

Prison authorities to reconsider gay segregation policy

FORT WORTH, Texas — After a meeting with gay activists, officials at the Tarrant County Jail have said they will reconsider a policy requiring lesbian, gay and bisexual inmates to wear colored wristbands.

Upon receiving information about the wristband rule, Thomas Bruner of the Tarrant County Gay Alliance said, "we were extremely alarmed." Bruner told GCN that members of the Alliance met with prison officials Sept. 6 to discuss the policy. At that meeting, said Bruner, officials

described the wristbands as a means of "protection" for lesbian, gay, and bisexual prisoners, who are often subject to threats and violence from homophobic inmates.

Although Bruner said activists were "somewhat relieved" to hear that the policy was not explicitly designed for the purpose of surveillance, he also said they remained concerned that the wristbands may create an "increased risk of victimization" because they identify non-heterosexual prisoners to their fellow inmates as well as to prison workers.

Prisoners are routinely asked their sexual orientation upon entering the prison. In addition, all prisoners in the jail wear wristbands: red for those who have been convicted of felony; blue for those convicted of misdemeanors; orange for those awaiting transfer to Federal prisons; and yellow for prisoners with serious medical problems. The bisexual/lesbian/gay wristband is gray.

Of the approximately 3,000 prisoners in the jail, Bruner said, 49 wear gray bands. He added that the small number was evidence that inmates are afraid to disclose their sexual orientation if they are not heterosexual. "In our judgement," said Bruner in reference to the 49 registered inmates, "that's a disproportionately low number of gay and bisexual people."

Chris Nealon

9/16/90 GCN

Smiley - Commission
for the Human Rights

Various Rights Project

Bill Rold -
212-547-3550

Anthem - 1st program -

Quashed by

Platbyrn
Reg. Schneider - 518-
Prisoners in 563-
N. Country 7300
Clinton -
outrageous
conditions

m

Beverly -
Aplonagetti

Ithaca office

273-2283

Med. Care could be greatly
improved.

Depending on what prison?
Pr. at facility could get ↓ ↑
medical care.

Provide AZT & pent - or don't have
right eq
T-cell at 500

Policy great in practice mess
clients refuse pent. administered in hallways
breach of confidentiality

- bunch of

hear about kicked out of food services
programs, not substantiated

not segregating anymore -

put in Special Needs Unit
which provides medical care

— no medical justification —

Prisoners Rights Project - covers
class action suit

Physicians in facilities very little AIDS educ
dont know what to look at -
this year - starting AIDS educ in general for 1st time

Connecticut docs

(filed)

NY State -
did a case

Family Chel
islatry
now challenged
Pro legal
Service

Pos on

Compassionate
release

only
Some
States
*

Mand. Costing

LA. IMPROV A AIDS Educ.

Judy
her Gen
Pomerantz
PL Services

nsuers
914-473-
3810

Trail visits
for

Breach of confidentiality
- repercussions
by guards
- sheer
fears

Biggest

Disincentive

CA / State

if don't know about
policy ? rule -

pre & post test counseling
should be advised
by state law

In Calif

99,000 men
up to 3%

tip inside

new[#] symptomatic

525 cases HIV+

206

intention

219 ARC

so kept in many
until

100 Full Blown

21 deaths this year

total 111 deaths

nearly even 100 to 1

possible screener

If no indication HIV+
come along with the
treatment

Medical lessons
for AIDS

Find inmates 7 doctors
not in one in gen pop.

Pilot programs to determine
new folks HIV+ face
But if successful -

do have prisoners who are HIV+
in all institutions throughout the
state

Want the policy of private
HIV+ inmates in other facilities as no room.

Initial reports
encouraging.
Some inmates due to
behavior always be
subject to
sit needs

> to do behavior than being &
LIVE

prob end up spe. this is

~~regard~~

regard

need greater controls
more like confinement

putting others at risk

~~Deals~~

Concern is getting the
medical care they
need & is not available
at every institution →

spend day -
in group. live in.
58 at Vacaville * nursing
sen

6 at CIW Futera

↓ ~~DB~~ at CMC ^{adult} ^{new} ^{story} San Luis Obispo
39 living in general population
aim to place 100 in CMC in ^{HW+} ~~sen~~ population *

pilot started for March

violating
sexual promises
behavior
or likelihood of being victim of
forced sexual
activity

screened to be

Assoc Wa
Carol Pinkins - 805-543-
2700
X7923

Va - 707-449-6509

Cent Rita Montez
Montez

? for Christine May (sp)?

try 2:00

DOC - Calif

916-445-4950

Current program? CMF

Mike Van Winkle

Tip Kindle
assoc in Dat Sac.

get name of:
Chief Medical Officer

section for unit
teacher 34%
w/le⁺ edu⁺ phys⁺
Cmo
industrial program
sewing unit
unit maintenance

Will there be mandatory testing? Any plans

In April 27
1994 - 14 -

several pieces of legislature - at this pt has passed leg w/ elec.
4/5 bills in that sen right now

How are pilot programs working?
= Walker Unit -

So all that met criteria
gen population * 4/5 up food services
medical services
no recent drug history, no or drug
no documented lmo behavior
recent history aggressive

Why denied cojugal visits w/ spouses & children?
before arrests
w/ parents * - grandparents parents
adult children
adult b/c dis in minor children
no birthing pairs

behavior
towards
staff/
inmate

Distribution of condoms or clean needles?

no doc history
G/G will
renew bmo
prematen mals
any comments.

Plans to implement program:

Opposed to Butte's but allow condoms city/county
Jabs! Sends out wrong message
sex u illicit, & providing assistance
then turning back on violation

AIDS Education:

feel strongly that it's illicit
each will give you condoms
and will turn our back

during orientation - presentation, contrachon
flyers, lets circulate on quarterly basis
videotapes in sanc area.

CMF

CW

2500 total

stuff psych. assigned to unit
AIDS prevention: talks about using drugs &
illicit behavior *

Inmates pretty much receptive, haven't disagreed
sympathetic w/ inmates in unit
in separate wing do anything they can to help them

no documentation
of HIV trans
inmate -
inmate

but do know sharing illicit drugs, but possibility is there - must have IPVU history - if want to be
tested
how will

voluntary testing Jan - July 31
131 of
vol. testing
thru 50
check of AIDS
4
w/ AIDS 27

of HIV+ 206 as of 7/17 F/M

In Calif.

died total since '81 - 111
in 1990 - 21 deaths → included in

cases of AIDS 100

ARC 219

total 525 HIV infected cases

Sen. John Doolittle - Mandatory Testing
916-445-3788

Family
Counseling Visiting Program not CT

spouse
children
parents

) to prevent spread of disease

CIW - Frontera Son 2 714-597-1771

of ♀ in p. program

X 219

still in reg

public info office

educ programs

Cint. Huyler

family
visitation w/ children

CMO - Dr. Nadim Khoury -

916-324-0876

202-331-0500

Recent stats on # of states ^{Judy} ^{success} ^{survey}
who test all incoming inmates 16

Segregate those w/ AIDS

Segregate if HIV+ → AIDS ~~But~~ Scoble

Fed. Prisons mand testing

Calif. - pilot programs
Colorado Sing nearby housing

people won't come up to
what they're doing

Miss Ala

New

Green - says not, but

Overall impression of the way prisons have handled
people w/ HIV disease

now < states say > testing

NPP firmly opposed mand test say

opp. w/ test w/ indirect pre/post test counseling
no confidentiality, could filter them
be reported to warden sup guards to push health dept
badly in
chance of
people

Have officials become more responsive to the needs
of inmates over the past few years?

Alabama - class action suit - outcome?

many drawbacks in
prison to testing

need mand. educ
not just 1 shot
educ by people
from outside

Opinion isolation wards/ segregation

most effective is
peer ed. some
correc threatened
by that. Mann Delancey

NYC: ~~Prisons~~

NYS have the worst
situation > # in prisons
seriously substance and
med care

3/9/17
5/2/17

Heard of instances prisoners denied parole based on HIV status?

Fed prisons mandatory testing before parole - anywhere else the same?

How important is condom distribution?

Sex between inmates a felony in every state?
Both ♀ & ♂?

Familiar w/ Mississippi?

Made condoms avail, yet also mand test + se exp. convs

Ed does not seg.

Get in locked of HIV & caught & drug
sex - controlled housing hard to get out of -
can take several years -

Still rather than educ, trying to punish
prisoners

High risk behavior could be sed thru
qual comp couns & educ.
its not happening

Refusal to educ $\Rightarrow$ ignorance

Alabama -
lost in courts

Is on appeal right now
85 - first step HIV unit

Made 8 / 7 wear
guns, body suits
stayed there all the
time

F's prison - AIDS
HIV section - old
death row section

Mississippi

Why is that this is old
policy but had failures?
any. who I didn't want to
setting prog before AIDS
epidemic.

Did testing "not being"
mandated.

Seg which is useless
reports on mistreatment
help racism HIV +
can be deleterious

Class Action lawsuit 100's of cases misdiagnosed
1/3 of cases - no treatment, not diagnosed
till biopsy

Must offer early treatment, make some efforts
to begin to offer DDI
↳ life & death matter

Prisoners in Fed system - exit testing - random screen
60 days before release

if test (+) make people contact outside
sexual partners, if not do, would do
info given to parole officer

heard about prisoners scheduled to be released
50% way have drug treatment
denied when found out HIV

In some state cant get fulcrum of HIV+
thats after when find place to live + job
needed for release
then app. often denied HIV+ AIDS
many insidious ways that it discriminate

Alabama

Class action suit
to stop mandating
{ segregation }
discrim based on
AIDS considered handicap

Mississippi

no opp for educ.
training
custodial good time
suffers - & for transfer
being produced

1 of 2 states that offer clemency - other
Vermont then med. staff

Case in Trenton NJ

Blay Gay charged w/ body guard
found guilty by jury 25 years
HIV-UP, BWM T - offered AIDS

Dangerous trend on outside - felony of HIV
infected to have sex if they don't

pub. stat used against gay & who have
consensual sex w/ & not legal age
can be used undictorily

Criminalization + what should be looked at
as public health program. Now treated as
a crime to be HIV(+)

No one taken to court

... not? of sodomy law

It's rule don't have sex

If they know you have HIV than it's a huge deal

Prison by refusing to educ & prov. condoms

created that situation

Don't know any better - Don't have tools to protect themselves

If have sex, be locked down for 1 yr

Prosec. HIV+ prisoners for biting, spitting
very serious?

Instead of getting treated for discip. infraction + locked
down for 2 wks mark on record

& charged w/ attempted murder

convicted, on 10 years sentence

that is the criminal act, becomes a death
sentence

Alabama

has gotten better med.

Still forced isolation totally unnecessary

trend category state by state
individual basis

We know sex + drug in prison

more p. greater cancer HIV +

Widespread 100% people coming in
more ♀ HIV(+) than ♂ / % is higher.

We advocate condom use + distribution

Philadelphia
say we can't, against the law

think black or something to clear works

Contravial - same-sex - recreational

At pt where shades where want allow condom in
1/2 condom is can prolong someone's life

Ted Hammitt

ABT Assoc

617 - 492 - 7100

name from Paul DiDonato
won't be in till Tue

55 Wheeler St - Cambridge Mass
Cam 82138

AIIDS

Calif. will attend -
it's just = disincentive
Authors in Calif
still committed
to seg.

hard to give
to total rules
should be
gone

Education *
[89]

Trend in housing away
86-87 > hard test.
not mad rush

Segreg declared in-
popularity
Score by case approach

Are necessary tests
VOT tests & confidentiality
not good enough
→ early made

Talking about risk good 40 paid conditions
is problem. Understand rest considerations overriden
that set down happen

HIU
Mississippi * Segregation

as 4 last Fall

4 Ala *

Make/Text

Calif

Color * -

Nev * -

Miss

Idue programs - some effort made
not a reg. educ

a lot more needs to get done

beyond lecture model → developing
more sophisticated Model for behavioral Δ.

All research shows behavior Δ's diff, one shot or video tapes or talk is
not sufficient > 1) don't know. # 2) start not enough

(Mississippi)

^{Facility.}
Parchman Hospital Admin. Prison Medical System
Bill Steiger - 601-745-6611 x4112

Monday

where are the
condemnation purchase?

Health
Dept.

Epidemiology - Ed Thompson - 601-960-7725

Chief of Bureau of Preventive Health Services

identified

how many are
sold?

~~***~~ Segregating all inmates w/ full blown AIDS

Some concerns about some inmates w/ AIDS may not
be getting access to services/ programs

retest

what if

someone

suicidal
aftermath

~~not getting AZT, primarily due to expense -~~

There is widespread support for segregation

People HIV+ mandatory screening

unclear if segregated, noted, grouped together

Ken Jones in Jackson

[Mark Marguardt]

Had good response from homosex pop.

praise from diff. orgs nationally

ACLU - 1st or 2nd state to do

Namenum requests for policy

Educ. program is key to this

Cohort. of HIV individuals

Will start self-help program next month

Depression, anxiety-

Place them in therapy to deal w/ emotions
generated by AIDS

When say HIV+, that's what they hear...

HIV+ - no conjugal visit

decided - no one trying to protect as many
people as possible not a right, its a privilege

Afraid 22,000 across bus people to various places

keep custody ^{status} separate

have GED program

- 4700. Over 5,00 almost 6,000
inmates

vocational school -

HIV- paranoid, don't want anything to do w/ them
many are identified, everybody knew who was
placed in protective custody for others, others mainstreamed.

Mississippi

Bill Steiger / try around 3:30
Hosp Adminstrator for Dept. of Correc.
spelling - position

How condoms purchased? [centens in 25x per condom
Aug 1987 anonymous inmates nuns
canteen

How many sold?

Ed Hansen *

1982
8 deaths since
diagnosing

Test upon entry - test later in case

HIV status D's

Is sex between inmates a felony? no - sodomy against the law

Large conjugal visiting program, 1st started 12-1520 visits per month

What are complications for condom distribution?

started issue since can be used as birth control devices.

Infection prevention - developing preventive program rec. Ser. Gen - permit condom made available
What about inmates? Also mandatory testing?

How many identified?

Why decide mandatory testing + segregation?

Did it at request of state health Dept & after blind study

began screening July 89

Medical care/drug available -

AZT, pentamidine - everything available
according to CDC recommendations.

screen to check
convict

85 currently

Central Mississippi reception center: 6 - 310

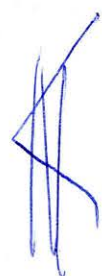
medical release program - anyone deemed terminal can be considered
then make recommend to Gov. - present for released none
participated *

go to classes,
live, eat, sleep

not barred from - DOC 

Family Visits -

 Conjugal visits policy studied might now

 If prevalence goes down might change

Liability if person not HIV becomes infected
concern & obligation for other inmates
since not all is consent

concern about not consent, Only if legal level #

 Condemns at inmate canteen or store

Parchman - almost all prisoners in 1 place

total 4-5000

physical arrangement # of sep housing units

largest holds 1500

smaller 150

So can cohort HIV + people together in 3 camps depending on

security since July 88 all are tested for HIV

4 test (+) then in this camp, given education for (+) person

Screening all inmates

(-) inmates, given education & placed in gen. population

Among all prisoners is drug use, sex, tattooing, real app. for virus

already 20 or so + found 40 more
addition (+)

In summer ~~89~~ ^{July} screened all inmates then 70 ← seg.

Rationale: physically feasible due to mult. housing units

2) act and presence of behavior

3) blended survey showed slightly over 1% in 100

1.4% currently

might be slightly over chance if in prison than in free world

contradicts that prison is hotbed

knew of 1 case where trans in prison

New York

Correctional Assoc: A public interest organization
an independent research group

...."says the report, which was written by attorney Cathy Potler
director of the association's Prison Conditions Project.

Nov 81 - First dianosis made at NY state prison

NYS prison system houses more inmates with AIDS than any other state

About 1/2 of the nation's IVU related AIDS cases are in NY city

Almost 89% of prisoners in NY state from NYC and its metropolitan area

Blacks and Latinos 80% of prisoners

60-70% have a history of drug use

Most inmates AIDS deaths = Black or Latino men around 34 from NYC with a
history of IVU

A prisoner with AIDS housed in the infirmary at Clinton:

"Your are a marked prisoner when you are housed on the AIDS ward. When you
go down for x-rays, you see other inmates and they would say to you, "I
heard your were dying." And their hand would go out as though they were
about to shake hands with you but then they would hesitate and put it
down. Some stand up on the bench in the x-ray area so they don't have to go
near you. It really hurts. You can't wait to get out and get the "sign" off - the
one around your neck that says, "he's got AIDS."

Said another inmate:

"If the guys in general population suspect that someone has AIDS, first they
throw water into that person's cell when he is not there. If that doesn't
work, they burn out the cell. So some guys are scared to leave their cells if
they think that people suspect them of having AIDS.. ."

Some superintendents at maximum security facilities intimated that the
security staff posed greater obstacles than the prisoners in
"mainstreaming" mecially cleared inmates with AIDS/ARC into general
population.

Said one superintendent about prisoners with AIDS/ARC, "I just want to get rid of them. I wish they would go some place else." ✓

CO's want to know the names of every inmate with AIDS/ARC and preferred that these prisoners be housed in a separate facility.

✓ At Clinton there are several officers assigned to the AIDS area of the infirmary who, according to both prisoners and medical staff, have said such things as, "Why don't you just die and get it over with already?" and "I don't know why we should take you for an x-ray, it's just a waste of equipment."

✓ At a maximum-security facility in western New York, one of the transporting officers took an AIDS patient to an outside hospital. On the way back to the prison, the officers made several stops at a deli and gas station where they asked if anyone there wanted to take a look at "a nigger with AIDS.". The officer was reprimanded, but continues to transport prisoners.

A superintendent at a maximum security facility said, "I know there are all kinds of drugs in here. As long as we have visits and packages there will be drugs ...About two weeks ago, there was over \$4,600 in drugs in one facility. .."

An inmate said:

"In practically any penitentiary in the state you can get drugs. A half to one ounce of heroin comes into Clinton per day through family or staff. You shoot up in the yard where you can easily exchange needles.

"Inside you do share [needles.] I stopped using heroin at Clinton because I found out friends of mine at Sing Sing had come down with AIDS. ...IV drug use is the biggest problem. Then comes homosexuality and tatooing....For IV drug users its more dangerous in jail than on the street. On the street you can buy new needles or bleach to clean your works, but not in the prisons. You may not be able to stop the use of drugs for prisoners, but at least you have to stop people from using the same needles. If we don't do something

today about AIDS in prisons, the prisons will be tomorrow's death camps. ✓
The administration just doesn't understand this."

A 1983 study of 330 inmates in 17 federal prison revealed that 20-30% have engaged in homosexual activities with other prisoners at their current institution.

NYC, Vermont and Mississippi have made condoms available to the general inmate population

Inmates diagnosed as AIDS/ARC are excluded from participation in the Family Reunion Program regardless of whether the visit would involve a spouse, child or parent.

Over 90% of the AIDS cases in the state correction system are men

There are no systemwide, ongoing, face to face AIDS education and training programs either for uniformed and civilian staff or for prisoners

There have been no AIDS education programs for inmates at Sing Sing

Infirmaries: usually no programming, recreational space or family visiting area

At Auburn, Attica and Clinton there are no alternatives to outside recreation when weather does not permit and AIDS/ARC inmates are restricted to the infirmaries from at least Nov-April. At Green Haven, the yard for AIDS/ARC patients, commonly referred to as "no man's land" was not equipped with any recreational equipment. ✓

Under state law inmates must be provided with one hour of recreation each day

Established in 1983, the Special Needs Unit at Sing Sing is the only designated unit in the state's prison system specifically reserved for prisoners with AIDS.

The physical limitation of the prison infirmaries provide the facility administrators with few housing options for the AIDS/ARC patient. The result is that segregated persons with AIDS, regardless of what stage of the illness they are experiencing, are housed together on the same ward or in close proximity in the infirmary for 24 hours a day, seven days a week.

In addition, a priest at Bedford explained to us that it is very important for children to see their mothers (or their fathers) for the last time in a hospital rather than a prison setting. At least the child will have a last picture of his or her parent dying in a place where people normally die.

There is no uniform policy or medical protocol concerning the prescription of AZT

At none of the facilities visited were there any Spanish speaking healthcare providers. Latino officers or inmates were used as interpreters - undermining confidentiality

The state's response to the AIDS in prison problem has been substantially inadequate.

Comments from inmate Cruz Salgado Attica inmate

"To say they are treated insensitively would be putting it mildly. The truth is there is no regard here for the betterment of prisoners nor the improvement of conditions in general let alone the care and treatment of HIV+ and prisoners with AIDS."

"Once an inmate is diagnosed HIV+ he is 'marked' as these people (i.e. security, medical and civilian staff) have no respect for confidentiality laws and believe they have a right to know who has AIDS. One officer personally informed me that he knew of two inmates who worked with me that had AIDS because he was told by the medical department."

"If the diagnosed inmate is either too ill to remain in the general population or unprepared to deal with the psychosocial issues of the disease, he is placed in the back of the second floor hospital dorm. There he is isolated and

prevented -both by wishes of officers and the indifference of administrators- from participating in programs of any kind.

"The treatment of "guards" borders on the obscene. They abhor these men and constantly demonstrate their distaste with jeers, snickers and/or snide remarks. The less they have to deal with them the better."

"Those inmates who have not received a minimal amount of basic AIDS education - which unfortunately includes a greater part of the population - display their ignorance at a more subtle level but nevertheless made felt by those HIV+ or with AIDS. At the present time two of my comrades and I are in the process of producing an AIDS Awareness Seminar which we hope will help us bring about a sense of understanding, responsibility and caring among the prison population.

"Thus far, what little education has been offered has been put forth by my two associates and I in the form of small presentations at those groups and/or organizations who have provided the opportunity. Whatever training the administration has conducted has been solely provided to officers and staff.

Prisoners at Green Haven worked to establish an AIDS Supportive Care and Counseling Program "Helping Hands Project" to assist PWA's as well as a Health Crisis Action committee to provide AIDS education and training to prisoners and staff

Alabama 1988 ask JUDY

HIV positive women prisoners forced to wear surgical masks outside their isolation cells and to clean telephone receivers with ammonia after every use

Male prisoners must use plastic eating utensils

First class action challenge to mandatory HIV testing and segregation of prisoners

DOCS calls isolation a precautionary measure

AIDS isolation wards at Julia Tutwiler Prison for women and at Limestone Correctional Facility for men

HIV positive prisoners are not permitted to work attend classes, receive furloughs or participate in work release or other community based programs

prisoners records are not confidential

no counseling for prisoners about their test results

their isolation and other actions perpetuate myths about how AIDS is spread

Limestone US NEWS QAND WORLD. Dorm 7 called "Thunderdorm" houses every

male prisoner in the state who is HIV positive approx 130 inmates, most of

whom show no symptoms of the disease surrounded by chain link fence

topped with razor ribbon and forbidden to have contact with other

inmates or perform ordinary prison jobs

1985 Daniel Ryan first person with AIDS: nurses not talk to him unless he

put on a surgical mask, when he showered he had to scrub the stall with pure

bleach afterwards and mop his way back to his cell afterwards

California

California Dept of Corrections (CDC) one of five states that has chosen to

segregate all prisoners who have AIDS, ARC and those who are HIV positive

Of 100,000 inmates about 6000 test HIV positive - according to Alston

Hardy. They have identified 5-600 either inmates who self-identify, reason

to believe have AIDS (visible reasons) or have been in the AIDS unit before.

No mandatory testing upon entry. In all facilities according to Hardy,

prisoners denied 48 hour trailer visits with family member that are

permitted to other inmates, may only have day contact.

Hardy: Inmates at Vacaville have done some education for other inmates and

the DOC maintains that they distribute materials on HIV, these claims are

dubious

Hardy: Try and get prisoners out on basis of compassionate release. Judges

don't often see these these petitions and don't know what to do and DOC has

been slow in writing their recommendations, although this has improved.

In one instance inmate didn't tell his PD had AIDS he was sentenced to 10

years for a robbery of \$2 and a McDonalds dinner. After sentencing when PD

learned, he had AIDS tried to get him into medical facility and petitioned the judge to resentence. Judge refused to do anything and he died in prison.

"Judges don't want the responsibility of releasing someone with HIV into the community."

"Compassionate release affects very few people - have only attained releases for 2 people. Prisoners to have a stable environment on the outside since they need medical care. "Our office doesn't want people to die with AIDS on the street, with no medical care. And there must be no violence on an inmates record - and few prisoners in that category.

Bill in Congress to allow distribution of Condoms in prison John Burton 916 - 445-8253. Trying to push through but opposed by DOC lobbied against it. Says Hardy, "They maintain that condoms could be used as slingshots" and so should not be distributed.

Oldest California state AIDS unit is at California Medical Facility at Vacaville, with 165-170 prisoners in its AIDS unit

In 1988 barred from vocational programs minimum security parole violators are housed with lifers along with prisoners with serious mental illnesses are housed in the AIDS wing because the facilities for the mentally ill refuse to accept prisoners who test HIV positive

Hardy: Now in response to law suit, new pilot program for 45 inmates not housed in segregated unit, can take part in work programs, work and eat integrated with other inmates. (Add Mat Coles) "Pilot program is a big step forward. Starting to treat prisoners on a case to case basis like other prisons in other states. Inmates report little to no harassment from other prisoners or staff which is particularly exciting since DOC said that putting prisoners into the general population would mean "they were at the mercy of other inmates and would not be accepted. This has been proven not to be true." "In the AIDS unit prisoners tend to lose hope, even if they are only HIV positive and are asymptomatic. It's difficult to be in a unit with 70 people and to see people sicker than you die. Watching others die they tend to think why keep fighting?"

hardy" Situation has improved over the past two years. Since 88 have hired two new AIDS specialists, now 3 extremely competent HIV specialists and inmates seem satisfied with the medical attention. Whereas Chino has

more prisoners, but only 1 doctor with no real AIDS background and who inmates say only works 1/2 time in their unit."

"Can get AZT and aere petn. Illegal to give experimental drugs to prisoners in Calif. due to legislation drafted to protect inmates. There is now legislation however that allows prisoners access to IND drugs - drugs that have been through some testing and DDI is available at Vacaville."

CIM CHINO - 223men in its AIDS unit

totally restricted from other prisoners locked into their wing where they have no educational, vocational or rehabilitative programs - now can take part in industries work program

Officials have ignored requests from the local AIDS foundation to provide support and education

CIW CHINO - 15-20 women Contact Rebecca Jurado 213-487-1720

segregated infirmary unit surrounded by two cyclone fences with a dead zone of about thirty feet between them creating the appearance of a concentration camp

Women are not permitted to attend high school or college courses vocational or rehabilitative programs Although many were required to participate in AA or NA as a condition of regaining custody of their children, they are barred from joining the prison groups and the NA and AA leaders may not visit the AIDS unit.

There is no common area so the women must congregate in the hallway to eat, watch TV have religious services or meet wit the AIDS education volunteer who visist weekly. Small exercise yard 15 feet by 15 feet which th ewomen are allowed to use, but the swarms of flies from the nearby dairy make the yard almost unusable.

visiting is restricted

Women not properly monitored on AZT
very little mental care

ACLU attorney, Rebecca Jurado: Doe vs. Calif Dept of Corrections filed in August 1999

Federal court action on behalf of women at Cal Institute for women who have found to be HIV positive are segregated from the rest of the population. As soon as found to be HIV+ put into this one unit. When first filed oneyear

ago women not allowed to leave the unit confined there no access to work or education or meals with others.

Suit says this is a violation of their right to privacy since HIV status is confidential but segregation allows others to know violation of right to be free from cruel and unusual punishment says discrimination - disqualified from jobs and services they could otherwise participate in

Since suit filed came to agreement with DOC to have 9 month pilot program which began in April. Still live in separate units, but women who qualify for this trial can get regular work or educational assignments and thus now get credit for work time which goes towards early release

"Prop 96 said that if sheriff or CO passed on HIV status info punishable by fine despite that DOC is "putting these women on display."

Women complain of hearing CO's say "You're going to die anyway, so what.?"

"There is an excellent Dr. in Vacaville who has information and expertise, but she is in N. Calif and although she could provide information no specific training for medical personnel.

"DOC feels 'its my policy and if it is incorrect, prove to me that it is, it doesn't matter what anyone else is doing."

"Guards and inmates call it the AIDS UNIT "Women stigmatized by this everyone knows then, even if only HIV +. Furthermore "information sheet posted daily available to all inmates and guards which says who is housed where There is no reason for this to be public information.

"This pilot program will be successful and the policies will change so that DOC will provide adequate medical services to women in their facilities." They were originally housed in a wing off of the infirmary locked in couldn't walk out to even get help from a nurse. Right before suit filed moved to a larger unit where conditions were somewhat improved

But medical care is inadequate. The physician providing treatment is not a specialist and has received no training on working with people who have AIDS

"Concerned that AZT is not monitored correctly. Antiretroviral women
supposed to go to outside facility. Transportation is inadequate; hospital
guidelines not followed.

Prison justifies for reasons of safety and security

"In 1987 first woman in prison to die of AIDS in complete violation of her
rights her name was announced on the radio "They said her name and that she
was the first woman to die of AIDS."

Has improved over the past three years. Three years ago "women were forced
to wear masks when out of their cells, given disposable clothing, utensils
and dishes" housed in max. security in CIW medical wing. If allowed out to
use the phone, Lysol the phone afterwards.

Earlier this year DOC changed policy and will allow (conjugal) trailer visits
with parents - but not with children or spouse.

women at any facility found to be HIV positive sent to CIW in blind study
3.2% of women entering are HIV+; 2% for men
CIW holds 24 women at one time 2600 women in facility; 6000 women
incarcerated throughout Calif.

Allen Crown, Lawyer for DOC

Institution selected women to participate screening criteria: medical
clearance, assault record, drug usage

Women segregated because : "trying to control spread of the disease" "protect
inmates from retaliation of other inmates" "better access to medical care"

AIDS ED "Videotapes, pamphlets, seminars for inmates and staff"

"Encourage testing"

Rationale "Easier to provide treatment if all housed together"

What, if only HIV? "More convenient for the Doctors. In unit can be checked more frequently. "Inmates rather be living in gen. pop. rather than in an isolated unit but it is in their own best interest."

Visitation: "Restricted - to prevent transmission of the disease" "No children to make sure no transmission; children can't appreciate the risks involved; they aren't consenting adults and could later sue so it's a liability problem" "Risk is small" but it's there.

New Unit in San Quentin 40-45 unit for short termers and as reception center; Hardy: has 14 jobs available and in the process of establishing a work program but no opportunities to take part in education programs

Another new unit now with pilot program in San Luis Obispo

AIDS IN PRISON AND JAILS Anita Arriola in AIDS Practice Manual

Mass screening is conducted in the federal system and some state and county systems of all new prisoners and prisoners being released. Some have tested all prisoners while other screen only members of certain groups such as gay men IVU's, female prostitutes, pregnant women or inmates with clinical indications of HIV infection.

Other Issues

In Philadelphia, a Black gay PWA prisoner was accused of trying to kill a prison guard with his saliva. Gregory Smith, sentenced 12 1/2-25 years for attempted murder based on guards' claim that he had bitten him to try and give him AIDS. On appeal

Prisons already coping with crowded institutions and limited budgets

Nevada, Colorado, Iowa and Missouri have mass screening programs for inmates

NYS and Calif. together account for almost 50% of the AIDS cases in the US while New Jersey, Florida and Texas collectively account for an additional 21%.

confidentiality of medical records is necessary for the safety of prisoners HIV+ or who have AIDS

DOC must discuss issues that are supposed to be punished

Paul DiDonato, National Gay Rights Advocates

"Pilot program is a compromise, now as move people into the pilot program, move more into the segregated unit."

"State tried scare tactics, said other inmates and staff opposed. In reality many inmates and staff not opposed and in fact in favor of it."

Inmates refer to it as a "leper colony."

"If have to stay locked up, detrimental to physical and psychological health. Prison programs are a lifeline for prisoners, having access to education program GED program."

"If want to control AIDS need to allow people to learn if they are HIV+. With segregation policy no incentive to be tested."

"Vast majority of people with AIDS unknown. State estimates 1,000 identified, estimate 2-4 times more than that."

"California dealing horribly, most AIDS phobic of states with large HIV population. Calif most backwards, unbelievable ignorance, reactionary attitudes."

"A more enlightened policy make them more able to control AIDS in prison. Still doing a horrible job. Only reason agreed to settlement is that Federal Court may have imposed end to seg. policy."

"No reason not to have all people with HIV disease in the pilot program."
Still have 140 guys in segregation - unconsciousable.

"Deukmajain is an ally to the DOC"

"Every one knows that there is tons of sex in prison no one wants to admit it because they can't deal with sexually between men. But the reality won't go away just because they say sex in prison is a felony. As if they didn't distribute condoms men wouldn't have sex.. So there is sex in prison without condoms and the transmission of AIDS and it costs the state twice as much to deal with their medical bills and kill them off as twice as quickly as they would if they were in a noncorrectional setting."

Dr Richard Reed - chief medical officer for
Dept of Corrections

J. Michael Quintana - director Federal Bureau of prisons

Federal Center for Disease Control

Dr. Harold Jaffe - Chief of Epidemiology

How are prisons dealing w/ AIDS?

What changes, if any, over the past 5 years?

Norman Carlson - director US Bureau of prisons

Alan Koenigsfest - health service coordinator

New Jersey Dept. of Corrections

prison medical center

Vacuelli, Calif - where inmates w/ AIDS in Calif are
sent

Dr. Nadim Khourey, medical director Calif.
Dept of Corrections

New York State Dept. of Correctional Services - James Flatau
spokesman

How many inmates w/ AIDS since 1981

Dr. Armond Start - Medical Director Texas Dept of
Corrections

Dr. Ronald Shansky - chief medical officer for
Illinois Dept. of Corrections

* Find out more about law suit in Florida over
medical treatment of Florida's inmates

Mr. Scarpulla (son died of AIDS related pneumonia
while in Florida State Prison)

In New York State

Metropolitan Hosp. in Manhattan

22 Bed wing for prisoners w/ AIDS

Margaret Wyle - Sing Sing's health service administrator

More info

Group of inmates at Sing Sing sued Westchester County Medical Center, one of the hospitals that has a contract w/ the state, to force it to treat any inmate w/ AIDS who requires hospital care.

New Jersey prisoners filed AIDS suit 1985, August in Avenal NJ at Adult Diagnostic & Treatment Center filed in US District Court

John F. Sheridan — where is he now? doing AIDS educ? at Rahway State Penitentiary N.J.
T. Gary Mitchell, director of Inmate Advocacy for the New Jersey office of the public defender

Justice - the Helping Hand in Newark

Joseph Patrossi - Vermont's corrections commissioner

Women AIDS Bureau Report 212-475-6713
Cathy Potter - director of the prison conditions project
of the Correctional Association of New York

1/7/88 Vacaville Prisoners file suit US District Court in
Sacramento 1st class action in the country to
challenge conditions, medical care PWAs

Donald Specter, attorney for the Prison Law
Office at San Quentin

Richard von Ossien-Boggs - criminal defense lawyer

US Medical Center for Federal Prisons in
Springfield Missouri - 600 bed facility
where male inmates w/ AIDS throughout the
country are housed.

Al Wardell Co-Chair 211und: Gay/Les Task Force
Member Prisoner Support Committee

AIDS Foundation Houston - 524-AIDS
3927 Essex Lane
Houston Tx 77027

Nat AIDS Network - 1012 14th St NW Suite 601
W, DC 20005 202-347-0880

Women's AIDS Resource Network 212-475-6713

AIDS Civil Rights Project, National Gay Rights Advocates SF

A. Billy S. Jones - Sunnyside Sherman -
AIDS Ed Proj. Whitman Walker Clinic
202-797-3560 - 6464 Wash. D.C.
- does work
with inmates

Mundy Domb, Mass Dept. of Pub Health
Robert Cohen M.D. NYC Health's Hospitals
Unrushi Vaid Nat. Gay's Lesbian Task Force
Gay Lesbian Advocate & Defenders
development's
~~efficiency~~
implementation
of AIDS educ
for inmates
HIV testing

ACCU National Prison Project

Al Wardell Co-Chair Illinois Gay/Les Task Force
Member Prisoner Support Committee

AIDS Foundation Houston - 512-524-AIDS
3927 Essex Lane
Houston Tx 77027

Nat AIDS Network - 1012 14th St NW Suite 601
W, DC 20005 202-347-0390

Gay Mens Health Crisis

212-807-7035

AIDS Action Counsel 202-547-3101

Center for Constitutional Rights

212-614-6464

HERO Health Educ Resource Org.

in Maryland 1-800-638-6252

Nat Gay/Les Task Force 202-332-6483

Boston AIDS Action Committee

Boston based prisoners Rights Group -

has 2 AIDS
prisoners at
Framingham

Social Justice for Women

Mass. Cerece legal Services

1-800-458-5231

Jan-Apr
M-Fri

Nat. AIDS Info Clearinghouse 1-~~301-762-5111~~

Natl AIDS Hotline - 1-800-342-AIDS

S.F. AIDS Foundation - 864-4376 (415)

Nat Lawyers Guild AIDS Network 415-861-8884

policies & treatment of prisoners HIV+ / AIDS

NY State

Prisoners Legal Services of NY

212-513-7373

newsletter recomm. policy analysis

Calif

Alameda County Health Care
Services Agency

415-268-2639

CMCC Assoc of NY

212-674-3390

Calif Pros Edu Proj
inmate

415-557-1437

Texas

P.P. Assoc of Hidalgo County

McAllen Tx

512-686-0585

Corpus Christi Drug Abuse Counsel

512-882-8201

area code Houston? 512

Fort Worth Sal Army.

817-332-1961

P's Action Alliance

212-532-8330

Q's AIDS Network

415 - 864 - 4376

* Judy Greenspan - Natl. Prison Project
AIDS Info Director ACLUF
202 - 331 - 0500

mentor
JG
Natl Headquarters ACLU - 212 - 944 - 9800
~~ask about~~
(AIDS: Prisons: The Facts for Inmates' Officers)

Maurie Gilligan Hein's
Syracuse
315 - 472 - 3107
w/NLG
familiar w/
AIDS Discrim Issues

Sue Jacobs
Asst. Att. General
Civil Rights Bureau
212 - 566 - 0819

Azadeh Khalili
NYC Commission on Human Rights
AIDS Discrim Unit
52 Duane St
NY NY 10007
212 - 566 - 5444
— Katherine Franke

Southern Prisoners Defense Committee

Alabama State Prison - Limestone Prison
Capshaw, Ala

"Thunderdorm" - houses every male prisoner in
the state who is HIV+

130 residents

talk to ACLU -

What 3 states segregate HIV inmates

Alabama, —, —

Update situation there

other inmates petition

} Thunder
Dorm

Prison Law Office

serving prisoners at Folsom State & Calif Med Facility
at Vacaville

Call (916) 752-6943

D

— About 20 ♀ there now - can be there 3mo - 4mo -
some longer

If allowed at night to use phone - Lysol phone
afterwards.

58 countries in Calif.

No countries since Prop 96 that seg. -
people w/ HIV

If indic. that HIV positive immediately segregated

They should be that HIV is any other med
cond. If med required be isolated then
treatment centers have priv. & opp. others
provided

DOC unable to negotiate on conjugal
visits - overnight family visits

HIV(+) not allowed these visits

Earlier this year S'd policy but only visit w/
parents, not children.

No complaints from ♀ made to feel bad from gen pop
Nor letters from gen pop that they don't want them
in Pop.

* Only DOC command.

Isolation not going to stop spread since
people don't know Serves no good purpose to
isolate them as if prisoners or staff are protected.

Some AIDS educ from Inland AIDS Project - limitations on pamphlets
couldn't learn into safe sex or IUD or any both are prohibited inside

Prison / ♀ counseled themselves - no real mental health support system

Sue Rochman

AIDS in Prison: updated stats. and other info.

pg. 2, paragraph 1: Currently **84** male and **2** female HIV positive prisoners...

pg. 3, paragraph continued from pg. 2:

--**74** men and **11** women-- to take part...

23 HIV positive prisoners to be mainstreamed...

pg. 3, paragraph 1: Alison Hardy, **staff attorney**, AIDS in prison project...

page 4, paragraph 1: But most of California's **545** HIV positive prisoners...

page 4, paragraph 3: Judy Greenspan, **AIDS Coordinator** of the Nat'l AIDS Project of the American... (a prisoner rights group?) add?

page 5, paragraph 1: some conditions have improved for the **20** women...

page 6, paragraph continued from pg 5:

Geri Pomerantz, **staff attorney**, New York...

page 12, paragraph 3: delete "Treated like lepers" **Whether** they are housed

page 13, paragraph 3: Cathy Potler, **Director of Prison Projects** of the Correctional Association...

page 14, paragraph 3: Potler, **Director of Prison Projects**

Bray Gt.

1515 S. St.
Rm 113 S.
P.O. Box 942883
Sacramento, Calif.
94283, - 0001

pg 1 - ACE 20 guests now?

pg 2 Mississippi

86 total -
Kim Jones - 601-354-6454
Now ~~80~~ 848
6 F 2 P
Segregated
ABO inmates
~~8324~~ 8,324

300

20

36 deaths 1990
total deaths 126 → since 81

total for Dept 232 HIV
226 ARC
7 AIDS

545 total

pg 3 Calif.

pilot programs

13 HIV 4 ARC 6 AIDS
23 total
9 in pilot

CMF - 58 8

CIM - 223 8

CIW 11 8

11 F in pilot program

CMC all 9 23 in pilot

98 at Vacaville

106 ARC
29 AIDS

245 at Vacaville
74 in pilot program

pg 4 how many known to be HIV? total: 525

staff atty.

pg 3. Alison Hardip title at AIDS in Prison Project of Calif Prison Law Office

Floyd

CIW 31 total

that 11 in pilot program

415-457-9144

9 not yet classified

pg 3 Leont Huxley - what's his opinion of pilot program now?

714-597-1771
x219

pg 4 Judy Greenspan, exact title? Information AIDS Coordination for Natl Prison Project

pg 5 - How many F at CIW - 31 segregated

pg 6 Geni Pomerant title at NY Prisoners Legal Services staff atty

pg 7 Cathy Potter title at Comm Assoc of NY - Director of Prison Projects

Calif?

New AIDS unit at San Luis Obispo as well?

How many inmates in system identified as HIV+

Calif - considering mandatory testing? Bill currently in legislature
a few years ago didn't go thru - which will provide for mandatory
testing - Senator John Doolittle

Condom distribution?

Support + y ^{Sacramento Area}
concept of qualifications +
mand. testing, but not bill as stands

What type of medical care available? What drug for AIDS

Info on New York prisons

Health Deputy
Comosener

Greifinger
Dr. Robert Greifinger
From Amy (Noddy)

AIDS Educ programs for inmates

being
program

- 1) peer support in large # of inmates
- 2) all inmates get seminar & see videotape on AIDS + booklet in Eng + Spanish
- 3) staff 1-1 counseling, health staff teaches correct

Chief Medical officer
BU 2
State (campus)
Albany 12224

SS Greifinger
770 +

the quality Medical Care - Wide Range of Services

not as def. but adeq. serving needs
Chronic diseases

spending \$93 a year

- 1200 self health services positions
- 24 hr. nursing full time physicians
- 5 secure units in
- 3 special needs units

5600 infected
770 - symptomatic HIV
sexual
transmission

Polices - testing, segregation

no more towards vol testing on demand

beginning to make anonymous testing available

Family Visitation Program for those HIV+

no restrictions

are restricted from Family Reunion Program

all family members
see HIV+

being reviewed, revised

children overnight

rule dpt for years
a lot of discussion

4 AIDS Educ training teams

3 - Graceland
Orat Meaden
Hudson

By end of yr.
20 facilities

Anon. testing
If know +

try to encourage to
not do any +
could be
monitored,
but he has a
right to
keep away

* Leading Cause of death 3 states ~~NY, NJ,~~

ΔS PyS ΔS ΔS

1) CMC is in San Luis Obispo

2) Mandatory Mass screening + - (Geo. Bureau of Prisons)

~~17~~ Alabama Nebraska (Judy)
Colorado ^{Arkansas} Nevada
Georgia New Hampshire AIDS in Correc
Idaho North Dakota Facilities
Iowa Oklahoma by NJ
Michigan Utah Rhode Island
Missouri Mississippi Wyoming

3) Segregate: HIV+

Seg. AIDS

(5) Alabama
Calif.
Mississippi
Colorado
Nevada

— pilot program
Calif + Colo made a
trend moving away from segregation

* consider in NY Gen Permerant ~~2~~ challenging that
* New Mexico must submit to counsel before —
* Outrageous — irony of NY State is that prisoner
denied, denied only HIV+ had participated

* For NY where want testing, discuss from testing. One of few privileges to deny access



PRISON LAW OFFICE

November 21, 1988

Director
Donald Specter

Staff Attorneys
Steven Fama
Sharon K. Heath
Margaret Littlefield

Alison Hardy

Judy Greenspan
ACLU National Prison Project
1616 P Street, NW
Washington, DC 20036

Dear Judy:

Thank you for sending me the copy of the excerpt from the Omnibus Health Bill. I've read through it and cannot seem to find the section that you mentioned earlier that ties research grants into testing programs. Is that in the legislative history? Have I missed something?

I am slowly but surely getting the AIDS in Prison Project off the ground. I have interviewed clients in the three California state facilities with AIDS units and have obtained information on conditions of confinement and medical treatment, so I thought I'd send you an update on the situation.

The California Department of Corrections (CDC) continues its misguided policy of segregating all prisoners who have AIDS, ARC and those who are HIV positive. There are currently about 140 men on the AIDS unit at the California Medical Facility (CMF) at Vacaville, 80 men on the unit at the California Institution for Men (CIM) at Chino, and 11 women at the California Institution for Women (CIW), also at Chino.

California Medical Facility

The oldest California state AIDS unit is at CMF. CMF is the site of the state's prison hospital, a hospital which has never qualified for licensure. When the unit first opened in 1985, the prisoners were isolated in single hospital cells for 23 hours each day, despite the fact that several of them were asymptomatic. Since then the unit has expanded so that there are now two seventy person wings, each at capacity, for prisoners with AIDS.

Since the ACLU, the PLO and a private law firm filed a class action suit against the state (Gates v Deukmejian), conditions on the wing have improved somewhat. The most significant change is that they have finally hired an AIDS specialist who is on the

wing twenty-five hours a week and provides excellent care. The prison has also installed a mini-kitchen so the prisoners no longer have to eat cold food three times a day. Prisoners on the AIDS units have been barred from participation in all educational and vocational programs, which are available to mainline prisoners. Recently, the staff has allowed a few of the prisoners to join mainline prisoners to join the mainline for college classes. They are still barred however from any vocational programs. They are also not allowed to have family visits.

Many of the basic problems stemming from the practice of punitive segregation remain. Because prisoners of all security levels are housed on the AIDS units, tension is high. Minimum security parole violators are housed with lifers who have little incentive to abide prison rules. Prisoners with serious mental illnesses are housed in the AIDS wings because the facilities for the mentally ill refuse to accept prisoners who test positive. Prisoners who have been in the unit since it opened have watched more than thirty of their fellow prisoners die. All of these factors work together to make the AIDS unit depressing and highly stressful.

California Institution for Men

In May, 1988, CIM opened its AIDS unit, called Del Norte. The eighty men now living at Del Norte are totally restricted from the mainline prisoners. They are locked into their wing where they have no educational, vocational or rehabilitative programs. Although the local AIDS foundation is eager to go into the prison to provide AIDS education and support groups for the men, the institution has ignored their requests for authorization to visit.

Most of the prisoners requiring medical attention are sent to CMF, however a few of the CIM inmates are currently on AZT. Because of its high toxicity, a patient on AZT must be monitored, particularly for its effect on the patients' blood. Prisoners I spoke to reported that no one followed up on their treatment. They claim that the two prison doctors know very little about AIDS and its treatment.

California Institution for Women

The women at CIW are treated worse than the men at either institution. There are currently two women with AIDS, two with ARC and seven who test HIV positive living in a segregated infirmary unit. The unit is surrounded by two cyclone fences, with a dead zone of about thirty feet between them, creating the appearance of a concentration camp.

The women are not permitted to attend high school or college courses, vocational or rehabilitative programs. Although many were ordered to participate in Alcoholics Anonymous or Narcotics

Anonymous as a condition to regaining custody of their children, they are barred from joining the prison groups, and the NA and AA groups leaders may not visit the AIDS unit.

The unit consists of four cells, each double-bunked, and a six-woman dormitory. There is no common area, so the women must congregate in the hallway to eat, watch TV, have religious services and meet with the AIDS education volunteer who visits weekly. There is a small exercise yard next to the unit (approximately 15' by 15') which the women are allowed to use, but the swarms of flies from the nearby dairy make the yard almost unusable.

The women are barred from using the law library and must instead rely on a cumbersome paging system. Although most of the women in the unit are mothers and would be entitled to family visits with their children if they were in the general population, they are restricted to visiting in the day visiting area.

The women receive very little medical attention. A nurse visits the wing daily for sick call, and the women must sign up for an appointment which is usually two or three weeks later. Only in extreme emergencies will women be taken to the outside hospital.

Several of the women have been on AZT. These women are not properly monitored for side effects. None of these women have had the necessary blood work done to see whether or not they might require transfusions, as patients on AZT often do.

The women get very little mental health care. One staff psychiatrist conducts "group therapy" on the unit twice a month. By his own admission, the sessions are not really therapy, rather he tells the women about new developments in AIDS treatment. If the women ask for appointments with a psychologist or psychiatrist, there requests seem to be ignored. The psychiatrist who conducts "group therapy" told me that the women hadn't shown any clinical indication that they needed psychological or psychiatric help. The women on the other hand told me that they would love to have counseling to help them cope with the stress of dealing with AIDS.

Goals of the AIDS in Prison Project

We are currently strategizing with a number of groups, including the Southern California ACLU, on how to best address the situations at CIM and CIW. We should be making a decision in the next month.

I am working on a dozen petitions for compassionate release on behalf of prisoners with AIDS and severe ARC. In California, the penal code authorizes the sentencing judge to recall a prisoner's sentence within one hundred and twenty days of

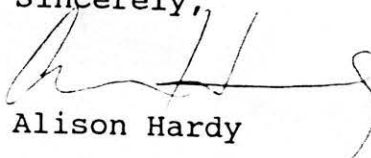
sentencing at her or his discretion. After that period, the judge may recall the sentence on the recommendation of the Department of Corrections. I just filed our first completed petition this week, so we don't have any indication on how successful this approach will be. I will let you know once we establish a track record.

The state legislature and the California voters recently enacted several laws which adversely affect prisoners. SB 1913 allows mandatory testing of prisoners in certain situations. SB 2643 allows forced testing of individuals who interfere with the duties of an officer if there is a "transfer of bodily fluids". The worst of the three, Proposition 96, overlaps with these two bills and authorizes widespread disclosure of test results. All three measures state that the information cannot be used in sentencing. We are considering challenges to all three on either a facial or "as applied" basis.

The state legislature begins a new session in January, and I am investigating certain issues which are likely to come up. I am meeting with a group of doctors and attorneys to discuss proposing legislation to make experimental treatment programs available to prisoners with AIDS. I am also preparing to battle against a proposed mandatory testing for state and county inmates bill. I am advising a legislative committee which is preparing a report on the status of AIDS education programs in the state prison.

Thanks for sending the copy of the Journal. I am very interested in your progress in the Alabama case and wish you the best of luck. I hope this gives you an idea of what is going on out here. If you would like more information about the project, please contact me.

Sincerely,



Alison Hardy

AH/

SENATE COMMITTEE ON JUDICIARY
Bill Lockyer, Chairman
1989-90 Regular Session

A
B
2
7
5
3

AB 2753 (Burton)
As amended June 13
Hearing date: July 3, 1990
Penal Code
ART/ps

CORRECTION FACILITIES: DISTRIBUTION OF CONDOMS

HISTORY

Source: Author

Prior Legislation: None

Support: Bayview-Hunter's Point Foundation for Community Improvement; California Medical Association; American Civil Liberties Union Foundation; Los Angeles Aids Project; city and County of San Francisco; Minority Aids Project; Hunter College Professor, Dr. Nicholas Freudenberg; Correctional Association of New York; Action Aids; National Commission on correctional Health Care; County of San Mateo; Prison Aids Resource Center; City of West Hollywood; ACLU; Montefiore Medical Center; California Conference of Local Health Officer; California Prostitutes Education Project; San Francisco Aids Foundation; California State Juvenile Officers Association; California Probation, Parole and Correctional Association; Asian Pacific Planning Council; Dr. Douglas Anglin, Director UCLA Drug Abuse Research Group Life Aids Lobby; National Lawyer's Guild; Prison Aids Resource Center

Opposition: California Federation of Republican Women; Committee on Moral Concerns; California Correctional Peace Officers Association; Department of Corrections; Women's Lobby

Assembly Floor vote: Ayes 43 - Noes 26

(More)

KEY ISSUE

SHOULD THE DEPARTMENT OF CORRECTIONS AND PERSONS IN CHARGE OF COUNTY OR CITY JAILS MAKE CONDOMS AVAILABLE TO ADULT INMATES IN THOSE FACILITIES?

PURPOSE

Under existing law any act of sodomy or oral copulation, whether consensual or forcible, committed by a person of any age while in state prison or in a local detention facility is an alternate felony/misdemeanor, punishable by 16 months, 2 or 3 years in state prison and/or a fine up to \$10,000, or by up to one year in county jail.

Existing law provides that criminal liability commensurates with the perpetrator extending vicariously to persons who aid and abet the commission of a criminal act when the aider and abettor:

- a) knows of the unlawful purpose of the perpetrator;
- b) acts with the intent to commit, encourage, or facilitate the commission of the offense; and
- c) by act or advice aids, promotes, encourages or instigates the commission of the crime. (Penal Code Section 31; People v. Beeman (1984) 35 Cal.3d 547)

Existing law provides no exemption or immunity by statute for official distribution of condoms in local detention facilities and/or state prisons, for public health exigencies.

This bill would statutorily authorize state and local officials to make condoms available to adult prisoners and detainees in California.

COMMENT

1. Stated need for the bill

Local detention facilities and state prisons are populated by disproportionately large numbers of AIDS, high-risk adults. For the most part these types of "high risk" behaviors engaged in by these adults do not cease upon entering the penal system but rather, due to the lack of education and access to condoms, exacerbates the inmate's risk of HIV transmission. The further implications being that a portion of these inmates, who are

(More)

already infected or become HIV, infected their heterosexual and homosexual partners both before and after their release. These facilities have a large gay population, and a large percentage of individuals who use intravenous drugs or acquire tattoos.

Accordingly, local and state lock-up facilities provide a unique and critically important opportunity to educate significant numbers of society's high-risk population and thereby potentially reduce transmission of the disease to the general population of this state.

2. Public Health or Custody Issue

Traditionally, the operation of jails and prisons has been the exclusive jurisdiction of their administrators. The question of general public safety has arisen with respect to the contagious and lethal AIDS disease. While some consensual sexual relations in jails and prisons are illegal, few doubt its existence. At issue only is how prevalent is it. Sexual activity has been documented in one jail on Rikers Island, New York. (Alcibes & Braslow 1988 "A Cluster of Cases of Penicillinase-Producing Neisseria Gonorrhea in an Adolescent Detention Center," New York Journal of Medicine (September) pages 495-96.) Should society at large be unprotected from persons released from the confined high-risk setting without providing potential transmitters the prophylactic devices essential to reduce or curtail the contagion?

3. In Operation In Other Locations

The state of Vermont has distributed condoms to its prisoners for two years. Condom distribution programs are in effect in New York City, Philadelphia, and San Francisco. Along with all of the other condom programs in secure facilities above, Atascadero State Hospital found in its six month pilot project on one ward, no increased incidence of violence, drug use, or sexual activity.

According to the Director of Medical Services, Rikers Island, New York, "Initially the New York City Department of Corrections was cautious about such a policy because of perceived security risks and the fear of encouragement of an illegal practice in a correctional facility. I believe that the Department is now happy with how well it has worked and appropriately proud. There have been no major or minor problems with our program from a 'security' point of view. The public health benefits are obvious.

4. Incidence of Consensual Sex in Prison

The California Department of Corrections (CDC) reports that its statistics in this area are incomplete. However, in fiscal year 1988-89 only 18 cases were referred for prosecution; of those, 12 were rejected and 6 were prosecuted. During this time fewer than 100 incident reports were filed for sexual assaults, both consensual and nonconsensual, and this number includes inmate with inmate, inmate with visitor, and inmate with staff. It also includes conduct that is not condom related, such as grabbing.

5. Legislative Analyst's Report

The Legislative Analyst has recommended across the board improvements in HIV education for prisoners and staff in the state's detention facilities. The report also included a recommendation that CDC "should examine its current policies on the demonstration and availability of condoms in prisons." (AIDS Education in Correctional Facilities: A Review, Legislative Analyst's Office, January 1990, p6)

6. Proponents

The Life Aids Lobby states that "[t]he Department of Corrections has expressed concerns that condom distribution would be perceived as government condoning an illegal activity, in this case, sex between inmates....when faced with a decision between protecting appearances and saving lives, the clear choice is the latter."

7. Educational portion of bill deleted

The second version of this bill would have required that prior to giving a condom to an inmate certain information regarding sexually transmitted diseases should be provided. This requirement is no longer a part of this bill. Many of the organizations in support of the bill, applauded this section of the bill as well. Condom use coupled with AIDS education has been shown to be the most effective preventive weapon that we have against the spread of AIDS both inside and outside prisons and jails.

SHOULD THIS BILL PROVIDE THAT INMATES BE PROVIDED INFORMATION ON SEXUALLY TRANSMITTED DISEASES UPON REQUESTING A CONDOM?

8. Opposition

The Committee on Moral Concerns opposes the bill for the following reasons:

(More)

- a) condoms do not work. The failure rate of condoms is high especially when used in sodomy;
- b) enactment of this bill would give tacit approval to illegal homosexual activity behind bars;
- c) it is naive to expect inmates, whose antisocial irresponsibility caused their incarceration in the first place, to suddenly act responsible toward their fellow man and use condoms.



Bureau of Justice Statistics Special Report

HIV in U.S. Prisons and Jails

By Caroline Wolf Harlow, Ph.D.
BJS Statistician

In 1991, 2.2% of Federal and State prison inmates — 17,479 of 792,176 inmates held in U.S. prisons — were infected with the human immunodeficiency virus (HIV) that causes AIDS. Of the total prison population 0.6% exhibited symptoms of HIV infection, including 0.2% with confirmed AIDS.

This report uses data from three Bureau of Justice Statistics (BJS) data series. Some information on prisoners with HIV comes from the annual reports made by State and Federal correctional authorities (National Prisoner Statistics or NPS). Other data on prisoner characteristics and drug use resulted from interviews with inmates (1991 Survey of Inmates in State Correctional Facilities). Jail data were provided by the Nation's 503 largest jail jurisdictions (1992 Annual Survey of Jails).

Additional findings about HIV in U.S. prisons and jails include the following:

- State prisons reported 2.3% of inmates were HIV positive, and Federal prisons reported 1.0%.
- Of HIV-positive inmates in State or Federal prisons, 9.6% had confirmed AIDS. In State prisons in the West, 21.1% of HIV-positive inmates had AIDS.
- All prison jurisdictions tested at least some inmates for HIV; 17 tested all prisoners.
- In 1991, 28% of all deaths in State prisons were attributable to AIDS. Between July 1, 1991, and June 30, 1992, 24% of deaths in jails were AIDS related.
- In 1991, about 51% of State prison inmates reported having been tested for HIV and knowing the results.
- In 1991, among those prison inmates tested, an estimated 3.3% of women, 3.7% of Hispanics, and 3.7% of those between age 35 and 44 tested positive to HIV.
- In 1991, an estimated 0.8% of tested prison inmates who said they never used drugs were HIV positive, as were 2.5% who ever used drugs, 4.9% who used needles to inject drugs, and 7.1% who shared needles.

September 1993

Because of their comparatively high rates of drug abuse, jail and prison inmates are at greater risk of contracting AIDS. In 1991 an estimated 1 in 4 State prisoners had been using cocaine or crack in the month before their imprisonment offense, and about 1 in 10 reported use of heroin or other opiates. During their lives, nearly 1 in 4 State prisoners had used a needle to inject illegal drugs.

This report provides the most recent information from BJS statistical programs covering State prisons and the largest jails nationwide on AIDS testing and the prevalence of AIDS and HIV seropositivity. It also provides information from State prisoners reporting on their personal characteristics and how these relate to HIV test results.

Nationwide, prison authorities in 1991 reported that 2.2% of those confined in State and Federal facilities had tested positive for HIV. That same year, in a nationally representative sample survey of State prisoners, 2.2% were estimated to be HIV positive, based upon interviews with prisoners. These comparable rates suggest that important and useful information about HIV exposure can be reliably obtained from prisoners.

On behalf of the Bureau, I express appreciation to authorities at the Centers for Disease Control for guidance in developing questions in our collection instruments and to State and local correctional authorities who supplied data. I also thank the nearly 14,000 inmates participating in our survey in 1991.

Lawrence A. Greenfield
Acting Director

Data sources

The NPS-1 program includes midyear and yearend numbers and movements of prison inmates, provided to BJS by the departments of corrections in the 50

States and the District of Columbia and by the U.S. Bureau of Prisons. In 1991 questions were added to the yearend report to determine the numbers of HIV-positive prisoners and the department policies on testing for the virus.

The 1991 Survey of Inmates in State Correctional Facilities questioned a nationally representative sample of almost 14,000 State prisoners about current offenses, prior drug use and treatment, personal characteristics, and other aspects of their life. Questions on whether prisoners had ever been tested for HIV and the results of the test were included in the interviews.

The Annual Survey of Jails obtains data on populations and movements of jail inmates. The sample includes all jail jurisdictions with 100 or more inmates and a sample of smaller jurisdictions. The 503 large jail jurisdictions provide figures on deaths in jails. In 1992, the jurisdictions that were the largest in 1991 were asked to indicate their policies for testing for HIV and numbers of HIV prisoners they were holding on June 30, 1992. (For further description of data sources, see *Methodology*.)

Prevalence of HIV infection in U.S. prisons

In 1991, 2.2% of Federal and State prison inmates were reported to have the human immunodeficiency virus that causes AIDS (table 1). In State prisons, 2.3% of inmates were reported testing HIV-positive; in Federal prisons, 1.0%. Of the total prison population, 0.6% showed symptoms of HIV infection, including 0.2% with confirmed AIDS.

States reporting the highest percentage of prisoners infected with HIV were New York (13.8%), Connecticut (5.4%), Massachusetts (5.3%), New Jersey (4.0%), Rhode Island (3.5%), and Georgia (3.4%). Twenty-nine States reported less than 1.0%. The percentage of inmates in prison on December 31, 1991, and known to be HIV positive is related in part to the testing policies of the individual prisons or departments of corrections.

States in the Northeast led the country in the percentage of inmates known to be infected with HIV (8.1%). Five of the six States with the highest rates of HIV-positive prisoners were in the Northeast. By contrast, States in the Midwest and West had less than 1% of prisoners with HIV.

Table 1. Inmates in custody of State or Federal correctional authorities known to be positive for the human immunodeficiency virus, yearend 1991

Jurisdiction	Type of HIV infection/AIDS cases				HIV/AIDS cases as a percent of total custody population
	Total	Asymptomatic	Symptomatic	Confirmed AIDS	
U.S. total	17,479	12,765	3,032	1,682	2.2 %
Federal	630	422	91	117	1.0
State	16,849	12,343	2,941	1,565	2.3
Northeast	10,247	7,420	1,922	905	8.1 %
Connecticut	574	229	264	81	5.4
Maine	1	1	0	0	.1
Massachusetts	484	100	362	22	5.3
New Hampshire	18	8	6	4	1.2
New Jersey	756	0	694	62	4.0
New York	8,000	6,833	474	693	13.8
Pennsylvania	313	247	34	32	1.3
Rhode Island	98	0	88	10	3.5
Vermont	3	2	0	1	.3
Midwest	1,128	733	268	127	.7 %
Illinois	299	216	66	17	1.0
Indiana	62	60	0	2	.5
Iowa	19	17	0	2	.5
Kansas	13	1	6	6	.2
Michigan	390	124	194	72	1.1
Minnesota	14	13	1	0	.4
Missouri	127	125	0	2	.8
Nebraska	11	10	1	0	.4
North Dakota	1	1	0	0	.2
Ohio	152	129	0	23	.4
South Dakota	—	—	—	—	—
Wisconsin	40	37	0	3	.5
South	4,314	3,513	513	288	1.5 %
Alabama	178	178	0	0	1.1
Arkansas	68	59	5	4	.9
Delaware	85	78	0	7	2.6
District of Columbia	—	—	—	—	—
Florida	1,105	1,015	0	90	2.4
Georgia	807	774	10	23	3.4
Kentucky	27	25	0	2	.3
Louisiana	100	100	0	0	.7
Maryland	478	324	135	19	2.5
Mississippi	106	106	0	0	1.3
North Carolina	170	116	35	19	.9
Oklahoma	74	64	0	10	.7
South Carolina	316	298	0	18	2.0
Tennessee	28	0	20	8	.3
Texas	615	251	307	57	1.2
Virginia	152	121	0	31	.9
West Virginia	5	4	1	0	.3
West	1,160	677	238	245	.7 %
Alaska	9	7	0	2	.4
Arizona	84	74	0	10	.5
California	714	407	136	171	.7
Colorado	82	37	41	4	1.0
Hawaii	19	17	1	1	.8
Idaho	10	3	3	4	.5
Montana	7	7	0	0	.5
Nevada	117	72	39	6	2.0
New Mexico	10	10	0	0	.3
Oregon	24	11	12	1	.4
Utah	35	0	5	30	1.3
Washington	42	32	0	10	.5
Wyoming	7	0	1	6	.6

—Not reported.

Source: 1991 National Prisoner Statistics-1.

Table 2. Testing policies for the antibody to the human immunodeficiency virus that causes AIDS, by jurisdiction, 1991

All incoming inmates	All inmates currently in custody	All inmates at time of release	High-risk groups	Upon inmate request	Upon clinical indication of need	Upon involvement in incident	Random sample	Other
Alabama	Rhode Island	Alabama	Arkansas	Alaska	Alaska	California	Arkansas	Hawaii ^c
Colorado	Utah	Federal	Connecticut	Arizona	Arizona	Florida	Dist. of Col.	Illinois
Georgia	Wyoming	Missouri	Dist. of Col.	Arkansas	California	Hawaii ^b	Federal	Mississippi
Idaho		Nevada	Illinois	California	Colorado	Kentucky	Maryland	New Jersey
Iowa		Wyoming	Indiana	Colorado	Connecticut	Louisiana	Massachusetts	New Mexico ^c
Michigan			Kentucky	Connecticut	Delaware	Maryland	New York	North Carolina
Mississippi			Minnesota	Delaware	Dist. of Col.	Massachusetts	Wyoming	Oregon
Missouri			New York	Dist. of Col.	Federal	Michigan		South Carolina
Nebraska			North Carolina	Federal	Florida	Minnesota		Tennessee ^a
Nevada			Ohio	Florida	Georgia	Missouri		Washington
New Hampshire			South Carolina	Georgia	Hawaii ^b	New Hampshire		Wisconsin ^c
North Dakota			South Dakota	Hawaii	Illinois	New Jersey		
Oklahoma			Tennessee ^a	Indiana	Indiana	New Mexico		
Rhode Island			Texas	Kansas	Kansas	New York		
Utah			West Virginia	Kentucky	Kentucky	Ohio		
Wyoming				Louisiana	Louisiana	South Carolina		
				Maine	Maryland	Tennessee ^a		
				Maryland	Massachusetts	Texas		
				Massachusetts	Michigan	Virginia		
				Michigan	Minnesota	Wyoming		
				Minnesota	Mississippi			
				Missouri	Missouri			
				New Hampshire	Montana			
				New York	New Hampshire			
				North Carolina	New Jersey			
				Ohio	New Mexico			
				Oregon	New York			
				Pennsylvania	North Carolina			
				Rhode Island	Ohio			
				South Carolina	Oregon			
				South Dakota	Pennsylvania			
				Tennessee ^a	Rhode Island			
				Texas	South Carolina			
				Vermont	Tennessee ^a			
				Virginia	Texas			
				Washington	Virginia			
				West Virginia	Washington			
				Wisconsin	West Virginia			
				Wyoming	Wisconsin			
					Wyoming			

Note: States could report more than one policy.

^aFollowing CDC guidelines, counseling, and inmate consent.

^bUpon inmate consent.

^cIncoming inmates upon consent.

Source: 1991 National Prisoner Statistics-1.

Of the inmates who tested HIV-positive, 73.0% of them were asymptomatic and 17.3% had symptoms but had not developed AIDS. The remaining 9.7% had AIDS. The West had the highest percentage of HIV-positive inmates with confirmed AIDS (21.1%), compared to the Northeast (8.8%), Midwest (11.3%), and South (6.7%).

Prison policies for testing for HIV

All the States, the District of Columbia, and the U.S. Bureau of Prisons tested inmates for HIV on some basis (table 2). Seventeen jurisdictions tested all prisoners, either at admission, release, or during custody. The remaining 35 jurisdictions tested at least some inmates.

Thirty-nine of the 52 jurisdictions tested if asked by an inmate and 40 if an inmate exhibited symptoms suggestive of HIV infection.

Testing policy	Number of jurisdictions
All incoming inmates	16
All inmates currently in custody	3
All inmates at time of release	5
High risk groups	15
Upon inmate request	39
Upon clinical indication of need	40
Upon involvement in incident	20
Random sample	7
Other	11

Note: Detail adds to more than 52 because a jurisdiction may have more than one policy.

Deaths in prison

During 1991, for every 1,000 inmates, 2.5 deaths occurred in State correctional facilities (table 3). Among the 10 States with the largest prison populations, New York had the highest rate of death, about 5.6 deaths per 1,000 inmates.

Table 3. Number of prison deaths per 1,000 inmates for all States and the 10 States with the largest prison populations, 1991

Jurisdiction	Total prison population 6/30/91	Total deaths, 1991	Rate of deaths per 1,000 inmates in 1991 midyear population*
All States	735,198	1,863	2.5
California	101,995	135	1.3
New York	56,530	318	5.6
Texas	50,611	111	2.2
Florida	46,233	133	2.9
Michigan	35,324	56	1.6
Ohio	33,715	41	1.2
Illinois	28,941	55	1.9
Georgia	23,300	62	2.7
Pennsylvania	22,710	83	3.7
New Jersey	22,346	96	4.3

*To calculate a rate of inmate deaths per 1,000 inmates, the midyear population is used as an approximation to the average population 'exposed to risk' of death during the year.

Source: National Prisoner Statistics-1.

AIDS-related deaths

Of the 1,863 deaths of prison inmates in 1991, 528 — or 28% — died of AIDS (table 4). In New York and New Jersey two-thirds of the reported deaths were caused by AIDS. These 2 States also had the largest number of AIDS-related deaths, 210 in New York and 66 in New Jersey. Twenty-one States had no AIDS-related deaths.

Of inmates who died of AIDS in prison, 3% were women. Eleven of the 15 women who died of AIDS were imprisoned in the Northeast.

Extent of HIV testing of State prison inmates

Based on interviews with State prison inmates for the 1991 Survey of Inmates in State Correctional Facilities, about half of State prison inmates knew they had been tested for the HIV and reported the result of the test.

HIV testing	Percent of State prison inmates
Reported HIV-test results	51.2%
Had never been tested	32.2
Did not know if they had been tested	9.0
Had been tested but did not know the results	7.5
Refused to report whether they had been tested or refused to report the test results	.1
Total number of inmates	711,643

Source: *Survey of Inmates in State Correctional Facilities, 1991*

Table 4. AIDS-related deaths reported for State prisons, 1991

Jurisdiction	Total deaths	AIDS-related deaths			AIDS-related deaths as a percent of all deaths
		Total	Male	Female	
U.S. total*	1,863	528	513	15	28.3 %
Northeast	612	315	304	11	51.5 %
Connecticut	75	11	11	0	14.7
Maine	4	0	0	0	0
Massachusetts	27	8	8	0	29.6
New Hampshire	6	0	0	0	0
New Jersey	96	66	66	0	68.8
New York	318	210	199	11	66.0
Pennsylvania	83	19	19	0	22.9
Rhode Island	3	1	1	0	**
Vermont	0	0	0	0	0
Midwest	236	20	20	0	8.5 %
Illinois	55	10	10	0	18.2
Indiana	27	5	5	0	18.5
Iowa	3	0	0	0	0
Kansas	10	2	2	0	20.0
Michigan*	56	—	—	—	0
Minnesota	10	0	0	0	0
Missouri	20	0	0	0	0
Nebraska	2	0	0	0	0
North Dakota	0	0	0	0	0
Ohio	41	2	2	0	4.9
South Dakota	7	0	0	0	0
Wisconsin	5	1	1	0	**
South	775	148	145	3	19.1 %
Alabama	52	0	0	0	0
Arkansas	22	1	1	0	4.5
Delaware	6	2	2	0	**
District of Columbia*	—	—	—	—	—
Florida	133	59	57	2	44.4
Georgia	62	13	13	0	21.0
Kentucky	22	2	2	0	9.1
Louisiana	35	0	0	0	0
Maryland	42	14	13	1	33.3
Mississippi	16	1	1	0	6.3
North Carolina	46	14	14	0	30.4
Oklahoma	32	3	3	0	9.4
South Carolina	49	12	12	0	24.5
Tennessee	37	1	1	0	2.7
Texas	111	18	18	0	16.2
Virginia	106	8	8	0	7.5
West Virginia	4	0	0	0	0
West	240	45	44	1	18.8 %
Alaska	1	0	0	0	0
Arizona	34	4	4	0	11.8
California	135	38	37	1	28.1
Colorado	10	1	1	0	10.0
Hawaii	2	1	1	0	**
Idaho	7	1	1	0	**
Montana	8	0	0	0	0
Nevada	9	0	0	0	0
New Mexico	5	0	0	0	0
Oregon	15	0	0	0	0
Utah	4	0	0	0	0
Washington	9	0	0	0	0
Wyoming	1	0	0	0	0

**Not calculated on fewer than 10 deaths.

—Not reported.

*The Federal Bureau of Prisons and the departments of corrections for the District of Columbia and Michigan did not report whether inmates died from AIDS-related causes.

Source: 1991 National Prisoner Statistics-1.

Table 5. State prison inmates ever tested for the human immunodeficiency virus and results, by selected characteristics, 1991

Characteristic	Percent of all inmates who were ever tested	Tested inmates who reported results	
		Number	Percent who were HIV positive
All inmates	51.2%	364,515	2.2%
Sex			
Male	50.3%	338,608	2.1%
Female	66.8	25,907	3.3
Race/Hispanic origin			
White non-Hispanic	52.6%	132,594	1.1%
Black non-Hispanic	52.1	168,873	2.6
Hispanic	46.0	54,563	3.7
Other	50.5	8,485	.9
Sex and race/Hispanic origin			
Male			
White non-Hispanic	51.7%	123,020	1.0%
Black non-Hispanic	51.2	156,866	2.5
Hispanic	45.2	51,103	3.5
Female			
White non-Hispanic	68.3%	9,574	1.9%
Black non-Hispanic	67.3	12,007	3.5
Hispanic	62.7	3,460	6.8
Age			
24 or younger	50.2%	78,242	.8%
25-34	53.1	172,772	2.1
35-44	51.1	82,614	3.7
45-54	47.0	21,832	1.9
55 or older	41.0	9,105	.7
Offense			
Violent	47.9%	157,224	1.4%
Property	56.8	99,103	2.7
Drug	52.4	78,729	3.2
Public-order	52.1	25,266	2.1
Criminal history			
No previous sentence	47.6%	63,879	1.3%
Violent recidivists	50.3	171,302	2.0
Nonviolent recidivists	55.6	124,044	2.8

Source: *Survey of Inmates in State Correctional Facilities, 1991*.

Women were more likely than men to know if they had been tested and whether the results were positive or negative — as were non-Hispanics compared to Hispanics, those under age 45 compared to older prisoners, offenders imprisoned for property, drug, or public-order offenses compared to those in prison for violent offenses, and recidivists compared to first timers (table 5).

HIV test results, by inmate characteristics

For inmates reporting test results, a higher percentage of women than men tested HIV positive (3.3% to 2.1%). Hispanics were more likely than blacks and blacks were more likely than whites to have antibodies to HIV (3.7%, 2.6%, and 1.1%).

An estimated 6.8% of Hispanic women were HIV positive, as were 3.5% of black women and 3.5% of Hispanic men. Among white inmates, 1.9% of the women and 1% of the men were positive.

Inmates 35 to 44 years of age were more likely than those in other age groups to be HIV positive; 3.7% were positive.

Inmates in prison for drug, property, and public-order offenses were more likely than violent offenders to be HIV positive.

Recidivists were more likely to be HIV positive than inmates who had not previously served a sentence to either probation or a term in a correctional facility.

Table 6. State prison inmates testing positive for the human immunodeficiency virus, by drug and needle use, sex, race/Hispanic origin, age, and offense

Characteristic	Percent of State prison inmates who tested positive for HIV and who				
	Never used drugs	Ever used drugs	Used drugs in the month before offense	Used a needle to inject drugs	Shared a needle to inject drugs
All inmates	.8%	2.5%	2.8%	4.9%	7.1%
Sex					
Male	.7%	2.4%	2.7%	4.7%	6.7%
Female	.9	3.8	4.6	6.7	10.0
Race/Hispanic origin					
White non-Hispanic	.3%	1.2%	1.5%	2.4%	3.7%
Black non-Hispanic	1.1	2.9	3.2	7.2	11.1
Hispanic	.6	4.3	5.2	8.2	11.3
Age					
24 or younger	0	1.0%	.8%	.8%	2.0%
25-34	1.3	2.3	2.7	4.6	5.8
35-44	.9	4.3	5.2	7.0	10.3
45-54	.8	2.5	2.7	4.4	5.4
55 or older	.2	2.1	0	0	0
Offense					
Violent	.9%	1.5%	1.4%	2.7%	3.8%
Property	.9	3.0	3.4	5.2	5.7
Drug	.2	3.6	4.5	8.5	15.4
Public-order	1.0	2.3	2.9	4.5	9.0

Note: See appendix table 1, page 8, for sample sizes upon which percentages are based.
Source: *Survey of Inmates in State Correctional Facilities, 1991*.

HIV results, by drug and needle use

About a fourth of all State prison inmates had used a needle to inject illegal drugs.* About 4 in 10 inmates who had used drugs in the month before the offense for which they were sentenced had injected drugs at some time; about 2 in 10 had ever shared a needle.

For inmates reporting test results, drug users had higher positive HIV rates than inmates who never used drugs (2.5% versus 0.8%) (table 6). Needle use further increased the likelihood of being HIV positive; 4.9% of inmates who had used needles to inject drugs and 7.1% who had shared needles were HIV positive.

*See *Survey of State Prison Inmates, 1991*, BJS report, NCJ-136949, March 1993, p. 25.

Although women and men who never used drugs had the same HIV rates (less than 1%), those women who used drugs and who used needles had higher infection rates than men with the same drug practices. Ten percent of women and

6.7% of men who had ever shared needles when using drugs were HIV positive.

Of those who reported sharing needles to inject illegal drugs, 1 in 10 black inmates, Hispanic inmates, and inmates between ages 35 and 44 were HIV positive. Over 15% of those sentenced for drug offenses and who had shared needles were HIV positive.

HIV test results, by type of prison

Maximum, medium, and minimum security level prisons had essentially the same rates of HIV infection (table 7). Inmates held in prisons with unclassified security levels, such as facilities for classification or reception, reported a positive rate of 11.6%.

Percentages of HIV-positive prisoners increased with the size of the prison. The HIV-positive rate in facilities holding fewer than 500 was 1.1%, compared to 2.8% in prisons with 2,500 or more.

HIV testing policies in the largest jail jurisdictions

The jail jurisdictions that were among the 25 largest in 1991 were asked what testing policies they were following. Sixteen jurisdictions tested when ordered by a court, and 12 checked high risk groups. Two jurisdictions tested all inmates at admission in at least one facility: Philadelphia, Pennsylvania, and Fulton County (Atlanta), Georgia.

