care and essential services such as housing on release.¹⁰⁷ Federal leadership is needed to address high rates of incarceration and to ensure availability of re-entry services in southern communities.

Additional health and human rights concerns are raised by prison policies in two southern states. Alabama and South Carolina are the only two states in the nation that segregate HIV-positive prisoners in designated HIV/AIDS units. Human Rights Watch and the American Civil Liberties Union have documented the harmful effects of this policy on prisoners and their families, which violates fundamental rights to confidentiality and non-discrimination. This policy, which has no medical justification, is accompanied by discrimination against HIV-positive prisoners in prison employment, programs, and re-entry opportunities including work release.¹⁰⁸ The United States Department of Justice is currently considering a legal challenge to the segregation policy in South Carolina prisons on the basis of the Americans with Disabilities Act, which extends to persons living with HIV, whether incarcerated or in the community.¹⁰⁹

Failure to Promote Access to Sterile Syringes for Drug Users

The sharing of needles during injection drug use is a major risk factor for the transmission of HIV, hepatitis C, and other blood-borne diseases. Nationally, injection drug users represent 12 percent of annual HIV infections and 19 percent of people living with HIV/AIDS.¹¹⁰ For drug users, the availability of drug dependence treatment and harm reduction services, including

¹⁰⁶ National AIDS Strategy, p. 13.

¹⁰⁷ See, e.g. Louisiana State Comprehensive HIV/AIDS Plan, pp. 33-34; North Carolina State Comprehensive HIV/AIDS Plan, p. 20.

¹⁰⁸ Human Rights Watch and ACLU, *Sentenced to Stigma: Segregation of HIV-Positive Prisoners in Alabama and South Carolina*, New York: April 2010, <http://www.hrw.org/en/reports/2010/04/14/sentenced-stigma-o> (accessed October 25, 2010.)

¹⁰⁹ Letter dated June 22, 2010 from the US Department of Justice to South Carolina Department of Corrections, available online at http://www.wfae.org/wfae/1_87_115.cfm?action=display&id=6357 (accessed October 25, 2010.)

¹¹⁰ CDC, "HIV in the United States," Factsheet, <http://www.cdc.gov/hiv/resources/factsheets/us.htm> (accessed October 22, 2010.)

access to sterile syringes, is a key component of the right to health.¹¹¹ Syringe exchange programs (SEP), like other effective harm reduction measures, “meet people where they are” by exchanging clean syringes for used ones, as sharing of used syringes greatly increases the of transmitting HIV/AIDS.

The effectiveness of syringe exchange in reducing HIV transmission and transmission of hepatitis C is well documented, globally and in the United States.¹¹² Syringe exchange and other effective harm reduction measures have made injection drug use the only mode of HIV transmission that has shown long-term, consistent decline since the epidemic began.¹¹³ The federal CDC endorse syringe exchange programs as part of comprehensive harm reduction for drug users that includes testing for HIV, hepatitis C, and STDs and linkage to drug dependence treatment.¹¹⁴ The federal ban on funding needle exchange programs was lifted in 2009, and the Department of Health and Human Services (DHHS) is developing comprehensive guidelines for implementation of SEPs at the state and local levels.¹¹⁵

However, laws in many states prohibit possession and transfer of drug paraphernalia and laws regulate the ability of medical providers and pharmacists to prescribe or sell clean syringes. Human Rights Watch has documented how these laws can impede access to sterile syringes for drug users and limit efforts to increase their availability in the community with harmful effects for HIV prevention efforts.¹¹⁶ Advocates argue, and courts have agreed, that these laws were not intended to impede public health efforts to reduce disease transmission and do not, in fact, apply to distribution of clean needles for health purposes.¹¹⁷ Yet apprehension on the part of drug users and outreach workers is real, and access would be

¹¹¹ UN Committee on Economic, Social and Cultural Rights, “Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights,” General Comment No. 14, The Right to the Highest Attainable Standard of Health. E/C.12/2000/4 (2000.); Special Rapporteur for the Highest Attainable Standard of Health, Foreword, “Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics, International Harm Reduction Association, 2008.

¹¹² WHO/UNAIDS/UNODC, *Policy Brief: Provision of Sterile Injecting Equipment to Reduce Transmission of HIV*, (Geneva) 2004; Hurley, et al, “Effectiveness of needle exchange programmes for the prevention of HIV infection, *The Lancet*, Vol. 349, June 21, 1997: 1797-1800.; Burris, S., Substance Abuse Policy Research Program, *Policy Brief on Needle Exchange*, January 2009; National AIDS Strategy, p. 6.

¹¹³ National AIDS Strategy, p. 6.

¹¹⁴ CDC, “Syringe Exchange Programs,” December 2005.

¹¹⁵ DHHS, “Implementation Guidance for Syringe Services Programs,” July 2010.