Deaths in 503 large jail jurisdictions

AIDS-related deaths
in local jails, 1991-92

Cause of death	Number
Total	445
AIDS	107
Other	338

Of the 445 deaths during the year ending June 30, 1992, in jail jurisdictions with average daily inmate populations of 100 or more, 24% were reported to be AIDS related.

Table 7. State prison inmates testing positive for human immunodeficiency virus, by security level and size of facility, 1991

State prison characteristic	Number of inmates reporting test results positive	Percent positive
Security level		
Maximum	89,440	2.0%
Medium	183,172	2.0%
Minimum	85,804	2.1%
Unclassified*	6,099	11.6%
Prison size		
Fewer than 500	72,097	1.1%
500-999	121,166	2.2%
1,000-2,499	117,094	2.5%
2,500 or more	54,159	2.8%

*Pre-release, work release, or medical facilities.
Source: *Survey of Inmates in State Correctional Facilities, 1991*.

Table 8. Policies determining testing for the antibody to the human immunodeficiency virus in the 25 largest jail jurisdictions, 1992

One or more facilities in the 25 largest jail jurisdictions testing					
All inmates at admission	Random samples of inmates while in custody	High risk groups	Upon inmate request	Upon court order	Upon involve- ment in incident
Fulton Co., GA Philadelphia, PA	Riverside Co., CA Sacramento Co., CA San Diego Co., CA Broward Co., FL Fulton Co., GA New York City, NY	Alameda Co., CA Riverside Co., CA Sacramento Co., CA San Bernardino Co., CA Santa Clara Co., CA Dade Co., FL Fulton Co., GA Orleans Parish, LA* New York, NY Shelby Co., TN Bexar Co., TX* Dallas Co., TX*	Maricopa Co., AZ Alameda Co., CA Kern Co., CA Los Angeles Co., CA* Orange Co., CA Riverside Co., CA Sacramento Co., CA San Bernardino Co., CA San Diego Co., CA Santa Clara Co., CA Washington, DC* Broward Co., FL* Dade Co., FL Orange Co., FL* Fulton Co., GA Orleans Parish, LA* Baltimore City, MD New York City, NY Philadelphia, PA Shelby Co., TN Bexar Co., TX* Dallas Co., TX* Harris Co., TX* Tarrant Co., TX	Alameda Co., CA Kern Co., CA Los Angeles Co., CA* Orange Co., CA Riverside Co., CA Sacramento Co., CA San Bernardino Co., CA San Diego Co., CA Santa Clara Co., CA Washington, DC* Broward Co., FL* Dade Co., FL Orange Co., FL* New York, NY Bexar Co., TX* Harris Co., TX*	Alameda Co., CA Los Angeles Co., CA* Orange Co., CA Riverside Co., CA Sacramento Co., CA San Bernardino Co., CA San Diego Co., CA Broward Co., FL* Dade Co., FL Orleans Parish, LA*

*Jurisdictions in which all facilities reported following the same policy to test for the HIV or in which authorities reported jurisdiction-wide policies. All other jurisdictions had one or more facilities with different testing policies. In some jurisdictions, facilities that differed were following "other" policies not presented in the table. Cook County, Illinois, provided no information.
Source: 1992 Annual Survey of Jails.

Methodology

Data sources

The data collection series National Prisoner Statistics has counted prisoners since 1926. The series provides annual summary measures of the movement of persons into and out of prison systems. At midyear and yearend, departments of corrections in the 50 States, the District of Columbia, and the Federal prison system are asked to provide basic numbers describing their prison population.

The Annual Survey of Jails was begun in 1982. For this survey complete enumerations of the Nation's jails are conducted every 5 years. The most recent census was in 1988. The sample for the 1992 survey was based on that census.

A local jail is a facility that holds inmates beyond arraignment, usually for more than 48 hours, and is administered by local officials. Specifically excluded from the counts of the Annual Survey of Jails are temporary lockups that house persons for less than 48 hours, physically separate drunk tanks, and other holding facilities that did not hold persons after they had been formally charged. Excluded from the Annual Survey of Jails and instead included in the National Prisoner Statistics series are Federal- or State-administered facilities, and the combined jail-prison systems of Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Included in the Annual Survey of Jails are five locally operated jails in Alaska and eight jails that were privately operated under contract for local governments.

The 1992 Annual Survey of Jails included 1,113 jails in 795 jurisdictions. A jurisdiction is a county, municipality, township, or regional authority that administers one or more local jails. The jails in 503 large jurisdictions were automatically included in the survey because the average daily inmate population in these jurisdictions was 100 or more in the 1988 census. The jurisdictions with large jail populations accounted for 814 jails and 362,217 inmates, or 81% of the estimated inmate population on June 30, 1992.

In 1992, the 25 jail jurisdictions that were the largest in 1991 were asked if any inmates were tested for HIV, and, if so, on what basis were inmates tested. They

Appendix table 1. Denominators for percents presented in table 6

	State prison inmates		Used drugs in the month before offense	Used a needle to inject drugs	Shared a needle to inject drugs
	Never used drugs	Ever used drugs			
All inmates	66,048	298,373	191,422	105,082	50,509
Sex					
Male	61,668	276,884	176,639	95,219	45,254
Female	4,380	21,489	14,784	9,863	5,255
Race/Hispanic origin					
White non-Hispanic	22,492	110,102	70,639	50,737	24,996
Black non-Hispanic	33,244	135,535	84,228	31,400	13,374
Hispanic	8,849	45,714	32,026	19,928	10,331
Age					
24 or younger	13,651	64,592	42,818	12,729	4,499
25-34	23,494	149,190	96,677	49,532	23,143
35-44	14,027	68,531	43,409	36,255	18,807
45-54	8,323	13,509	7,671	5,941	3,583
55 or older	6,554	2,551	847	625	476
Offense					
Violent	35,846	121,379	76,276	38,498	19,293
Property	13,762	85,261	55,908	37,120	17,912
Drug	9,723	69,006	47,846	21,841	10,136
Public-order	5,095	20,157	9,811	6,874	2,854

were also asked the number of males and females who were asymptomatic, symptomatic, and full-blown AIDS victims.

The 1991 Survey of Inmates in State Correctional Facilities uses personal interviews of a representative sample of prison inmates to gather detailed information on prison inmates. Data are collected on personal and criminal justice characteristics of prison inmates.

The sample for the Survey of Inmates in State Correctional Facilities was a two-stage selection. In the first stage 277 prisons were selected from a universe of 1,239 State prisons. In the second stage interviewers visited each selected facility and systematically selected a sample of male and female inmates using predetermined procedures. As a result, approximately 1 in every 52 male inmates and 1 in every 11 female inmates were selected. A total of 13,986 interviews were completed, yielding an overall response rate of 93.7%.

The data reported from the BJS surveys supplement those collected in a survey series sponsored by the National Institute of Justice and the Centers for Disease Control and Prevention. A forthcoming report, *1992 Update: HIV/AIDS in Correctional Facilities*, will present findings from the seventh in the series, which did not cover 1991. The 1992 update contains reporting about prevalence, testing, treatment, and education for HIV and AIDS in Federal, State, and 31 large city/county

correctional systems. A subsequent report will summarize collected information on testing, treatment, and education for tuberculosis in correctional settings.

Accuracy of the estimates

All data collection series are subject to nonsampling error. Nonsampling error can be attributed to many sources, such as nonresponse, differences in the interpretation of questions, recall difficulties, and processing errors. The full extent of nonsampling error is never known. Surveys, such as the Survey of Inmates in State Correctional Facilities, are also subject to sampling error. Sampling error is the variation that may occur by chance because a sample rather than a complete enumeration of the population was conducted.

The sampling error, as measured by an estimated standard error, varies by the size of the estimate and the size of the base population. Estimates of the standard errors have been calculated for the 1991 survey of inmates (see appendix table and *Survey of State Prison Inmates, 1991*). These estimates may be used to construct confidence intervals around percentages in this report. For example, the 95-percent confidence interval around the percentage of inmates who tested positive for HIV is approximately 2.2% plus or minus 1.96 times 0.05% (or 1.7% to 2.7%).

These standard errors may also be used to test the significance of the difference between two sample statistics by pooling the standard errors of the two sample estimates. For example, the standard error of the difference between black and white inmates in the percent testing positive for HIV would be .547% (or the square root of the sum of the squared standard errors for each group). The 95-percent confidence interval around the difference would be 1.96 times .547% (or 1.1%). Since the difference of 1.5% (2.6% minus 1.1%) is greater than 1.1%, the difference would be considered statistically significant.

All comparisons using data from the Survey of Inmates in State Correctional Facilities were statistically significant at the 95-percent confidence level. To test the significance of comparisons not mentioned in the report, use percentages in text or tables. The standard errors reported below should be used only for tests on all inmates. Comparisons of male and female inmates require different standard errors.

Appendix table 2. Standard errors of the estimated percentages, State prison inmates, 1991

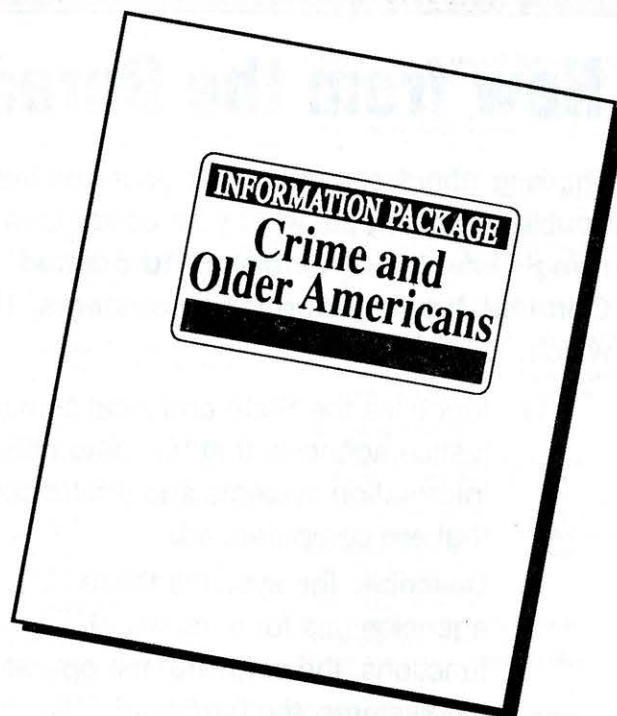
Base of the estimate	Estimated percentages					
	98 or 2	95 or 5	90 or 10	80 or 20	70 or 30	50
1,000	4.9	7.7	10.6	14.1	16.2	17.7
5,000	2.2	3.4	4.7	6.3	7.2	7.9
10,000	1.6	2.4	3.4	4.5	5.1	5.6
25,000	1.0	1.5	2.1	2.8	3.2	3.5
50,000	0.7	1.1	1.5	2.0	2.3	2.5
100,000	0.5	0.8	1.1	1.4	1.6	1.8
200,000	0.4	0.5	0.8	1.0	1.1	1.2
400,000	0.2	0.4	0.5	0.7	0.8	0.9
600,000	0.2	0.3	0.4	0.6	0.7	0.7
711,643	0.2	0.3	0.4	0.5	0.6	0.7

Bureau of Justice Statistics Special Reports are written principally by BJS staff. Caroline Wolf Harlow wrote this report, under the supervision of Allen Beck. Virginia Baldau and Cheryl Crawford of the National Institute of Justice, Theodore Hammett of Abt Associates Inc. and William Darrow, Steven Jones, and Sandra Kerr of the Centers for Disease Control and Prevention gave expert advice on measurement and presentation of the HIV-related data collected. Louis Jankowski provided statistical assistance. Corrections reports are produced under the general guidance of Lawrence A. Greenfeld. Tom Hester edited the report. Marilyn Marbrook, assisted by Betty Sherman and Jayne Pugh, produced the report.

September 1993, NCJ-143292

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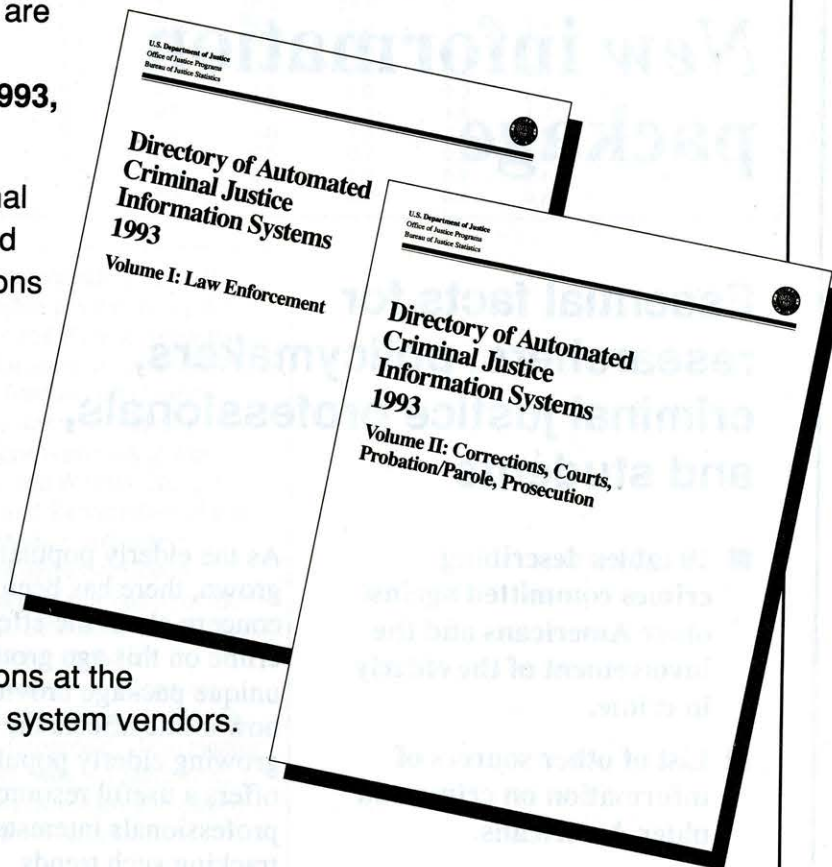
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In 1988 New York State drafted a "Five Year Interagency Plan" that outlined a comprehensive response to HIV and AIDS in New York State. The Plan defined the state's priorities as effective case management; the integration of services; regional coordination; and community involvement in the development and administration of HIV- and AIDS-related policies and programs.

Nearly five years and thousands of AIDS deaths later, many of the Plan's key goals have not been met.

ACTUPWestern New York, ACTUPIthaca, ACTUPAlbany and ACTUPNew York are at the New York State AIDS Institute's Fourth Annual Statewide HIV/AIDS Conference to expose the State's poor record of implementing its own policy objectives. In several crucial areas, that record has been one of broken promises, bureaucratic inefficiencies and alarming shifts in priorities:

Prisons

The Five Year Plan states that New York State Department of Correctional Services will "implement a comprehensive system of medical care for inmates, including case management." But serious access problems exist. Prisoners incarcerated in remote areas travel up to 5 hours each way to get care. There are no enforced standards governing the provision of primary or specialty care. Some prisoners with virtually no T-cells and with histories of opportunistic infections have never had access to infectious disease clinics. The Plan also states that "by 1990 DOH in partnership with DOCS will make anonymous HIV testing and counselling available" to all inmates. Yet anonymous testing is only provided by four travelling teams, which cannot meet inmate demand.

Case Management and Human Services

The Plan states that New York State will by 1990 "establish Memoranda of Understanding defining referral patterns and the care and case management roles of regional hospitals, ... community service programs, primary ambulatory and residential care providers ... and local health and social service units." However, too many PWAs, including those who are clients of state-funded corporations, receive inadequate and incorrect coordination of care and entitlements. Such problems impact most strongly people with AIDS and HIV in rural areas, where options for treatment and human services are limited. At present, there are no uniform standards for insuring the quality of care and services. As a result, people with AIDS or HIV who are dissatisfied with their care and case management often have no accessible mechanism for holding those who serve them accountable.

Testing and Confidentiality Protection

The Plan states that "by 1991 the Department of Health will ensure that anonymous testing is available in every county." However, the State provides anonymous testing in only roughly half its counties. Recently, the AIDS Institute declared that anonymous testing—repeatedly shown to be the preferred option for individuals who fear disclosure of HIV information—is now a "supplement" to the State's "central thrust" of confidential testing. The Plan also states that "Confidentiality is central to the physician-patient relationship." Yet the State is now considering mandatory lab-based name reporting of individuals with CD4 counts below 200.

ACT UP at the AIDS Institute Conference (continued)

Primary Health Care

The Department of Social Services (DSS) pays health insurance premiums when PWAs are nearly eligible for Medicaid. However, information about the AIDS Health Insurance Program (AHIP) is not adequately distributed to case managers, who frequently urge PWAs to drop coverage and "spend down" to Medicaid. The State also provides an AIDS Drug Assistance Program (ADAP) that covers drugs and some services. However, this program does not cover in-patient expenses and remains underutilized because the State has failed to recruit enough upstate providers.

New Yorkers need more than empty promises and an annual conference. We need effective State action.

The AIDS Institute conference will gather over one thousand service and health care providers to discuss "Issues on HIV/AIDS Policy and Programs." Members of ACT UP will participate in the conference and network with service providers, who frequently confront the inadequacies of the State's policies and programs. Our presence at the AIDS Institute Conference strongly reflects the needs and interests of residents of upstate New York. Services and coordination are consistently poorer in New York's smaller cities and rural areas. People with HIV and AIDS must contend with special problems. Few doctors will take AIDS patients or accept Medicaid; service organizations often have functional monopolies in their communities, restricting options for those who need services; state data consistently under-reports the number of HIV infections and AIDS cases, depriving some areas of desperately needed funds; geographical distance makes communication among health care and service providers more difficult; and "controversial" prevention efforts such as needle exchange take longer in small cities to receive state approval. **New York State must recognize the scope of the AIDS crisis and develop a *truly* statewide response to it.**

ACT UP demands:

- Coordination of care and services across agencies; development of standards for treatment; accountability of service providers to those they serve.
- Decriminalization of needle possession and support of community-based needle-exchange; integration of HIV services into drug treatment programs; aggressive pursuit of alternatives to methadone treatment.
- Comprehensive HIV/AIDS education for inmates and staff in prisons statewide; quality care and case management for inmates with HIV and AIDS; alternatives to incarceration for substance abusers; a *real* compassionate release program for dying inmates.
- An enduring commitment to the availability and accessibility of free and anonymous HIV testing; an anonymous coding system for reporting CD4 cell counts under 200.
- Comprehensive HIV and AIDS education of health care providers on a statewide basis; integration of HIV treatment into existing health care settings.

New York State Must Assure the Quality of Services Provided to PWAs

Community Service Providers (CSPs) are often the first and only place PWAs will turn for help with AIDS-related concerns. PWAs need greater assistance in understanding and navigating the complex system of entitlements, benefits and healthcare programs offered by federal, state, and county agencies and the private sector.

- The Five Year Plan states that by 1990 CSPs will "enter into 'Memoranda of Understanding' addressing working relationships, referral patterns and coordination of services for HIV infected persons [and that DOH] consultants will assist in defining service components and standardizing program guidelines." However, too many PWAs, including those who are clients of state-funded not-for-profit corporations, receive inadequate and incorrect coordination of care and entitlements. The quality of services can vary greatly from CSP to CSP and from case manager to case manager. Outside greater New York City, if PWAs do not get information and services from their local CSPs they will probably not get them at all. The victories of advocates working in the legislature, the medical community, and the social service system are compromised if PWAs have restricted access to information and services.

- CSPs are usually not-for-profit corporations and essentially govern themselves. This has often led to misdirected priorities, poor services for PWAs and the waste of taxpayer money. Grassroots volunteer organizations have appeared in many upstate cities because of the failure of CSPs to respond to PWA needs. Yet these organizations cannot be expected to do the jobs that CSPs are funded to do.

- There is no systematic, effective mechanism for processing client complaints about CSPs. The AIDS Institute's existing evaluation procedures are inadequate and have not assured quality care and services for PWAs.

ACT UP demands that New York State:

- Set concrete standards for client services and case management; improve the evaluation process of CSPs; make evaluation reports available to clients.
- Establish systems for direct communication between funding sources and PWAs and mechanisms for processing client complaints.
- Insist that CSPs have more PWAs on their boards of directors and involve more clients in policy decisions.
- Fund grassroots organizations to supply PWAs with services when existing CSPs fail to do so.

New York State Must Improve Access to Primary Health Care

The AIDS Institute has created landmark programs to provide care to HIV-positive New Yorkers. But such programs are not useful if people do not know about them or are not within driving distance of providers.

AIDS Health Insurance Program (AHIP)

For years the Department of Social Services (DSS) has paid health insurance premiums when a PWA nearly qualifies for Medicaid. But many people do not know about AHIP. Case managers frequently urge people with AIDS and HIV to drop coverage and "spend down to Medicaid." Ignorance about the program and lack of coordination robs PWAs of coverage.

AIDS Drug Assistance Program (ADAP)

ADAP provides coverage for drugs, doctor visits, home health care, and nutritional supplements. However, the program is underutilized due to a lack of upstate providers. In addition, there is no in-patient coverage, as ADAP does not pay hospital bills.

Medicaid Enhanced Fees Program

The AIDS Institute initiated the Enhanced Medicaid Fees Program, raising reimbursements for providers serving HIV-positive people. But not enough doctors are signed up, especially upstate.

Medicaid Managed Care

Managed care through a capitated HMO is inappropriate care for people with HIV. Under Medicaid Managed Care (MMC) people with HIV are restricted to seeing first a "gatekeeper" doctor (who may know nothing about HIV) who is supposed to keep the client from visiting expensive specialists or getting expensive lab tests. In addition, under MMC the doctor gets the same amount of money whether he or she sees the client or not. Forcing people with HIV into capitated MMC robs people with HIV of asymptomatic years and sets them up for repeated opportunistic infections.

ACT UP demands that New York State:

- Train CBOs and CSPs *throughout* the state about AHIP and give yearly reminders to DSS staff and AIDS Institute contracting agencies about AHIP.
- Make AHIP brochures available through the AIDS Institute literature ordering system; send them to all CBOs, CSPs, hospital social work departments, primary care clinics and testing sites.
- Send information about AHIP to ADAP applicants and recipients.
- Insist that all house staff of Designated AIDS Centers accept ADAP clients.
- Provide ADAP coverage when someone goes to the hospital.
- Recruit more upstate providers for both ADAP and the Medicaid Enhanced Fees Program.
- Change licensure laws to require all doctors to maintain at least a small percentage of Medicaid recipients on their case load, or risk non-renewal of licenses.
- Allow people with AIDS and HIV to "opt out" of Medicaid Managed Care.

New York State Must Respond to the Upstate AIDS Crisis

People in upstate New York face several obstacles and deficiencies in health care, social service delivery and education and prevention programs. Particularly in rural areas, problems with access and the dissemination of information can undermine the efforts of even the most ambitious State initiatives.

Health Care Access

In many areas of upstate New York there are few or no local primary care physicians who accept PWAs on Medicaid, doctors with sufficient knowledge about AIDS/HIV-related care or dentists who accept PWAs on Medicaid. The DOH has not recruited enough upstate physicians for the state's Medicaid Enhanced Fees Program. At the same time, many upstate PWAs cannot find local primary care physicians because DOH does not make publicly available the names of physicians who have signed up to receive increased Medicaid reimbursements.

ACTUP demands that the DOH finally make AIDS education of health care and social service providers a top priority. The AIDS Institute must also develop a more efficient way of disseminating updated treatment information *throughout* New York State.

Education and Prevention

While the AIDS Institute has established needle exchange programs in New York City, only one program has been approved upstate. The State took three times longer to approve this program than the ones in New York City. And while the State Department of Education (DOE) spent more than \$100,000 on an update to the state AIDS Curriculum, it succumbed to political pressure and recalled the update weeks later. Without more advocacy work in upstate New York by the DOH, DOE, and AIDS service providers, local school districts will not exert the leadership needed to implement comprehensive AIDS education programs.

Regional Coordination and Community Input

The Five Year Plan states that, "Regional HIV Planning Coordinators employed by the AIDS Institute will be responsible for convening regional . . . HIV planning bodies to elicit local input into eight annual regional AIDS plans." However, the AIDS Institute has never had a Regional HIV Planning Coordinator staff. In addition, the Institute still has not developed regional advisory networks with sufficient power to influence state policy and evaluate case management, advocacy and prevention programs at state-funded AIDS service organizations. Moreover, the AIDS Institute has not established planning bodies which incorporate input from upstate PWAs and AIDS advocates when forming state policies. The current Ryan White Regional HIV Care Networks do not have the authority to perform the functions outlined above.

New York State Must Respond to the Upstate AIDS Crisis (continued)

Anonymous Testing and Counselling

The Plan states that by 1991 the DOH will ensure that anonymous HIV testing is available in every county in the state. However, the DOH has only provided anonymous testing services in roughly half of the state's counties over the last three years. The DOH has not expanded its staffing levels at anonymous test sites to meet the increased demand for the services. People living in rural areas frequently must wait weeks to get an appointment and/or travel long distances in order to use anonymous testing services. The AIDS Institute claims that it cannot afford to provide anonymous testing throughout the year in every county of the state. This indicates that New York State has largely abandoned its goal of providing accessible outreach and education to individuals at risk for HIV who live in rural and isolated areas of the state.

Access to Clinical Trials

New York State does not adequately distribute information about clinical trials to people living in rural areas of the state. The AIDS Institute must bring clinical trials into rural areas or develop mechanisms—such as providing for people's transportation or sending people's blood to the clinical trial site—so that PWAs in rural areas have the same opportunities to participate in clinical trials as people living in more urban areas of the state.

Data Dissemination and Funding of Upstate Services

The DOH has been suppressing certain epidemiological information on the scope of the epidemic in upstate New York. The Five Year Plan states that, "By 1989 and every year thereafter, the DOH will make information on seropositivity . . . from all HIV testing and counseling sites available quarterly to all DOH regional offices, county health departments, community service organizations and health and social service providers." Yet the AIDS Institute began to reevaluate the suppression of this data only after activists pointed out that its timely release is crucial for upstate county health departments and service organizations, which must plan education efforts and appeal for funds for AIDS/HIV-related services. The AIDS Institute must distribute seropositivity information in a more timely fashion and help counties secure more funding for AIDS-related services.

New York State currently distributes funding for AIDS/HIV care based on each region's number of documented AIDS cases, systematically underfunding rural communities where the number of official AIDS cases frequently undercounts the actual number of people living with AIDS in the region. New York State must develop another mechanism for funding of community services, because a significant number of PWAs living in rural areas have moved from larger cities or prisons where they received their diagnosis and currently do not get counted in the statistics of the upstate regions in which they receive care.

New York State Must Institute Comprehensive AIDS and HIV-Related Services in the State Prison System

New York State Department of Correctional Services (DOCS) now has a significantly higher incidence of HIV than any other institution in the country. As much as 30% of the inmate population is HIV-positive and 1600 people have been diagnosed with AIDS. Largely due to overcrowding and unsanitary conditions, 23% of the entire State's inmate population has tested positive for tuberculosis. Prisoners with AIDS in New York State still die in half the time and under more miserable conditions than people on the outside. The Five Year Plan states that New York State must respond to this crisis by providing and coordinating extensive AIDS and HIV-related services for prisoners.

Yet the Department of Health has not even included a panel on prisons in its conference "Issues on HIV/AIDS Policy and Programs."

- The Plan states that DOCS will "implement a comprehensive system of medical care for inmates, including case management." However, when the TB outbreak put the system to the test, serious access problems became apparent. Many prisons are located in remote areas where a sick prisoner may have to travel 4 to 5 hours each way to get care. Because of coordination problems there are no enforced standards governing the provision of primary or speciality care. The Legal Aid Society's Prisoner's Rights Project has seen people with virtually no T-cells and histories of opportunistic infections who have never had access to an infectious disease clinic.
- It is widely acknowledged that there is sexual activity and injection drug use in the New York State prison system and that condoms, bleach and education programs are effective means of reducing the risks of HIV transmission. However, condoms and bleach are forbidden in the prison system and peer education programs have not been extended throughout the State.
- The Plan states that "by 1990 DOH in partnership with DOCS will make anonymous HIV testing and counselling available" to all inmates. However, anonymous testing—not strongly encouraged by the State—is only provided by four travelling teams and needs to be greatly expanded.

New York State Must Institute Comprehensive AIDS and HIV-Related Services its Prison System (continued)

- The Plan states that DOH "will assist DOCS and the Department of Parole (DOP) in developing standards for medical discharge of dying patients, including medical leave of absence for temporary release of dying patients." However, in 1992 two hundred and thirty people with AIDS died in prisons in New York State, while only fourteen prisoners were granted "compassionate release."
- The Plan states that DOCS will "review the pre-sentencing process, and design pilot drug treatment alternatives to incarceration for substance abusers." However, drug treatment slots in New York went from 40,040 in 1983 to 54,400 in 1992, increasing nearly 300% more slowly than the State's prison beds.
- The Plan states that "by 1990, the DOP will work with the Department of Social Services to ensure that comprehensive assistance packages will be in place prior to release for inmates eligible for and in need of SSI, Medicaid, Home Relief and other entitlement or benefit programs." However, these programs frequently are not made available to exiting inmates.

ACT UP demands that New York State:

- Establish coordinated medical care and human service programs.
- Make a variety of treatment options available, including alternative therapies.
- Hire more staff to educate the estimated 79,000 staff and inmates in the State's correctional system on HIV and AIDS issues.
- Expand peer education programs and make safer sex materials and bleach kits available in prisons throughout the state.
- Increase the number of travelling teams to make anonymous testing more accessible to prisoners throughout the state.
- Create a real compassionate release program.

New York State Must Improve and Expand Drug Treatment Programs

Between fiscal years 1992-4 a total of \$30 million was cut from the Organization of Adult Substance Abuse Services (OASAS) budget. In 1993-4 alone, one billion dollars was allocated for building and maintaining prisons, while \$18 million was cut from OASAS for drug treatment services. This represents a dangerously skewed approach to coping with the double HIV/IV epidemic. Due to the cuts, the state's promise of HIV coordinators in alcohol and drug treatment settings has remained unfulfilled. Without such coordination, frontline workers at drug treatment sites often remain unaware of HIV symptomology and unable to adapt substance abuse treatment to the special needs of HIV+ clients. The majority of upstate programs, particularly in Buffalo and Rochester which have the second and third highest rates of drug use in the state, cannot afford a specialized staff person on AIDS without state support.

- **In the Five Year Plan, New York state promised that the Department of Health (DOH) and OASAS would fund street outreach programs statewide.** However, OASAS has targeted no money for street outreach programs upstate. Street outreach programs upstate are funded through the CDC and this money must be linked to partner notification, counselling and testing programs. OASAS has targeted only \$1.5 million for street outreach programs within New York City.
- **The state promised DOH/OASAS funded services for the homeless and drug-using populations.** However no such services funded by these agencies exist upstate.
- **The state promised a survey of current state- and city-owned sites for use as drug treatment or AIDS facilities.** This survey has either never been conducted or is unavailable to proponents of new treatment programs. The state has been unwilling to be proactive in the face of community ("not in my backyard!") opposition to drug treatment siting - particularly upstate. Siting problems are perhaps the greatest obstacle to the creation of desperately needed drug treatment programs.
- **The state promised expansion of drug treatment slots by 7,000 - approximately half methadone, half drug-free.** As of July 1993, the only step toward fulfilling this promise has been the creation of one new methadone program in New York City. In 1989-90, the then Department of Substance Abuse Services (DSAS) was taking steps toward creating drug-free programs upstate, but this effort was halted by massive budget cuts.

New York State Must Expand Drug Treatment and Create Needle Exchange Programs

Only after tens of thousands of New Yorkers statewide had become infected through dirty syringes and infection rates amongst IV drug users in New York City had reached 60% did the Department of Health approve needle exchange programs. But the regulations for approval of these programs are so cumbersome that most agencies - particularly upstate - do not have the resources to comply. Buffalo's Columbus Hospital program is the first upstate needle exchange program to be approved by the state. From the time of the first application for a needle exchange program in Buffalo, to the time that one was finally approved a year later, Columbus Hospital reported a 100% increase in drug use-related HIV infection in Buffalo.

ACT UP demands that New York State:

- Provide substance abuse treatment on demand. New York State's allocations for treatment and prevention do not reflect the immensity of its substance use problems.
- Emphasize alternative models for treatment and fully fund such programs.
- Educate substance abuse treatment workers in HIV/AIDS related concerns.
- Take seriously the drug treatment program siting problems and work proactively to overcome community resistance.
- Simplify the approval process for needle exchange, allowing more organizations to apply.
- Allow for flexibility in needle exchange programs so that programs can adapt to specific needs without state approval.
- Take needle exchange out of the realm of research and into the realm of practice. It is widely acknowledged that these programs work. The state is wasting valuable time and money forcing each proposed program to prove itself.

New York State Must Make Anonymous HIV Testing More Accessible

New York State acknowledges the importance of accessible HIV testing services as part of its education, prevention and treatment efforts. The state expressed its commitment to testing in its 1989 Five Year Interagency Plan, recognizing: that anonymity within the testing process is crucial, particularly for those who perceive themselves at greatest risk; that there is a need to distribute information about testing services; and that fears of disclosure and discrimination are real.

Yet New York State has failed to make good on a number of its promises.

- The Plan states: "By 1991 DOH will ensure that anonymous testing is available in every county in New York State." However, over the last three years the State has only provided anonymous testing in approximately half of its counties.
- New York State boasts of its "strong public health commitment to anonymous testing." However, the AIDS Institute now views anonymous testing as a "supplement" to the "central thrust" of "mainstreaming" confidential testing. By encouraging confidential testing—through private laboratories—the DOH is abandoning its commitment to anonymous testing.
- The Plan claims that the DOH will provide "free laboratory analyses of all blood specimens." However, New York State's Wadsworth Laboratory announced in December 1992 that aside from State test sites, it would "only accept specimens for HIV antibody testing for patients who lack insurance or are not covered by Medicaid."

ACT UP demands that New York State:

- Make anonymous HIV testing and counseling services available in every county.
- Publicize the availability of HIV testing services, particularly in those communities with the highest rates of HIV seropositivity.
- Increase staffing levels at HIV testing centers to meet the increased demand for testing services.
- Coordinate services across agencies for individuals who test positive.

New York State Must Take a Stand Against Name Reporting

With the CDC's new definition of AIDS, implemented in January 1993, New York State had to adopt a system for reporting CD4 counts under 200. The State proved ready to sacrifice confidentiality protections by proposing lab-based name reporting of people with low CD4 counts. The State wanted the names so that it could compete for Federal funding based on the number of documented AIDS cases. Due to activist pressure, the State is now studying alternatives to name reporting.

New York State has not ensured confidentiality protection of CD4 information.

- The Plan states that "Confidentiality is central to the physician-patient relationship." However, lab-based name reporting would override the doctor's sole discretion to report the names of people with AIDS and would thereby undermine patient trust. Knowing that labs can report their names without their consent, HIV-positive people might be less likely to get T-cell counts in New York State.
- The DOH has been "studying" ways of protecting the confidentiality of CD4 information for the past eleven months. However, they still haven't developed an informed consent policy and only now, after continuous pressure from activists, are they convening a working group to seriously investigate implementation of a "unique identifier" system of reporting.
- The DOH claims that there are "many obstacles" to implementing unique identifier reporting of CD4 counts. However, the State already uses a unique identifier system to report fetal deaths, which greatly exceed the number of low CD4 counts.

ACT UP demands that New York State:

- Adopt a unique identifier system for lab-based reporting of low CD4 counts.
- Pressure the Federal Government to change its criteria for the distribution of federal funds, so as not to punish states that protect confidentiality.
- Thoroughly train lab workers in confidentiality protocols relating to CD4 information.

State releases a tiny fraction of dying prisoners

► The idea was to show mercy. Inmate advocates say it's working too slowly.

The Associated Press

ALBANY — Family members and advocates for prison inmates are upset with the state's handling of a medical parole program meant to allow terminally ill prisoners to die at home.

State officials said Thursday that in the first year of the program, only nine of 237 New York state prison inmates who applied for medical parole have been freed.

The medical parole measure, agreed to last year after two years of negotiations between Gov. Mario Cuomo and legislative leaders, is aimed at inmates suffering through the final stages of AIDS, cancer or other fatal diseases.

Prison officials said 52 inmates have died either while waiting for rulings on their requests or after their requests were rejected.

While state officials said they are working with a strict law designed to protect society, others said the bureaucrats aren't showing enough compassion.

"Politicians and bureaucrats are afraid of releasing people early because of the political fallout if something goes wrong," said Robert Gangi, executive director of the Correctional Association of New York.

One of those who died while awaiting a ruling was Bernard Ocasio. He had told his family in New York City that he was suffering from AIDS.

Nearing the end of a 4½-to-9 year sentence for robbery and drug dealing, Ocasio applied for medical parole in July 1992. He died in September.

The medical parole legislation requires an eligible inmate to be terminally ill and "so debilitated or incapacitated as to create a reasonable probability that he or she is physically incapable of presenting any danger to society." Murderers and sex offenders are not eligible.

Most inmate deaths in state from AIDS

More than half of the prison inmates nationwide who died from AIDS in 1991 were in New York and New Jersey, where widespread drug abuse has caused much of the spread of the disease, a government study said.

Two-thirds of the inmate deaths in New York and New Jersey prisons that year were from AIDS, said the study issued Sunday in Washington by the Justice Department's Bureau of Justice Statistics.

The AIDS deaths among inmates in both states appear to reflect widespread intravenous injection of drugs among males in New York City and neighboring cities, said Dr. Mervyn Silverman, president of the American Foundation for AIDS Research. AIDS cases resulting from intravenous drug use are much more prevalent in the Northeast.

AD 9-11-93

NEW JERSEY

Inmate With H.I.V. Who Bit Guard Loses Appeal

By JOSEPH F. SULLIVAN

Special to The New York Times

TRENTON, Feb. 17 — An appeals court today upheld the attempted murder conviction of an H.I.V.-infected prisoner who bit a prison guard. The court said it did not matter whether the virus that causes AIDS can actually be transmitted by biting as long as the prisoner believed it could.

The ruling by the Appellate Division of the Superior Court included part of the jury instruction given by

the trial judge, John B. Mariano of Superior Court, who said, "Impossibility is not a defense to the charge of attempted murder."

"That is because our law, our criminal statutes punish conduct based on state of mind," Judge Mariano said. "It punishes purposeful actions regardless of whether the result can be accomplished."

Judge Mariano said this would be true "even if the result, which in this case would be death, was a scientific or factual impossibility."

The prisoner, Gregory Dean Smith,

was serving five years for robbery in Camden County Jail in 1989 when the biting incident occurred. His resulting conviction added 25 years to his sentence, and he was sent to Trenton State Prison.

Ruling Called 'AIDS Hysteria'

His lawyers, Ronald L. Kuby and William M. Kunstler of the Center for Constitutional Rights, said they would appeal today's ruling to the New Jersey Supreme Court.

In a prepared statement the lawyers accused the appeals court of

surrendering to "AIDS hysteria," and said the ruling not only affects the prisoner, but "is a tragedy for the hundreds of thousands of H.I.V.-positive people who will continue to face irrational discrimination at the hands of the ignorant and fearful."

In his appeal, Mr. Smith, 30, said Judge Mariano erred by not asking the jury to decide whether a "reasonable person" would have concluded that Mr. Smith's actions constituted a serious murder attempt. The "reasonable person" test is part of the same statute under which Mr. Mariano instructed the jury, but the appeals court upheld his decision not to ask the jury to consider this test.

The appeals panel also cited cases

since 1989 in which courts in Georgia, Texas and Indiana have upheld attempted murder charges against infected defendants who bit or spit at people with the intent of giving them the virus that causes AIDS.

Confrontation in Hospital

Mr. Smith, who was diagnosed as H.I.V.-positive in September 1988, was sent to the county jail on April 14, 1989. On June 11, after he fell in his cell, Mr. Smith was taken to Cooper Hospital in Camden for an examination. He was accompanied by two corrections officers, Albert Waddington and John Snow, who donned rubber gloves on being told the prisoner was infected was H.I.V.-positive.

According to trial testimony, Mr. Smith became angry when hospital staff members refused to take an X-ray of his back. He scuffled with the officers as they tried to get him back in the patrol car for the return trip to jail.

Both officers said their gloves came off during the struggle and that Mr. Smith bit Mr. Waddington on the hand, saying, "Now die, you pig! Die from what I have!"

Mr. Smith denied biting anyone and said the officer's injuries came from Mr. Smith's handcuffs. Mr. Waddington has been tested several times and has shown no signs of H.I.V. infection.

AIDS Practice Manual: A Legal and Educational Guide

Second Edition

A joint publication of

National Gay Rights Advocates

and the

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AIDS Networks

AIDS IN PRISONS AND JAILS

Anita P. Arriola

quite paraphrase

AIDS presents serious legal and administrative problems in the correctional setting, whether a county jail or a major prison system. Decisions concerning prevention, housing, and the delivery of medical care are frequently complicated because of the potential for a high concentration of individuals at risk for the disease and institutional constraints of overcrowding and limited budgets.

Unfortunately, many institutions have dealt with these issues in an ill-informed and haphazard manner, conducting HIV antibody testing and needlessly segregating seropositive prisoners and prisoners with AIDS or ARC under inhuman conditions of confinement. Such policies reflect both a lack of AIDS awareness on the part of prison administrators and an overriding concern for maintaining security and order. And, unfortunately, public hysteria and misinformation about the disease have brought political pressure to bear on an essentially medical question, with the result that mandatory HIV antibody testing of prisoners and other "hard-line" measures are being introduced in legislatures around the country.

Prisoners with AIDS or ARC or who are seropositive face special medical problems. When ill, they are often in need of acute medical care which frequently is not available in a prison hospital. Even when asymptomatic, it may be necessary for them to take AZT or another drug which can retard the development of opportunistic infections but is not available to them in prison. Prisoners who are dying need the comfort and support of friends and families, yet they are often denied visitation "privileges."

Anita Arriola is an attorney at Public Advocates, Inc., a non-profit public interest law firm located in San Francisco, California. She represents male inmates at San Quentin, Folsom, Deuel Vocational Institution and Soledad prisons; pregnant and postpartum inmates at the Santa Rita Rehabilitation Center; and inmates confined in the AIDS wings at the California Medical Facility - Vacaville.

This chapter addresses the legal aspects of AIDS-related measures in correctional institutions. It is worth noting at the outset that, with respect to federal constitutional law, the United States Supreme Court has been granting ever broader discretion to prison administrators on matters relating to institutional security. This can make challenges to correctional policies difficult. Great caution should therefore be exercised before the filing of an action.¹

Nonetheless, the resolution of some AIDS-related prison cases has resulted in beneficial changes of policy and there are numerous instances in which the legal and policy arguments set forth in this chapter can be used without the necessity of filing a suit. In systems where an ill-informed policy exists, for example, confronting the administration with medical, public health and ethical arguments may prove effective. In addition, advocates may raise these issues on behalf of individual clients in criminal matters, habeas corpus proceedings, motions for sentence modification or in opposition to actions to compel testing.

With these caveats in mind, we now address the legal implications of policies and practices in correctional systems concerning AIDS. In particular, the following topics will be addressed: (1) testing (mandatory and voluntary testing; confidentiality of test results); (2) the quarantine or segregation of prisoners with AIDS, ARC or who are seropositive and the conditions of confinement (overcrowding, general sanitation, exercise, visitation, legal research materials, etc.); (3) quality of medical care and (4) early release.

I. HIV ANTIBODY TESTING OF PRISONERS

The HIV antibody testing of prisoners arises in a variety of contexts. [Presently, mass screening is conducted in the federal system and some state and county systems of all new prisoners and prisoners being released. Some systems have tested all prisoners, while others screen

only members of certain groups, such as gay men, IV drug users, female prostitutes, pregnant women, inmates with clinical indications of HIV infections, or "in response to incidents."² In other systems, testing is conducted on a voluntary basis or on request.)

The key issues are whether such HIV antibody testing is legal and whether there is a right of refusal based on law, policy or ethical considerations. It may be argued that because of the potentially very serious negative effects of test results, medical ethics requires that there be a right of refusal, regardless of law or policy. For example, this may be likened to a patient's right to refuse a potentially risky surgical procedure, such as open heart surgery. With respect to the law, testing can be challenged as a violation of both federal and state constitutional privacy rights as well as a violation of state statutes. We turn to a discussion of these rights.

A. Constitutional protection of the right to privacy.

It is well settled that prisoners maintain civil rights under the United States Constitution.³ Convicted prisoners are to be accorded those rights not fundamentally inconsistent with prisoner status or incompatible with the legitimate objectives of incarceration.⁴ Consequently, courts, although reluctant to interfere with the internal administration of prisons, will intervene to remedy violations of those rights retained by prisoners.⁵

Prisoners retain some fundamental rights of personal privacy.⁶ We shall examine this right with respect to mandatory HIV antibody testing under (1) the fourth amendment protection against unreasonable searches and (2) the generalized right to privacy. Both of these rights apply to state prisoners under the fourteenth amendment's due process clause and they may be asserted as the basis for a claim for damages or equitable relief under the federal civil rights statute (42 USC 1983).⁷ They may also be raised in a petition for writ of habeas corpus⁸ to challenge segregation based on seropositive test results. Or they may be raised as a defense in a criminal or civil proceeding where testing is sought.

1. The Fourth Amendment.

The fourth amendment of the United States Constitution states:

"The right of the people to be secure in their persons, houses, papers and effects, against

unreasonable searches and seizures, shall not be violated . . ."

The Supreme Court has recently reaffirmed the principle that "the overriding function of the fourth amendment is to protect personal privacy and dignity against unwarranted intrusion by the State."⁹ The Court has noted that such intrusions are restricted through imposition of "a standard of reasonableness upon the exercise of discretion by government officials."¹⁰

In the prison context, a fourth amendment violation may occur when the bodily integrity of a prisoner is invaded.¹¹ Courts will closely scrutinize the reasonableness of strip searches or body cavity searches.¹² The constitutionality of these searches will be determined by balancing the state's need for the particular search against the extent of the invasion suffered by the prisoner.¹³ It may be argued that mandatory testing programs are an unreasonable intrusion upon the privacy rights of prisoners, thus constituting both a search and a seizure under the fourth amendment.¹⁴

In this regard, mandatory testing programs may be likened to compulsory drug testing by urinalysis, which courts have held with singular unanimity to constitute a fourth amendment search or seizure.¹⁵ In order to establish a claim under the fourth amendment, mandatory testing programs must be shown to constitute an "unreasonable" search and seizure. The benchmark of a search which is "reasonable" under the fourth amendment is a warrant based on probable cause. *Katz v. United States*, 389 U.S. 347, 357 (1967). The fourth amendment warrant and probable cause requirements will be abandoned "only in those exceptional circumstances in which special needs, beyond the need for law enforcement, make the warrant and probable cause impracticable." *New Jersey v. T.L.O.*, 469 U.S. 325, 340-1 (1985) (Blackmun J., concurring); *O'Connor v. Ortega*, 107 S. Ct. 1492, 1500, 94 L. Ed.2d 714, 725 (1987). Absent the "exceptional circumstances," even a compelling governmental interest will not justify departure from the customary requirements of prior judicial approval for a government search or seizure. *United States v. U.S. District Court*, 407 U.S. 297, 321 (1972).

The Supreme Court has limited prisoners' privacy rights under the fourth amendment in certain circumstances. In *Hudson v. Palmer*,¹⁶ the Court ruled that the fourth amendment does not prohibit prison officials from conducting random searches of prisoners' cells. However, in *Bell v. Wolfish*, 441 U.S. 520, 560, 99 S. Ct. 1861, 1884 (1979), the Court applied a test for security-related body

cavity searches of prisoners which balanced "the need for the particular search against the invasion of personal rights that the search entails." Factors to be considered include "the scope of the particular intrusion, the manner in which it is conducted, the justification for initiating it, and the place in which it is conducted." Thus, in the balancing analysis, it has been noted that "the greater the intrusion, the greater must be the reason for conducting a search" and that the government must demonstrate not only a legitimate need to conduct the body cavity search but also "that less intrusive measures would not satisfy that need." See *Levoy v. Mills*, 788 F.2d 1437, 1439 (10th Cir. 1986).

In applying the *Bell* test to body cavity searches in prisons, courts have considered such factors as whether the search involves physical contact, whether the searches are conducted by police officers instead of medical personnel, whether the search is conducted in a private area and in a hygienic manner, and the genuineness of the alleged security threat. These factors clearly determine the extent of the invasion suffered by the prisoner.¹⁷

The *Bell* standard has also been applied by several courts to the random urine testing of prisoners for drugs.¹⁸ Under existing case law, however, it may be argued that prisoners should have greater protection from mandatory HIV antibody testing. Cases involving the Fourth Amendment rights of prisoners to date involve either (1) blood or urine testing designed to detect inmate drug use or (2) body cavity searches or cell searches to detect the smuggle or presence of money, drugs, weapons or other contraband. In both instances, the courts have upheld such practices where the level of intrusion on prisoners' privacy rights has been minimal and where prison administrators have demonstrated that the practices are necessary to maintain institutional security and to preserve internal order and discipline. Mandatory HIV testing programs are distinguishable in that they are not designed to detect or deter criminal activity or misconduct in prison, they involve a substantial infringement on prisoners' reasonable expectations of privacy, and they are not necessary to maintain internal security in prisons.

Whether *Bell* or a more stringent standard is applied, it will be necessary for a prisoner challenging a testing program to substantiate the high level of intrusion caused by the HIV antibody test, the unreasonableness of the search, the alternatives available to the prison administration to deal with the problems posed by AIDS, and the problems associated with the administration and reliability of the test.¹⁹

1. There is no question that the level of intrusion of HIV antibody testing on the personal privacy of prisoners is great. It involves a forced penetration of body tissues and an involuntary extraction of body fluids. Apart from the physical act of drawing blood, the psychological impact of learning that one is seropositive has been compared to receiving a death sentence. Because of the consequences of a positive test result, the testing process produces enormous anxiety and, for seropositive prisoners, can result in severe psychological trauma, including depression, rage reactions and severe social withdrawal.²⁰

HIV antibody testing can affect additional privacy interests because of the enormous stigma attached to seropositivity and AIDS. Disruption of family relationships²¹ due to rejection or visiting restrictions is a frequent occurrence. In addition, the privacy right of confidentiality in medical records may be violated²² if the test results are kept in a manner in which they may be made known to staff or inmates. This can result in severe consequences, including the enmity of staff and other prisoners, isolation in housing units with loss of access to prison programs or privileges, and discrimination in housing, employment and insurability after discharge.

The magnitude of these dire consequences is increased by the fact that there is currently no treatment available for most asymptomatic seropositive persons. Under all these circumstances, it is clear that the level of physical and psychological trauma associated with a mandatory testing program is great and that mandatory HIV testing involves a type of search that offends "human dignity and privacy"²³ to a much greater degree than urinalyses or body cavity searches.

2. The key element in the *Bell* balancing test is the need for a particular search. In contrast to the dire consequences of mandatory HIV antibody testing of prisoners, official justifications for the need for such testing are weak. The primary reasons advanced for mandatory HIV testing programs are: (1) identification of seropositive inmates is necessary to prevent transmission of the disease within the prison (and therefore provide effective medical care and treatment); (2) providing seropositive inmates with special housing and programming is necessary to maintain institutional security and order; and (3) identifying and segregating seropositive prisoners is necessary to provide a safe working environment for correctional staff and to protect those prisoners from abuse or violence by other inmates.

These arguments are without medical or legal basis. First, testing to identify and segregate asymptomatic

seropositive inmates will not prevent the spread of AIDS. Second, there is no evidence that seropositive prisoners are more likely than others to engage in misconduct or criminal activity, thereby justifying segregated housing for them. Indeed, segregation may actually create more problems of institutional security and order because prison systems may be unable to meet demands for more housing where there are large numbers of prisoners. Third, rather than protecting them, segregation of seropositive inmates may stigmatize them, subjecting them to intimidation, threats or actual violence from others concerned about the possible spread of AIDS. Indeed, segregation of all seropositive prisoners in an environment with the likelihood of repeated exposure to the virus and in unhealthy living conditions may actually pose a significantly increased health hazard. Finally, staff and prisoners must be educated about the dangers of AIDS and must take precautions in dealing with blood or other body fluids regardless of the antibody status of an inmate. Thus, widespread testing might lull seronegative inmates and those dealing with them into a false sense of security and undermine the important educational message that everyone needs to be very careful about behaviors known to be associated with transmitting the AIDS virus.

Additional arguments against the use of testing include the absence of proof of high rates of AIDS transmission in prison and therefore the need to screen.²⁴ Testing also undermines education and prevention programs by needlessly dividing the inmate population into a stigmatized class and a "safe" class, thus weakening the important educational message that everyone should be careful.²⁵

3. There are alternatives available to correctional systems that are both more effective and avoid the negative consequences of mass screening. These alternatives include astute medical surveillance, blind (anonymous) testing, creative diagnostic procedures and carefully designed epidemiological studies. These alternatives can help correctional administrators assess the prevalence of seropositivity and project future incidence of AIDS and ARC for budgeting and treatment purposes.

Because there is presently no cure for the disease, leaders of the scientific community are united in their insistence that broad educational programs are the key in dealing with AIDS.²⁶ The report of the National Institute of Justice has emphasized the importance of on-going educational programs for both inmates and staff.²⁷ Instead of utilizing scarce prison resources to detect who is seropositive and who is not, more effective public health policies would stress educational efforts designed to inform inmates about preventive and risk behaviors, such

as unsafe sex, forced sexual acts or intravenous drug use. Moreover, an education program does not harm the civil liberties interests of inmates discussed above. For this reason, a prison system which engages in mandatory testing without implementation of a thorough educational program is not using the least restrictive alternative in dealing with the problem.²⁸

Another alternative is to adopt a safe and rational policy of treating every individual as if he or she were at risk for AIDS. The Centers for Disease Control has issued excellent recommendations for correctional practice in several precautionary areas and these should be followed by staff in all situations in which there is a potential for HIV transmission, not just when dealing with inmates or staff members who have been identified as seropositive.²⁹ Similarly, the U.S. Department of Labor has recently issued detailed guidelines for protection of health workers against the HIV.³⁰ These guidelines call for employer training in the modes of transmission, recognition of which procedures are dangerous and the types of protections an employee should utilize. Protective clothing and equipment is specified.³¹ Implementation of these procedures in the prison setting is necessary and appropriate and would help to diminish fear and anxiety on the part of prison staff.

4. Details of the testing procedures should also be examined to determine if they are being conducted in the least intrusive manner. Even if a court finds that the justifications for a mandatory testing program are reasonable, a prisoner's rights may still be violated if the manner in which it is carried out is unreasonable.³² Factors to be considered include:

(a) Are the tests being conducted in a manner to minimize the number of false positives? Studies have demonstrated a wide range in accuracy among various laboratories.³³ In light of the drastic consequences of a false positive to an inmate, the laboratories used should be monitored by the prison to insure the accuracy and reliability of the test.

(b) No testing program should occur without psychological counseling for each individual tested. Counseling of seronegative persons is important to ensure that they do not interpret their test result as an indication that they can engage in unsafe practices. On-going (and not simply post-test) counseling of seropositive persons is needed to help them deal with the psychological traumas and devastation often stemming from this diagnosis. Counseling should be done by professional counselors in light of the serious repercussions of the test, and is an expensive

component of the testing process. However, any testing program which ignores it is magnifying both the problem of AIDS in prison and the trauma associated with the invasion of prisoners' privacy rights.

(c) Closely related to the accuracy of the antibody test is the sensitive issue of confidentiality of test results. One of the negative consequences of mandatory testing is the lack of confidentiality of prison medical records. As mentioned above, the right to privacy encompasses the confidentiality of medical information, so this inquiry is both relevant to a least restrictive alternative analysis as well as to a violation of this right itself.³⁴

Most correctional systems have general or specific confidentiality policies or laws regarding who should receive HIV antibody test results and who should be notified regarding diagnoses of AIDS or ARC. In some states, such as California and Wisconsin,³⁵ there are very restrictive laws governing disclosure of HIV antibody test results. In other states, the laws require that correctional authorities be notified of the results of the antibody test, but prohibit notification of the inmate.³⁶ Other systems routinely notify public health agencies when an inmate is diagnosed as having AIDS or ARC or when such an inmate is released.³⁷ The laws in each jurisdiction, as well as the correctional system's own policies and rules, should be consulted in order to challenge the disclosure of any antibody test results.

(d) The manner in which prisoners are selected for testing is also relevant. If only certain prisoners are tested, then the criteria for selection of inmates should be examined both for rationality and for whether its implementation may lead to harassment. One court voided a "random" drug testing program because guards knew the identity of the inmates being selected. The court held that the selection must be "truly random."³⁸

If tests are given to inmates described as "homosexuals" or "IV drug users," then the criteria for identifying these inmates should be examined. Similarly, a rule that calls for tests in response to "an incident" may be particularly vulnerable to attack since individual motives of staff members may come into play. A Massachusetts court refused to order HIV testing of a prisoner who scratched a guard on the grounds that the tests would constitute a deprivation of the inmate's civil rights.³⁹

(3) In voluntary programs, the correctional system may request all or certain inmates to be tested, but cannot or will not compel cooperation. In Montgomery County, Maryland, for example, all members of known high-risk

groups are requested to submit to the antibody test, but no testing is performed without informed consent.⁴⁰

The legal issue involved here is whether certain forms of coercion, such as threats of segregation or loss of privileges, may be applied in ostensibly voluntary testing programs. In addition to all of the possible theories mentioned above, it is also possible to challenge the "consent" as being given under duress, fraud or coercion. Further, an inmate's consent may be challenged under various rules and regulations governing the correctional institution, which prohibit coercion or intimidation of inmates.

In conclusion, a Fourth Amendment challenge to HIV antibody testing of prisoners should be considered by prisoner advocates. As shown below, many of the issues raised in a Fourth Amendment claim are equally applicable to other constitutional and statutory challenges to the testing of prisoners.

2. Federal and State Rights to Privacy.

While the U.S. Constitution does not explicitly mention any right of privacy, the United States Supreme Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. In various decisions⁴¹ the Court has made it clear that only personal rights that can be deemed "fundamental" or "implicit in the concept of ordered liberty"⁴² are included in this guarantee of personal privacy. From each or all of these cases it may be argued that mandatory HIV antibody testing programs intrude upon prisoners' basic right to privacy. It is the "right to be left alone"⁴³ that is paramount.

Most prison cases involving this right to privacy have concerned intimate physical contact between inmates and staff or viewing of prisoners by guards of the opposite sex. In approaching these cases, the courts have examined in great detail the extent and nature of the intrusion, the need for such intrusion and possible alternative procedures.⁴⁴ Some courts have fashioned detailed orders specifying with particularity when a guard may view inmates or regulating the ability of inmates to shield their cells or their bodies from view.⁴⁵

The Supreme Court has recognized that prisoners have the right to privacy. In the recent case of Turner v. Safley, 107 S. Ct. 2254 (1987), the Court struck down a restriction on the ability of prisoners to marry. In doing so, the Court held that a regulation which impinges on

inmates' constitutional rights must be "reasonably related to legitimate penological interests." First, there must be a valid, rational connection between the regulation and the governmental interest asserted to justify it. *Id.* at 2262. Second, in determining the reasonableness of a prison restriction, it is important to inquire whether there are alternative means of exercising the prisoners' rights. A third consideration is "the impact accommodation of the asserted constitutional right will have on guards and other inmates, and on the allocation of resources generally." Finally, the absence of ready alternatives is evidence of the reasonableness of a prison regulation. *Id.*

Application of the *Turner* "reasonable relationship" standard to HIV testing of prisoners raises many of the same issues discussed in the previous section. The lack of a reasonable relationship between testing and penological interests, the lack of an adverse impact on guards and inmates in abandoning testing, the better use of funds in AIDS-related educational programs, and the existence of other alternatives all can be advanced to demonstrate that the program violates constitutionally protected privacy rights of prisoners.

Some state constitutions also afford a right to privacy.⁴⁶ In California, for example, the right to privacy under Article I, section 1, is explicit. That section protects two types of privacy rights: substantive and informational. Like the right to be left alone under the federal constitution, Article I protects substantive rights such as the right to procreative choice⁴⁷ and the right to live in a household with unrelated individuals.⁴⁸ The second aspect protected by the Constitution is informational privacy; accordingly, Article I, section 1 has been held to protect medical records against disclosure absent a narrowly-tailored compelling interest.⁴⁹ Prisoners retain their right to privacy under the California constitution.⁵⁰

B. State and local laws.

Mandatory testing programs may be challenged under existing laws or policies in some jurisdictions. For example, recently passed laws in California and Wisconsin prohibit HIV antibody testing without the informed consent of the subject. As a matter of policy, Louisiana and Montgomery, Maryland do no testing without informed consent. In addition, a number of other states prohibit drawing blood for any purpose without informed consent.⁵¹ Such laws or policies may conflict with mandatory testing and should be consulted.

II. CONDITIONS OF CONFINEMENT

Correctional systems have adopted various housing policies once an inmate has been tested and identified as being seropositive or having ARC or AIDS. Routinely, jurisdictions segregate or quarantine the inmates from the rest of the general population indefinitely and under more restrictive conditions of confinement.⁵² Often, they are deprived of numerous programs and services such as visitation,⁵³ exercise, access to legal research materials, the telephone, written correspondence, medical care and religious services.⁵⁴ These programs are vitally important to the emotional and physical well-being of inmates.⁵⁵

Challenges to the quarantine or segregation of inmates based on their medical status (seropositivity, AIDS or ARC) and the conditions under which they are housed may be brought on the basis of federal or state constitutional standards, federal and state statutes or common law. We discuss below several of these claims and also the feasibility of raising them by means of a writ of habeas corpus.

1. Equal Protection.

In cases invoking the equal protection clause, courts have traditionally employed a strict scrutiny analysis in a limited category of cases where a statute or regulation singles out a "suspect class" for special treatment, or when the challenged law infringes upon a fundamental right.⁵⁶ Suspect classes have been generally limited to race, alienage, or national origin.⁵⁷ While classifications based on sex and illegitimacy have not been held to be suspect, they have nonetheless been subjected to heightened scrutiny.⁵⁸ Suspect classification status has not been granted to the aged or to the mentally retarded.⁵⁹ It is unlikely, therefore, that the Supreme Court would consider gays, hemophiliacs or intravenous drug users (members of the groups considered at high-risk for contracting AIDS) or prisoners to be members of a suspect classification.⁶⁰

Denial of equal protection under the Fourteenth Amendment has been a basis for a number of suits brought by inmates who have been segregated or denied access to programs because of seropositivity or a diagnosis of AIDS or ARC. In general, courts have upheld unequal treatment of these prisoners so long as there exists a rational basis for such treatment.⁶¹

Prison officials have advanced both security and medical reasons to justify segregation or denial of access to programs. Medical justifications have focused on the desire to limit the spread of the disease,⁶² while security reasons have dealt with protection of seropositive prisoners and prisoners with AIDS from the tensions and harm that could result from the fears of other prisoners.⁶³

The courts have upheld the prison administration in all these cases. In part, these decisions reflect the deference which the Supreme Court has insisted be paid to prison administrators in matters relating to security. When medical justifications are advanced, however, the usual deference is less,⁶⁴ and the asserted justifications can be attacked with expert witnesses and evidence showing that there is no rational basis for a particular policy or program. In such cases, the courts must determine, for example, whether it is medically rational to restrict access of seropositive inmates to programs. In this regard, prison officials' concern about preventing spread of the virus through casual contact are not advancing sound medical arguments.⁶⁵

On the other hand, prison officials should conduct AIDS educational programs in order to end fears justifying segregation. It was not an idle comment that one court noted in upholding a segregation policy that it was rational "at least until some better system is developed" and that the prison authorities were changing their programs as they worked "to improve their ability to cope with the needs of prisoners with AIDS."⁶⁶

2. The Eighth Amendment.

The eighth amendment prohibits the infliction of "cruel and unusual punishment." For convicted persons,⁶⁷ it is necessary to demonstrate that conditions violate the eighth amendment in that they constitute "the wanton and unnecessary infliction of pain" or are "grossly disproportionate to the severity of the crime warranting imprisonment." *Rhodes v. Chapman*, 452 U.S. 337 (1981).

The Supreme Court has described cruel and unusual punishment as treatment that is incompatible with evolving standards of decency or that involves unnecessary, wanton infliction of pain. *Id.* at 346. In determining whether the actions of prison officials constitute cruel and unusual punishment, courts will consider whether those actions further legitimate penal interests. *Id.* Not every hardship, therefore, will constitute cruel and unusual punishment.

Id. at 347. The eighth amendment also places certain affirmative duties on prison officials: Failure to provide adequate medical care amounting to "deliberate indifference" to prisoners' needs violates the eighth amendment.⁶⁸

Each or all of the following conditions of confinement may be challenged by inmates who are quarantined or isolated based on their medical status: the size of the cells; double-celling of inmates;⁶⁹ heating and ventilation; lighting; noise; plumbing, electrical systems; fire safety; earthquake safety; clothing, laundry and bedding; personal hygiene; general sanitation; pests; food; exercises; visitation; idleness (no opportunity or access to work, educational or vocational programs); protection of inmates from constant threats of violence by other inmates or staff; and overcrowding. In addition, the length of time of the deprivations is relevant.⁷⁰

To challenge conditions of confinement, the so-called "totality of circumstances" test is applicable; i.e., whether taken as a whole, conditions violate the prohibition against cruel and unusual punishment. *Id.* at 362-63. Virtually every lower federal court has utilized this test, with the notable exception of the Ninth Circuit, which has rejected the totality approach and has stated: "... the court must consider the effect of each condition in the context of the prison environment, especially where the ill effects of particular conditions are exacerbated by other related conditions." *Wright v. Rushen*, 642 F.2d 1129, 1133 (9th Cir. 1981)(emphasis added).⁷¹

3. Other constitutional grounds.

In addition to the equal protection and eighth amendment grounds, particular correctional practices or conditions may also be struck down on the ground that they violate the more specific guarantees of the first, fourth, sixth amendments, as well as the guarantees of procedural due process and equal protection.⁷² The due process clauses of the fifth and fourteenth amendments mandate that prisoners may not be deprived of life, liberty, or property without a meaningful opportunity to be heard.⁷³ The touchstone of due process is protection of the individual against arbitrary governmental action.⁷⁴ The threshold question in determining whether due process has been denied is whether the individual's claim represents a liberty interest protected under the due process clause.⁷⁵ Liberty interests may be created by the Constitution or court order, or by the states through statutes, regulations, or standard practices, policies or customs.⁷⁶ After estab-

lishing that a protected liberty interest is involved, courts must determine the adequacy of the process provided.⁷⁷ In doing so, courts weigh the private interest affected, the risk of erroneous deprivation of the interest through the procedures used, and the government's interest.⁷⁸

Suits have been successfully settled with respect to restrictions on access to law libraries and religious services.⁷⁹ If access to legal research materials is limited, a claim founded on the requirements of due process can be raised. Due process requires that prison authorities must assist inmates in the preparation and filing of meaningful legal papers by providing prisoners with either access to adequate law libraries or adequate assistance from persons trained in the law. *Bounds v. Smith*, 430 U.S. 817 (1977). Due process also requires that the libraries available to inmates be "adequate" and that regulations governing inmate use of the library permit the meaningful use of the library. *Ramos v. Lamm*, 639 F.2d 559, 582-83 (10th Cir. 1980), *cert. denied*, 101 S. Ct. 1759 (1981).

4. The Rehabilitation Act of 1973.

Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. sec. 794) forbids discrimination against handicapped individuals in any program which receives federal funds. This Act may apply if a prisoner with AIDS or ARC or who is seropositive is being denied access to a particular program that is funded in part by federal monies. It is not enough that the institution receive federal funds for another program (see *Doe v. Coughlin*, 509 N.Y.S.2d at 212), although a bill passed by the U.S. Senate at the time of publication would amend the law to provide coverage for all programs of an institution receiving federal funds.

Once it is determined that a program receives federal funds, the next question is whether a person with AIDS, ARC or who is seropositive is "handicapped" under the terms of the Act. The Supreme Court recently held that a person with tuberculosis, a communicable disease, was covered by the Act and that the legislative history of the bill demonstrates that "Congress was as concerned about the effect of an impairment on others as it was about its effect on the individual."⁸⁰ In light of this recent decision and the justification advanced by prison authorities that seropositive inmates must be segregated because of the fears the condition generates in other prisoners, a strong argument can be made that the Act covers both seropositive prisoners and prisoners with AIDS.

Finally, prison authorities must demonstrate that there is a rational reason why the prisoner is not "otherwise

qualified" to participate in the program. In this regard, they may assert that the restrictions are necessary for medical reasons; that is, to halt the spread of the disease.⁸¹ However, as discussed above, a prisoner's claims have a greater likelihood of success when the prison advances a medical justification, rather than one based on security because the degree of deference is less.⁸²

5. Writs of Habeas Corpus.

A writ of habeas corpus is an order, signed by a judge, mandating the person in charge of a prison or jail (such as a Warden or Sheriff) to bring a prisoner in his or her custody to court. The traditional purpose of the writ is to secure the release of a defendant from illegal incarceration or illegal restraint of any kind. Prisoners may seek writs of habeas corpus to challenge both the conditions of their confinement as well as the illegality of confinement. For example, the eighth amendment may be used as grounds for a writ. The conditions in which prisoners with AIDS are confined present a number of possibilities for bringing a writ of habeas corpus. These include mandatory segregation without demonstrated medical necessity, lack of access to law libraries, poor food, inadequate health care, and restrictions on the use of prison facilities, such as exercise yards.

While some courts have found that conditions of confinement may be litigated pursuant to the federal habeas corpus statutes,⁸³ this is not preferable since the litigator will be burdened with the requirement of exhaustion of state remedies⁸⁴ and with other rules limiting the usefulness of this remedy.⁸⁵ In some states, habeas corpus is an appropriate vehicle for litigating conditions of confinement and obtaining broad relief. The writ may be used to "obtain declaration and enforcement of prisoner's rights in confinement."⁸⁶

Constitutional rights of prisoners may also be enforced through state writs of habeas corpus. In California, the courts have held that prisoners may obtain release on habeas corpus because of cruel, inhuman, or excessive punishment in prison.⁸⁷ Cruel and excessive punishment often focuses on restrictions on prisoners, as well as excessively poor conditions in the prisons. For prisoners with AIDS, the restrictions and conditions they face are extremely severe. Segregation with other persons who may have opportunistic infections, lack of exercise, and inadequate nutrition create life-threatening situations for these prisoners.

III. QUALITY OF MEDICAL CARE

The most pressing issue faced by prisoners with AIDS, ARC or who are seropositive is access to and availability of adequate medical care. This is because many prison medical personnel are ill-informed about AIDS and about the specific clinical manifestations and treatment options for the disease; prison infirmaries are poorly equipped to provide decent medical care; and prison medical facilities are woefully understaffed. Conditions in a California prison were so bad in 1987 that even the U.S. Justice Department found that the medical care provided constituted cruel and unusual punishment.⁸⁸

Suits on the quality of correctional medical care may be brought on the basis of federal constitutional standards, state law, or common law. We discuss below these issues with respect to the eighth amendment and state provisions.⁸⁹

1. The Eighth Amendment.

The eighth amendment proscription against "cruel and unusual punishment" requires that prison authorities provide adequate medical care to inmates. The eighth amendment is violated when, by act or omission, authorities demonstrate "deliberate indifference to serious medical needs." Estelle v. Gamble, 429 U.S. 97, 106, 97 S. Ct. 235, 290-91 (1976). In discussing this standard, the Court noted that:

"An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torture or a lingering death,' ... the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose.... The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that '[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty care for himself.'"

Id. (citations omitted).

In applying this standard to medical treatment of prisoners with AIDS or ARC or who are seropositive, the following factors are noteworthy:

- The Supreme Court recently noted that the delivery of adequate medical care to prisoners does not "ordinarily clash" with other responsibilities of prison authorities. Therefore, the existence of deliberate indifference to a prisoner's serious medical illness can "typically be established or disproved without the necessity of balancing competing institutional concerns for the safety of prison staff or other inmates." Whitley v. Albers, 475 U.S. 312, 106 S. Ct. 1078, 1086 (1986). Courts are less willing to take "a broad hands-off attitude towards the daily problems of prison administration ... when matters of medical care are involved, as opposed to matters of prison discipline and security." Guglielmoni v. Alexander, 583 F. Supp. 821, 827 (D. Conn. 1984).⁹⁰ Under this standard, courts are therefore less willing to defer to prison officials' actions relating to the medical care and treatment of prisoners.

- Deliberate indifference to the serious medical needs of inmates can be demonstrated either by (1) a showing of a pattern of individual incidents involving inadequate medical care; or (2) pointing to systemic deficiencies in the delivery of medical care which make unnecessary suffering inevitable.⁹¹

- The standard for evaluating the adequacy of care is not static but reflects "the evolving standards of decency that mark the progress of a maturing society." Estelle v. Gamble, 429 U.S. at 103, 97 S. Ct. at 290.

- The requirements of adequate medical care apply equally to psychiatric care. The high salaries earned by psychiatrists are not a justification for not providing such treatment.⁹²

Applying the foregoing standards to prisoners with AIDS, ARC or who are seropositive, each or all of the following may be asserted as bases for an eighth amendment claim: intentional interference with treatment or intentional misdiagnosis;⁹³ refusal to treat ailments or ignoring complaints;⁹⁴ deliberate refusal to provide medical therapy and pain-killers;⁹⁵ allegation that official knew of prisoner's pain from tooth infection but refused to allow prisoner to see dentist;⁹⁶ inadequate access to medical care in isolation cells which deprived inmate of nearly all fresh air and light;⁹⁷ and, that prison officials knowingly denied medical attention for a chronic disease.⁹⁸

2. State laws.

There are also a variety of state laws that are relevant to the delivery of medical care to prisoners. Most states have legislation that sets forth a general standard of care or that specifies duties of prison officials. *See* Comment, Medical Rights of Prisoners, 42 Univ. of Chicago L. Rev. 705, 707 (1975) for statutory listing. The Comment notes that these statutes can be difficult to rely upon in litigation because many of them are broadly worded, they are generally silent on the issue of enforcement, and their purpose may not be to create a right of action.

In some states, correctional medical care may be subject to suits for common law torts, such as negligence. Medical malpractice suits are also a possibility. *See, e.g., Church v. Hegstrom*, 416 F.2d 449, 451 n.1 (2d Cir. 1969) (Connecticut statute provides a method for obtaining monetary damages in cases of official negligence).

In addition, medical care in correctional institutions is usually governed by the state laws (e.g., Medical Practice and Nursing Practice Acts) that apply to the standard and quality of care in the community at large. However, inmates are not necessarily entitled to all aspects of medical care available in the community at large -- for example, the right to choose one's own physician and the right to a second medical opinion.⁹⁹

IV. EARLY RELEASE OF PRISONERS WITH AIDS OR ARC

As discussed above, prisoners dying of AIDS or severe ARC have a multitude of medical needs which frequently cannot be met in the prison setting. In addition, these dying people are deprived of psycho-social support services in the community and have sharply restricted access to their families. The early release of prisoners who are seriously ill with AIDS or ARC may be obtained through pardon, parole or sentence modification. Prisoner advocates can help effect the release of sick prisoners by preparing the prisoner's application for release. The following discussion covers only the general characteristics of each option, as the specifics are governed by state and federal statutory schemes.

A. Parole

Most jurisdictions will grant parole to prisoners who are statutorily eligible if they are likely to abide by the law

and if their release will not disturb societal welfare.¹⁰⁰ Parole is not a sentence modification but rather an integral part of the inmate's sentence. Inmates released on parole continue to be supervised for the duration of their sentences.¹⁰¹

In most jurisdictions, the prisoner must serve a minimum sentence before being considered for parole. In California, for example, prisoners may be paroled once they have served the minimum term prescribed by law for their crime if their parole is approved by the Board of Prison Terms.¹⁰² Prisoners may also have to meet other statutory eligibility requirements to qualify for parole; some states stipulate that prisoners previously convicted of a felony or serving a life sentence may not be eligible for parole.¹⁰³

In some jurisdictions, prisoners will automatically come before the parole board for consideration, while others require prisoners to file an application when they become eligible.¹⁰⁴ In New York State, approximately 50 inmates with AIDS have been paroled in the past two years if they have suffered at least one of the opportunistic infections associated with the virus and if they are considered no danger to the community.¹⁰⁵

B. Sentence Modification

Sentence modification is probably the most feasible way to obtain early release for a prisoner with AIDS if the jurisdiction has a sentence modification statute. Whereas early paroles must be granted by the parole board, sentences may only be modified by the sentencing court.

In most states, the sentencing court may only modify a sentence on a defendant's motion during a specified period of time after its pronouncement. For example, the time limit in California is 120 days. In a small number of states, sentencing courts maintain jurisdiction to reduce or modify a sentence "at any time."¹⁰⁶ A court rule in New Jersey permits a prisoner at any time to make a motion to reduce a sentence based on existence of a serious illness and the deleterious effect of incarceration on the prisoner's health.¹⁰⁷

The American Bar Association has recommended continuing jurisdiction over sentences by the trial court on motion of the correction or releasing authorities.¹⁰⁸ California has such a system¹⁰⁹ whereby the court may modify a sentence on the recommendation of either the Director of the Department of Corrections or the Board of Prison Terms. At the federal level, a prisoner must apply

to the Bureau of Prisons which in turn files a motion with the sentencing court for sentence modification. The court may act on the motion at any time and is authorized to reduce the prisoner's sentence to the time already served.¹¹⁰ Similarly, under Rule 35 of the Federal Rules of Criminal Procedure, a defendant may make a motion to reduce his or her sentence or the court may reduce a sentence without motion, within 120 days after the sentence is imposed or probation is revoked.¹¹¹ The obvious advantage of this provision over a parole application is that the prisoner may file an application for sentence modification long before he or she is eligible for parole.

In states such as California where two mechanisms exist for a sentencing court to modify a sentence, the prisoner should file an application for resentencing with either the Director of Corrections or the Bureau of Prison Terms or request the sentencing court to resentence within the 120 day period. Unfortunately, some jurisdictions (notably, New York State) do not have resentencing provisions. In those jurisdictions the prisoner will have to rely on early parole statutes or clemency provisions.

C. Pardon

In contrast to sentence modifications or parole, applications for reprieve or pardon are probably the least likely to be granted. Under the United States Constitution, the President has the power to grant pardons for offenses against the United States. Most state constitutions confer the power to pardon on the Governor, with some states creating a pardon board and others vesting the power to pardon exclusively with the Governor. The power to pardon traditionally rests in the executive branch and is probably not subject to judicial review.¹¹²

The executive may exercise the power to pardon when a pardon will promote the public good¹¹³ or to mitigate the unduly harsh effects of enforcing criminal law in a specific case.¹¹⁴ A Mississippi case specifically notes that a prisoner's health is an appropriate factor to consider when deciding whether to grant a pardon.¹¹⁵ Historically, the governor's clemency power has been exercised under subjective standards, unbounded by precedent and under procedures which need not comply with even minimal standards of due process.¹¹⁶

Some states have specific statutory regulations regarding how and when an application for pardon must be filed, while in other states the prisoner simply files the petition with the Governor.¹¹⁷ In any case, the petition should describe the inmate's medical condition and describe any

other factors that are pertinent to an application for pardon in that jurisdiction.

CONCLUSION

The decision to impose mass screening and segregation of prisoners raises the question of why correctional systems are adopting measures not being adopted in the community at large to deal with the AIDS epidemic. In large part, this is due to the political impotence of prisoners, who, historically, have been easy targets of measures that severely restrict their civil rights. The real question, however, is whether screening and segregation are effective public health measures and whether there are less restrictive, more effective measures available.

Mandatory screening and segregation in prison facilities create the damaging impression that prisoners are to be treated as modern day lepers and that, like gay men and drug users, they are to be stigmatized as HIV carriers. The creation of AIDS wings or AIDS prisons also conveys a harmful message that will affect public perception about the nature of the disease and how to deal with it. Finally, such policies entail a massive expenditure of limited resources on measures that are unnecessary, unmanageable and ineffective in halting the spread of the disease.

The primary right of all prisoners is the right to a healthy and safe environment. It is critical that prisoner advocates explore both well-established precedent and creative theories to challenge AIDS-related policies that undermine that right.

Notes

1. The National Prison Project of the ACLU has recently developed an AIDS program and can be consulted for the latest information about cases and technical assistance. The Project is located at 1616 P Street NW, Washington, DC 20036 ((202) 331-0500). The Practice Manual editors and the author of this article are also available for assistance.

2. Hammett, AIDS in Correctional Facilities: Issues and Options xx-xxi (1987)(sponsored by the National Institute of Justice) [hereafter cited as "NIJ Study"].

3. See generally Project: Criminal Procedure, "Prisoners' Rights," 74 Geo. L.J. 973 (1986); Rudovsky, Bronstein & Koren, *The Rights of Prisoners*, American Civil Liberties Union (1973).

4. See *Hudson v. Palmer*, 468 U.S. 517, 525, 104 S. Ct. 3194, 3199 (1984)(prisoners retain those rights consistent with imprisonment or compatible with objectives of incarceration); *Meadows v. Hopkins*, 713 F.2d 206, 209 (6th Cir. 1983)(prisoners not stripped

of all rights at prison gate). See also *Bounds v. Smith*, 430 U.S. 817 (1977)(prisoners retain right of access to courts); *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976)(prisoners retain right to freedom from cruel and unusual punishment); *Wolff v. McDonnell*, 418 U.S. 539, 556 (1974)(prisoners retain right to due process subject to restriction imposed by nature of penal system); *Cruz v. Beto*, 405 U.S. 319, 322 n.2 (1972)(per curiam)(prisoners retain limited first amendment right to free exercise of religion); *Lee v. Washington*, 390 U.S. 333, 333-34 (1968)(per curiam)(prisoners retain right to equal protection).

5. See, e.g., *Hutto v. Finney*, 437 U.S. 678, 687 (1978)(comprehensive district court order correcting many constitutional violations justified by inadequate compliance with prior court orders); *Bounds v. Smith*, 430 U.S. 817, 832-33 (1977)(affirming district court order requiring that inmates have access to legal research facilities).

6. See *Hudson v. Palmer*, 468 U.S. at 542, 104 S. Ct. at 3208 (Stevens, J., dissenting in part)(quoting *Houchins v. KQED*, 438 U.S. 1, 5 n.2 (1978)(Burger, C.J.)(plurality opinion)("It is true that inmates lose many rights when they are lawfully confined, but they do not lose all civil rights.... Inmates in jails, prisons or mental institutions retain certain fundamental rights of privacy").

7. The statute provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage of any State, Territory, or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or the proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

For a comprehensive review of Sec. 1983 and other federal civil rights statutes, see *Nahmond*, *Civil Rights and Civil Liberties Litigation* (Shepard's 1979).

8. For federal habeas corpus practice, see *Wright*, *Miller & Cooper*, *Jurisdiction*, sec. 4261 *et seq.*; see also *State Bar of California*, *Standing Committee on Legal Services for Prisoners: Manual for Use of Habeas Corpus by California Prisoners* (1982).

9. *Winston v. Lee*, 470 U.S. 753, 759-60 (1985)(quoting *Schmerber v. California*, 384 U.S. 757, 767 (1966)).

10. *Delaware v. Prouse*, 440 U.S. 648, 653-54, 99 S. Ct. 1391, 1396 (1979); *Camara v. Muni. Court*, 387 U.S. 523, 528, 87 S. Ct. 1727, 1730 (1967).

11. See *McKinley v. Trattles*, 732 F.2d 1320, 1325 (7th Cir. 1984)(upholding jury verdict against guard who allegedly subjected prisoner to anal cavity search in violation of prisoner's rights); *Lee v. Winston*, 717 F.2d 888, 900-01 (4th Cir. 1983)(requiring surgery to remove possibly incriminating bullet violates fourth amendment when surgery requires deep incision

and general anesthetic); *cert. granted*, 466 U.S. 935 (1984), *cert. denied* 466 U.S. 942 (1984), *judgment aff'd*, 470 U.S. 753 (1985); cf. *United States v. Caldwell*, 750 F.2d 341, 343 n.2 (5th Cir. 1984)(suggesting that *Hudson* may imply relaxed fourth amendment standard in context of body cavity searches performed in prison), *cert. denied*, 105 S. Ct. 1873 (1985).

12. See generally Note, *Constitutional Limitations on Body Searches in Prisons*, 82 Colum. L. Rev. 1033 (1982).

13. See *Bell v. Wolfish*, 441 U.S. 520, 559 (1979)(courts must consider "the scope of the particular intrusion, the manner in which it is conducted, the justification for initiating it and the place where it is conducted").

14. Caution is advised in presenting this claim, since no case has yet decided this and, as discussed below, the prerequisites for establishing a fourth amendment "search and seizure" claim are stringent.

15. *National Treasury Employees Union v. Von Raab*, 816 F.2d 170, 176 (5th Cir. 1987); *McDonnell v. Hunter*, 809 F.2d 1302 (8th Cir. 1987); *Shoemaker v. Handel*, 795 F.2d 1136 (3rd Cir. 1986), *cert. denied*, 107 S. Ct. 577 (1986); *Capua v. City of Plainfield*, 643 F. Supp. 1507, 1514 (D.N.J. 1986). A very recently decided case, *Amalgamated Transit Union, Local 1277 v. Sunline Transit Agency*, No. CV086-827ORG(GX), slip op. at 10-19 (C.D. Cal. July 7, 1987), thoroughly analyzes the applicability of the fourth amendment to drug testing. Similarly, blood tests have been held to fall within the fourth amendment in *Schmerber v. California*, 384 U.S. 757, 767-68 (1966).

16. 468 U.S. 517, 104 S. Ct. 3194 (1984).

17. See *Bonitz v. Fair*, 804 F.2d 164, 172 (1st Cir. 1986); *Blackburn v. Snow*, 771 F.2d 556 (1st Cir. 1985); *Arruda v. Fair*, 710 F.2d 886, 888 (1st Cir. 1983) *cert. denied* 464 U.S. 999 (1983); *Logan v. Shealy*, 660 F.2d 1007, 1013 (4th Cir. 1981), *cert. denied* 455 U.S. 942 (1982); *Hill v. Bogans*, 735 F.2d 391, 394 (10th Cir. 1984); *Frazier v. Ward*, 528 F. Supp. 80, 83 (N.D.N.Y. 1981); *Sims v. Brierton*, 500 F. Supp. 813, 817 (N.D. Ill. 1980)(stating that the prison administration's "security concerns are excessive"); *Hodges v. Klein*, 412 F. Supp. 896 (D.N.J. 1976).

18. These cases have explicitly rejected the argument that the restrictive standard for random searches of cells under *Hudson* should apply to the forced extraction of body fluids. *Storms v. Coughlin*, 600 F. Supp. 1214 (S.D.N.Y. 1984); *Tucker v. Dickey*, 613 F. Supp. 1124 (D.C. Wis. 1985).

19. Information on these issues is contained in other sections of this Manual, including the chapter on medical issues (which contains a section on testing), the issue of *The Exchange* on mandatory testing which is a Manual Appendix, and the issue of this publication on prisons and jails which is attached to this article.

20. See *The Exchange*, August 1987, at 2 (reprinted in the appendix to this article).

21. The Supreme Court has noted the importance of family relationships to prisoners and found a "constitutionally protected marital relationship in the prison context." *Turner v. Safley*, 107

- S. Ct. 2254, 2265 (1987).
22. See, e.g., *Shoemaker v. Handel*, 795 F.2d 1136, 1144 (3rd Cir. 1986) cert. denied 107 S. Ct. 577 (1986); *U.S. v. Westinghouse Electric Corp.*, 638 F.2d 570, 577 (3rd Cir. 1980); *Capua v. City of Plainfield*, 643 F. Supp. 1507, 1515 (D.N.J. 1986).
 23. See *Schmerber v. California*, 348 U.S. at 770.
 24. A survey of 58 federal, state and local prison systems conducted by the National Institute of Justice in 1986 found that AIDS cases were rising more slowly among prison inmates than in the population at large. *New York Times*, March 12, 1987, at 8.
 25. For further discussion, see the excerpt from the article by Urvashi Vaid reprinted in the December 1986 issue of *The Exchange*.
 26. An extremely authoritative source in this regard is the publication by the National Academy of Sciences, *Confronting AIDS: Directions for Public Health, Health Care and Research* (1986).
 27. See NIJ Study, note 2 above, at xviii ("education and training must continue to be the cornerstone of the response to AIDS in correctional facilities, as in society at large.")
 28. One court has, in fact, ordered the distribution of an AIDS brochure to all inmates at a New York prison. See *LaRocca v. Dalsheim*, 120 Misc. 2d 697, 707, 467 N.Y.S.2d 302, 310 (Sup. Ct. 1983).
 29. See Centers for Disease Control, *Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace*, 34 MMWR 681 (Nov. 15, 1985).
 30. Dep't. of Labor, Dep't of Health and Human Services, *Joint Advisory Notice: Protection Against Occupational Exposure to Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV)*, 52 Fed. Reg. 41818 (Oct. 30, 1987). For information, call the National OSHA Information Office at (202) 523-8148.
 31. With regard to inmates, distribution of condoms would be another means of reducing the spread of HIV in prisons. Such a policy has been implemented in Vermont, Vermont Dept. of Corrections Medical Procedures 412 JJ (Addendum) and as part of a pilot program in certain city jails in New York. See *New York Times*, June 30, 1987. Texas is considering a measure similar to Vermont's. *San Francisco Examiner*, April 15, 1987.
 32. See *Tucker v. Dickey*, 613 F. Supp. 1124, 1131 (D.C. Wis. 1985).
 33. The Congressional Office of Technology Assessment conducted a study of the false positivity and negativity rates of approximately 700 U.S. laboratories. It found that some laboratories achieve performance standards close to the ideal of 0.5 percent false positives and 0.4 percent false negatives. Other laboratories had false positive rates greater than 4.7 percent and false negative rates greater than 9.3 percent. See *Washington Post*, October 27, 1987, at 5.
 34. In New Jersey, inmates have filed suit seeking strict confidentiality of all AIDS-related medical records. *Sheridan v. Fauver*, No. 85-3042 (U.S.D.C. N.J. filed Aug. 1985).
 35. In California, only the subject may receive the results of the test unless he or she gives written authorization for others to receive it. Written consent is required for each separate disclosure. Cal. Health & Safety Code sec. 199.21. In Wisconsin, the only legal recipients of test results are the subject, the subject's health-care provider, laboratory personnel and other staff of health-care facilities, and the state epidemiologist. Any disclosure to others requires a court order. Wisc. Stat. Ann. sec. 146.025 (West Supp. 1986).
 36. NIJ Study, note 2 above, at 58.
 37. *Id.*
 38. *Storms v. Coughlin*, 600 F. Supp. at 1223.
 39. *Dean v. Bowie*, No. 87-4745 (Suffolk Super. Ct. filed Aug. 27, 1987).
 40. NIJ Study, note 2 above, at 42.
 41. The court has found the roots of that right to privacy in the first amendment, *Stanley v. Georgia*, 394 U.S. 557 (1969) in the fourth and fifth amendments, *Terry v. Ohio*, 392 U.S. 1 (1969), in the penumbra of the Bill of Rights, *Griswold v. Connecticut*, 381 U.S. 479 (1965) and in the ninth amendment, *id.*, or in the concept of liberty guaranteed by the first section of the fourteenth amendment. *Meyer v. Nebraska*, 262 U.S. 390 (1923).
 42. *Roe v. Wade*, 410 U.S. 113, 152 (1973) citing *Palko v. Conn.*, 302 U.S. 319, 325 (1937).
 43. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).
 44. *Grummett v. Rushen*, 779 F.2d 491 (9th Cir. 1985); *Cumbey v. Meachum*, 684 F.2d 712 (10th Cir. 1982); *Dawson v. Kendrick*, 527 F. Supp. 1252, 1316-17 (E.D.W. Va. 1981); *Bowling v. Enomoto*, 514 F. Supp. 201 (N.D. Cal. 1980).
 45. *Forts v. Ward*, 471 F. Supp. 1095 (S.D.N.Y. 1979) vacated in part 621 F.2d 1210 (2d Cir. 1980); *Hudson v. Goodlander*, 494 F. Supp. 890, 894-95 (D. Md. 1980).
 46. The constitutions of the states of Alaska, Arizona, California, Florida, Hawaii, Illinois, Louisiana, Montana, South Carolina and Washington contain privacy provisions. In some other states (including Georgia, Idaho and Massachusetts), the right to privacy has been judicially recognized. See also 1987 *Lesbian/Gay Law Notes* 1 (Minnesota); 1986 *Lesbian/Gay Law Notes* 71 (Kentucky).
 47. *Committee to Defend Reproductive Rights v. Meyers*, 29 Cal.3d 252 (1981).
 48. *City of Santa Barbara v. Adamson*, 27 Cal. 3d 123 (1980).
 49. *Board of Medical Quality Assurance v. Gherardini*, 93 Cal. App. 3d 669 (1979).

50. *See In re Long*, 127 Cal. Rptr. 732 (App. 1976). *See also* *Sterling v. Cupp*, 625 P.2d 123 (Or. 1981)(prisoners' privacy protected under Oregon constitution).
51. NIJ Study, note 2 above, at 41.
52. The NIJ Study revealed that 27 percent of responding jail systems segregate all seropositive inmates and an additional 30 percent make case-by-case determinations. The incidence of segregation of prisoners with AIDS or ARC is still higher. *See* NIJ Study, note 2 above, at xxii. The study notes that the 27 percent figure is a decrease from 41 percent the previous year.
53. In one case, conjugal visits were denied. *See Doe v. Coughlin*, 125 A.D.2d 783, 509 N.Y.S.2d 209 (1986), *aff'd*, 56 U.S.L.W. 2330 (1987).
54. In *Jones v. North Carolina Prisoners' Labor Union*, 433 U.S. 119 (1977), the court held that prison administrators were justified in restricting the right to group worship.
55. On the other hand, some inmates have filed actions seeking separate housing for those who test positive (*see La Rocca v. Dalsheim*, 120 Misc. 2d 697, 467 N.Y.S.2d 302 (N.Y. Sup. 1983); *Herring v. Keeney*, (U.S.D.C. Or., filed Sept. 17, 1985); *Sheppard v. Keeney*, (U.S.D.C. Or. filed Oct. 7, 1985); *Malport v. Keeney*, (U.S.D.C. Or. filed Oct. 11, 1985); *Telepo v. Fauver*, No. 85-1742A (U.S.D.C. N.J. filed April 15, 1985)) or seeking mass screening of inmates, *Potter v. Wainwright*, No. 85-1616-CIV-T15 (U.S.D.C. Fla. Mid. D.). Other inmates have filed suit to prevent homosexuals from working in the prison food service and to obtain protection against homosexuals spreading HIV infection through assaultive and consensual acts. *Stalling v. Cane*, (Fla. 2d Cir., DeLeon County). Finally, one inmate has claimed severe emotional distress as a result of being housed in the same unit with ARC inmates. *Yates v. Lewis*, No. CIV-86-1538-PHX (U.S.D.C. Ariz.). *See also* *Foy v. Owens*, No. 85-6909, slip. op. (E.D. Pa. Mar. 19, 1986)(inmate claimed right to be free from exposure to AIDS but court dismissed claim as frivolous).
56. *See San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 4-5, 9-10 (1973)(strict scrutiny applied to constitutional claims brought under equal protection clauses by class of poor families challenging state system for financing public education based on local property tax).
57. *See Graham v. Richardson*, 403 U.S. 365, 376 (1971)(statutes providing different welfare benefits to aliens and non-aliens subject to strict scrutiny under equal protection clause); *McLaughlin v. Florida*, 379 U.S. 184, 196 (1964)(state statute prohibiting co-habitation of whites and blacks to be invalid subject to strict scrutiny by court).
58. *See Mississippi University for Women v. Hogan*, 458 U.S. 718, 723-27 (1982)(court found discriminatory admissions practice unconstitutional where male sought admissions to all female university nursing school, applying heightened standard of review); *Gomez v. Perez*, 409 U.S. 535 (1973)(state classification providing that only legitimate children had judicially enforceable rights to support from natural fathers struck down under middle tier standard of review).
59. *See Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 312 (1976)(age classification subject to rational basis test); *see also* *City of Cleburne v. Cleburne Living Center*, 105 S. Ct. 3249, 3255-58 (1985)(mentally retarded not a suspect class).
60. *See Bowers v. Hardwick*, 106 S. Ct. 2841, 2844 (1986)(denying that right to engage in homosexual sodomy is fundamental); *see also* *Cordero v. Coughlin*, 607 F. Supp. 9, 10 (S.D.N.Y. 1984)(persons with AIDS not a "suspect class").
61. *See Cordero v. Coughlin*, 607 F. Supp. (segregation of prisoners with AIDS bears rational relation to legitimate governmental objectives of safeguarding them from threats and violence and similarly protecting others).
62. *See Judd v. Packard*, 669 F. Supp. 741 (D. Md. 1987)(segregation justified as part of a "program of AIDS prevention"); *Doe v. Coughlin*, note 53 above (denial of access to conjugal visit program rational as a means of preventing the transmission of AIDS); NIJ Study, note 2 above, at xxiv.
63. *See Cordero v. Coughlin*, note 60 above; *Powell v. Department of Corrections*, 647 F. Supp. 968 (N.D. Okla. 1986) (court dismissed seropositive inmates' 14th Amendment claim challenging his segregation from the general prison population, citing protection of other inmates from spread of the disease).
64. *See Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983) *cert. denied*, 468 U.S. 1217 (1984); *Todaro v. Ward*, 565 F.2d 48, 54 (2d Cir. 1977)("policy of deference to state officials is less substantial when ... matters of prison discipline and security are not at issue"); *Burks v. Teasdale*, 492 F. Supp. 650, 655 (W.D. Mo. 1980); *Guglielmoni v. Alexander*, 583 F. Supp. 821, 826-27 (D. Conn. 1984). *See also* *Whitley v. Albers*, 106 S. Ct. 1078, 1084-86 (1986)(discussed below in medical section). Although these cases all deal with the right to medical treatment, it is arguable that less deference would also be paid when a medical justification is given for housing or program denial.
65. Nonetheless, such an argument was accepted by one court in approving a ban on conjugal visits by prisoners with AIDS because "the possible risk of transmission from close contact with an AIDS sufferer remains an unresolved question of great concern." *Doe v. Coughlin*, 509 N.Y.S.2d at 212.
66. *Cordero v. Coughlin*, 607 F. Supp. at 10. If sex among inmates is raised by the administration as a rationale for segregating seropositive inmates, *see LaRocca v. Dalsheim*, note 28 above, at 702(court orders distribution of AIDS brochure noting that "the dissemination of information among inmates may reduce the incidence of prison sex").
67. This section focuses solely on the rights of convicted persons. For *pre-trial detainees*, it must be established that the conditions of confinement deny substantive due process by subjecting such prisoners to "genuine privation and hardships over an extended period of time" or to restrictions or conditions which are not "reasonably related to a legitimate goal." *Bell v. Wolfish*, 441 U.S. 520 (1979).
68. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976), *reh'g denied*, 429 U.S. 1066 (1977). *See* section III on medical care below.

69. Double-celling of prisoners alone, however, does not make prison conditions cruel or unusual. *Rhodes v. Chapman*, 452 U.S. at 347-49.
70. See *Spain v. Procunier*, 600 F.2d 189, 199-200 (9th Cir. 1979).
71. See also *Hoptowit v. Spellman*, 753 F.2d 779, 783 (9th Cir. 1985) (district court must consider and decide whether each condition amounts to unnecessary and wanton infliction of pain).
72. See, e.g., *Bell v. Wolfish*, 441 U.S. 520 (1979) (first and fourth amendments, due process claims); *Kincaid v. Rusk*, 670 F.2d 737 (7th Cir. 1982) (first amendment claim); *Smith v. Jordan*, 527 F. Supp. 167 (S.D. Ohio 1981) (fourth amendment claim); *Dawson v. Kendrick*, 527 F. Supp. 1252 (S.D.W. Va. 1981) (procedural due process, sixth amendment, equal protection claims). But see *Hewitt v. Helms*, 459 U.S. 460, 103 S.Ct. 864, 869-70 (1983) ("the transfer of an inmate to less amenable and more restrictive quarters for nonpunitive reasons is well within the terms of confinement ordinarily contemplated by a prison sentence") and *Turner v. Safley*, discussed in sec. 1A(2) above (limited test for correspondence).
73. *Parratt v. Taylor*, 451 U.S. 527, 540 (1981).
74. *Wolff v. McDonnell*, 418 U.S. 539, 558 (1974).
75. *Meachum v. Fano*, 427 U.S. 215, 223-24 (1976).
76. See generally *Project: Criminal Procedure* note 3 above, at 983-84.
77. *Quick v. Jones*, 754 F.2d 1521, 1523 (9th Cir. 1985).
78. See *Mathews v. Eldridge*, 424 U.S. 319, 334-35 (1976).
79. See *NIJ Study*, note 2 above, at xxiv.
80. *School Board of Nassau County v. Arline*, 478 U.S. ___, 107 S.Ct. 1123, 94 L. Ed. 2d 307 (1987).
81. See *Doe v. Coughlin*, 509 N.Y.S.2d at 212.
82. See discussion accompanying note 64 above.
83. *Roba v. United States*, 604 F.2d 215 (2d Cir. 1979); *Knell v. Bensinger*, 522 F.2d 720 (7th Cir. 1975).
84. *Harris v. McDonald*, 555 F.Supp. 137 (N.D. Ill. 1982).
85. See, e.g., *United States ex rel. Hoover v. Franzen*, 669 F.2d 433 (7th Cir. 1982) (pendent jurisdiction not available under habeas corpus statutes).
86. In re *Davis*, 25 Cal. 3d 384, 158 Cal. Rptr. 384 (1979) (detention of prisoners in administrative segregation without a hearing violates their due process rights; writ of habeas corpus is proper method to enforce their rights).
87. See, e.g., In re *Riddle*, 57 Cal. 2d 848, 22 Cal. Rptr. 472 (1962).
88. *San Francisco Chronicle*, June 14, 1987, at 1 (medical and psychiatric care at the California Medical Facility at Vacaville violates inmates' constitutional rights "to be free from deliberate indifference to their serious medical needs" stated Assistant U.S. Attorney General William Bradford Reynolds in a letter to California Governor George Deukmejian).
89. Claims relating to the denial of medical care as a violation of the equal protection clause were discussed in the previous section.
90. See also *Burks v. Teasdale*, 492 F. Supp. 650, 655 (W.D. Mo. 1980).
91. See *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980), *aff. in part, rev. in part*, 679 F.2d 1115 (5th Cir.), *amended in part, vacated in part*, 688 F.2d 266, *cert. denied*, 460 U.S. 1042 (1983).
92. *Wellman v. Falkner*, note 64 above, at 273 (weighs against the state the facts that a psychiatric position remained vacant for two years and the authorized salary was "woefully inadequate"). See also *Guglielmoni v. Alexander*, 583 F. Supp. at 826-28.
93. *Benson v. Cady*, 761 F.2d 335, 340-41 (7th Cir. 1985).
94. *Johnson v. Treen*, 759 F.2d 1236, 1238 (5th Cir. 1985).
95. *McCarthy v. Weinberg*, 753 F.2d 836, 839 (10th Cir. 1985).
96. *Fields v. Gander*, 734 F.2d 1313, 1314-15 (8th Cir. 1984).
97. *Hoptowit v. Ray*, 682 F.2d 1237, 1257-58 (9th Cir. 1982).
98. *Williams v. Treen*, 671 F.2d 892, 901 (5th Cir. 1982).
99. However, in some jurisdictions, including California, certain statutes allow for the ability of an inmate to see a physician of his or her own choice or to obtain a second medical opinion. See Cal. Civ. Code sec. 3354(b). These statutes and their implementing rules and regulations should be consulted and often provide a solution for those inmates in need of immediate transfer to an outside physician or hospital.
100. *Lewis v. Rockefeller*, 305 F. Supp. 258, 259, *aff'd*, 431 F.2d 368 (2d Cir. 1970).
101. *Geraghty v. U.S. Parole Commission*, 429 F. Supp. 737, 741 (M.D. Pa. 1977), *aff'd*, 719 F.2d 1199 (3d Cir. 1983) *cert. denied*, 465 U.S. 1103 (1984).
102. California Penal Code secs. 3040, 3049.
103. See *Commonwealth ex rel. Banks v. Cain*, 345 Pa. 581, 28 A.2d 897, 143 A.L.R. 1473 (1942); *Eisentrager v. State Board of Parole Commissioners*, 85 Nev. 672, 462 P.2d 40 (1969).
104. Federal prisoners must file such an application, for example. 28 CFR 2.11 (1987).
105. *N.Y. Times*, March 7, 1987, at 1.
106. These jurisdictions include New Jersey, Wisconsin, Kansas and District of Columbia. See Note, *Survey of Criminal Proce-*

dure, note 3 above. Statutes and caselaw in various states relevant to sentence modification are set forth in an appendix to this article.

107. Court Rule 3:21-10(b)(2). See *State v. Priester*, 99 N.J. 123, 491 A.2d 650 (1985).

108. ABA Comm. on Minimum Standards for Administration of Criminal Justice, Standards Relating to Sentencing Alternatives and Procedures, sec. 6.2 (Approved Draft 1968).

109. California Penal Code sec. 1170(d).

110. 18 U.S.C. 4205(g)(1976) ("At any time upon motion of the Bureau of Prisons, the court may reduce any minimum term to the time the defendant has served.")

111. This provision also applies within 120 days after affirmance of the judgment or dismissal of the appeal, or within 120 days after entry of any order or judgment of the Supreme Court denying review of or upholding a conviction or probation revocation.

112. *Sollesbee v. Balkcom*, 339 U.S. 926, 70 S. Ct. 618 (1950).

113. *Moore v. Lawrence*, 192 Ga. 441, 15 S.E.2d 519, 521 (1941).

114. *Egan v. United States*, 268 F.2d 820, 824, cert. denied 361 U.S. 868 (1959).

115. *Ex Parte Chain*, 210 Miss. 415, 49 So. 2d 722, 725 (1951) ("the responsibility for determining whether the petitioner is a fit subject for clemency, whether because of the condition of his health he should be pardoned ... is a responsibility that rests upon the governor.")

116. See Note, Survey of Criminal Procedure - Modification of Sentences, 30 Rutgers L. Rev. 657, 672-73 (1977) (citing Goldfarb & Singer, After Conviction 330, 340 (1973)).

117. See, e.g., Cal. Penal Code sec. 4852.01 et seq.

Appendices

1. Reduction or Change of Sentence.

2. AIDS in Jails and Prisons, The Exchange (National Lawyers Guild AIDS Network, Dec. 1986).

APPENDIX 1

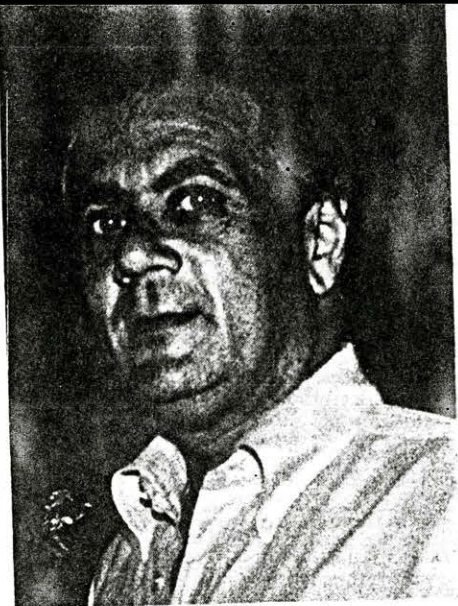
Wisconsin, Kansas, and the District of Columbia allow reduction or change of sentence "at any time" in specified circumstances. See *State v. Wuensch*, 69 Wis. 2d 467, 480, 230 N.W.2d 665, 671-72 (1975) (modification on application of the defendant based on new factors or an abuse of discretion); *Kutcher v. State*, 69 Wis. 2d 534, 552-53, 230 N.W.2d 750, 760 (1975) (modification

because of change of law); D.C. Code sec. 24201(c)(1967) (modification of minimum sentence to time served on application of correctional authorities, except for conviction of assault with intent to rape or armed robbery after prior conviction for crime of violence); Kansas Stat. sec. 21-4603 (Supp. 1975) (modification of minimum sentence to time served on recommendation of Secretary of Corrections).

Most jurisdictions allowing reduction or change of sentence provide a specific time period within which such change may occur. ABA Comm. on Minimum Standards for Administration of Criminal Justice, Standards Relating to Sentencing Alternatives and Procedures, sec. 6.1(a) commentary (Approved Draft 1968). See, e.g., Ariz. Rev. Stat. ch. 17, sec. 24.3 (1973) (within 60 days after entry of judgment but before appeal filed); Ill. Ann. Stat. ch. 38, sec. 1005-8-1(d) (Smith-Hurd 1973) (within 30 days after imposition of sentence); Fed. R. Crim. Pro. 35 (within 120 days of imposition of sentence or resolution of appeal); Fla. R. Crim. Pro. 3.800 (within longer of the same term of court or 60 days from imposition or resolution of appeal).

Some jurisdictions follow the old common law rule, allowing change of sentence only during the term of court, until service of sentence has begun. See, e.g., Mich. Stat. Ann. sec. 28.1097 (1972); *People v. Fox*, 312 Mich. 577, 581, 20 N.W.2d 732, 733 (Sup. Ct. 1945). Some jurisdictions allow no change of sentence other than to correct error. See, e.g., Vt. R. Crim. Pro. 36 (change only to correct clerical error).

The constitutionality of the "at any time" provisions of the New Jersey motion to reduce sentence has been upheld. *State v. Robinson*, No. A-2669-75 (N.J. Super. Ct. App. Div. Mar. 17, 1977), rev'g 140 N.J. Super. 459, 356 A.2d 449 (Law Div. 1976).



Barney Frank, featured speaker at les/gay immigration forum.

and Immigration, Congressman Barney Frank, lawyer Richard Iandoli and the U.N. High Commissioner for Refugees, Fernando Chang-Muy.

The event, which is free, will take place at the Univ. of Mass., 250 Stuart St., Room 222. For more information, call GLAD at 617/426-1350.

□ Stephanie Poggi

Rights of seropositive prisoners

SAN FRANCISCO — *The Exchange*, a publication of the National Lawyers Guild AIDS Network, notes that "after a series of defeats, there have been several recent cases protecting the rights of seropositive prisoners."

Two of these cases involved the right to privacy, specifically protection against non-consensus disclosure of a prisoner's diagnosis. In *Doe v. Coughlin*, (N.D.N.Y.) 1988) a federal district court granted a preliminary injunction against the involuntary transfer of seropositive prisoners to a segregated dorm because the transfer would result in the disclosure of their HIV status. The court held that "there are few matters of more personal nature, and there are few decisions over which a person could have a greater desire to exercise control, than the manner in which he reveals [an HIV seropositive] diagnosis to others.... Within the confines of the prison, the infected prisoner is likely to suffer from harassment and psychological pressures. Beyond the prison's walls, the person suffering from AIDS is often subject to discrimination." (Memorandum decision of Oct. 14, 1988)

Similarly, a federal district court in Wisconsin held that prisoners have a constitutionally protected right of privacy with regard to medical records (*Woods v. White*, 689 F. Supp. 874 — W.D. Wis.1988).

A third court held that the exclusion on medical grounds of a prisoner with AIDS

Carolina, Black and White Men Together (BWMT) of Los Angeles, and the Asian AIDS Project of San Francisco.

"It's easy for AIDS to reach minority groups concentrated in our cities, but it's difficult for AIDS education to reach them," said Thomas Cochran, director of the Mayor's Conference. "This is why our grants go to the local community groups who demonstrate that they are in touch with the people whose behavior puts them at risk, that they can reach these people in schools, on the streets, in bars, or wherever they may be."

Richard Asch of Stop AIDS Chicago — which received a \$40,000 grant for an education project aimed at gay Latino and other minority youth—praised the grant. "It's a tremendously important for the government to acknowledge that there is a group called gay Latinos and that it needs AIDS education.... It's not everything we need but it's a good start," Asch told *GCN*.

Asch said Stop AIDS Chicago has not experienced problems with the "Helms amendment," a federal law authored by Sen. Jesse Helms (R-N.C.), that forbids federal funds for organizations that "promote homosexuality." The law requires that local review boards review all materials developed by AIDS groups. Review boards include representatives of local health departments, civic organizations, substance abuse clinics and other groups involved in AIDS prevention in the cities. Asch said "So far we have not run into problems presenting educational material to targeted populations. I think most health officials, including those at the Centers for Disease Control, support our work."

□ Chris Bull

Girl power

BERLIN, West Germany — Fifteen young women between the ages of 14 and 21 have been editing a magazine for girls called *The Little Witch* (*Die kleine Hexe*). According to a translation in the most recent issue of *Connexions* of a 1984 article in the West



Die kleine Hexe

camera and wrote one page of the script time. Then we started filming." The consists of a dramatization of the meeting a girl group in which problems of young women are discussed, interspersed scenes illustrating the problems in real life. The film won a national student film festival award.

The girls say they hope their story "inspire other girls to resist. For our future we wish to gain much more power."

□ Stephanie P

Local legal group seeks board members

BOSTON — Gay and Lesbian Advocates and Defenders (GLAD), New England public interest legal foundation for lesbian and gay rights, seeks members for its Board of Directors. Members will work with a committed group of women and men growing and dynamic organization does cutting edge work in areas such as AIDS discrimination, foster care, violence and civil rights," according to GLAD.

Board meetings are monthly and members serve on Board committees. GLAD is looking for people with an interest and some experience in financial management, personnel, and fundraising. People of all ages and backgrounds are especially encouraged to respond. Send a resume or other information about relevant experience and a cover letter to Board Search, GLAD, P.O. Box 218, Boston, MA 02111, January 15, 1989. For further information call (617) 426-1350.

□ Cindy

Help sisters say it

BOSTON — "Say it, Sister!," a public affairs call-in program on WMFO 88.1 FM provides a forum for local women to explore their talents and issues in a supportive setting. It has been broadcast nearly three years with community support and the current production group wants you to become a part of this vital role by contributing to fundraising recruiting drives now in progress. We need to raise \$1500 for a tape editing machine \$800 for high quality reel tape for the studio. We also invite women interested in the collective production group or in airing an issue to drop us a line.

Donations or messages can be left for "Say it, Sister!" Box 426, Cambridge 02139. The collective can also be reached by leaving a message for Ellen Reynolds at 617/576-1502.

Shows in January include discussion of the housing crisis, with Barbara Nettie Diaz's recent trip to Cuba; and experiences of incarcerated women.

NEWSNOTES

Quote of the week

"Boy, I sure hope people apply for all the jobs we need filled here at the paper."

— Frequently stated around the office at GCN by staff members.

Boston immigration law forum

BOSTON — A forum on how U.S. immigration law affects gay men and lesbians will be held January 17 at 7:30 p.m. Sponsored by the Gay and Lesbian Advocates and Defenders (GLAD) of Boston and the Alliance of Mass. Asian Lesbians and Gay Men, the event will present information on how U.S. law allows for exclusion of gay people and people with AIDS/ARC or HIV-positive status. Also discussed will be how to apply for permanent residency status and HIV testing requirements. In addition, an update on the Immigration Reform Act will be offered and there will be a question-and-answer period.

Panelists at the forum are Doralba Munoz-Godales of the Office for Refugees

from a furlough program violated the equal protection clause. The court said that the denial was based on generalizations and possibly false assumptions (*Lopez v. Coughlin*, 139 Misc. 2d 851q — N.Y. Sup. Ct. 1988). "In general it is easier to attack a prison administration action based on medical grounds as opposed to security grounds," said Ken Stephens, of Prisoners Legal Services of New York, 2 Catharine St., Poughkeepsie, NY 12601.

□ Mike Riegler

Mayors allocate annual AIDS grants

WASHINGTON — The U.S. Conference of Mayors Dec. 5 announced \$913,000 in grants to 23 community-based AIDS education groups around the country. Since its inception in 1983, the Conference's AIDS Prevention Program has awarded \$2.5 million in grants to 88 organizations, using funds provided by the federal Centers for Disease Control (CDC).

Groups awarded grants this year include: the Austin Latino Lesbian and Gay Organization (ALLGO), Stop AIDS Chicago, the PWA Coalition of Dallas, Migrant Family Health Services in North Carolina, Black and White Men Together (BWMT) of Los Angeles, and the Asian AIDS Project of San Francisco.

"It's easy for AIDS to reach minority groups concentrated in our cities, but it's difficult for AIDS education to reach them," said Thomas Cochran, director of the Mayor's Conference. "This is why our grants go to the local community groups who demonstrate that they are in touch with the people whose behavior puts them at risk, that they can reach these people in schools, on the streets, in bars, or wherever they may be."

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German *Emma*, the editors of *The Little Witch* say they began their magazine because "[W]e were simply fed up with having to justify why we wanted to talk and to write about girl-specific issues in mixed school groups and papers.... We spontaneously decided to form a girls-only group at our school." After a year of meeting, they came up with the idea of producing a magazine — as a way to present their issue publicly and to reach other young women in West Berlin.

The group wrote articles about sexual harassment by teachers and fellow students, violence against women, masturbation and birth control. They solicited ads and articles and organized the distribution of the paper in front of eight different schools. Then, according to the editors, "The magazine hit like a bomb. In the subway people talked about it. At school everybody talked about it. Parents ran amok. Girls had dared to put out their own paper. They had written openly about their own sexuality. At special meetings, parents deliberated about how to prohibit our publication. Anonymous callers threatened our ad clients.... We were a smashing success."

The Little Witch went on to attract 20 new girls from other schools and in 1982 won first prize in a youth magazine contest. The group also produced a film called *Girls' Power* ("We simply borrowed a Super-8 camera and wrote one page of the script at a time. Then we started filming."). The film consists of a dramatization of the meeting of a girl group in which problems of young women are discussed, interspersed with scenes illustrating the problems in real life. The film won a national student film festival award.

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U.S.; and music from American orchestra

N.E. Community Research launched

BOSTON — At sessions and AIDS at Boston's Club Cational meeting for Research. The develop and conduct explore the efficacy aggressive therapies in gression of HIV in

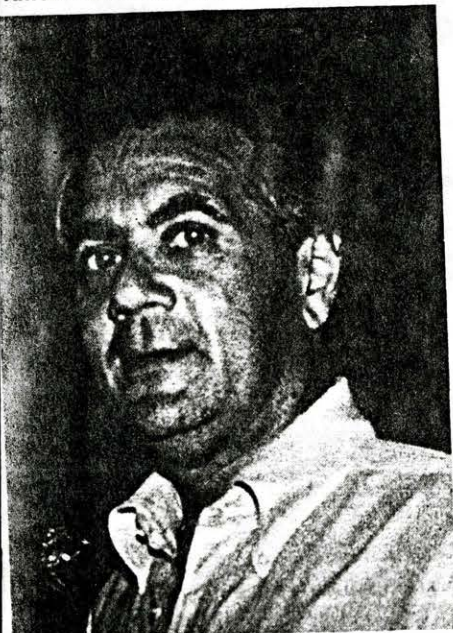
Issues to be meetings include:

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3. the development based research ini

To participate tional meetings, magazine, (617) 4 at Fenway Comm 267-7573.



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JOHN C

Robin Dietrich
Box 9007

Framingham MA 01701
enjoys reading, writing, drawing, poetry etc

Cynthia Lorne Williams

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AC Status

1479 Collins Ave
Mansville Ohio 43040

**National Institute
of Justice**

Research in Brief

February 1986

AIDS in Prisons and Jails: Issues and Options

Theodore M. Hammett

Acquired Immunodeficiency Syndrome (AIDS) has rapidly become one of the most difficult and complex public health issues facing the United States. Since AIDS was first identified in this country in 1981, over 17,000 Americans have developed the disease. The rapid increase in cases, particularly in the past 2 years, and the continued uncertainties as to the future course of the disease's spread have led the President to term AIDS "the Nation's number one health priority."

In the correctional context, dealing with the problem of AIDS may pose

even more difficult problems since inmate populations may include high proportions of individuals in AIDS risk groups, particularly intravenous drug users. Correctional administrators must formulate policies that allow them to manage their institutions effectively, while dealing with a serious health problem that may cause fears among staff and inmates. Administrators face difficult decisions concerning prevention, housing, and the provision of medical care, decisions which are frequently complicated by legal and cost issues.

In response to urgent information needs expressed by corrections professionals, the National Institute of Justice and the American Correctional Association sponsored a study entitled *AIDS in Correctional Facilities: Issues and Options*. The study was based, in large part, on responses to a national mail questionnaire from all 50 State correctional departments, the Federal Bureau of Prisons, and 33 large city and county jail systems. The responses were received between November 1985 and January 1986.

From the Director

Acquired Immunodeficiency Syndrome (AIDS) represents a serious challenge for American correctional systems.

Recognizing that many inmate populations contain a high concentration of individuals at risk for the disease—primarily because of histories of intravenous drug use and, to a lesser degree, homosexual behavior—correctional administrators are concerned with developing effective policies to ensure the health and safety of both inmates and staff.

Often already coping with crowded institutions and limited budgets, they face difficult decisions regarding prevention, institutional management, and the identification and treatment of inmates with AIDS. These decisions are further complicated by a range of legal

issues, the high costs of medical care, and the need to control fear and misinformation throughout the institution.

Recognizing the potential scope of these problems, many correctional administrators have expressed interest in receiving information that can help them in formulating policies on AIDS. To address this need, the National Institute of Justice and the American Correctional Association jointly sponsored the development of a report entitled *AIDS in Correctional Facilities: Issues and Options*.

Given the urgency of the need, the study was an intensive effort, conducted over a 4-month time period. In addition to the dedication of the project director, Theodore M. Hammett, the cooperation of the National Institute of Corrections, the Association of State Correctional Administrators, the Centers for Disease

Control, and the American Correctional Association should be recognized.

This *Research in Brief* summarizes the major findings and conclusions of the full report. Like the full report, it is intended to be informational rather than prescriptive.

Certain principles, such as the importance of inmate and staff education on AIDS, are indisputable. Still, there are many other issues and policy questions that continue to spur debate both within and between the correctional and medical communities.

By outlining these debates and providing the most current information available, the National Institute of Justice and ACA hope that correctional administrators will be better equipped to deal with the problem of AIDS.

James K. Stewart
Director
National Institute of Justice

The study summarizes the latest medical information on AIDS, presents statistics on the incidence of AIDS in correctional facilities, and enumerates the key issues and options facing correctional administrators as they formulate policy responses to this complex problem. This Research in Brief summarizes the major findings and conclusions of that report.

Cause and transmission of AIDS

AIDS is a serious communicable disease that undermines the human body's ability to combat infections. In 1983 and 1984, the probable cause of AIDS—variously called human t-cell lymphotropic virus type III (HTLV-III) and lymphadenopathy-associated virus (LAV)—was identified. Thus far, most cases in the United States have been among homosexuals and intravenous drug abusers, with cases primarily concentrated in large metropolitan areas on the east and west coasts.

End-stage AIDS is almost always fatal. However, a range of milder forms of illness, sometimes called AIDS-Related Complex (ARC), may also appear among those infected with the AIDS virus.

Infection with HTLV-III is transmitted through contaminated blood and semen, primarily during sexual activity and needle-sharing related to intravenous drug abuse. The virus is difficult to transmit and there is absolutely no evidence of its transmission through casual contact, such as coughing, hugging, handshaking, sharing eating and drinking utensils, or using the same toilet facilities.

In 1985, a test was developed and made widely available to detect the presence of antibodies (evidence of the body's attempt to fight off an infection) to HTLV-III. While the test does not detect the presence of the virus itself, seropositivity (i.e., presence of antibodies) means that an individual has been infected with the AIDS virus at

some time, although the body may have subsequently fought off the infection.

The likelihood that HTLV-III seropositivity means current infection with the virus is considered much greater for individuals in identified AIDS risk groups (e.g., homosexual or bisexual males, intravenous drug abusers). Nevertheless, seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS.

Currently, the Centers for Disease Control (CDC) estimate that 5 to 6 percent of seropositive individuals will develop end-stage AIDS while another 25 percent will develop ARC. However, recent research suggests that the percentage of seropositive individuals who will develop AIDS may be somewhat higher. Moreover, CDC cautions that seropositive individuals

may be able to transmit the infection to others, even if they never develop symptoms themselves. Exhibit 1 summarizes the relationships among exposure, infection, seropositivity, ARC, and AIDS.

AIDS in the correctional population

Responses to the study questionnaire reveal that, since 1981, there have been a cumulative total of 455 confirmed AIDS cases in 25 State and Federal prison systems. Twenty large city and county jail systems reported 311 cases of AIDS among inmates. These figures represent *cumulative* total cases since the responding jurisdictions began keeping records.

As of the period November 1985 to January 1986, there were 144 cases of

Exhibit 1

Relationships among exposure, infection, HTLV-III seropositivity, and development of ARC or AIDS

Stage	Meaning	Relationship to previous stage(s)
Exposure	Individual has contact with HTLV-III in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	—
Infection	Individual is infected with HTLV-III. Infection may be permanent or body may successfully combat the virus.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HTLV-III. Infection has occurred at some time in the past, but date of infection or whether individual remains infected cannot be determined.	CDC considers the HTLV-III antibody test a reliable indicator that infection has occurred at some time. Repeat and confirmatory testing increase reliability.
ARC	A combination of conditions that together give evidence of infection with AIDS virus.	About 25 percent of seropositive individuals will probably develop ARC (CDC estimate). This estimate is uncertain due to the lengthy incubation period.
AIDS	Illness characterized by one or more opportunistic infections at least moderately indicative of underlying cellular immunodeficiency.	About 5 to 6 percent of seropositive individuals will probably develop AIDS. (CDC estimate). Recent studies place the fraction as high as one-third. Again, all estimates are uncertain due to the lengthy incubation period.

Opinions or points of view expressed in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

AIDS among State and Federal inmates in 19 systems and 35 cases among city and county inmates in 11 systems.

No known AIDS cases have occurred among correctional staff as a result of contact with inmates. Questionnaire respondents reported nine cases of AIDS among current or former staff, but none of these individuals had been involved in an incident with an inmate in which transmission of the AIDS virus might have occurred. Indeed, most were known or suspected to have been in AIDS risk groups.

The distribution of AIDS cases across correctional systems is highly skewed (Exhibit 2). Fifty-one percent of the prison systems have had *no* cases and 80 percent have had fewer than four cases. Among responding city and county jail systems, 39 percent have had no cases and 70 percent have had fewer than four cases.

At the other extreme, two State prison systems and only one of the responding city and county jail systems have had more than 50 cases. The regional distribution is also highly uneven. Over 70 percent of the cases, both in State prison systems and in city and county jail systems, have occurred in the mid-Atlantic region, with all other parts of the United States contributing much smaller percentages.

The vast majority of correctional AIDS cases, particularly in jurisdictions with large numbers of cases, are believed to be associated with prior intravenous drug abuse. There is substantial debate, but little hard data, on the extent to which the AIDS virus is being transmitted within correctional institutions. The two primary means of transmission are prohibited behavior in all corrections systems. However, logic and common sense suggest that, even in the best-managed correctional facilities, there may be at least some transmission of the infection occurring among inmates.

Correctional policy issues and options

The major policy areas involved in the correctional response to AIDS are education and training; HTLV-III antibody testing; and medical, legal, and correctional management issues.

Exhibit 2

Distribution of cumulative total AIDS cases among inmates, by type of system

Range of total AIDS cases	State/Federal prison systems		City/county jail systems	
	n systems	%	n cases	%
0	26	51%	0	0%
1-3	15	29	24	5
4-10	5	10	30	7
11-25	2	4	42	9
26-50	1	2	33	7
51-100	1	2	95	21
> 100	1	2	231	51
TOTAL	51	100%	455	100%

Source: NIJ/ACA questionnaire responses

^a Due to rounding

Education and training

Because there is no vaccine or cure for the disease, education and training programs are the cornerstone of efforts to curb the spread of AIDS in prisons and jails, as well as in the population at large. Education and training programs also provide the opportunity to counteract misinformation, rumors, and fear concerning the disease. For example, the majority of systems responding to the questionnaire reported that inmates and staff worried about the possibility of contracting AIDS; many responses referred to fear of casual contact or types of contact not actually associated with transmission of the virus.

As a result, many correctional administrators feel strongly that education and training are not options but absolute requirements. Ninety-three percent of the responding jurisdictions currently offer or are developing AIDS educational programs for staff; 83 percent offer or are developing such programs for inmates.

Among respondents whose educational programs have operated for some time,

the vast majority believe these programs to be effective in reducing the fears of staff and inmates. Several jurisdictions reported that timely educational efforts had successfully averted threatened job actions by correctional staff unions.

Experience suggests that training and education programs should be instituted before deep-seated fears have developed, and repeated periodically so that the latest medical information can be presented and new staff and inmates can be reached on a timely basis.

Effective education programs may include live presentations by training teams, printed materials, and videotapes. Program curricula and materials should be brief, clear, and straightforward and tailored to the particular knowledge gaps and concerns of the audience. They should discuss the means of transmission of the AIDS virus and emphasize everyone's responsibility to avoid behaviors known to be associated with transmission. They should also guard against encouraging a false sense of security in

any group. At the same time, programs should not create needless fear by advocating unnecessary precautionary measures.

HTLV-III antibody testing

There is substantial debate, both in corrections and in society at large, surrounding the uses of the HTLV-III antibody test and the meaning of the test results. The most controversial testing application in corrections is mass screening: the testing of all inmates or all new inmates, regardless of the presence of symptoms or other clinical indications.

Correctional policies on HTLV-III antibody testing. Only four State correctional systems (Nevada, Colorado, Iowa, and Missouri) have implemented or plan to implement mass screening programs for inmates; no city or county systems responding to the questionnaire have instituted or planned such programs. However, almost 90 percent of the responding jurisdictions do employ testing for more limited purposes. These include testing of risk-group members, testing in support of diagnoses of AIDS or ARC, testing in response to incidents in which the AIDS virus might have been transmitted, testing on inmate request, and testing carried out as part of anonymous epidemiological studies. Exhibit 3 summarizes study findings on correctional testing policies.

Mass screening: the debate. The debate over mass screening for antibody to HTLV-III in correctional institutions involves the following major questions:

- *Should correctional systems take steps not being taken in the community at large?*

Proponents of testing argue that rates of HTLV-III seropositivity are higher among inmates and that the virus is likely to be transmitted within institutions; they believe that screening is necessary to identify infectious individuals and to target prevention programs.

Opponents argue that there is no proof of higher rates of HTLV-III transmission in prison and therefore there is no legitimate reason to screen.

Policy category	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Mass screening (all or all new inmates)	4	8%	0	0%
• Screening of risk groups	2	4	7	21
• Testing <i>only</i> for diagnoses, incident response, or epidemiological studies	39	77	20	61
• Testing <i>only</i> on inmate request	1	2	1	3
• No testing	5	10	5	15
TOTAL	51	101% ^b	33	100%

^aIncludes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening of risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiology studies.

^bDue to rounding.

- *What are the policy implications of identifying seropositive individuals?*

Proponents of screening argue that seropositive individuals must be identified so they can be given special supervision, counseling, and other programming.

Opponents argue that mass identification of seropositives would serve no purposes not better addressed by educational programs and would, in fact, create significant correctional management problems—particularly if large numbers of seropositives were identified and there was irresistible pressure to segregate them.

- *How would mass screening affect education and prevention programs?*

Proponents argue that screening is necessary to inform and target education and prevention programs.

Opponents argue that screening needlessly and misleadingly divides the inmate population into a stigmatized class and a "safe" class, thereby undermining the important educational message that everyone should be careful.

- *Is it possible to develop a reliable and confidential screening program?*

Proponents argue that the antibody test is reliable and that confidentiality of results can be maintained.

Opponents argue that the test results are often unreliable and that real and rumored results would inevitably become known to the inmate population and others outside the institution, potentially subjecting actual or supposed seropositives to threats and intimidation while in prison and to discrimination in housing, employment, and insurability after discharge.

- *What are the legal implications of screening?*

Proponents argue that mass screening is legal and proper and, in fact, that failure to conduct mass screening may result in serious legal liabilities.

Opponents point out that laws and policies requiring subjects' informed consent for HTLV-III antibody testing preclude mandatory mass screening and suggest that liability issues can be effectively managed.

● *What are the costs of mass screening?*

Proponents of screening argue that the test can be economically administered.

Opponents argue that when the costs of repeat and confirmatory tests and the costs of separate correctional programming for seropositives are included, the total price could become prohibitive, particularly for large systems and/or those likely to identify large numbers of seropositive inmates.

● *Will mass screening allay or inflame fears?*

Proponents argue that screening could help to calm the concerns of inmates and staff if it found low rates of seropositivity. Moreover, regardless of the seropositivity rates, failure to screen could cause serious public relations problems.

Opponents argue that mass screening will needlessly inflame fears, particularly if the seropositivity rate is found to be high.

● *Are there feasible alternatives to screening?*

Proponents argue that screening is the best method of obtaining the necessary information on HTLV-III seropositivity and transmission.

Opponents argue that there are better ways to identify high-risk individuals and diagnose AIDS and ARC that avoid the negative consequences of mass screening. These include astute medical surveillance and alternative laboratory work for diagnoses.

In addition, anonymous epidemiological studies may permit estimation of HTLV-III seropositivity and transmission rates while avoiding the correctional management and confidentiality problems of mass screening.

Implementation issues. Correctional administrators who decide to implement any mass or selective testing program face a range of issues, including when and where to administer the test, and whether testing should be voluntary, mandatory, or on request.

In 60 percent of the responding jurisdictions, all testing is either voluntary or on inmate request. In 15 percent of the jurisdictions, all testing is mandatory.

There are serious legal and ethical issues involving both whether inmates can be compelled to submit to testing and whether they have a right to testing on request. Laws in some jurisdictions (e.g., California and Wisconsin) prohibit HTLV-III antibody testing without the informed consent of the subject.

Those who oppose mandatory testing argue that, because of the potentially serious negative effects of testing (e.g., discrimination in housing, employment, insurability), medical ethics require that there be a right of refusal, regardless of law or policy.

Some also argue that correctional systems have an obligation to provide the test to any or all inmates who request it. However, if such testing is provided, many physicians believe that inmates should be fully and accurately informed of the potential personal and psychological effects of testing before they make any decisions and that those who are tested be counseled on the meaning and implications of the results.

Medical, legal, and correctional management issues

Correctional administrators responding to the challenging problem of AIDS in prisons and jails must balance medical considerations and medical advice against complex correctional management factors. Decisionmaking is further complicated by legal and cost concerns. The following section discusses these issues.

Medical issues. Perhaps the highest priority in the correctional response to AIDS is providing timely, professional, and compassionate medical care to inmates who become ill with the disease. As in society at large, prompt detection and diagnosis are needed to minimize spread of the disease and alleviate the suffering of patients.

Whether or not HTLV-III testing is used, appropriate diagnostic workups are necessary to identify immunosuppression, ARC, and AIDS. Also, certain tests may be able to detect early evidence of opportunistic infections typically seen in AIDS patients.

Careful surveillance and regular followup are extremely important for

patients with AIDS, ARC, and HTLV-III seropositivity, since life-threatening symptoms can develop very quickly. Because AIDS patients experience serious psychological as well as physical problems, counseling and support systems involving correctional staff and family members are also considered important components of care.

Correctional management issues.

Ironically, the medical treatment of AIDS patients may be the simplest issue confronting correctional administrators. Other questions—where to house and treat the inmate, how to prevent the spread of the disease, and how to pay for medical care—are likely to be even more difficult to resolve.

Housing policies. One of the most critical and difficult decisions for correctional administrators is where to house and treat inmates with AIDS, ARC, or HTLV-III seropositivity. Of course, medical considerations dictate many of these decisions. Most jurisdictions place inmates with confirmed diagnoses of AIDS in a medical facility either within the correctional system or in the community, although the duration of such hospitalization varies considerably.

Preventing the spread of AIDS within the prison and protecting affected inmates from intimidation and violence are important considerations. Other factors in treatment and housing decisions include availability and location of facilities able to provide appropriate care, costs of any new construction or renovations necessary to prepare special units, and staffing of any special AIDS units (correctional as well as medical).

Correctional administrators have a number of options concerning treatment and housing placements for inmates with AIDS, ARC, or HTLV-III seropositivity. The key options are the following:

1. maintaining inmates in the general population;
2. returning inmates to the general population when their illnesses are in remission;
3. administratively segregating inmates in a separate unit or relying on single-cell housing;

4. hospitalization; and
5. case-by-case determination of all housing and treatment decisions.

Exhibit 4 summarizes the housing policies of the responding systems. Two-thirds of the Federal and State systems, and 70 percent of responding city and county systems have written policies in place or in development for managing inmates with AIDS, ARC, and HTLV-III seropositivity.

Most jurisdictions hospitalize or administratively segregate at least some of the three AIDS-related inmate categories.

City and county jurisdictions are more likely to use segregation: 39 percent of responding city and county jail systems segregate all three AIDS-related inmate categories, as opposed to only 16 percent of State and Federal prison systems. Almost one-third of all responding systems have basic policies involving case-by-case determination of treatment and housing programs.

While Exhibit 4 indicates the wide variation in correctional policies on housing and treatment of inmates with AIDS, the four jurisdictions with almost 75 percent of the correctional AIDS cases (New York State, New York City, New Jersey, and Florida) all follow the same combination of policies:

1. medical segregation of AIDS patients, but no segregation of inmates with ARC or HTLV-III seropositivity;
2. careful evaluation and ongoing monitoring of inmates suspected of having ARC or AIDS;
3. no mass screening for antibody to HTLV-III; and
4. extensive staff and inmate educational programs.

All four of these systems report that equilibrium has been reached on the AIDS issue, with no widespread fear among staff or inmates regarding transmission of the virus within the institutions.

Precautionary measures. Correctional agencies have adopted a wide range of precautionary measures to control spread of AIDS within institutions; many are based on Centers for Disease

Exhibit 4

Summary of responding jurisdictions' housing policies^a for inmates with AIDS, ARC, and HTLV-III seropositivity

Policy combination	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Segregate AIDS cases; ARC cases and seropositives maintained in general population	3	6%	3	9%
• Segregate AIDS and ARC cases; seropositives maintained in general population	10	20	3	9
• Segregate all categories	8	16	13	41
• No segregation of any categories	2	4	0	0
• No policy	8	16	1	3
• Combinations involving case-by-case determination	16	31	10	30
• Other policy combinations	4	8	3	9
TOTAL	51	101% ^b	33	101% ^b

^aFor the purposes of this categorization, segregation means that the basic policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

^bDue to rounding.

Control guidelines for clinical staff.¹ The CDC guidelines advise clinical and laboratory staff "to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis-B virus infection...Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin or mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS."

Several physicians interviewed for this study believe that, since the AIDS virus is less hardy and more difficult to transmit than the hepatitis-B virus, precautions designed to prevent transmission of hepatitis-B should more than suffice to prevent transmission of AIDS.

Some correctional agencies have instituted precautionary measures which go far beyond those recommended by CDC. Many of these measures are designed to limit exposure under extremely unusual circumstances or to prevent exposure through casual contact. However, all evidence indicates that AIDS cannot be transmitted by a single exposure of any kind or through casual contact. This is a major theme in most AIDS education programs.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that the disease is spread by the very sort of unusual or casual contacts they seek to prevent. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also may foster suspicion of the correctional

¹CDC, *Morbidity and Mortality Weekly Report* (MMWR) 1982; 31:577-580; see also MMWR 1985; 34: 681-695.

system for, in effect, saying one thing about the transmission of AIDS but doing something else.

Notification and confidentiality.

One of the most difficult and sensitive issues regarding AIDS in corrections is who receives information on the medical status of inmates with AIDS, ARC, or HTLV-III seropositivity. Decisions regarding who should receive HTLV-III antibody test results and who should be notified of AIDS or ARC diagnoses may be dictated by precise legal and policy standards such as requirements for written authorization to release test results or other medical records.

Two-thirds of State and Federal prison systems and 91 percent of responding city and county jail systems have general or specific confidentiality policies covering AIDS-related medical information.

Some argue that decisions regarding disclosure versus confidentiality of medical information in cases of AIDS or ARC should be based solely on legal requirements—that is, no information should be reported to anyone unless it is required by law. This position is based on the premise that correctional systems should bear no greater responsibility for notification than do institutions in the community at large.

Where law or policy allows any discretion, decisions regarding disclosure versus confidentiality invariably raise the question of which should take precedence: the inmate's right to have medical information kept confidential or the correctional system's perceived legal and moral responsibility to protect its staff and other inmates, as well as the public, from HTLV-III infection.

There are valid claims on both sides. On the one hand are arguments that correctional staff have a right to know when they are dealing with inmates who may be infectious or who have a serious communicable disease, and that other inmates, spouses, or sexual partners have a right to know who may be carrying a sexually transmitted disease. Notification to public health departments and inmates' former and/or subsequent correctional systems may also be considered important to facilitate treatment, prevention measures, and contact tracing. Such disclo-

tures may also be designed to reduce or eliminate the correctional system's legal liability should a released or transferred inmate transmit AIDS to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or HTLV-III seropositivity may suffer ostracism, threats, and possibly violent intimidation while in prison, and discrimination in employment, housing, and insurance availability after they are discharged.

Because of their rapid population turnover rates, jails face even more difficult policy decisions and logistical problems regarding disclosure and confidentiality of medical information.

The most notable study finding regarding disclosure is that a relatively small number of systems provide test results to inmates (31 percent of State and Federal systems and 52 percent of responding city and county systems). No State or Federal system and a small fraction of city-county systems (19 percent) disclose results to inmates *only*. Seventy percent of State and Federal systems and 61 percent of responding city and county systems provide results to medical staff.

No jurisdictions responding to the questionnaire specifically reported that spouses or sexual partners or previous correctional facilities of seropositive inmates are notified of test results.

Costs of care and associated services.

Questionnaire responses showed that correctional systems are almost universally concerned about the costs of medical care and associated services for inmates with AIDS. Questions regarding range of costs elicited widely varying estimates, but all agreed that medical care for AIDS patients is extremely expensive, whether it is provided in a correctional medical facility, in another public medical facility, or in a hospital in the community, particularly because correctional inmates are ineligible for Medicaid reimbursement.

Correctional systems should plan on spending anywhere from \$40,000 to over \$600,000 for hospitalization and associated medical costs of caring for

each inmate with AIDS.² The costs will vary depending on the amount of acute care required; they will also probably be higher if inmates are placed in hospitals in the community than if they are retained in correctional medical facilities or other public medical facilities.

To the figures for hospitalization and medical care must be added costs of ancillary services such as counseling, possible legal assistance, increased insurance (unless the system is self-insured), and funerals. Obviously, medical care and associated services for inmates with AIDS could have serious budgetary implications for correctional systems.

Legal issues. There is currently very little law specifically on correctional systems' policies regarding AIDS cases, though several cases have been filed in New York and other States. Otherwise, specific AIDS-related legal concerns remain largely hypothetical. Still, there is substantial caselaw on correctional medical care in general, which is important for administrators to consider in developing policies regarding AIDS.

Suits on the quality of correctional medical care³ may be brought on the basis of Federal constitutional standards, State law, or common law. There are three constitutional principles relevant to correctional medical care.

First, under the eighth amendment, inmates are entitled to a safe, decent, and humane environment.⁴ Second, in *Estelle v. Gamble*,⁵ "deliberate indifference to serious medical need" was held to violate the eighth amendment protection against "cruel and unusual punishment." Finally, the constitutional guarantee of "equal protection of the laws" applies to correctional medical care cases, and particularly to

²The low figure is from "Special Report: The AIDS Epidemic," *New England Journal of Medicine* 1985; 312:523; the high figure is based on 2 years at New York City's annual estimate of \$300,000 for patients requiring acute care.

³This discussion is based largely on the presentation of Clair Cripe, Esq., of the Federal Bureau of Prisons, at a meeting of Correctional Commissioners on AIDS, sponsored by the National Institute of Corrections, Atlanta, Georgia, November 6, 1985.

⁴See, e.g., *Rhodes v. Chapman*, 452 US 337 (1981).

⁵429 US 97 (1976).

cases involving AIDS inmates, because of the segregation issues.

Medical care in correctional institutions is usually governed by the same State laws (e.g., medical practice and nursing practice acts) that apply to care in the community at large. Finally, in some States, correctional medical care may be subject to suits for common law torts such as negligence. Medical malpractice suits are also a possibility.

Existing caselaw on AIDS in correctional facilities falls into the following three major categories:

1. Equal protection. Cases filed by inmates alleging denial of equal protection based solely on the fact that they had AIDS (e.g., *Cordero v. Coughlin*).⁶ This case was decided in favor of the correctional department.

2. Quality of care. Cases filed by inmates alleging inadequacies in

medical care and associated services (e.g., *Storms v. Coughlin*).⁷

3. Failure to protect others from AIDS. Cases filed by inmates and potentially also by staff alleging inadequate protective measures and seeking additional steps such as mass screening of inmates and segregation of inmates with AIDS, ARC, or HTLV-III seropositivity (e.g., *Mtr La Rocca v. Dalsheim*).⁸ The *La Rocca* case was decided in favor of the correctional department; other cases on these issues are still pending.

⁷*Storms v. Coughlin* was filed in U.S. District Court for the Southern District of New York. Some of the issues may be mooted by new State regulations, but the plaintiff's attorney believes that there are a number of important quality-of-care issues to litigate. See also *Thagard v. County of Cook*, unreported opinion: No. 85 C 4429 (N.D. Ill., May 20, 1985).

⁸120 Misc 2d 697 (N.Y. 1983). See also *Herring v. Keeney* (U.S.D.C., Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C., Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C., Oregon, filed October 11, 1985); *Telepo et al. v. Kean et al.* Civil Action 85-1742A (U.S.D.C., New Jersey, filed May 1985).

AIDS poses complex and difficult problems for correctional systems. The only certainty is that the problems will not disappear. Every correctional system should develop comprehensive policies and procedures for managing the AIDS problem in its institutions. The information provided here and in the full report can help correctional administrators consider the range of options available and the strengths and weaknesses of each.

Theodore M. Hammett was project director for Abt Associates, Inc., in the urgent 4-month study that led to this condensed report. To learn about availability of the full report, call the National Institute of Justice/NCJRS at 800-851-3420 and give the title and identifying number, NCJ 100126. (From Alaska, Maryland, and the Metropolitan Washington, D.C., area, call 301-251-5500.)

⁶607 F Supp 9 (S.D.N.Y., 1984)

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INMATES AND OFFICERS

AIDS & PRISONS

THE FACTS

Introduction

Today a phantom haunts American prisons and jails. This phantom is AIDS-phobia—the fear of Acquired Immune Deficiency Syndrome (AIDS). Prisoners and corrections officers alike are worrying, asking themselves if they are at risk simply by being inside prison walls. This booklet will shed light on this phantom. We want to give you the facts about AIDS in prison. We want to help each prisoner and officer fight the real enemy—which is AIDS, and not the phantom enemy—the fear of AIDS.

Definitions – Meaning of Words

AIDS—Abbreviation for a disease called Acquired Immune Deficiency Syndrome

ARC—Abbreviation for AIDS Related Complex

HIV—Abbreviation for the virus believed to cause AIDS—Human Immune Deficiency Virus

HIV Positive—a test result which shows a person has been infected with the AIDS virus

HIV Negative—a test result which shows a person has not been infected with the AIDS virus

ELISA—one of the blood tests used to find out if a person is infected with the AIDS virus. This is a screening test.

Western Blot—another test used to find out if a person is infected with the AIDS virus. This is a confirmatory test.

IV Needles—Abbreviation for intravenous needles or “works”

Questions and Answers About AIDS

1. What is it?

AIDS is the shorthand for Acquired Immune Deficiency Syndrome—a disease that affects the immune system. Your immune system helps your body fight off many simple illnesses like colds and the flu. Your immune system also helps your body heal when it is attacked by more serious illness—like hepatitis, tuberculosis or pneumonia.

When a person gets AIDS, he or she is not able to fight back as well against simple and serious illnesses. AIDS leaves the body open to attack by all sorts of viruses, cancer and sicknesses that a healthy person does not have to fear.

When people have AIDS, they fall sick again and again, because their immune system is not strong. Eventually, most people with AIDS die. There is no cure for it. A lot of drugs are being tested to help people with AIDS, but so far only one drug, AZT, has been shown to have an impact. We will talk about this drug later on.

2. What causes AIDS?

In 1983, doctors learned that AIDS was caused by a virus. A virus is like a germ that infects your body and makes you sick. The AIDS virus is called HIV—short for Human Immune Deficiency Virus. The HIV virus enters the blood and destroys the body's immune system.

There are many differences between someone who is infected with the HIV virus, and someone who has the AIDS disease. To understand these differences, it helps to think of AIDS as a road with a series of possible paths.

The road begins when a person is infected with the HIV virus. We will talk about how a person gets infected later on in this booklet. The road ends when a person gets full-blown AIDS. In the middle of the road are those people who are not completely sick,

and not completely healthy; these people have what is called AIDS Related Complex (ARC). People with ARC have many of the same symptoms as people with AIDS, but their immune system is still working and they are not as seriously ill.

The road from HIV infection to full-blown AIDS is not a straight road. Not all people infected with HIV go on to develop AIDS. But doctors have learned that as time passes, the odds increase that a person who has HIV infection will get sicker. Doctors say that at least 30% of those with HIV infection will go on to get the AIDS disease within seven (7) years of being infected. That percentage does appear to be increasing as more information becomes available.

Scientists are not yet sure why some people get sick more quickly than others.

HIV Infection

ARC AIDS-Related Complex

Full Blown AIDS

There is new evidence that people who have been infected with other illnesses that hurt their immune system get sicker more quickly than those who get HIV infected but have had a pretty healthy life before that. Many experts

believe that the more times you are exposed to the HIV virus, the greater your chances of becoming ill. It is possible to become infected with the AIDS virus in just one encounter.

3. How do you learn if you are infected with the AIDS virus?

To find out if a person has HIV infection, doctors must do a series of blood tests. These tests can tell you if you have been exposed to the HIV virus. People who have been exposed to the HIV virus are sometimes referred to as HIV positive (infected). Those people who test negative for the HIV virus are called HIV negative (uninfected).

The blood tests that are used today to detect the HIV virus are simple. If they are done carefully, they are usually accurate. But there are many problems with the tests that you should know about.

First of all, the blood tests only tell you that you have been exposed to AIDS, and that you are infected with HIV. The blood

tests we use measure what are called *antibodies* to the HIV virus. Usually antibodies are the ammunition your body makes to kill infections. If you test positive to HIV, doctors are telling you that you have antibodies to AIDS and that you can be sure that you have been infected with the virus.

The second problem with the AIDS blood tests is that they can be wrong. Sometimes an HIV test comes out positive even though a person is not infected (false positive). Sometimes a negative test result is not accurate either (false negative). In other words, the person was infected but the test did not show it.

To correct for most of these errors, doc-

tors must do three tests on your blood. They must do two ELISA tests. If these two tests come back positive, they must do a third test called a Western Blot. The third test is essential to correct errors which are common on ELISA tests. Until all three tests are done, you will not know whether a positive result is accurate.

Another problem is the lack of privacy or confidentiality in jails and prisons. Rumors spread quickly and people may be discriminated against because they had a positive test or because others think they had a posi-

tive test.

The final thing to remember about HIV tests is that they cannot predict what will happen to you in the future. So that if you test negative today, there is no guarantee that you will remain negative tomorrow, unless you take great care of yourself. Also, if you test positive today, there is no way to know whether or when you will become ill. This means that anyone who finds out his/her test results needs to take care of their health to make sure that they do not get the AIDS disease.

4. How are AIDS and the HIV virus transmitted?

AIDS is passed along in two ways: (1) blood to blood contact; and (2) sex of all kinds where the body's fluids are passed between people.

The HIV virus is hard to transmit unless blood or other body fluids (like semen) are involved. Doctors have shown that AIDS can be passed on in these ways:

- Man to man anal intercourse; both partners are at risk to pass along and receive the HIV virus
- Man to woman during vaginal and anal intercourse
- Woman to man during vaginal and anal intercourse
- Man to man or woman to man oral sex

- Pregnant woman to infant baby
- Through blood transfusion if infected blood is used
- Through sharing IV needles and works, either with drugs or tattoos

AIDS CANNOT BE SPREAD BY:

- playing sports
- shaking hands
- eating food cooked by an HIV positive person
- hugging
- breathing the same air
- touching objects
- sharing plates and utensils
- sharing toilets, showers and facilities
- any other ordinary, casual, day-to-day contact

In a series of studies of families where one member had the AIDS virus (from infected blood transfusions), there was no evidence of any other family members becoming

infected even though they shared everything in the family home.

It is here that the phantom enters the prison picture. Corrections officers and inmates say that because prison is so different from the free world, AIDS transmission inside prison must be different from what it is like on the outside.

This is not true. AIDS in prison can only be spread in the same ways as it is in the free world: through blood to blood contact; and through sex of any kind that involves the exchange of bodily fluids.

Remember three things:

1. The HIV virus is spread through very specific behavior. It will not fly across the room and infect you on its own.
2. Anyone who does certain things is at risk for getting AIDS. Even if you are not an IV Drug user, or not a homosexual, or have never had anal sex with a man—you could still get AIDS. For example, if you have unprotected sex with another person who has the virus or AIDS, you can get AIDS.

3. *You can protect yourself against AIDS.* It's up to you. There are things you can do to make sure that you never get infected. There are also ways to improve your chances of liv-

ing even if you are infected with HIV or even if you do have AIDS. We will talk about these later on.

5. How many people have AIDS? Who are they?

As of April 4, 1988, 58,270 Americans are sick with AIDS. Of these people, 32,545 are already dead. The rest will die unless a cure is found soon.

Doctors say that at least 1 million people are infected with the AIDS virus today. Many of these people show no signs of being sick. But each of them might pass the virus along to someone who is not infected.

As of October 1987, there were 1,964 prisoners in state and federal prisons and jails who had been diagnosed with AIDS. At least 875 of these inmates are dead. No corrections officers have gotten AIDS on the job. The only cases of corrections officers developing AIDS involve those who got infected

by using dirty needles outside of work, through blood transfusions or through sexual contact with an infected person. NO CO's have gotten AIDS on the job.

Avoiding AIDS in Prison

People who have taken drugs intravenously (with a needle), have a high rate of HIV infection. Because of the large number of inmates with a history of IV drug use it is important to be very careful about certain kinds of behavior in prison.

1. Do not share tattoo needles.
2. Do not share IV drug needles or works.
3. Do not have sex or have only safe sex. If you have any kind of sex, use a condom. Safe sex is when no body fluid such as semen is passed along from one person into another person.
4. You cannot get infected just by touching blood because the infection only passes on when the infected blood is in

contact with your blood; however, it is important to be very careful around blood.

5. You cannot get infected with AIDS by coming into contact with urine, feces or spit.

6. It is very difficult to get infected with AIDS just because you were bitten or in a fight. We know of no cases of this. However, if you think someone else's blood came into contact with your blood, consult the prison medical staff.

7. If you are raped or forced to engage in sex, consult the prison medical staff and discuss testing.

8. Consult with prison medical staff if you have any questions about AIDS.

Medical Care for People with AIDS or HIV

There is no cure at this time for AIDS. Doctors and scientists are working on finding a cure and hopefully that will happen.

The diseases or opportunistic infections that result from having AIDS (such as forms of cancer and pneumonia) can be treated. The particular kind of treatment and where it should take place (prison infirmary, hospital or regular housing unit) should be decided by prison medical staff based upon good medical practice.

There is one experimental drug, called AZT, which appears to "slow down" AIDS. It is not a cure but in a number of cases it can delay the progression of the illness. There are some side effects from AZT and not everyone can take the drug. Other drugs may be licensed soon for use in AIDS or HIV infection. If you have AIDS or HIV infection, you should discuss treatment and access to new drugs with the prison medical staff.

Your Legal Rights and Responsibilities

AIDS is a very new disease and many of the legal issues have not yet been fully decided by the courts. The following is our opinion of what the law is or should be.

1. It is unlawful in jail or prison to use IV drug needles or works *unless* they are administered by prison medical staff.

2. It is unlawful in most jails or prisons to engage in sexual activity *unless* it takes place during a regular prison program such as private family visits.

3. Inmates and officers should have the right to ask for an AIDS test if they believe that they have been exposed to

the AIDS virus.

4. Inmates and officers should have the right to refuse an AIDS test *unless* there is a medical reason for a particular person to be tested. Mass testing of all inmates or all staff is inappropriate. There should be no punishment for an inmate or officer who refuses to participate in mass or individual testing.

5. It is unlawful for any person to force or coerce another person to engage in sex.

6. Inmates should not be segregated just because they have tested HIV positive or have ARC or AIDS. They should *only*

be placed in separate housing if there is a real medical or security reason to do so: for example, a prison doctor may believe that a particular inmate needs to be separated for treatment purposes *or* a particular HIV positive inmate may have a history of committing sexual assaults.

7. Inmates with AIDS or HIV should have full access to prison programs and services unless there is a medical reason why a particular inmate cannot participate.

8. Prisoners or officers cannot be punished in any way just because they test HIV positive or have AIDS.

9. Prisoners with AIDS or related diseases must be provided with complete medical care no matter how costly it may be. The Supreme Court has ruled that "deliberate indifference to a prisoner's serious medical needs" is a violation of the U.S. Constitution.

10. Inmates and officers should have the right to have all of their medical records and any medical test results treated confidentially. Medical records and test results should not be released without their permission.

How to Get More Information About AIDS

1. Consult with the medical staff at your jail or prison.

2. Write:

AIDS Program
Center for Infectious Diseases
Centers for Disease Control
1600 Clifton Road, N.E.
Atlanta, GA 30333
404/639-2891 (general information)
404/639-3352

U.S. Public Health Service
Room 725-H
200 Independence Avenue, S.W.
Washington, D.C. 20201
202/245-6867 (office of communications)
1-800/342-AIDS (AIDS hotline open
24 hours a day)

(The U.S. Surgeon General can be
reached through the U.S. Public
Health Service) (same address)

3. Write:

AIDS Information
The National Prison Project
1616 P Street, N.W.
Washington, D.C. 20036

AIDS Information

The National Prison Project
1616 P Street, N.W.
Washington, D.C. 20036

FOR BULK ORDERS CALL:
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AIDS in correctional Facilities.

Issues & Options

Theodore M. Hammett	HV
U.S. Dept of Justice	8843
Natl Institute of Justice	H36
	1988

xiv

1 Key element of AIDS educ² training
"correctional systems should involve inmates
and staff in the development of AIDS educ.
programs. This can be done by soliciting
particular questions and concerns and using
them as the basis of the training

"credibility is critical... can build credibility...
by using peer trainers who are able to
develop strong rapport with audiences

xiv

12 state correc. facilities have implemented or are
planning to implement mass screening programs for
inmates - no city or county system has done so or plans to
The Fed. Bureau of Prisons tests all inmates on release
and a 10% random sample of incoming inmates

4 In the Spring of '87 Pres Regan recommended that all
prison inmates be screened. Soon after Att. Gen.
ordered Fed. Bureau of Prisons to begin testing all new
inmates and all inmates about to be released

Overall 57% of persons diagnosed w/ AIDS have died

16 1gt of saliva or urine would have to enter the bloodstream of an individual for infection to occur

person cannot be infected by the blood of the person committing the bite unless that person somehow has blood in his or her mouth that then comes ~~in~~ in contact with the blood of the person bitten

-no reports of HIV transmission thru biting

21 NYS: Calif together account for almost 50% of the AIDS cases in the US, while New Jersey, Florida & Texas collectively account for an additional 21%.

The World Health Organization on Prisoners with AIDS

A Consultation on Prevention and Control of AIDS in Prisons was convened by the World Health Organization's Special Program on AIDS in November 1987.

Thirty-seven specialists from 26 countries participated, including experts in epidemiology, public health policy, prison and medical administration, and occupational health and safety. The consultation adopted the following policy recommendations:

1. Prison administrations should recognize their responsibility to minimize HIV transmission in prison (and consequently in the general community when prisoners are released).

2. Prisoners should be treated in a manner similar to other members of the community, with the same right of access to:

a. educational programs designed to minimize spread of the disease, including up-to-date information on AIDS and preventive measures;

b. testing for HIV infection on prisoner request, with confidentiality of results, timely pre- and post-test counseling, and support from

appropriately-trained persons [sic] acceptable to the prisoner;

c. medical, nursing, inpatient and outpatient services of the same quality as those for AIDS patients in the community at large;

d. information on treatment programs and the freedom to refuse such treatment.