¹¹⁶ Human Rights Watch, “Injecting Reason: Human Rights and HIV Prevention for Drug Users,” New York, September 2003, <http://www.hrw.org/en/node/12269/section/1>

¹¹⁷ In *Spokane Health District v Brockett*, 120 Wash.2d 140, 839 P.2d 324 (1992) the Washington Supreme Court found syringe exchange programs not prohibited by the state’s drug paraphernalia laws. See also Burris et al, “The Legal Strategies Used in Operating Syringe Exchange in the US,” 86 *American Journal of Public Health* 1161 (1996); for analysis of the legality of SEPs in all 50 states, see “Project on Harm Reduction in the Health Care System,” Temple University School of Law, <http://www.temple.edu/lawschool/aidspolicy/>, accessed November 11, 2010.

increased if laws were clarified and state officials provided public support for access to clean syringes for drug users.

In the South, the percentage of people living with HIV/AIDS who were exposed through injection drug use ranges from 1 percent in Mississippi to 5.7 percent in Georgia to 21 percent in Louisiana.¹¹⁸ Yet syringe-exchange programs are nearly nonexistent in the region. A handful of SEPs operate in the South and are concentrated in only 4 states.¹¹⁹ These states are Florida, where eight percent of people living with HIV/AIDS acquired it through injection drug use, Georgia (5.7 percent), Louisiana (21 percent), and North Carolina (8.9 percent).¹²⁰

The experience of the North Carolina Harm Reduction Coalition provides an example of the need for legal clarification surrounding access to clean syringes. In North Carolina, it is estimated that 21,000 injection drug users live in the urban region of Charlotte, Greensboro, and Raleigh-Durham.¹²¹ North Carolina law permits syringe purchase at pharmacies, but it is a class A misdemeanor to possess or distribute syringes or other paraphernalia that may be used for injection of illegal substances.¹²² There were nearly 2000 arrests for illegal possession of drug paraphernalia in 2008. Though not all of these involved syringes, a recent study found that fear of arrest was a likely factor in reducing purchase of syringes in pharmacies, particularly among African-Americans.¹²³

Robert Childs, Director of the North Carolina Harm Reduction Coalition, told Human Rights Watch that outreach workers depend on their relationship with local law enforcement to facilitate syringe access programs, and apprehension continues even when the relationship is positive. According to Mr. Childs, “In North Carolina, everyone involved in needle exchange risks arrest.”¹²⁴

¹¹⁸ Mississippi State Comprehensive HIV/AIDS Plan; Georgia State Comprehensive HIV/AIDS Plan; Louisiana State Comprehensive HIV/AIDS Plan. Comp plans. Nationally, injection drug users represent 12 percent of annual HIV infections and 19 percent of people living with HIV/AIDS. CDC “HIV in the United States,” Factsheet, <http://www.cdc.gov/hiv/resources/factsheets/us.htm> (accessed October 22, 2010.)

¹¹⁹ Harm Reduction Coalition, “Local Resources Map,” <http://www.harmreduction.org/article.php?id=530> (accessed October 25, 2010); Kaiser Family Foundation, statehealthfacts.org, “Sterile Syringe Programs,” <http://www.statehealthfacts.kff.org/comparetable.jsp?ind=566&cat=11> (accessed October 25, 2010.); Human Rights Watch telephone interview with Robert Childs, Director of North Carolina Harm Reduction Coalition, October 16, 2010.

¹²⁰ State Comprehensive HIV Plans.

¹²¹ Friedman, SR et al, “Estimating numbers of injecting drug users in metropolitan areas,” *Journal of Urban Health* 2004 September; 81 (3): 377-400.

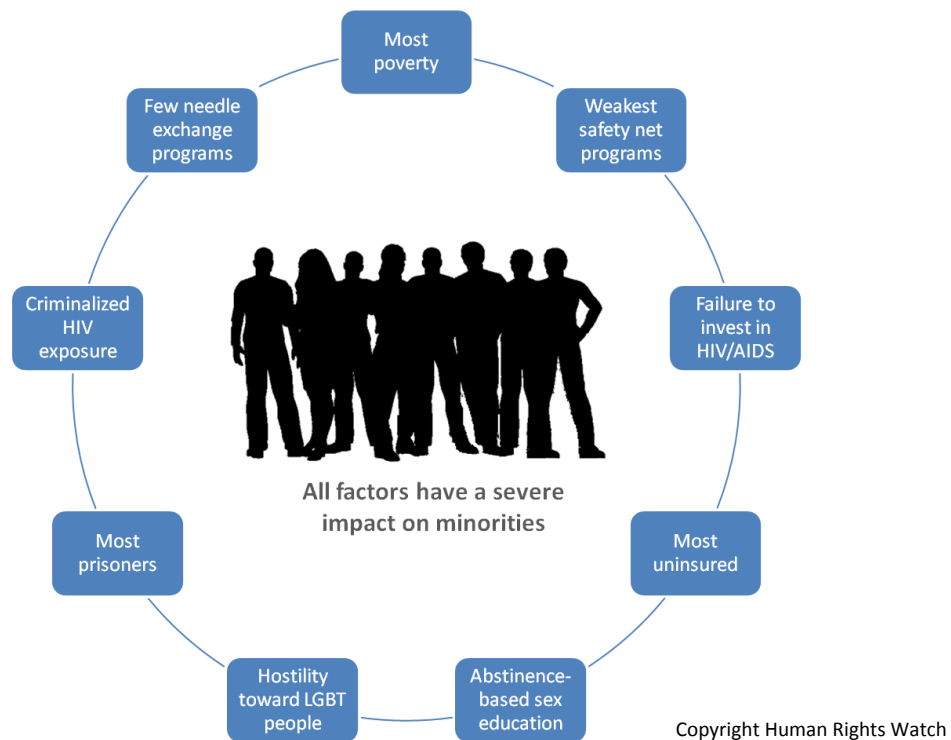
¹²² North Carolina General Statutes 90-113.22.