3. In addition, prisoners with AIDS should be considered for compassionate early release to die in dignity and freedom.

4. Prisoners should not be subjected to discriminatory practices relating to HIV infection or AIDS such as involuntary testing, segregation or isolation, except when required for the prisoner's own well-being.

5. All prison staff should receive up-to-date information and education on AIDS prevention and control in prisons, as part of broader training in occupational health and hygiene. Information on AIDS should include recognition of possible AIDS-associated conditions and guidance on the most humane management of HIV-infected prisoners.

U The
Body
Positive
June 1988



THERE'S A MONSTER IN THE STREET

A new booklet about AIDS has been published by inmate Tony DeFarlo entitled "There's a Monster in the Street." Tony is currently incarcerated at the Taconic Correctional Facility in Bedford Hills, but expects to be released on October 7th. It is written in "street language" and is aimed at "street people, prison inmates, drug users and other 'fast laners' who might have trouble understanding the medical jargon that appears in a lot of literature about AIDS.

According to the author, "the profits will go to provide housing for [paroled] PWAs." The price is \$1 plus \$.50 for postage and handling. It is currently also available in Spanish. Tony, a musician, is currently working on a rap version of "There's a Monster in the Street."

Those interested in obtaining a copy should write: Tony DeFarlo, 85A4222, A-4, 250 Harris Road, Bedford Hills, NY 10507.

PRISON BOOK PROGRAM

All prisoners, and especially women, are encouraged to write the Prison Book Program (c/o Redbook, 92 Jamaica Plain, MA 02130) to request free books on women's issues, fiction, political topics, racism, prisons and laws, gay/lesbian, & other issues. (We usually run about 2 months behind in filling requests.) We also have a resource list for prisoners which includes listings of prisoner support organizations, newspapers and penpals.

PWA COALITION "NEWSLINE" SEPT. 1988
NEW YORK

TREATMENT INFORMATION

These are some, not all, sources for AIDS treatment information.

AIDS Treatment News

c/o John James
PO BOX 411256
San Francisco CA 94111

415-282-0110

Treatment Issues

GMHC
Dept. of Medical Information
132 West 24th St. Box 274
NY NY 10011

212-807-6655

AMFAR Directory for Experimental Treatments

10 West 57th Street
Suite 405
NY NY 10019

212-333-3113

H.E.A.L. Health Education AIDS Liaison Newsletter

Lesbian and Gay Community Center
208 West 13th Street
NY NY 10011

212-674-HOPE

Project Inform

25 Taylor Street
San Francisco CA 94102

Nat'l 800-822-7422
Cal 800-334-7422

PWA Coalition Newsline

263A 19th Street
NY NY 10011

212-627-1810

Body Positive

2638 West 19th Street Rm 107
NY NY 10011

212-633-1783

ACT*UP Issues Committee

c/o Dr. Iris Long
496 A Hudson Street Suite G4
NY NY 10014

212-533-8888

Focus

UCSF AIDS Health Project
PO BOX 0884
San Francisco CA 94143-0884

415-476-6430

D.A.I.R. Document AIDS Issues and Research

2336 Market Street #33
San Francisco CA 94114

415-928-0292

Healing Alternative Buyer's Club

273 Church Street
San Francisco CA 94114

415-863-2437

AIDS Alternative Healing Hotline

415-558-9292

"They keep their eyes shut"

As HIV infection in prisons skyrockets, health care for prisoners remains negligible

By Elizabeth Pincus

BOSTON — Last year at Deer Island, House of Corrections, a county jail in the Boston Harbor, a man died during an asthma attack when correctional officers refused to provide him with medical attention. Recently at the MCI-Framingham state facility, a woman who was nine months pregnant was shackled with leg and wrist irons, and roughly escorted to the hospital for her delivery. According to Linda Thurston, who coordinates the Criminal Justice Program at the American Friends Service Committee (AFSC) New England Region, such abuse of inmates and neglect of their health care needs is commonplace in prisons and jails.

Thurston explained that many prisoners are particularly vulnerable to health problems due to prior histories of drug use, poverty, scanty medical care, poor nutrition and a lack of physical safety. She added that



additional problems are inevitably brought on by incarceration. These include stress, emotional problems, vision impairment for prisoners in isolation, and contagious diseases ranging from flu to hepatitis to AIDS, ARC and HIV-infection.

Uneven delivery of medical care in prisons further aggravates health problems. Many conditions are often overlooked, including Agent Orange poisoning and PTSD (Post Traumatic Stress Disorder) for veterans, and medical complications for prisoners with drug or alcohol dependencies. Pregnant women often suffer from particular neglect, and access to abortion may be limited or dangerously delayed. For lesbians and gay men, already overlooked or mistreated by the medical establishment, imprisonment can lead to further harassment and physical abuse.

"The medical care in prison facilities is abysmal," said Deborah Shields, attorney with the legal task force of Boston's AIDS Action Committee (AAC). "We get complaints by the dozens. Each facility is supposed to have some health care — but it's generally very limited and inadequate."

Shields described what she called the appalling conditions of Lemuel Shattuck Hospital, a prison medical facility in Boston. She said the Shattuck is an ancient building without fans, air conditioning or windows that open. According to Shields, prisoners who need hospital care are locked up 24 hours a day in cockroach-ridden rooms with no access to education, training or recreation programs.

"Health care in prison? Imprisonment itself leads to ill health, whether through the medical conditions, or through the effects of physical violence in prison," stated a recent editorial in *Outlook on Justice*, an AFSC newsletter. "Beatings by guards and prisoner on prisoner violence result in traumatic injuries which may or may not be adequately treated by prison medical personnel. The stress from the constant threat of violence plays havoc with both emotional and physical well-being."

AIDS, ARC, and HIV-infection in prisons

A report released this spring by the Massachusetts Department of Correction (DOC) revealed that out of 250 women prisoners in the state who voluntarily submitted to an HIV-antibody test, 100 tested

positive. The DOC did not release comparable statistics about men prisoners. Lila Austin, co-director of the Boston-based prisoners' rights group, Social Justice for Women, said that advocacy workers for prisoners estimate that up to 90 percent of people incarcerated in state prisons may be infected with HIV.

"AIDS is by far the most serious health issue in prisons," Austin said. "There's a very high instance of IV drug use, and conditions are very over-crowded." She explained that between 70 to 90 percent of all prisoners are present or former IV drug users, putting them at high risk for contracting AIDS through shared contaminated needles. Nonetheless, according to Austin, prison officials have responded slowly to the AIDS epidemic, failing to provide adequate medical and social services or substance abuse treatment.

Other prisoner advocates and AIDS educators agreed that lack of access to AIDS information and safer sex materials is a deplorable problem in prisons. A recent letter to the GCN Prisoner Project outlines the situation.

"The two most common ways of contracting [HIV] are nearly second nature to most inmates: homosexuality and drug use," wrote a prisoner from Louisiana. "But the Department of 'Corrections' has chosen to keep their eyes shut and their mouths open — open to tell the lies that they don't have any AIDS problem to speak of. And since nobody else out there seems to want to speak of it either, our deaths and the education it would take to prevent them, are ignored. The 'corrections' people are more worried about how to protect their staff than they are about prisoners already dying (alone)."

Prisoners who are diagnosed with AIDS, ARC and HIV-infection may receive little or no medical treatment, and may be harassed or ostracized from other prisoners and staff. According to Billy Jones, a health educator with the Whitman-Walker Clinic in Washington, D.C., prisoners with AIDS, ARC or positive HIV status are usually isolated in so-called "protective custody."

Describing the cold, drab and unhealthy circumstances of being "locked down," Jones explained that prisoners in protective custody lose the opportunity to work or participate in other programs to earn good time — that is, credit for early release. In fact, HIV-positive prisoners are increasingly being warehoused indefinitely in prison isolation units, according to prisoner advocates.

"Prisoners with AIDS can't get medications, can't go to hospitals of their choice and are locked up in isolated settings," said Diane McLaughlin of Massachusetts Correctional Legal Services. She described how prisoners with AIDS, who are not granted confidentiality protections, are often subject to additional brutality and constitutional rights violations. McLaughlin's organization provides legal advocacy for prisoners; increasingly, she said, the cases they handle involve complaints about medical care.

Other community organizations are also attempting to improve the quality of health care within prisons. APCS's Criminal Justice Program provides education and advocacy for prisoners, sponsors community forums and attempts to increase citizen access to prisons. Social Justice for Women, an umbrella group that encompasses a number of organizations working for prisoner's rights, has recently begun a Women and AIDS Program at MCI Framingham to provide education, counseling and other services.

Another Social Justice for Women program, called the Women's Health and Learning Center, offers substance abuse support services for women prisoners, lobbies for improved health care and focuses on particular needs of Black and Latina prisoners. The Center has recently begun doing AIDS

Prisoners

Continued from page 8
education within MCI Framingham such programs remain scarce and funded. Advocates stressed that people groups working with prisoners must efforts to share strategies about mental the psychological and physical at prisoners, while working to increase awareness of the issues. □

Note: The National Prison Project (NPP) will send FREE to prisoners a booklet "AIDS and Prisons" a results of their survey on AIDS in prisons. Send for them to: ACLU-NPP, 1615 NW, Washington, DC 20036.

Continued on page 16

AIDS TREATMENT NEWS

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Stockholm AIDS Conference: The Untold Story

by John S. James

The "IV International Conference on AIDS", June 12-16 in Stockholm, Sweden, included over three thousand scientific presentations--more than twice as many as last years' meeting in Washington, D.C. We covered these conferences to gather information on promising treatment possibilities and related scientific research. This article gives our overview; details will follow in the next several installments, starting below and continuing every other issue.

What's Right?

Despite largely pessimistic press reports, we found more good news than bad from the Stockholm conference:

- * Tremendous nuts-and-bolts progress in basic research represents major advance toward an eventual cure or highly effective treatment--for AIDS and many other diseases as well. Little of this progress makes headlines, however.

- * The conference reflected a new stage of effective worldwide mobilization in many areas of AIDS. (Unfortunately there are also glaring deficiencies, illustrated below.)

- * In civil liberties and related areas (outside our treatment focus) the world's experts have developed strong consensus which

Statement of Purpose

AIDS Treatment News reports on experimental and alternative treatments, especially those available now. It collects information from medical journals, and from interviews with scientists, physicians and other health practitioners, and persons with AIDS or ARC.

Long-term AIDS survivors have usually tried many different treatments, and found combinations which work for them. AIDS Treatment News does not recommend particular therapies, but seeks to increase the options available.

We will also examine the ethical and public-policy issues around AIDS treatment research.

recognizes the concerns and dignity of persons with AIDS. For example, balancing the rights of infected persons against those of the uninfected is seen as a false issue; on the contrary, antidiscrimination protection is regarded as absolutely crucial to effective control of the spread of the virus. Far from being opposed, the interests of those with AIDS and the larger society correspond.

The developing consensus easily crosses national borders. For example, telephone hotlines throughout the world are now providing roughly the same information.

This writer is too busy covering treatments to give nondiscrimination and related issues the attention they deserve. Those working in these areas should examine the Stockholm results and other forums for ammunition against the political demagoguery still very much with us.

Behind the Bad News: Analysis and Comment

The bad news is the lack of major treatment advances in the last year.

Most commentators have assumed that lack of progress on treatments reflects the difficulty of the disease. But analysis of the Stockholm presentations contradicts this assumption. The evidence suggests another cause for lack of treatments.

If the intractability of the disease were responsible, we would have expected to see a string of treatment failures at Stockholm--many reports of drugs or other therapies which were tried but failed to work. In fact there were very few such reports. Very few new treatments failed in the last year. Very few were tried at all.

The problem is political, not technical. The impressive worldwide mobilization around basic research, prevention, and other areas has glaringly omitted any serious mobilization or commitment to save the lives of those now infected or ill. These people were written off several years ago, and since then there has been no institutional constituency for mobilizing research to save lives.

The major thrust of the scientists at Stockholm has been to find a cure through elegant molecular biology, maybe in five to ten years. There is no urgency or mobilization to test the dozens if not hundreds of treatment possibilities widely agreed to be available now--dozens of which could be tested within the next few months if only there were the will.

Some of the scientists now realize that there is a problem, in that current policies all but guarantee that hundreds of thousands of people will die of AIDS during the next few years. Some have reached the "isn't it a pity" stage. But few have broken through the aura of inevitability to see the problem as resulting from human attitudes and decisions which can and should be changed.

The one common factor behind virtually every treatment attempt receiving serious research attention--AZT, vaccines, interferons, CD4, Ampligen, IMREG-1, and a few others--is not prospects for commercial gain. No major institution, government as well as private, will seriously consider a treatment solely on its medical and scientific (as opposed to commercial) merit. If it's a plant that anyone could pick, a food in general use, a common industrial chemical, or a health-food product, it won't be considered, no matter what the evidence.

Scientists as well as corporations have vested interests. It has unfortunately always been hard to find financial support for basic

biological and medical research--work which doesn't make headlines, but on which future progress depends. AIDS is now driving huge advances in fundamental knowledge of viruses and the immune system, as well as related technology such as improved scientific tests. The research community involved in this effort has never had it so good.

No one is deliberately conspiring to keep AIDS going to feed the multi-billion dollar research and pharmaceutical industries. No one has needed to. For the interests of the powerful are only threatened by doing what needs to be done--creating a mechanism to promptly test the dozens of promising treatments already known and available, regardless of commercial prospects--each with perhaps ten to 20 volunteers. The problem isn't money--this testing wouldn't need to cost much--but pervasive obstructionism throughout the institutions involved.

This problem may seem so big as to be hopeless. But there is a key place to start, where attainable public effort can have critical results: namely the lobbying of AIDS, gay, hemophilia, and physicians' organizations to investigate and address the issues of clinical trials and treatment access for saving the lives of the millions of people already infected with the AIDS virus.

The decision to write off those already ill probably started from homophobia. But now it continues from its own momentum, due to the almost total lack of institutional support to change it. We saw this lack in Stockholm, when scientists didn't even feel the need to address the issue of the "drugjam" in clinical trials.

Like the first candle in a dark room, the first advocacy makes all the difference when there has been none before.

Treatments at Stockholm

Dozens of treatment possibilities appeared somewhere among the three thousand presentations at Stockholm. Most were largely ignored, however, with their poster sessions usually empty; the scientists just walked by. Usually no evidence suggested that these treatment prospects were any worse than the ones getting the attention. They lacked political and commercial currency, not necessarily scientific merit.

Nobody could cover all three thousand presentations in the few days of the conference; scientists naturally focused on what was hot in their fields. In our own coverage, however, we decided to emphasize those treatments most likely to be overlooked. Therefore we de-emphasized those which will get attention, namely AZT, interferons, vaccines, and the very important area of improved medical management. We will cover these subjects mainly by interviewing physicians who were at the conference; we spent our own time gathering as much information as possible about other treatment leads. We may have been the only journalist at the conference whose primary business was to seek out precisely those treatments most likely to be overlooked.

Treatments possibilities not at the conference which we would like to have seen there included BHT, DHEA, DNCB, garlic, and MM1. Apparently nobody submitted papers on these.

Treatments or leads presented in Stockholm which we plan to cover include (in alphabetical order) acyclovir, aerosolized pentamidine, AL 721, ampliten, antabuse, antisense DNA, apurinic acid, AS 101, avarone,

carrisyn, castanospermine, CD4, corticosteroids, dapsone, DDC, dextran sulfate, fluconazole, foscarnet, fusidic acid, ganciclovir (DHPG), germanium, ginseng, glycans, glycopeptides, glycyrrhizin, GM-CSF, gonadotropins, heparin, HPA-23, Immunotoxins, interferons, IMREG-1, imuthiol, isoprinosine, itraconazole, ozone, peptide T, pine cone extract, PMEA, prostaglandin inhibitors, ribavirin, rifabutin, selenium, somatostatin, THF, thymostimulin, trimetrexate, tumor necrosis factor, and zinc.

We will also look at new research directions and improved methods, such as new scientific tests.

Covering treatment news at the "IV International Conference On AIDS" presents unusual difficulties--problems which help explain why treatment developments received less press coverage than they deserved.

Reporters faced a huge mass of information with no organizing principle, and no help in deciding what was important other than following the "conventional wisdom" of what was in style among physicians and scientists. No single treatment or small group of them compelled special interest based on actual data presented at Stockholm--although chances are good that a number of treatments discussed may prove very important in the future. But for now, even from the mass of reports taken together, no pattern emerged.

Mainstream reporters complained that you could take any angle you wanted at this conference, and support it. As one commented, you could shoot anywhere and hit something. This excessive freedom makes the reporter's job more difficult, because no guidance emerges from the material itself. Reporters do not want their basic relationship to the story to be arbitrary.

In this situation we owe the reader some explanation of our own biases and approach, as we begin a series of several articles on dozens of specific treatment possibilities about which information was presented in Stockholm.

First, we have not considered treatments unless we saw some thread of possible usefulness in the foreseeable future. But many of the potential treatments we report are not ready for people to use now, and some will never be.

We considered selecting what to report from the point of view of what information is most useful now, but decided against this approach for several reasons. First, hundreds of practicing physicians attended the conference, and they are in the best position to know what is immediately important. We can interview them about this information, and plan to do so.

Second, no one can know at this time which treatment leads presented at Stockholm will turn out to be important. The more suggestive, unproven developments are the ones most likely to be overlooked by the conference attenders; often in the history of science and medicine valuable information is lost for years in this way. We want to make this information available to those who did not happen to attend the conference and read a particular poster.

The remaining question is how to make coherent to our readers a massive body of facts which fits no particular pattern, no particular categories. We expect to organize each article as a guided tour, using particular treatments to illustrate concepts or viewpoints which may help in understanding the overall picture of AIDS research. We cannot

organize the articles in advance, however, as it will take us several weeks to go through the material, as we are writing about it; and in any case we have not found useful ways to categorize the treatments. Each article will consist of what emerges at that time from material not covered so far.

HOE/BAY 964 (Poster #3656)

We never heard of this substance before, and conference attenders could easily have missed it, as no mention appeared in the published book of abstracts (abstracts submitted months in advance, therefore lacking the most current information). Instead, HOE/BAY 964 appeared only at the conference itself, at the end of a poster ostensibly about something else. The poster, titled "Development Of HIV-Variants With Higher Resistance Against AZT Under Treatment With AZT", was presented by seven German scientists from two research institutions in West Germany, and one from the Karolinska Institute in Sweden. What caught our attention was the statement that this substance is already in clinical study in Germany; therefore we thought we should know about it.

The poster primarily reports on a study of what may be a reason that the effectiveness of AZT often falls off after long-term use--development of drug resistance by HIV.

Other reports have suggested that evolution of HIV within each patient may be an important part of the natural history of disease. HIV evolves far faster than other viruses or organisms, and the development of drug resistance may occur independently within each person. It is certainly conceivable that due to prevention methods such as safer sex--which patients will probably have adapted well before their diagnosis and treatment with AZT--the resistant virus would be unlikely to spread to others, and therefore the cumulative development of resistant strains may not be a problem. (This possibility reinforces the advice that persons who are HIV positive or who have AIDS must avoid unsafe sex with each other.)

The poster (#3656) included a summary, the first two paragraphs of which were identical to the published abstract (except for updating the number of persons known to have developed AIDS from 64,000 when the poster was submitted to 84,000 when the conference took place). The researchers followed 60 AIDS patients receiving AZT for periods up to one year, and during this time AZT did not reduce the ability to culture virus from the patients' blood.

Three of the 60 patients were studied more intensively by testing the susceptibility of their virus to AZT in the laboratory. The researchers found that the virus from these patients was significantly less sensitive to AZT late during the course of the treatment, meaning that drug resistance had developed.

Then the summary included the following apparently new results, introducing HOE/BAY 946 almost as an afterthought:

"In contrast, HOE/BAY 964 (chemically a xylan(hydrogensulfate) disodium salt), an inhibitor of HIV currently under clinical investigation in Germany, did not show significant differences in the inhibition of the RT from sequential virus isolates from these patients." The poster also included a diagram with the chemical structure of HOE/BAY 964, and clinical results from the three patients whose virus was studied.

We cannot tell from the poster whether or not HOE/BAY 964 has ever been given to humans; apparently it was not used by the three patients whose virus was tested. The poster therefore does not address the question of whether HIV could develop resistance to this chemical, but only shows that such resistance does not automatically occur as a consequence of development of resistance to AZT.

As the poster suggests that HOE/BAY 964 may be at least a serious candidate for clinical trials, we would like to learn more about it. We did not meet the scientists at the conference; this presentation was one of dozens we could only photograph for later analysis.

AmFAR (the American Foundation For AIDS Research) is following up on HOE/BAY 964 to see if it deserves inclusion in the new issue of its treatment directory. AmFAR is in an excellent position to collect this kind of information, since it is a well-known, respected organization, and it gives several million dollars a year in research grants. We will continue to report on this treatment possibility as more information becomes available.

Note On Treatments:

More readers have asked us questions about dextran sulfate and AL 721 than about any other experimental treatments. We will cover these later when we have time to assemble the information. Briefly, both dextran sulfate and AL 721 had some new information presented at Stockholm, but nothing spectacular. Perhaps the biggest news was the great interest in dextran sulfate among physicians and scientists at the conference. Only a little new human data was available, however.

Notes and Announcements

Stockholm conference abstracts available

(1) **In San Francisco:** A copy of the abstracts of all three thousand presentations at the Stockholm conference is kept at the library of The Healing Alternatives Foundation (formerly the Healing Alternatives Buyers' Club), 273 Church Street, in San Francisco, open Tuesday through Saturday 1-5 PM, 626-2316. There is a keyword subject index and an author index, so you can find the abstracts on the above treatments, or on other subjects. Individual abstracts can be photocopied at the library for five cents each.

If you want the complete set, we have arranged for a photocopy shop to keep a master set on hand so that anybody can order a copy. The complete abstracts, enlarged for legibility and now a stack of paper seven inches thick, can be obtained for the photocopying charges, about \$55., from Copy Mat, 2370 Market Street (near Castro), 864-2679. Ask for the "Stockholm Conference Abstracts".

(2) **From elsewhere:** Persons out of town who cannot pick up a copy personally can obtain one through Project Inform, (800) 334-7422 in California, (800) 822-7422 elsewhere in the U.S., or (415) 558-9051 from anywhere. The total cost of photocopying, shipping, and handling will be under \$100.

Long-Term Survivor Study. The AIDS Healing Alliance (a San Francisco organization not to be confused with The Healing Alternatives Foundation) is conducting a long-term survivor study. It needs

participants for its pilot study within the next week. It is seeking persons who have had

- * An AIDS diagnosis for at least two years, or
- * An ARC diagnosis for at least seven years, or
- * A seropositive status for at least seven years.

Participants will fill out a medical and lifestyle survey questionnaire.

For more information or to request a questionnaire, call Tom Greaney, (415) 863-7725 (message phone).

Major New York Fundraiser July 10. A little-known group which organized a very successful fundraiser last year hopes to do even better this July 10. This effort can also be a model for fundraising elsewhere.

People Taking Action Against AIDS (PTAAA) last year raised more than \$120,000 at a single even, with less than \$5000 in expenses. The key was an auction of donated work by well-known artists, some world famous, at an event at a home in Bellport, Long Island. PTAAA gave \$50,000 to the Community Research Initiative to fund a lipid study, and the remainder to a local AIDS service organization, LIAAC, the Long Island Association for AIDS Care.

This year PTAAA will not only help the same beneficiaries, it will also reserve money for small seed grants to help other communities organize their own events. It is particularly interested in supporting organizing outside of major metropolitan centers, in areas where there is currently not much AIDS activity or information access.

For information about the July 10 event, or the community grants, or how similar events might be organized in San Francisco or elsewhere, call Don Hall, PTAAA, (516) 286-2374, or write PTAAA, P.O. Box 378, Belport, NY 11713.

California: Help Needed Against Dannemeyer Initiative. An "AIDS Initiative" which would close California's anonymous testing sites and force physicians to report anyone they know or "suspect" to be antibody positive will be on the November ballot in California. It would also allow insurance companies to use the HIV antibody test to deny coverage, and require anyone who has tested antibody positive to report themselves to authorities within seven days.

While the voters just rejected the similar LaRouche Initiative by a large margin, the Dannemeyer "AIDS Initiative" is much stronger politically. It has important Republican Party support and is not associated with La Rouché. Also, it may have insurance industry support because it would repeal the current law against using the HIV antibody test for insurance.

This initiative threatens the movement to get people to be tested earlier and treated earlier. It gives everybody strong reasons to delay getting tested as long as possible, delaying medical intervention and AIDS-prevention counseling. It is likely to exacerbate the AIDS disaster.

To support the effort against the Dannemeyer Initiative, contact Mobilization Against AIDS, (415) 863-4676. New help is urgently needed because the people who usually fight these initiatives are overextended with AIDS work already.

Comment On HIV Testing and Insurance: Legislation which passed the California Assembly this week would let insurance companies use the

HIV antibody test to deny health insurance to persons with HIV (a provision also included in the Dannemeyer "AIDS Initiative", above). This issue illustrates a long-term problem for the whole U.S. health-care system, not just AIDS. For the HIV antibody test is only the first of an expected wave of high-tech tests to detect persons at higher risk for cancer, heart diseases, arthritis, and other expensive illnesses, as well as AIDS.

In the past the whole point of insurance has been to share the risk. But in the future the industry will inexorably drive to use the new tests to cut costs, by excluding those at risk and betting only on a sure thing--clients screened to exclude any detectable risks. Others will be dumped onto the increasingly overburdened public sector. They may also face employment discrimination, as they cannot qualify for the often-mandatory "benefit" of group health insurance--or would raise the employer's premium if they were hired.

FDA Backs Off On AL 721. Last week the FDA moved against two suppliers of AL 721 or related products: Ethigen Corporation, the patent and trademark holder on AL 721, and Nutricology Inc., in San Leandro, CA. Protests began immediately and the FDA rescinded both actions in the same week. It appears that the central FDA office near Washington, DC did not even know about the actions of the regional offices until the protests began.

The four people central to the negotiation for the AIDS community were attorneys Jay Lipner and David Barr with Lambda Legal Defense in New York, Martin Delaney with Project Inform, and Curtis Ponzi, attorney for The Healing Alternatives Foundation in San Francisco. We spoke to both Lipner and Ponzi; they saw the outcome as a message of community empowerment, but Lipner commented that the ultimate results are unknown and warned that we must keep watching the FDA in the future.

The New York Times ran a page-one story on these events on Sunday, June 26.

How to Subscribe to AIDS Treatment News

Send \$100. per year (26 issues), or \$30. reduced rate for persons with AIDS or ARC, to: ATN Publications, P.O. Box 411256, San Francisco, CA 94141. A six-month subscription (13 issues) is \$55., or \$16. reduced rate. Subscriptions include several back issues at no extra charge.

You can subscribe by phone, (415) 255-0588 during business days.

For the complete set of over 55 back issues, send \$50. (\$12. for persons with AIDS or ARC) to the above address. The back issues include information on dextran sulfate, AL 721, DTC (Imuthiol), naltrexone, DHEA, lentinan, propolis, coenzyme Q, monolaurin, fu zheng herbal therapy, DNCB, aerosol pentamidine, fluconazole, ganciclovir (DHPG), and other experimental or alternative treatments.

To protect your privacy, we mail first class without mentioning AIDS on the envelope, and keep our subscriber list confidential.

Outside North America, add \$20. per year for airmail postage, and \$15 airmail for back issues.

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**MEMO
THE
NATIONAL
PRISON
PROJECT**

1616 P Street NW
Suite 340
Washington, D.C. 20036
(202) 331-0500

Judy Greenspan

Aug. 3, 1988

Sue,

I think I understand your question. The only group of prisoners doing AIDS education that I know of are in the AIDS unit in Chino, California. There are 2 AIDS units for men in Calif. - one at Vacaville & one at Chino.

You can contact:

James T. Jones
P.O. Box 500 320-L
Chino, CA 91708

By the way, don't let the cost of the AIDS booklet deter you. If you want it,

**MEMO
THE
NATIONAL
PRISON
PROJECT**

1616 P Street NW
Suite 340
Washington, D.C. 20036
(202) 331-0500

Judy Greenspan

We can make a
deal.

Sincerely,

—
Judy
Greenspan

Mike Reagle of GEN may
have more information
about this.

Not Needed for Bedford

Urvashi Vaid - Prisons AIDS: the Law

Prisoners treated differently in regards to AIDS than the general population

U - # of states = mand. testing

segregate inmates w/ AIDS, ARC or HIV(+)

many prisons do not have adequate med. staff or facilities = lack of ^{allocated} \$ by state & fed legislatures

~~Prisons~~ Overcrowded conditions

Vast majority of prison^{er} AIDS have been ~~100%~~ HIV transmission

Sex between inmates takes 3 forms

- consensual sex = the most prevalent
- coerced sex = sexual favors traded for protection from assaults & other benefits (almost as common)

- rape

Sharing needles & tattooing implements

Pg 241 Strongest argument against mandatory testing: testing exposes HIV(+) inmates to discriminatory & substandard conditions of confinement

segregation permanently brands a prisoner, an inmate segregated as HIV(+) cannot return to gen pop. Yorsky's life

Almost 80% of state prisoners are from NYC and its metropolitan area

Blacks & Latinos comprise about 80% of the more than 41,000 prisoners housed in the state's 52 prisons

60-70% of all inmates are believed to have a history of drug use

Most of inmates w/ AIDS are Black & Latino - 31, from NYC, history of IV drug use, average of 2 kids

ACE had to combat misinformation among staff - casual contact, how virus transmitted, lack of understanding $\Rightarrow$ hostility, malicious acts

(9) Surrey shared co's wanting to know which inmates were ~~with~~ AIDS/ARC & preferred they be housed in a separate facility - Must get all inmates should be tested

2) Inmates diagnosed w/ AIDS/ARC are excluded from participation in the Family Reunion Program regardless of whether the visit would include involve a spouse, child or parent"

ACE has acted in a situation where
"there is no systematic, ongoing, face to face
AIDS educ & training programs either for
uniformed and civilian staff or for prisoners.

SEPTEMBER 20, 1988

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

TITLE	STOCK NUMBER	PRICE
<i>US Court Printing Office</i> AIDS in Correctional Facilities: Issues and Options (Provides information to correctional administrators to assist them in addressing AIDS in the institutional setting). 1987. 222 pages	027-000-01291-4	\$12.00
Law Enforcement Officer and AIDS	027-001-00046-7	\$2.75
Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives	017-024-01345-5	\$5.50

Law Library HV8843.H22 1988

PUBLICATIONS AVAILABLE FROM OTHER SOURCES

TITLE: Facts About AIDS (issued by the Department of Health and Human Services)
PRICE: 50¢

SOURCE: Orders should be addressed to: R. Woods
Consumer Information Center
Pueblo, CO 81002

TITLE: Surgeon General's Report on AIDS (Issued by the Public Health Service)
PRICE: Free

SOURCE: Request should be addressed to: AIDS
PO Box 100
Washington, DC 20044

TITLE: Confronting AIDS (issued by the National Academy of Sciences)
PRICE: \$24.95

SOURCE: Orders should be addressed to : National Academy Press
National Academy of Sciences
2101 Constitution Ave., NW
Washington, DC 20418

ADVANCE PAYMENT REQUIRED

Use the following price quote identifier
when ordering. Price quoted is valid
for 90 days.

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The Exchange

♀ who test positive for HIV antibodies

The majority of ♀ w/ AIDS are members of minority groups or low income. A May are also IVU's.

As of July 1, 1987 AIDS became the leading cause of death for ♀ age 25-34.

84% of these ♀ are minorities

50% are Bl.

22% are Latina

27% Caucasian

Issue 7
Mar 88

Demands for the segregation of people w/ AIDS have come from both guards and other inmates

Issue 2
Dec 86

consensual & forced sex are common in prison, as are IVU use & tattooing.

Confidentiality of medical records is essential to the safety of prisoners w/ AIDS-related conditions & in the general prison population

Dealing w/ the problem of discussing practices that are supposed to be punished

NPP Journal
#16 Summer 88

13 states have policy of mandating testing upon entry.

Rules & Regs around confidentiality, housing, testing vary state to state.

As noted in Spring '88 NPP Journal
"Inadequate med. care" in the NY prison system
is partially to blame for the high mortality rate
of prisoners w/ AIDS. According to a study
conducted by the NYS State Commission of Correction
prisoners w/ AIDS live only $\frac{1}{2}$ as long as people
w/ AIDS who are not ~~dear~~ incarcerated.

NAN Multicult. Vol 1 #6 Nov '87

"Despite taboos, penalties & laws prohibiting
consensual sexual activities between
fellow inmates & correctional officers, non-coercive
sex does occur. To a lesser extent, coercive
sexual activities and rape also take place.
At least 10% of incarcerated populations are
self-identified or closeted lesbians, gays, bisexuals,
or are involved in what sex researchers call
"situational" same gender relationships."

ACE fought for the right to have — inmates
trained in AIDS education to offer peer counseling
to other inmates.

AIDS in prison : A Crisis in NYS State Corrections
Correctional Assoc. of NY - June '88

NY prison system houses more inmates w/ AIDS
than any other state

AIDS in prison

Special Missouri hospital facility houses federal inmates with AIDS

By Ellen Hale
AMN CORRESPONDENT

From a wheelchair, he recites the litany of his problems: "My liver's so bad I can't walk anymore. Every time I stand up it burns. My knees hurt, my wrist hurts. Everywhere there's bone and joint, it hurts."

He's young, he has AIDS, and he wants to know why he can't go home and die.

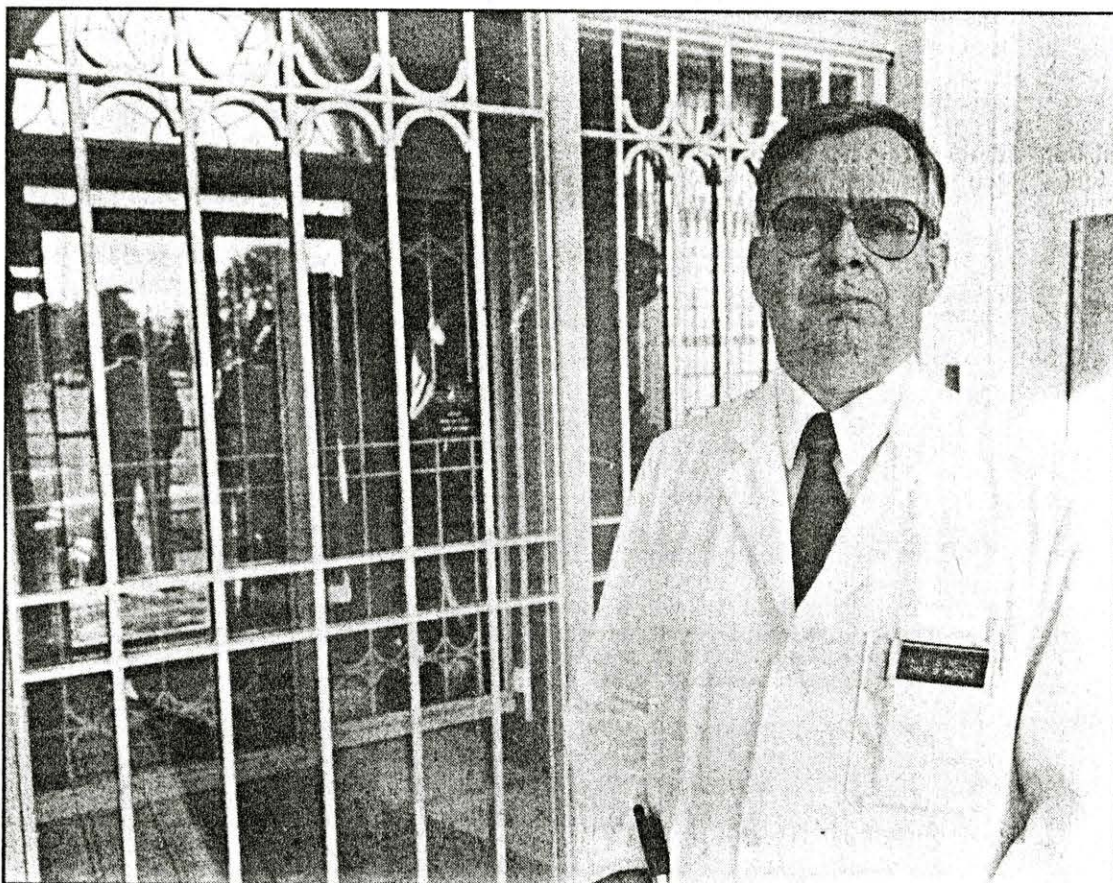
The reason: the bars on his hospital room window.

This is the U.S. Medical Center for Federal Prisons in Springfield, Mo., a 600-bed facility where male inmates with AIDS throughout the country are housed.

Since it opened 55 years ago, federal prisoners in need of special medical attention always have been taken to this sprawling facility that looks less like a prison than a scenic college campus.

By roving bus, commercial airline, and even chartered jet, they're brought here for medical care superior to that which most of them would get if they were outside the bars that hold them in.

For the past two years, however, the center has taken a new challenge: caring for inmates with acquired immune deficiency syndrome. Of about three dozen federal prisoners now diagnosed with end-stage AIDS, two-thirds live here in Springfield. Caring for them



Photos: Michael S. Green

Zidovudine rule

"We have a hard and fast rule about AZT here since it is so expensive," says Stanley Nelson, MD, prison chief of medicine. "You either take it right or don't take it at all."

has presented medical center physicians and nurses with new problems and concerns, and has changed the way they practice prison medicine.

Still relatively rare, among

prisoners, AIDS nonetheless threatens to become a major problem for the country's prison system. Homosexual activity — a major risk factor for AIDS — is believed to be common among prisoners in some facilities, and many prisoners have histories of intravenous drug abuse, a second major risk factor.

TWO YEARS AGO, federal officials were so worried about AIDS outbreaks in the nation's prisons that they decided inmates infected with the human immunodeficiency virus should be quarantined in Springfield, at the country's only federal acute care maximum security facility. About 30 men, most brought in from other institutions, were locked into a ward in Building 10 at the medical center.

"I was there 10 months ago and hated every day of it," says the 31-year-old inmate, serving time for robbing a bank to get money to support his drug addiction. He believes he became infected with the AIDS virus from sharing contaminated needles while incarcerated at Sing Sing Prison in New York.

"You gotta be there every day, watch people die. There was only three guys there who weren't gay," the inmate says. "To be honest, I don't got anything against no homosexuals, but I didn't like living with them."

The AIDS ward was short-lived. When it became evident to scientists and medical experts that AIDS was not transmitted casually, the ward at Springfield was closed down and the inmates "main-

streamed" back into the general prison population.

THIS JUNE, the Federal Bureau of Prisons began testing all newly sentenced prisoners for HIV antibodies, as well as testing inmates soon to be released. Those newly admitted inmates whose tests are negative are tested again in 90 days, and then again 90 days later if their tests still turn up negative. Thereafter, they are tested every six months.

Inmates found to be infected who are not sick are left in their usual prison environment, says J. Michael Quinlan,

'At first, we feared . . . these prisoners with AIDS would be assaulted by others. When the AIDS unit was under way, everyone knew who was there. But we've had no problem. I rarely have a non-infected prisoner ask me about it.'

Dr. Nelson
Chief of medicine,
Springfield prison

director of the Federal Bureau of Prisons. Male prisoners with AIDS who need medical care are sent to Springfield; diseased female federal prisoners are taken care of at a prison hospital near Lexington, Ky.

Surveys show that most infected inmates entered prison already carrying the virus and, so far, it appears that most prisoners who carry the AIDS virus became infected through intravenous drug use. Early studies revealed that more than 90% of HIV-infected inmates got that way through sharing needles, says James W.

Clawson, MD, head of the health program at Springfield.

No one knows yet how many inmates have been exposed to the AIDS virus inside of prison walls.

OF 44,000 PRISONERS throughout the federal system, 33 are known to have AIDS in its most advanced form; the number with the disease in lesser stages or infected with the virus is certainly higher, officials say.

About 500 prisoners have been tested at the medical center in Springfield, and nearly 5% of them were found to carry HIV antibodies. There have been 22 deaths from AIDS among inmates at the center; cancer unrelated to AIDS remains the leading cause of death.

"At first, we feared and anticipated these prisoners with AIDS would be assaulted by others. When the AIDS unit was under way, everyone knew who was there. But we've had no problem," says Stanley Nelson, MD, chief of medicine at the Springfield prison. "I rarely have a non-infected prisoner ask me about it."

Nor, says prison public relations officer Keith Hayes, have any prisoners ever questioned the safety of the food service or the prisoners who help prepare food.

"AIDS is just accepted here now; it is everywhere," adds prison physician Donald Lieberwitz, MD.

ALL INMATES, STAFF, and health care workers are required to undergo AIDS education, which includes watching an AIDS education videotape, and inmates have access to physicians and nurses to talk about any apprehensions. Prisoners infected with the virus are counseled by physicians, nurses, and psychologists.

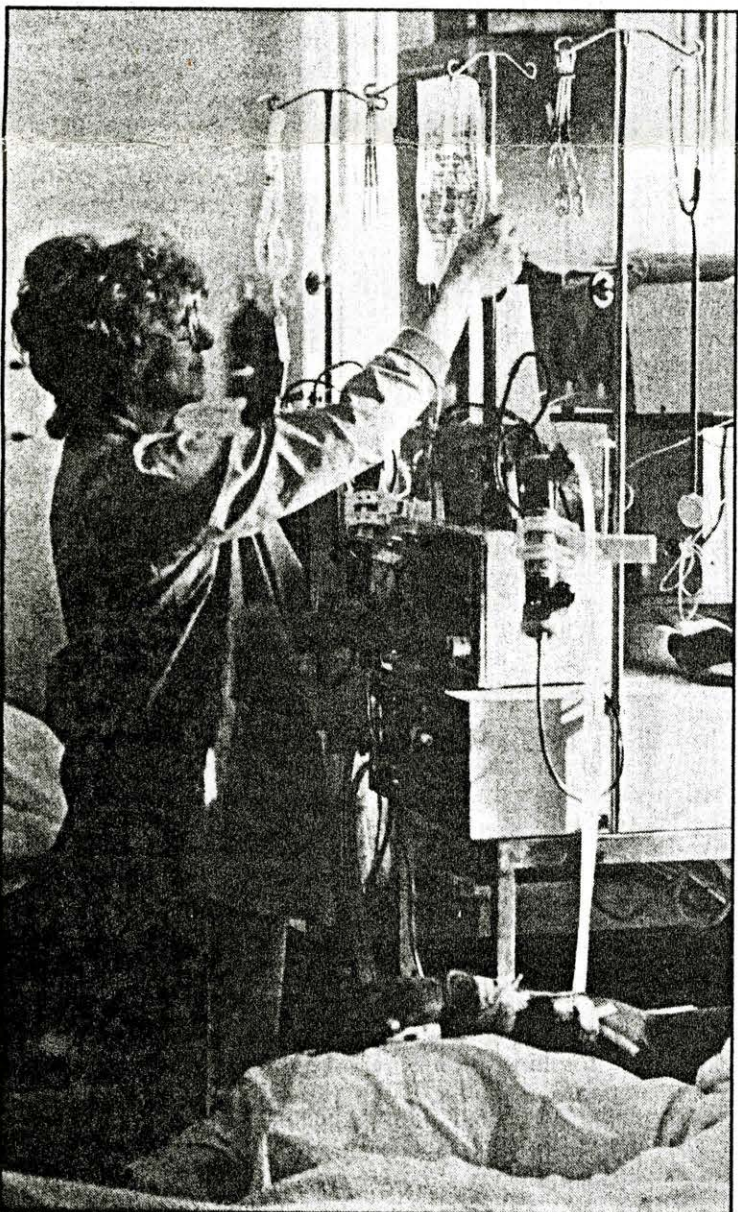
But the disease has caused problems in the medical center.

Among the most serious have been in the kidney dialysis unit, where three nurses have either quit or transferred rather than continue to treat AIDS-infected dialysis patients.

"This is a tremendous problem," admits Dr. Clawson. "There is a great fear of handling equipment."

"I've had several nurses with needlestick injuries and two with massive amounts of blood spilled on them. None have turned HIV positive, thank God," says Carrie Simmons, RN, director of the dialysis unit until she stepped down in September. Her decision, she says, had little to do with treating AIDS-infected inmates but much to do with the general stress of working in a dialysis unit.

"DIALYSIS patients everywhere are more emotionally labile, and then there are the See PRISON AIDS, next page



Fear of AIDS

Carrie Simmons, RN, in the dialysis unit. Three nurses either quit or transferred rather than treat AIDS patients.

Prison AIDS

Continued from preceding page
stressors of being part of the prison population," says Simmons. "I'm not concerned myself because of AIDS, as long as we have proper staffing and equipment and space."

Of 20 inmates at the medical center who have kidney failure and who require dialysis, three are infected with the AIDS virus. When nurses first began dialyzing them, they treated them as they treated all their patients. Now, they treat all patients as though they were infected with the AIDS virus.

"We wear goggles or face masks. We use more bleach as a disinfectant. We take more precautions when we deal with open blood lines. There are no such things as puncture-free gloves," Simmons says.

Of particular concern for her and for other health care officials at the center are inmates who suffer AIDS-related neurological problems that may make them violent, as well as inmates who are violent by nature and may be infected with the virus. One AIDS inmate reportedly bit at least one prison guard in an attempt to spread the virus; the disease was not transmitted.

Everyone who has regular contact with prisoners at the center is told who is HIV positive. Hospitals in the Springfield community, where prisoners are taken for tests and treatments not available in the prison, also are informed, as are the parole officers for infected inmates who are released. About half a dozen infected inmates have been released into the community after serving their sentences.

Most prisoners with AIDS here are housed in "3-2," Building Three, Floor Two, the acute care ward of the medical center. Some are considered safe and their crimes relatively minor, so they need no guards and are allowed to walk about freely. Others may be extremely violent and require as many as four guards to escort them, says Dr. Clawson.

Regardless of how dangerous an inmate is considered to be or what his crime is, however, his medical care is as good — and possibly better — than that many people receive. Says Dr. Clawson, "Many of these guys get better medical care here than they would on the outside."

Twenty MDs from the Springfield area serve as consultants, offering the latest and most sophisticated medical care and surgical techniques. Three full-time dentists provide dental care for all inmates at the center, as well as dental and oral surgical care for the system's other penal institutions.

A nearly full-service medical laboratory, accredited by the College of American Pathologists, provides immediate results for lab tests. Procedures the center cannot perform, such as computed tomographic (CT) scans, are done in private labs in Springfield, which has a growing reputation as a regional center for medical care in the Midwest.

Dr. Nelson was cleared to use the anti-viral drug zidovudine (formerly known as AZT or azidothymidine) on inmates at the prison medical center before it was approved for general use by the federal Food and Drug Administration. About one dozen prisoners are now using it — free of charge — at an annual cost of \$8,250 each. A few have refused it.

Prison officials are strict about the use of zidovudine: Inmates must adhere rigidly to its use and take it correctly in four daily doses.

"We have a hard and fast rule about AZT here since it is so expensive," says Dr. Nelson. "You either take it right or don't take it at all."

Once an inmate is released, however, the prison system bears no responsibility to take care of him anymore. For

many, that means an end to the life-saving zidovudine treatment.

"Some of these guys would have to rob a bank to be able to buy the AZT, and that would put them back in prison," points out Dr. Lieberwitz.

John H. is an inmate with AIDS who benefited — he was literally rescued from near death — by the medical care at the center.

He weighed only 90 pounds when he was flown into Springfield this past summer on a chartered jet from a low-security prison camp in Boron, Calif., where he was serving time for conspiracy to sell narcotics.

"This man was frightfully ill when he came to us," recalls Dr. Nelson. "He was so sick, we thought he had neuropsychiatric disease because of AIDS. He didn't. He was just so ravaged with illness he was mentally confused."

Physicians put him through a battery of tests and found he had tuberculosis, among other opportunistic illnesses. Because he met federal guidelines for use of zidovudine, he was put on it.

In three months, John H. gained 21 pounds. "Just think how much I would have gained if the food was good," he jokes. "They treat me very well here; I

"The one benefit we have here is that we don't get close to the AIDS patients here as you might on the outside," Dr. Nelson says. "We keep an arm's length away."

couldn't get better care at home."

Now serving out the last of his 18-month prison sentence, John H. steadfastly maintains that he contracted AIDS while serving time earlier for a drunk driving offense. He was allowed to complete his six-day sentence on weekends, and, during one of those times, he says, he cut himself shaving using a common razor shared with other prisoners. Physicians at Springfield are skeptical of his explanation.

Despite his excellent care at the U.S. Medical Center for Federal Prisoners, John H. doesn't worry about his future health care, even though, he admits, he does not have medical insurance and will not be able to afford to continue the zidovudine treatment that has saved his life. "I'm not worried. I have friends who are doctors and nurses," he says confidently. "And I'm sure they'll find a cure."

Can Springfield prison physicians rule out that prisoners don't come into contact with the virus there?

"Of course," says Dr. Clawson with a smile. "It's illegal in prison to engage in any sexual activity."

Seriously, Dr. Clawson adds, the bureau of prisons has no intention of distributing condoms because "if we were to hand out condoms, it would appear we are condoning sex."

For the most part, he and Dr. Nelson believe that the addition of AIDS patients to the prison roster there has improved the way they practice medicine.

"We don't really have any problem with AIDS patients," says Dr. Nelson. "We treat them like anyone else unless we get in the situation of blood flow. We wear gloves and we take great care."

Says Dr. Lieberwitz, "I'm a lot more careful than I was before. I never worried about getting blood on my hands. ... AIDS has sharpened us all up."

In addition to routine use of gloves now, a new protocol for Code Blue emergencies provides for use of special aspirators to prevent mouth-to-mouth contact. But the disease has not taken anything away from the quality of care offered at the Springfield facility, the physicians stressed.

"All of us, if we had someone bleeding all over us, would prefer that they not be HIV positive," said Dr. Clawson. "But we are not going to not help someone because we don't know if they are or aren't."

Dr. Nelson was a physician in private practice in the Springfield area until seven years ago, when, at 50, he decided he needed a change. "I've been having a ball ever since," he said.

But, he added, he's "never seen anything like AIDS in all those years."

"To see someone go from looking healthy to dying in a matter of days or weeks is incredible," said Dr. Nelson. "The one benefit we have here is that we don't get close to the AIDS patients here as you might on the outside. We keep an arm's length away."

Still, that makes AIDS no less tragic for those who have it within prison walls.

Inmate Robert R., the 31-year-old who was exposed to the AIDS virus through IV drug use, is a case in point.

Institutionalized off and on since the age of 10, he was sent to Springfield in 1985 after being found to have AIDS while serving time at a federal prison in Lewisburg, Pa.

"I got a rash on my face. I thought it was a sunburn, but before I knew it I was itching myself crazy. I told them I had to see a doctor and finally got to one. He took one look at me, told me to open my mouth, and it was thrush."

"He took some blood and came back a day later and said 'I got some bad news; you may have AIDS.' It hit me like a ton of bricks. They said they were going to do a couple more tests, and then they sent me here."

"Physically I felt all right. Got some medicines and got better. The only thing on my mind was that I've got to stay in shape, got to stay healthy. I started lifting weights. I gained weight and went from 170 to 185."

"Then all of a sudden around November last year, I got pains in my chest. I thought it was a pulled muscle. I went from 185 to 160 pounds. A CT scan and biopsy showed TB. They treated me for that, but I was losing a lot of weight and strength. One day I couldn't smell cigarettes no more."

"They found another lump, did another operation, and found I had lymphoma, not TB. I started taking chemotherapy. I think I handled it pretty well so far; I have one more series to go."

"Then they did some more biopsies and found I have TB in my bones. Incurable and untreatable."

"That's it. I've been here ever since, hanging out, going through changes. I got granuloma of the liver, from where the cancer was on the liver. I got non-A, non-B hepatitis. I guess that's all I got, but I got it all."

"The thing I don't understand is why I can't go home. I can see there are guys in here you can't let out. They'd kill or rob. But I can't even walk. What am I gonna do out there? Just go to my mother's house and die. I sure don't want to die in here."

"I been doing bad all my life," admits Robert R., "but I paid for it."

There is a provision that allows dying prisoners to be released, but federal officials do not like to use it often in case the prisoner's condition improves. The chances of that are slim for Robert R., who, because he also has liver failure, can't take zidovudine.

But Dr. Lieberwitz, his physician for the past two years, says that Robert R.'s family doesn't want him home because they could not care for him.

"Therein lies the dilemma of prisoners who are ill," says public relations director Hayes. "They get better care here than they'll ever get in the community, and their families don't want them."

Says Robert R., "The parole board wants me to stay here until 1991. I'll never make it."

Business asks how to foot AIDS bill

By Leigh Page
AMN STAFF

Corporate America is paying widely varying charges to treat employees with AIDS — prompting some companies to consider tighter cost controls, said business people on a panel last month in Washington.

Though AIDS bills were expected in one estimate to reach 3% of corporate health care costs by 1991, companies are committed to covering AIDS just like any other serious disease, panelists said. However, with AIDS bills ranging from less than \$40,000 to more than \$150,000, several felt a need for more aggressive case-management.

The panel, part of a meeting on "Health Agenda 1988," sponsored by the Washington Business Group on Health and the National Assn. of Manufacturers, noted a growing corporate awareness of acquired immune deficiency syndrome.

Last fall, an East Coast executive told an NAM-sponsored AIDS panel that "we don't have that sort of behavior where we are." No one expressed that attitude this time, and the growing problem became apparent with the absence of one attendee: James, a Houston AIDS patient whose company named him employee of the year, had died the previous Saturday.

But even at the largest corporations, very few employees have been identified as having AIDS. Out of 52,000 worldwide employees at San Francisco-based Chevron Corp., for example, about 13 employees have been listed as having AIDS, said panelist J.D. Hufford from Chevron.

Hufford said Chevron's costs average \$40,000 a case — less than half a national average of \$94,000 identified by the Rand Corp. He said generous community assistance for Chevron's mostly San Francisco AIDS patients helped keep the bill low.

One Houston AIDS case cost more than \$150,000, said Sandra Person, executive director of the Houston Area Health Care Coalition. As AIDS cases grow, "Who's going to make money?" she asked. Person said the new expenses for AIDS could be met by weeding out what she sees as waste that exists in health care.

Hospital days for AIDS patients vary from averages of 31-50 days on the East Coast to 11-14 days on the West Coast, said panelist Thomas Fitzsimmonds of Dayton, Ohio-based Mead Corp.

To make AIDS treatment more efficient, Chevron has discussed funding home health care, but so far the company has not changed health care coverage at all because of AIDS.

Meanwhile, Chevron, Mead, and other pioneers in corporate involvement with AIDS have been educating employees about AIDS. Chevron also has spent a considerable amount educating the wider Bay Area community. The oil company says it has contributed to local patients with AIDS and financed two local TV productions on AIDS.

frightened face of the two women I saw last night and today. I have witnessed three assaults by men against women and one violent window display in just over a 24-hour period.

The good news is that we are not powerless! We can act. "The Limited" is sending a very clear message to passersby that it's O.K. to brutalize women. We, as women and men of this "civilized" society, must respond clearly and loudly that we will not tolerate abusive advertising! I encourage you to visit "The Limited" and experience firsthand this violent assault. Don't be silent! Write a letter. Boycott "The Limited." Demand that this abhorrent display be removed immediately. (It is legal to peacefully picket on the sidewalk in front of a store during busy shopping hours, i.e. weekday lunch hours and/or weekends.)

Women comprise half of the Earth's population and we deserve a safe place to live!

Sandy Perpignani
Jamaica Plain, Mass.

AIDS information reduced to a trickle behind prison walls

Dear GCN:

I'm writing this to inform your readers as to what happens to Federal Prisoners who test HIV positive or have AIDS/ARC.

There are tons of printed information on AIDS out there but this flow is reduced to a mere trickle when it hits a prison's walls. Numerous requests of staff to provide AIDS information have met with indifference. Little counseling is made available, and none by experienced AIDS counselors. Staff go through the motions of protecting the PWA's confidentiality, but often his medical condition is revealed to other prisoners (most of whom are homophobic and, of course, know very little about AIDS).

Medical treatment takes on an almost totally passive role here. The PWA is doing little more than waiting for an opportunistic disease to kill him. The Bureau of Prisons policy also leaves no room for a patient-doctor relationship. Instead these relations are always patient-prison policy-doctor relationships, which can interfere with treatment since a doctor must always refer to prison policy before dealing with a patient's request.

Having lost the confidentiality here around my being a PWA, I have become outspoken on the subject of AIDS and will attempt to 'educate' any inmate with inquiries. I am currently researching AIDS related material, experimental drugs, and their possible (voluntary) use on prisoners. Any helpful information would be appreciated.

Passivity is the acceptance of death before the fact. If I should passively accept the way I'm treated here, then AIDS has already killed me.

Holding on,
L.A. Snyder
08324-000
Box 4000

Springfield, MO 65808

Why do they have to make it harder than it is already?

Dear GCN:

By now you have received Jo's and my newspapers which they have refused to us because they said it was contraband because of a nude picture and controversial material.

Mike, Jo is really sick with her Lupus disease and they are not giving her any medicine and they are very much aware of her problem. But they really don't care about us in here. I don't know why I'm writing you except I just need to let someone know what is going on. Why when a person makes a mistake and goes to prison do they have to make the time harder than it already is?

I hope we can get our paper back again.

Sincerely your friend,
Judy McNece
2591 Unit 1 Rm 16
8000 W. 7th St.
Pine Bluff, AR 71603

AIDS: They don't give a shit because it isn't happening to them

By Vito Russo

A friend of mine has a half fare transit card which he uses on buses and subways. The other day when he showed his card, the token attendant asked what his disability was—he said, "I have AIDS," and the attendant said, "No you don't. If you had AIDS you'd be home — dying." I'm here to speak out today as a PWA [person with AIDS] who is not dying from — but for the last three years — quite successfully living with — AIDS.

Members of my family who get all their information from reading the newspapers and watching television know two things about me — that I'm going to die and that the government is doing everything in its power to save me. They're wrong on both counts.

If I'm dying from anything it's from homophobia. If I'm dying from anything it's from racism. If I'm dying from anything it's from indifference and red tape. If I'm dying from anything, I'm dying from Jesse Helms. If I'm dying from anything, I'm dying from Ronald Reagan. If I'm dying from anything, I'm dying from the sensationalism of newspapers and magazines and television

Living with AIDS in this country is like living in the Twilight Zone. Living with AIDS is living through a war which is happening only for those people who are in the trenches. Every time a shell explodes you look around to discover that you've lost more of your friends.

shows which are interested in me as a human interest story only as long as I'm willing to be a helpless victim but not if I'm fighting for my life. If I'm dying from anything, I'm dying from the fact that not enough rich, white, heterosexual men have gotten AIDS for anybody to give a shit.

Living with AIDS in this country is like living in the Twilight Zone. Living with AIDS is living through a war which is happening only for those people who are in the trenches. Every time a shell explodes you look around to discover that you've lost more of your friends. But nobody else notices. It isn't happening to them. They're walking the streets as though we weren't living through a nightmare. Only you can hear the screams of the people dying and their cries for help. No one else seems to be noticing. It's worse than wartime because during a war the people are united in a shared experience. This war has not united us. It's divided us. It's separated those of us with AIDS and those of us who fight for people with AIDS from the rest of the population.

Two and a half years ago I read a *Life* magazine editorial on AIDS which said it's time to pay attention because "This disease is now beginning to strike the rest of us." It was as if I wasn't the one holding the magazine in my hand. Since then nothing has changed to alter the perception that AIDS is not happening to the real people in this country. It's not happening to us in the United States. It's happening to them, to the disposable populations of fags and junkies who deserve what they get. The media tell people they don't have to care because the citizens who really matter are in no danger. Twice, three times, maybe four, the *New York Times* has published editorials saying "Don't panic yet over AIDS" — it still hasn't entered the general population and until it does we don't have to give a shit.

And the days and the months and the years pass by. And they don't spend those days and nights and months and years trying to figure out how to get a hold of the latest experimental drug and which dose to take it at and in what combination with what other drugs and from what source and for how much money because it isn't happening to them and so they don't give a shit. And they don't sit in television studios surrounded by technicians who wear rubber gloves and refuse to put a body mike on them because it

isn't happening to them so they don't give a shit. And they don't have their houses burned down by bigots and morons. They only watch it on the news and then they eat their dinner and they go to bed because it isn't happening to them so they don't give a shit. They don't spend their waking hours going from one hospital to another, watching the people they love die slowly of neglect and bigotry because it isn't happening to them so they don't give a shit. They haven't been to two funerals a week for the last three, four or five years so they don't give a shit. It's not happening to them.

We read on the front page of the *New York Times* that Dr. Anthony Fauci now says that all sorts of promising drugs for treatment haven't even been tested in the last two years because he can't afford to hire the people to test them. We're supposed to be grateful that this story has appeared. Nobody wonders why some reporter didn't dig up that story and print it 18 months ago, before Fauci went public with his complaints before a congressional committee. How many people have died in the last two years who might be alive today if those drugs had been speedily tested? Reporters all over the country are busy printing government press releases. They don't give a shit — it isn't happening to them, meaning that it isn't happening to the real people, the world famous general public we all keep hearing about. Legionnaires Disease was happening to them because it hit people who looked like them, sounded like them, were the same color as them. And that fucking story about a couple of dozen people hit the front pages of every newspaper and magazine in the country and stayed there until the mystery was over.

All I read in the newspapers tells me that the mainstream heterosexual population is not at risk for this disease. All the newspapers I read tell me that IV drug users and homosexuals still account for the overwhelming majority of cases and those at risk. Then can somebody please tell me why every single penny allocated for education and prevention gets spent on ad campaigns directed almost exclusively to white, heterosexual teenagers who they keep telling us are not at risk for this disease? Can somebody tell me why the only television movie ever produced by a major network in this country is not about a young man with AIDS but about the impact of the disease on his straight, white nuclear family? Why for

AIDS is not what it appears to be at this moment in history. It is more than just a disease which ignorant people have turned into an excuse to exercise bigotry they already feel.... AIDS is a test of who we are as a people.

eight years has every newspaper and magazine in this country done cover stories on AIDS only when the threat of heterosexual transmission is raised? Why for eight years has every single educational film designed for use in high schools eliminated any gay-positive material before being approved by the Board of Education? Why in the past eight years has every single public information pamphlet and videotape distributed by establishment sources ignored specific homosexual content? Why is every bus and subway ad I read and every advertisement and billboard I see specifically not directed at gay men?

Don't believe the lie that the gay community has done its job and done it well and successfully educated its people. The gay community and IV drug users are not all politicized people living in New York and San Francisco. Members of minority populations, including so-called sophisticated gay men are abysmally ignorant about AIDS. If it is true that gay men and IV drug users are the populations at risk for this disease, we have a right to demand that education and prevention be targeted specifically to these people and it is not hap-

pening. We are being allowed to die while low risk populations are being panicked — not educated — panicked into believing that we deserve to die.

AIDS is not what it appears to be at this moment in history. It is more than just a disease which ignorant people have turned into an excuse to exercise bigotry they already feel. It is more than a horror story to be exploited by the tabloids. AIDS is a test of who we are as a people. When future generations ask what we did in the war, we have to be able to tell them that we were out here fighting. And we have to leave a legacy to the generations of people who will come after us. Remember that someday the AIDS crisis will be over. And when that day has come and gone there will be people alive on this earth — gay people and straight people, Black people and white people, men and women — who will hear the story that once there was a terrible disease, and that a brave group of people stood up and fought and in some cases died so that others might live and be free.

I'm proud to be out here today with the people I love and to see the faces of those heroes who are fighting this war and to be a part of that fight. To steal a phrase from Mike Callan's song, "All we have is love right now — What we don't have is time." Like the unsung, anonymous doctors who are fighting this disease and are so busy putting out fires that they don't have time to strategize, AIDS activists are stretched to the limit of their time and energy, putting out the fires of bigotry and hatred and misinformation when they need to be fighting for drugs and research money. We need luxury time to strategize the next year of this battle and we need our friends to join us so we can buy that time. And after we kick the shit out of this disease I intend to be alive to kick the shit out of this system so that this will never happen again.

Vito Russo is a co-founder of ACT UP/New York and lives in Manhattan. This speech was given at ACT UP's Albany rally, May 7, organized as part of the nationwide ACT NOW demonstrations. Russo hopes that this speech will "encourage more lesbians and gay men to become angry and involved in fighting back." He "urges people to take to the streets in order to lengthen and perhaps even save the lives of the people they love."

"Speaking Out" is part of our continuing effort to provide a true forum of opinion for the community. We encourage you to send your ideas, feelings and comments to us, and to respond to ideas expressed in this space. The opinions expressed are those of the author and are not intended to represent the views of the GCN membership. Submissions must be TYPED, DOUBLE-SPACED, AND NO LONGER THAN FIVE PAGES. Send to: Speaking Out, GCN, 62 Berkeley St., Boston, MA 02116.

Glowing Thank You

A special thanks to GLOW (Gays and Lesbians of Watertown) for dropping by GCN last week to help out our regular hard-working Friday night staffers. Please come again!

GCN Membership Meeting

Tuesday, July 26, 6:30 p.m.

All GCN members (staff, Board, and volunteers) are welcome for an invigorating and exciting discussion of staff hirings, the yet-to-be-funded AIDS Coordinator position and the politics and policies of phone sex advertising.

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INSIDE AN AIDS COLONY

As the nation tries to come to grips with the killer epidemic, a prison in Capshaw, Ala., has attempted the ultimate solution to stopping the spread of AIDS—quarantine

"Here was our own world, unlike anything else; here were our own laws, our own dress, our own manners and customs, here was the house of the living dead."

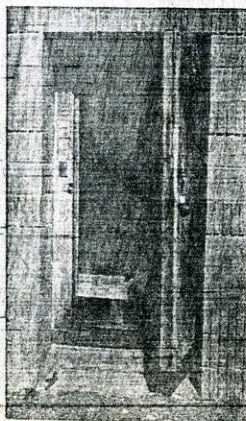
—Fyodor Dostoevsky

As the Alabama state-prison van rumbled north toward Huntsville, its lone passenger forced himself to lift his head and look out the window. Normally, Daniel Ryan savored an excursion. He loved to study the neatly cultivated cotton fields, with their brown stalks and brilliant white puffs. He enjoyed inspecting the small-town pawn shops, the fish-and-tackle stores and boxlike brick houses where children played on front porches. But today was different. Today, the route was unfamiliar and no one would say why he was being moved. Ryan was just

21 years old, serving 25 years for robbing a house and jumping prison, and now he rubbed a few tears off his cheek. He knew, all right.

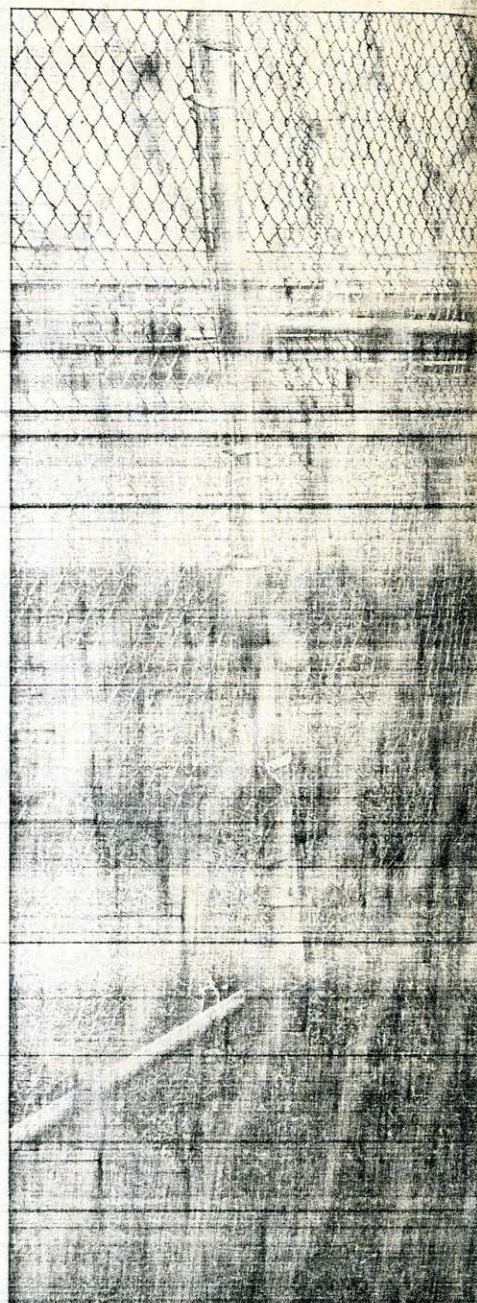
Yet when the van pulled up to the gates of Limestone penitentiary in the fall of 1985, even Ryan failed to anticipate the reception that awaited him. The guards, normally scrupulous in searching a new prisoner, refused to touch him.

Nurses outside his infirmary cell balked at even talking to him unless he first put on a surgical mask. When he showered, Ryan had to scrub the stall with pure bleach afterwards and mop his way back to his nearby cell, while armed guards in paper masks watched nervously. Ryan lived in isolation for five days, and then a doctor with a yellow mask came in and summarily announced: *"You have AIDS and are going to die from it."* After that, his first-floor cell was like a circus cage, as



The morgue awaits

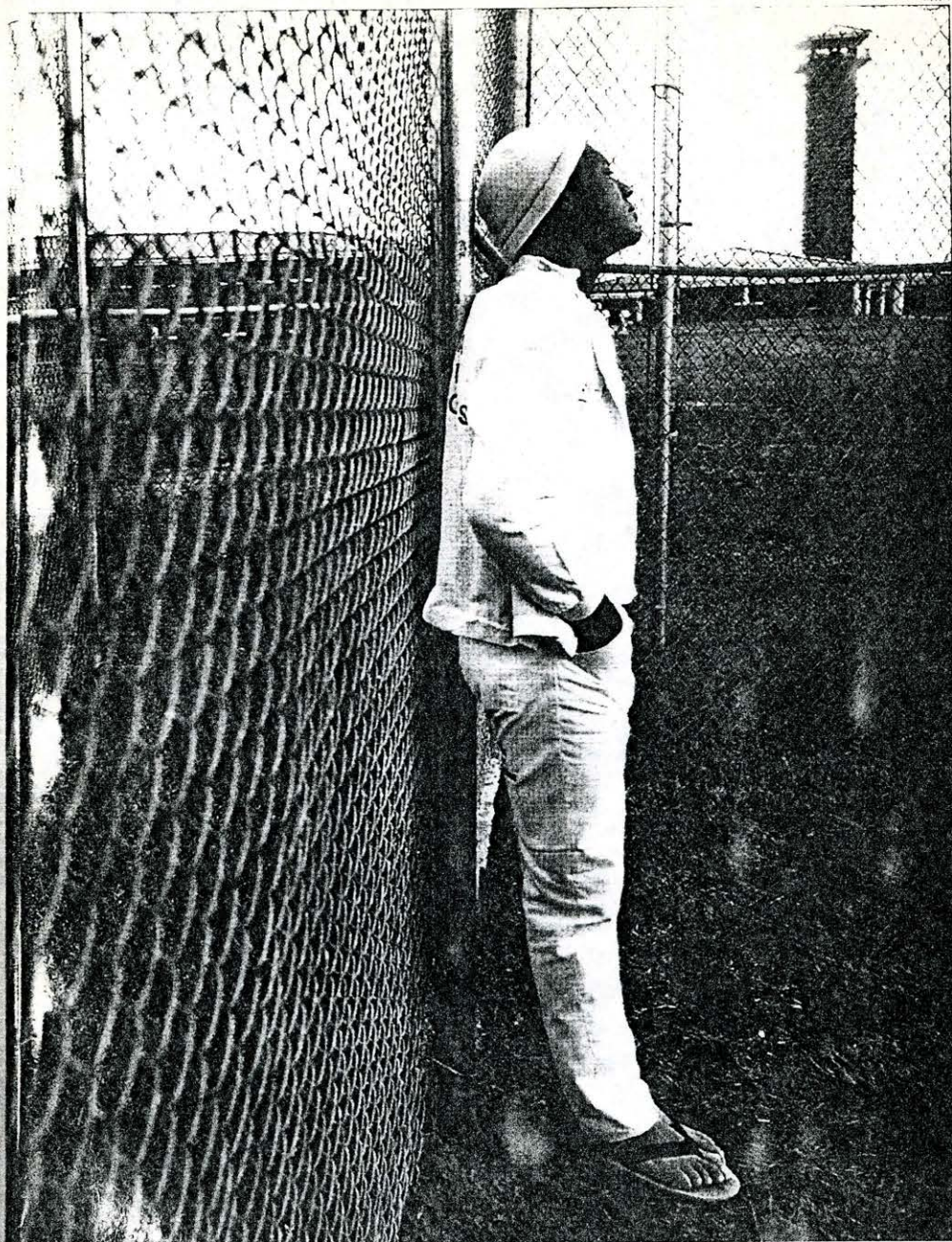
SCOTT HOPE FOR USMARS



THIRL KILL: He was one of those w

officers congregated outside his window in twos and threes, whispering, "Is that him? He's got AIDS." And that was how the House of the Dead began.

Just over a century ago, the famed Russian novelist Fyodor Dostoevsky penned a thinly disguised memoir titled *The House of the Dead* that recounted his four years in a hellish Siberian prison camp. In Dostoevsky's day, the prisoners ate cabbage soup that swam with cockroaches, endured darkened barracks with windows blocked by inch-thick hoarfrost and used fetid tubs as communal latrines at night. Yet in some respects, the House of the Dead at Alabama's modern, tidy Limestone prison in Capshaw, Ala., is



left Limestone prison more benumbed morally than when he entered

more insidious than its primitive Siberian predecessor. The prison's raucous "Thunderdorm" is a new kind of death row, one that houses every male prisoner in the state who carries the AIDS virus. Hemmed in by double chain-link fences topped by razor ribbon, and forbidden to have contact with other, uninfected prisoners or perform ordinary prison jobs, the 130 residents of the Thunderdorm form one of America's first AIDS colonies.

Not everyone thinks that an AIDS prison is a good idea. The American Civil Liberties Union says that Alabama has violated the inmates' constitutional rights, likening the HIV cellblock to a medieval leper colony. Prison officials,

by contrast, compare the Thunderdorm to a modern-day Sodom and Gomorrah, a debauched home for men who have insisted on breaking the law, using intravenous drugs or having sex with other men. (Even the Thunderdorm nickname, prison authorities note, derives from the so-called Thunderdome, a brutal arena where gladiators fight to the death in a "Mad Max" film.) Yet whichever side is right, Limestone's HIV colony has already provided an extraordinary laboratory, a test of an inevitable question in the debate over AIDS treatment: Does quarantining work?

The concept of isolating disease victims is certainly not new. For centuries,

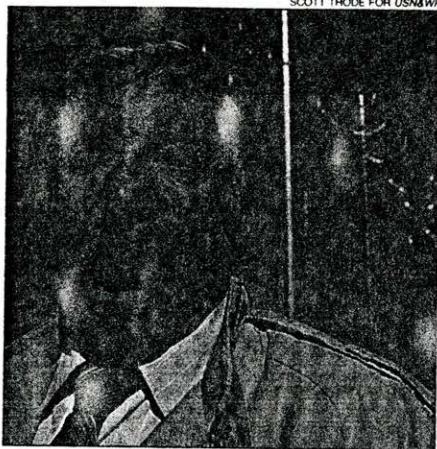
public-health authorities have resorted to quarantines to contain the spread of diseases. But despite the pleas of some conservatives, quarantine has never been tried with AIDS on a broad scale. In the few states like Alabama that have attempted to segregate criminals carrying the AIDS virus, there is no proof yet that quarantine is necessary, even within prisons. One fact, though, is unassailable: In the Alabama experiment and similar prison programs, the toll upon the personal dignity and peace of mind of everyone involved has been chilling. For the Thunderdorm may be the last house in America that anyone would want to call home.

THE MORGUE

"On this first day of my prison life [in Siberia] I made one observation which the passage of time convinced me was correct. ... Every convict, no matter how bold and cheeky, is afraid of everything in the prison."

For Daniel Ryan, the nightmares began after the first prisoner died. In the months that followed his October, 1985, arrival at Limestone, half a dozen other seropositive inmates joined Ryan, but only Grady Thomas was seriously ill. At first, Ryan and the other prisoners were too busy fighting among themselves to heed the 37-year-old Thomas. Many of the HIV inmates, including Ryan, were homosexual, and they bickered frequently over lovers. Ryan once karate-kicked another prisoner while the inmate sat on the toilet just because the inmate "had a smart mouth." During the day, there was nothing to do except watch television, smoke cigarettes and have surreptitious sex. There were no work assignments, no religious services, no educational offerings, no vocational training. And everyone was all jumbled together, white and black, shoplifter and drug abuser, rapist and murderer. The only thing they had in common was a deadly virus and the dread it inspired—until Thomas started getting worse.

Nicknamed "Schoolboy" for his thick glasses and love of books, the college-educated Thomas had earned the respect and admiration of many inmates when he served time at Alabama's Atmore prison farm (for receiving stolen property). Thomas did not seem to be afraid of anything or anyone, and the convicts liked the way he talked back to prison officials whenever he felt they had violated an inmate's rights. But now, as one HIV inmate put it, the once proud Thomas was the "most pitiful one of us all." His hair began falling out in clumps, his fingers were twice their normal size. Each day, large chunks of his skin flaked off on the floor and sheets. The nurses

**WARDEN WHITE: Seeking order**

and guards, horrified, shunned Thomas, sometimes letting him lie in urine-stained sheets for hours.

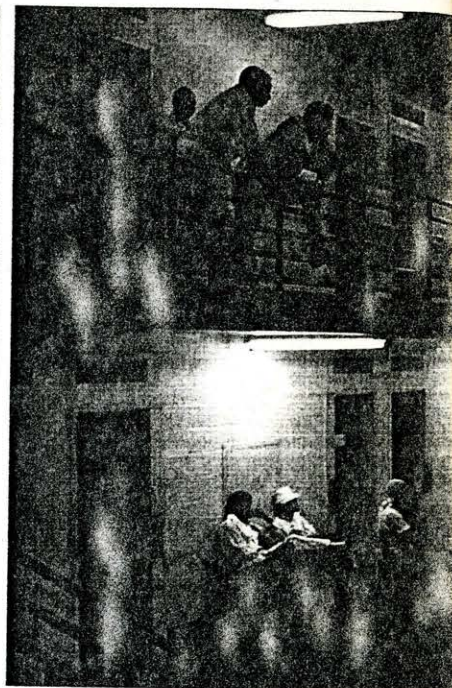
The inmates were horrified, too. Every time they passed Thomas's cell, they saw themselves lying there in his place. "Grady was dying from the same virus we all might die from some day," recalls fellow inmate Bennie Williams, a convicted cocaine dealer. "And none of us wanted to be reminded that we might die that way, alone." But something besides fear stirred in the inmates' minds too. As they sat around in furtive discussion of Thomas's condition, they found themselves searching for ways to relieve his pain and ease his loneliness. Besides, if they helped

Thomas, they reasoned, perhaps they could prove to the nurses and guards that there was nothing to fear, so that Thomas—and perhaps they themselves—would no longer be treated as pariahs.

In time, clad in surgical masks and gloves, Ryan and the other "HIV's" started tromping over to Thomas's infirmary cell to remove his trash and change his bedding. Some days, they would also shake out the pile of flaking skin that accumulated in his sheets and sweep up. Once, while a nurse stood by watching, they lifted the enfeebled man off the white linoleum floor after he fell on his way to the shower and helped him open the shower-stall door.

When Thomas finally died on the night of May 14, 1986, no one on the prison staff would touch him. Because of a misunderstanding with his family, no funeral home was initially asked to pick up Thomas's body, and so he lay in his infirmary cell for 12 hours, decaying. Warden J. D. White was in his office when the director of nursing came rushing over early the next morning to say that the stench from Thomas's body was overwhelming and the inmates in nearby cells were starting to panic. White hastily consulted a forensic expert at the Huntsville branch of the University of Alabama and then ordered that Thomas be zipped up in a body bag, strapped onto a gurney and stored, like a side of beef, in an empty food freezer.

After Thomas's body was retrieved

**THUNDERDORM: A new kind of de**

that afternoon, embarrassed state officials were so alarmed that White might again store an AIDS victim in the freezer that they promptly shipped to the prison a 10-by-12-foot refrigerated morgue on a flatbed truck. Shortly afterward, the warden showed off his new acquisition to a local television reporter, speaking to the

Why quarantining isn't necessary

By all accounts, convicts and AIDS should go hand in hand as naturally as prizefighters and black eyes. A large proportion of inmates in U.S. penitentiaries—perhaps most—have indulged in "high risk" activities such as homosexual acts and sharing needles. Yet for reasons no one quite understands, AIDS has not raced through the prison system, and that fact weakens the rationale for Alabama's quarantine policy. Here are some examples of how the conventional wisdom went awry:

■ **The breeding-ground myth.** Contrary to popular expectation, prisons, to date, have not proved to be breeding grounds for AIDS. Annual surveys funded by the National Institute of Justice show that since 1985, AIDS has spread at a slightly slower rate within prisons than outside of them. While inmates are still more likely than the average citizen to have AIDS, the NIJ survey indicates that since the start of the AIDS epidemic, fewer than 1 percent of the nation's 700,000 state and

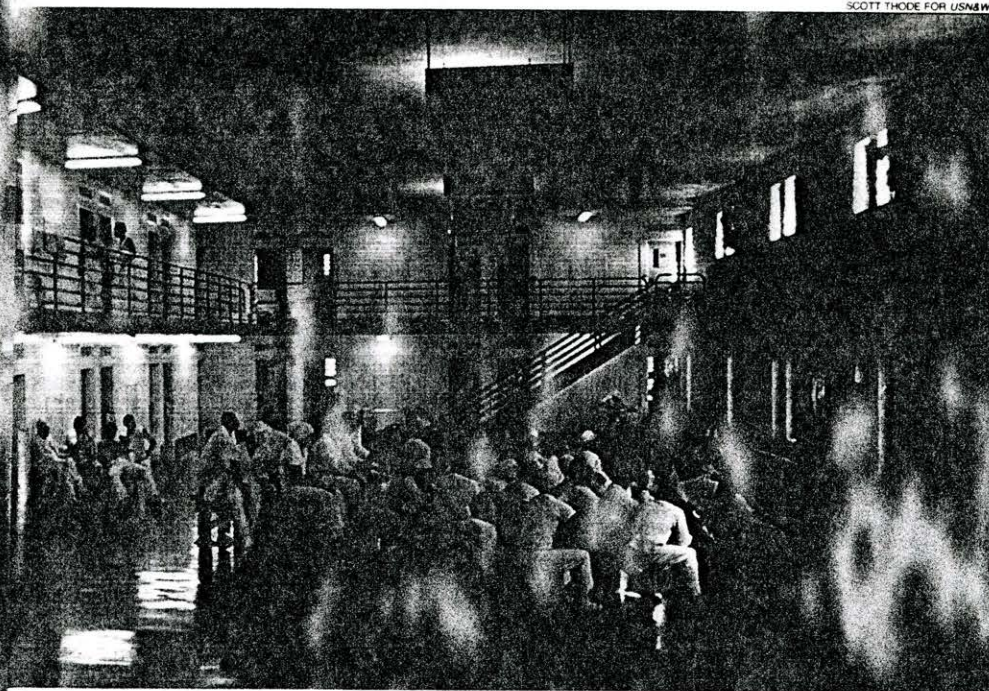
federal inmates have developed AIDS; a recent analysis of HIV-antibody tests of 11,200 convicts found fewer than 5 percent were seropositive as well.

■ **The protected-prisoner myth.** Some corrections officials contend that segregation works to the prisoners' advantage because infected inmates can be shielded from those who have ordinary infections, such as a common cold. At the same time, quarantine affords guards and general-population prisoners enhanced protection because they will not be unknowingly exposed to the HIV virus. But there are few medical data to support that argument. Historically, quarantine has often been mistakenly used to control plagues such as leprosy and yellow fever that, like AIDS, later turned out not to be spread easily through human contagion. Although it can be helpful to segregate an inmate who is dying or seriously ill from AIDS, there is no evidence yet that routine isolation advances the health of asymptomatic

HIV carriers—such as most of those in Limestone's Thunderdorm.

A more predictable outcome of prison quarantines is that they foster administrative and legal headaches. Ideally, the recreational, educational, work and parole programs offered to general-population inmates should also be separate and available for HIV-segregated inmates. Few states, though, have set up a duplicate system for HIV prisoners because it is too costly. In the face of such complications, most corrections officials have abandoned blanket segregation policies, shifting to a case-by-case approach for isolating HIV inmates. Only three states besides Alabama now segregate all known seropositive prisoners, and only one (California) has a sizable number of HIV-infected inmates. In California, corrections officials have just started a pilot program to give HIV inmates broader access to prison programs.

■ **The endangered-guard myth.** Corrections officials often argue that prison guards require far more protection from AIDS than those in other professions because they routinely encounter bleed-



row, where leaden days and fearful nights take an excruciating toll

cameras in front of the morgue door. From the temporary AIDS isolation ward across the prison yard, the HIV inmates, who had watched the morgue's arrival and installation through their cellblock windows, now watched the warden with fear and bitterness.

For nights afterward, Ryan had the

same nightmare. Two nurses in surgical masks and gloves were standing over him as he lay in his infirmary bed, and one said to the other, "Yeah, he's dead. Go get the doctor." And then the doctor came in and pronounced him dead, too, and they put him on a stretcher headed for the morgue. But when the morgue door opened, Ryan

was startled. A furnace was inside. He screamed, "Wait! I ain't dead! Don't put me in there!" and slipped off the stretcher. But the nurses and doctors couldn't hear his screams. They kept pushing him into the furnace, into the flames. As he went flying toward the door, he awoke, his chest heaving.

THE GUARDS

"Hardly any of these men inwardly admitted his own lawlessness. . . . The ability not to be surprised by anything was considered the greatest virtue."

Jim Wohl, 34, never wanted much more than to take home his \$756 paycheck every two weeks, go bass fishing on the weekends and be home early Saturday nights to watch "Star Trek: The Next Generation." A burly, laconic man, Wohl filled out a Limestone job application in 1985 "as a fluke" after a girlfriend dropped it off at his apartment. From the beginning, his preferred prison job was supervising men weeding and picking crops on the 1,000-acre prison farm. But one chilly January day in 1988, Wohl found himself, along with a female guard, conducting the morning "shake-down" of the 76 cells in the Thunderdorm, looking for contraband.

Although Wohl and his partner did not say anything about it, they both always felt a little nervous when they got to a cell halfway down the bottom tier

ing prisoners; sometimes, inmates even throw feces and urine at officers and spit on them. In September, 1986, when an officer at Limestone prison was scratched by a prisoner and later tested HIV positive, Warden J. D. White faced a near mutiny among his staff. However, the Limestone guard's test subsequently proved to be a false positive, just like all other known reports of prison personnel involuntarily contracting AIDS from prisoners. Five consecutive NIJ surveys have found no cases of HIV infection or AIDS in correctional staff that could be linked to an on-the-job accident. Corrections experts do advise prison personnel to take traditional "universal precautions," such as wearing gloves and cleaning up with a bleach solution whenever any prisoner's blood

is spilled or if contact with body fluids is likely. Such precautions, however, should be taken when loose blood is evident even if the inmate is *not* a known HIV carrier (since he or she may later test HIV positive).

■ **The blood-bath myth.** Warden White believes he would quickly "have a riot on my hands" if he abandoned the quarantine system—an argument with some plausibility. More than 400 general-population prisoners at Limestone have already asked a federal court to keep the HIV inmates in quarantine, and a recent state-sponsored survey of inmates and correctional officers revealed that more than 60 percent of the convicts polled felt that threats, stabbings and beatings would increase if HIV inmates were mixed with others.



Even the trash is segregated

Still, convicts and correctional officials have mistakenly forecast riots and wholesale bloodshed in other states that have returned HIV-infected inmates to their general prison populations. Although there have been several violent incidents, most occurred in the early years of the AIDS epidemic. Since mid-1987, New York State has moved AIDS-infected prisoners who are in remission from infirmaries to the general prison population without a single report of violence.

For the foreseeable future, the fate of Alabama's quarantine policy lies with the federal courts. The American Civil Liberties Union has brought a precedent-setting suit against Alabama, claiming that the state discriminated against HIV inmates by denying them work and training opportunities. But earlier this month, Judge Robert Varner upheld Alabama's HIV-segregation policy, saying there "is no right to rehabilitation in the Constitution." Even so, if Limestone's quarantine policy is upheld on appeal, the question will persist: Does it make much sense?

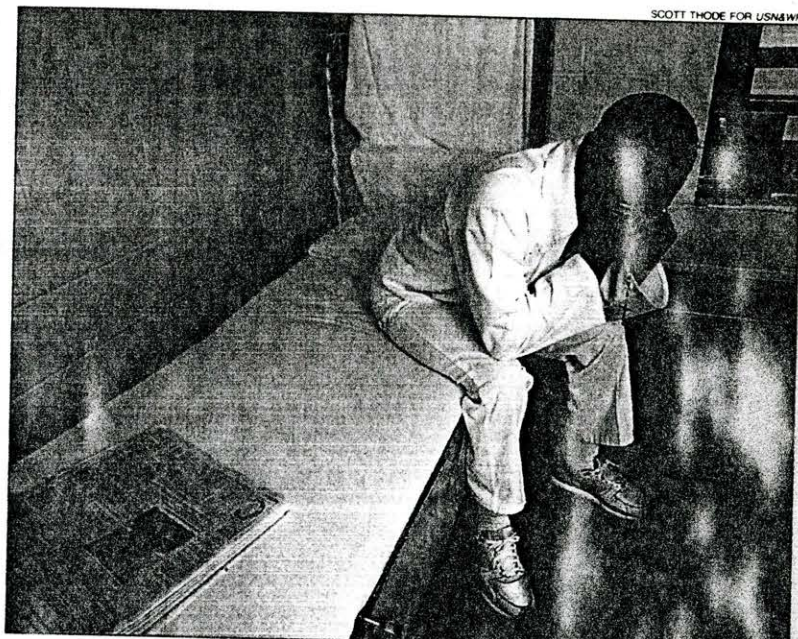
that housed Adam Watts, a convicted burglar. Watts was fast becoming legendary for his unpredictable and explosive temper. In fact, the closer the wiry 5-foot-5-inch inmate got to being released, the more disturbed he seemed to act. The inmates had jokingly taken to calling Watts "Adam-12," as though he were some sort of "Twilight Zone" police cruiser. Just a few months earlier, not long before his sentence was about to expire, Watts became so enraged when his lunch was delayed a few minutes that he smashed a guard on the head repeatedly with a combination lock, opening a bloody gash.

On this particular morning, Wohl ordered Watts out of bed and began patting down his mattress. He found nothing, but his partner discovered two black pens in the box under Watts's bunk bed. Only clear-barrel pens are allowed at Limestone, since prisoners sometimes conceal illegal drugs in opaque pens. But when the officer laid the pens on the mattress, Watts seized them. Wohl grabbed the pens back, and before he knew it, the inmate started screaming: "Get me a damn captain down here. You ain't going to take this away from me!"

Wohl tried to assert himself. It was important, he knew, not to let prisoners intimidate him into abandoning a shake-down, because sometimes inmates "will give you a little something—like pens—to hide something worse, like a hatchet." Wohl decided to handcuff Watts, but after pushing the inmate down on his bed, his right arm slipped off Watts's shoulder. To his horror, the inmate deliberately fastened his teeth onto Wohl's forearm, piercing the skin and leaving a welt the size of a half dollar. By the time other officers arrived to subdue Watts, the HIV inmate was snapping his teeth at all of them, seeking to bite them as though he were a rabid dog.

As he briskly walked the 150 yards to the infirmary, Wohl vacillated between fury and panic. "A million things went through my mind," Wohl recalls. "Was I going to get AIDS? And I was hating Watts, too. How could I let this happen—hell, I could have cuffed Watts a dozen other times without him biting me."

A nurse finally helped disinfect his bite and took a HIV-antibody blood test, while Wohl decided to swear out a war-



ARRINGTON: Gave those who suffer an overdose of love

rant for attempted murder against Watts, one of the first such cases in the nation. From the courthouse, he called his fiancée, April, a nurse at the prison infirmary who was off duty that day. "Don't worry, Jim," she reassured him. "I still want to marry you." But not everyone took the news so calmly. By the time Wohl drove 15 miles that afternoon to his parents' house, he found his dad stretched over the bed weeping and his mother crying on the plaid couch in the living room. "They both saw the noon television reports and thought I was sure to get AIDS," Wohl recalls. He did his best to console them, telling them the bite "was just a little ol' plug."

Wohl himself wasn't so sure. "I ain't close to being a woman," he says now, "but I understand a lot better how a woman feels who got raped—you can wash and scrub afterwards, but the memory don't ever come out between your ears." For months, the memory of Watts's bite and the dread of infection plagued Wohl at odd moments. The worst times were after the blood tests, four of them stretched over 18 months, when Wohl would lie awake at night, his mind playing out a dozen scenarios. Most of his fears involved the baby he had dreamed about having, the child whom he planned "to show off to my mom and dad, to everyone." What would matter most was that the child was healthy, and if Wohl tested HIV positive, he knew he would never risk fathering a child with April. After a restless night, Wohl often would be on the phone the next morning with the infirmary. "Are the results in yet?" he would ask anxiously. "Are they in yet?"

Since biting Wohl, Watts has bitten two more guards, screaming "I am going to kill you!" while spitting in their faces. Even though Wohl and the others know that no one is known to have contracted AIDS from saliva, they also understand that AIDS can remain latent for several years. Physicians at the Centers for Disease Control have told them that there is a "remote, one-in-a-million" possibility of transmission through a bite. That uncertainty sticks with the guards when they make their rounds of the HIV cell-blocks, nourishing a hatred of Watts, the inmate they cannot stop from trying to use his

disease against them, the inmate they feel has "got nothing to lose." As for Watts himself, he shows no remorse. "I'm not sorry" he says. "Every fight I get into, the guards provoke me first. I did not bite [Wohl] to pass on the virus—that's just the way I fight; I scratch, I bite."

So far, Wohl feels as though the courts are more intent on protecting Watts than in helping a wounded officer. Last August, an Alabama appeals panel reduced the first-degree-assault conviction by a lower court in the Wohl case to third-degree assault, on the ground that there was no scientific evidence AIDS can be transmitted by a bite. Now, Warden White has a new idea: He has asked state attorneys to seek court approval for pulling Watts's teeth. The lawyers, however, have refused to do so, claiming that a court would consider that "maiming a man." But if a judge ever does grant permission to pull Watts's teeth, says Wohl, "I will be the first one through the door to hold him down."

THE NEW DEATH ROW
"The continual animosity and quarreling around you, the cursing, the shouting, the noise, the hubbub, always being under guard, never alone, and this for four years without a break..."

As the years passed, Ryan and other veteran inmates saw most of the overt stigma disappear from the Thunderdorm. By the fall of 1986, the HIV inmates no longer had to wear surgical masks and gloves outside their cells or wipe the phone down with alcohol after making a call. Yet the mental toll grew. Ryan and

the other inmates felt like spiders in a glass jar. Week after week, months stretching into years, there was no work or training. Even though most HIV inmates were robust and showed few signs of developing AIDS, prison officials had declared all but a few prison programs off limits because training courses and work-release jobs were too expensive or controversial to set up just for HIV inmates. Every day, the central, common area in both dorm wings was filled by the noise of blaring radios, inmates joking and yelling, and the incessant whirring of three huge exhaust fans mounted on the wall. In the adjacent 12-by-15-foot white-walled television room, daytime soap operas played at rock-concert volume, and in the HIV's modest exercise yard, where inmates were allowed to play volleyball and basketball and lift weights, the summer humidity made the outdoors almost as oppressive as inside.

The lack of solitude and meaningful activity fed a loathing among inmates that extended not only to their guards and cellmates but to themselves. Some became almost delusional, denying that they were HIV-positive and claiming that the laboratory had "screwed up" their tests. But the most pernicious trait of the Thunderdorm was that it seemed to rob prisoners of their secret dream, the hope for a better life some day outside the penitentiary. When Ryan first arrived in prison, he planned to "go straight" when he got out and have kids like his older brother in the Air Force. But he soon found he could not rid himself of the feeling that he simply had no future—in or out of prison. In time, other inmates stopped answering their mail and taking showers and many abandoned their aspirations to learn a trade. "Every day," officer Sam Mitchell recalls, "prisoners told me: 'I'm going to die. Why should I care what I do?'"

If the inmates eventually gave up on themselves, the corrections department did so virtually from the start. Few prisoners lucky enough to get out of the Thunderdorm alive got the training or counseling that might have made them productive citizens—or perhaps at least stopped them from spreading the AIDS virus. Inmate Jimmy Hughes Thirlkill, 27, was one of those who left Limestone more morally benumbed than when he entered. A high-school dropout and one-



WATTS: Spits and shouts, 'I'm going to kill you!'

time IV-drug user, Thirlkill said little in the Thunderdorm and was known as one of the less articulate prisoners. By the time he left prison in May, 1988, after serving a six-year sentence for burglary and theft of property, Thirlkill's years of isolation and his lack of job skills had left him totally unprepared for life on the outside.

Ten days after he got home, Thirlkill had unprotected sex with a woman without telling her that he was HIV-infected. Two weeks later, he was arrested for breaking into an auto-repair shop and stealing a car. Imprisoned in a county jail, he momentarily went berserk after his jailers stuck a small cardboard sign on his cell that said "AIDS." The convict set his mattress on fire, kicked a porcelain sink off the wall of his cell, cut his forearms and hands on the shards of the sink—and then tried spattering his blood on police who arrived to subdue him. "I got the AIDS virus and I'm going to make sure you get it too!" he told them. Nineteen months later, Thirlkill is back in the Thunderdorm, serving six consecutive life sentences under Alabama's habitual-offender act. "I didn't really care

whether I got caught or not breaking into the repair shop," he says. "I don't know why I didn't care—I'm still trying to figure that out."

THE CHAPLAIN
"Even in penal servitude, among thieves and bandits, in the course of four years I finally succeeded in discovering human beings..."

Only a handful of people want to spend time in the House of the Dead, and Bill Lindsey is one of them. Nine years ago, the jowly cheeked Lindsey quit his job as a truck-driver to do volunteer work for the Baptist church. At the time, he hated prison and especially disliked the work-release prisoners he had met because "they were always cussin' and lustin'" after women. But when an opening for a full-time chaplain at Limestone became available in 1987, Lindsey reconsidered the prison ministry. "God is a second-chance God," he reasoned, and so he joined the Limestone staff, without, as he later put it, "ever realizing the kind of people I would be ministering to."

When Lindsey decided to hold evening evangelical services in the HIV's television room in July of 1987, his four children told him he was crazy. "Inmates can't be saved," his 31-year-old son told him. Lindsey himself believes homosexuality and drug abuse are sins, but, as he told other skeptical ministers, HIV inmates were "precious people, too." When Mildred, his wife of 37 years, expressed concern about Lindsey's practice of touching or hugging grieving prisoners, he explained: "It's easy enough to tell a man you love him. You've got to show him."

In many ways, Lindsey soon found

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the upbeat preacher sometimes wondered whether that was enough to console the isolated men. It hadn't seemed enough for Charles Hickson, a convicted burglar.

Hickson was known as the orneriest man in the Thunderdorm—"too mean to die" in the words of career shoplifter Michael Arrington. A former high-school-basketball star, the 6-foot-tall Hickson could jog for hours around the exercise yard, slam-dunk handily and bench press a whopping 360 pounds, twice his own weight. He was a braggart, but the majority of prisoners respected Hickson because he was not afraid to curse out an officer. Yet Hickson, who got AIDS through IV-drug use, also had one hang-up that kept him from becoming better friends with most of the men. He detested homosexuals. In fact, for months after his arrival in December, 1987, Hickson would not even talk to a gay or bisexual prisoner, except, after a while, to cuss at them.

Preacher Lindsey met Hickson after the inmate came down with a painful brain abscess and had to spend several months recuperating at the Limestone infirmary. Hickson was busy there making life hell for the infirmary's doctors and nurses. Every few hours, it seemed, he would curse out the nurses. Sometimes Hickson refused to take his medicine or be weighed. He also blamed the staff for giving him medication that caused an allergic reaction and turned his skin jet black. But each day, the chaplain visited the sick inmate. In time, Hickson grew to trust the minister, and even began praying with him. The two would hold hands while Lindsey assured him: "God gets no pleasure out of watching a man suffer." "I'm praying," Hickson would respond, "but I don't seem to get no answers. It's harder than I can bear."

For a time, though, Hickson seemed to bear it. With his skin blackened and peeling and his feet so painfully swollen that he could barely walk, Hickson returned to the Thunderdorm in January, 1989. There, perhaps for the first time in his life, the hardened inmate began to soften. Moved by Hickson's helplessness, the Christian inmates, several of whom were gay, began to mount an informal round-the-clock vigil to help the enfeebled inmate feed and clean himself. Michael Arrington, an avowed bisexual whom Hickson had once mocked, took to washing Hickson's clothes. Tommy "Saint T" Wilson*, in Limestone for murdering a man at age 13, would rub baby oil on



CHAPLAIN LINDSEY: Show a man you love him

Hickson's peeling, inflamed back. "The reason we helped Hickson was simple," Wilson says. "He needed it—wouldn't any decent Christian do the same?"

With the help of the other prisoners, Hickson even started to open up to his inmate companions. "Everyone acts like they're scared of me," Hickson hesitantly told Arrington in private. "But you don't. Thanks." After their noon prayer service, three or four inmates would walk up to Hickson's cell, sit down next to his bed and pray. Placing their hands in Hickson's green, scabby palm, the inmates would quietly sing "I Found All I Need in the Lord" and "Leanin' on Jesus." On several occasions, tears rolled down Hickson's face. He looked away, out the cell window, so the men would not clearly see him. "Lord, clean me up," he once whispered when the inmates finished singing. When Hickson cried, inmate Wilson recalled, "it was almost like he had gotten an overdose of love."

Yet love, like just about everything else in the Thunderdorm, never seems to last long. No one really knew why Hickson finally gave up. But after the HIV inmates nurtured him back to health, Hickson quit attending their prayer services. He refused to go to the infirmary for health-care checkups or take his AZT, an anti-AIDS drug, and once he was written up for a disciplinary infraction after he reached into the infirmary ice machine, leaving flakes of his skin in the ice and juice jug.

When Hickson finally returned to the infirmary in May, 1989, the emaciated 27-year-old looked 60. His hair had fallen out, and he walked out of the dorm in his underwear, absent-mindedly carrying his

white bed linens in his hands. A few weeks later, he died. Alone in his cell, Wilson, the murderer, cried. At home, in the privacy of his bedroom, so did Lindsey, the chaplain. "Hickson had a mother who loved him, too," says Lindsey, who once prayed with Hickson's mother by the inmate's bedside after he became ill. "I'll never forget wanting to tear the hurt out of his mother's eyes."

After Hickson died, the Thunderdorm quieted for several days. The HIV dorm often quiets when an inmate dies, says officer Sam Mitchell, because the other prisoners, "particularly the older ones, realize they're in the same boat, with the same virus." Within a couple of days of Hickson's death, however, the dorm was again a din and

all was back to normal.

It is tempting to draw a soothing conclusion from Charles Hickson's death, to fashion a cheerful ending to his painful life. It would be easy to conclude, for instance, that Hickson, too, could have been redeemed, that every inmate in the Thunderdorm, no matter how hard-boiled, has a tender spot nestled deep within. But however comforting that may be, it ignores the unique nature of Limestone's HIV colony, and perhaps that of any long-term, enforced quarantine. For the Thunderdorm, like a frightening fun-house mirror, distorts and irrevocably alters its residents.

Inside its walls, the struggles of everyday life, the passions and the pain, are present but gruesomely exaggerated. The *Angst* of officer Wohl, the nightmares of Ryan, the rage of Watts, the power of Hickson, all were magnified and distorted by the Thunderdorm. But to what end? For Dostoevsky, and for thousands of other prisoners, the perversions of prison life were softened over the years by the prospect of resurrection and renewal. His "passionate desire" for a new life, Dostoevsky wrote, "strengthened my will to wait and hope." But for the quarantined residents of the HIV dorm, there is no new life for which to wait and hope. The fun-house mirror never disappears. In Alabama's House of the Dead, the men with their dreams have already been buried—alive.

by David Whitman

*The last names of inmates Daniel Ryan, Bennie Williams, Adam Watts, Charles Hickson and Tommy Wilson are pseudonyms, used to protect their identities. Officer Wohl is also an alias, used at his request.

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FOR SEVENTEEN YEARS, THE LESBIAN AND GAY WEEKLY

PWA sentenced for biting guard

*Status now
of appeal?*

*Calling the case a 'farce,' Philadelphia AIDS
activists mobilize around the Black gay prisoner*

By Chris Nealon

PHILADELPHIA — The sentencing last month of a Black gay PWA who was accused of trying to kill a prison guard with his saliva has sparked new activism here. The case of Gregory Smith, sentenced for attempted murder May 18 in New Jersey's Camden County Superior Court, has led to a new coalition among gay organizations, prisoners' rights advocates, and AIDS action groups.

"We're seeing the criminalization of AIDS," said Judy Greenspan of the National Prison Project of the American Civil Liberties Union (ACLU). She said that laws which classify the intentional transmission of HIV as a felony are "springing up all over the country." Greenspan added, "It's a manipulation of state law, taking fear of AIDS and applying it to prisoners."

Smith was convicted of attempted murder in April based on a prison guard's claim that Smith bit him with the intent of giving the guard AIDS. At that time, Smith told *GCN* that despite inconsistent testimonies from witnesses, the jury believed he bit the guard. More alarmingly, said Smith, the fact that he has AIDS also influenced the jury to

believe that he was guilty. (See *GCN*, April 22-28, 1990.) Smith was sentenced to 12½-25 years in prison. According to Greenspan, he is appealing the decision and has decided to countersue the prison guards.

After his conviction, Smith sent letters to various gay and AIDS advocacy organizations in the Philadelphia area, as well as to the ACLU, explaining his plight and asking for assistance. Several groups sent representatives to Smith's sentencing, including ACT UP/Philadelphia, We The People With AIDS/ARC, and Black and White Men Together (BWMT)/Philadelphia.

John Spear, a member of BWMT, told *GCN* that he thought Smith's conviction and sentencing were indicative of hysteria about AIDS. "It's a farce," he said. "It's intolerable." He added that spreading accurate information about AIDS during Smith's appeal might increase the chances of his conviction being overturned. Public health officials and medical researchers have long agreed that saliva is not a means of transmission for HIV. (HIV is a virus

Continued on page 11

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thought by many to be a cause of AIDS.)

"If we can educate the prison system about [AIDS], that biting can't transmit HIV," said Spear, "then it's a moot point whether or not he bit the guard."

Greenspan said that many HIV-transmission laws reflect ignorance about AIDS, and are open to dangerously wide interpretation. For instance, she said, under the New Jersey law used to convict Smith, the prosecution was not required to prove that Smith had the ability to kill the prison guard with his saliva, but only that he *believed* he did.

Coalition-building

Although they were not involved in Smith's initial trial, AIDS activists here have gradually come to focus on his case. "I think it would have helped if we could have applied pressure [on the court] right from the beginning," said Paul Champion, a member of ACT UP/Philadelphia. "We lamented at the sentencing that we had missed out so badly."

Nonetheless, BWMT's Spear told GCN he was pleased by the range of groups now working on Smith's case. For instance, he said, "there are very few Black members of ACT UP, and we're proud that ACT UP is taking a genuine interest in this." He also said that he believed a variety of organizations working together would be important in overcoming the prejudices levelled at people with AIDS. "We need a coalition of diverse groups dealing with HIV infection," he said.

Greenspan was also optimistic about the coalition forming around Smith, calling it "tremendously significant." "AIDS activists have traditionally focused on AIDS drugs and the federal government," she said.

"The courts don't see a prisoners' rights movement," said Greenspan. "But the more they do see it, the less likely things like Greg's case are going to be." She said she thought it was particularly courageous of Smith to stand up so vigilantly for his rights, knowing that "the outspoken [prisoners] are targeted for the worst treatment."

Loretta Desvernine, another member of ACT UP/Philadelphia, told GCN that news of Smith's conviction, although belated, moved the group to attend Smith's sentencing. "We went in support because [the conviction] was unjust," she said. She added that several groups in the area were planning to provide follow-up assistance to Smith, initially through a Gregory Smith forum to be held June 22 at the Church of St. Luke and the Epiphany in Philadelphia. The primary organizers of the forum are We The People, ACT UP and BWMT.

In the meantime, Smith awaits the rescheduling of his appeal, which was delayed June 6 for reasons that remain unclear. "It's purposely an incredibly inefficient system," said Champion. "But if there's any justice, this thing will get overturned."

☐ filed from Boston

For AIDS Inmates, a Prison in Prison

By PETER APPLEBOME
Special to The New York Times

CAPSHAW, Ala. — To prisoners, Dorm 7 at the Limestone Correctional Facility here is a prison within a prison, a white masonry-block barracks in which Alabama segregates all prisoners who tests indicate carry the AIDS virus.

To legal experts, Dorm 7 is a battleground, the focus of a lawsuit objecting to Alabama's policy of testing all inmates for AIDS and segregating those shown to carry the virus. The suit is the first involving prisoners as a class, rather than case by case, that is likely to go to trial as a challenge to policies for the treatment and care of inmates with AIDS.

At the heart of the suit is an issue that will be of growing importance as the disease becomes less an affliction of homosexuals and more one of drug abusers and the urban poor, groups overrepresented in the prison population.

While the legal issues unfold, life drags on for about 130 prisoners in Dorm 7, most of whom show no symptoms of the disease. Prisoners in the noisy barracks, which they call the Thunder Dorm, eat, sleep, pray and exercise in isolation from other inmates in an environment their suit likens to leper colony.

Policy Called Overreaction

Lawyers for the prisoners argue that the segregation policy is an overreaction, ineffective in limiting the disease while depriving inmates of most of the programs available at the prison.

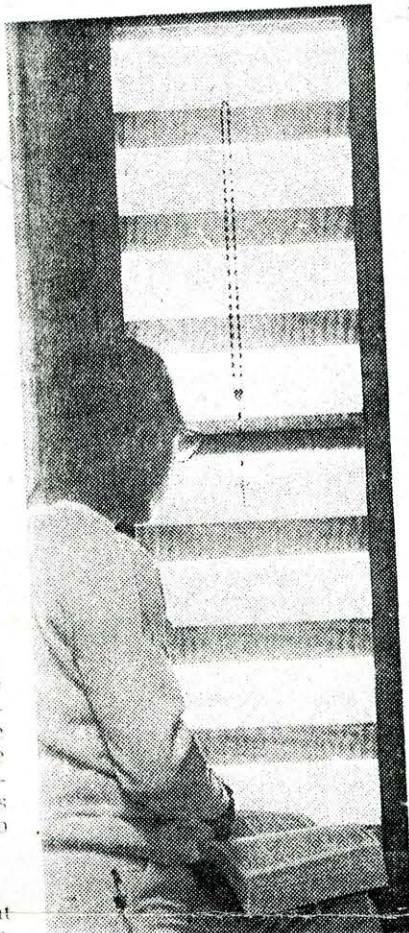
"You know the phrase in the Bible about the Valley of the Shadow of Death?" said Michael Marsh, a 40-year-old convict confined to Dorm 7. "That's what this is like."

Fourteen states test all incoming inmates for AIDS or plan to begin such testing. A total of 20 states segregate all prisoners diagnosed with AIDS. Eight of those states also segregate those diagnosed with AIDS-related complex, the condition that usually precedes the onset of full AIDS symptoms. Six states segregate all those shown to carry the virus, even if they have no symptoms. Federal prisons, which test a randomly selected 10 percent of entering prisoners and all those leaving the system, do not segregate those with AIDS or the AIDS virus.

Dozens of prisoners around the country have filed suits either calling for segregation or trying to block it. Most of the suits have been filed by inmates on their own behalf and courts have almost unanimously ruled against them on both sides of the issue.

"What the cases are saying so far is that it's very difficult to challenge what prison authorities want to do," said Benjamin Schatz, director of the AIDS Civil Rights Project of the National Gay Rights Advocates of San Francisco. "If they want to segregate people, it's difficult to stop them; if they don't want to segregate, it's very difficult to force them to do so."

There are at least three pending lawsuits in the country with professional legal representation challenging segregation policies, but the Alabama suit, filed by the National Prison Project of the American Civil Liberties Union, is likely to be the first to go to trial. The other cases are in California and Connecticut.



The New York Times

Michael Arrington, in inmate in Dorm 7. "I feel like I'm being retri- ed, resentenced and sent to Death Row," he said.

virus after they have been tested.

Alabama prison officials say the number of inmates who have been shown by tests to carry the AIDS virus, the human immunodeficiency virus, or HIV, remains small, at 138 out of 12,000 prisoners in the system. But they say the nature of prison life makes segregation a necessity.

"Two things you are going to have in prison are homosexual activity and drug use," said J. D. White, warden of the Limestone prison. "Those are the two main ways this disease is transmitted. I believe the general population has constitutional rights equal to the HIV-positive population and has the right not to be exposed to those people."

Still, even prison officials agree that the inmates of Alabama's prison within a prison face particular problems. They are confined to the two units of Dorm 7 and a fenced outdoor exercise yard attached to it. They do everything from eating to worshipping apart from other prisoners.

They are restricted from virtually all of the educational, vocational and recreational activities at the prison, including those that allow them to accumulate credits toward early release. Their segregation makes any notion of confidentiality about their condition impossible.

Although Limestone is a prison of minimum to medium security, violent offenders carrying the AIDS virus are grouped in Dorm 7 with less dangerous inmates. Prisoners say the constant reminder of their condition that segregation creates adds a debilitating overlay to prison life, what the suit calls "a sense of doom."

"Incarceration is punishment for the crime I committed," said Michael Arrington, a 32-year-old habitual offender serving time for shoplifting. "Anything beyond that is another sentence. I feel like I'm being retri- ed, resentenced and sent to Death Row."

7,000 Inmates Sign Petitions

But other inmates have entered the case in support of the segregation policy. About 7,000 of the state's prisoners have signed petitions urging its continuation. Prisoners representing those who do not have the AIDS virus have filed as intervenors in the suit in support of the segregation policies.

"Outside these walls, if you want to be away from someone who's got it, you can," said Tim Barbee, 32. "We don't have that choice. I'm not saying those people are going to come and attack anyone, but you take a guy who's weak, not aggressive. He could come in here with a three-year sentence and end up with a death sentence."

Officials of Alabama's prisons acknowledge that segregation is expensive and especially burdensome at a time of rising financial pressures and overcrowded conditions. Some experts say the cost alone will limit the growth of segregation policies.

Still, Alabama's officials believe if the program restricts the spread of the disease and protects the general prison population, it is worth pursuing.

"It boils down to whose civil rights get violated," said Mr. White, the warden at Limestone. "Do you violate the rights of 132 people who test positive or do you violate the rights of the 12,000 who don't?"

Treatment of those infected will be of growing concern.

The Alabama case asks a Federal court to declare the state's testing and segregation policies illegal, saying they subject prisoners to "harmful, humiliating, unlawful and unconstitutional practices and conditions." The first hearings in the case are set to begin March 27.

"We argue that there's no justification in terms of penology or medical treatment for mandatory testing and segregation," said Alexa Freeman, a lawyer for the A.C.L.U. "I don't think the state thought through the consequences of this program. They panicked and now they've created a monster."

Rate of Spread No Faster

Attorneys for the prisoners will argue that in addition to stigmatizing prisoners, the segregation is an overreaction because there is no indication AIDS is spreading any faster in prisons than outside. They also contend it gives prisons a false sense of security because other prisoners may develop the

ic Theology

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s divided on how much the verge from the 1967 profes- a, which included the tradi- ne Creed plus an affirma- ters taught by the church as they are proposed by it." phrase allowed for the fact tholic church claims some ings to be more certain and believers than other teach-

Lower Range of Views

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Intravenous Drug Use and Human Immunodeficiency Virus (HIV) Infection in Prison

David Vlahov and B. Frank Polk

Between 1982, when the first cases of AIDS in prison inmates were reported,¹ and October 1986, when the National Institute of Justice (NIJ) completed a survey of 58 federal, state, and local correctional systems, 1,232 cases of AIDS have been identified in US prisons.² The seriousness of the problem is underscored by the observation that in the New York State prison system, AIDS represents the leading cause of death.³

The occurrence of AIDS in the correctional setting is not unexpected, because two major risk groups for AIDS, intravenous drug users (IVDUs) and homosexual/bisexual men, can be found in prison. In various surveys, between 27 and 41 percent of inmates self-reported a pre-incarceration history of intravenous drug use, and between 3.6 and 7.0 percent self-reported a pre-incarceration history of homosexual activity.^{4,6} Corresponding proportions in the population have been estimated at approximately 0.6 percent for ever-used intravenous drugs and 10 percent for male homosexuality.⁷ Thus, compared to the general population, prisons contain a disproportionate representation of IVDUs.

That IVDUs represent the major established risk group for AIDS in prison is supported by two lines of reasoning. First, the geographic distribution of the 1,232 cases of AIDS identified in US prisons through October 1986 parallels the geographic distribution of cases reported to the Centers for Disease Control AIDS Surveillance Program for whom intravenous drug use was the primary risk factor. The NIJ survey noted that 838, or 70.2 percent, of the cases were reported from New York, New Jersey, and Pennsylvania,² whereas Centers for Disease Control Surveillance data indicate that approximately 80 percent of the AIDS cases among IVDUs are from New York, New Jersey, and Connecticut. Second, within the New York State prison system, which conducts risk factor investigations on diagnosed

cases of AIDS, approximately 95 percent of inmates with AIDS report a history of intravenous drug use, whereas 3 percent claim to be exclusively homosexual.⁸ Although these sparse data suggest that intravenous drug use is a major risk factor for AIDS diagnosed in prison, the first example may be subject to ecological fallacy and the second example to reporting bias from respondents.

Additional support for the notion that IVDUs are the major group at risk for AIDS in prison would be derived from seroepidemiologic surveys of HIV infection among inmates. To date, only a limited number of serosurveys have been reported from the correctional setting. In the US, prevalence has ranged from 0 percent in Iowa to 15 percent in Massachusetts.^{2,9-12} In Europe, the proportion of seropositive inmates ranges from 0 percent in Cyprus to 16.8 percent in Italy.¹³ These reports suggest that the prevalence of HIV among prison inmates varies considerably by jurisdiction. Almost all of the prison systems, however, report only crude prevalence. Also, the prevalence of antibody to HIV in prison samples probably exceeds prevalence in the general population. For example, the 1 percent prevalence of HIV infection among entrants to a military maximum security prison¹¹ contrasts with the 0.15 percent prevalence among applicants for US military service.¹⁴ The two groups are not, however, strictly comparable, because the samples were drawn at separate times in the subjects' respective military careers. Of the nine seropositive inmates in the military prison, six were convicted for drug offenses.¹¹

Descriptive and, especially, analytic studies of HIV infection among prison inmates are sparse. Recently, a study of 500 consecutive inmates entering a French prison showed 12.6 percent to be seropositive.¹⁵ In another sample of 113 drug users in the same French prison, 61 percent were seropositive.¹⁵ These figures suggest that the overall proportion of seropositives in prison will be closely related to the proportion of

IV Drug Users in the Prison System

incarcerated IVDUs.¹³ However, because IVDU status was not assessed in the overall sample and the degree of overlap between samples was not reported, the association is suggestive rather than conclusive.

In summary, available data suggest that a pre-incarceration history of intravenous drug use is probably the single most important risk factor for HIV infection in the correctional setting. However, the association is indirect. The identification of IVDUs as the major risk group for HIV infection and AIDS in prison would involve an epidemiologic survey of HIV infection among prison inmates. If IVDUs are the group at greatest risk of HIV infection upon entry into prison, such data may assist correctional health officials to focus medical monitoring of symptoms for HIV-related conditions and to further target educational interventions.

Seroprevalence studies of HIV infection among prison inmates are important for several reasons. First, given that the costs of treatment for patients with AIDS are considerable^{16,17} and that funds for correctional health care are budgeted annually by legislatures, seroprevalence studies provide a basis for projecting the number of cases of AIDS and AIDS-related complex in prison and, in turn, the requisite resources.

Second, given that homosexual activity and intravenous drug use are practiced by a proportion of inmates during incarceration,^{5,18} seroprevalence studies of HIV infection among new entrants into prison provide an estimate of the reservoir from which intraprisson transmission may occur. That HIV may be transmitted during incarceration was suggested by a study conducted by the Maryland State Division of Corrections.¹² This research involved approaching 338 inmates who had been incarcerated for at least seven years prior to 1985; of the 137 volunteers tested, the two seropositives (1.5 percent) had each been incarcerated for nine years. Although no baseline specimens were available, the extended duration of incarceration suggests that infection was probably acquired in prison. Because the response rate was low, bias cannot be excluded. Subsequent studies have suggested that prevalence of HIV infection among entrants into prison may reflect risk of transmission. At a military maximum security prison reporting a baseline prevalence of 1 percent, serologic follow-up was performed on 567 inmates for whom negative baseline specimens were available; no seroconversions were identified.¹¹ In another prison system reporting a baseline prevalence of 7 percent, serologic follow-up of 393 inmates for whom negative baseline specimens were available suggested a transmission rate of 0.41 percent per prison-year.¹⁹ Although the samples

in each study included only those from inmates who were still incarcerated at time of follow-up, the data suggest that the risk of intraprisson transmission is low.

This information could provide a basis for the development of rational policies within a correctional setting. Without an effective vaccine, options for preventing intraprisson transmission of HIV infection are limited. Distribution of condoms and clean syringes is unlikely unless the associated activities are decriminalized within the prison system. A program of mass screening and informing inmates of their antibody status assumes that confidentiality can be maintained inside prison and that informed inmates will act responsibly. Segregation of seropositives involves enormous logistical considerations, particularly if the prevalence of infection is nontrivial. Incorrect assumptions could impair the theoretical risk:benefit ratio of each of these approaches. Further documentation of infrequent transmission in the prison setting and of the apparent direct relationship between prevalence at intake and risk of transmission underscores the importance of education, rather than screening and segregation, as a rational approach to infection control in most correctional systems.

A third benefit of seroprevalence studies is that they will provide information to supplement existing or planned educational interventions among prison inmates.

Seroprevalence studies among those entering prison are important for another reason. Intravenous drug use is a major risk factor for AIDS and has been implicated directly in 25 percent of the cases reported to the Centers for Disease Control and indirectly in the majority of the pediatric cases and those involving heterosexual contact with a member of an established risk group.^{20,21} Major public health interventions are indicated.

Given the illegal and deviant nature of intravenous drug use, access to IVDUs for study and public health intervention is difficult. For example, access through general population approaches is inefficient because intravenous drug use is relatively rare and the nature of illicit drug use lends itself to concealment (particularly for those who have not already been labeled as users). Another approach to accessing drug users is through ethnographic and "street outreach" methods. Although these strategies achieve a concentrated sample of users for study, they depend upon accidental or purposive contacts who, in turn, refer other contacts; representativeness of accidental contacts cannot be readily evaluated, and contact referrals

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are likely to be similar, thereby reducing sampling variation.

Access to IVDUs for study has also been accomplished through drug abuse treatment programs. Although this approach efficiently yields a concentrated sample of users, only a small proportion of IVDUs are estimated to be in treatment at any given time.²² Whether characteristics differ between treatment and non-treatment samples is unknown. However, a comparison of demographic data from the DAWN project (emergency room visits that involved heroin), the Drug Enforcement Agency Registry of Active Narcotic Users, and the CODAP program (data on admissions to drug abuse treatment programs) for the year 1973 suggests some differences by race and sex,²³ although the results from each of these investigations have been criticized as biased.²⁴ That treatment samples may differ from non-treatment samples has been suggested by an examination of program dropouts.²⁵ This analysis indicates that if cross-sectional studies of IVDUs in treatment settings tend to select against dropouts, results may be biased. Even between different treatment modalities, substantial demographic differences have been noted;^{26,27} this suggests that study results derived from single treatment facilities should be interpreted with caution.

In addition to the problems of data interpretation, the application of findings from one setting to another should be carefully considered. For example, negative opinions about methadone users expressed by participants in the Heroin Lifestyle Study²⁸ suggest that results derived solely from the treatment setting may be interpreted with scorn by an at-risk, non-treatment sample. However, studies conducted in different treatment settings and with non-treatment "street outreach" samples can complement each other to provide a broader definition of high risk sub-groups and use-related risk factors for HIV infection among IVDUs.

An alternative approach to accessing IVDUs is the prison setting. Prisons provide a high concentration of IVDUs; as noted previously, various surveys have reported pre-incarceration intravenous drug use among 27 to 41 percent of prison inmates.⁴⁻⁶ Also, samples of incoming inmates to a regional prison system involve large numbers of IVDUs from a wide geographic area over a relatively short period of time (e.g., approximately 1,500 IVDUs per year in the Maryland State Division of Corrections enter through a single facility). If IVDUs evaluated upon entry into prison can be considered as a means of sampling IVDUs from the community, ongoing evaluation of the large numbers

processed through the reception center of a statewide or regional system provides the opportunity to estimate geographic and secular trends of HIV infection among IVDUs.

Data drawn from among IVDUs in the prison setting may be valuable for another reason. IVDUs who enter prison include those who have been treated for drug abuse and those who have not. In two nationwide prison surveys, approximately one-third of imprisoned heroin users had a history of methadone treatment.^{29,30} This suggests that samples of IVDUs obtained at entry into prison may be more heterogeneous with respect to drug use-related behaviors than samples drawn exclusively from treatment centers. Other explanations are possible, but it seems reasonable that samples of incoming inmates will overlap and extend samples drawn from treatment settings.

Using samples of inmates entering prison to draw inferences about HIV infection among IVDUs involves distinct limitations. Information obtained may be distorted because prisons select for IVDUs who commit crimes and cannot otherwise avoid incarceration. Not all IVDUs are incarcerated. Although numerous reports indicate that a substantial proportion of IVDUs in treatment have a history of arrest and incarceration,³¹ street outreach surveys suggest that IVDUs with neither a history of treatment nor prison records may not be unusual.^{32,33} The degree to which prevalence and risk factors for HIV infection differ between those with and without records of incarceration is unknown. Nevertheless, information obtained from the prison setting can complement data obtained from other (e.g., treatment) settings so as to provide a more complete view of HIV infection among IVDUs. Also, results of such studies could facilitate the refinement of educational interventions directed at large numbers of IVDUs entering and leaving prison.

Given that the occurrence of AIDS among blacks and Hispanics has been disproportionate to their representation in the general population^{34,35} and that minorities constitute a substantial proportion of the prison population in many jurisdictions, HIV infection among minorities in prison is a special area for concern. Within the Maryland (State) Division of Corrections, the prevalence of infection among minorities has been elevated compared to the rate among whites, even after stratification for a history of intravenous drug use.¹² Although the reasons for an elevated prevalence of antibody to HIV cannot be determined with a cross-sectional survey design, these preliminary findings underscore the need to develop or refine culturally relevant educational strategies in the prison setting.

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AIDS and Intravenous Drug Users in Australia

Alexander Wodak and Bruce M. Whyte

Australia has a federal system of government, with responsibilities jointly shared between the commonwealth government and the governments of the six states and two territories. The Commonwealth Department of Community Services handles national health matters, but the state and territory departments of health are responsible for the implementation and management of health programs. Soon after the AIDS epidemic was recognized, a national AIDS task force was established to oversee scientific developments relating to AIDS in Australia and to provide advice on policy matters. The National Advisory Committee on AIDS (NACAIDS) was organized to act as a liaison to the public and to produce educational programs in collaboration with specific population groups. All states and territories have responded by establishing organizations with responsibilities similar to those of the federal bodies.

Epidemiology of AIDS in Australia

The first case of AIDS in Australia was diagnosed in 1982. Since then, another 845 cases have been diagnosed (as of May 10, 1988), representing a cumulative incidence of 52.9 cases per million of population.¹ In the western world, this incidence is surpassed only by the US, Canada, and Switzerland.² However, only four of these 846 cases have been attributed solely to the habit of sharing needles and syringes among intravenous (IV) drug users, in comparison to 18 percent of cases in the US³ and 64 percent in Italy.² In an additional 24 cases, IV drug use and homosexual activities were both identified as possible routes of transmission.¹

A 1985 study of 200 IV drug users in Sydney found only one seropositive user.⁴ Six persons who had had sexual or needle contact with the seropositive user were tested for antibodies to human immunodeficiency virus (HIV), and four were found to be seropositive. During the course of the study, another eight seropositive IV drug users were referred to the researchers. These 13

persons represented the entire known population of seropositive drug users in Australia in 1985. Later that year, another 75 IV drug users were found to be seropositive in one clinic in Sydney alone; 22 seropositive drug users were identified in Adelaide, the capital of South Australia, and smaller numbers in the other states. The spread of HIV infection among IV drug users was regarded as imminent. Dr. James Curran of the US Centers for Disease Control visited Australia in September 1985 and, noting the low levels of HIV infection among drug users, recommended the implementation of preventive measures.

IV Drug User Population in Australia

As in all other western countries, estimates of the prevalence of IV drug use are imprecise, but in 1980 it was estimated that there were between 14,000 and 20,000 IV drug users in Australia,⁵ which has a population of 16 million people. More recent calculations suggest that the state of New South Wales, which includes more than one-third of the population of Australia, has 10,000 to 14,000 heroin users likely to come to the attention of authorities in a 12 month period.⁶ The wide variation in these estimates is a result of the varying definitions of "drug user" and the different timing and methodology of studies designed to estimate the numbers of drug users. These figures are likely to represent only compulsive users. A more recent survey estimated the proportion of persons who inject on a sporadic basis at 5 percent of all adults (equally divided between males and females), and 2 percent of all adults had used IV drugs in the past 12 months.⁷ Moreover, 40 percent of male users and 71 percent of the female users had shared needles in the past 12 months.

In early 1985, state premiers and the prime minister held a "drug summit" to discuss means of reducing the drug problem in Australia. The conferees agreed to

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AIDS UPDATE

Judy Greenspan

No Uniformity Nationwide on AIDS

No nationwide corrections policy has been formulated in response to the AIDS epidemic within prison walls. Each sector—federal, state, or county—follows its own procedures. And, according to one state corrections health director, these procedures have often been made up as they go along.

Recently, corrections officials in Connecticut agreed in a court settlement to stop segregating prisoners with AIDS, the first time a state has rescinded an AIDS quarantine policy. The Connecticut Department of Corrections had segregated all prisoners with AIDS into a special unit at the Somers Correctional Institution. Prisoners were confined to this small housing unit for 23 hours a day, and allowed no contact with the prisoners housed in general population. Prisoners with AIDS had no job, educational or programming opportunities.

At least 20 states currently segregate prisoners who have AIDS, despite the absence of medical justification for the practice. Approximately 14 states force HIV testing, and six segregate all prisoners who test positive to the Human Immunodeficiency (HIV) test, which reflects exposure to the virus known to cause AIDS.

In our view, the worst scenario in corrections today is the system which requires HIV testing, then segregates those whose test results are positive. Many medical administrators admit that segregation is more for the appeasement of state legislators than for penological or medical purposes.

The most progressive, informed response to the AIDS epidemic is a system which offers voluntary testing and counseling for seropositive prisoners, mainstreaming seropositive prisoners and those with AIDS into the general prison population until they become ill. There is a slow but growing trend in this direction. Arizona and Colorado have now begun mainstreaming after segregating for several years. Georgia is beginning to move towards mainstreaming HIV-positive prisoners in some of its institutions.

Some more enlightened health educa-

tors and prison administrators have recognized that the only way to combat AIDS and HIV infection in prison is through education and counseling. However, letters received at the National Prison Project from hundreds of prisoners around the country and from many AIDS activists clearly reveal that neither the Bureau of Prisons nor the state departments of correction are doing an adequate job on either count. Some prisoners complain that their AIDS education program amounts to distribution of the Surgeon General's pamphlet on AIDS. Others say that the one video they are shown is already out of date. Counseling and support groups are almost nonexistent in prisons and jails. Prisoners point out that there are no educational sessions for those already infected with HIV.

A recent National Institute of Justice report, *Update 1988: AIDS in Correctional Facilities*, stated that "only through regular live training can the persistent misinformation about AIDS be effectively countered." Unfortunately, since 1987 there has been little movement in that direction by state corrections officials.

Prisoners Form Self-Help Groups

In response to the need for meaningful AIDS education, groups of prisoners in institutions across this country are beginning to develop their own AIDS education and peer counseling programs:

■ *Prisoners in New York State*, which has the largest number of HIV-positive prisoners and prisoners with AIDS, were the first to come together to develop these programs. The New York State prison system does not conduct mandatory HIV testing but offers voluntary testing with some counseling. While it is impossible to know exactly how many prisoners in New York State are HIV-infected, a blind seroprevalence study (to determine what percentage are HIV-positive) conducted in 1988 found that 17% of the men entering Brooklyn's Downstate Correctional Facility were seropositive. Corrections health educators and peer counselors believe that number to be much higher since many people entering the prison system are IV drug users.

■ *Members of Hispanics United for Progress* and other prisoners at Green Haven Correctional Facility in Stormville, New York, have formed their own Health Crisis (AIDS) Action Committee in response to the AIDS epidemic. This committee has been instrumental in develop-

ing peer counseling, buddy programs and risk reduction sessions. The Green Haven prisoners have hosted two AIDS seminars at the facility. The most recent one was held in June 1989 on the critical topic of medical clemency for prisoners with AIDS.

■ *The AIDS Counseling and Educational Program (ACE)* is a project developed by women prisoners at Bedford Hills Correctional Facility in New York. The women of ACE are actively involved in education, peer counseling and buddy support services. ACE also provides legal assistance and has incorporated a "creativity workshop" into their activities.

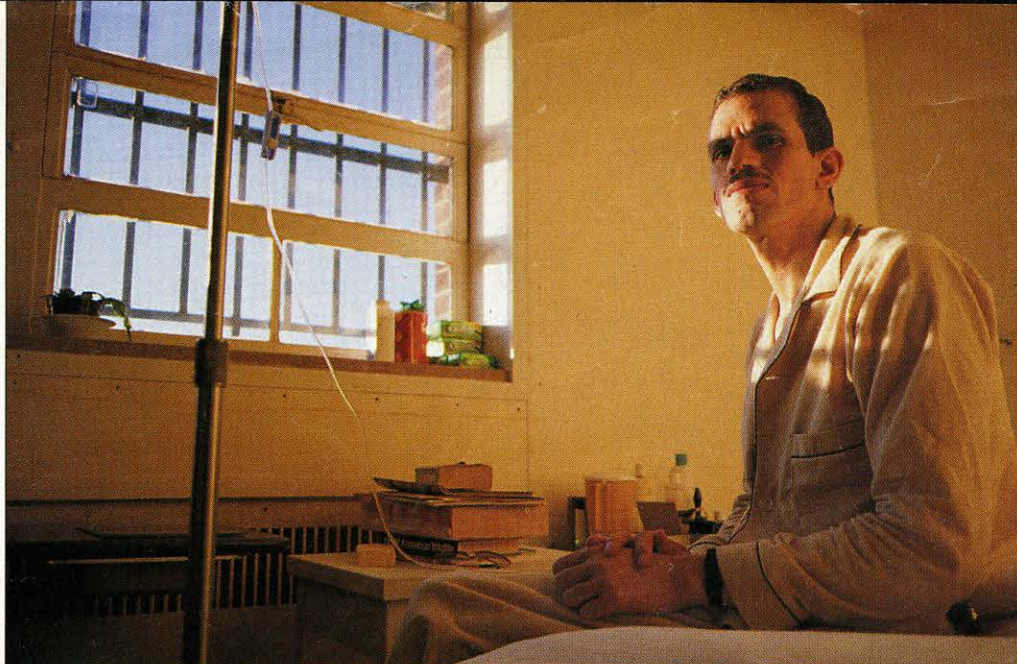
Prisoner-run programs face an uphill battle. Prison and jail administrators have not generally welcomed these educational initiatives on the part of prisoners. In one instance, the prisoner-organizer of an AIDS education program was abruptly transferred to another prison. In another case, the AIDS education program was forced to go underground for over a year because of political pressure from the state administration. At an East Coast adult diagnostic center for men, a group of prisoners had their AIDS educational material from the Centers for Disease Control confiscated by prison authorities who insisted it was contraband.

Despite these obstacles, many programs are now off the ground and running, and can begin to serve as examples for prisoners and health educators around the country. As Cruz Salgado, a prisoner at Green Haven wrote, "I think it's time for society and prison administrators to recognize the concerns and efforts of prisoners and our willingness to do what staff can't, won't, or are unprepared to do. I have made that commitment to the cause of alleviating the grueling effects of this 'monster.' I invite all prisoners to unite in the struggle against AIDS in prison and help calm the echoing scream of frustration, despair and fear of our fellow PWAs (people with AIDS) within the 'belly of the beast.'" ■

FOR THE RECORD

■ Alvin J. Bronstein, executive director of the National Prison Project, has been awarded a MacArthur Foundation Fellowship. The fellowship was given to Bronstein for his significant contributions in the development of prisoners' rights and correctional case law. Bronstein has

Judy Greenspan is the AIDS information coordinator at the National Prison Project, and contributes a regular column to the NPP JOURNAL on AIDS.



ROBERT MAASS—PHOTOREPORTERS

Prisons are not the AIDS 'hotbeds' that everyone predicted: DeMaio at the AIDS unit in Sing Sing

Learning to Live With AIDS in Prison

Behind bars, there is a new death row, but its inmates are being dealt with in enlightened ways

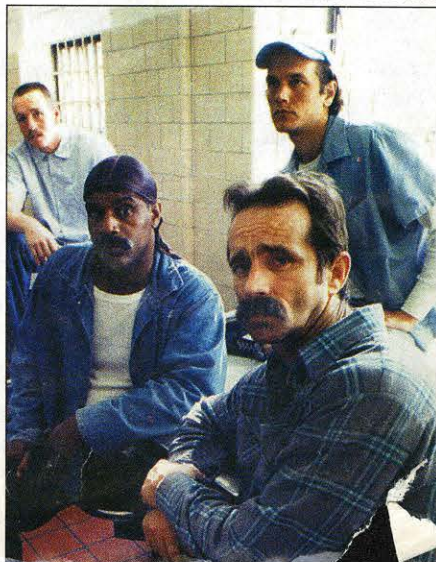
Inside the walls of American prisons, convicts call it "the package." AIDS, an agonizing, protracted form of execution, has created a new death row, more dreaded than the old. Over the years, cellblock grapevines buzzed with tales of prisoners who were beaten and stabbed by other inmates, or thrown into solitary confinement by guards—just for having AIDS. But now prisons, sometimes prodded by lawsuits filed by prisoner-rights organizations, are beginning to adopt enlightened policies toward convicts with AIDS. In New York state, for example, inmates who are not currently hospitalized with an AIDS-related illness can return to the "mainstream" prison population. To reduce fear among staff and inmates, many prison systems have set up AIDS-education programs (box, page 28). Guards no longer automatically wear masks and gloves when escorting inmates with AIDS. Some states even allow inmates to go home to die.

When the AIDS epidemic hit in 1981, doomsayers predicted prison hospitals would overflow with junkies, homosexual rapists and cellblock "queens." "We're going to see a whopping epidemic," complained one Maryland prison official a few years ago. But to date, this grievous scenario has proved exaggerated. According to a study funded by the Justice Department,

there have been only 3,136 confirmed cases of AIDS behind bars, less than 4 percent of the national total. The number of prison AIDS cases increased by 60 percent last year, but on the outside, the rate of increase was 76 percent. Of the 49,414 federal prisoners tested for AIDS antibodies since 1987, only 1,417 inmates tested positive. In 1988 less than 3 percent of new federal inmates coming in from the outside were found to be HIV positive. Says James Riley of the Texas Department of Corrections,

Quarantined: Prisoners at Vacaville

JAMES D. WILSON—NEWSWEEK



"It's a myth that prisons are breeding grounds."

One reason that the AIDS rate in prison may be lower than expected is caution on the part of the prisoners. Some inmates say that high-risk behavior—unsafe sex in which body fluids are exchanged, sharing smuggled drugs and needles, even tattooing—has dropped off substantially. "It's gone down to a minimum," says AIDS patient Robert DeMaio, 36, who is serving time for second-degree murder in New York's Sing Sing prison.

While the stigma of AIDS has eased, reports of serious abuse continue. In a well-publicized case last year, guards in a federal prison in Richmond, Va., allegedly handcuffed Michael Henson, 33,

and tossed him into "the hole" after he tested positive for AIDS antibodies. (The prison denies Henson's charges.) In Nocatee, Fla., Scott Brewer—who later tested negative—told a jailer that he might have been exposed to the virus. "They stuck me in an isolation cell with an AIDS patient," Brewer said. "The officer yelled, 'I've got one with AIDS here'." A bigger problem than abuse is unreliable medical treatment. At the U.S. Medical Center for Federal Prisoners in Springfield, Mo., Michael Lingard had to sue for the right to take regular doses of AZT, the drug that appears to prolong the lives of people with AIDS. Around the country, numerous inmates have died prematurely because prison doctors misdiagnosed their symptoms. A New York state study made last year found the mean survival of AIDS inmates was 128 days—about eight months less than on the outside.

Home to die: But even the most critical AIDS activists concede that some progress has been made. One of the most welcome reforms has been the "compassionate release" parole. California has had the policy for three years, but only two patients have gone home. New York's plan is little more than a year old, and 46 parolees have taken advantage. "Most families accept them," says Ann Quinlan, nurse administrator at Sing Sing. "They see how we deal with patients, and learn by osmosis." Some families still say no. "No one wants to die in jail," said "Lucky," 39, a Georgia convict, "but that's the way it is sometimes." (Last month Lucky died in a prison hospital.)

Allowing prisoners access to condoms for "safe sex" in prison has been the most controversial new policy. Prisons in Vermont and Mississippi, as well as New York City jails, make prophylactics available. But in Bible-belt Mississippi, where sod-



JAMES D. WILSON—NEWSWEEK

Fighting fear and ignorance: An AIDS counselor visits the San Francisco County Jail

omy laws are still on the books, church groups protested loudly. Nationwide, prison officials are largely opposed on the ground that free condoms might encourage sexual activity, even rape, as well as create other problems. "Our security people are concerned about this," says Texas administrator Riley. "These things can be turned into slingshots. They can be filled up with a variety of items, and turned into bombs."

Several states, including California, cite the threat of homosexual rape and needle sharing to justify quarantine policies. At the California Medical Facility at Vacaville, healthy HIV-positive inmates are segregated alongside AIDS patients. Some officials fear the situation could erupt into violence. "Parole violators are living with lifers and murderers," says physician Jan Diamond who treats AIDS patients at Vacaville, "and that creates stress." David Wayne Smith, 33, a petty thief housed in the unit, agrees: "Something's not clicking and the tension is mounting all the time," he says. In a recent incident at an AIDS unit in the California Institution for Men in Chino, 15 HIV-positive inmates broke 220 windows to protest their segregation. Elsewhere, even in states that allow AIDS inmates to live in the general population, anyone with a potentially violent nature is isolated: in 1987 a Florida convict laced a guard's coffee with his own AIDS-infected blood.

But at the federal medical center in Springfield, AIDS patients find a potentially positive advantage in being forced

to live on a rigid schedule: they welcome being guinea pigs for experimental drugs such as CD-4, which impedes the virus's destruction of the immune system. "You've got inmates in a controlled environment," says Michael Miller, 43, who is HIV positive. "I, for one, would be standing in line for any test."

Prisons sometimes actually involve AIDS activists in policymaking, bringing them in to develop education programs. "We do role playing," says John Egan of the Mid-Hudson AIDS Task Force in White Plains, N.Y. "Inmates act out scenes like being tested or being told they're antibody

positive." But some activists say prison officials, reluctant to concede that sex and drug use cannot be controlled, provide too little education. And even when programs exist, the critics say, institutions do not require attendance, rarely offer follow-up sessions and rely on printed material for people with a high illiteracy rate.

If ignorance is one obstacle, complacency is another. Many prison officials are encouraged by the low number of AIDS cases in federal prisons, but they know that most inmates are in state facilities. Only 13 states, largely in areas where AIDS is relatively rare, screen for antibodies. Moreover, the full force of the epidemic may not have hit prisons yet. "There's no hotbed now," says Dr. C. E. Alexander, medical director of Texas prisons. "But what's going to happen in 1995?" Indeed, on the outside, AIDS continues to spread rapidly among i.v.-drug addicts, and in New York state alone, the Department of Correctional Services estimates that between 60 and 70 percent of all inmates have a history of i.v.-drug abuse. Epidemiologists now believe the incubation period for the virus can be more than eight years, maybe as high as 20. Prison officials have to stay vigilant: if the numbers start to climb in the 1990s, the new death row may yet become as overcrowded as was originally feared.

JAMES N. BAKER with SUE HUTCHISON in Boston, NADINE JOSEPH in Vacaville, HOWARD MANLY in Atlanta, DANIEL PEDERSEN in Houston, KAREN SPRINGEN in Springfield and NED ZEMAN in New York

For Women: Education and Mutual Support

They tell a parable about "Blackie" at the Bedford Hills Correctional Facility, New York's maximum-security prison for women. Blackie, an inmate who died of AIDS last year, used to say she could always leave her things lying around because she knew no one would dare touch them for fear of being exposed to the virus. Then in 1985 the prison had its first AIDS Counseling and Education program (ACE), and attitudes started to change. "Eventually everyone started stealing [Blackie's things]," an ACE participant recalls. "That was a good sign."

Around the country, some of the most innovative AIDS education programs have been developed for women be-

hind bars. In San Francisco, Sean Reynolds, an AIDS counselor for the county public-health department, uses tough talk to teach women in the tanks. "Think of condoms as your American Express card, honey," she says. "Don't leave home without it." In Boston, an activist organization called Social Justice for Women developed "AIDS 101" that features "speak outs" where inmates can go to an open mike and say what's on their minds about the disease. "Before, if women tested positive, [inmates] would call them 'AIDS-carrying bitches,'" says Francine Melanson, a former drug addict who runs AIDS 101 at the Massachusetts Correctional Institute at Framingham.

"Now they're knocking down my door, asking how they can help."

The programs often inspire women to take the antibody test. "I'm going to get tested when I get out," said Michelle Thompson, 23, after one of Reynolds's seminars. "I've been on the streets since I was 11... doing heroin." ACE has stayed in touch with a number of parolees and hopes to set up counseling groups on the outside. But the biggest benefit may be to prisoners who are dying of AIDS. Says Sonya, a frail Bedford Hills inmate who can remember what it was like to be harassed for having AIDS, "These people take care of you."

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Alabama suit challenges prison testing and isolation policies

Class action suit also calls for AIDS education and access to treatment

By Chris Bull

MONTGOMERY, Ala. — Women prisoners in Alabama who test positive for HIV antibodies are forced to wear surgical masks outside their isolation cells and to clean telephone receivers with ammonia after every use. Seropositive male prisoners must use plastic utensils to eat their meals. Prisoners who test HIV antibody-positive or who have AIDS are routinely placed in isolation wards, denied basic medical care and access to safer sex information, and stripped of rights other prisoners receive, according to an April 29 suit filed by the American Civil Liberties Union (ACLU) National Prison Project.

In the first class-action challenge to mandatory HIV testing and segregation of prisoners, five Alabama inmates have asked the U.S. District Court of Northern Alabama to order the Alabama Department of Corrections (DOC) to end "humiliating, unlawful and unconstitutional practices and conditions" in "AIDS isolation wards" at Alabama's Julia Tutwiler Prison for Women and at the Limestone Correctional Facility. A district court judge is expected to hear the case in the next few months.

The federal lawsuit seeks to overturn the current Alabama prison policy of forced testing of all Alabama prisoners entering the system and the subsequent "segregation" of inmates whose test results are positive.

The DOC denies that its practices are un-

fair and claims it treats prisoners with AIDS the same as prisoners with other "infectious" diseases. "We know that homosexual activity does take place. This [isolation] is a precautionary measure to protect prisoners from infection," said spokesperson Debbie Herbert. When asked why the state refuses to distribute condoms or provide safer sex information rather than isolate prisoners, Herbert replied that "homosexual activity is illegal. We can't encourage illegal behavior."

Although prisoners who test HIV antibody-positive or who have AIDS are mistreated throughout the country's prison system, conditions are particularly "egregious" in Alabama, says Nancy Ortega, a staff lawyer for Southern Prisoners Defense Committee, which is participating in the suit. "Alabama has one of the most backward systems in the country. In some other states, such as New York, there is at least a pretense of human treatment. But in Alabama the situation is devastating," said Ortega.

Wide range of abuses

The suit seeks to end a wide range of abuses in Alabama prisons that directly results from repressive mandatory testing and isolation policies:

- *HIV antibody-positive prisoners are not

Continued on page 13

Alabama

Continued from page 1

permitted to work, attend classes, receive furloughs, or participate in work release or other community-based programs

- *prisoners' medical records are not kept confidential

- *prisoners are denied equal access to law libraries, which they often need to prepare legal challenges.

In addition, the suit demands that prisoners receive important AIDS treatments such as AZT and other life-prolonging therapies.

Despite the fact that tests for HIV antibodies have a significant margin of error, Herbert said the Alabama DOC makes no provisions for false positive or false negative test results and does not provide counseling for prisoners about the results of their tests. Consequently, according to the suit, many prisoners "suffer extreme emotional anguish believing they have AIDS. They are told that they have a dread disease for which there is no cure. Prisoners who test positive are provided no emotional support or counseling. Prisoners who falsely test positive needlessly suffer pain and anguish."

Confidentiality is impossible to guarantee in the prison setting, according to the suit. Many prisoners who test positive are immediately labelled "faggots" and "lepers" by the entire prison community and subjected to verbal harassment and physical abuse. The antibody status of prisoners is often leaked to friends and family members.

Judy Greenspan of the ACLU National Prison Project said lesbian and gay prisoners, regardless of their antibody status, are often singled out for abuse based on the perception that they are "spreading" AIDS. In Alabama, openly gay inmate Nathaniel Barnes was stabbed by another inmate while working on the AIDS memorial quilt. Barnes, in a recent letter to *GCN*, said the prison administration has ignored the attack. (See *GCN* Vol. 15, No. 47.)

Widespread testing and isolation

Prisoner advocates from around the country hailed the suit as an important part of the effort to stem the growing national trend toward repressive AIDS measures in federal and state prisons.

Ken Stevens, of Prisoner Legal Services of New York, said the suit represents a rare opportunity to expose the mistreatment of prisoners and force changes in the prison AIDS policy. "Sufficient public pressure has yet to be exerted on prison administrations to instigate humane AIDS programs," said Stevens.

Greenspan said that isolation wards established at many prisons are "dumping grounds for those the prison system cares least about — people of color, gays and lesbians and people that are sick.... I mean, what century are these [prison administrators] from?" She said prisoners in isolation wards suffer from depression, malnutrition and generally unhealthy living conditions which contribute to the progression of the disease.

Large numbers of prisoners are affected by prison AIDS policies, although the only statistics available are compiled by prison administrators who have consistently attempted to minimize the extent of the epidemic in prisons. The ACLU Prison Project, which relies upon prison administrators for data, estimates there are at least 1,500 prisoners with AIDS in state and federal correctional facilities.

The New York State Department of Health estimates that 25 percent of inmates in New York State prisons are HIV antibody-positive. The Alabama DOC claims that of over 15,000 prisoners tested, 132 are HIV antibody-positive. Those prisoners are currently confined in isolation wards.

In addition to isolating prisoners who have AIDS or who test HIV antibody-positive, prison authorities often prevent them from leaving the prison system. The federal prison system requires HIV testing before prisoners can be granted parole. Greenspan said hundreds of prisoners have already been denied parole because of their antibody status. Connecticut prisoner Lewis Sierra recently told *GCN* the new policy amounts to "quarantine" for PWAs and those who test antibody-positive. Sierra said prison doctors refused to sign his release papers after they discovered his positive antibody status.

Withholding education

Stevens told *GCN* the Alabama suit could help prisoners obtain the potentially life-saving AIDS counseling, safer-sex information and AIDS treatments often withheld by prison administrations.

The suit claims the lack of education puts prisoners at greater risk of transmission because they are ignorant of how the virus is actually transmitted. By isolating prisoners who test HIV positive, and by forcing them to use disposable utensils and wear surgical masks outside their cells, prison authorities perpetuate the myth that the disease is spread through casual contact.

Ortega said prison administrations often foster an "AIDS-phobic" environment by refusing to provide AIDS information to prisoners. Prisoner rights advocates believe that instead of teaching prisoners and prison workers to work and live together, prison authorities encourage existing prejudices based on sexual orientation among prisoners in order to keep them fighting among themselves.

□filed from Boston



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Safer sex heats up

"Hot, Horny and Healthy" workshop a big hit at the Black and White Men Together conference

By Chris Bull

BOSTON — "Somebody told me recently that he and his boyfriend were jacking off on opposite sides of the bed, and his boyfriend shot across the bed and the cum landed in his mouth. 'Was that unsafe?' he asked me. I said 'That's a good shot!'" So began "Hot, Horny and Healthy," a July 6 safe sex workshop conducted by sexy, dynamic Los Angeles AIDS activist extraordinaire Phill Wilson.

Part of the eighth annual National Association of Black and White Men Together (BWMT) conference at Boston's ritzy Park Plaza Hotel, the workshop focused on eroticizing safer sex through a series of graphic demonstrations and explicit safer sex discussions. A put-the-condom-on-a-dildo race, safer sex "true confessions," and condom-balloon volleyball highlighted the spirited event.

"Safer sex is a sharing, experiential process that only works if we can talk openly about sucking, fucking and eating ass. The point is to bring the fun back into our sex lives," said Wilson, adding, "Boy, things sure have changed. We used to 'fuck.' Now we 'penetrate.'"

Wilson scribbled on the Park Plaza chalk board as participants recited their dislikes about safer sex. To a complaint about the tightness of condoms, Wilson told one participant to "stop bragging." Told about the trials of shopping for spermicides and condoms, Wilson cried "What is this? A gay man who doesn't like to shop?" Other dislikes included: hating the bad taste of condoms; losing the momentum of sex; losing the feel of flesh on flesh; worrying about condom breakage; dealing with the messiness and difficulty of handling condoms; having trouble understanding safer sex definitions; being reminded constantly of death and disease rather than pure pleasure; and losing wild sexual abandon.

Wilson, who is a Black person with ARC, explained to the audience of 25 white, Black, Latino and Asian men from BWMT chapters around the country that he uses the term "safer sex" not because there is no

such thing as "safe sex," but because it implies an interactive, learning process rather than an objective set of rules.

To the delight of the crowd, Wilson highlighted the "positive side" of safer sex, including: focusing on more erogenous zones; pouring champagne all over the body; tonguing nipples; biting ass; enjoying cum smeared on the body; beating gently; talking dirty; sharing all-body massages; playing with food like bananas; spreading whipping cream, warm syrup and honey between the legs; having public sex; tickling; self-stimulation; and increasing emotional intimacy.

The cornerstone of safer sex

"Condoms don't always work, but don't blame the condoms for that. They must be used properly. Practice makes perfect," said Wilson, launching the condom-dildo race. Armed with Gold Circle brand condoms, four groups of seven men raced to roll the condoms over four large black and white dildos. "Some of you need lots of practice," taunted Wilson to the embarrassment of several men struggling with rubber dildos. "I swear it's easier to thread a needle," whispered one exasperated contestant.

"The number one complaint I hear about condoms is that they are too small," beamed Wilson as he pulled a condom over his fist and up to his elbow. "You guys better get used to it, the days of spitting and jamming are over.... But condoms can still be fun," he continued, blowing up a condom to the size of a watermelon.

While the condom-balloon was batted about the room, Wilson extolled the virtues of jelly, honey and milkshakes to improve the taste of latex. Out of his trusty "sexcase," he shared black and white butt plugs ("for that full, free feeling all day long"), tit clamps, straps, lube applicators and lace panties.

Concluded one participant from Memphis with a sigh of pleasure, "All I need is Apricot oil, Samba music, low lights and a warm belly button, and I'm in heaven." □

LESBIAN & GAY HEALTH SUPPLEMENT

LESBIAN & GAY HEALTH SUPPLEMENT

Lipservice

Francie and Brenda negotiate the nasty

By Shirley Haught

It was a stormy week of innuendo: Francie and Brenda, footloose and new to Baltimore, were exchanging quips, handshakes and furtive glances. Brenda had just blown in from Albuquerque to work at "Hot Talk," Baltimore's lesbian/gay hotline. Francie herself was a fledgling employee, and the two quickly discovered sympatico tastes in divey bars and tacky music.

"...They're still hard to find, but I suggest you check with dental supply stores...uh huh, no problem, goodbye."

Francie turned to Brenda. "Shit howdy, that's the third call about dental dams I've had today. Whoever gets those things on the lesbian retail market is going to make a bundle."

Brenda, eyes still glued to the log sheet on her desk, remarked, "Only a few of my friends have tried 'em, and they say they're still trying to get the hang of it."

She threw Francie a casual glance. "Ever tried one?"

"Well, I've got a few at home," she said jauntily, "but I'm going to need a lab partner to really get the low down." Francie cocked a brow at Brenda, and ventured a bashful smile.

At the end of their hectic Friday afternoon shift, the two headed for Tootsie's, a favorite local watering hole, where Frank Sinatra and k.d. lang shared billing on the tinny jukebox.

Brenda winced slightly as Francie ordered a peach wine cooler. "I'll take a scotch, neat," she told the waiter, as they settled into the turquoise naugahyde booth.

The playful little crush that Francie had sprouted for Brenda a mere week ago was now a raging obsession. She sipped her cooler and absently ripped at the label. That Brenda was a cool cookie, Francie thought. Was the electricity between them all in her mind? How long could she keep from blurring her desire?

Brenda was perusing the barroom, taking elegant sips and tapping her foot to "Can't Hurry Love."

"So Francie," Brenda said suddenly. "Have you ever messed around with anyone at Hot Talk?"

Francie blushed and looked quickly away at the glowing beer sign on the wall: a bubbling stream flowed out from between the letters. "No, I haven't really, ah, gotten around much."

Brenda took a deep breath and leaned across the booth towards Francie. "That's funny," Brenda said, with an impish smile. "You're the hottest ticket in Baltimore."

An hour later they were cozily fumbling with each other's clothing on Francie's futon. Brenda spied Francie's softball trophy for "Best Spirit" on the window sill and felt herself swoon slightly; she was finding every little thing about Francie so endearing. "Francie," she said, "Remember in the staff meeting when you were talking about coming out with your driver's ed instructor? I thought I was gonna die, you were so cute."

"Aw shucks," Francie said. "You should've seen the instructor."

Brenda stroked Francie's collarbone, teasing her shirt aside even further. Francie arched as Brenda's lips began exploring an exposed breast. "I've fantasized about this all week," Francie sighed, rolling Brenda onto her back. As she reached under Brenda's plaid miniskirt, Francie paused, mid-grope.

"So, how do you start these safer sex conversations, anyway?"

"Maybe we should call Hot Talk for advice," Brenda laughed, turning onto her side to look at Francie. "But really, in terms of AIDS, I think I'm at low risk."

"Yeah, me too. I broke up with my lover eight months ago, and we'd been monogamous for six years. And the only one before that was my driving instructor — and we kept all our clothes on in the back seat!" Francie rolled her eyeballs.

"Well, I've had more than a few lovers," said Brenda, "but I'm pretty confident we all fall into low risk categories."

"God, it's so weird," Francie replied, "there's no certainty about any of this risk stuff."

Francie and Brenda talked some more about their pasts. Neither, it turned out, had used IV drugs or had a blood transfusion. Francie said she had never been sexual with men, whereas Brenda revealed a brief het liaison during a seasonal job at the Grand Canyon. She told Francie that she and the canyon man used condoms, and that she and her sole high school boyfriend also



relied on rubbers.

They talked some more about AIDS, the lack of data about lesbian transmission, and some of the tricky issues that had come up at the hotline. For example, the staff couldn't even agree whether wet kissing should be considered safe.

"I think it is," said Francie, planting a juicy one on Brenda's adoring mug. Francie resumed groping.

Brenda, pushing her hand gently aside, said, "I think kissing is okay, too, but...there's something else we have to talk about."

Francie looked up curiously. "Oh yeah?"

"I have herpes," Brenda said, hesitating. "You know, the genital kind."

"Oh, um, I don't know too much about that," Francie checked her initial surprise at the revelation and quickly added, reassuringly, "What should I know?"

Brenda smiled, relieved that Francie wasn't going to be the flip-out sort of gal. "It's so hard when I have to tell people about it, but herpes is really not much of a problem for me."