¹²³ Costenbader, et al, “Racial Difference in Acquisition of Syringes from Pharmacies Under Condition of Legal but Restricted Sales”, *International Journal of Drug Policy*, doi:10.1016/j.drugpo.2009.12.006 (accessed October 22, 2010.)

¹²⁴ Human Rights Watch telephone interview with Robert Childs, Director of the North Carolina Harm Reduction Coalition, October 16, 2010.

Jeffrey McDowell, Executive Director of the Atlanta Harm Reduction Center, confirmed the need for clarification of laws surrounding syringe exchange. The center’s SEP has been operating openly for 16 years with the support of local police, who “see the benefits of the program” not only for drug users but for police officers as SEPs reduce injuries from hidden and discarded syringes.¹²⁵ Georgia law does not prohibit sale of syringes in pharmacies, but according to Mr. McDowell, “nobody knows that, so people avoid buying clean needles. The laws need to be clear and people need to be educated as to what the law really means.”¹²⁶

HIV and Human Rights in the U.S. South: An Environment of Risk



In South Carolina, advocates have attempted to establish a dialogue with police concerning the need for clean syringe access. Carmen Julious, Executive Director of Palmetto AIDS Life Support Services in Columbia, South Carolina, told Human Rights Watch that she once explored the possibility of needle exchange with local law enforcement. “It was a very short meeting,” she said. “They said ‘we’ll arrest you’ and that was that.”¹²⁷ In Florida, public

¹²⁵ Human Rights Watch telephone interview with Jeffrey McDowell, Atlanta Harm Reduction Center, November 11, 2011.

¹²⁶ Ibid.

¹²⁷ Human Rights Watch interview with Carmen Julious, Executive Director of Palmetto AIDS Life Support Services, Columbia South Carolina, June 15, 2010.

health officials support syringe exchange but consider Florida law to be a barrier to implementation. They have asked the state legislature to pass a specific exemption for public health purposes.¹²⁸

Lack of legal clarity surrounding syringe access is a national problem not unique to the South. But as the epicenter of HIV/AIDS, southern states should take all possible steps to ensure that transmission by injection drug use is reduced. Possession, distribution, and sale of sterile syringes for the purpose of prevention of HIV, hepatitis C, and other blood-borne diseases should be clearly authorized in all southern states.

IV. Conclusion: A Call to Act

Strong federal and state leadership is needed to address the human rights violations and other misguided policies that contribute to the alarming rates of HIV infection and AIDS deaths in the South. The National AIDS Strategy promises to redirect federal HIV funding to the region, and identifies issues such as abstinence-based education and criminalization of HIV exposure as barriers to HIV prevention efforts. But international law obligates the federal government to ensure that southern state governments abandon harmful laws and policies that undermine human rights and endanger public health.

Model legislation from the federal government should provide guidance to states regarding criminalization of HIV exposure and access to sterile syringes. This relatively low cost measure could have significant impact and should be implemented without delay. In the arena of public education, the federal government has inaugurated a “race to the top,” where states that discard failed formulas and embrace evidence-based methods are rewarded with federal support and technical assistance. A similar “race to the top” could transform state HIV/AIDS policies in the South and in other regions and is long overdue.

State governments should reexamine their investment in HIV/AIDS programs and try to maximize federal support. States should eliminate policies that conflict with federal and international guidelines for reducing HIV infection. Most importantly, federal and state governments should urgently respond to the “perfect storm” of socio-economic factors and human rights issues that drive the epidemic with a devastating impact on minorities. Without immediate action on human rights conditions in the South, the vision of a nation where HIV infection is rare and treatment is equally accessible for all will never be realized.

¹²⁸ Robin Williams Adams, “Proven Effective, Needle Exchange Banned in Florida,” *The Ledger*, January 16, 2010.