"The only time it's contagious is when I have an open sore — and I can usually tell when one is coming on," Brenda explained. "So I try to be careful. But when I do have a sore, you shouldn't touch me with your hands or go down on me."

"Bummer," Francie frowned. "How often do you get sores?"

Brenda said she rarely got more than one or two sores a year and they weren't very painful, but that other people with herpes had them more often and more severely. She recounted the various advice she'd been given about things that could bring on a herpes attack.

"Certain foods are bad for herpes," Brenda said, "for example, nuts and pepper. Then there's stress, having a cold, having your period — they're all implicated. And get this. My dyke doctor just told me that herpes could be brought on by the excitement of having a new sex partner."

"Yikes," said Francie, "are you 'herp-free' right now?"

"Yes," Brenda replied, grinning broadly. "But I'm getting pretty excited." □

Try everything outrageous

The case for needle exchange

By Marea Murray

"Mary" is an IV drug using woman with AIDS. She steals syringes from the hospital where her daughter is being treated for ARC in an attempt to be "safer" in her habit and with her partner. Like many people with HIV infection or AIDS, she does not want treatment to get out from under the needle. She figures she is dying anyway.

Even if "Mary" were interested in treatment, it's not accessible. Because she is on Medicaid, there is only one place that will give her methadone, the synthetic heroin substitute used to maintain addicts and eventually help them break their dependency on heroin. That place is Boston City Hospital (BCH), which has a waiting list of months. "Mary" could "make use" of her AIDS diagnosis to be pushed ahead on the list at BCH; if she told them she had AIDS, she would be "prioritized" for methadone because she would be seen as a public health risk. The problem is that such a disclosure would put her at risk of losing custody of her child.

In any case, there isn't any transportation available to take her from outside Boston where she lives into the hospital for a daily dose of methadone. Nor is there child care provided for her daughter.

Bizarre priorities underlie AIDS policy in the drug addiction context, with few tenable options offered to people like "Mary." Instead of attempting to address the full gamut of issues "Mary's" experience raises, the debate about AIDS and drug use usually focuses on two alternatives considered mutually exclusive: needle exchange programs and treatment to alleviate drug use. While certainly not the only answer to the continuing spread of HIV infection among — which offer clean needles in exchange for used ones — have demonstrated positive results. In Massachusetts, Governor Michael Dukakis has vowed to oppose needle exchange programs "even if shown to curb the spread of AIDS." Presidential contender Dukakis has insisted that more treatment slots will be made available for addicts who want them. Critics suggest that his approach to drug users and AIDS is reminiscent of his approach to gay men and AIDS. For example, Dukakis opposes explicit safer sex education, despite its proven effectiveness. (See *GCN*, May 29, 1988 for more on Dukakis and AIDS.)

One of 11 states where purchase and possession of hypodermic needles without a prescription is illegal, Massachusetts is also estimated to be home to some 40,000 IV drug users, with an estimated 14,000 in the Boston area. Last month, the State Legislature "just said no" to the proposed Boston needle exchange program. They voted instead to have a commission study the legal issues surrounding clean needle exchange.

With soaring rates of HIV infection and full-blown AIDS diagnoses in the IV drug using population, Mayor Ray Flynn of Boston will try again for state legislative approval of the needle exchange home rule petition, which was recommended by the Boston City Council last spring. The effort has faced stiff opposition from Dukakis, Public Health Commissioner Deborah Prothrow-Stith and the Massachusetts Medical Society.

The proposed Boston exchange would entail distribution of clean hypodermic needles and syringes ("works" or "rigs") to 200 addicts (less than two percent of the addict population in the city) over a six month period. With the defeat of the proposal before the Health Care Committee (which voted it down 10-5 with 2 abstentions) in June, the Portland, Oregon exchange program has become the first of its kind in the nation this month. In a state where needles can be purchased over the counter, Oregon's program will cost \$67,000. It involves 125 IV drug users who visit the clinic and present injection marks and a used needle.

Meanwhile, the presidential AIDS Com-

mission's final report suggests small and "controlled" clean needle programs. AIDS Action Committee Executive Director Larry Kessler has called for guerilla needle distribution as "civil disobedience," a strategy employed for some time by the Boston AIDS Brigade (run by two recovering addicts) and other (more anonymous) health care providers and activists.

As for Dukakis' proposed alternative to needle exchange, i.e. treatment and education, there are few indications the state is willing to back up its plan with adequate resources. The \$6 million proposed for expanded "AIDS drug treatment" and preventative education has recently been sliced to \$2.65 million in the Mass. Senate Ways and Means Committee. In the most recent budget, the program is "priority two," which means that funds will only be allocated if revenue projections are met halfway through 1989. The latest June

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Fill glass with one part
bleach/nine parts water.



Fill syringe with bleach
and water solution.



Let soak at least 10
minutes.



Rinse thoroughly with tap
water to remove bleach.

**BLEACH IS DEADLY IF
INJECTED. Make sure
you rinse needle and
syringe well.**

revenue figures for the state were again lower than anticipated, so more cuts are likely before a final FY89 budget is implemented.

Dr. Sandy Lamb, Deputy Commissioner of Boston's Health and Hospitals and a strong proponent of needle exchange, has noted that treatment slots for all users in Massachusetts would entail expenditures of upwards of \$30-40 million.

In addition, the limitations of a treatment strategy are many. Programs only reach those addicts willing and able to enter treatment. It is difficult to recruit and train staff for these programs. Obtaining sites for treatment centers has already met with vocal local community resistance. Weekly rates for methadone maintenance are \$80-100 in Boston. While some programs have sliding scale fees for drug-free and residential treatment, generally these programs don't offer methadone.

Finally, not all addicts are heroin users, so methadone is neither the only "treatment" necessary nor the "solution to the AIDS problem." In fact, cocaine is more popular, and the nature of the high it produces with intravenous, intramuscular and other forms of "shooting" necessitates injection several

Continued on page 16

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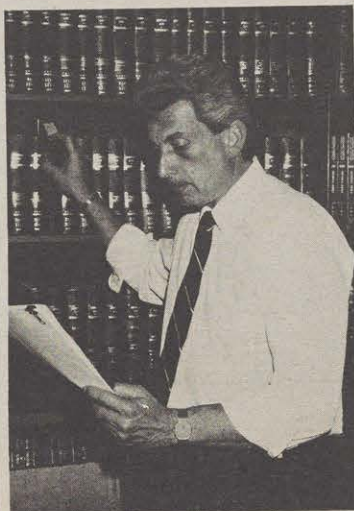
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Lesbian health: where are we now? (Part 1 of 2)

By Shelley Mains

Like so many other aspects of lesbian lives, our health issues receive little public attention. Pitifully few studies on lesbian health have been undertaken or supported, and few books or articles have addressed the topic. Many practitioners we depend on for care are bewildered about possible lesbian practices and consequently ignorant of our health care needs.

Because we have little access to reliable information, lesbians have been largely unaccustomed to discussing health matters, and many of us don't even feel comfortable coming out to our health care providers. While the feminist health movement of the 1970s encouraged discussion about specific needs of lesbians, concerns about AIDS have been the most recent impetus to further conversation about our physical, emotional and sexual health.

Thinking and talking about HIV transmission among lesbians give rise to questions about the broader context of lesbian health: What other sexually transmitted diseases (STDs) might pose risk for us? How can they be prevented? What other physical and mental health problems are of particular concern for lesbians? What barriers do we face in obtaining health services? How do these issues vary among lesbians of different races, ages and classes? And what has become of the feminist health movement of the '70s?

To address some of these questions, GCN organized a discussion with three Boston-area women who have worked in the field of lesbian health — Vicky Nunez, Loraine Obler and P. Clay Stephens.

Vicky, formerly with the HIV Antibody Testing Program at the Fenway Community Health Center, is currently involved in developing the Women's AIDS Information Project. The Project aims to provide AIDS information specific to women. Vicky is also helping conduct an "anecdotal survey" of health practitioners from across the country about the transmission of STDs — particularly HIV-infection — between women. The results will be presented by Jennifer Walters of the Fenway Community Health Center during a panel at this year's Lesbian and Gay Health Conference. Vicky belongs to Amigas Latinas en Accion Pro-Salud (ALAS), a Boston group of Latina women who work on Latina health issues.

Loraine Obler, a neuropsychologist, was formerly on the board of the Fenway Community Health Center, where she helped set up the alternative insemination (AI) program. She worked with the Boston Lesbian

Psychologies Collective on the book *Lesbian Psychologies* and is currently working on the Boston Lesbian Health Project, which examines a broad range of lesbian health issues. Questionnaires have been returned from 1,500 lesbians across the country and the study will be discussed at the health conference. Loraine will also soon be a lesbian mom.

P. Clay Stephens is a physician's associate who has worked in the field of OB/GYN and STDs. She has been active in the women's health movement for over 20 years, including working on reproductive rights issues, and in women's clinics — many of them free clinics — in the Southwest. Since moving to Boston in 1985, P. Clay has worked at the Fenway Community Health Center in several capacities: practicing women's health care, doing clinical research on HIV-infection and running the AI program. Since November, she has worked at the Massachusetts Department of Public Health as coordinator of AIDS resource development. The opinions she expresses are not necessarily those of the Dept. of Public Health.

The topics explored in this discussion reflect the interests and expertise of the participants. By no means are we implying that these are the only — or the most important — health issues facing lesbians. Nor are these exhaustive presentations on the subjects. Our aim is to broach the topic of lesbian health, offer ideas, provoke discussions, and get us all thinking about how to better take care of ourselves and each other.

Sexually-Transmitted Diseases

Shelley: Let's start by talking about lesbians and sexually-transmitted diseases (STDs). Our community is buzzing about HIV transmission and safer sex because of AIDS, but it seems there's little discussion or information about other STDs we may be at greater risk for, and how we can prevent their transmission.

Vicky: There's precious little written or spoken about the whole issue of STDs. One of the questions we're asking providers in our informal survey is whether they talked to their lesbian clients about safer sexual practices before the AIDS epidemic. I have a feeling a lot of people are going to say "yes" because they don't want to look bad, but I doubt they were talking about dental dams or gloves or finger cots. If anything, they were giving advice like "avoid contact if one partner has herpes lesions or open sores" — the kind of recommendation that go to women who already have STDs. But the real

gaps in care and information exist in the area of prevention.

P. Clay: In response to your comment on finger cots and gloves and dental dams, I want to mention that women's clinics in Los Angeles and San Francisco have recommended finger cots and gloves and dental dams for more than ten years. This is where the current dental dam movement developed — people were already talking about barriers in response to herpes. Not for people who had open lesions, because then it was too sore to do anything, but when the lesions were closed and the skin was not yet clear — [the barriers could be used in] an intermediate stage when the person who had the lesions could feel comfortable enough to have sex.

Vicky: The idea that lesbians should even think about STDs isn't widely accepted. It seems the impression of most providers is that if neither partner is sleeping with men, chances are they don't have to worry about STDs. And maybe to a large [degree] that's true, but that's not to say that STDs can't be transmitted from woman to woman. When you speak with providers who have extensive experience working with lesbians, they do talk about seeing a number of STDs. For instance, a woman we've contacted in New York City says the number one reason she sees lesbians is because of chlamydia [a bacterial infection that is the most widespread STD in the U.S.]. But from people we've talked to in Boston, it doesn't seem like they're seeing much chlamydia. Our findings are all anecdotal, but we're seeing different patterns in different areas.

Shelley: Is there an accepted understanding about which STDs are transmissible between women? I don't think it's common knowledge.

Vicky: I think if you asked three providers about an STD: "Can it be transmitted from woman to woman?" some persons would give you a very authoritative "yes," and some would give you a very authoritative "no." So that's certainly part of the problem. And I think that probably some providers just don't believe you can transmit STDs from woman to woman. Part of that is ignorance on the part of practitioners as to what lesbian sex practices are, and the other is that the medical information just isn't clear at this point.

I also want to mention vaginitis and different kinds of vaginal infections. These can be sexually transmitted, and they can also develop spontaneously in a woman, so you don't have to get an infection from somebody in order to have it and give it to somebody else.

P. Clay: People also very rarely mention dermatitis in discussions of STDs. If a woman has a very acid or base vagina because her pH balance was thrown off by even a fairly minor vaginal infection, through oral sex her partner can develop a very severe dermatitis around the mouth and/or cheeks.

Vicky: That brings up a point nobody talks about because we don't want to say vaginal secretions are yucky and therefore you should get up and wash your face immediately — but there does seem to be a basis for recommending that you wash your face and your hands after sex. It seems one of the ways you can transmit chlamydia is if your fingers come in contact with infected vaginal secretions, and then you may rub your eye and infect yourself. Another issue about transmission — and something specific to women — is that we tend to share things like underwear "because we're all women," or take baths together and things like that. It's not that every woman is going to get vaginitis by sharing underwear with an infected partner, but for some women, that's the kind of thing that can cause infection and reinfection.

Shelley: What about the links between STDs and cervical cancer and other cancers?

P. Clay: Viruses, especially the herpes virus and papilloma (the virus that causes condylomata acuminata or venereal warts) have very definitely been implicated in epidemiological studies of cervical cancer. So were you to have either of these things and transmit the virus somehow — for example through digital penetration — to your cervix or your partner's cervix, that could be an issue.

Vicky: Then again, cervical cancer seems to

develop so slowly, and since pap smears are so regular for a lot of women, it seems like the development of something that's cancerous could be caught fairly early on. But this hooks into the issue of whether lesbians receive regular gynecological checkups and pap smears.

P. Clay: Some people erroneously think that if you don't have sex with men you don't need a pap smear, even though you may have been heterosexually active for many years before coming out. Then you can get into a long discussion of how pap smears are not reliable if done by computer, and most of the cheap places in the country that read pap smears do them by computer. The other issue is that there are people who believe there are certain forms of cervical cancer that are developing faster and deeper than the previous forms. This reopens the issue of how frequently you need a pap smear. It's also important to remember that abnormal pap smears and cervical cancer are more common in lower socio-economic groups than upper.

Loraine: That's a question in the Boston Lesbian Health Project: "Do lesbians need pap smears?" If your general belief is that sex with large numbers of men brings about the general risk of cervical cancer, we should find less in the lesbian community. If it's low socio-economic status, we should find more in the lesbian community. That's the sort of information we're gathering.

Access to health care for lesbians

Shelley: The issues we discussed earlier about who gets pap smears point to the larger issue of access: who sees practitioners and what are barriers to seeing practitioners, ranging from economics to racism to the obstacle of whether to come out to your doctor?

Loraine: There's no doubt that lesbians' attitudes toward the health care patriarchy and providers interact with issues of socio-economic status. It's more likely that lesbians aren't getting the health care we need because of the additional barrier of talking to a doctor about who you are and what your behaviors are.

P. Clay: One thing to throw in about access is that when we're talking about younger women — college age or younger — we have to remember that all the women's health care that's funded through the various family planning organizations is based on reproduction and on family planning and birth control. So you have to make a decision, if you're a lesbian, either to pay for your own health care, or else, regardless of what you say at the clinic about your practices, you must take foam and condoms outside the front door of the clinic to get your visit paid for. This is a real issue for a woman who wants to be out and proud of her sexuality.

Vicky: There are also different levels of being out. If you're with someone you consider to be a lesbian practitioner or someone who's lesbian-sensitive, and you come out as a lesbian, it might be hard to bring up the fact that you had sex with a man a few months ago. To put yourself out that way is another level of being out. Something else that comes up is substance abuse; you can be out as a lesbian, but are you going to take that other step, which is really scary, to be out about a substance abuse past or something in the present?

P. Clay: That's a really interesting point. Doing abortions for years, it struck me that I did a lot of abortions on lesbians who had sex with men. I think in a funny way we saw, in that setting, more lesbians who had deviated from "official lesbianhood." To me that says there's an enormous number of women who may identify one way and may have an unusually broad range of practices — maybe wider than other groups because our identity is socio-political in addition to being sexual.

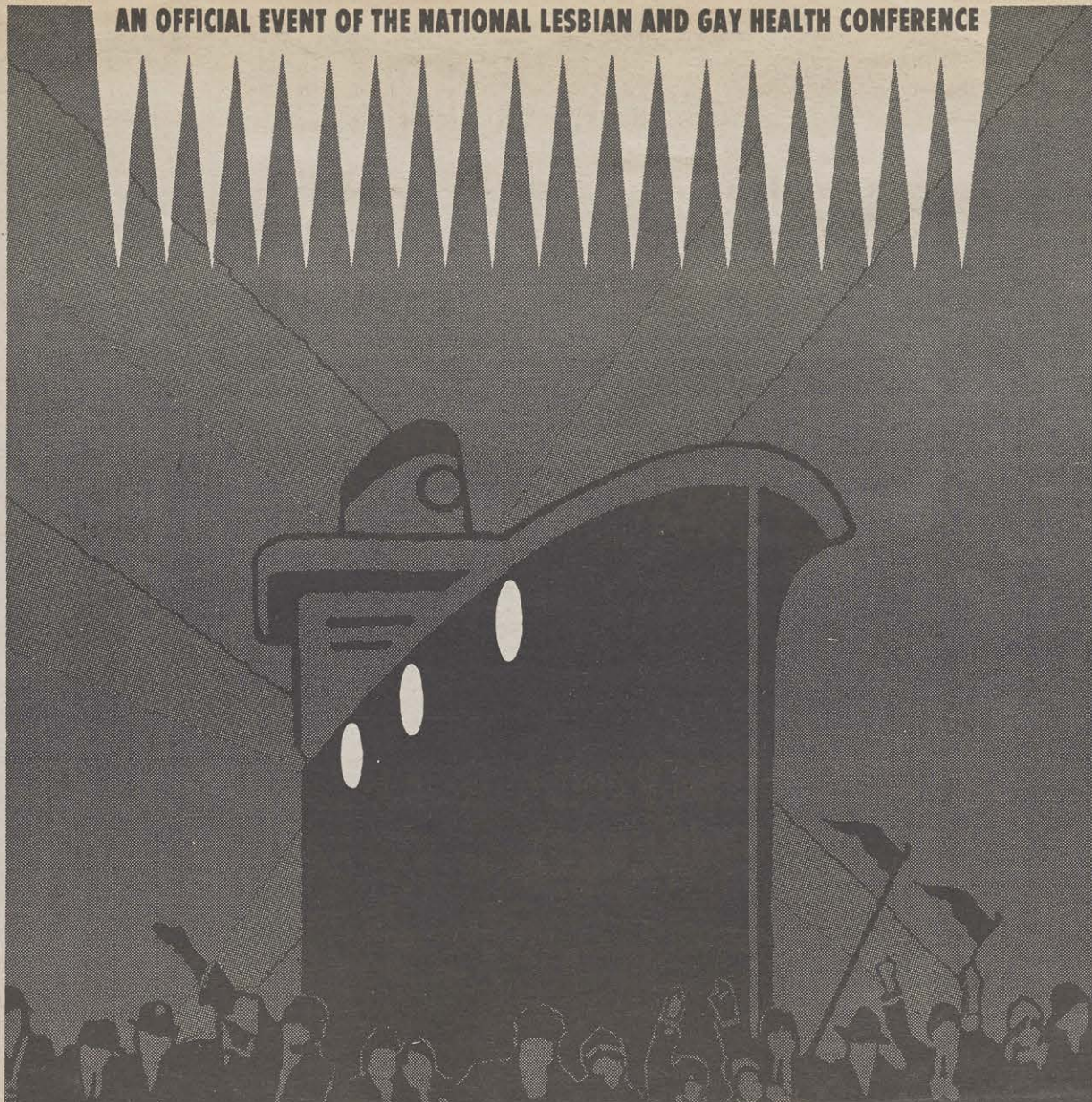
Shelley: So we're talking about two issues: what we do and how we identify ourselves.

P. Clay: The importance of self-identification came up in two very interesting studies on lesbians and AIDS at the [recent international conference on AIDS in] Stockholm. The first was a study by the CDC [Centers for Disease Control] in which they mechanically went through all their

Continued on page 13



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LESBIAN & GAY HEALTH SUPPLEMENT

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Lesbian health

Continued from page 11

AIDS reports and came up with seven cases in women who hadn't had sex with a man for several years. They therefore declared these women to be lesbians. The women were not necessarily self-identified lesbians. For all of them, the first and most obvious way they could have been infected was through IV drug use, so that's the way they were categorized. Thus the CDC will tell you that there are seven lesbians with HIV infection that have gone on to full-blown AIDS, based on IV drug use. That's their total summation of the lesbian health risk for AIDS; in fact the title of some of their literature in Stockholm said "Lesbians are not at risk for AIDS, except for IV drug use."

At the same presentation was Patricia Case, representing a group of women who did an IV drug use study in San Francisco. Using anthropological methods, they got lesbians to refer them to other lesbians until they were able to identify a group of about 55 or 60 women who identified as lesbians and who used IV drugs recently. They focused on a group of about 35 or 40 women who used IV drugs in the last three months — an amount of time the researchers thought indicated "current" use. Out of that group approximately 25 had had sex with men.

The study looked at some identity questions: the women could say they identified as lesbians, as IV drug users, or as neither. And you could almost predict what they knew about AIDS from the category they identified with. The ones who called themselves IV drug users and identified with that community knew everything there was



to know about cleaning needles with bleach. That message had clearly gotten through. The ones who identified with the lesbian community knew nothing about perinatal [birth-related] transmission, cleaning needles, or safer sex with men — regardless of their practices and childbearing patterns. And the ones who identified as neither knew hardly anything about anything. So as much as we've been saying we should look at practices instead of identity I think after we work through that we have to turn around and look at identity and see if our message has gotten through. And I think it's an important message not only about who defines what a lesbian is, but about what we, the lesbian community, admits happens within our community.

The other thing about the San Francisco study is that the women identified a need in their community and worked after hours and got more information — on no money — than the CDC [has] with all its computers and resources.

Shelley: What direct implications do these identity issues have for lesbian health care?

P. Clay: If you walk into an emergency room bent over with lower abdominal pain on the right side, severe fever and you haven't had sex with men for 15 years, you wouldn't need a big workup to rule out ectopic pregnancy [implantation of a fertilized egg outside the uterus]. The practitioner could dive right into appendicitis. But women who feel their own security will be compromised by coming out may not share that information and will lose out on lifesaving time. And it's always a double-edged sword — just coming out won't solve your problems. You may even get shoddier treatment or get shoved around on the table or get homophobia — and now AIDSphobia — dumped on you.

We have to be very aware of the race and class issues. There's an incredible excess loss of life, for instance, in the Black community caused by diseases that could be prevented. This problem is compounded if you're a lesbian or speak a different language than your practitioner

or anything else that's a barrier to effective communication with a health provider.

Shelley: With all the public policy debates about Medicare and catastrophic care coverage for people over age 65, I've been thinking lately about access issues for lesbians growing older. Most lesbians — especially those who don't have children — won't have the whole free care network that many of our grandparents had, with younger wives, daughters, nieces, and all kinds of female family members taking care of them at no cost.

P. Clay: This plugs into my thinking about the "survivor syndrome" that the lesbian community will be in for — as a larger and larger part of the gay community literally dies [due to AIDS]. What's that going to mean to us in terms of institutions and campaigns currently supported largely by gay men with more resources? Lesbians have never been the monied group among the homosexuals. What's that going to mean when we apply it to old women seeking care and assistance? How are we going to take care of each other?

For instance, now you can get federal Medicare payments for taking a PWA into your household and caring for that person as an unrelated adult. They have a similar program for elderly foster care, which is where the model came from. The question for me is, how many of us are going to take on the caretaking role because nobody will take the people in and there's no more hospital space? If we have to deal with that model in our young lives will we keep the model in our older lives, both in terms of being the foster-cared-for person as well as being available to provide foster care for older people?

Shelley: Can you talk more about the effects of having such limited resources devoted to lesbian health, whether direct services, training, or research?

P. Clay: One of the problems I've had with some gay clinics was that money generated by the AI programs was going into paying for services for gay male STDs, often for men who had the ability to pay. Yet the clinics were spending money on men that was hard-earned by women — at 64 cents to the dollar, or 59 cents to the dollar, or 33 cents to the dollar — in spite of women's sentiment that that money should stay in the lesbian community and support lesbian health services.

Other clinics have felt that they were doing lesbian health care by hiring lesbian health care workers, but giving them no support to develop special programs, ordering no special brochures — nothing that would approach a way to get into the lesbian community.

Shelley: Limited resources also affect your research, Loraine; you need resources to get research done, and to get the information out there for people, whether practitioner, or women doing self-help, or whatever.

Loraine: Our lesbian health research was supported by the Chicago Resource Center, [a foundation that funds lesbian/gay projects nationally]. Another major lesbian health study received funds from the Ms. Foundation and the National Institutes of Health. They were prepared to take government monies, which raises other issues. Funding considerations obviously affect your outcome: they affect the pace at which you can work — which is relatively slow in our case; and they certainly affect the way you pose your questions, where you choose to publish your results, and how you frame these results.

P. Clay: Most books that deal with women's health were produced one of two ways. Either there was such a vacuum for the book — as in the case of the early *Our Bodies, Ourselves* — that early book sales produced a financial base to continue updating the book; or, in the case of books produced by feminist health centers, the national feminist health centers, the Federation of Feminist Women's Health Centers childbirthing, and other services that they were able to support writing the books. So nobody has ever written comprehensive books on women's health from a major women's college, even. No one's had that kind of backup and support. I think the fact that we can name as many books, or films, or pamphlets as we can is a statement of the determination of women to prepare these materials for each other.

What concerns me is that unless writers

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AIDS and health insurance: Public health versus private profit

By Martin Heggstad

AIDS-related discrimination in the U.S. health insurance industry demonstrates not only institutionalized homophobia, but the fundamental contradictions of a health-care system that attempts to meet the needs of both public health and the private quest for profits.

Health insurers have been excluding or limiting coverage to those believed to be at risk for AIDS. People with AIDS (PWAs) have faced particular problems. Those with health insurance have experienced loss of coverage, long delays in the processing of claims, and denial of coverage for "experimental" treatments. Those without insurance have had to rely on meager public assistance, as the U.S. remains the only industrialized nation besides South Africa without some form of comprehensive national health insurance.

Insurers nationwide have been taking steps to avoid paying for AIDS-related health care. A study issued in February by the Congressional Office of Technology Assessment (OTA) found that most insurers — whether commercial companies, health maintenance organizations, or non-profit Blue Cross and Blue Shield plans — attempt in various ways to avoid selling individual policies to people they fear may be at risk for AIDS.

One method used by insurers has been to require HIV antibody testing which the OTA study says is now a common practice. Half of the commercial insurers surveyed routinely require testing for some applicants. In states where HIV antibody testing by insurers is not permitted, companies often substitute other tests believed to indicate risk for AIDS, such as T-cell subset studies.

Over 30 percent of the commercial insurers surveyed admitted using sexual orientation as a factor in underwriting, even though this practice violates the industry's own guidelines. Rather than directly asking applicants about their sexual orientation, which is forbidden in many states, some insurers apparently "redline" occupations — such as waitering, interior design and other "non-heavy lifting" occupations — and neighborhoods — such as the Castro and Greenwich Village — they assume to be predominantly gay. Some AIDS activists speculate that insurers comb medical records of male applicants and reject those with a history of diseases thought to be typically gay. According to the OTA, insurers also resort to such tactics as questioning applicant's neighbors about whether applicants are gay.

Although the OTA study focuses on individual plans, most people who have health insurance are covered under group plans provided by employers. Insurers underwriting these plans do not generally screen applicants to eliminate those who may have extensive health care needs, as they do with individual plans. Insurers assume that such people will be a small minority and that the premiums paid by the group as a whole will cover the cost of caring for individuals with large medical expenses.

Perhaps as many as 50 percent of the total number of employers in the U.S. are "self-insured." These companies design and pay for their own insurance plans and hire insurance companies to run them, as permitted under the 1974 federal Employee Retirement Income Security Act (ERISA). ERISA plans are exempt from state regulation — including state protections against AIDS-related discrimination — so employers are free to limit or exclude coverage.

Denise McWilliams, director of the AIDS Law Project at Boston's Gay and Lesbian Advocates and Defenders (GLAD), claims that "ERISA plans present one of the most dangerous problems, since employers have a strong financial incentive to discriminate against people who they fear may be at risk for AIDS."

PWAs and insurance

While insurers and employers are doing their best to save money and increase profits, PWAs and those at risk for AIDS face a very different set of concerns. And employment and insurance discrimination are only the beginning of their struggles for quality health care.

PWAs who are no longer able to work ultimately lose their insurance benefits. Under the 1986 federal Comprehensive Omnibus Reconciliation Act (COBRA), coverage may be extended for up to 18 months, provided that one works for a firm with at least 25 employees. Once an employee leaves the firm, she or he must pay the full group premium, which includes contributions normally made by both the individual and the firm. Those who obtain extended benefits sometimes have trouble keeping them, however. According to Steven Busby of ACT UP/Boston, "Many PWAs have trouble maintaining the cost of premiums, which can be quite high. One must either pay or lose coverage."

For those who do retain coverage, insurers use various means to avoid paying AIDS-related claims. Both individual and group plans generally include clauses limiting coverage for "pre-existing conditions."

There have been numerous reports of companies using even more unsavory methods to avoid paying claims. Some companies stall reimbursement for as long as possible in the hope that the policyholder will die before the company is forced to pay and that no one will follow up the claims.

Then there are the problems encountered by PWAs trying to get coverage for specific line items like home health care and prescription drugs. Mark Schueppert, a financial benefits advocate for Boston's AIDS Action Committee, says of his clients, "Most of the problems they encounter are not AIDS-specific, but rather the same as those which affect other people with life-threatening illnesses." As an example, he noted that many insurers limit benefits for home health care, which PWAs often depend on.

Schueppert also pointed out that some insurers do not cover the cost of prescription drugs, which can be extremely expensive in AIDS treatment. Busby noted that insurers who do provide medical coverage are not compelled to pay for experimental treatments. "Virtually all AIDS treatments are experimental. Even AZT is approved by the FDA only for use in relatively advanced cases," he said.

The situation can be even worse for PWAs who do not have insurance coverage or who lose their coverage. Without insurance, PWAs must face not only serious illness but also a rigid and unwieldy state bureaucracy which may require, among other things, that they spend almost all of their money — if indeed they have money — to qualify for public assistance. These PWAs face struggles for quality health care similar to non-PWAs who do not have health insurance or money and are stricken with "expensive" illnesses. It is estimated that 30 million Americans do not have any form of health insurance.

Proposals

AIDS activists and policy-makers have put forward many proposals for dealing with the rapidly-growing problem of financing AIDS care. An approach taken by a number of state insurance commissioners is to prohibit or limit HIV testing and other attempts to exclude people perceived to be at risk for AIDS. According to McWilliams, such regulations are better than nothing but may be difficult to enforce.

McWilliams suggested that state legislatures require insurers to cover people with AIDS-related conditions, as has been done

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Needles

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times in an hour for some, a routine which enhances sharing behaviors.

Despite the myriad problems with current and proposed treatment programs, they continue to be prioritized over clean needle exchange and all other experimental programs. One of the arguments voiced most frequently by those opposed to needle exchange is that such programs support the continuation of drug habits, condone self-destructive behaviors, and perhaps even encourage others to use needles.

But this analysis ignores a number of key questions: How many addicts will be able and willing to enter and stay with treatment? How many addicts will continue to use and share while on the waiting lists? How many will become infected as the state Health Care Committee studies the merits of clean needle exchange? How many addicts will die from overdoses, the usual gamut of drug-related illnesses, and/or HIV infection?

"Desperate times call for desperate measures." By not "trying everything outrageous," as Billy Jones, a Washington D.C.-based recovering addict and AIDS educator puts it, policymakers are conducting a "limited war," one which allows the spread of HIV infection to "unprioritized" addicts.

Speaking at the National Black and White Men Together conference in Boston on July 6, Jones made it clear that prisoners are one group yet to be "prioritized." He referred to a Washington D.C. area study of 1,000 incarcerated persons, which found that 40 percent had had unprotected sexual encounters and 60 percent had "done some form of drugs" while behind the walls. Despite the obvious need, there are few to no treatment options in prison: no methadone, little or no safer sex or drug use education, and few works and needles to meet the demand. And, prisoners are at constant risk of being further isolated and castigated if they test positive for HIV antibodies, develop symptoms or are perceived to be gay or lesbian.

Underlying the notion that addicts can indeed "just say no," or "just say I want treatment" is a profound lack of knowledge about addiction and a belief that drug users are expendable. In other words, they deserve what they get. After all, the argument goes, they don't control themselves. Of course, that's what was said about gay men, too, when they started getting sick and dying with AIDS.

Also like gay men, IV drug users face discrimination; the oppression they encounter is most clearly based on racism and class bias, although users do run the gamut of class, color and sexual preference. Eighty-five percent of those categorized in the IV drug using category by the Centers for Disease Control are Black and Latino. In contrast, 40 percent of all PWAs in the U.S. are People of Color.

So, while not limited to "minority" communities, drug use coupled with AIDS is increasingly and disproportionately killing Black and Latino people in the U.S. Sexually-transmitted disease studies indicate that white gay men are responding to safer sex education and rates of HIV infection are dropping off somewhat in that community. But, as Jones pointed out, sexually-transmitted disease and HIV infection rates are still rising among IV drug users and in the Black and Latino communities, gay and straight.

Clearly, current approaches are not working and culturally sensitive materials accessible to people of varying literacy levels are still not considered priorities by the federal and state governments.

Susan Elberger, Director of the East Boston Multi-Service Center, which runs a residence for addicts, describes official approaches to drug use and AIDS as criminal and "hypocritical": "You can't be a nation of pushers for some drugs (alcohol and diet pills) and prohibition of others. We can't prosecute small time hoods and support foreign governments who promote the drug trade, nor can we permit public officials to commit murder and get away with it."

Resources

Hotlines

Boston City Hospital (women operators) (617) 424-5916
AIDS Action Committee (10-6pm) (617) 536-7733
Massachusetts (toll free) 1-800-235-2331

Narcotics Anonymous (617) 569-0021
AIDS Hotline for Kids (415) 435-5022

Testing

Alternative Test Sites (free) (617) 267-0159 (hotline)
(617) 522-4090 (appts.)
Project Trust (free drop in for IV drug users,
testing/counseling/support groups) (617) 424-4495.

Drug Treatment in Boston

Women Inc. (inpatient, outpatient, some child care)
(617) 442-6166
Boston City Hospital Triage (methadone, outpatient)
(617) 424-5554
FIRST (inpatient, outpatient) (617) 445-5230
Alianza Hispana (drug free, outpatient) (617) 427-7175

HIV Related Groups/Services

Children's AIDS Program (wait-list only) (617) 424-5903
Project WIN (IV drug-using families with children under six)
(617) 783-7300
Fenway Community Health Center (617) 267-7573
AIDS Action Committee (617) 437-6200
AIDS Action Committee Addict Support Group (drug free and HIV issues) (617) 437-6200 ext. 235
Faces of New England (401) 831-6155 and (617) 222-1653

For information about women and AIDS, contact the Women's AIDS Network, c/o San Francisco AIDS Foundation, 333 Valencia Street, San Francisco, CA 94103 □

Insurance

Continued from page 15

in California. This type of legislation has precedents. In Massachusetts for example, insurers must provide coverage for ulcerated colitis, alcoholism and various other conditions.

Herbert Juli, an insurance counselor for Gay Men's Health Crisis in New York, suggested increasing the 18 month limit on the expansion of benefits under COBRA to 36 months, calling the shorter limit "almost criminal." He suggested that extending the limit is a realistic goal for AIDS activists.

James Watkins, chair of the Presidential AIDS Commission, has suggested that the government subsidize private health insurance premiums for PWAs. Others have suggested extending Medicare benefits to cover AIDS, or creating special risk pools to spread the cost of AIDS more equally among insurers.

All of the proposals have in common that they would leave our private health care system intact. McWilliams criticized such suggestions as "Band-Aid" solutions which seek to appease people with an investment in the health-care system as it is." According to McWilliams, "AIDS is the problems of our society writ large: homophobia, racism, lack of access to medical care. With AIDS, these problems are magnified in a way we could never have imagined." She asserted that broad reforms to begin developing a national health insurance system are necessary if the U.S. is to meet the challenges posed by AIDS. □

Prisoners

Continued from page 8

education within MCI Framingham. But such programs remain scarce and underfunded. Advocates stressed that people and groups working with prisoners must renew efforts to share strategies about minimizing the psychological and physical abuse of prisoners, while working to increase public awareness of the issues. □

Note: The National Prison Project of the ACLU will send FREE to prisoners both the booklet "AIDS and Prisons" and the results of their survey on AIDS in prisons. Send for them to: ACLU-NPP, 1616 P. St. NW, Washington, DC 20036.



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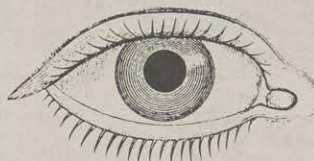
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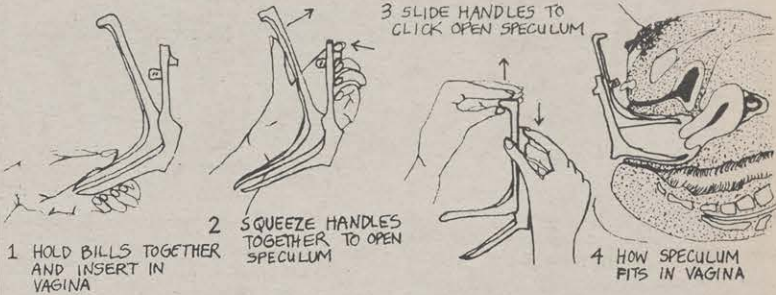
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Lesbian health
Continued from page 13

and researchers can travel—which implies a great deal of money, time, and the freedom from a job—they aren't going to know what's going on in some little town here or some little town there. One of the joys of the heyday of the Federation of Feminist Women's Health Centers was the existence of a network of clinics that basically covered the nation. If everyone knew what was going on in a 500 mile ring around their city, it was possible to know what was going on in the U.S. That simply isn't true any more. Most of the women's clinics have closed, and very few of those remaining are self-supporting. Some now accept federal birth control money. Others have chosen not to accept that money because they still want to do abortions and therefore can't receive federal funds. Because of economic pressures, almost none of these clinics have the staff time to be able to produce more books and pamphlets.

get their x number of federal dollars. The other part of our work is not so nice: there's an incredible amount of sexism within the larger gay male community. There's a lot of "Oh, they're just dykes," or "They just have some gripe to bitch about." I'm still astounded by something that happened at last year's National Lesbian/Gay Health Conference held in Los Angeles. There was a panel called "Lessons from the Recent Past: What the gay male AIDS community can learn from the women's health movement." The panel was very poorly attended; only about 40 men out of 800-900 men at the conference came to that session. There was a glass wall on the other side of the auditorium, and all of the men were out on the other side of the glass wall drinking tea and socializing. Eric Rofes, chair of the conference and organizer of the panel, went out on the patio to ask the heads of gay agencies and AIDS service organizations



How to do a self-exam with a speculum, from **lesbian health matters!** by the Santa Cruz Women's Health Collective, published in 1979

We have to talk about access in terms of what's happened to organizations. The women's health movement as it existed ten years ago does not exist now. The few hangers-on have been incredibly hurt by the costliness of some of the advances in medicine or some of the issues around malpractice. The Burlington Women's Health Center quit doing alternative insemination because their insurance carrier found out they did AI and refused to insure them except via a premium that was about twice what they earned a year. That made it impossible for them to continue. Other clinics currently face ongoing legal harassment.

why they and their staffs weren't inside the room, and they said things like "They don't have anything to teach me," or "They just have an axe to grind." The speaker just before the panel had been an apologist sent by the CDC to address the conference and everyone had attended the session. But they walked out when it was time for the women's panel. So I think even within our own community there is incredible sexism and on the one hand it's a reflection of the greater society; and on the other hand, it's inexcusable. Lesbians have been asked to become incredibly conversant in every issue of gay male sexuality, and males aren't expected to return the favor; there is not a

*"Support groups came from the women's movement.
Sexually explicit hotlines came from the women's movement.
Needing to deal with sexuality because it can cause your death came from the women's movement."*

Lessons from the feminist health movement
Shelley: I'm interested in where you think we are now in relationship to the self-help and feminist health movements. What lessons can we learn from that history?
P. Clay: The list is fairly exhaustive. In terms of self-help, I can say there's virtually nothing I do in AIDS work on a daily basis that I didn't learn how to do either in the early women's movement or in the early civil rights movement. Those are the two places I've learned the most about community organizing and skill building.

woman's health unit for training of AIDS hotline staff; there are many hotlines across the country that don't know birth control, so they don't know which methods protect against HIV infection and STDs. The question we keep asking ourselves, given the AIDS work we're doing is "Why do we have to work under these circumstances? Why is the AIDS movement and the prevention of the destruction of the gay and lesbian community not a safe place to work?" □

There are tenets of the women's movement that we're starting to bring into AIDS work — that access should not be determined by race, sex, age, language, physical ability. That didn't occur in the early development of AIDS service organizations, where white male privilege was your entree into services. We're now looking at how people of color need to have access into services. Reaching out to other communities by having people tell their stories, and using consciousness-raising methodology to share information are ways to design programs or services that certainly came from the women's movement.

The "lesbian portion" of the women's health movement fell into two categories: programs that were aimed at lesbians, and the incredible number of lesbians who supported the women's health movement for all women. Certainly that model is being followed by the lesbians working in AIDS service organizations. They're working for more than just lesbians; they aren't just there to make sure that x number of lesbians



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Safer Sex and Drug Use Guidelines

Assessing individual risk for AIDS and other illnesses is the first step towards using safer sex and drug use guidelines. Only you and your partner(s) can decide how much risk is acceptable — take stock of your sexual and drug use histories.

Be aware that the highest concentrations of HIV (the virus widely thought to cause AIDS) are found in blood and semen. The most common routes of HIV transmission are through sharing needles and unprotected anal or vaginal intercourse.

GCN's guidelines come from a wide variety of sources aimed at various communities concerned about the AIDS epidemic and health in general. We want to confront the prevailing "no sex is best" attitude and present an approach that is as sex-positive as possible.

Information for gay male, lesbian and bisexual communities

Safer sex can include: massage, hugging, kissing, erotic talk, phone sex, masturbation (solo, pairs and groups), using your own vibrators, dildos or other sex toys and s/m, butch/fem role-playing, fantasy scenes, bondage and other activities that do not involve the exchange of semen or blood (including menstrual blood).

Do not allow a partner's semen or blood (including menstrual blood and blood drawn from piercing, cutting or shaving) to enter your vagina, anus, mouth or breaks in your skin.

Use condoms for fucking (anal and vaginal intercourse), for licking/sucking penises and for covering dildos and other sex toys. Use water-based lubricants. Use latex barriers (dental dams or other plastic/latex materials) between the genital area and mouth when licking/sucking cunts and assholes. Be especially careful to avoid the exchange of menstrual blood. Using nonoxonyl-9 or other spermicides with condoms and latex barriers may add extra protection.

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penetration with fingers or hands), use latex gloves or finger cots. Use water-based lubricants.

Alternative insemination may put you at risk. Be sure to discuss risk for AIDS with potential donors or sperm bank.

Be aware that some risk of exposure to immune-suppressing infections (such as mono and amoebiasis) may be associated with rimming (anal-oral contact) — use a latex barrier. Risk may also be associated with watersports (urine) or feces in the mouth, rectum or in open cuts. If you share dildos, vibrators or other sex toys, use condoms or clean toys with hydrogen peroxide.

Your body's ability to fight all disease, including AIDS and its related illnesses (such as Kaposi's Sarcoma and pneumocystis carinii pneumonia), may be benefitted by general good health — good nutrition, lots of rest, exercise and nonabuse of alcohol, poppers and other drugs.

If you use IV drugs, follow the guidelines below.

Intravenous drug use

Do not share works (needles, syringes, droppers, spoons, cottons or cookers).

Do not re-use needles; use fresh cottons each time.

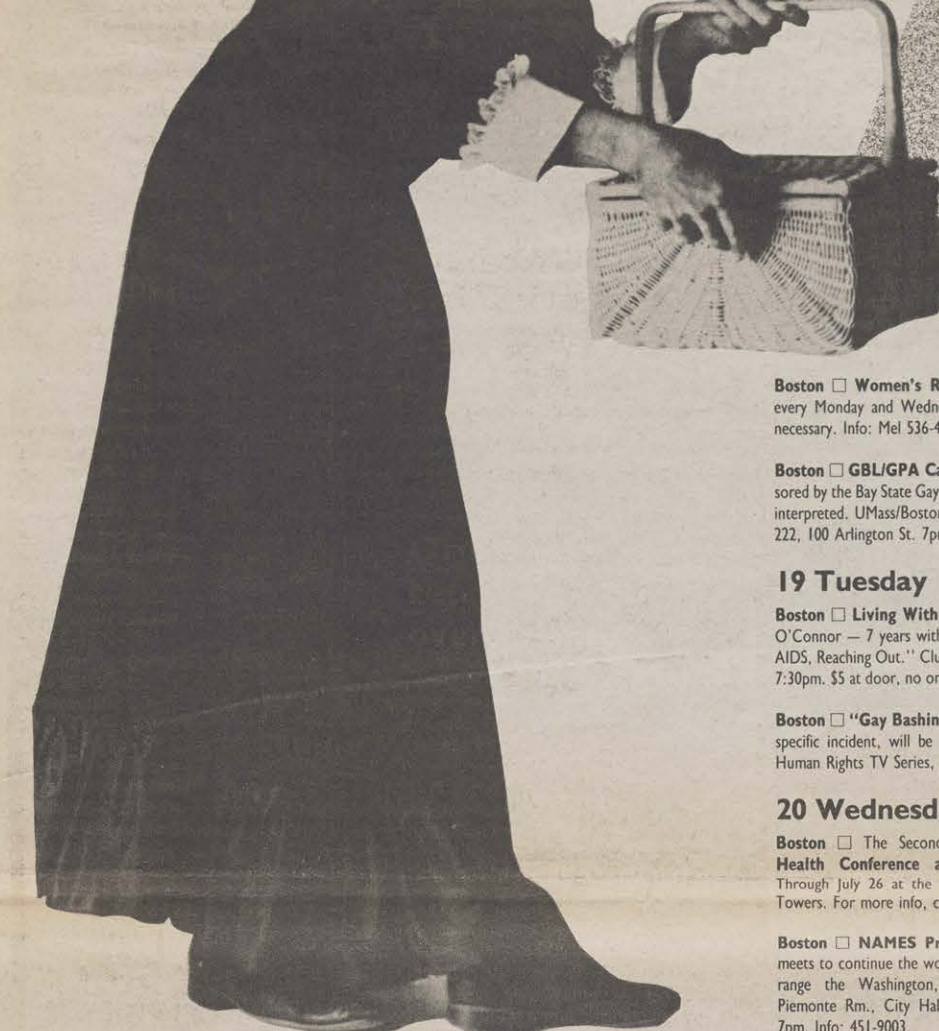
If you must share or re-use your works, clean them as follows: dip needle and works into 100 percent bleach, draw up and release three times, dip needle and works into water, draw up and release three times (in an emergency, rubbing alcohol, vodka or wine can also be used). As an alternative, boil works in water for at least fifteen minutes. Use a fresh solution each time you clean your works.

Resource phone numbers

National AIDS Hotline: 1 (800) 342-7514
AIDS Action Committee (AAC), Boston: (617) 437-7733
AIDS Action Committee (AAC) IV Drug Use Taskforce, Boston: (617) 437-4200
Gay Men's Health Crisis (GMHC), New York: (212) 807-6655
National Minority AIDS Council (NMAC), Washington, D.C.: (202) 544-1076
Women's AIDS Network, San Francisco: (415) 864-4376

GAY COMMUNITY NEWS □ JULY 17-23, 1988 □ PAGE 21

Calendar



Please note: Calendar listings must be received by the Monday before the week of the event. Photos with listings are encouraged.

16 Saturday

Boston ☐ **Something about the Women** airs WINGS, the Women's International News Gathering Service's half-hour monthly news program. Every Sat. 10am-2pm. WMFO 91.5FM.

Boston ☐ **Living With AIDS Theatre Project** presents a workshop to collect the experiences and stories of those connected in any way with the AIDS crisis every Saturday. The goal is to create a theater music piece based on the workshop material. No performance experience necessary. Club Cabaret, 209 Columbus Ave. 10:30am.

Boston ☐ **Prime Timers** monthly meeting. An organization for older gay males. Visitors welcome. Refreshments, socializing. Lindemann Health Center, 25 Staniford St. 2-4pm. \$1. Info: Box 352, Reading, MA 01867.

Boston ☐ **Noel Coward's "Marvelous Party."** Club Cabaret, 209 Columbus Ave. (also 7/17) 7:30pm. Sat. \$16, Sun. \$14. Info: 536-0966.

Boston ☐ **Nora Theatre Company** presents "A Taste of Honey" by Shelagh Delaney, a non-sentimental play about a working-class adolescent girl. Lyric Stage, 54 Charles St. 8pm. \$10-\$13. Info: 742-8703.

Provincetown ☐ **Lucie Blue Tremblay.** Unitarian Universalist Meeting House, 236 Commercial St. 8pm. (Also 7/17.) \$10/advance, \$12/door. Info: 487-9344 or 487-4121.

Randolph ☐ Join the **Dot Dykes** at Randolph Country Club for fun in the sun. Meet by the pool in the early afternoon. Info: Barbara 282-2962 (eves.).

Boston ☐ **New Ehrlich Theatre** presents Joe Orton's **Entertaining Mr. Sloane.** Thu.-Sat., through 8/6. 539 Tremont St. 8pm. \$13. Info: 482-6316.

Boston ☐ **Boston Area Women's Self-Defense Collective** offers **Women's Self-Defense Classes** for women of all ages and abilities. Meets Wednesday evenings and Saturday afternoons in the South End. Info: 574-9433.

Arlington ☐ Join Am Tikva for a **picnic outing to Spy Pond.** Bring your own dairy/veggie lunch. Beverages and salads provided. Wind surfing lessons available. 10am onward. Rain date: 7/17. Info: Sue 232-9115.

Cambridge ☐ Ninth anniversary of the Nicaraguan Revolution **dance party.** With Jorge Arce and Grupo Humano. M.I.T. Walker Memorial Building, 142 Memorial Dr. 8pm-1am. \$10 in advance, \$12 at door. Info: 492-8699.

17 Sunday

No. Conway, NH ☐ Chiltern Mountain Club **Saco River canoeing.** Bring your own boat, canoe shuttle service available for \$5 fee. Info: Paul or Alan (603)367-8304.

Lowell ☐ **Gay in the Merrimack Valley monthly potluck.** Bring dish to share. First Grace Fellowship Hall (Unitarian), 79 Florence Ave. 6pm. Info: 452-4686.

Cambridge ☐ **Newoman potluck.** All women welcome. Come to meet other women, visit the Women's Center. Potluck at 6:30pm, movie "Black Widow" shows at 8pm. The Women's Center, 46 Pleasant St. Free. Info: 354-8807 (TTY/voice).

Somerville ☐ **Lesbian potluck.** Bring food and non-alcoholic beverage. 6pm. Call for details and directions: 628-7487.

Boston ☐ **Metro Healing** presents **ongoing healing group** for PWAs and all those wishing to be of support. Meets every Sunday. Metropolitan Health Club aerobics room, 209 Columbus Ave. 7:30-9:30pm. Info: Brian 267-1154, Joseph 357-6926.

Boston ☐ **Boston's Other Voice** special guest Shoshona Rosenfeld. WROR 98.5FM. 11:30pm.

18 Monday

Cambridge ☐ **Lesbian Rap** topic: "The Politically Correct Way to Be Politically Incorrect." The Women's Center, 46 Pleasant St. 8-10pm. Free. Info: 354-8807 (TTY/voice).

20 Wednesday ☐ **Fred Barton** brings his one-man musical revue "Miss Gulch Returns!" to Club Cabaret in Boston. Tell all your friends — and your little dog, too! Through Sunday. Tickets and info: 536-0972.

Boston ☐ **Women's Rugby Club** summer practice every Monday and Wednesday, 6-8pm. No experience necessary. Info: Mel 536-4943, message 932-5401.

Boston ☐ **GBL/GPA Candidates Night II.** Cosponsored by the Bay State Gay/Lesbian Democratic Club. ASL interpreted. UMass/Boston, Park Square Campus, Room 222, 100 Arlington St. 7pm.

19 Tuesday

Boston ☐ **Living With AIDS,** an evening with Tom O'Connor — 7 years with ARC, author of "Living with AIDS, Reaching Out." Club Cabaret, 209 Columbus Ave. 7:30pm. \$5 at door, no one turned away. Info: 536-0966.

Boston ☐ **"Gay Bashing,"** a workshop dissecting one specific incident, will be shown at 9pm. Repeats 7/21. Human Rights TV Series, Cable channel A-22.

20 Wednesday

Boston ☐ **The Second International Lesbian/Gay Health Conference and AIDS Forum** opens. Through July 26 at the Boston Park Plaza Hotel and Towers. For more info, call (202) 797-3708.

Boston ☐ **NAMES Project.** New England Chapter meets to continue the work of the Quilt and to help arrange the Washington, D.C. display in October. Piemonte Rm., City Hall, use Congress St. entrance. 7pm. Info: 451-9003.

Boston ☐ **"Miss Gulch Returns!,"** a one-man musical revue of the bicycle-riding villainess from the Wizard of Oz. Starring Fred Barton. Through 7/24. Club Cabaret, 209 Columbus Ave. 8pm. \$10 Wed., Thu., Sun.; \$12 Fri. & Sat. Info: 536-0972.

21 Thursday

Boston ☐ **GCN's production night.** All welcome. Proofreading starts at 5pm. Paste-up after 7pm. 62 Berkeley St., near Arlington & Back Bay T-stops. Info: GCN, 426-4469.

Boston ☐ **"Hey Queer!,"** a workshop on personal responses to anti-gay and -lesbian harassment with Kevin Berrill, Director, Anti-Violence Project, National Gay and Lesbian Task Force. Park Plaza Hotel. 7:30-9:30pm. \$5. Info: Gordon Tuttle, 267-1538.

Boston ☐ **Volunteer open house** to learn how to get involved with the **Boston Women's Fund.** Boston Women's Fund Office, 31 St. James Ave., Suite 902. 7-9pm. Info: 542-5955.

Boston ☐ **African Influence** gallery opening reception for "Ebakhweteni...The Place of Initiation," pastels and oils by Arne Bass. 150 Lincoln St. 3-6pm. Info: 426-3366.

Boston ☐ **Summer Dance** in conjunction with the 2nd Int'l Lesbian/Gay Health Conference and AIDS Forum. The Links Club, 120 Boylston. 9pm-1am. \$10. Info: 661-3661.

22 Friday

Boston ☐ **GCN mailing.** Come help stuff the paper and meet new friends. 5pm to 10pm. 62 Berkeley St., near Arlington & Back Bay T-stops. Info: GCN, 426-4469.

Boston ☐ Reception for **Cheryl Crane,** author of "Detour, a Hollywood Story." Sponsored by Pride Institute. Park Plaza Hotel & Towers. 7:30pm. Free. Info: 603/883-9228.

Boston ☐ **Clean 'n Sober Dance** featuring the music of D.J. Clarie. Alcohol- and drug-free dance for gays and lesbians. In conjunction with the 2nd Int'l Lesbian/Gay Health Conference and AIDS Forum. Imperial Ballroom, Park Plaza Hotel & Towers. 8:30pm. \$6. Info: 603/883-9228.

Cambridge ☐ **Women's Coffeehouse.** Children's Night, children & women friends welcome for a night of feminist children's readings, stories, and conversations. The Women's Center, 46 Pleasant St. 8pm-midnight. Info: 354-8807 (TTY/voice).

Boston ☐ **Ongoing healing group** for PWAs and all those wishing to be of support. Meets every Friday. Santa Fe Hair Salon, 528 Tremont St. 7:30-9:30pm. Info: Brian 267-1154, Joseph 357-6926.

Worcester ☐ **AIDS Project** — Worcester **support group** meets every Friday night for HIV positive, PWA's, PWARC's, lovers, friends, and the worried well. Open to all lesbians and gay men regardless of HIV status. 51 Jackson St. 7-9pm. Info: Dana, 755-3773.

23 Saturday

Boston ☐ **Boston Bisexual Women's and Men's Network's Dim Sum brunch** in Chinatown. Meet at the small park next to the Chinatown arch, corner of Beach and Hudson Sts. 10:45am. Info: 247-6683.

Waltham ☐ **International Foundation for Gender Education** open house. Non-profit organization serving the cross-dressing/transsexual community. Also 7/24. 6 Cushing St., 2nd floor. 11am until ? Info: 894-8340, 899-2212, or 358-2305.

Cambridge ☐ **Susie Bright's "Behind the Scenes at On Our Backs: 4 Years of Lesbian Sex"** plus the East Coast Premiere of **CLIPS,** the outrageous new lesbian erotic video. Benefit for **On Our Backs** and **GCN.** Info: 426-4469.

Provincetown ☐ **Sixth Annual Gay and Lesbian Advocates and Defenders Provincetown GALA.** Home of Vin McCarthy, 453 Commercial St. 5-8pm. Donations at door or in advance, \$15-\$250. Info: 426-1350.

Boston ☐ **Gay Boston,** a weekly cable program, features highlights of Gay Pride Day. Boston Neighborhood Network, channels A3 and A8. 7:30-8pm.

Boston ☐ **Banquet** in conjunction with the 2nd Int'l Lesbian/Gay Health Conference and AIDS Forum. Park Plaza Ballroom. 8pm. \$45. Info: 536-0972.

24 Sunday

Belmont ☐ **Girth & Mirth** of New England holds its annual barbeque picnic at Richard P's. Info: Lenny 389-5635, Joe 926-5827.

Boston ☐ **Boston's Other Voice** special guest Cindy Rizzo speaks about the Lesbians Choosing Children Network. WROR 98.5FM. 11:30pm.

Boston ☐ **Cruise Boston '88** aboard the Provincetown II, Commonwealth Pier. Dancing, raffle, free admission to the Metro following cruise. In conjunction with the 2nd Int'l Lesbian/Gay Health Conference and AIDS Forum. To benefit Fenway Community Health Center. 8-11pm. \$15 in advance, \$17 at the pier. Info: 267-7573.

Brookline ☐ Join **Am Tikva** for a discussion and program. Topic TBA. Workmen's Circle, 1762 Beacon St. 11:15am. Info: 782-8894.

Boston ☐ **The Fund for Human Dignity** presents the **Lesbian and Gay Education Conference:** "Initiatives for a National Education Agenda for Our Culturally Diverse Community." Park Plaza Hotel and Towers. Info: 212/529-1600.

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FOR SIXTEEN YEARS, THE LESBIAN AND GAY WEEKLY

ACT NOW sparks national AIDS activism

S.F. Conference reaches out to women, people of color and PWAs

By Chris Bull

SAN FRANCISCO — Calling for socialized medical care, an increased emphasis on civil disobedience and a national movement of AIDS activism, ACT NOW (AIDS Coalition to Network, Organize and Win) held a national organizing conference July 2nd and 3rd at the Women's Building in San Francisco. Some 60 AIDS activists from 15 ACT UP and ACT UP-styled groups across the country attended.

"It's beginning to feel like we all are making history, instead of being dragged along by it. The government hasn't done enough, the gay leadership hasn't done enough, so we have filled the gap. The conference drove home just how powerful this movement has become," said John Fall of ACT UP/Los Angeles.

One of the highlights of the conference was finalization of plans to hold major demonstrations at the upcoming Democratic and Republican conventions and at the Food and Drug Administration in Washington on October 11, the first anniversary of the massive National March on Washington.

ACT NOW grew out of a meeting of AIDS activists entitled "Agitate, Educate and Organize" on October 12 in Washington, D.C., the day after the March on Washington. ACT NOW demands include: funding for culturally sensitive, local and worldwide educational programs; coordinated AIDS research; a national health care program; public accountability of AIDS programs; an end to quarantine, mandatory testing and discrimination against PWAs.

Designed as a communication network for AIDS activist groups across the country, ACT NOW has begun to serve as a centerpiece of a growing national movement, said Terry Beswick, former ACT NOW staff coordinator in San Francisco. The group now collects dues from member organizations and plans to open national headquarters in Washington, D.C.

Inclusivity

Responding to criticism that AIDS activism has been dominated by gay white men, ACT NOW formed new committees at the conference — for women, people of color and people with AIDS, ARC and HIV antibodies. The organization also pledged to focus on increasing the availability of AIDS treatments.

Debra Levine of ACT UP/NY explained that many women "went into the conference feeling invisible in the AIDS community." She said many health problems facing women are often ignored. "We reached consensus on a broad range of issues, on inclusivity and on the primacy of health care for all. AIDS is now seen as a specific issue in a broad range of health care issues. The women were responsible for raising many larger issues and came away feeling empowered and more a part of the organization," said Levine.

Levine said ACT UP/New York and ACT NOW have come a long way in dealing with sexism and racism. The radically different levels of political experience and

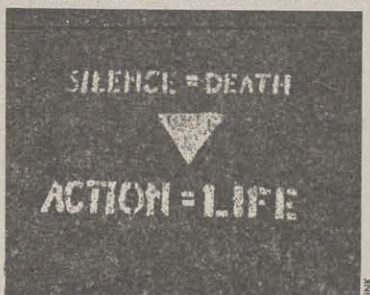
geographic diversity complicate the issues within ACT NOW, said Levine. "But ultimately we are a stronger group because of the struggle."

Robert Vasquez, a member of ACT NOW's people of color caucus, agreed with Levine. "Everyone seems committed to inclusivity. The problem is that some people are further along the road to sensitivity than others. Some people are simply more educated about what sexism and racism look like in the group," said Vasquez.

Martin Hiraga, an Asian member of ACT UP/NY, reported that one HIV-negative white gay man asked the group, "What am I supposed to do here?" Hiraga answered, "You have always been represented, now it's our turn." He told GCM that there is a "growing recognition in the group that it is everyone's responsibility" to reach out to women, people of color, and people with AIDS, ARC and HIV. "The affected groups can recommend possible paths toward inclusion, but there is plenty of work for everyone. It was great to see ACT NOW moving in that direction," said Hiraga.

Disrupting the conventions

ACT NOW scheduled major demonstrations to be held at the Democratic convention in Atlanta from July 18 to 21 and at the Republican convention in New Orleans August 15 to 18. The Lesbian and Gay Freedom Ride will tour from Atlanta to

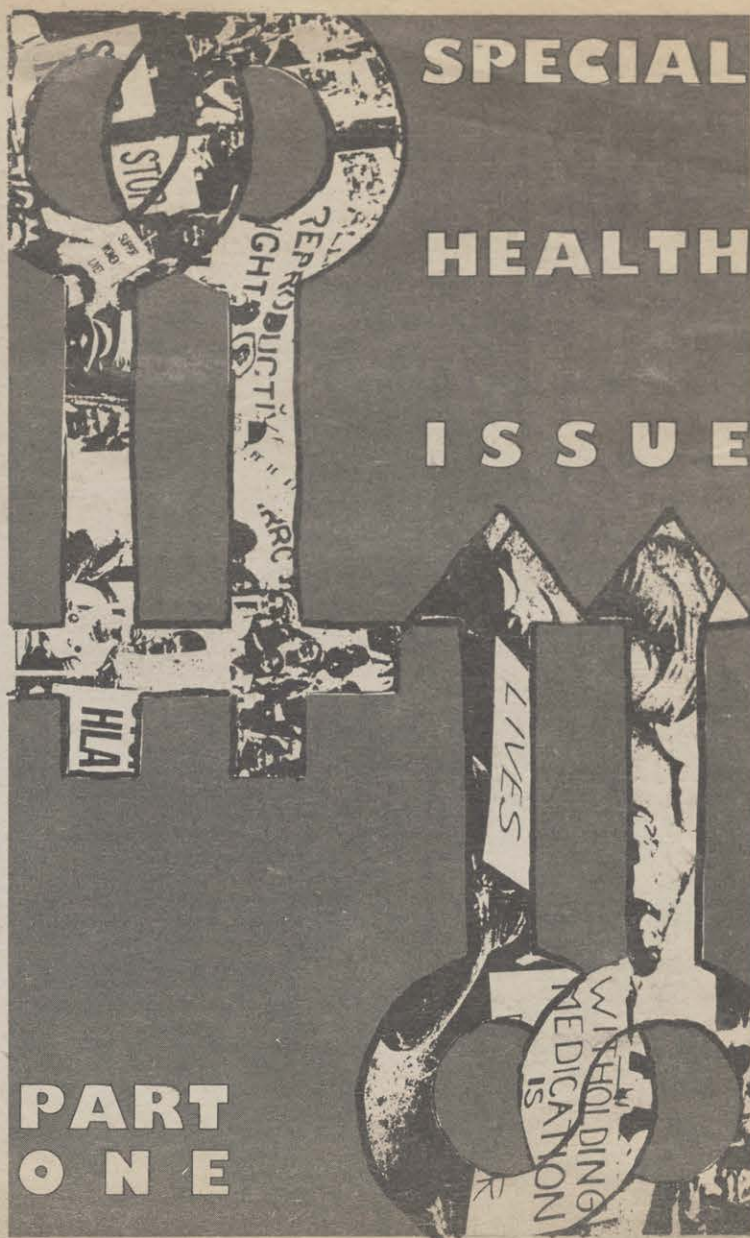


New Orleans to increase lesbian and gay visibility at the conventions and in the South. The Freedom Ride also plans to unveil the Bailey House AIDS memorial quilt in the New Orleans French Quarter during the convention. Bailey House is a residence for homeless people with AIDS in New York. Twenty-seven Bailey House residents are memorialized in the NAMES Project Quilt.

ACT NOW also plans civil disobedience at the Food and Drug Administration Building on October 11 to protest the lack of AIDS treatments and commemorate the first anniversary of the March on Washington. On October 8 and 9, the group will host national strategy meetings and workshops to discuss the future of AIDS activism. Activists noted that the NAMES Project will conclude its National Tour October 8 and 9 with an unveiling of the entire Quilt on the Washington Mall.

"This is the foundation of something big. Many local AIDS groups have outgrown

Continued on page 3



Community grapples with Fenway violence

At a Boston public forum, people concerned about a rise in queerbashing discuss strategies to educate Fens-goers and the implications of stepped-up police presence

By Elizabeth Pincus

BOSTON — At the first community meeting held this summer to address the increase of violent crime in the Fenway neighborhood, tempers were kept barely in check. Participants at the July 12 discussion disagreed about the most effective ways to curb the violence, which, since June, has included several rapes, stabbings and a murder. The dissension arose mainly between people favoring a law-and-order approach, involving increased police presence in the Fenway, and those advocating community education and empowerment.

At one point, community activist Bruce Goldstein, upon hearing that park regulations prohibit the display of warning posters in Fenway park areas, exclaimed, "You're saying that laws are more important than saving lives?!"

The meeting — held at the Seventh Day Adventist Church in the Fenway — was convened by an ad hoc group of concerned people, including: Joyce Collier and Gordon Tuttle of the Fenway Community Health Center's Victim Recovery Program; John Deveny, police sergeant from Area D, which encompasses the Fenway; Steve LeBlanc, chair of the public safety committee of the Greater Boston Lesbian and Gay Political Alliance (GBL/GPA); the mayor's liaison to the lesbian/gay community, Ann Sanders; and representatives from Street SAFE, the Fenway's community crime prevention program.

Also present were about 30 area residents, Fenway gardeners and gay men who use the Fens as a cruising spot. Following introductions, Collier opened discussion by describing the significant rise in documented violence, particularly assaults against gay men. Asking for suggestions on how to curtail the problem, she encouraged the establishment of ongoing community

dialogue.

Deveny, who was accompanied by several other police officers, explained new procedures which he said were intended to increase safety and police visibility in the Fens and other neighborhoods. For example, since July 1, officers on horseback have been patrolling the Fenway at night. Deveny also explained a new city-wide police program called "sector integrity": every day, the same officers patrol the same neighborhoods on the same shifts. According to Deveny, the plan will encourage familiarity and communication between police and area residents. He added that police officers are now required to attend various community meetings in their precincts.

While some activists at the meeting expressed optimism about Deveny's remarks, concerns were aired about the possibility of increased harassment of gay men if police presence escalates in the Fens. At first, Deveny told the gathering the police department was only concerned with insuring safety. But when the question arose later in the meeting, Deveny replied that police officers had the discretion to enforce public sex laws by arresting anyone found having sex. When he said, however, that arresting gay men for "sex offenses" was not a police priority, several people responded that gay men have historically been victims of police entrapment and round-ups.

Throughout the evening, GBL/GPA's LeBlanc attempted to steer the meeting towards discussion of how the community can work together to curb Fenway violence. He described several efforts already underway; a group of concerned people have been distributing safety whistles and posting warning notices throughout the Fenway neighborhood, including in gay bars.

Continued on page 3

Quote of the week

"These women rape young boys; beat up on their husbands; sneer at 'sensitive new-age guys' as 'wimps,' 'lumps' and 'pigs'; and, in the corporate world, knife male backs as casually as they polish their nails."

"They are the flip side of the familiar sex-abuse-and-discrimination coin, and men, long guardians of a 'macho' culture that forbids them to hit back or admit being physically abused, are their bewildered victims: confused, battered, scarcely able to cope."

— Chicago Tribune TV columnist Kenneth R. Clark, describing the subjects of the NBC documentary "Of Macho and Men." Clark quotes the show's producer, Robert Rogers, as saying the program was an effort to provide "fair" coverage, since he produced a show in 1986 called "Divorce is Changing America" that included information about the large number of divorced men who do not pay child support. Rogers said "a large number of men's groups" contacted him after he did the divorce show, "pointing out that there are many sides to all of our social problems."

Clark, in his column, said "In pursuit of those other sides, Rogers turned up a bizarre and, for those steeped in traditional values, frightening collection of women whose violence toward men is stunning."

Order to test retarded man overturned

WORCESTER, Mass. — A ruling by a Worcester County probate judge ordering a mentally retarded man and his male sexual partner to undergo an HIV antibody test was overruled by the Massachusetts Supreme Judicial Court (SJC) on July 5. By a 5-0 vote, the SJC decided that Judge Eliot K. Cohen exceeded his authority in demanding that the 41-year-old man — whose name was withheld for his own protection — submit to testing.

The matter arose last year when the Mass. Department of Mental Health asked the probate court to officially change the treatment plan for the mentally retarded man, who resides at the Walter E. Fernald State School. Judge Cohen dismissed the appeal, but inquired into the man's sexual history and ordered HIV antibody testing for both him and his unidentified sexual partner. In the ruling, Cohen chastised Fernald School officials for failing to provide adequate AIDS information to residents, despite sworn testimony from the school that the man and his partner had received safer sex education and instruction in the use of condoms.

Denise McWilliams, director of the AIDS Law Project for Gay and Lesbian Advocates and Defenders (GLAD), said she was pleased by the high court decision. But according to McWilliams, who represented the mentally retarded man, the ruling was so narrow it would not set a precedent protecting the rights of the "mentally incompetent" to refuse HIV antibody testing.

□ Elizabeth Pincus

Stiff punishment for Saudi gays

JEDDAH, Saudi Arabia — At a recent symposium on viral diseases held in Riyadh, two doctors from King Saud University hospital argued that stiff punishment of homosexuals, prohibition of extra-marital sex, screening of blood donors and HIV antibody testing would provide the best protection against AIDS in Saudi Arabia.

The two doctors, Abdul Wahab Elidrisy and H. Abu-Aisha said that Saudi society must use a "moral vaccine" against AIDS. "We must take strict measures against homosexuality as an abnormal and illegal behavior that deserves only the fate of sodomy. It is condemned by Islam, Judaism and Christianity," said Elidrisy. The punishment for Saudis caught engaging in homosexual acts is public flogging for the first offense and death by decapitation for the second offense.

Currently, foreign workers living in Saudi Arabia are required to produce a negative

HIV antibody result to be able to work in the country. The government is considering requiring a second test, six months after foreigners enter the country.

Many believe that mandatory testing for Saudis would produce protests from those concerned about privacy rights and from religious groups, who believe it immoral to assume that young, unmarried Saudis have sex and that married Saudis have sex outside of marriage.

The Saudi government denied that there were any people with AIDS in the country until last March, when 18 cases were disclosed. Seven of the 18 had already died.

□ Muhammad Jamil

Hold the telephone lines

WASHINGTON, D.C. — The government has agreed to not enforce a law banning pornographic telephone messages until July 25 at the earliest, according to Justice Department sources cited by AP. The action follows suits filed in federal courts in Los Angeles by one of the country's largest "dial-a-porn" providers and in New York by Consenting Adults Telephone Rights Association. The ban, which was scheduled to take effect July 1, will be reviewed by a California federal judge later this month.

The law applies only to interstate and Washington, D.C. telephone services. Most "dial-a-porn" providers use a 976 prefix and are dialed locally. However, in California and several other states, "dial-a-porn" can be reached long-distance with an area code.

□ Marc Stein

Happy birthday Sharon

WASHINGTON, D.C. — Sharon Kowalski's 32nd birthday will be marked on August 7 by demonstrations in cities across the country. Kowalski, a victim of a drunk driving accident in 1983, has been forcibly kept at a nursing home in Hibbing, Minnesota by her father, who refuses to permit court-ordered competency tests and refuses to allow her lover of nine years, Karen



Sharon Kowalski's lover, Karen Thompson

Thompson, to see her. Thompson, who has engaged in legal battles to gain access to her lover, also charges Kowalski's father has failed to provide adequate rehabilitation for his daughter.

Vigils, processions, rallies, street theater and birthday cakes will highlight local actions in Washington, D.C.; Boston; New York; Piscataway, N.J.; Brunswick, Maine; Colorado Springs, Colo.; Tallahassee, Fla.; Minneapolis; and Madison, Wis.

□ Marc Stein

AIDS Vigil in Australia

SYDNEY, Australia — About 2000 people, including a number of people with AIDS (PWAs), marched through the center of Sydney as part of the annual International AIDS Vigil on May 20.

Speakers at a memorial service held after the march included: Supreme Court Justice

Michael Kirby; New South Wales Health Minister Peter Collins; Chief AIDS Education and Services Advisor to the Australian Government Ron Penny; and Elizabeth Reid, a consultant on AIDS for the Australian Government whose husband Bill, a hemophiliac, died with AIDS last year.

"To many in this community, including some politicians, AIDS is a minority group disease. I join with you to light a candle against the darkness and ignorance on which this view is sustained," Collins said. Bill Whittaker of the AIDS Council of New South Wales, interviewed during the candlelight march, said, "So much of the discussion about AIDS is taken up with clinical, policy and education issues and we tend to forget there is a human side to the problem. We need to remind ourselves of that human side."

□ Kendall Lovett

Boston restaurant owner requests trial

BOSTON — Dan Holmes, owner of The Downtown Cafe, a gay restaurant in Boston's Combat Zone, was found not guilty of resisting arrest and assault and battery against a police officer on July 7 by a Boston Municipal Court Judge. However, Holmes was sentenced to one year of probation and a \$400 fine for assault and battery with a deadly weapon.

Holmes was involved in a skirmish with a Boston police officer outside his restaurant on May 26. According to Holmes' attorney, Norman Zelkind, the officer went out of his way to confront Holmes for no apparent reason.

According to Debra Benkov, spokesperson for the Dan Holmes Defense Fund, several Downtown Cafe customers witnessed the officer harass Holmes and shut down the restaurant on May 26. "It's hard to prove that it was anti-gay harassment, but I think that was part of why they treated him so badly. The charges against Dan are trumped up to cover up the actions of an over-zealous police officer," said Benkov.

Benkov said Holmes has requested a jury trial. "We need a not guilty decision. It is not acceptable for Dan, running a licensed business in this city, to have anything on his record. This has been an emotionally and financially difficult time for Dan so we have come to his defense," said Benkov.

Holmes explained that a felony charge on his record would make it difficult for him to maintain his liquor license. He said Downtown Cafe would close unless he is cleared of the charge. No date has been set for the trial.

The Boston Police Department refused to comment on the case.

Donations to the Dan Holmes Defense Fund may be sent to Debra Benkov, c/o Downtown Cafe, 12 LaGrange Street, Boston, MA 02116.

□ Chris Bull

Somerville lesbians encouraged to apply

SOMERVILLE, Mass. — The city of Somerville currently seeks members to fill the 15 positions on the newly-formed Commission for Women. The commission was established "to act as a centralizing force in the city, which will deal with women's issues" and "work to ensure the equal status of women of every race, creed, national origin, age and sexual orientation."

People interested in a position must live in Somerville and have a commitment to women's equality. Lesbians are strongly encouraged to apply.

Send resume or letter of interest by July 29 to the Department of Human Services, c/o Rose Boardman, 167 Holland St., Somerville, MA 02144.

□ Rose Boardman

As part of GCN's efforts to increase its coverage of AIDS medical and treatment issues, we plan to regularly publish "AIDS Treatment Notes." Most of the information here comes from newsletters written and published by people with AIDS (PWAs), people with ARC (PWARCs) and other AIDS activists.

Many of these newsletters print disclaimers withholding their endorsement from any particular treatment options. Like these other sources, GCN provides medical information to encourage discussion about the politics of health and medicine and to help people make personal decisions about AIDS treatments. We do not endorse any specific treatment or study.

Stockholm conference abstracts available

SAN FRANCISCO — Abstracts of about 3,000 presentations made at the Stockholm AIDS conference in June 1988 are available at the Healing Alternative Foundation, located at 273 Church Street. Articles are indexed by subject and author. The Foundation library is open Tuesday-Saturday, 1-5:00pm (415-626-2316).

Each abstract may be copied for five cents at the library. Complete sets are available at cost, which is about \$55.00, plus about \$45.00 for handling and shipping. They can be ordered in San Francisco from Copy Mat, 2370 Market Street (415-864-2316) and from Project Inform (800-334-7422 in Calif. or 800-822-7422 elsewhere).

□ Michael Bronski

Sunlight shown to depress body's immune system

NEW YORK — New evidence reported by Ann Giudici Fetner in the *Village Voice* suggests that sunlight may have an even more dangerous effect than previously thought on those who are already infected with HIV. Scientists in the U.S. and Belgium have reported that HIV grows at a rate 150 times faster than "normal" in cells exposed to ultra-violet light. The same effect is observed after half an hour of sunlight. Sun bathing and tanning may thus accelerate HIV infection. Some suggest that this may explain why HIV infections peak in the summer months.

Ultra-violet light has also been linked to skin cancer and rapid skin aging. Most health care practitioners recommend a sunscreen of 15 or higher. PABA, an agent contained in some sunscreens, effectively reduces the immunological effects of ultra-violet radiation.

□ Michael Bronski

Aerosolized pentamidine available free in new study

SAN FRANCISCO — People with AIDS who have had pneumocystis pneumonia in the last six months may be eligible to receive free aerosolized pentamidine in a study conducted at the Institute for HIV Research and Treatment at the Davies Medical Center in San Francisco. The study will give some participants 30mg and the rest 150mg, every two weeks.

There is some disagreement over whether the 30mg dosage is enough to help and whether large doses will prove unsafe over a long period of time. Some evidence suggests that when pneumocystis does occur in those using AP, even at the 30mg dosage, it tends to be mild and only rarely results in death.

□ Michael Bronski

PWA newsletters:

Treatment News, GMHC Department of Medical Information, 132 West 24th Street, Box 274, New York, NY 10011

AIDS Treatment News, Box 411256, San Francisco, CA 94141

PWA Coalition Newline, 263A West 19th Street, Room 125, New York, NY 10011

Alert, 5300 Santa Monica Blvd., Suite 304, Los Angeles, CA 90029

The Body Positive 263A West 19th Street, New York, NY 10011

NEWS NOTES COMPILED BY
JENNIE MCKNIGHT

S.F. Pride organizers anger "fringe" groups

By Chris Bull

SAN FRANCISCO — While lesbian and gay pride swept most of the country in June with little controversy, the San Francisco Parade Committee created a storm of protest by rejecting the applications to march of two groups — the North American Man/Boy Love Association (NAMBLA) and Uhuru House, a Black nationalist organization. After a series of appeals, the Parade Committee board of directors voted 6-4 to allow NAMBLA to march. An appeal by Uhuru House, however, was rejected and the group plans to hold a forum to educate the lesbian and gay community about its aims.

The controversy highlighted tensions in the lesbian and gay community over the political content of lesbian and gay Pride Day in San Francisco. Several activists told *GCN* that the increasingly conservative Parade Committee was attempting to "depoliticize" the day by excluding radical "fringe groups such as NAMBLA and Uhuru House."

"It's ironic that when the lesbian and gay community has become more progressive because of AIDS — when more and more people realize we cannot divorce ourselves from poverty, racism and wars going on around the world — the Parade Committee is actually becoming more narrow and conservative," said lesbian activist Carmen Vasquez, recently appointed director of Lesbian and Gay Health Services in San Francisco.

NAMBLA

After receiving a letter of rejection from the Parade Committee, NAMBLA, which, according to its literature, "organizes support for men and boys involved in consensual relationships," demanded an emergency board meeting on June 28, the day before the parade. According to NAMBLA spokesperson Mark McHarry, the Parade Committee was "simply ignorant about NAMBLA."

The Committee, said McHarry, cited three reasons for rejecting NAMBLA's application: that the group promotes child molestation; that it allegedly supported the now infamous John Wayne Gacy, who in 1978 was convicted of having sex with and murdering several teenagers; and that NAMBLA members' safety might be in danger at the parade. Parade Committee spokespeople declined to discuss who on the committee voted against NAMBLA.

McHarry said the Parade Committee initially refused to meet with NAMBLA and only agreed to the emergency meeting after considerable pressure from the community and the threat of a lawsuit. He said support from a number of community leaders, including lesbian writer Gayle Rubin; Kim Corsaro, editor of *Coming Up!*; Suzie Bright of *On Our Backs*; Harry Hay of the Radical Fairies; and Steve Morin, aide to congressperson Nancy Pelosi, forced the committee to back down. "It was heartwarming to see so many people come to our defense," said McHarry.

McHarry said NAMBLA told the Parade Committee at the meeting that the group supports only consensual relationships and deplores violence or child abuse of any kind.

Doug Conrad, co-chair of the Parade Committee, told *GCN* that during the appeal process the committee came to view NAMBLA's participation in terms of civil rights. "NAMBLA may be offensive to some people, but there is general feeling to people now that Pride is a civil rights parade and that NAMBLA is a part of the lesbian and gay community. To exclude anyone would be very serious."

Board member Marsha Levine said next year the application review system would be changed to allow a broader discussion of controversial issues. "We simply didn't get the whole story the first time around," said

Levine. "We must look more at how we go about deciding who's in the parade."

The San Francisco incident is not the first time NAMBLA has been denied the right to march in a lesbian and gay Pride parade. In Los Angeles, Christopher Street West, the for-profit corporation that runs Pride in that city, denied NAMBLA's application last year. The group's New York chapter has also been banned from New York Pride several times.

Uhuru House

Uhuru House, based in Oakland, Calif., is a grass-roots community center for the Black community. Run by the African Peoples Socialist Party (APSP), a Black Nationalist organization, the group raises several thousand dollars every year at its Gay Pride booths, according to spokesperson O'Mali.

Pride committee members who spoke to *GCN* gave different accounts of why Uhuru House was denied this year. One said the denial of the group's application was due to Uhuru House's unwillingness to comply with Parade regulations. Another said the group's exclusion involved its political stance on housing issues and their relationship to the gay community.

Conrad of the Parade Committee said the Committee "heard rumors" that APSP blamed the lesbian and gay community for the gentrification of many of San Francisco's poor neighborhoods. Asked for a statement declaring solidarity with lesbian and gay liberation, Uhuru House declined, according to Conrad. "We had heard they were a homophobic group and it's not asking much for them to simply set the record straight," said Conrad.

O'Mali said the Committee's demand unfairly singled out Uhuru House. "The Parade Committee is a middle-class, white-run organization. A working-class, Black organization should not have to validate itself for a white organization. It's a bogus and extraordinary requirement that covers up the real issues we are dealing with." O'Mali added that APSP supports the struggle of all oppressed people including the lesbian and gay community.

The white lesbian and gay community is often unconscious of its racism, said Penny Hess, chairperson of African Peoples Solidarity Committee, a white support group for APSP. "In San Francisco, the white gay community wields considerable economic and political clout. And what the lesbian and gay community doesn't seem to realize is that the Parade Committee controls power and resources that the Black community desperately needs.... We make over \$2,000 for every booth we have. I mean, there are nearly one quarter of a million people there and to ban us from the Parade is really hard on us," said Hess. The Parade Committee, according to Hess, told APSC that they were "tired" of hearing about the Black community.

Another member of the Parade Committee, Marsha Levine, said the Uhuru House application was denied because of past problems working with the group, not politics. "There is no validity to their charge of racism. For three years running they disregarded our booth requirements and threatened us when we notified them of the problems. On top of that they consistently refuse to meet with us to discuss our differences," said Levine.

Vasquez, a long-time community activist, was critical of the Parade committee's action. "I think they have given the message recently that they don't want to think about the 'isms' anymore and concentrate on 'us,'" so its no surprise that this happened," she said.

Vasquez said members of Uhuru House are often disruptive and "not always comfortable working with multi-racial groups like parts of the lesbian and gay community, but they certainly are not dangerous and there was no reason to censor them from the parade." □ filed from Boston

ACT NOW

Continued from page 1

their cities and need to address national issues. We hope a national movement will also give momentum back to the local groups," said Greg Bordowitz of ACT UP/New York. □

Boston rally trashes homophobia

By Elizabeth Pincus

BOSTON — Last week on the State House steps, a gay man held up a faggot: a crudely bundled bunch of sticks, like those used to ignite fires in Inquisition times for the burning of witches and other queers. The man explained the origin of the word "faggot," and — condemning the Catholic Church and other institutions he said were hate-mongering — threw the bundle into a trash can containing symbols of homophobia.

The gesture was proud, defiant, great street theater. As close to a score of lesbians and gay men filed up to toss other emblems of homophobia in the trash can, the 200-strong crowd applauded, hooted and hissed. MASS ACT OUT staged a lively and participatory protest; the July 7 action could otherwise have been yet another hapless demonstration before the state corridors of government to support the ever-stalled lesbian/gay civil rights bill.

As it turned out, the "trash homophobia" rally was a spunky display of outrage at state lawmakers for continuing to delay passage of the civil rights measure, now in its sixteenth year before the Bay State legislature. Wisconsin remains the only U.S. state with anti-discrimination protections for lesbians and gay men; as the Mass. legislature prepares to recess this week until elections are finished in the fall, some activists expressed doubt that Massachusetts would alter those stats this year. Though the bill, S.47, moved quickly through the Senate Committee on Steering and Policy in late June, key opponents of the gay rights measure, Senate President William Bulger (D-South Boston) and Sen. Arthur Lewis (D-Jamaica Plain), will still be around come autumn to exercise their powerful delaying tactics.

Nonetheless, speakers at the rally said the lesbian/gay community would continue to put on the pressure. "We may not have the bill this year," stated Judy Andler of MASS ACT OUT, "but we'll be back again next year. We're not satisfied."

Another MASS ACT OUT member, Nancy Wechsler, said the July 7 demonstration was intended to address far more than just the lesbian/gay rights legislation. She explained, "We want the gay rights bill to pass, but we also want to create a society where our lives are valued and where we will never again be allowed to die in such great numbers while our government does nothing."

"We need to build a movement strong enough," Wechsler continued, "so that the legislature agrees to fund explicit safe sex brochures for gay men and others at risk for AIDS.... We also need a legislature that overturns Dukakis' anti-gay foster care policy and begins to actively recruit gays/lesbians as foster parents. We also need to build a movement that challenges the homophobia of the society we live in so

that gays/lesbians are no longer targets of queerbashing. We will only achieve that by committing ourselves to building a visible, proud and activist gay/lesbian liberation movement."

While those at the protest loudly shouted their agreement, other supporters of the gay rights bill had expressed reservations about "trash homophobia" prior to the event. Notably absent were bill lobbyist Arline Isaacson of the Mass. Gay and Lesbian Political Caucus (MGLPC) and Sen. Michael Barrett (D-Cambridge), sponsor of the bill, who have appeared at other gay rights bill demonstrations.

"[They aren't] giving a good sense of community cohesiveness," said David Candeias of MASS ACT OUT. "The rally was intended to be upbeat and inclusive — what else can we do to make it 'acceptable' to them? MASS ACT OUT can't worry about every little thing that might offend someone in the State House."

Isaacson, who told *GCN* she had intended to stop by the protest if she had time, expressed continued optimism about the bill's chances this legislative round. "Things are going surprisingly well this year," Isaacson said. She pointed to a 20-15 vote by senators on July 7 to prevent the measure from being tabled.

Members of the Greater Boston Lesbian and Gay Political Alliance (GBL/GPA) supported the protest as did a host of other speakers, including: candidate for state Senate Stephen Holt; City Councillor David Scodras; Sen. Royal Bolling (D-Boston); and ACT UP's Steven Busby. Busby, who thanked MASS ACT OUT for incorporating an analysis of homophobia into AIDS activism, cited two examples of how gay-hatred is evidenced in the AIDS crisis. He explained that a new House bill in Massachusetts, Sec. 555A, may allow doctors to inform the sex partners of people who test positive for HIV antibodies, without the consent of the person tested. Busby also expressed anger that Fison, the company which makes nebulizers used to dispense aerosolized pentamidine, will not release information about new concerns that their nebulizers may not be fully effective.

The "trashing" of homophobic symbols came at the end of the demonstration. A lively, witty group of lesbians and gay men came forward to announce their debris: photos of Gov. Michael Dukakis, a hockey stick to represent weapons of queerbashing, the *Boston Globe*, the *Boston Herald*, the Catholic Church newspaper the *Pilot*, the *Bay Windows* editorial denouncing gay male sex in the Fenway neighborhood, Clause 28, camouflage clothing to represent the military, the Mass. foster care policy, the Capitol Police, redlining in the insurance industry....

And the dumping went on. □

Fens

Continued from page 1

LeBlanc called for additional measures, such as placing extra lights and public phones along streets and in parks. Collier, Tuttle and StreetSAFE workers applauded LeBlanc's suggestions, and stressed the need for ongoing community education.

The meeting became most contentious when Victoria Williams, Assistant Commissioner of the Boston Parks and Recreation Department, explained department policies that prohibit poster or distribution of literature in the city parks. Williams said park employees have been removing the bright yellow warning posters being distributed by LeBlanc and his associates. (The posters describe the rash of violence in the Fens, provide safety tips, encourage community togetherness and give informational phone numbers.)

Angered participants in the discussion suggested a number of compromises to get around the park regulations. Several proposals included: posting the warning notices on small placards in the ground to prevent damage to trees; posting the notices on a temporary basis only; erecting a community bulletin board for display of such notices; and petitioning the Parks Commission to amend its policy. Williams said she could

not support any of these proposals. A few other people at the meeting agreed, saying warning notices in nearby stores, restaurants and bars would be sufficient.

The group reached no consensus on the problem of regulations against warning posters, though LeBlanc later told several people that continuing to leaflet and poster would be "great civil disobedience." As the meeting wound to a close, more people made comments about working with the police and supporting their increased presence in the Fens. Collier thanked everyone for attending, and reassured the commitment of the Fenway Victim Recovery Program, StreetSAFE, and other activists in working towards ending violence in the Fenway.

According to Lisa Price, assistant director of StreetSAFE, "The meeting was definitely worthwhile. We may have to try for some compromises, but it's important to call the community together to open up dialogue. We need to continue working on how to educate people about safety, both to help each other and to help themselves."

For further information about strategies to curb violence in the Fenway, call the Victim Recovery Program at 267-1538, or StreetSAFE at 262-0060. □

GCN welcomes all letters to the editor except personal attacks. Carbon copies of letters sent elsewhere are printed on a space-available basis. The opinions expressed here are those of the author and are not intended to represent the views of the GCN membership. Letters must be TYPED, DOUBLE-SPACED AND NO LONGER THAN THREE PAGES. Send to: Community Voices, GCN, 62 Berkeley Street, Boston, MA 02116.

The way I'll miss Fred

Ed. Note: This letter was received in response to GCN's standing request for submissions by PWAs.

Dear GCN:

Fred died last night. The virus actually shrunk his brain until he wasn't Fred anymore. We were friends. For the last few months we had our doctor appointments at the same time so I could take him. He would always tell me things he kept from his doctor and his case manager.

I know this because my mother is the Alameda County case manager for AIDS. She shares this job with one other woman. At this point in time, all of her clients have died.

I have lived here in Berkeley with her almost two years now. I moved from the East Coast when I couldn't work anymore, was living on a friend's couch in a one-room apartment and had bills starting to get to a point where I didn't know what to do. Because I lived in New Jersey, Gay Men's Health Crisis in New York City wouldn't help me. At the time, I was 24.

Finally in May, 1987, I got pneumocystis pneumonia (PCP) and it was all official. I've been in hospital four times since. While seriously ill in November I decided to at least make it to my birthday, five months away. Now I'm aiming for Halloween, and then my birthday again.

People say you have to think day to day, but I can't. It's too scary that way. I can't even count how many people I've met since moving that have died. Fred and I weren't very close, but we got along. He was funny. Even though he didn't remember me or my mother toward the end, he still asked if we had brought him some Mocha Mix. I'll miss him. I hope people will miss me but in a good way, the way I'll miss Fred.

David Rolland
Berkeley, Calif.

Using a feminist politic to attack the grieving

Dear GCN:

As a lesbian, a feminist and an activist for more than 15 years I am writing to convey my anger about Liz Galst's piece about the Quilt (Vol. 15, No. 48). I must also say that I have made three Quilt panels myself — one for my brother, who was gay; one for a middle-class woman friend who was an IV user; and one for a poor woman, a prostitute, who was connected with a program I work with.

Galst claims she is mad because "AIDS was not the only issue in Cheryl's life," implying, with some perverted logic, that it is the only issue in the lives of gay men. Anyone who has lived life long enough and who has taken a good, hard, non-self-indulgent look at what happens around her knows that AIDS is not the only issue in anyone's life. The three people I have made Quilts for have had to deal with sexism, homophobia, battering, eating disorders, self-hatred, racism, intolerance, addiction, no money, being cast out by their parents and family, stress related to shitty and dead-end jobs, housing problems, fear of living and fear of dying. As I type this, I am amazed at how much they have in common: this middle-class black man, a middle-class woman who worked hard to come up from her poverty, and this poor woman who came from what is called a "good family" and who ended up selling her body in the Combat Zone.

To claim that a Quilt panel that says "Honey, Wasn't it Fabulous" — a memorial for a gay man — does not do justice to Cheryl's life and pain is not only to miss the point but insults everyone who has died of AIDS. The Quilt is not a "Queen for a Day" TV show to see who rates higher on the oppression-meter. I suppose that one could point out that Cheryl was mourned by

the many panels to homeless people and the unknown AIDS victim, and by Women, Inc. One could even point out that if it were so important to Galst to have Cheryl mourned at the Quilt she could have made a panel herself. But as I read her article again I realize that these arguments are all fatuous. Galst's complaint is not that Cheryl wasn't mourned or represented at the Quilt, it is that other people — specifically gay men, whom she sees as being privileged and frivolous — are. This assumption would be offensive if it were not so absurd. I could list the many ways that my brother was oppressed, had suffered, was hurt and humiliated. But it is a pointless task. This listing and evaluation of oppressions I will leave to those with small minds and even smaller emotions.

What upsets me more than anything else however is how Galst and GCN by printing the piece, uses a feminist politic to attack others who are grieving and who are coming to terms with their own politics. After all of these years, have we come to this?

My feelings about the Quilt — or maybe this being GCN I should say the feelings of this black, lesbian, feminist, activist and whatever — are nothing but positive. If anything they have proven to me that my instincts toward political inclusivity are right and accurate. I am sorry that Liz Galst did not find any comfort in the Quilt, or see, as I did, how it illuminated everyone's life. Nothing is simple, or easy, or clearly defined in this world, and I myself would rather find ways to fight for everyone rather than spend time and grief trying to figure out who suffered more and who is more deserving of my pity and anger.

Tracy Jackson
Cambridge, Mass.

Stop the war on women

Dear GCN:

The following is a chronological account of actual events that took place on Friday, May 6, and Saturday, May 7.

On Friday night, as I walked with a friend along Massachusetts Avenue in Cambridge, I observed an argument between two strangers. He threatened her with his words and body language, but somehow never crossed that imaginary line that would have left me no choice but to intervene, possibly endangering my own life. We followed and watched for a few minutes, but soon recognized our own inability to help. Judging from the non-reactions of most of the public in these kinds of situations, our society considers violence against women to be acceptable. Violence against women is not acceptable!

Later that same night I passed the new window display at "The Limited," on the corner of Washington and Winter. At first glance this display is only slightly offensive — just another female mannequin scantily clad. However, a second look reveals the true nature of this violent assault. This woman is bound by ropes and has arrows penetrating her body and head, some aimed toward the groin. This is clearly an example of advertisers using violence against women to sell products and is ABSOLUTELY UNACCEPTABLE.

Saturday afternoon, in the crowded Downtown Crossing area, I witnessed a second couple engaged in a violent confrontation. He pushed her and shoved her, shouting threateningly "You'd better get in line!!!" He was quite large and she petite. She cowered in fear. Again my friend and I watched the scene carefully, following. Again we felt helpless. No one teaches us how to react in these situations, so most of us don't. It is not O.K. to beat on women!

Saturday evening, as I sat on the "T" platform at Downtown Crossing, engrossed in a good book, I was struck by a bottle firmly against the side of my head, smashing into my right ear. I looked up to discover a young man, my apparent assailant. His two friends embarrassed, he tried to joke his way out of this tense situation. Following this unsuccessful attempt to excuse his behavior, he walked over to the bottle, picked it up, and pretended to aim for my head, shattering it against the wall several inches away.

Our society is inundated with advertisements. These television commercials, billboards, magazine ads, and STORE WINDOW DISPLAYS affect our lives. They influence attitudes, values and behaviors. As I write this, my ear still throbbing, I can see "The Limited" window display clearly in my mind. I can see the face of the man who assaulted me — and the

Gay Community News is produced by a collective dedicated to providing coverage of events and news in the interest of gay and lesbian liberation. The collective consists of a paid staff of eleven, a general membership of volunteers, and a board of directors elected by the membership.

Opinions reflected in "editorials" represent the views of the paid staff collective. Signed letters and columns represent the views and opinions of the authors only. We encourage all readers to send us comments, criticism, and information, and to volunteer and become members.

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By Elizabeth Pincus

For the next two weeks, *GCN's* pages will expand to offer extensive coverage of lesbian and gay health care concerns. These special editions — produced with the assistance of writers, activists, and health workers involved in the lesbian/gay community — are planned to coincide with the upcoming International Lesbian and Gay Health Conference and AIDS Forum. Scheduled for July 20-26 at Boston's Park Plaza Hotel, the conference will draw together an estimated 2,000 health professionals and health care activists to discuss a broad range of subjects, with a special focus on lesbian health issues, concerns of people of color and AIDS-related topics.

With our expanded health coverage, *GCN* hopes to provide diverse perspectives on some of the issues affecting our communities. The health care needs of lesbians and gay men have long been inadequately met, as so glaringly exemplified by the homophobia and racism that continue to stymie effective responses to the AIDS crisis. And women in particular — especially poor women, incarcerated women and women of color — have traditionally been mistreated by medical practitioners and/or denied access to adequate care. *GCN* will attempt to incorporate these concerns in our special issues with stories about, for example: substance abuse and AIDS; lesbians and eating disorders; buyers' clubs that enable PWAs/PWARCs to obtain experimental drug treatments; lesbians of color working on AIDS issues; the HIV antibody testing debate; lesbians and chronic fatigue syndrome; and Asians and AIDS. And *GCN* will continue to deliver true safer sex stories, now from the pens of lesbians as well as gay men.

Largest les/gay health conference ever

This year's health conference and AIDS forum is the second international event organized by the Washington, D.C.-based National Lesbian and Gay Health Foundation (NLGHF), the oldest national lesbian/gay health association in the U.S. NLGHF held its first annual national conference in 1978, and has since expanded the event to include international participation and a yearly AIDS forum. Last year's conference in Los Angeles drew about 1,500 attendees; organizers are expecting several hundred additional participants this year. Conference Director Ellen Ratner said that pre-registration is not necessary to attend any or all of the conference. Interested persons may register at the Park Plaza Hotel at any time beginning July 20 at 8 a.m.

The 1988 conference — co-sponsored by the American Association of Physicians for Human Rights (AAPHR) and the George Washington University Medical Center — will include over 500 presentations on medical and legal issues, community organizing, health education and many other topics. A number of special events will also be offered, such as seminars on Grieving and Loss, Gender Issues for the '90s and Youth Services and Spirituality. In addition, various organizations are working with NLGHF to plan concurrent programs. For example, AAPHR is offering a full-day medical AIDS update on July 25, and New York's Fund for Human Dignity will present the First National Lesbian and Gay Education Conference on July 24.

"The conference brings together people from diverse areas for open and frank discussion of lesbian and gay health concerns," said Michael Weeks, project coordinator for NLGHF. "We work to provide quality presentations — to offer a forum for the exchange of information, support, training and technical assistance."

Ratner, NLGHF Board President as well as chief conference organizer, explained that NLGHF works year-round to develop as inclusive a conference agenda as possible. "Unfortunately, it's harder now to get non-

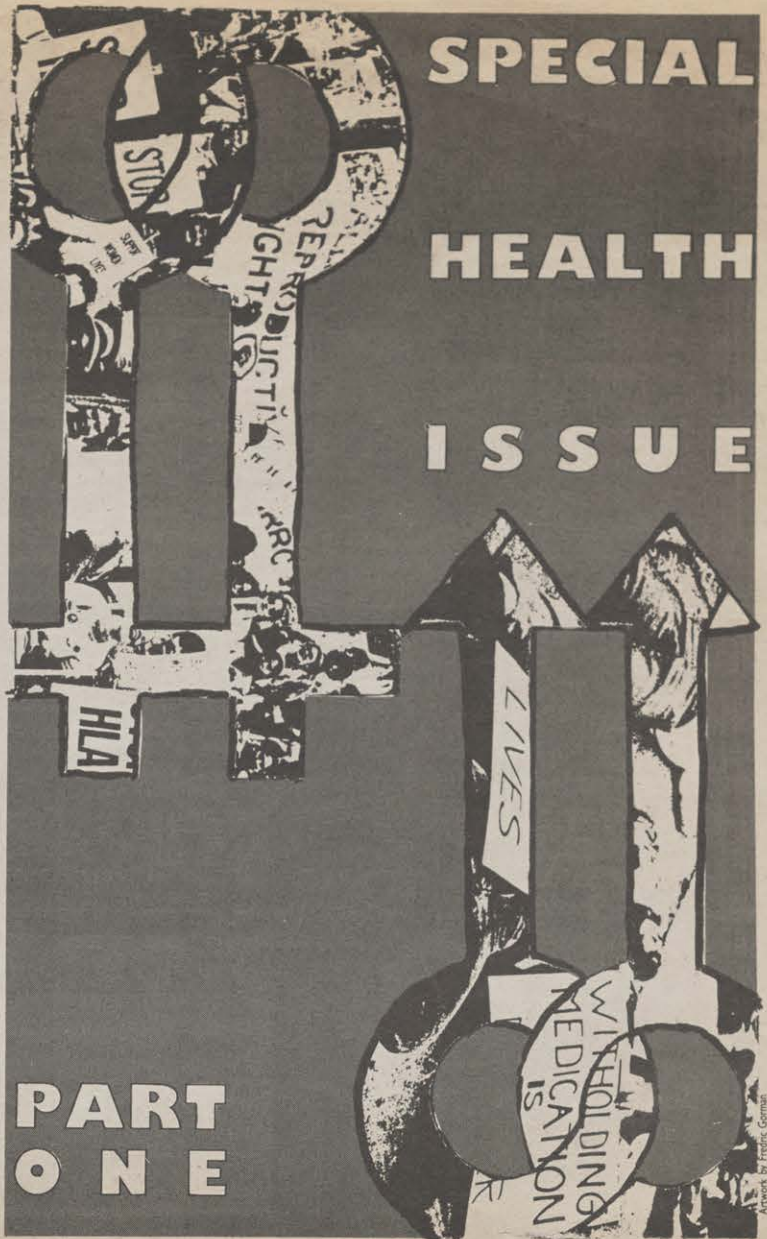
AIDS presentations," Ratner said. "People's energy has turned to AIDS, and rightly so, but we still need to hustle on other [issues]. It's particularly a struggle to get lesbian presentations."

Ratner explained that individual caucuses will meet throughout the conference. Planned caucus categories include: people of color; differently abled; lesbian mental health; international delegates; and the erotica industry. The conference will provide childcare, sign language interpretation, 12-step groups and meetings for PWAs/PWARCs. A number of awards will be presented at the conference by NLGHF and AAPHR. Recipients include Black lesbian activist Pat Norman, Boston's Fenway Community Health Center, Carl Bean from L.A.'s Minority AIDS Project, lesbian sex educator JoAnn Loulan and New York's Lambda Legal Defense and Education Fund.

A whole array of social events, dubbed a "Cecil B. DeMille production" by Ratner, will augment the conference activities. As well as musical performances by Sharon McNight and the Cheek to Cheek Swing Band, conference-goers can participate in banquets, a harbor cruise, film presentations, a clean and sober dance and a talk with Cheryl Crane, author of *Detour: A Hollywood Story*.

According to Ratner, the conference fees charged to both participants and presenters are necessary to cover the conference expenses. Scholarships and scholarship/work exchange arrangements are available for those unable to pay the \$135-250 fee. Some of the conference social events are open to the public without charge, including the awards ceremony on July 24 at 1 p.m. and a reception with NAMES Project organizers later that afternoon.

For further information about the Second International Lesbian and Gay Health Conference and AIDS Forum, call (202) 797-3708 before July 20, or stop by the Park Plaza Hotel, 50 Park Plaza, Boston from July 20-26. □



Featured in the *GCN* Health Supplement Part I:

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Highlights of Part II, next week:

Roundtable Discussion of HIV testing, Report on the presidential AIDS Commission, Lesbians of Color on AIDS, and Lesbians and Eating Disorders

GCN's Lesbian and Gay Health Supplement was planned and edited by *GCN* staff members Jennie McKnight, Stephanie Poggi and Marc Stein.

Special thanks to Shelley Mains for her many contributions to the supplement; and to Marea Murray, for suggesting that we plan special issues to coincide with the International Lesbian and Gay Health Conference and AIDS Forum.

"They keep their eyes shut"

As HIV infection in prisons skyrockets, health care for prisoners remains negligible

By Elizabeth Pincus

BOSTON — Last year at Deer Island House of Corrections, a county jail in the Boston Harbor, a man died during an asthma attack when correctional officers refused to provide him with medical attention. Recently at the MCI-Framingham state facility, a woman who was nine months pregnant was shackled with leg and wrist irons, and roughly escorted to the hospital for her delivery. According to Linda Thurston, who coordinates the Criminal Justice Program at the American Friends Service Committee (AFSC) New England Region, such abuse of inmates and neglect of their health care needs is commonplace in prisons and jails.

Thurston explained that many prisoners are particularly vulnerable to health problems due to prior histories of drug use, poverty, scanty medical care, poor nutrition and a lack of physical safety. She added that



additional problems are inevitably brought on by incarceration. These include stress, emotional problems, vision impairment for prisoners in isolation, and contagious diseases ranging from flu to hepatitis to AIDS, ARC and HIV-infection.

Uneven delivery of medical care in prisons further aggravates health problems. Many conditions are often overlooked, including Agent Orange poisoning and PTSD (Post Traumatic Stress Disorder) for veterans, and medical complications for prisoners with drug or alcohol dependencies. Pregnant women often suffer from particular neglect, and access to abortion may be limited or dangerously delayed. For lesbians and gay men, already overlooked or mistreated by the medical establishment, imprisonment can lead to further harassment and physical abuse.

"The medical care in prison facilities is abysmal," said Deborah Shields, attorney with the legal task force of Boston's AIDS Action Committee (AAC). "We get complaints by the dozens. Each facility is supposed to have some health care — but it's generally very limited and inadequate."

Shields described what she called the appalling conditions of Lemuel Shattuck Hospital, a prison medical facility in Boston. She said the Shattuck is an ancient building without fans, air conditioning or windows that open. According to Shields, prisoners who need hospital care are locked up 24 hours a day in cockroach-ridden rooms with no access to education, training or recreation programs.

"Health care in prison? Imprisonment itself leads to ill health, whether through the medical conditions, or through the effects of physical violence in prison," stated a recent editorial in *Outlook on Justice*, an AFSC newsletter. "Beatings by guards and prisoner on prisoner violence result in traumatic injuries which may or may not be adequately treated by prison medical personnel. The stress from the constant threat of violence plays havoc with both emotional and physical well-being."

AIDS, ARC, and HIV-infection in prisons

A report released this spring by the Massachusetts Department of Correction (DOC) revealed that out of 250 women prisoners in the state who voluntarily submitted to an HIV-antibody test, 100 tested

positive. The DOC did not release comparable statistics about men prisoners. Lila Austin, co-director of the Boston-based prisoners' rights group, Social Justice for Women, said that advocacy workers for prisoners estimate that up to 90 percent of people incarcerated in state prisons may be infected with HIV.

"AIDS is by far the most serious health issue in prisons," Austin said. "There's a very high instance of IV drug use, and conditions are very over-crowded." She explained that between 70 to 90 percent of all prisoners are present or former IV drug users, putting them at high risk for contracting AIDS through shared contaminated needles. Nonetheless, according to Austin, prison officials have responded slowly to the AIDS epidemic, failing to provide adequate medical and social services or substance abuse treatment.

Other prisoner advocates and AIDS educators agreed that lack of access to AIDS information and safer sex materials is a deplorable problem in prisons. A recent letter to the GCN Prisoner Project outlines the situation.

"The two most common ways of contracting [HIV] are nearly second nature to most inmates: homosexuality and drug use," wrote a prisoner from Louisiana. "But the Department of 'Corrections' has chosen to keep their eyes shut and their mouths open — open to tell the lies that they don't have any AIDS problem to speak of. And since nobody else out there seems to want to speak of it either, our deaths and the education it would take to prevent them, are ignored. The 'corrections' people are more worried about how to protect their staff than they are about prisoners already dying (alone)."

Prisoners who are diagnosed with AIDS, ARC and HIV-infection may receive little or no medical treatment, and may be harassed or ostracized from other prisoners and staff. According to Billy Jones, a health educator with the Whitman-Walker Clinic in Washington, D.C., prisoners with AIDS, ARC or positive HIV status are usually isolated in so-called "protective custody."

Describing the cold, drab and unhealthy circumstances of being "locked down," Jones explained that prisoners in protective custody lose the opportunity to work or participate in other programs to earn good time — that is, credit for early release. In fact, HIV-positive prisoners are increasingly being warehoused indefinitely in prison isolation units, according to prisoner advocates.

"Prisoners with AIDS can't get medications, can't go to hospitals of their choice and are locked up in isolated settings," said Diane McLaughlin of Massachusetts Correctional Legal Services. She described how prisoners with AIDS, who are not granted confidentiality protections, are often subject to additional brutality and constitutional rights violations. McLaughlin's organization provides legal advocacy for prisoners; increasingly, she said, the cases they handle involve complaints about medical care.

Other community organizations are also attempting to improve the quality of health care within prisons. AFSC's Criminal Justice Program provides education and advocacy for prisoners, sponsors community forums and attempts to increase citizen access to prisons. Social Justice for Women, an umbrella group that encompasses a number of organizations working for prisoner's rights, has recently begun a Women and AIDS Program at MCI Framingham to provide education, counseling and other services.

Another Social Justice for Women program, called the Women's Health and Learning Center, offers substance abuse support services for women prisoners, lobbies for improved health care and focuses on particular needs of Black and Latina prisoners. The Center has recently begun doing AIDS

Continued on page 16

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We deserve better treatment than this

Dear GCN:

Last year, March '89, I wrote you a letter about the conditions in California's Special Treatment Unit, which houses inmates who have tested positive for HIV. Now a year later, I would like to do a "follow-up" on the conditions here.

The Del Norte Special Treatment Unit (STU) has taken a tremendous turn for the worse. Since March '89 the unit has doubled in population from 75 inmates to 190, and is continuously growing as more men take the HIV test. The room to properly house people is running out. There is barely enough room to move around, which is causing stress and spreading disease. Now they are transferring people to Northern California, far away from our families making visits very difficult, if not impossible, for many.

There have also been changes in staff, so that now there is more lack of communication, cell searching and other forms of harassment, just for acting in an effeminate manner, or what they consider "gay." The staff turnover has been complete and the new staff know little or nothing about HIV.

The deaths that have occurred have certainly been partially due to lack of proper medical treatment and housing. It hurts to see someone you care for pass away knowing that more could have been done, but was not.

The ventilation here is very poor. So now in the summer time we have to be locked in our cells with temperatures rising to 100 degrees and more. There are inmates with fans in their cells, but what about those who are indigent and can not have one sent in?

Throughout the California prison system there is a program called Men's Advisory Group where each ethnic group (black, white, hispanic, and others) is represented by an inmate from their own race to speak up for them if a problem should arise between them and staff. It is easy to get

cooperation from the inmates because all of us become as one. But the staff is not so cooperative. This is why we need a Men's Advisory Council here too, so we can find a better way of communicating, and to try to make this unit a better place. Letters of support should be sent to the Warden, CIM-East, Del Norte SPU, PO Box 500, Chino, CA 91708.

Just because we are in prison does not mean we are not human. We deserve better treatment than this.

Sincerely,

Robert Ray White

D-30210 - 393U

CIM-East Del Norte

Box 500, Chino, CA 91708

GCN Aug 12-18, 1990

AIDS. We covered both what to do if one was HIV/AIDS positive and how to prevent becoming infected. In these seminars both drug use and sexual activity were discussed frankly and openly with only the usual few sarcastic comments regarding homosexuality. Most of the inmates listened respectfully and with interest to anything presented regarding AIDS. Those few who found it necessary to make negative comments about gays were trying to protect their macho image and were soon silenced by the other inmates.

Those inmates who are HIV/AIDS positive almost invariably claim to have contracted the disease from drug use. Only those who are already openly gay admit unsafe sex was the cause. But they were already shunned by the majority of inmates. They continued to be shunned by those claiming drug use as the cause of their disease.

As a law librarian I was quite involved with legal issues regarding AIDS. In such an advocacy position in behalf of those infected, I was often confided in and learned that about fifty percent of the time the afflicted inmate did not know whether he had contracted the disease from sex or drugs. Those who did know averaged about thirty percent drugs and twenty percent gay. Of course, I cannot be sure of these informal statistics because of the difficulty these men had trusting anyone in prison with confidential information. I suspect they are not correct. It is very difficult to admit homosexual activity to another prisoner.

If I were asked to make a guess, I would estimate that AIDS contracted in prison is caused by drug use twenty to twenty-five percent of the time and that gay sex accounts for the rest.

The prison officials go out of their way to make both drug use and sex unsafe. Where a few years ago bleach was commonly available, as soon as it became known that one could protect oneself by rinsing one's needle in bleach, the bleach disappeared. Not only are condoms considered contraband and are forbidden, where once one could obtain Saran Wrap or a similar product, this is no longer possible. Hence, the prison officials have found a way to make capital punishment legal while it is still illegal.

I don't know if any of this is any help, but I would be happy to discuss it with you.

Kenneth Gordon
Dorchester, MA

How gay and drug using HIV/PWA prisoners are getting along at Norfolk

Dear GCN:

I am writing in response to your request for information regarding how gay and drug using HIV/PWA prisoners are getting along together.

It is my experience that most gay men in prison do not live openly gay lives. If one does come out publicly, then one's social life is severely curtailed. The straight prisoners feel that their reputations as macho men will not withstand association with openly gay men. However, if one never mentions that one is gay and if one does not "flaunt" one's sexual orientation, then one is accepted by nearly all the other prisoners.

While I was at MCI [Massachusetts Correctional Institution] Norfolk, we formed an AIDS awareness committee for the purpose of presenting information on

Prisons not coping with AIDS crisis

Dear GCN:

The prison here is trying to ignore my illness (HIV) and staff members have informed me that they believe I am trying to use my health concerns for "favoritism". Unfortunately, I am the only known person at this institution with HIV.

I am writing now because of an article

that appeared in the *Louisville Courier-Journal* in August entitled "Prisons not coping with AIDS crisis." This problem is nationwide. It is at your own back door.

Here, for example, after I saw an outside doctor, who immediately put me on AZT, members of the prison staff found they had the authority to countermand the doctor's orders on superficial grounds. This is just an example of what prisoners need to go through in dealing with their administrations. There are several other incidents that I have been required to tolerate without proper institutional control involving discrimination by residents and staff (haircuts, staff jokes, etc. etc)

If you wish to learn more about how HIV positive people are treated in this system, feel free to contact me. I am willing to take a stand for myself and for any PWAs who are afraid to speak up about the way we are treated.

Sincerely,

Mykel Westermeyer

93812, Hwy 146
LaGrange, KY 40032

GCN

Sept 23-29 '90

SPEAKING OUT

AIDS, prison and hopelessness is a deadly combination

By Daniel Trzebiatowski

Having HIV/AIDS is undoubtedly a challenge. Having HIV and being behind bars only adds to our helplessness, hopelessness and isolation. But what we frequently and comfortably tend to let escape us is the reality that we have choices available to us, whether in society or behind walls of confinement. We are the only ones who can make the choice of whether we want to be a person living positively with HIV/AIDS in prison or a person dying with this disease in prison.

We cannot look to the federal or state governments for compassion and support. They conceive that being a prisoner strips us of all our rights, both human and civil. And being an inmate with HIV only supplies them with the inhumane excuse to let us exist without rights, without adequate medical care, and to exist and die without dignity.

We can choose to pity ourselves because we have HIV and because we are prisoners, but isn't being behind steel bars enough! Do we need to reinforce our confinement by adding additional barriers?

Whether we have long or short sentences, placing blame on our "time" for hopelessness is a copout. When we were out on the streets we were not provided with the luxury of unlimited time to live, to live free. This being the case, we should be living each day as if there is no tomorrow coming. Being behind walls is no exception.

Since we are free from some of the responsibilities and obligations that crowded us on the outside, we can concentrate totally on ourselves. A luxury many don't have.

Many of us were unaware of our HIV status before coming to prison and were ignorant when we tested positive. The prisons have often done nothing to help us understand what was going on, so we feel threatened, isolated and lost. Now is the time to start bringing down the walls surrounding the lack of knowledge about the disease, the living with the disease, and ways in which we can live positively and successfully with HIV/AIDS. It can be done, no matter

how hopeless it may seem at times. We do not have to fall into and accept the "victim" role that our government, prison administration, and our own sense of helplessness tend to string in front of us.

As with any learning process we have to look to our own experience and strength in order to learn to stand on our own two feet and risk those first few steps. We can't afford to let our fear of being "found out" hamper our efforts. We can first look within the system for AIDS information and supportive resources. But at best, these will be very basic, and often non-existent. Our best bet is to look to outside resources. Since many of us are unfamiliar with what outside resources are available, and fear to have revealing material such as AIDS info sent in to us, we may allow another wall to enclose us unnecessarily. As inmates, however, we have some resources of our own.

Here at Rochester, a handful of us initiated an info gathering mission by going through the pastoral care dept. and the infection control dept. Through these departments and with a lot of determination, we started to compile some needed outside resources. But instead of having the resources mail info back to us personally, we had them mailed back through the departments named. This also gave us some extra pull in the eyes of the resource agencies. Now we have an impressive HIV/AIDS resource library available for our use.

By the time we established this we realized there was a small number of men determined and concerned enough to take the initiative and some risks in order to improve their situation. So we decided to take another chance and form an HIV support group, which became known to known to no one else, including the administration, other than as a grief support group. This has not only improved our emotional well-being but has been the main factor in our remaining supportive and united with each other.

With this united, empowered force we continue to grab onto the things which we

need. This month we are inviting the Minnesota AIDS Project in to hear our views and needs as prisoners with HIV. Through this relationship we have also developed a "buddy" program, in order for us to receive regular and confidential visits, and letter/phone correspondence to discuss our issues openly and honestly. It also looks as if I will get approval from the BOP [Federal Bureau of Prisons] to give an HIV/AIDS person perspective inservice for both the general population and the staff.

Though this may seem far-reaching for many, the point here is that we can accomplish many more of our goals than we give ourselves a chance to! Whether we want to develop a friendship with another HIV positive person, track down some AIDS info brochures, or start a support group, you will be surprised how much can be done if you only really try.

It's not easy. It takes time, patience, hard-work, determination and spirit. And often we will want to give up because of the endless red tape, rejection and feeling of helplessness. But we took risks on the street. Now it's time to take some life-improving risks on the inside. It's our choice.

Reality reminds us that some of us will die in prison/jail, and some of us will die because of HIV/AIDS complications. In the end, though, it is not how long we lived, but how we chose to live.

Daniel will be completing his sentence in October, 1990, and will be establishing a National Correspondence Network for HIV positive prisoners. He will be developing a correspondence network for those prisoners who can't write each other. For letters that are sent via his network, postage needs to be included to help cut costs. Daniel can be reached at the address below. With your help we can make this a success. He can be reached at: Daniel Trzebiatowski, 02577-089, Box 4600, Rochester, MN 55903.

Gay PWA wins round in court battle

CAMDEN, N.J. — African-American gay PWA Gregory Smith, sentenced to 12 1/2 to 25 years for "attempted murder" on the basis of claims that he bit a prison guard (see GCN, June 17), won a postponement Aug. 28 in his case against two Camden prison guards for assault and harassment.

Representing himself, Smith convinced Camden Municipal Judge A. Morton Shapiro that since his lawyers were on vacation the case should be postponed. According to Lois Lax, a member of ACT UP/Philadelphia and the Justice for Gregory Smith Coalition, supporters of Smith hope that the trial against the guards will be delayed until after the completion of Smith's appeal of his attempted murder conviction.

Activists from Philadelphia to New York have planned two major actions during September. On Sept. 20, Smith's lawyers, Ron Kuby and William Kunstler of the center for Constitutional Rights, and Judy Greenspan of the National Prisoner Project of the American Civil Liberties Union, will speak at a press conference in Philadelphia. On Sept 29, lesbian/gay, AIDS, and prisoners' rights activists from New York, New Jersey, and Pennsylvania will demonstrate at the New Jersey state capitol in Trenton. Busses are currently being organized for New York and Philadelphia. For more information, call ACT UP/Philadelphia at

(215) 222-8815.

Marc Stein

Sue,

9-12-90

F Y I. This is for the current Adv issue #561.

-B

L A W

AIDS Groups Prepare for Appeal in New Jersey Prison Case

BY CHRIS BULL

The New Jersey state appeals court is scheduled to hear pleas in November on behalf of Gregory Smith, an inmate who was convicted of attempted murder and sentenced to 25 years in prison last summer for biting a Camden County jail guard.

Groups that monitor treatment of prisoners in the nation's jails, meanwhile, said they are taking a particular interest in Smith's case because it underscores the plight of a growing number of prisoners across the country who are being prosecuted for allegedly trying to spread HIV, the suspected AIDS virus.

Prosecuting Smith for attempted murder is "like saying that if you fire a gun with blanks at someone, you can be convicted of murder," said Lois Lax, a Philadelphia member of the Justice for Gregory Smith Coalition, a group of AIDS activists and prisoner's rights advocates.

"We want to put [the judicial system] on notice that this type of treatment will not be tolerated," she said. "Gregory's sentence simply plays into the kind of AIDS hysteria we have been fighting for years."

William Kunstler, the well-known lawyer who is representing Smith as a volunteer staff attorney for the Center for Constitutional Rights, a New York City legal group, called Smith's trial on the biting charge "a legally and politically tainted prosecution from the beginning."

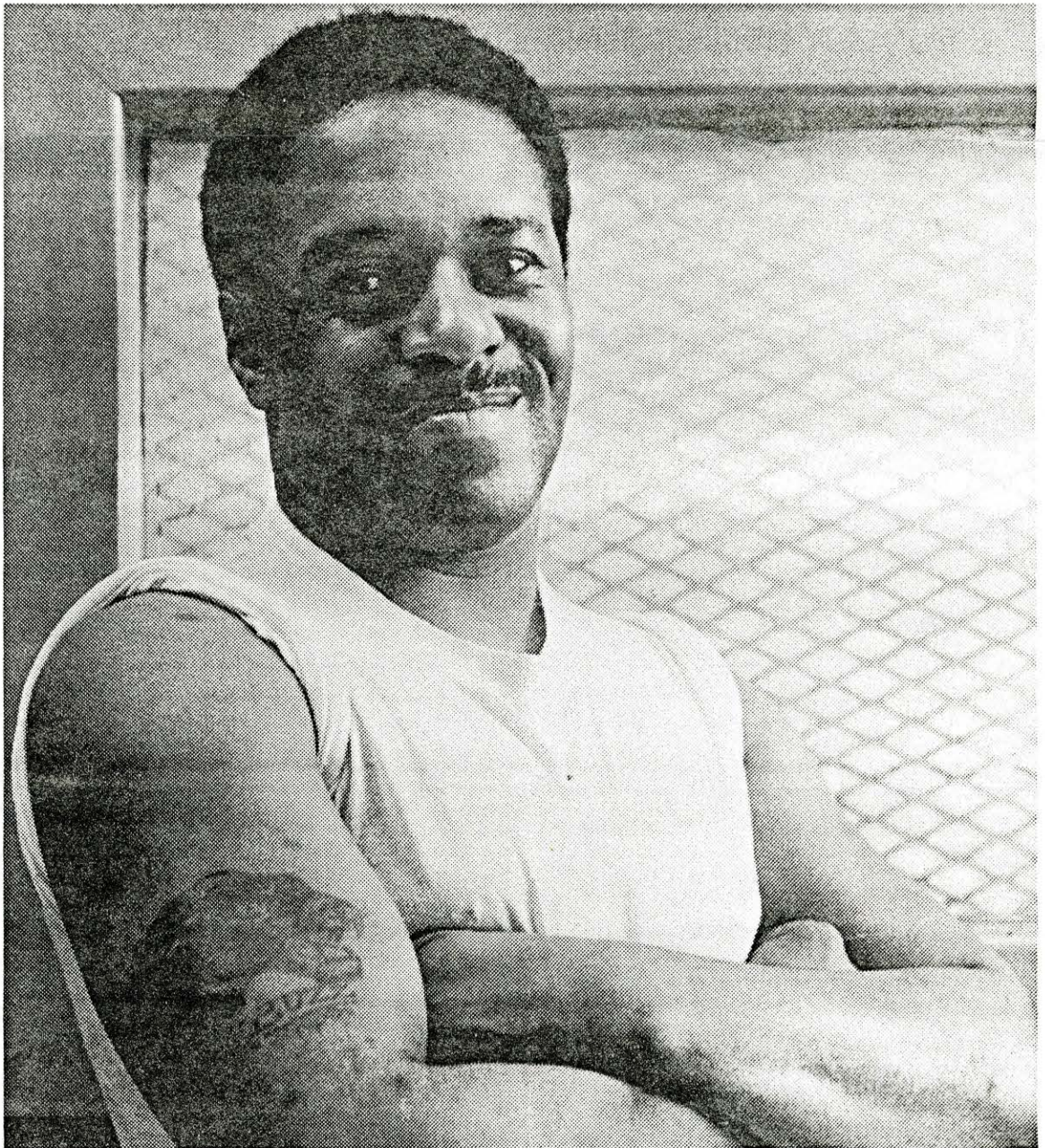
In sentencing Smith, Kunstler said, superior court judge John Mariano ignored evidence that HIV cannot be transmitted through a bite. "Gregory was punished because he is black, gay, HIV-positive, and a

former [intravenous drug] user," Kunstler said. Smith was sentenced to a long term "because he is a social pariah...not because he did anything wrong," Kunstler said.

Judy Greenspan, AIDS information coordinator for the American Civil Liberties Union's prisons project, said Smith's case is

not an isolated one. Prisoners across the country have been given long sentences after being accused of trying to transmit HIV and then convicted of assault or attempted murder, he said. Some of the most widely publicized cases include those of the following men:

- Adam Brock, an Alabama prisoner with AIDS who was convicted of biting a guard and sentenced to 15 years in prison until an appeals court overturned his conviction,
- William Brown, a Pennsylvania inmate with AIDS who was convicted of aggravated assault for throwing his feces at a prison guard,
- Donald Haines, an Indiana inmate with AIDS who was convicted of attempted murder for biting a police officer and spraying him with blood while the officer tried to keep him from committing suicide,
- Gregory Scroggins, a Georgia inmate



HIV-POSITIVE INMATE GREGORY SMITH
His appeal goes to New Jersey's appellate court in November.

"Most of the time, they just let the AIDS prisoners die."

with AIDS who was convicted of assault with intent to commit murder for biting a police officer during an arrest, and

• Curtis Weeks, an HIV-positive but asymptomatic prisoner in Texas who was convicted of attempted murder and sentenced to life in prison for spitting at a guard and saying that he wanted to "take someone out."

In each case, Greenspan said, the incidents would have gone virtually unnoticed had the defendants been HIV-negative. But because the inmates were HIV-positive,

Smith: "It's Pretty Rough" for Prisoners With AIDS

Hours after his fateful skirmish with guard Albert Waddington, inmate Gregory Smith said he was awakened at 4 a.m. by six guards who were wielding police batons.

"I was in the corner of my cell crying, 'Please just leave me alone,'" Smith said. "They shackled me to the bed. I thought they were going to beat me again. They had come to revenge [Waddington]. They said, 'You bit Officer Waddington,' and I said, 'What?' They said, 'You bit Officer Waddington.'"

Smith said the guards left without harming him, but the incident shook him up anyway. "It's pretty rough here," said Smith, who is incarcerated at the readjustment center at Trenton State Prison, where inmates who are considered troublemakers are often housed.

"There is a lot of AIDS hysteria" in prison, Smith said. Prison officials "refused to cut my hair, and other inmates asked to have the shower [sterilized] after I used it. My TV was destroyed, and a note pinned to it read, WE DON'T WANT AIDS ON THIS TIER. This comes from other prisoners who I know are HIV-positive, like me, but I just keep quiet about it. They give me a lot of shit... because I've been on the news."

Smith said he hopes to be transferred to a special state-prison medical unit so he can get better medical care. "I was down to about 100 pounds at one point," he said. "Now I'm on AZT and am stronger, but I still don't get much care. Most of the time, they just let the AIDS prisoners die."

she said, they were vigorously prosecuted.

"The conditions in prisons are rough," she said. "There are many fights, and they are usually treated in a routine manner. But if the prisoner is [HIV-] positive, everything gets blown out of proportion." She said she is aware of no instance in which a prison guard contracted HIV on the job.

Prisoners with AIDS often face isolation, poor medical care, and harassment from prison guards and other inmates, Greenspan said. "Sentencing someone with AIDS to 25 years in prison [for an AIDS-related conviction] is a death sentence," she said.

Smith's case began June 11, one month before Smith was due to be released from the Camden County jail, where he was serving a five-year sentence for robbery and credit card fraud.

Smith had hurt his back on his cell floor and was taken to a nearby hospital by two guards, Albert Waddington and James Snow. Doctors examined him but didn't X-ray him, and Smith demanded that doctors take the X-ray.

Smith said that when he refused to leave the hospital, Waddington dragged him across the floor and beat him. "He kept punching me all over the back, telling me how much he hated niggers, and he kept hitting me over and over," Smith said.

Waddington and Snow testified that as Waddington tried to put Smith into a patrol car for the trip back to jail, Smith yelled, "I hope you die, pig," and bit Waddington on the hand. Waddington did return from the trip to the hospital with a laceration on his hand. Waddington and Snow said it was a bite, but Smith said it was a cut, caused by handcuffs.

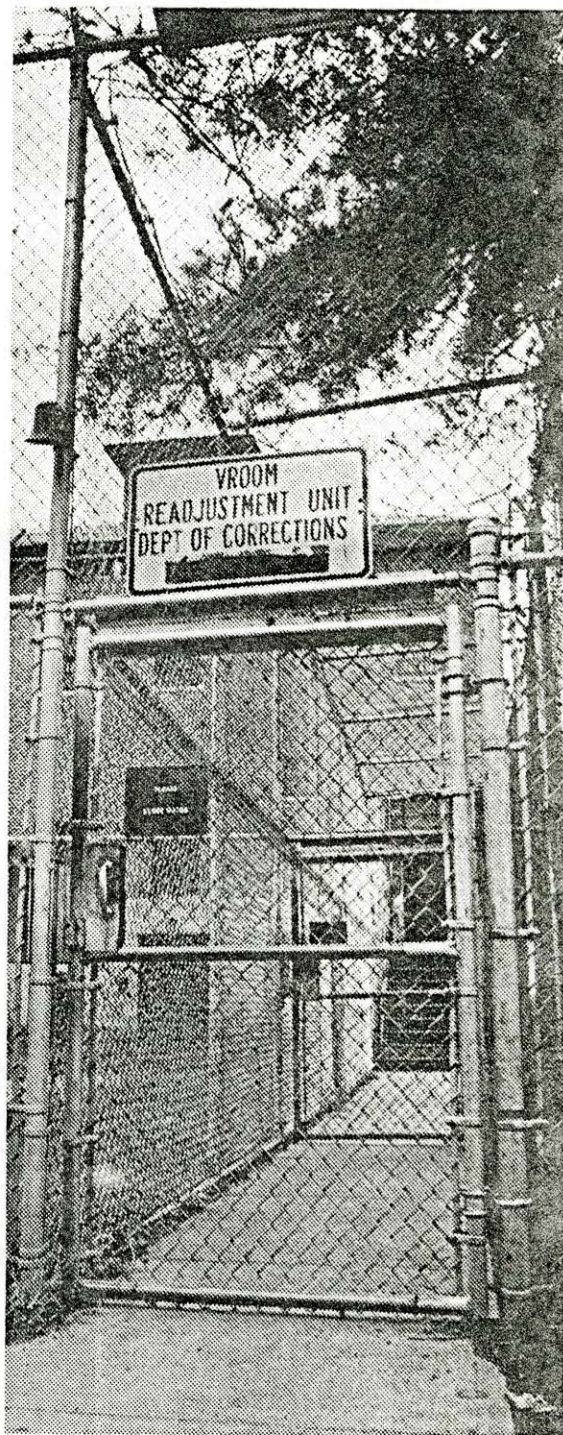
Smith said the guards lied to jail officials who investigated the incident. "Officer Snow came to me later," Smith said, "and I said, 'Why did you lie?' He said, 'I didn't say I saw you bite him. I said I saw some blood on his hand! But when the trial came around, [Snow] changed his story' and said he witnessed the bite. Neither Waddington nor Snow could be reached to comment for this article.

Camden County prosecutor Harold Kasselmann conceded during the trial that biting is unlikely to transmit HIV, and Waddington had not developed antibodies to HIV by the

time of the trial. But he successfully argued that all he needed to show was that Smith intended to kill Waddington.

Under New Jersey law, a successful prosecution on an attempted-murder charge required Kasselmann to show only that Smith believed he could kill Waddington with a bite at the time of the scuffle. "Impossibility," he told the court, "is no defense to a charge of attempted murder."

But Smith, interviewed after his sentencing, had a different point of view. "I was not on trial," he said. "AIDS was."



TRENTON STATE PRISON
Smith is housed there, along with some of the toughest prisoners in the state.

NY Times Aug 19, 1990

PRISONS CRITICIZED ON AIDS PROGRAMS

Health and Legal Experts Say Inmates With Disease Face a Disastrous Situation

By **BRUCE LAMBERT**

America's jails and prisons are not coping with the rapid increase of AIDS among inmates, causing needless suffering, say health and legal experts from around the country.

Some of the experts called prison AIDS wards the new death row.

Ailing prisoners at the Limestone Correctional Facility in Alabama were sometimes left to suffer with nothing more than Tylenol to ease the pain and were not given the only Federally approved drug to treat acquired immune deficiency syndrome until the disease was in an advanced stage, said Alexa Freeman, director of the AIDS prison project of the American Civil Liberties Union.

These criticisms came at a public hearing on Friday in New York City by the National Commission on AIDS, an advisory panel on Federal policy that is holding hearings on topics affecting AIDS policy.

Even more vivid than the experts' testimony were dozens of letters from prisoners, which included carefully reasoned critiques, polished proposals and desperate pleas for help.

'We Are Sentenced Twice'

"We are sentenced twice for our violations — once for the crime, and once for having the disease," wrote Michael Mullis, an inmate in Florida.

Among the problems the health and prison officials cited were poor medical care and lack of medicine, ostracism and harassment by prison employees and other prisoners, violation of patient confidentiality, mandatory testing with little or no counseling and a lack of educational efforts to prevent the further spread of AIDS.

Infected prisoners were often quarantined and denied standard programs

Some call AIDS units a second death row.

like recreation and vocational training, the witnesses said. And restrictions originally designed to protect inmates from the coercive scientific experimentation of earlier eras have the unintended result of impeding access to new drugs that are sometimes the only hope that AIDS patients have.

"There's a lot of work to be done here," said Dr. June Osborn, the dean of the School of Public Health at the University of Michigan who is chairwoman of the commission. Another member, Dr. Don C. DesJarlias, a leading researcher on drug abuse at Beth Israel Medical Center in New York, said "Our prisons are in a disastrous situation."

Needs Are Acknowledged

The panel's vice chairman, Dr. David E. Rogers, the head of the New York City and State AIDS Advisory Council who is on the staff of the N. Y. U.-Cornell Medical Center, called the problems "appalling."

Prison officials who testified before the panel, which visited Fishkill State Prison in New York and talked with workers from the New York City jails on Rikers Island, defended their efforts with educational programs and in expanding health care. But all acknowledged that the current situation needed to be improved, even though many said budget restrictions made that difficult.

As of last fall, there had been at least 5,400 AIDS cases among the Federal, state and local prisons surveyed, said Dr. Kenneth G. Castro of the Federal Centers for Disease Control in Atlanta.

New cases recorded each year rose sixfold over a four-year period, and about 80 percent of the prison AIDS cases were on the East Coast, with 40 percent in New York State, Dr. Castro said. In addition to the certified AIDS cases, many times more prisoners were believed to be in earlier stages of infection and illness, he said.

Ms. Freeman, of the civil liberties union, said that at the Alabama prison: "Some inmates were required to scrub the telephones with alcohol after each use. Their clothing and laundry bags were stamped with the word HIV," for the human immunodeficiency virus that causes AIDS. "One prisoner described how he was required to scrub the shower stall and toilet seat with pure bleach after each use, and then scrub the floor behind him as he walked back to his cell."

Dr. Robert L. Cohen, a Manhattan doctor and hospital official who has reviewed prisons in several states, said AIDS care is "dangerously inadequate" and "death comes too early" for inmates, compared with patients outside prisons, who live longer because of better treatment.

Dr. Cohen criticized the segregation of Rikers Island prisoners with AIDS. And Dr. Charles A. Braslow, who directs health services at Rikers Island, said he agreed that the policy was "totally medically inappropriate, and we have tried not to follow this policy."

But Dr. Braslow said that unless prisoners who have AIDS were segregated an inmate discharged from a medical unit could be harassed by other prisoners.

The inmates' letters to the panel were presented by Judy Greenspan of the American Civil Liberties Union Foundation.

David L. Berryman, a Georgia prisoner, wrote: "I was segregated in a cell with 'Beware' signs. They gave me reason to believe I was going to die shortly, and it broke me down mentally and emotionally." Another Georgia inmate, Calvin Lee, wrote that after he was tested, "I was then placed in the so-called AIDS ward, where I was made to sleep on the floor."

AIDS commission releases hard-hitting prison study

The government-appointed National Commission on AIDS finds gross inadequacies in HIV care and education in prisons

By Elizabeth Yukins

WASHINGTON—The National Commission on AIDS released in late March an unprecedented study on the state of HIV care and education in the nation's prison facilities. The Commission, comprising high-ranking government officials and AIDS health care advocates, found gross inadequacies on the parts of prison administrators and public officials in addressing the prevalence of HIV among prisoners.

Prisoners' rights advocates and health care workers lauded the report's hard-hitting findings. They said they were pleased with the breadth of the Commission's recommendations for improving HIV care and education in prisons. They also expressed satisfaction with the way the Commission critically examined the failure of government officials and prison administrators to competently deal with HIV issues at federal, state and local levels.

"The prison HIV population's greatest impediment to getting anything done is that it has been isolated and hidden from public view," said Sue Sullivan, a staff attorney at Massachusetts Correctional Legal Services, a prisoner advocacy group. "This report provides the first step of publicly identifying

the nature and magnitude of the [HIV] problem," Sullivan told GCN.

"The report is extremely important to people who are trying to pressure the government to develop reasonable policies to deal with HIV issues in the prisons," echoed Judy Greenspan of the American Civil Liberties Union's (ACLU) Prisoner Project. "It is a mandate from the government's own commission saying that things are wrong and changes must be made," she told GCN, adding, "The report can now be our weapon, our rallying cry, to further" help prisoners cope with HIV.

'Sobering and troubling' findings

The Commission addresses two main issues in its report: the need to deal compassionately with the rapidly growing number of HIV-positive prisoners; and the important opportunities prisons offer for HIV prevention education. The report asserts that because the prison system consists of a large population of drug users and former drug users, "no other institution in this society has a higher concentration of people at a substantial risk of HIV infection."

In the report's introduction, the

Continued on page 7

GEN 4/14/91

staff workers, administration officials, health care workers and court officers.

According to prisoners' rights activists, the report is crucial because it candidly addresses and seeks to dispel myths about HIV and prisoners. For instance, the report discredits the notion that prisoners should not be allowed to have condoms for security reasons. Contradicting the long-standing idea that condoms will be used to smuggle drugs into the prison, the report encourages condom distribution, saying that "two years of experience with condom availability in the New York City system have resulted in no adverse security incidents."

Another myth the report rejects is that HIV segregation can be used as a viable means to handle HIV-positive prisoners. "The Commission finds automatic segregation to be wholly without public health merit, often giving rise to dangerous circumstances for the correctional community as a whole," the report reads.

The Commission says that by sequestering prisoners who have tested positive for HIV, prison officials both create a false sense of security among other prisoners, and effectively label the HIV-positive prisoners as targets for "assaults, discrimination, and disparate treatment." Currently, 16 state prisons segregate all prisoners with full-blown AIDS, five segregate those with AIDS Related Complex, and four segregate all those who are seropositive.

The ACLU's Greenspan said the report is unique because it takes into account testimony by prisoners with HIV. "One of the reasons I really like this report and think it should have wide-spread influence is that it really does speak with the voices of the prisoners," she said. Prisoners' experiences with HIV in prison are quoted throughout the report, and their testimonies are often used to illustrate the desperate need of health care reform within prison facilities.

'Public health responsibilities'

The report approaches HIV in prisons from a new vantage point by showing how prisoner education about drug use and HIV prevention affects those inside and outside the prison system. With the high rate of turnover in the prison population, the report reads, "Interventions among prisoners will save lives and will have a significant impact upon the course of the epidemic in communities to which prisoners will return."

"What's different about this report is that it frames [HIV issues] in terms of public health responsibilities," said Larry Kessler, executive director of the AIDS Action Committee in Boston and a member of the Commission. "It makes it clear that you can't just say, 'Oh that's a problem for the corrections people, let them figure it out,'" he told *GCN*. "The report shows that there has to be dialogue and partnerships developed here to fully combat this problem."

Kessler said that the report will hopefully help develop uniform standards for HIV care and education in prisons, and will help eradicate inequalities and irregularities that occur throughout the prison system.

Greenspan similarly said that she hopes that the report will help establish a uniform HIV policy for prisons throughout the country. She cautioned, however, that such a policy will not come about immediately or easily just because a government study has been released. "No one in prison administration is going to jump into line in response to this report. But it will be our political agitation tool," she said.

Greenspan added that she believes the report will become a means by which prisoners and prisoners' rights advocates can show the government how it should be handling issues about HIV in prisons. "The report validated everything we've been saying for the past five years, and now we can use [the government's] own words to really make our point," she said.

"I envision us enlarging the pages of the report and making them into placards we could carry at demonstrations," Greenspan concluded. "We would carry these signs and shout, 'Here's your report, now live up to your promises!'"

—filed from Boston

Prisons

Continued from page 1

Commission states that its findings are "sobering and troubling." It cites facts and statistics to prove how HIV has become a severe health problem in prisons, and it makes grave predictions about future prison conditions if officials don't implement progressive and humane HIV care policies.

Most importantly, the Commission affirms the fundamental right of all prisoners to receive proper medical care, and explicitly reveals how prisoners' rights are repeatedly violated by HIV discrimination, poor education and counseling programs, and inadequate medical attention in prisons.

Key proposals in the report include recommendations for giving HIV-positive prisoners greater access to drug treatments and clinical trials, and focusing more attention on the medical needs of imprisoned women and adolescents. In addition, the report advises that extensive HIV education programs be developed for prisoners, prison

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Change medical care

Dear GCN:

Greetings. I am an inmate currently being housed at the California Institution for Men's East Facility. To be more specific, Del-Norte, SPU. It is where the inmates who have tested positive for the HIV virus are housed.

The reason for this letter is not to cry or complain about having the virus but to let some people exactly how the CIM-E treats HIV infected inmates.

For the most part the medical care here is the pits. Del-Norte is supposed to be an AIDS/HIV unit, yet the staff (MTAs, Doctors and others) treat it like nothing of the kind. It's basically like this around here; if an inmate needs treatment, the inmate must almost be on his deathbed before he gets proper medical care. Too often I have seen it happen, a man gets to the point where they finally do something and by that time it is too late. The inmate doesn't come back.

There is *no* AIDS/HIV specialist here at Del-Norte. The people who work as the MDs are most often people that know very little about the disease itself. I have looked into some of the reasons why Del-Norte still lacks the proper medical staff to deal with situations in here. The result of that came out to be, they don't want to spend the money on things like that.

In my opinion, there should be a specialist to deal with us instead of just a person who thinks he knows something. There should also be a dietician to plan meals and help out in that area.

The security staff here at Del-Norte do their job. There is nothing that can be said bad about them. They follow the general orders handed to them. For the most part Del-Norte is just like any other place in the system.

If I could change its medical care it would make a big difference to a lot of people. I guess what I want to do is ask if anybody has a suggestion on helping us get proper medical care, please contact me. Thank you.

Jacque Ferguson

E17686-302

P.O. Box 500

East Chino, CA 91708

Prison Settles a Lawsuit on AIDS

PHILADELPHIA, May 27 (AP) — A county prison has abandoned its policy of segregating inmates with the AIDS virus to settle a lawsuit filed on behalf of prisoners who carry the virus.

The Delaware County Prison also agreed Friday to make broad changes in the way it treats prisoners who test positive for the virus, including AIDS education for staff and inmates, counseling for victims, and confidential testing for inmates who request it.

"I think that prisons are going to pay attention to this," said Lynanne B. Wescott, the inmates' lawyer.

'Comprehensive AIDS Settlement'

Scott Burris, counsel to the American Civil Liberties Union's AIDS and Civil Liberties Project in Philadelphia, called the agreement "the most comprehensive AIDS settlement ever reached in a case involving a county jail."

The Delaware County Prison began separating inmates with the AIDS virus in an infirmary in 1988. About 50 of the prison's 1,100 inmates have voluntarily identified themselves as infected with the virus.

As many as 15 inmates at one time lived in the 20-foot-long room, which included a shower, a toilet, a television and a radio, Ms. Wescott said.

Ms. Wescott filed a Federal lawsuit in January 1990. After more than a year of negotiation, the prison agreed to most of the inmates' demands, and court papers to that effect were filed Friday, Ms. Wescott said.

"I was flabbergasted at the amount of cooperation that we did receive," she said.

Under the settlement, the prison will no longer admit prisoners into the infirmary solely because they have the virus.

The prison will also add educational material on acquired immune deficiency syndrome to a handbook all inmates receive when they enter the prison, and offer confidential testing on request.

The National Commission on AIDS has reported that AIDS cases in prisons increased by six times between 1985 and 1989. About 5 percent of the inmates in Philadelphia-area prisons have the AIDS virus, Ms. Wescott said.

147 5/28/91

Prisoners form AIDS education program

The AIDS Education Workshop is run for -- and by -- prisoners

By Elizabeth Yukins

NORFOLK, Mass.—At a time when budget cutbacks are severely hampering state health care programs, a group of prisoners have taken the task of AIDS education into their own hands. In a startlingly progressive program, prisoners have joined together to form an AIDS workshop that teaches other prisoners the causes, symptoms, and effects of HIV- and AIDS-related illnesses.

"The program came about when a bunch of guys began to see the pain of HIV-positive people in the prison," said Doc, the director of the AIDS Education Workshop. He told GCN, "The program is aimed at creating a better understanding of AIDS and a little more compassion for those who are HIV positive."

Doc, who asked that his real name not be used, has been involved with the AIDS project since it began at Mass. Correctional Institute, Norfolk in December 1989. At a conference designed to introduce the AIDS Workshop to the public, Doc reported that 26 trained prisoners now staff the project, and that over 1300 Norfolk prisoners have graduated from the AIDS awareness classes.

Doc said that the program is bilingual, and he stressed that it is run by a "diverse and multicultural board of directors." He also said that the program seeks to educate the prisoners about all different AIDS risk factors. "We teach the men that drug use can infect a person with HIV," he said, "but during the course of our classes men become very aware of dangerous sexual practices too."

The Norfolk program is unusual in the United States prison system because it has been completely initiated, organized, and funded by prisoners. Judy Greenspan, the AIDS information coordinator of the American Civil Liberties Union National Prison Project, praised the prisoners efforts, saying, "Norfolk is a prison in the forefront of peer education and counseling."

Greenspan told GCN that the peer model for AIDS instruction "is the best and most enlightened way to reach prisoners because the men are more likely to believe and

identify with one another."

She explained that the "official" version of AIDS education consisted of an outdated video and a 10-minute lecture from a correctional officer. "This information is rarely even listened to," Greenspan added, "because often a man has just entered the prison system and is feeling disoriented and withdrawn."

Tim Gagnon, the AIDS coordinator for the state's Department of Correction (DOC), echoed Greenspan, saying that the workshop "gives the men three and one-half hours of solid AIDS education, and it is taught to them by people they live with and trust." Gagnon has been involved with the project since its inception, and numerous prisoners commented to GCN that he was instrumental in getting the prison administration to accept the program.

Discussion about an AIDS workshop began in October, 1989, when a group of prisoners approached Gagnon about the need for AIDS education. Gagnon and the DOC's Department of Health then began working with prisoners to design the program and establish a 16-week educational course to train prisoner instructors.

The AIDS education project is divided into a two-session workshop. In the first class, prisoners are taught history about AIDS and HIV, disease definitions, how HIV is transmitted, and symptoms of AIDS- and HIV-related illnesses. In the second session, the men are instructed on the importance of HIV testing and confidentiality, and the prevention of HIV transmission. They also learn how to obtain treatment information.

"Often the teaching is difficult," Doc said, "because a lot of the men don't read and write well." The Workshop has responded to this problem, he explained, by breaking down AIDS information and the curriculum's format into very basic categories.

Gagnon told GCN that approximately 360 prisoners in the state prison system are currently identified as having AIDS. He said, however, that this is a very low and rough figure because the state only

Continued on page 7

Prisoners

Continued from page 3

recognizes those prisoners who are HIV positive and have full-blown AIDS-related illness. In general, Gagnon said, "We only know that about one in 30 prisoners carry the HIV virus. This means that there is two-thirds of the prison population that we don't know about."

Similarly, Judy Greenspan said that while there have been 7,000 reported cases of AIDS in prisons throughout the country as of November 1990, she believes that this too is a low figure.

Greenspan said that there are similar types of prisoner-initiated AIDS education programs in New York State, but that prisoners there "have run into a lot more red tape." She said that the Massachusetts program is by far the "most sanctioned by prison officials," and that in New York prisons there has to be "a lot of underground activity."

"The fact that Norfolk had a public press conference shows the strength of their AIDS program," said Greenspan. "If the administration didn't support the project, it would have been squelched right away."

On a national scale, Greenspan said she doesn't "foresee any correctional administrations starting this type of program themselves." She explained that, "Prisons operate on control relationships, and often administration officials feel nervous about independent prisoner initiatives."

However, Greenspan said she does "see similar programs being started through the influence of outside AIDS and prisoner advocacy groups." She also said that she believes ex-prisoners could play a critical role in setting up these workshops "if they are willing to return to the prisons and help the prisoners to convince the officials and organize the programs."

Doc said that the Norfolk program has been so successful because the instructors have taken the time to work individually with the prisoners, and because many of the prisoners "have a personal experience with AIDS." He explained, "Either they know someone who is HIV positive, or they know someone who has died."

"I saw that the program worked," Doc said, "when I was standing in the line at the prison canteen, and I heard one guy make a joke about another guy at the front of the line who was HIV positive. His friend, who had been through the AIDS workshop, turned to him and said, 'Hey, cool it, that could be you.'"

Correction

A photographer's credit was inadvertently left out of the Jan. 21-27 edition of GCN. The photo of the Dec. 8 demo in memory of the Montreal Massacre was taken by Jane Cleland. GCN regrets the error.

Higher AIDS rate found in prisons

BALTIMORE (AP) — More inmates enter prison carrying the AIDS virus than previously thought and women prisoners have a higher infection rate than men, according to a new study.

The study's principal researcher said the higher overall rate reflected a broader sampling of prisoners nationwide. But the higher infection rate among women — almost 50 percent higher at some prisons — came as a surprise.

"The higher rate for women inmates is in direct contrast to the higher HIV-1 infection rates found in other U.S. groups," said David Vlahov, an assistant professor at Johns Hopkins University.

The New Journal 3/6/91

HIV prisoner support

Dear GCN:

I would like to thank you for your support in our struggle to institute a Peer Support Group for HIV positive prisoners here at Attica. After numerous meetings with the administration our proposal was approved. It included outside speakers and inside group discussions on feelings about HIV status; concerns with deteriorating health and death; living with HIV in prison; responsibility and means to be sure not to spread the virus; promoting better care of one's health; relating to family and friends about this condition; and available outside resources.

I would like to stress for prisoners around the country that if there are no HIV peer support groups (run by prisoners for prisoners), take the initiative and draw up a proposal and submit it to the administration. If you need help, write to me and I will be glad to give you any information I have. It is a proven fact that such groups ease the stress of living with HIV and greatly extend your life expectancy.

When I was first diagnosed in January 1989, I was in solitary confinement, in a room in the hospital with a solid door on it and allowed no human contact for 90 days, except the guard and the nurse who brought food and medication. It would have been easy just to lay down and die, but I got so mad at the way I was being treated for being HIV positive that I refused to give in and decided to stand up and fight.

I would also like to thank the guys working with me here: David Gilbert, David Hunter and Cruz Salgado, for giving me the strength to go on. Our goal is to have an office staffed by inmates to offer pre- and post-test counseling, and to do educational seminars for general population.

If there is anybody who would like to help us with literature or videos about living with AIDS or HIV, they are greatly needed and will be appreciated.

In closing this letter I would just like to say to everybody who is HIV positive, whether in prison or free, that there is hope and don't give up. Stand up and fight for your rights as a human being and to be treated as such.

Sincerely,
Joseph Keller
86A 0508

Box 149
Attica, NY 14011

PWAs win landmark case in Conn.

The state Department of Corrections settles a lawsuit that calls for adequate and confidential medical services for prisoners with AIDS and HIV. A district court is expected to ratify the settlement in early December.

By Laura Briggs

HARTFORD—Lawyers for Connecticut prisoners recently announced a groundbreaking settlement of a lawsuit demanding appropriate and confidential medical services for prisoners with AIDS. The settlement, hailed by some as the most progressive yet in the U.S., has been approved by the Department of Corrections (DOC) and is awaiting ratification by a U.S. District Court Dec. 4.

The agreement provides for the establishment of infectious disease specialist services at every facility, access to special diets, appropriate drugs, and referrals for prisoners when they are released. It also limits access to prisoner files by Corrections staff and requires that health care providers examine and question prisoners away from other inmates and staff. Prisoners entering the system who are deemed to be at high risk for AIDS would be offered HIV testing and counselling.

"With this settlement, Connecticut has the most enlightened policy in the country," said Judy Greenspan of the Prisoner Project of the American Civil Liberties Union (ACLU). "It's a very significant step forward."

The settlement marks the end of a two-year battle by prisoners, the Connecticut Civil Liberties Union (CCLU), and Yale Legal Services to force state corrections officials to halt abusive practices against prisoners with AIDS. When the class action suit was filed in August, 1988, corrections officials were marking the cells and the belongings of HIV positive prisoners with prominent red dots to indicate their status. According to Shelley Geballe of CCLU, prisoners often discovered the results of an HIV test "when red dots started appearing on all of their stuff."

In addition to the absence of HIV post-test information and counselling, the state DOC failed to provide adequate medical care. "Medical care was inadequate, as a baseline, and there was no continuity of care," Geballe told GCN. "Often, when prisoners were transferred, their medical records were not transferred with them, and someone who had been getting AZT would no longer be able to get it," she said.

The first part of the suit, argued by Geballe and John Pottenger, Jr. of Yale Legal Services, was settled in May, 1989, when the DOC agreed to provide information to all incoming prisoners about AIDS transmission, to abolish the red dot system, and to provide pre- and post-HIV test counselling.

Geballe said the settlement on that part of the suit came when "it became apparent that the state's own witnesses were sounding like ours. They were talking about the need for confidentiality and pre- and post-test counselling," during a 16-day hearing. After that initial hearing, the state decided that negotiating a settlement would be less costly than continuing to litigate the case.

After a year of further negotiation, the two sides have reached a new agreement, filed in U.S. District Court Oct. 31. A "fairness hearing," required under federal law for all settlements in class action hearings, is scheduled for Dec. 4.

The new settlement provides for more strict confidentiality. Inmates will be able to file their requests for medical care in a locked box, and health care staff must privately—and promptly—inform them of the results of any medical tests.

The agreement also provides for improved continuity of care, as well as a strict schedule of medical screening and health care for prisoners who are HIV positive or who have AIDS. Health care providers must also inform prisoners about the nature, risks and benefits of any medical treatment before it is undertaken. And, perhaps most importantly, the settlement provides for a monitoring board that includes representatives from CCLU and Yale Legal Services, as well as the state, that will make regular reports about prisons' compliance with the agreement.

Connecticut at the forefront

This is not the first time that litigation in Connecticut has provided a significant victory for prisoners who are HIV positive or have AIDS. In *Doe v. Meecham*, the state was forced to stop segregating prisoners with AIDS. And, she said, "When Massachusetts saw that Connecticut was mainstreaming prisoners with AIDS, Massachusetts did it on its own." (See GCN, Feb. 25 1990) Shortly afterward, following a similar victory for prisoners in California, Arizona also desegregated its prisons.

The ACLU is currently appealing a decision in Alabama that allows a quarantine policy (see GCN, Feb. 4, 1990).

In addition, recent legislation and legal action have put Connecticut at the forefront in releasing terminally ill prisoners. A "compassionate release" program allows prisons to release inmates who do not pose a "risk to society" and who are terminally ill.

Continued on page 3

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Prisoners

Continued from page 1

Formerly, prisoners either died in prison or were released only when they were at the point of death.

The Connecticut medical settlement, says Greenspan, "in some sense proves what we have been saying all along—that it is economically more feasible for a state to provide decent care for prisoners with AIDS" because of the high cost of lawsuits and liability. (The settlement allows Connecticut prisoners to preserve their right to sue if they believe their health was irreparably harmed by DOC policies. According to Geballe, a number of prisoners have chosen to exercise that option, and may pursue individual lawsuits against the state.)

Improved medical care, however, does not by any means solve all the problems for prisoners with AIDS, said Greenspan. "Prison is medically—and in every other way—the worst place for people with AIDS and HIV," she said. Even if a prison could provide all of the services and medical care that were available to people outside, "the difference between being in prison and not being in prison is control. And we know that people who are involved in their treatment live longer," said Greenspan. "A three-year sentence for a prisoner with AIDS is a death sentence," she said. However, Greenspan added, the Connecticut settlement is still "a very significant step forward."

HIV Infection among Prisoners

Judy Greenspan

The fear that HIV infection is running rampant among incarcerated populations has led to a scramble for new prison policies. Federal and state prison systems and county jail administrations in the United States have responded to this perceived threat in different and conflicting ways, often to the detriment of the health and welfare of prisoners. Among the issues state lawmakers and corrections officials most frequently debate are mandatory HIV antibody testing, segregation of HIV-infected inmates, and the appropriate medical care and education programs for prison populations. This article examines these issues.

In the United States, there are three levels of prisons. The Federal Bureau of Prisons operates institutions for those convicted of crimes against the federal government. Each state operates facilities housing prisoners convicted of state crimes. Cities and counties operate hundreds of jails used, in general, for short-term incarceration or pretrial detention. There are over 500,000 men and women incarcerated in U.S. institutions, a disproportionate number of whom are Black, Latino, Native American and poor.

While prisoners lose many of their civil rights when incarcerated, the courts have ruled that the most basic constitutional rights must be preserved, including: the right to live free of cruel and inhuman conditions, the right to adequate medical care and sanitation, the right to communication and free speech, and the right to due process. Many state prison systems, however, are understaffed and unsafe for their growing prison populations.

Incidence of HIV Infection in Jails

The incidence of AIDS is increasing in prisons and jails, but this is not necessarily due to an increase in the transmission of HIV within the inmate population. A 1987 survey by the U.S. Department of Justice, National Institute of Justice (NIJ) shows that seroprevalence in prisons has increased 190 percent since 1985.¹ A 1988 study by the American Civil Liberties Union (ACLU) National Prison Project demonstrates a similar rise in HIV infection.

Both studies suggest that increased testing for HIV antibody in prison populations may be one reason for the apparent rise in seroprevalence. According to the NIJ study, "Incidence rates are predictably higher...because of the concentration in inmate populations of persons with histories of high-risk behavior, particularly intravenous drug use." In addition, the studies note that the rise is consistent with the increased incidence of AIDS in the general population. The largest number of AIDS cases—both inside and outside prisons—is concentrated in the Mid-Atlantic states of New York, New Jersey and Pennsylvania.

Many states have conducted their own seroprevalence studies of incoming prisoners. These results range from 0.2 percent in Indiana to 17 percent in New York, with seroprevalence in most states falling below 1 percent. The rates in a given prison or prison system correspond directly to the rates in the non-prison population that feed that facility or system.

The big unknown for most corrections and public health experts is the rate of HIV transmission within prisons. The Maryland Division of Corrections recently completed two studies

on transmission. The most recent study showed an infection rate of 0.5 percent a year. (See Recent Reports below for information on this study.) This low transmission rate, however, does not mean the AIDS incidence in Maryland prisons will decrease.

The results imply that the high rate of HIV infection among Maryland prisoners is due primarily to exposure to the virus prior to incarceration. Transmission studies in both New York and Florida have yielded similar results and medical experts conclude that the risk of transmission of HIV to seronegative I.V. drug users is likely to be much greater outside than inside prison.²

To date, there have been no cases of transmission of HIV from a prisoner to a corrections officer.

Testing Policies

In 1987, the Federal Bureau of Prisons (BOP) conducted mandatory intake testing for all federal prisoners over a six-month period. This testing revealed a low seroprevalence of HIV infection, 2.44 percent, among incoming prisoners. (Note that this represents a high seroprevalence rate among the general population). At present, the federal system does not test on intake except for occasional 10 percent random samplings. BOP does test 60 days prior to release. Prisoners testing positive must inform their spouses or sexual partners as a prerequisite to release from prison. BOP routinely informs parole and probation officers about the antibody status of ex-prisoners.

The experience of the AIDS epidemic inside prisons reflects the experience outside prisons. There is isolation, fear, pain, loss, and depression, as well as healing, support and community.

There is a growing trend among state departments of correction to conduct forced testing of the prison population. More than 13 states now conduct entry testing on all prisoners. In addition, more than 20 states have mandated HIV antibody testing for people convicted of sex and drug-related offenses. A provision of the recently passed federal Health Omnibus Bill enables the federal government to withhold funding from states adopting testing of only those convicted of sex and drug related offenses. The effect of this bill may be to encourage states to adopt mandatory testing programs for all prisoners.

A shrinking number of states test only prisoners who display certain AIDS-related symptoms or who voluntarily request to be tested. Public health advocates strongly support voluntary testing.

Confidentiality of test results is rarely protected in prisons, even in systems where testing is voluntary. Usually, prison staff are told the names of prisoners who have tested positive. In addition, actions, such as quarantine or confinement to a single cell, indicate to staff and other prisoners that an inmate is seropositive.

Housing and Medical Care Policies

In the early 1970s, the substandard medical care of prisons was challenged in the courts. In a landmark case, *Estelle v. Gamble*, a standard was set whereby prison systems must provide some degree of accessible and adequate medical care for prisoners. In the early 1980s, the courts ruled that prison conditions, including housing, must not constitute "cruel and unusual punishment."

continued on page 2

HIV among Prisoners. . .

continued from cover

Housing policies for HIV-infected prisoners and prisoners with AIDS differ among prison systems. Alabama has one of the harshest housing policies. The state segregates seropositive male and female prisoners in separate HIV units. When the two HIV units were first established in 1986, HIV positive prisoners were forced to wear masks. The women were told to wipe telephone receivers with alcohol after making phone calls. While these practices have ceased, the segregation remains and the HIV prisoners are not allowed to attend vocational school, participate in work release or community custody programs, or hold jobs within the prison facility.

At the other end of the spectrum, the Maryland Department of Corrections does not house HIV-infected prisoners separately, preferring to "mainstream" these prisoners with the rest of the prison population. Seropositive prisoners live, eat and work with uninfected prisoners. The Maryland approach tends toward medical surveillance and education of the prison population rather than testing and segregation.

In 1989, almost 20 years after *Estelle*, medical care offered by most prisons and jails is still inadequate. For HIV-infected prisoners, this substandard care can be deadly. A 1986 study by the New York State Commission of Correction found that state prisoners with AIDS lived only half as long as people with AIDS outside of prisons.³ The main cause of the high prison mortality rate was the deficiency in medical care.

In many prisons, housing and medical needs of prisoners with AIDS are neglected because of inadequate staffing and poor staff education. Inadequate medical treatment is related to medical staff fears of HIV transmission from prisoners with AIDS, and the lack of experience and training among staff in caring for these patients. Finally, while most prison systems have some kind of compassionate release program for terminally-ill prisoners, most do not handle requests quickly enough to be effective for prisoners with AIDS, who may die before the requests are processed.

Education and Counseling

Comprehensive AIDS education and counseling, for prison staff as well as inmates, are two weapons that can be used by prison and jail administrations to combat the AIDS epidemic. Administrators have a responsibility to teach both safe sex and clean needle practices to a prison population in which unsafe behaviors occur. Condoms are available in only a handful of prisons and jails throughout the U.S. Programs that provide bleach for cleaning needles or needle exchange do not exist in any prison.

A joint study conducted by the Oregon State Health Division and the state's Department of Corrections, found that counseling, not mandatory testing, helped prisoners change their high-risk behaviors.⁴ Some prisoners opted for voluntary testing following counseling and an even greater number of prisoners learned about the importance of changing high-risk behaviors. Following this study, the Oregon state legislature approved the funding needed to begin a comprehensive voluntary HIV counseling and testing program in the state's prison system.

Most states provide some kind of AIDS education for both prisoners and corrections staff. However less than 50 percent of the state departments of correction surveyed in a recent NIJ study provided live training presentations, which NIJ found to be the most effective vehicle for AIDS education. Most educational programs consisted of the distribution of brochures and the presentation of a videotape, during one-time orientation sessions for prisoners or staff. The NIJ study found the most commonly used video to be out-dated and sensationalistic, and expressed the concern that written material was inadequate in prisons, where the rate of illiteracy is high. In addition, AIDS education requires periodic updates for both staff and prisoners.

In prisons across the country, prisoners have begun to develop their own AIDS education curriculum. Corrections administrators have not welcomed these attempts. The National Prison Project substantiated complaints including: prisoners at a New Jersey facility that houses a large number of men convicted of sex-related crimes were denied permission to receive copies of the US Surgeon General's brochure, "Understanding AIDS"; and prisoners in New York State complain that their attempts to organize AIDS awareness programs have been sabotaged by a reluctant prison administration. A prisoner in Massachusetts who prepared an AIDS course curriculum has alleged that he was abruptly transferred to another institution after submitting this document to the warden.

The AIDS Counseling and Education Program (ACE) at Bedford Hills Correctional Facility, a New York state women's prison, was established by five prisoners. While the program was approved initially by state prison administrators, administration obstacles forced ACE to suspend operations for about a year. Over the past few months, the program—comprised of peer counseling, a buddy support program, pre-and post-test counseling, and classroom presentations—is in full operation.

Conclusion

It is important to realize that the experience of the AIDS epidemic inside prisons reflects the experience outside prisons. There is isolation, fear, pain, loss and depression, as well as healing, support and community. Many health and legal professionals agree that the medical, educational and testing approaches to AIDS in prisons should reflect the approaches used outside. Oppressive conditions, such as overcrowding, quarantine and substandard medical care, may constitute cruel and unusual punishment and should be a prime concern of health providers, educators and corrections administrators.

AIDS is not running rampant in prisons, but misinformation and discrimination are. Health professionals and AIDS services agencies can play an essential role in developing positive AIDS programs for prisons and jails by offering education and counseling services to prisoners and prison systems. In addition, they can facilitate this effort by devoting money and resources to these issues, especially in situations where prison systems are reluctant to support such programs themselves.

Judy Greenspan is the AIDS Information Director of the ACLU National Prison Project, legal advocates dealing with prison conditions. The AIDS Information program provides information and education to prisoners, prison administrators, educators and the media, and monitors government policy on prisons and AIDS.

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- For a complete list of references, please write Judy Greenspan at the National Prison Project, 1616 P Street, NW, Suite 340, Washington, DC 20036.

Request for Submissions and Comments

We invite readers to send letters responding to articles published in **FOCUS** or dealing with current AIDS research and counseling issues. We also encourage readers to submit article proposals, including a summary of the idea and a detailed outline of the article. Send correspondence to:

Editor, **FOCUS: A Guide to AIDS Research and Counseling**
UCSF AIDS Health Project, Box 0884
San Francisco, CA 94143-0884

Views from Inside: Prisoners Offer Perspectives about AIDS

Juan Rivera: Emotional Reactions

People who are imprisoned often are overcome with a sense of loss. For most of us, though, it's more than a feeling: we actually lose our wives and children, and even our parents give us up to the care of the state. Under these conditions, freedom is something we never forget. But, once diagnosed with HIV infection or AIDS, prisoners feel condemned to death. And the reality is that most prisoners with AIDS will die in prison.

It is especially hard for HIV-infected prisoners whose families reject them and refuse to communicate with them. A man like this really hurts, because he believes he is going to die and wants the chance to face his family, to tell them that he loves them and to hear that they love him, to explain his illness and the cause of it, and, if he finds it necessary, to express some of the guilt he feels. When this emotional release is denied, these prisoners are at their most vulnerable. They become overwhelmed with depression, loneliness and despair.

At the Greenhaven Correctional Facility in New York, where I have been incarcerated for five years, many prisoners are losing friends to HIV infection. To deal with this situation and an environment that drives prisoners with AIDS to give up on life, we formed the Health Crisis Action Committee (HCAC). Our objective is to improve living conditions for prisoners with HIV infection. We advocate mandatory AIDS education; peer counseling; expanded and better medical care; social workers assigned specifically to HIV-infected prisoners; family therapy groups; new provisions to allow the release of terminally-ill patients; more risk reduction education and counseling for the general population of prisoners; and anti-discrimination measures to protect prisoners.

HCAC adopted a buddy system, developed by women prisoners at the Bedford Hill Correctional Facility, to provide care and support to prisoners with HIV-infection. Volunteers from among the prison's population provide practical support, such as writing letters, serving as interpreters, and providing information. But, the most significant contribution we offer is the emotional support of listening. To be a good listener and facilitate emotional release is essential to the mental well-being of these men.

HCAC also organizes weekly support groups for HIV-infected prisoners that meet without administrative involvement. The atmosphere of these meetings is comfortable and open. Men speak honestly about homosexuality or I.V. drug use, for example, without the fear of disciplinary actions from the prison administration. Many prisoners are concerned that since prison staff do not understand the lifestyles of prisoners, administrators would secretly denigrate us at such support meetings where we are at our most vulnerable.

In addition to programs for HIV-infected prisoners, programs must be developed for continuous risk-reduction education for the general prison population. But education must be done with a sensitivity to the prison society. For example, although homosexual relationships are a reality of prison life and may once have been overt, they are now secret occurrences. The fear of being labeled HIV-infected by guards and fellow inmates is as great among prisoners as the fear of contracting the virus itself, since prisoners with HIV may be ostracized. This complicates the job of prison educators trying to reach men who engage in homosexual activities.

Some prisoners who continue to practice high-risk activities believe that fate will determine the outcome of their lives. It is common to hear prisoners say, "If I'm gonna get it, I already have it," or, "If I haven't already gotten it, I'm not gonna get it." Many prisoners believe that a cure for AIDS has been developed, but that there is a government conspiracy to keep this secret, particularly from so-called undesirables like prisoners.

Ongoing education, including statistical information, can help prisoners evaluate this sort of speculation and help them realize that fate is in their own hands. It can also teach them about drug use, nutrition, exercise and other practices and their effects on health and the body's ability to fight HIV infection.

All of these ideas are great, but what good are they if we cannot put them into practice? Our buddy system and self-help group are working fine, but how long before the prison administration stops them? And how long before they get tired of trouble-making prisoners like myself and transfer us to another prison? For these reasons we keep most of our efforts independent from the prison administration.

David Gilbert: Educating Prisoners

AIDS is now the main cause of death in New York state prisons. Prisoners with AIDS average only one-half the survival time, from diagnosis to death, as people with AIDS in New York City. Yet prison administrators continue to ignore the scope of this problem.

New York state prison officials claim that there is no "apparent" spread of HIV among prisoners, that sharing needles and sex are now rare. We prisoners know differently. These activities are common, and the situation is more serious in prisons than on the streets because condoms, needles, and disinfectants are contraband and rarely found in prisons. Unsterilized needles are widely shared and condoms are seldom used.

Peer education, so successful in the control of AIDS in the gay community in San Francisco, is doubly important in prisons, where there is a gut distrust of authorities and professionals, and where the very activities that must be discussed frankly — sex and drugs — are against prison rules. Peer education is also an effective way to ease fears of casual transmission among prisoners and to promote support among inmates for people with AIDS, who are often ostracized and isolated in prisons.

The motivations for sexual and drug-using practices are strong and deep, and people will go to great lengths to deny the dangers involved in these practices unless they are presented with positive alternatives. Many prisoners however, can change high-risk practices when someone they trust works with them in a detailed and painstaking way over time.

Three key criteria define a program that can reach prisoners and make a change. It must be sponsored by an outside organization whose primary work is AIDS and counseling; it must provide extensive prisoner-to-prisoner education; and it must be ongoing, thorough, and persistent.

More specifically, a successful prison AIDS program must: train inmates as AIDS education counselors; develop seminars directed at existing inmate organizations and coordinate these with substance abuse programs; provide pamphlets and programs in languages other than English; provide pre-release HIV transmission counseling; and provide counseling and support for prisoners already infected with HIV.

Juan Rivera is studying computer science while serving a term of 10 years to life at the Greenhaven Correctional Facility in New York. In addition to his involvement in HCAC, he is a member of *Hispanics United for Progress*, a prison interest group. **David Gilbert** is a New York State prisoner who founded the Prisoner Education Project on AIDS at Auburn Correctional Facility in 1987. He believes he was transferred to Clinton Correctional Facility as a result of his proposal for an AIDS education program.

Recent Reports

World Health Organization Statement on AIDS and Prisons. Global Programme on AIDS: Statement from the Consultation on Prevention and Control of AIDS in Prisons; WHO/SPA/INF/87.14, November 1987.

After a three-day conference on AIDS and prisons, experts from 26 countries recommended a variety of measures including: improvement of the overall hygiene and health facilities of prisons; education of prisoners about the risk of HIV infection from sharing needles during intravenous drug use and high-risk sexual behavior; maintenance of the same level and quality of education, treatment, serological testing, and care inside prisons as exists in the community outside of prisons; use of compassionate release for prisoners with AIDS; guidance for prison staff so that HIV-infected prisoners receive humane treatment; and provision of condoms and, perhaps in lower-security institutions, of sterilized needles.

Seroprevalence and Transmission in Prisons. University of Iowa and the Iowa Department of Corrections (*American Journal of Public Health*, April 1988). Maryland State Division of Corrections and Johns University (*AIDS*, 1988, Vol. 2, No. 5).

Two recent studies examined HIV seroprevalence and transmission in prison populations. The first found three of 859 predominantly young, white men (0.3 percent) tested HIV antibody positive upon entrance to the Iowa prison system, despite the fact that over 20 percent reported using I.V. drugs and about 5 percent reported engaging in homosexual behavior.

The study population included 363 prisoners, incarcerated for the first time, 389 prisoners who were returning to prison and 107 forensic psychiatric patients. The Iowa researchers predict that as the presence of HIV increases in Iowa, HIV seroprevalence among prisoners will increase.

In the second study, Maryland researchers found that two out of 393 prisoners (0.5 percent) seroconverted while incarcerated over a two-year period. The researchers conclude that while this number is low, the results provide the strongest evidence to date that transmission of HIV does occur in prisons.

In 1985 and 1986, blood samples for HIV analysis were taken during routine blood drawing of all male prisoners entering the Maryland prison system. Of the 2,286 prisoners initially sampled, 422 were still incarcerated in 1987, had completed a demographic survey, and were willing to provide another blood sample at that time. Twenty-nine (6.6 percent) of the 422 were found to be HIV seropositive at the time of incarceration and were not included.

Reducing Risk of Infection among Incarcerated Drug Users. Lenape Valley Foundation, Doylestown, Pennsylvania and Bucks County Correctional Facility. (*Hospital and Community Psychiatry*, September 1988).

Incarcerated drug users are fairly knowledgeable about HIV infection and transmission; and those who take the most effective steps to avoid transmission are likely to perceive external influences, such as chance or powerful others, rather than themselves as having control over their lives.

Fifty-eight drug-using inmates of a medium-security prison participated in a survey including three scales: an AIDS knowledge profile, a drug-related behavior profile and a test of a person's

expectations of locus of control (sense of whether the control in a person's life is external or internal). Researchers classified 27 inmates as intravenous drug users and 31 inmates as nonintravenous drug users. The two groups did not differ significantly by age, educational level or race.

Members of both groups responded correctly to about 60 percent of the factual items relating to AIDS knowledge, including the principal modes of transmission. Fewer than half, however, knew the length of the HIV incubation period or the fact that individuals need not be symptomatic to transmit the virus. Only 26 percent of the I.V. drug users knew that asymptomatic individuals could transmit HIV by sharing contaminated needles.

The researchers classified as maximal risk reduction the substantial changes made by I.V. drug users to avoid contracting HIV: no longer sharing needles or shooting drugs. They classified other changes—cleaning needles, avoiding shooting galleries and reducing I.V. drug use—as partial risk reduction. A higher percentage of partial risk reducers reported daily drug use. The researchers warn that use of partial risk reduction measures, which are not completely effective, may create a false sense of safety and decrease motivation to engage in more appropriate risk reduction.

Finally, the researchers found that maximal risk reducers were more likely to rely on external influences to make decisions than were partial risk reducers, who tended to rely on internal influences.

Next Month

Although the sexual behaviors of bisexual men and gay men may be similar, bisexual men differ in their concerns about their sexuality and HIV infection, and in their reactions to AIDS education and counseling. In the June issue of **FOCUS**, **Jay Paul, PhD**, a researcher at the University of California San Francisco and a faculty member of The Institute For Advanced Study of Human Sexuality, offers insights into bisexual identity and AIDS prevention strategies.

In some cultures, bisexual behavior may occur among people who do not identify themselves as either gay or bisexual. In the June issue, **Ernesto de la Vega**, an AIDS trainer and a staff member of the Brooklyn AIDS Task Force, explores AIDS and bisexuality among Latino men.

FOCUS Changes. We have instituted some major changes to better serve our readers. Our new name more accurately reflects our commitment to exploring relevant counseling issues. We have redesigned our layout to allow for easier reading, and to continue to provide the depth of information our readers have come to expect. We have added a box on page 2 that encourages readers to communicate with us. **Larry Cichosz** and **Joseph Wilson** executed these changes.

We have also instituted changes in staffing. **Michael Helquist**, Editor of **FOCUS** since its inception in December 1985, is now Founding Editor and Advisor. He will continue his work as a Program Officer for AIDSCOM, a Washington, D.C. group providing AIDS education and training in developing countries. **Robert Marks**, formerly Assistant Editor, is now Editor.

FOCUS A GUIDE TO AIDS RESEARCH AND COUNSELING

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gress as a nation in combatting religious intolerance, racism, sexism and xenophobia, discrimination against homosexuals remains socially accepted, intellectually justified and codified in law.

Believing that gay behavior is simply learned behavior, religiously inspired bigots have justified their discrimination by saying that lesbians and gays are misguided in their immoral actions. But as more research points to gay behavior as a biological orientation, it is becoming increasingly clear that talking negatively about homosexuality is a form of physical and emotional child abuse. Physical child abuse because talking negatively about homosexuality encourages anti-gay violence; emotional child abuse because talking negatively about homosexuality teaches a child to hate himself or herself.

Recently, the U.S. Department of Health and Human Services released a report that estimated that lesbian and gay youth "may comprise up to 30 percent of youth suicides annually." Citing that suicide was the leading cause of death among young lesbians and gay men, the report called for an end to discrimination on the basis of sexual orientation.

Thousands of lives were lost at the hands of the KGB before they had the courage to admit their errors. Hundreds of lives were lost in flights to freedom before the East German government had the courage to admit their error in constructing the Berlin Wall. How many lives of young gays and lesbians will be lost by suicide or rendered dysfunctional by internalized and external homophobia before our political and religious leaders have the courage to admit that they too have been wrong? Homophobia is the illness, not homosexuality.

Our democratic freedoms and the economic prosperity those freedoms create have served to inspire people worldwide. Let us respond to the courage of the Eastern European and Soviet Communist leaders in launching their reforms by destroying the remaining walls of prejudice within our own society.

In recent generations, we have seen many leaps of consciousness as the bigotry of the day has been rejected. It is time for another leap of consciousness. It is time for society to recognize the legitimacy of homosexual love and to welcome its gay and lesbian citizens as equal citizens under the law. It is time for our nation to fulfill its national destiny by ending discrimination once and for all.

Neil Isbin
Albuquerque, N.M.

Prisoner AIDS education and treatment programs: battling the odds

[GCN received this letter from Cruz Salgado, a prisoner instrumental in establishing a buddy and peer counseling program for prisoners at Green Haven Correctional Facility, N. Y. — Ed.]

Dear GCN,

When transferred from Green Haven to Attica Correctional Facility, I immediately noticed not a few drastic differences in the climate of environments, attitudes and personalities. These upsetting turn of events propel me to make the following commentary.

It's so true that one never knows whether the grass is going to be greener on the other side until one is actually there. When it comes down to the rights, conditions, privileges and common courtesies offered PWAs (People With AIDS) here at Attica, the "grass" is unattended, stunted, and in a state of devastation.

While at Green Haven, I became seriously involved with the issues surrounding AIDS in prisons. In comparison — if that term suitably can be applied here, which I doubt — Attica is negligent in every sense of the word when it comes to PWAs. There is no education, prevention, therapeutic, or supportive program to speak of. Neither is there an interest to see one developed. Moreover, whenever the rare breed of prisoner arrives with an active interest in developing supportive measures, it is readily discouraged and quickly squashed. This was demonstrated in the case of Mr. Yusuf Shakur, who was "booted out" of Attica for his efforts. It is not my intention to "beat the horse to death" at this point. There is, nevertheless, a very critical issue at stake which needs to be brought to the core: the issue of confidentiality.

Once again we see a revived clamor in the papers about "AIDS programs to help inmates," but looking at Attica, one can only ask where all the "help" is going. The *New York Times* recently wrote about a New York state advisory panel proposing "major" new programs to deal with the ever-increasing epidemic of AIDS among prison inmates. Among the ideal recommendations in its report is the encouraging of testing with privacy protection. This indeed is a lofty aim, however seen in the eyes of the beholder, for the proposition in terms of Attica is remote.

The thought of privacy for anyone — let alone for PWAs — is like a fish in water, too elusive to grasp. As an Assistant Inmate AIDS Educator down at Green Haven, it was necessary to stress the point of confidentiality and the right to pre- and post-counseling when requesting a test for HIV-positive. I distinctly remember the first time I requested to be seen by the nurse ("sick call") here at Attica and thinking how far-fetched the notion of confidentiality is from what is real.

When one applies for "sick call" one does not only speak with the nurse, but with the officer standing there right along with him/her and any given number of inmates waiting to see the nurse as well. "Sick call" here at Attica is held at the front of the "company" (gallery) where there is not room allowing for privacy, and usually, where officers congregate. Not only is there an officer breathing down the nurses' neck,

at times you might also find him/her actually handling medical records. The procedure is right out atrocious. Can you imagine how uncomfortable and discouraging it must feel to confide your wishes for a test as socially controversial as that for HIV? I can, and it scares the "bejeezus" out of me.

To better appreciate the situation — for anyone familiar and who can take a trip back in time prior to the Attica uprising — one must consider this tightly-knit and inter-related, small community of staff where everyone and everything is shared and known as well as the inmate-officer relations which can still be characterized by fear, hostility and mistrust nurtured by racism.

Cruz Salgado
82-A-4688

Attica Correctional Facility
Attica, N.Y. 14011

Readership Survey Update

A big thanks to all you subscribers out there who sent in your readership surveys! We have received phenomenal response (over 1000 surveys returned) and are just now beginning to tabulate the results. Highlights of the results will be printed on these pages in April. Keep your eyes out!

Safer Sex and Drug Use

GCN offers these guidelines for all of us who are making decisions about sex and drug use in the midst of the AIDS epidemic. HIV is a virus widely thought to be a cause of AIDS. The highest concentrations of HIV are found in blood and semen. So it's important to avoid any way in which HIV-infected blood or semen can get from one person's body into another person's bloodstream.

• **Fucking (anal and vaginal) without a condom and sharing needles account for almost all the documented cases of HIV transmission.**

• Oral sex without a condom or dental dam accounts for a very few documented cases of HIV transmission.

• Other ways of transmitting HIV that have not been documented but which could be theoretically risky include: fisting, finger fucking, rimming, deep kissing, sharing uncleaned dildos. The theory here is that any way HIV-infected bodily fluids get from one person into another involves risk. For example, HIV could be transmitted if a person with a cut on their hand fistfucked their partner and caused bleeding in their rectum or vagina.

How to Play Safer

Only you can decide what risks you are willing to take. Some people use safer sex practices with all their partners. Other people make decisions about the risks they are willing to take based on their own and their partners' sexual and drug use history and/or HIV status. People also make decisions based on how comfortable they feel negotiating safer sex in any particular situation. If you and your partner have not talked about past practices and/or HIV status, don't make assumptions. (For example, many lesbians have had unprotected intercourse with a man in the last ten years.)

• **Use a condom when fucking.** On the condoms, use water-based lubricants like KY. Oil-based lubricants like Crisco, Vaseline, and baby oil may make condoms break.

• **Use a condom when sucking dick if your partner is going to come in your mouth.** If HIV-infected cum or pre-cum gets in your mouth, it may get in your bloodstream through cuts in your gums or sores in your mouth.

• **Use dental dams (latex squares) when going down on a woman** if she is having her period or has a vaginal infection. Menstrual blood and secretions from vaginal infections have more HIV than healthy vaginal secretions or urine. No information has been gathered about the concentration of HIV in "female ejaculate."

• **Use latex gloves for fisting or finger-fucking** if you have any sores or cuts on your hands.

• Keep semen and blood (including menstrual blood and blood drawn from piercing, cutting or shaving) out of your vagina, anus, mouth, or breaks in your skin.

• If you share dildos, vibrators or other sex toys, use a new condom each time, or clean toys with hydrogen peroxide or soap and water.

• Alternative insemination may put you at risk. Discuss this risk with potential donors or sperm banks.

• Massage, hugging, dirty talk, role-playing, masturbation (solo, with a partner, in a group) and other activities that don't let blood or semen into your bloodstream are safe.

• Alcohol, poppers or other drugs may lower your ability to make good decisions. Many people have reported that they have been unable to maintain safer sex practices after getting high.

• Good nutrition, lots of rest, exercise and nonabuse of alcohol and other drugs may help you fight all illnesses, including AIDS.

Intravenous Drug Use

• **Don't share works** (needles, syringes, droppers, spoons, cottons or cookers)!

• If you must share or re-use works, clean them before and after **each** injection as follows: dip needle and works into bleach, draw up and release three times, dip needle and works into fresh water, draw up and release three times. In an emergency, rubbing alcohol or vodka can be used instead of bleach. Or you can boil works that aren't plastic in water for at least 15 minutes. (Use a fresh solution each time you clean your works.)

Resource phone numbers

National AIDS Hotline: 1 (800) 342-7514
AIDS Action Committee (AAC) Boston: 1 (800) 235-2331
Latino AIDS Hotline (bilingual), Boston: (617) 262-7248
AIDS Action Committee (AAC) IV Drug Use Taskforce, Boston: (617) 437-4200
Gay Men's Health Crisis (GMHC), New York: (212) 807-6655
National Minority AIDS Council (NMAC), Washington, D.C.: (202) 544-1076
Women's AIDS Network, San Francisco: (415) 864-4376

July 13, 1991
GCN

HINDSIGHTS

Gilbert Serrano is a former prisoner who is living with AIDS. Serrano discovered that he was HIV-positive while in prison and immediately became involved as an AIDS educator and peer counselor. Now back out on the streets, Serrano has been working tirelessly on behalf of prisoners with AIDS with organizations like the Prison Issues Committee of ACT UP/New York and the Correctional Association of New York. Serrano, who is the author of Inmate to Inmate, an excellent AIDS education brochure, has much to offer the AIDS activist movement. He recently spoke at a program in Washington, D.C. sponsored by the ACLU National Prison Project. The following text is based on that speech.

—Judy Greenspan, ACLU National Prison Project

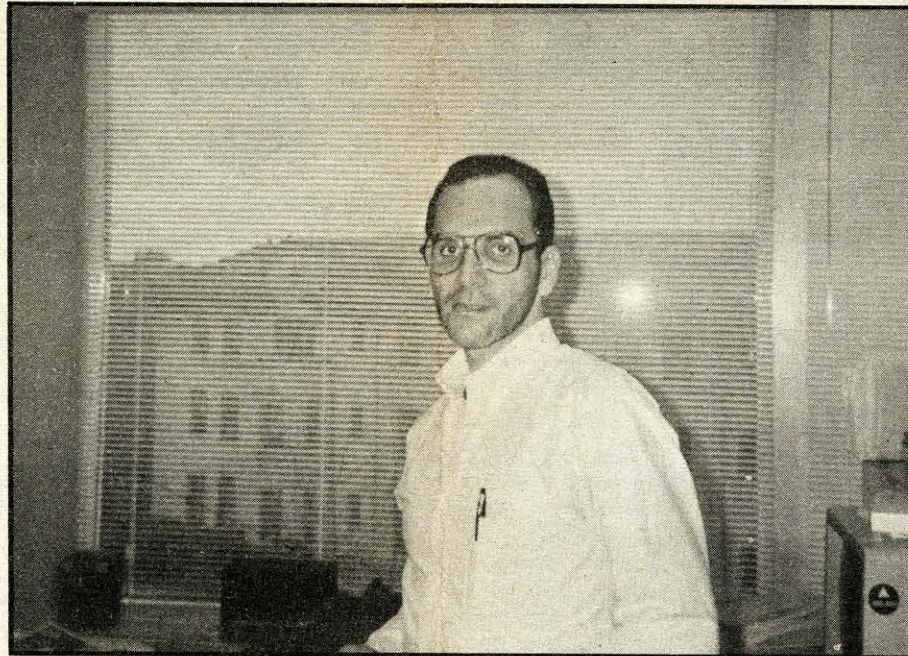
By Gil Serrano

I don't consider myself a radical. I really don't even consider myself an advocate. I guess maybe my Christian upbringing makes this my mission. Seven months after I graduated, my mother died and they told me my wife had cancer and I just fell apart. I started using drugs and that led to crime and consequently ten-twenty years in prison. While in prison for 9 1/2 years, I had never been sick. Six months prior to seeing the parole board, I had an infection in my mouth and I went down to the infirmary. The nurse took one look, reared back and said, "Oh my god, what's that?" Then I was ushered in to see a physician's assistant. He started mumbling and I caught the words, "immune system" and I knew enough. So I asked him, "Are you trying to tell me I have AIDS?" He said yes. It was a Friday at about 3:30. He had to go home and there was no one in the prison who could even give me a sense of what was going on.

Many of us feel that this will not touch us so we don't invest too much time on it. Then, when it does touch us, we are in a fog. This happened to me. It was a very horrific experience. Here I had survived ten years of prison, five in Clinton, which is a super-max joint near the Canadian border. I survived all this, had six months to the parole board and now I get told that I have the virus. I've read a lot of material through the ACLU and other organizations in New York, and I've learned that things are really bad all over. I wouldn't want to take exception and say that New York has the worst scenario. But the attitude

AIDS is where you find it

Including prisoners in designing programs to deal with the epidemic



Gilbert Serrano

overall [in the system] is a refusal to deal with this because one, the economic ramifications are too great (that's usually at the top of the list); and two, in effect we will be opening up a tremendous can of worms that even people on the outside are not ready to deal with.

Doing AIDS work is not something novel like a fad where things just come into vogue, and now we are going to get behind the AIDS movement and next summer it will be gone because it lost its pizzazz. But unless we hang in there tenaciously, that's exactly what will happen. It will fade. Well, we can't get any farther on the back burner. Right now we're in the oven. I'm serious.

The friend I stayed with in Washington, D.C., took me to her church. After the service, they have different working

groups—prisons, AIDS, homeless—groups like that. So I said to her, "You have a prison group here?" She said yeah. Well, they are very proud of the groups that they have and all that they do. I said, "Does the prison group get together with the AIDS group?" She said, "No, we never get together with them." I said okay.

So, I went into the AIDS meeting. After the meeting, I went to the chairperson and said, "I understand you have a prison group here at this church."

"Yes, we've been running it for about five years."

I said, "But you've never worked with them?" Fortunately, I didn't have to go any further because as I was talking it dawned on her and she felt really bad. Five years these groups have been running and not once did

anyone think of saying, "How about going to the prison group?" Hey, AIDS is where you find it. So, they are investing all this time and energy—which is great—but somehow or another they forgot about the people behind the wall.

I went to a conference up in Albany, New York. It was supposed to be a real big shindig to try to convince the state legislators about not slashing the AIDS budget. On the proposal being tendered by the organization that hosted this affair, they asked for \$1.5 million for prison. There were close to 600 people up there. I was trying to find someone who was going to be the spokesperson or coordinator for prisoners with AIDS. I mean, after all, you are proposing \$1.5 million. Well, the truth is, I couldn't find anyone. It was on their agenda but there was no one to try to convince the legislature about the need for this. So, I made myself a spokesperson. I took a tag and wrote, "Gilbert Serrano, Prisoners with AIDS Project," and I said that I represented prisoners with AIDS in the state of New York. The message that I left with them is that we have to deal with this. The time of philosophical discussion, intrigue and planning is long past. Now the doing has got to take place.

Let's get busy. Whether it's on the legislative side, the advocacy side or the civil disobedience side. The message I left with the assembly people was that, "Either you deal with us now while, in truth, we are a captive audience and receptive to what you will bring to us because we are so desperately in need, or you'll have to deal with us when we come out. None of us is doing natural life and through the miracle of poisons like AZT, a lot of us are living much longer. So you will have to face us eventually. The point is that in there—because we are in such desperate need of intervention—we will listen and we will come and hear what you have to say. Maybe we will even interpret it as a fact that you believe and care about us. And that will be enough motivation for us to open up our hearts and take down the chains and walls that we've built because of where we are."

Once I came out here I got to go hustle for a job and a house and this and that. I ain't got time to be going to no meetings. We all have different agendas and we all think about what's important, what can we do.

Some agendas speak about the medical

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AIDS

Continued from back page

parole bill that would allow early release for terminally ill prisoners. I said to the person who was trying to sell this, that in New York a lot of us would be better off in prison. I know this sounds crazy because you read all the stuff about how people die twice as fast in prison and people are just dying to get out.

The logic behind this statement is this: had I been told when I was in prison, especially when I was at Clinton, that we've got a group out here and we're doing everything possible to get you out, I would have said, "Well, put me down on that list." Basically because I didn't have a reference, I was just going by what was in prison. That was horrible. Well, now I'm out and the horror hasn't stopped. As a matter of fact, if it weren't for the grace of god and members of my family and friends, I don't think I would have been able to survive coming out. You are struggling to get out individuals and you have nothing out here for them. What will people become, homeless people with HIV and AIDS? There are no entitlements in place. The paroled people don't know what the hell is going on and yet we're killing ourselves to get people out and tear down the wall. It's frightening because you can put us from the pan to the fire.

So, once you have accomplished what you are trying to do, well, then your work has just begun. It's not just a question of bringing this to the forefront and letting people know the horror that happens behind the walls. Eventually these individuals are coming out and they need support.

Of course, I don't mean that each organization should sponsor an inmate to their house. That's not what I'm talking about. A lot of organizations have the resources and the power to do great things. But just like I said to the woman at the church, Have you ever thought of working with the prison group? A lot of the agendas developed—even by the so-called experts—are so far afield of the population that they intend to help.

I have an incurable disease and I'm trying to fight to stay alive and the more infighting there is, the less chance I have. I can't do it by myself and I need help. The only way we are going to do it is by working together.

I'm not a statistician. I can't tell you how many people are dying in prison but I've seen them. I worked in the AIDS hospital, which is what they call the special unit for individuals who can no longer function in population. I saw a lot of my friends die. I'm not a doctor but I can tell you this, for a lot of people who died it wasn't just the virus. It was the indifference and just giving up on life because nobody cared. And if people keep telling you that you're going to die, why should you fight it?

The fact is that the individuals who were dying didn't have anything to come out here to anyway. So where's the incentive or the will to live? That's a population that for the most part doesn't have families, and you know the reactions out here, well, imagine them in there. We are talking about an overwhelming population of Black and Hispanic people, so now you have a cultural influence and all that stuff and the attitude of "Oh my god, he was a homosexual," or whatever.

The only way that we will fight to stay alive is with help. I'm out here on the frontline but without you, my support services, I'm dead. Now, I'm willing to get beat up and I'm willing to get shot from one prison to another because of what I'm trying to do. But don't make me promises and then, when the shit hits the fan, you're nowhere to be found. When you develop all these strategies and whatnot on intervention—whether it's through the legislature or through ACT UP—remember that I will pay the consequences of your actions.

The idea is that the strategies that we develop have to be geared toward the population that we are actually trying to help. It took the governor of the state of New York ten years to give a pardon to one individual with AIDS. Every day inmates are dying. What we need in prison is immediate outreach intervention. We need individuals out here to begin finding ways, either individually or through groups, to breach that wall. We need community organizations to come in and provide the services that the system won't. We need comprehensive AIDS education programs in prison. There are a lot of dedicated brothers [and sisters] that are really ready to go the Attica way. That's as strong as it is.

But not everyone is creative enough or has the ingenuity to put this together, present it to an administration and say, "Look, this is what we have in mind." It takes a lot of guts

to go before an administration and introduce something that will change the basic fabric of that prison. But you're not going to change one atom of this atmosphere when it has no type of outside support. If there's any excuse for them to step on you, they will.

Well, after I was told that I was HIV positive—after the initial shock that lasted about two weeks—I said, "Hey, I'm not giving up, I've always been a fighter." My motto became *get busy*. Once the word got out that I was involved with this, because I was so respected in the prison as a no-nonsense individual and had been doing time since the 60s, inmates would come to me and ask to talk. Our so-called HIV counselors—who are really just correctional officers who have become counselors—don't have the time and you know all the excuses. Not one of the five pre- and post- test counselors spoke Spanish. So, I collected a lot of information. This was all underground and before I thought about approaching the administration. I felt that we needed to develop an HIV support group but not a gripe group. It came together and was very successful. It became so big that the administration began to put obstacles in the way.

The fact is, especially for people of color, I say that we are facing cultural and ethnic extinction. Again, I'm not a statistician but it's very plain for all of us people of color that the numbers just don't jive. White people in the United States make up about 75 percent of the population. But, out of all the women who are HIV-positive, three out of five are Hispanic. That's almost every other woman. We don't have the numbers to work with something like that.

When I created the *Inmate to Inmate* brochure, I sent it to Bedford and Taconic, the principal women's prisons in New York. They loved it and the senior correctional counselors got in touch with me. One of them said that eight out of ten women at Taconic are HIV-positive. No one deserves this, no one. We didn't ask for this and we really didn't know. You've read the papers, the greatest proportion of people being infected are women and children. People of color have no future without women and children.

I hope I have given everybody some food for thought. Without concerned people around the country, people on the inside would have no support. We have no voice in prison. They are our voice and they are so very important to us. All I'm saying is, "Next time you're ready to speak up, please check with me first so at least I'll be prepared. I might be able to provide you with some insights that you overlooked." □

since then mandating ways to restrain prisoners who resist, "in an appropriate manner." The ACLU, MAP and ACT UP/Madison have called for the investigation to be reopened.

The three groups are also calling for the compassionate early release for prisoners with AIDS, identifying Waupun PWA Roger Hillman as an ideal candidate, partially because his severe diabetes complicates treatment for his AIDS related conditions.

Peanut butter and jelly 'supplements'

Hillman's diet has been the subject of controversy. While state officials claim he is receiving appropriate dietary supplements, prison and AIDS advocates say the food he is receiving—which includes a daily "supplement" of a peanut butter and jelly sandwich—is grossly inadequate and even dangerous to his health. "According to Roger, they're giving him food that will kill him," said Greenspan, referring to his diabetic condition and the sugar-filled sandwiches. While diet is a concern for all prison inmates, Greenspan noted, it becomes absolutely critical for those who have AIDS.

Hillman's diabetes complicates his treatment in other ways as well, because he cannot tolerate AZT—the only AIDS-treatment drug available to prisoners. "He has severe side-effects from AZT," said ACT UP's Junikka, adding that Hillman has to take the drug sometimes anyway when his T-cell count becomes dangerously low, since nothing else is available to him as a prisoner.

The ACLU's Greenspan said that forcing the state to make experimental drugs available to prisoners is a top priority, along with providing AIDS education to all prisoners and prison guards and upgrading prison medical facilities. "Prisoners with AIDS do not get the type of daily care they need," she said.

David Clarenbach, a state representative from Madison who last year sponsored the successful "Bill of Rights for PWAs and People with HIV," said the state is "violating the letter and the spirit of the law" in its treatment of prisoners with HIV/AIDS. He said the law was "intended to prevent the kind of mistreatment that the Department of Corrections is engaged in," such as subjecting HIV-positive prisoners to humiliation, loss of dignity and low standards of care. He emphasized that demanding the governor implement the recommendations of his own task force is not a radical gesture and denounced "the cavalier attitude with which the administration is responding to ACT UP's demands."

Members of ACT UP/Madison have been a daily presence at the state capitol, delivering symbolic peanut butter and jelly sandwiches and towels to Thompson's office. In addition, they held a march and a die-in outside the state DOC July 1, protesting the treatment of prisoners with AIDS.

Nelson of MAP stressed the importance of education in the prison system, calling for "culturally sensitive HIV education for inmates, staff and parole agents." Another need, he said, is on-going counseling opportunities for HIV-positive inmates. "Seventy-five percent of inmates with HIV are released back to their communities within five years," he said. "There's an opportunity to really make an impact on AIDS prevention."

—filed from Boston

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FOR EIGHTEEN YEARS, THE LESBIAN AND GAY WEEKLY

AIDS death sparks outcry in Wisconsin

Prisoner and AIDS rights activists intensify pressure on the governor and his Department of Corrections following the 'negligent' treatment of a dying prisoner with AIDS

By Dawn Schmitz

WAUPUN, Wis.—In the wake of another suspicious AIDS death in a Wisconsin prison, activists in the state have intensified their pressure on the governor and the state Department of Corrections (DOC) to improve the treatment of prisoners with AIDS. Ricardo Thomas died on June 27 at the University of Wisconsin Hospital, six hours after being transferred there from Waupun Prison.

Doug Nelson, executive director of the Milwaukee AIDS Project (MAP), told GCN he feels the prison acted negligently. "I don't have much faith at all in [the DOC's] ability to provide appropriate care for a PWA," he said. "To send someone to the hospital the day they're dying—to me, that's inappropriate care."

In a statement, ACT UP/Madison called for an investigation into Thomas' death, accusing the DOC of holding Thomas at the prison until he was near death, then transferring him to a hospital in order to avoid an investigation. According to Jari Junikka of ACT UP/Madison, who learned of Thomas' death by phone from another prisoner at Waupun, "It was very clear he should have been taken [to the hospital] several days before."

The state does not plan an investigation, according to Julie Hertel, Gov. Tommy Thompson's deputy press secretary. She told GCN that Thomas' death "was not any fault of the Department of Corrections or the state of Wisconsin." Thomas had been at UW Hospital from May 15-30, at which time "he refused treatment." On May 31, she said, he was transferred back to Waupun and immediately given a court-appointed legal guardian.

Joe Slisowicz, DOC information officer, said Thomas "died under a physician's care... He was under care the entire time he was in the health services unit [at Waupun]."

When asked why Thomas was transferred to UW Hospital only after his condition had significantly deteriorated, Slisowicz responded that that decision was made by Waupun staff in communication with the hospital. According to ACT UP's Junikka, Thomas—who was suffering from dementia—was being held in isolation at the prison and receiving grossly inadequate care.

Even before Thomas' death, Wisconsin AIDS advocates had begun putting pressure on the DOC and Thompson to improve the treatment and conditions of PWAs in prison, calling for the governor to implement recommendations made by his appointed HIV/AIDS Technical Advisory Committee, which had issued a report in May, 1990. While the DOC says it has implemented 17 of the 25 recommendations, members of many organizations—including ACT UP, the Milwaukee AIDS Project, the American Civil Liberties Union and the Wisconsin legislature—say the state has yet to put into practice many of the most important ones.

The activists are calling for the prison

system to comply with task force recommendations that it halt practices that reveal a prisoner's HIV status—single-celling, imposing work restrictions, and marking prisoners' identification cards with a code that stands for "blood-born illness." The task force report states that the latter practice "should be abolished since there is no medical indication for this practice and since it places such inmates at an unreasonable risk for discrimination."

Hertel of the governor's office stated that marking identification cards continues because it is demanded by the prison guard union. Stopping single-celling HIV-positive inmates "could pose a security risk for the prison overall." When asked about the details of such a risk, Hertel stated that HIV-positive persons were not considered a risk as such, but despite adequate AIDS education in prison, "obviously there could be some who don't take that education to heart." Hertel said she didn't know why lifting work restrictions was opposed by the DOC.

When asked about the DOC's position on keeping prisoners' HIV statuses confidential, Slisowicz stated, "They do come in and fraternize and generally speaking it's very difficult to keep a secret in prison." In a general statement about the treatment of prisoners with HIV, he said, "They're not in there because they're HIV-positive, they're in there because they're criminals."

An earlier death

Another PWA at Waupun, Donald Woods, suffocated to death on Sept. 8 of last year when prison guards in full riot gear—boots, gloves and facemasks—forcibly restrained him and placed or shoved a towel in his mouth in an effort, the guards said, to prevent contracting HIV. He was placed in isolation, stripped and fully restrained.

A special prosecutor who investigated the death found no wrongdoing, stating in part that the "placing of a towel around the mouth of Mr. Woods was not an unreasonable response to his attempt to bite and spit at institution staff" because their fear of contracting HIV was reasonable under the circumstances. The prosecutor, Royce A. Finne, also speculated that Woods may not have died immediately as a direct result of suffocation, disregarding an autopsy report which produced evidence that Woods died quickly.

"Donald Woods was an outspoken person—he sued the Wisconsin system for breach of confidentiality and won," said Judy Greenspan, AIDS information coordinator for the ACLU National Prison Project. She cited a 1988 precedent-setting case initiated when a member of the prison medical staff disclosed Woods' HIV status. "When you see the system, you're marked," Greenspan said.

Hertel said that although the "thorough" investigation into Woods' death found no fault on the part of the guards, recommendations have been implemented

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RECOVERY

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press

AIDS LATEST TRAGEDY



VJR photo

by Martha Sheehan

This is the last in a three-part series on recovery and criminal justice.

If you are not living with AIDS or a positive HIV identification, you might not think about this disease until you read a sad or shocking story about it. If you are a Person With AIDS (a PWA), it will be the first thing that comes into your consciousness every morning when you wake up. You may see your doctor frequently, you might go to meetings for PWAs, you could be surrounded by a strong support group of family and friends and you have the option of being counseled at an agency that has been established to help individuals who are HIV+ or have AIDS. If, however, you are a PWA who is incarcerated, you may have a long wait to see a physician, you may be manacled to your bed when you are admitted to the medical clinic affiliated with your facility, you may or may not have some cursory counseling or education about your disease. You may not receive medication on a regular basis: if you do, there is still the possibility that in being transferred from one facility to

another, your medication will be interrupted and you could ultimately end up in a facility that does not have your medication available. These "may or may not" situations are dreary at best. When this population is provided medication in jail, they are taking drugs with terrible side effects that render the person ill and in need of supplemental prescriptions. Upon release from jail, they will have to face a lifetime of dependence on health care in addition to dealing with the emotional ramifications of being, not only an ex-offender, but a PWA. AIDS is a disease that makes its victims feel particularly frightened and powerless; and for an incarcerated individual who has been rendered powerless to begin with, it is a double dose of frustration. But of all the forebodings associated with AIDS, the most dreadful is the impending threat of death. And if you are in jail with AIDS, you could die — die alone handcuffed to a bed in a prison hospital.

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on the Mean Streets

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Publisher's Notes

by Victor J. Rugg

Thank you. It is because of our loyal readers and advertisers that Recovery Press is taking a giant step forward. Starting with this issue, Recovery Press will be on every newstand in New York City. As you can see we have a new banner, added color and upgraded the paper we print on. As I promised you months ago, Recovery Press will grow to meet the needs of our supporters. The editorial side of the paper continues to grow and refine itself month after month. With this issue we have added an article that addresses financial matters in recovery. We will be including more departments and features in the upcoming months. Our advertisers are pleased to see our new format and we are sure our readers will like it also. I can promise you that Recovery Press will continue to be the leader and innovator in the months and years to follow.

This month's story is about AIDS. Those of us who have worked on this problem for the last few years remember when the government wouldn't do anything about it. It was considered a political "hot potato". When Reagan was president, he did nothing for a long time. Many local politicians followed suit. The word on the street was that it is a gay problem. I don't have to waste your time here on what was said. It's always been my firm belief that if a person is sick that person needs help regardless of their orientation and origin. Well, now it has caught up with us. Magic Johnson has AIDS. Washington's answer to Magic's problem is that it is a great photo opportunity, so they put Magic in front of the camera with George Bush to make it appear as if they are doing something.

Come on Washington, wake up please. There are people dying out there. What did Desert Storm do? I remember just before the war social issues were being written about all the time. It looks like the storm came and went and took all our social problems with it. At least that's what Washington is hoping and continues to hope for. Yes, we have money problems in this country and yes, they are very

serious. Bouncing checks and taking trips all over the world shows a Congress out of control. How can we expect them to buckle down to the problem of AIDS, alcohol and drugs? It's no wonder the problem is so out of hand.

In New York, Assemblyman Daniel Feldman is doing what he can to address the problem. Three years ago, he proposed a piece of legislation that would permit terminally ill AIDS patients to be released from correctional facilities to die in dignity at home or in a hospital. The cost of treating these individuals in the prison setting is astronomical; if released, the cost of care would be shared between federal and state programs and the full burden would be taken off the New York State taxpayers. Therefore, the bill would have both humane and financial benefits. We support Mr. Feldman's Medical Parole Bill. This bill not only is humane but it can save the taxpayers a lot of money. But this is not enough.

When do we wake up and realize that AIDS is being spread like wild fire through the heterosexual community? Latest reports show that in the gay community, it has started to slow down. Even heroin addicts are getting shifted from needles to smoking and snorting. Today if you are not practicing safe sex you are playing with a loaded gun. We need more education programs, not only dealing with safe sex but they must also deal with substance abuse. Recently a new TV ad has been aired showing a couple in the back seat of a car. First you think the narrator is talking about drinking and driving. Later you find out he is talking about substance abuse and sex. The point is well taken. If you take mind altering substances and then get involved in sex, your chances of getting AIDS and other diseases are greatly increased.

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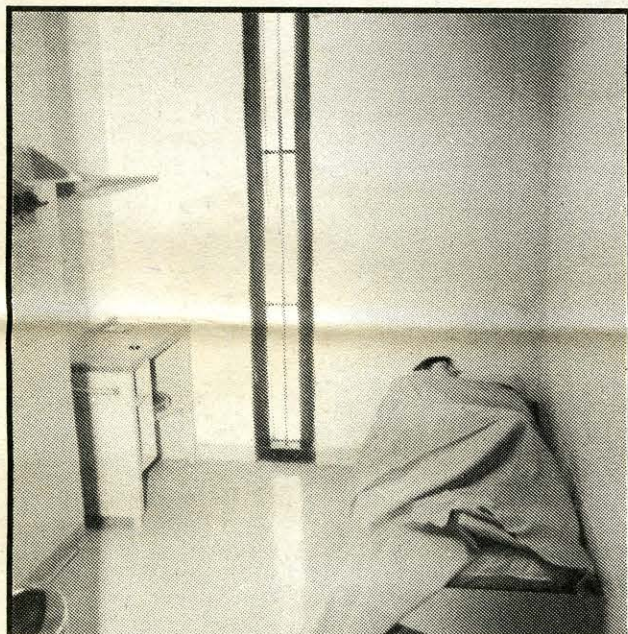
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Cover Story

"AIDS", continued from cover

Loss of Life and Hope

Last year a distraught father wrote to the Long Island Association for AIDS Care, Inc. (LIAAC) with a plea for help and intervention in the case of his son who was terminally ill with AIDS in a Louisiana prison. He was working with the prison authorities in Louisiana to have his 22-year-old son sent home to die. The jail officials were in agreement, however, the police in the boy's Long Island home town were unwilling to accept the responsibility of the boy's return. In a letter to LIAAC, the father wrote, "My son's weight is down to 90 pounds; he is nothing but skin and bones and in much pain." Despite the boy's feeble and emaciated condition, the Long Island police officials were reticent; there is presently no mechanism within the State that allows a prisoner to be released from jail to go home — for any reason, not even to die. One month after his first correspondence with LIAAC, the father contacted them again: "This letter is being written from the hallway of the (correctional facility) where I am going to view the remains of my son."



"These are individuals who are too ill to constitute a threat to society."

- Assemblyman Daniel Feldman

VJR photo

Jeffery Reynolds, a case management worker at LIAAC, keeps this letter in a heavy file with other mail from concerned prisoners with AIDS and HIV. Reynolds has seen some of the conditions under which prisoners are "treated" for AIDS. "In one facility," said Reynolds, "we have seen prisoners shackled to the bed. People who are really ill — I'm talking DAYS in terms of life span. One or two corrections officers will be outside the door who sit there, on over time, and watch TV — to keep an eye on the prisoner. Not all persons with AIDS and HIV+ require hospitalization, but they have very specific needs, needs that are not being addressed at this time in most prisons. "Prison officials don't want to deal with this," said Reynolds. "They have enough to deal with: budget cuts, substance use issues. But the reality is that it IS in the jails and it HAS to be dealt with. If not, it is going to spread in the jails and people are going to get sick and die quicker. It is just not being addressed." According to Reynolds, prison officials do not see inmates as

being at risk to contract AIDS. "I think that officials go on the premise that people don't share needles in jail, that there are no drugs in jail, that people don't have sex in jail when clearly they do, be it forced or otherwise," Reynolds stated. "Prisoners are engaging in sexual activities in jail with no access to condoms whatsoever." Reynolds related that attempts LIAAC has made to involve prison authorities in condom distribution programs has met with rejection because officials claim that inmates are not supposed to have sexual relations while incarcerated. "We have met with officials ad nauseam," said Reynolds. "I don't know what else we can do to drive home the point that HIV infection is a real big problem."

Last month a forum was held in New York City to address some of the problems associated with HIV and AIDS in the prison setting. Sponsored by the Alliance for Inmates with AIDS, it was well attended by a number of concerned agencies, community members and former inmates. Throughout the open microphone period in the morning, there were many emotional appeals on the part of the attendees regarding the need for immediately addressing this problem in the prison system. Nancy Mahon, Director of the AIDS in Prison Project for the Correctional Association of New York and the coordinator of the forum, thinks there is a head-in-the-sand attitude on the part of many prison officials about the spread of HIV and AIDS behind prison walls. "The rules are that high risk behavior is prohibited," said Mahon. "The reality is that they are occurring. There is sex and intravenous drug use going on." According to Mahon, attempts at distributing condoms and bleach to clean intravenous drug works have been foiled by officials in Upstate prisons. The Correctional Association is attempting to generate some literature to

distribute in the jails on the importance of safe sex and clean IV drug works. Although they are in no way promoting these activities, they feel that it is more sound reasoning to accept that the problems are going on than to deny them and see the perpetuation of AIDS. Said Mahon, "Our advice is that if you are going to abuse substances, open a condom first before you get high. Whether in or out of prison, people do things when they are high that they wouldn't ordinarily do."

Class Action on AIDS

LIAAC receives at least one letter a week from a PWA in jail. Recently, a letter arrived with 27 signatures from inmates saying they have no access to information on AIDS, no medical care, that their confidentiality is being violated, that they are being verbally harassed. Some claim they are afraid to take their medication because other inmates may identify it as being prescribed for AIDS and they would be stigmatized and badgered. In May of 1990, a group of inmates diagnosed HIV+ filed

a suit against the Governor and various prison officials. Their grievances included: Denial of medical treatment, denial of mental health services, denial of education and preventive services and breach of confidentiality. This is not a monetary suit but one that claims the constitutional rights of HIV+ prisoners have been violated and seeks to have services provided for these individuals during their incarceration. Although these prisoners might be receiving medication and will be hospitalized if they become ill, they are in need of support services and programs to be set up for their care after release. No decision has been made yet in this case, and for the terminally ill patient who faces death in jail, time is running out.

Legislation Pending

In March of 1989, a bill was introduced in the New York State Assembly that would provide for the parole of a person in jail who has been determined incurably ill from AIDS and facing imminent death. Referred to as the Medical Parole Bill, it specifically outlines provisions for the parole: The release will only be granted after an appointed board is satisfied that the parolee is too ill to jeopardize public safety and will not "deprecate the seriousness of the crime [for which they are incarcerated] as to undermine respect for the law." Assemblyman Daniel Feldman (D - Brooklyn) originally introduced this legislation and remains one of the most staunch supporters. "The principle is straight forward," stated Feldman who is the Chairman of the New York Assembly Committee on Corrections. "These are individuals who are too ill to constitute a threat to society. It's a tough standard: they aren't sharing needles and having sex. I feel they should be permitted to die outside of prison. I am by no means a knee jerk liberal," he continued, "but if a person can't move, is wasted away, has lost 75% of muscle mass, can't lift a needle, I don't feel they pose a danger to society."

In addition to the obvious humanitarian issue of dying with dignity in a hospital, hospice or home environment, Feldman cites the financial logic behind the bill. It costs between \$20,000 and \$40,000 per year to treat a seriously ill AIDS patient in jail — and this is ON TOP of the usual incarceration price tag of about \$40,000 per year. Since 1981, over 1,000 prisoners have died of AIDS in jail. Last year alone, over 200 died of the disease while in the custody of the New York State Department of Corrections. Pres-

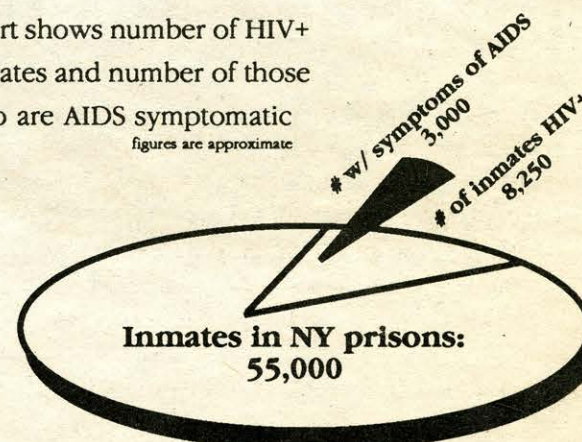
Number of deaths from AIDS in prison:

1991 - over 203
1990 - 175
1986 to 1989 - 557

the terminally ill AIDS inmate, if released, would have 50% of his care paid for by Medicaid, thereby relieving the State of one-half of the medical expenses. According to Feldman, there are hundreds of terminally ill AIDS victims in jail and the cost savings to the State would be between \$1 and 2 million per year if these individuals were paroled. The point of fiscal feasibility is what Feldman hopes will persuade the skeptics in the Senate. The bill has met with opposition because legislators fear they would become politically unpopular if they supported a bill that lets criminals out of jail. Feldman also feels strongly that some constituents are enthusiastic about having jails in their region because these facilities provide jobs for local residents and income for the community when families come to visit incarcerated relatives and friends. "We are filling up our jails with people who are essentially addicts who do not fit the criminal profile," Feldman stated firmly. "The criminal justice approach to drug abuse is wasteful and inefficient. But there are political and economic interests in ensuring a steady stream of inmates because of the economic benefit for certain regions. That might be good for East Overlook, but it's not good for the State of New York." Feldman said he sees an "ever increasing pool of people not paying taxes (inmates) being supported by an ever shrinking pool of people who do", which does nothing to help a staggering economy. Feldman supports the decriminalization of drug abuse which he feels would ease the overcrowding of prisons by channelling substance abusers into programs rather than penitentiaries. He feels such measures and such legislation as the Medical Parole Bill would save countless millions in the dark red New York State budget.

continued on page 23

Chart shows number of HIV+ inmates and number of those who are AIDS symptomatic
figures are approximate



"AIDS", from page 4

The Onus of Death

The dread of facing death from AIDS can only be truly understood by the victims of the disease. For the criminal justice client, this fear is likely to be compounded by substance abuse issues. Statistically, most individuals attached to the criminal justice system have some type of substance abuse problem. "I would say that

It costs between \$20,000 and \$40,000 per year to treat a seriously ill AIDS patient in jail — and this is ON TOP of the usual incarceration price tag of about \$40,000 per year.

most of the people in jail with AIDS have a direct connection to alcohol or addiction," said Therese Bertsch, Coordinator of the Alcohol/Chemical Dependency Program for LIAAC. "The addiction is the underpinning of the behavior which led them to act out anti-socially." LIAAC Alcohol/AIDS Case Manager Michael J. Engrassia agrees with this. "I believe there is a direct route between the way the virus is transmitted and substance abuse itself," he stated. "There are needles, of course, but also when the person is drinking, they are not able to make clear decisions and they put themselves at risk. There is definitely a hand-in-hand relationship between AIDS and substance abuse; people don't engage in safe sex, or they prostitute for drugs." Therese Bertsch went on to add that if an individual is in jail, is addicted and, furthermore has AIDS, they are facing remarkable recovery issues. "If you are looking at someone who in the

late stages of HIV," said Bertsch, "someone terminally in needing hospitalization, consider that if they are addicted, they probably haven't worked through a lot of issues. Now they are facing their death soon without being able to mend bridges and work through family issues." Bertsch pointed out that these are very critical needs for the ailing AIDS patient in jail, but there are special ramifications because of their environment. "AIDS is a health issue that affects the job of the warden, but his job is a much larger scope than that. People are already doing very difficult jobs (in criminal justice systems) and AIDS puts another stress on them. They need support and help." Bertsch suggests that if the Medical Parole bill is passed, there should be a board of community or county members determining the criteria for the continued care of the parolee. "Perhaps it could be made up of Health Department members, AIDS agencies and wardens; not in terms of watch dogging one another, but in terms of giving information." She feels that there is not a great deal of expertise in the treatment field addressing AIDS and addiction. "People aren't seeing the whole picture," she said. "and that is how you juxtapose the whole range of the medical needs of the AIDS patient with treatment for addiction."

As the problem of AIDS continues to grow in correctional facilities, there is no question that treatment models will need to be developed. The passage of the Medical Parole Bill could free up much needed funds to implement treatment programs for substance abuse and AIDS issues. The problem of substance abuse must be addressed in order to modify the original behavior that lead to AIDS and incarceration. When dealing with AIDS, whether in the prison setting or on the streets, there needs to be treatment for substance abuse. Therese Bertsch sees it in her work at LIAAC; in the gay and lesbian community, with adolescents who socialize around drinking and drug use, with runaways who come from dysfunctional households. "With AIDS," said Bertsch, "wherever you look, you will see addiction in the shadows." ■



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by Luis Alberto Agudo

Mis Queridos lectores,

Este mes vamos hablar sobre lo que podemos hacer si tenemos muchas tensiones o problemas que nos pueden dar el deseo para retornar a la bebida o la droga. Estas son sugerencias que le van ayudar se las emplean.

ONCE SUGERENCIAS QUE LE VAN AYUDAR CON SUS TENSIONES.

1. HABLE SOBRE LO QUE LE ESTA MOLESTANDO. Cuando algo le molesta, no se lo embotelle. Busque una persona con quien usted tiene confianza como su esposa o esposo, padre o madre, un buen amigo, su padrino y confie en esa persona lo que le esta molestando. El hablar le va aliviar su tension y le va ayudar a ver su preocupacion en una luz diferente para comprender lo que usted puede hacer sobre sus problemas.

2. ESCAPECE POR UN TIEMPO. A veces cuando cosas salen mal le va ayudar si escapa su problema doloroso por un tiempo. Puede perderse en un cine, un libro, un juego o un pequeño viaje para cambiar de ambiente. Si se queda en su problema y continúa a sufrir esto es una forma de castigo de si mismo y no va a resolver su problema. Es perfectamente realistico y saludable en escapar su problema por cierto tiempo para recuperar su balance. Pero esté preparado para regresar y tratar con su dificultad cuando usted este mas compuesto, y cuando usted y los otros envuelto estan en una mejor condicion emocional y intelectual para tratar con su problema.

3. RESUELVA SU IRA. Si usted siente que esta utilizando ira como un modo de comportamiento, recuerde que mientras ira te puede dar un sentido temporal de rectitud o

hasta de poder, generalmente te va a dejar en fin muy pesado. Si sientes que tienes que azotar en contra de alguien que te ha provocado, aguanta ese impulso por un tiempo. Espera hasta mañana. Mientras tanto haz algo constructivo con la energia que tienes acorralada. Haz alguna actividad fisica como trabajar en el jardin, limpieza de tu casa, carpinteria o un proyecto fisico que tengas en mente. Tambien puedes dar una caminata larga. Tratando de trabajar tu ira afuera de tu sistema por un dia o dos te va a dejar mejor preparado para manejar tus problemas inteligentemente y ventajosamente.

4. CEDA OCASIONALMENTE. Si frecuentemente te encuentras en argumentos con personas, y te sientes obstinado e insolente, recuerda que esa es la manera que niños que estan frustrados actuan. Mantenga su postura en lo que usted conoce que es recto, pero hazlo calmamente y con la concesión que lo que tu pensabas que era recto puede haber sido incorrecto. Y aunque tu tengas la razon, de vez en cuando es mejor para tu sistema cuando cedas. Si tu debes en cuando cedas vas a ver que otros van hacer lo mismo. El resultado de todo esto va hacer el alivio que vas a sentir con tus tensiones y el lograr una solucion practica para tu problema junto con un sentido de satisfacción y madurez como una persona.

5. HAZ ALGO PARA OTRAS PERSONAS. Si sientes que siempre estas preocupado por ti mismo, trata de hacer algo para otra persona. Vas ha encontrar que esto va a evaporar tus propias preocupaciones y mejor que esto te va ha dar un sentido de haber hecho algo bueno.

6. HAGA UNA COSA A LA VEZ. Para gente bajo mucha tension la carga ordinaria de trabajo puede parecer a veces insoportable. La carga aparece ser tan grande que es muy doloroso manejar cualquier parte de ella, hasta las mismas cosas de que necesidades tenemos que hacer. Cuando esto esta pasando recuerda que esto es transitorio y que usted puede sobre llevar esto. El modo mas seguro de hacer esto es tomar las tareas mas urgente, y trabajar con ellas una a la vez. Una vez que usted dispone de estas va a ver que las otras no son tan horrible al fin al cabo. Usted va estar en mejor balance personal y las otras tareas le van a ir mas facil.

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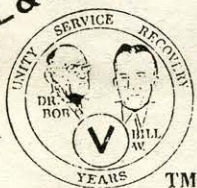


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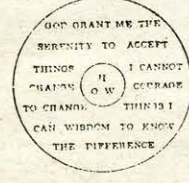
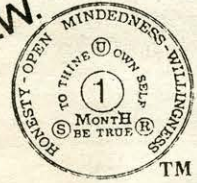
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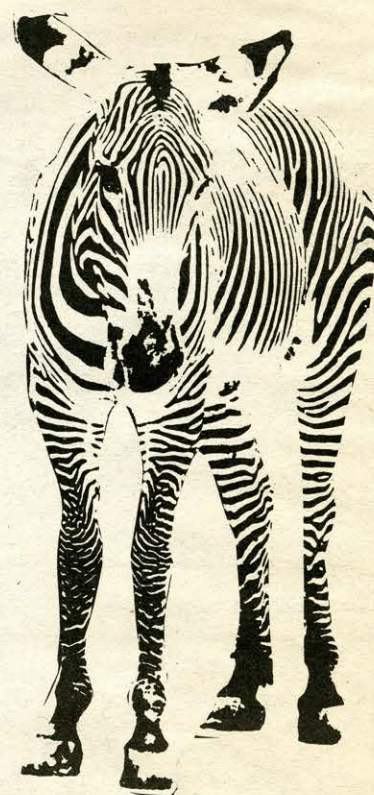
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U.S. Disease Control Centers Fault Prisons for Lack of AIDS Testing

ATLANTA, June 5 (AP) — Prisons have the highest rate of H.I.V. infection of any public institutions, yet only a fraction of the inmates are tested for the virus that causes AIDS or are taught about the virus, the Centers for Disease Control says.

"The correctional system provides excellent opportunities to reach persons at risk, or if they're already infected, prevent the spread to others," said Gary West, assistant deputy director of the Federal Centers for Disease Control's H.I.V. unit. "There are some good efforts out there, but it's obvious there's a lot more that needs to be done."

The agency reported Thursday that 50,000 of the nation's 4.3 million prison inmates were tested for AIDS last year, and that even fewer received education about acquired immune deficiency syndrome. Four percent of those tested had the human immunodeficiency virus.

Mr. West found 430 prisons in 42 states, the District of Columbia and Puerto Rico that tested inmates for AIDS. Most inmates who were tested volunteered, although some prisons have mandatory testing. Forty-eight other prisons provide AIDS education and programs about how to reduce the risk of acquiring the H.I.V.

Parolees Given Condoms

The District of Columbia, which has the nation's highest rate of AIDS, offers education about AIDS, including advice on how to reduce risks, to inmates at a prison for juveniles.

Palm Beach County, Fla., gives parolees condoms and information on how to clean needles used for injecting drugs. The virus is spread through blood from an infected person, which can occur from sharing hypodermic needles, as well as through sexual intercourse.

"It's hard to characterize success rates for any of these programs," Mr. West said. "But the programs report

that persons in correctional systems are very receptive to education and prevention services, so we need to strengthen that effort."

On Wednesday, Harvard University researchers estimated that at least 13 million people are infected with AIDS around the world and that as many as 120 million could be infected by 2000. Those estimates were sharply higher than previous estimates by the World Health Organization.

The Centers for Disease Control, in Atlanta, warned last year that prisons have a higher incidence of H.I.V. infection than any other public institutions. In a 1990 survey, 5.8 percent of prison inmates were found to be infected, compared with 5.3 percent for patients at drug treatment centers and 2.9 percent for patients at clinics for sexually transmitted diseases.

In contrast, less than one-half of 1 percent of first-time blood donors are infected.

The 1991 prison testing was not extensive enough to tell if the overall rate of AIDS in prisons had changed, "but it's high enough to demand more testing," Mr. West said. Most significant, he said, was that 67 percent of those who showed up for the prison testing identified themselves as intravenous drug users.

"They were just the ones who knew that injecting drugs was risky," Mr. West said. "That could account for the high rate we're seeing, but other inmates need to know how to prevent infection also."

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June 6 '92

Court Upholds Prison Policy On Separating AIDS Inmates

MONTGOMERY, Ala., Sept. 19 (AP)

— In what Alabama officials called a national test case, a Federal appeals court has upheld the state's policy of segregating prisoners who have the AIDS virus from the other inmates.

The ruling, issued Wednesday by a unanimous three-judge panel of the United States Court of Appeals for the 11th Circuit, in Atlanta, backed a lower court's finding that Alabama's policy was a reasonable response to prison behavior that might otherwise cause rapid spread of the disease.

The decision turned back a lawsuit filed by 150 infected prisoners who sought to overturn the policy.

Alabama prison officials contend that the prevalence of high-risk behavior behind bars, including drug use and homosexuality, makes it necessary for them to take steps to control the spread of AIDS. As a result, the state began testing all inmates for the AIDS virus in 1987. Those who test positive are segregated in special units at the Limestone Correctional Facility in northern Alabama and the Julia Tutwiler Prison for Women near Montgomery. About 180 of more than 16,000 state prisoners are now in these special units.

A 'Reasonable Infringement'

In its ruling, the appellate court panel held that given the state's interest in controlling AIDS, the segregation policy was a "reasonable infringement" on the rights of infected prisoners. And the panel agreed with the earlier decision, issued by a Federal district judge in Montgomery, in finding that the Alabama prison system gave adequate

medical care to those inmates.

But in another 3-to-0 vote, the judges ordered the district court to reassess another argument of the plaintiffs and arrive at a more complete finding of fact. That argument held that the state's policy had deprived the segregated inmates of equal access to prison educational and recreation programs and to legal assistance.

This part of the appeals court's ruling allowed the plaintiffs to claim a partial victory. "It's no longer as simple as locking them away and throwing away the key," said Alexa Freeman of the American Civil Liberties Union's National Prison Project, who represented the plaintiffs. Ms. Freeman said she was considering an appeal of the policy to the Supreme Court.

Morris Thigpen, the Alabama Prison Commissioner, called the fight over the suit a national test case. "I know there is a great deal of interest," he said. "I certainly have received questions from fellow commissioners in other states."

But Ms. Freeman said Alabama was out of step with most of the nation in its handling of inmates who test positive for the virus. She said that only Alabama and Mississippi still isolated infected inmates, that California and Colorado had begun reintegrating them and that the rest of the states had never had such a policy.

The ruling Wednesday was issued by Judges Peter T. Fay, who was appointed to the Federal bench by President Richard M. Nixon; Stanley F. Birch, appointed by President Bush, and Walter E. Hoffman, appointed by President Dwight D. Eisenhower.

NYT 9/20/91

Ex-Inmate Wins Award In Bias Case

Woman With AIDS Granted \$155,000

By RONALD SULLIVAN

A Buffalo woman with AIDS has been awarded \$155,000 for what a Federal judge said was the humiliating and improper treatment she received when she was in the Erie County jail on bad check and forgery charges.

The woman, Louise K. Nolley, was placed in a five-cell forensic unit usually reserved for mentally disturbed and suicidal inmates, forced to wear plastic gloves when she used a typewriter in the jail library and denied regular attendance at Roman Catholic services.

The prison also placed red stickers on all her belongings to indicate that she had AIDS.

In making the award last Thursday, Judge John T. Curtain of Federal District Court in Buffalo criticized John Dray, the superintendent of the Erie County Holding Center, for his "indefensible conduct" in placing the woman, who was judged to be "perfectly sane" in the forensic unit.

He also castigated Mr. Dray and other jail officials for placing the stickers on Ms. Nolley's belongings and records in violation of a New York State law that prohibits the disclosure that a person has tested positive for H.I.V., the virus that causes AIDS.

"There is no question," Judge Curtain said, "that the red-sticker policy was developed, not in response to contagious diseases in general, but specifically in response to the hysteria over H.I.V. and AIDS."

Against State Rules

Mr. Dray said yesterday that the red stickers were first used in the jail in 1986 when he said "AIDS became the epidemic that was terrorizing everybody in the business."

"I was only trying to protect the 13,000 inmates we have in our system every year," he said, adding that he and the county would appeal the award.

James L. Tuppen, an assistant Erie County counsel, said the practices cited by the court had all been changed since the judge originally found county officials liable for damages last October.

Judge Curtain said the practices applied to Ms. Nolley violated regulations adopted by the New York State Department of Correction Services in 1987 under which inmates who test H.I.V. positive cannot be isolated from the general prison population.

Ms. Nolley's lawyer, Jennifer Coleman, said Judge Curtain's ruling was the first in New York to award both compensatory and punitive damages for AIDS discrimination.

\$20,000 Punitive Award

"There are some other pending court cases of similar kinds of discrimination," Ms. Coleman said, "but as such cases go, the red stickers were pretty extreme."

The bulk of the award consisted of \$48,000 in compensatory damages against the county and nearly \$87,000 in lawyer's fees and court costs, but Judge Curtain also ordered Mr. Dray to pay \$20,000 in punitive damages.

Norman Siegel, executive director of the New York Civil Liberties Union, said: "We applaud Judge Curtain for his courageous and legally correct decision. It sends a strong message that such stigmatization will not be tolerated by the courts and that once and for all we must end this kind of hysteria."

Ms. Nolley, who is 38 years old, was jailed in 1988, 1989, and 1990 and released in March 1990. Her lawyer, Jennifer Coleman, said she is now in an advanced stage of AIDS and works as a community volunteer.

Ms. Coleman said she took Ms. Nolley's case at no charge because she is a member of the State Bar Association's special committee on AIDS. She said yesterday that she hoped the award would "compel people to act differently" when dealing with people with AIDS.

Court Rules On Prisoners With H.I.V.

SAN FRANCISCO, Nov. 5 (AP) — A Federal judge's ruling allowing prisoners infected with the virus that causes AIDS to serve food to other inmates has been overturned by a Federal appeals court, which said the health risks were slight but cited the authorities' fears of a prison riot.

Prison officials at the Vacaville penitentiary, formally known as the California Medical Facility, testified that "other inmates will perceive a threat regardless of scientific research or medical pronouncements," said the United States Court of Appeals for the Ninth Circuit, in San Francisco.

"If they have no assurance that the infected inmates are removed" from food service jobs, the court said, "there may be violent actions against the inmates with the virus, inmates they perceive to have the virus, or the staff that permits the perceived risk."

The unanimous ruling by a three-judge panel reversed a May 1993 order by Judge Lawrence K. Karlton of Federal district court in Sacramento, Calif., which allowed prisoners with H.I.V., the virus that causes AIDS, to work as food servers at Vacaville. The order was not enforced during the state's appeal.

About 450 of the prison's 3,200 inmates have the virus, said Tony Madden, a prison spokesman.

In an aspect of the case that was not appealed, the prison agreed in 1991 to allow H.I.V.-infected prisoners to be housed in the general prison population, except for inmates who had engaged in assaults or high-risk sexual behavior.

Matthew Coles, a lawyer with the American Civil Liberties Union, said the ruling barring H.I.V.-infected prisoners from working in the food service was "a serious setback for the rights of disabled prisoners."

Mr. Coles noted that the court had refused to apply to a prison setting a Federal law that forbids discrimination against the handicapped. Under that law, he said, the irrational fears or prejudice of others would not justify denying employment to the disabled that could be performed safely.

Instead, the court said it would follow the constitutional standard set by the Supreme Court in other prison disputes, deferring to the legitimate security concerns of prison officials.

The opinion, by Judge Procter Hug Jr., appointed by President Jimmy Carter in 1977, said that people outside prison walls who had irrational fears could choose to eat elsewhere, but that prisoners could not do so. In response to Mr. Coles's argument that the prison should educate inmates about the transmission of H.I.V., Judge Hug pointed to testimony by prison officials that "many members of the general prison population are not necessarily motivated by rational thought."

Mr. Coles said the prison had made the same predictions of "utter chaos" when first asked to end the segregation of H.I.V.-infected inmates, but eventually produced an educational program that had worked well. But on the issue of food service, "they scream 'irrational fear' and the court, sadly, has let them do it," he said.